Community Services Reimbursement Rate Commission

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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 financial condition of providers and 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) How incentives to provide quality of care can be built into a rate setting methodology; and

(V) The recommended methodologies for the calculation of rate update factors and the rate update factors recommended for the next succeeding fiscal year.

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 and October 1, 2005 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 7 years. Each year the Commission publishes an Annual Report on its activities, findings, and recommendations. This is the seventh 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) and further by House Bill 454 (2002). 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 Appendix B. 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.

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 Commission has designed a suitable system, and calculated the update factor that would result from its application.

- 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 data submission from the providers has substantially improved in the past year.

- 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

In considering the results reported here it should be kept in mind that our assessment of the financial condition of the providers is based on available data, which involves a lag of more than a year. The bulk of the psychiatric rehabilitation providers contracting with MHA appear to be in a stable financial situation. The majority of the providers contracting with DDA have a positive margin, but the mean margin dropped to about 1% in fiscal year 2001. A majority of the outpatient mental health clinics (OMHC) are losing money, and have 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, with further reduction expected for 2003. These effects will be somewhat mitigated by rate increases provided by MHA to some OMHC rates effective July 1, 2002.

In accordance with the legislative requirement to assess "the financial condition of providers and 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 Commission intends to maintain a close watch on the financial condition of the providers by obtaining updated information as soon as it becomes available, replicating the analyses reported here, and reporting the results in interim work papers.

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.

CSRRC Recommendations pertaining to MHA

1. The Governor should direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to implement the rate updates recommended by the Commission.

A systematic approach to adjusting rates for the reasonable impact of inflation and other factors is included in most national and state payment systems. As required by the legislature the Commission has prepared a paper suggesting a design for such a system, and quantifying the update factor. These recommendations should be implemented.

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, among other factors. 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.

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. MHA should continue to examine issues regarding individual rates or classes of services, and work to remedy these problems.

The change in rates developed through the updating system should be taken into account in the development of the MHA budget.

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.

2. Uncompensated care (both for clients with no insurance and for clients with inadequate insurance) and inadequate payments for Medicare and Medicare/Medicaid beneficiaries are of major concern. 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 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. Last year a bill to provide increased Medicaid payments for dual eligible beneficiaries failed in the legislature. However, this is an important issue and the legislature should reconsider increasing the level of payments for Medicare copayments for clients who are dually eligible for Medicaid and Medicare.

Uncompensated care is a growing problem for the providers, particularly with the reductions being made in gray zone eligibility. Uncompensated are occurs as a result of clients who have no insurance, and clients who have some health insurance, but that insurance either does not cover the services, or involves copayments and deductibles that the client is unable or unwilling to pay.

3. The legislature should reverse the requirement that MHA pay for gray zone services through grants or contracts and allow MHA to pay for such services through the fee-for-service system. The requirement that payments must be through grants or contracts is unduly restrictive and adds administrative complexity for both MHA and the providers.

The requirement that gray zone services may not be paid through the fee-for-service system requires that contracts be developed with all providers treating gray zone clients, however small the revenue involved. This provision is unlikely to save much money given that gray zone payments represent only 8% of the total MHA payments, and is burdensome for both MHA and the providers, particularly OMHCs that see a small number of gray zone clients. MHA should be allowed some flexibility in how they pay for services to gray zone clients. The providers are required to dummy bill in order that the services being provided can be tracked, and payments are reconciled with the dummy billings every couple of months. The interim payments were based on data for fiscal year 2001, and so can be substantially out of alignment with the services currently being provided.

Commission Recommendations pertaining to DDA

1. The Governor should direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to implement the rate updates recommended by the Commission.

In general the increases provided to DDA providers have often been tied to the cost of living increases provided to state workers and only have applied it to the wage and salary component of the provider costs. The providers have, thus, not been recompensed for inflation on other components of their costs. 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, among other factors. 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.

The community services budget of DDA was increased in fiscal years 1999, 2000, 2001 and 2002 partly for rate increases and partly because the number of people served has increased. 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.

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.

The change in rates developed through the updating system should be taken into account in the development of the DDA budget.

2. The legislature should preserve the additional funds to be provided to increase the wages and fringe benefits being paid to direct care workers.

The Commission's wage survey confirmed that the wage rates and the level of fringe benefits 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 and fringe benefits 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 and fringe

benefits being paid to direct care workers. The Commission believes that it is important to continue with the planned rate increases when quantified by DDA.

The Commission's most recent analysis of the financial condition of the providers shows a weak and deteriorating financial condition. The median margin dropped from about 3.2% in FY 2000 to about 0.7% in FY 2001. The providers have given wage increases in excess of the rate increases, and this has eroded their profit margin.

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
December 2, 2002
January 6, 2003
April 7, 2003
September 8, 2003
December 1, 2003

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

March 4, 2002
April 1, 2002
May 6, 2002
August 5, 2002
October 7, 2002
November 4, 2002
February 3, 2003
March 3, 2003
May 5, 2003
June 2, 2003
August 4, 2003
October 6, 2003
November 3, 2003

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 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 recommend update factors annually.

- The Commission will review the relationship between the changes in wages paid by providers the change in rates paid to providers by the Department and the sources of funds for the wage increases provided. 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, quality and outcomes, and rate structures.

- The Commission shall study the DDA high cost users and any proposed changes to the payment 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 January or February of each year to make them more useful for the legislative process.

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.

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, resource coordination/case management, behavioral support services, medical day care, transportation, community-supported living arrangements, residential alternative living units, and residential group homes. Approximately $399 million of the Developmental Disabilities Administration's (DDA) FY 2002 budget was for community programs and $65.9 million was for institutional services. Approximately $123 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 2002 are shown in Charts 2 to 5.

The principal current DDA payment system is the Fee Payment System (FPS). $239 million is paid out under the FPS. The balance of payments for community programs are made through grants and the CSLA payment system (approximately $33 million). 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 was completed 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 DDA 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 Commission has sponsored a paper on the measurement tools available, and the activities currently under way in Maryland, and this paper is attached as Appendix B-5 to this report.

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, 2001 and 2002, with similar conclusions. The latest report on the wage survey is attached as Appendix B-2.

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 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. However, in the 2002 legislative session the responsibilities of the Commission were expanded to include the design of an updating system, and a recommendation of the specific amount that rates should be updated. Because of the importance that the Commission assigns to this topic work was commenced on this project immediately, and the Commission has prepared a paper on the subject. This paper is attached as Appendix B-3.

On the second aspect of updating, 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 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.

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[1].

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. There have also been suggestions that AGC&T costs may vary with the intensity of the care requirements of the clients served. The Cost Report analysis the Commission is now undertaking should cast light on both these issues.

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 have 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

[1] 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.

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 continue to monitor the financial condition of the providers annually. The full impact of the new system on the financial condition of the providers was felt in FY 2002, and the Commission will be analyzing the audited financial reports for that year as soon as they become available, early in 2003.

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.

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, 2000 and 2001. 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 financial condition of the providers deteriorated substantially in fiscal year 2001, with a drop in the weighted mean operating margin to 0.4%, with 43% of the providers studied reporting negative margins. The Commission's report on these financial analyses is attached as Appendix B-1.

Relative performance measures of providers

The revised enabling legislation requires the Commission to use the data submitted in the Cost Reports to develop relative performance measures of providers. To this end the Commission staff have gathered the Cost Reports for about 60 providers for FY 2001, and have commenced reviewing that data and planning possible analyses. These data and analyses will be discussed with the DDA TAG. A more comprehensive analysis is planned using the data for FY 2002.

Turnover and wage levels

Based on input and advice from the Technical Advisory Group on DDA the Commission has designed a wage and turnover survey. This survey has been mailed to the providers annually. A report summarizing the results of these surveys is attached as Appendix B-2 to this Annual Report. The analysis of these survey responses has consistently showed that direct care workers

are paid substantially less than corresponding state workers, particularly when fringe benefits are taken into account. Turnover rates are around 50% for aides overall.

Wage rates of direct care workers increased about 8% between fiscal year 2001 and fiscal year 2002, substantially higher than the increase the providers received in their rates, but the wage rates are still well below the wage rates of comparable state positions. The major sources of the additional wages were the rate increase provided and a reduction in the operating margins of the providers.

Consumer safety costs

The 2002 enabling statute requires the assessment of the impact of consumer safety costs and whether the rates have been adjusted to provide for consumer safety costs. "Consumer safety costs" are defined to mean costs that are incurred by a provider for care that is provided to comply with any regulatory requirements in the staffing or manner of care, including: i) 24-hour awake supervision; and ii) other cost factors related to health and safety that are stated in the case plan required for an individual.

The Commission has started its consideration of this issue by a discussion in the DDA TAG of what these costs are, and whether any adjustment in rates has been made for them.

Future system

The Commission is currently working on responding to questions from DDA on the design of a special rate system for high cost users, and will continue to review changes to the FPS, and to the system used for augmentation grants, and will comment as appropriate.

Recommendations

1. The Governor should direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to implement the rate updates recommended by the Commission.

In general the increases provided to DDA providers have often been tied to the cost of living increases provided to state workers and only have applied it to the wage and salary component of the provider costs. The providers have, thus, not been recompensed for inflation on other components of their costs. 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, among other factors. 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.

The community services budget of DDA was increased in fiscal years 1999, 2000, 2001 and 2002 partly for rate increases and partly because the number of people served has increased. 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.

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.

The change in rates developed through the updating system should be taken into account in the development of the DDA budget.

2. The legislature should preserve the additional funds to be provided to increase the wages and fringe benefits being paid to direct care workers.

The Commission's wage survey confirmed that the wage rates and the level of fringe benefits 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 and fringe benefits 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 and fringe

benefits being paid to direct care workers. The Commission believes that it is important to continue with the planned rate increases when quantified by DDA.

The Commission's most recent analysis of the financial condition of the providers shows a weak and deteriorating financial condition. The median margin dropped from about 3.2% in FY 2000 to about 0.7% in FY 2001. The providers have given wage increases in excess of the rate increases, and this has eroded their profit margin.

- 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, 2001 and 2002. 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. Expenditures on psychiatric rehabilitation services have been growing particularly fast, more than doubling between 1998 and 2002.

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, and additional changes were made effective July 1, 2002.

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, as did a subsequent survey in 2000.

The Commission has prepared a paper on the measurement of quality and outcomes and this paper is attached as Appendix B-5 to this Annual Report.

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.

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.

Community Behavioral Health (CBH, formerly the Maryland Association of Psychiatric Support Services (MAPSS)) conducted studies of wage levels in 1998, 1999, 2000, 2001 and 2002 and summaries of the results have been included in prior Annual Reports. A summary of the results of the fiscal year 2002 study is attached as Appendix B-4 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 outpatient mental health clinics (OMHCs) are in very poor financial condition, with major losses. This problem is sufficiently widespread that it could result in access problems. This report was expanded based on additional information and was attached as Appendix C-1 to the February 2002 Annual 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.

In response to a legislative requirement, MHA is currently sponsoring a study on the adequacy of the rates paid for community services. This study will compare the rates for the individual procedures with the costs being incurred by providers to provide these procedures. A report is expected to be published in December 2002 summarizing the results of this study.

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.

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. However, in the 2002 legislative session the responsibilities of the Commission were expanded to include the design of an updating system, and a recommendation of the specific amount that rates should be updated. Because of the importance that the Commission assigns to this topic work was commenced on this project immediately, and the Commission has prepared a paper on the subject. This paper is attached as Appendix B-3.

On the second aspect of updating, MHA is currently funding a detailed cost study of providers to determine how rates are related to costs. A Commission staff person is serving on the Work Group for this project.

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.

CBH carried out wage surveys in the falls of 1999, 2000, and 2001. 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) was attached as Appendix C-3 to the February 2002 Annual 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 (PRPs) 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.

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 using billing data available under the new payment system.

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 Commission is in the process of collecting FY 2001 AFRs from the CSAs. While only about 20 have been received so far, preliminary analysis suggest that the financial condition in FY 2000 and FY 2001 is similar to that reported for 1999, but changes for the worse are expected in FY 2002 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. A rate update was provided effective July 1, 2002.

The survey of OMHCs discussed in the previous section showed that the providers responding were generally in very poor financial condition. A more recent survey performed by Community Behavioral Health (CBH) showed that the financial condition of the OMHCs continues to be poor, and a study of the public OMHCs commissioned by MHA showed their financial condition to be dire. A paper discussing all these results was attached as Appendix C-1 to the February 2002 Annual Report. 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. A more extensive analysis of the financial condition of the psychiatric rehabilitation providers is in process.

The MHA has experienced budget shortfalls in recent years. These shortfalls appear to have been due to an underestimate of the volume of services that was provided. In FY 2002, 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 is instructed in the new enabling legislation to work with MHA to expand the use of the billing data collected by MHP in order to evaluate performance. To that end Commission staff have had several discussions with MHA staff regarding the data being collected, and the reports currently being generated from these data.

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. However, the development of good quality review and outcome measures for behavioral health is still at the developmental stage.

Consumer safety costs

The 2002 enabling statute requires the assessment of the impact of consumer safety costs and whether the rates have been adjusted to provide for consumer safety costs. “Consumer safety costs” are defined to mean costs that are incurred by a provider for care that is provided to comply with any regulatory requirements in the staffing or manner of care, including: i) 24-hour awake supervision; and ii) other cost factors related to health and safety that are stated in the case plan required for an individual.

The Commission has started its consideration of this issue by a discussion in the MHA TAG of what these costs are, and whether any adjustment in rates has been made for them.

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[2] 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.

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

RECOMMENDATIONS

1. The Governor should direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to implement the rate updates recommended by the Commission.

A systematic approach to adjusting rates for the reasonable impact of inflation and other factors is included in most national and state payment systems. As required by the legislature the Commission has prepared a paper suggesting a design for such a system, and quantifying the update factor. These recommendations should be implemented.

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, among other factors. 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.

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. MHA should continue to examine issues regarding individual rates or classes of services, and work to remedy these problems.

The change in rates developed through the updating system should be taken into account in the development of the MHA budget.

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.

2. Uncompensated care (both for clients with no insurance and for clients with inadequate insurance) and inadequate payments for Medicare and Medicare/Medicaid beneficiaries are of major concern. 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 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. Last year a bill to provide increased Medicaid payments for dual eligible beneficiaries failed in the legislature. However, this is an important issue and the legislature should reconsider increasing the level of payments for Medicare copayments for clients who are dually eligible for Medicaid and Medicare.

Uncompensated care is a growing problem for the providers, particularly with the reductions being made in gray zone eligibility. Uncompensated are occurs as a result of clients who have no insurance, and clients who have some health insurance, but that insurance either does not cover the services, or involves copayments and deductibles that the client is unable or unwilling to pay.

3. The legislature should reverse the requirement that MHA pay for gray zone services through grants or contracts and allow MHA to pay for such services through the fee-for-service system. The requirement that payments must be through grants or contracts is unduly restrictive and adds administrative complexity for both MHA and the providers.

The requirement that gray zone services may not be paid through the fee-for-service system requires that contracts be developed with all providers treating gray zone clients, however small the revenue involved. This provision is unlikely to save much money given that gray zone payments represent only 8% of the total MHA payments, and is burdensome for both MHA and the providers, particularly OMHCs that see a small number of gray zone clients. MHA should be allowed some flexibility in how they pay for services to gray zone clients. The providers are required to dummy bill in order that the services being provided can be tracked, and payments are reconciled with the dummy billings every couple of months. The interim payments were based on data for fiscal year 2001, and so can be substantially out of alignment with the services currently being provided.

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

PRP: Psychiatric Rehabilitation Provider

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.

Center for Medicare and Medicaid Services: The Federal agency responsible for, among other responsibilities, administering the Medicare and Medicaid programs.

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

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.

Queenie C. Plater, B.S., M.S.

Queenie Plater is currently the Director of Employment and Employee Relations at Sibley Hospital in Washington, D.C.. Ms. Plater has held a few position in Human Resources at Sibley during the past 12 years. Her experience ranges from recruitment and retention, benefits, through compensation and employee relations. As EEO Officer at the hospital she represents the hospital at hearings and advises managers on policy interpretation and administration.

Ms. Plater received her B.S. in Organizational Management from Columbia Union College, and her M.S. in Applied Behavioral Science from Johns Hopkins University.

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.

Lori Somerville, B.S., M.S.

Lori Somerville is currently the Chief Operating Officer of Humanim. Humanim is a private, non-profit organization that provides clinical, residential, and vocational services to children and adults with disabilities. Prior to serving as COO, Lori served as the Director of Human Resources. She came to Humanim in 1998 by way of a merger with Vantage Place, a residential program for adults with psychiatric disabilities and adults with brain injuries. Lori had spent fourteen years at Vantage Place and over 6 as the Executive Director. She is a graduate of Leadership Howard County and currently serves on the board of Children of Separation and Divorce. Lori's previous experience includes serving on the Community Behavioral Health Association Board of Directors and serving as President of the Association of Community Services and Supported Living Boards.

Lori received her undergraduate degree from Towson State in Psychology and a Master's from Johns Hopkins in Organizational Development.

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
Tracy Deshields - DHMH
Jerry Lymas - Commisisoner
John Plaskon - Commissioner
Richard Bayer - Upper Bay Counseling and Support Services
Herb Cromwell - Community Behavioral Health
Lori Doyle - Dulaney Station
Ray Lewis - MHA
Tim Santoni - MHA
Bob Pitcher / Frank Sullivan - MACSA
Theodore Giovanis - Commissioner (ex-officio)

Technical Advisory Group on DDA issues

Jean Frank - Commissioner, Chair
Tracy Deshields - DHMH
Alan Lovell - Commissioner
Jerry Lymas - Commissioner
Dianne Hutto McComb - MACS
Scott Uhl - DDA
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APPENDIX B

This appendix includes the following papers recently produced by the CSRRC on issues concerning providers contracting with DDA and MHA.

B-1. The Financial Situation of Providers of Community Services Contracting with DDA, Fiscal Years 1997, 1998, 1999, 2000, and 2001

B-2. Wage Rate Survey of DDA Providers - 2002

B-3 Proposed Update System for DDA and MHA Rates

B-4 Psychiatric Rehabilitation Program Salary Survey

B-5 Quality Measurement for Behavioral Health

Appendix B-1

The Financial Situation of Providers of Community Services Contracting with DDA, Fiscal Years 1997, 1998, 1999, 2000, and 2001

The Financial Situation of Providers of Community Services Contracting with DDA, Fiscal Years 1997, 1998, 1999, 2000 and 2001

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, 2000 and 2001.

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. A separate analysis using Cost Report data and focusing on DDA revenues and expenses is planned.

Data sources

The data used for this analysis were extracted from the fiscal year 1997, 1998, 1999, 2000 and 2001 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, 89 for 2000 and 94 for 2001. Providers were required by regulation to provide their Audited Financial Reports. Of the 86 providers used for the 2001 analysis, 36 were from the Central Region, 11 from the Eastern Region, 30 from the Southern Region, and 17 from the Western Region.

The following data fields were extracted from the fiscal year 2001 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
Contributions
Cash and investments

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 losses, but only a small proportion of their business is with Maryland DDA. In order to adjust for this in FY 2000 and FY 2001 the mean ratios were calculated weighting the results by the total Maryland DDA payments to the provider. These payments included CSLA, FPS, and contracts. 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. The mean margin of the providers of community services reporting to DDA was 2.1% in FY 1997, 3.8% in FY 1998, 3.2% in FY 1999, 3.5% in FY 2000 and 0.4% in FY 2001. The spread of the margin is shown in Table 1.

Table 1: Profit Margins	FY 1997	FY 1998	FY 1999	FY 2000[1]	FY 2001[1]
Upper quartile	7.0%	7.8%	8.3%	8.1%	3.9%
Median	2.1%	4.4%	3.1%	3.2%	0.7%
Lower quartile	-2.7%	1.2%	0.0%	0.0%	-2.8%
Mean	2.1%	3.8%	3.2%	3.5%	0.4%

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, 22 of the 89 had negative margins in FY 2000 (i.e., 25%), and 40 of the 94 had negative margins in FY 2001 (i.e., 43%).

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

[1] Mean margin weighted by DDA payments.

Profit margins by region of the state

Table 1A shows the mean profit margins (DDA revenue weighted for 2000 and 2001) for the providers located in the 4 DDA regions of the state for FY 1997, 1998, 1999, 2000 and 2001* and Table 1B shows the median profit margins[2] for 1999, 2000, and 2001. These profit margins should be interpreted with caution as the number of providers involved is quite small.

* In FY 2001 contributions made up 4.3% of the total revenue of the providers in the study. The contributions are distributed unevenly over the providers, with a few providers receiving a large amount in contributions, and other providers receiving little or nothing. Many providers receive contributions mainly for capital or special projects, rather than for operations.

Table 1A: Mean profit margin by region	1997	1998	1999	2000[3]	2001[3]
Central (Baltimore & area)	0.1%	2.4%	3.0%	2.0%	0.3%
East (Eastern Shore)	4.5%	7.8%	8.2%	5.5%	-0.5%
South (Washington suburbs & South)	2.0%	4.3%	2.3%	5.2%	1.2%[4]
West (Western Maryland)	1.4%	2.9%	3.2%	3.5%	-1.3%
State	2.1%	3.8%	3.2%	3.5%	0.4%

Table 1B: Median profit margin by region	1999	2000	2001
Central (Baltimore & area)	2.9%	1.4%	0.2%
East (Eastern Shore)	6.7%	3.6%	0.0%
South (Washington suburbs & South)	2.5%	6.2%	2.7%
West (Western Maryland)	2.6%	2.2%	-0.3%
State	3.1%	3.2%	0.7%

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.

[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.

[3] Weighted by DDA payments.

[4] The mean profit margin in the Southern region is much lower than the median due to the influence of a relatively large provider that experienced a large loss in FY 2001.

Table 2: Current ratio	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001
Upper quartile	2.4	3.2	3.4	3.1	3.5
Median	1.8	1.7	1.9	1.4	1.8
Lower quartile	1.0	0.9	1.0	1.0	0.9

The providers of community services reporting to DDA experienced an increase in their current ratio from 1997 to 1999, a drop in 2000, and a recovery in 2001.

FY 2001 median current ratio by region:

Table 2A: Current ratio	Central	East	South	West
Median	1.5	1.3	1.9	1.9

Cash and investments are closely related to the current ratio, so will be discussed under this heading. They represent money that is available to the provider in the short term.

Cash and investments

Cash and investments comprised 14% of the total revenue. The cash available, thus, represents 1.7 months of revenue. Some of this cash may be restricted or allocated for specific capital projects and so may not be available for operations. Revenue from investments is often an important source of revenue for the providers, and this has dropped substantially in recent years, with the downturn in the stock market, and the lowering of interest rates.

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	FY 2001
Upper quartile	8.3%	8.9%	10.3%	11.7%	6.9%
Median	2.9%	5.2%	4.4%	4.7%	1.0%
Lower quartile	-3.4%	0.5%	0.1%	0.3%	-4.1%

Return on assets improved between FY 1997 and FY 1998 and the median dropped slightly from 1998 to 1999, increased to FY 2000, and dropped in FY 2001. The drop between FY 2000 and FY 2001 is related to the drop in the profit margin between these two years.

FY 2001 median return on assets by region:

Table 3A: Return on assets	Central	East	South	West
Median	0.2%	0.0%	2.6%	-0.5%

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	FY 2001
Upper quartile	1.9	2.3	2.0	1.7	2.4
Median	1.4	1.6	1.4	1.4	1.5
Lower quartile	0.9	0.8	0.9	0.9	1.0

FY 2001 asset turnover by region:

Table 4A: Asset turnover	Central	East	South	West
Median	1.7	1.4	1.6	1.2

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, only two had negative net assets in FY 2000, and 7 had negative net assets in FY 2001. 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.

Of the 7 providers with negative net assets in FY 2001, 2 also had negative net assets in FY 2000 4 had positive net assets in FY 2000, and data for the other was not available. 6 had losses (i.e., expenses exceeded revenues) in FY 2001.

Summary

The ratios examined are in a reasonable range for fiscal years 1998, 1999, 2000 and 2001. 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, but with a deterioration in FY 2001.

	1997	1998	1999	2000	2001
% with negative margins	36%	22%	20%	25%	43%
% with positive margins	64%	78%	80%	75%	57%
% with current ratio < 1	25%	22%	23%	26%	31%

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%), in FY 2000 22 of the 89 (25%) and in FY 2001 40 out of 94 (43%) had negative margins. This is generally a favorable trend until FY 2001. 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, 67 of 89 (75%) in FY 2000, and 54 out of 94 (57%) in FY 2001.

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, in FY 2000 26% had current liabilities greater than current assets, and 31% in FY 2001. This could be indicative of a number of conditions, such as the existence of a short term working capital loan, and should be investigated.

The tight labor market in FY 2001 resulted in providers increasing wages by more than the rate increase they received. This could explain the drop in the operating margin.

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 - 2002

Wage Rate Survey of DDA Providers - 2002

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, and in cooperation with DDA carried out a survey of these providers. The survey instrument asked for information on wages paid during a pay period in February 2002. Surveys were sent to over 120 providers. The survey was sent again to non-respondents in June. Responses were received from 118 of the providers and 113 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, and the 2001 survey, additional minor changes were made to the FY 2002 survey form. The survey was then mailed to over 100 providers. Both the Developmental Disabilities Administration (DDA) and 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.

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*	Base hourly rate - 2002*	% change 00-02	% change 01-02
Aide	$7.44	$8.64	$9.41	26.5%	8.9%
Service worker	$8.57	$9.15	$9.89	15.4%	8.1%
First line supervisor	$13.44	$14.83	$14.88	10.7%	0.3%
Driver - CDL[5]	$8.61	$9.45	$11.92	38.4%	26.1%
Driver- non-CDL	$8.08	$8.86	$9.34	15.6%	5.4%

* The set of providers responding differed among the three years, with 47 providers included in the 2000 analysis, compared with over 115 in the 2001 analysis, and 113 in the 2002 analysis. The difference in the set of providers responding may explain part of the change in wage rates between 2000 and 2001.

Staff turnover rates and tenure

78 providers gave information on turnover. The turnover rates for the employees categories for all services were:

Aides	45%
Service workers	44%
First line supervisors	28%
Drivers CDL	25%
Drivers - non-CDL	27%

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.

[5] A Commercial Drivers License (CDL) is required for driving a school bus or a large van. This category comprises a relatively small number of employees.

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

	Avg. tenure	% of employees in each category
Aides	39 months	32%
Service workers	45 months	54%
First line supervisors	52 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.

Tenure can be influenced substantially by long term employees. Some providers did not provider information on tenure, others did not provide information on turnover, and some provided neither, so the sets of providers used for these two analyses differ, and they both differ from the set used to calculate average wage rates.

Fringe benefits

Fringe benefit[6] 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%. In 2002, 97 providers submitted fringe benefits, with a mean of 20.5% and a median of 20%. Thus, there was no substantial change from 2000 to 2001 to 2002 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 three surveys the comparison will not be precise. These wage increases are greater than, and for aides in FY 2001, much greater than, the rate of increase in the Consumer Price Index between 2000, 2001 and 2002. However, it should be kept in mind that the wage levels are substantially lower than those of corresponding state workers.

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 gave their direct care employees wage increases at least as large as the rate increases they have been receiving. Between FY 2001 and FY 2002 a Cost of Living Adjustment of 4% was provided. This converted into a rate increase of approximately 3%. the wage increases were similar in magnitude to the COLA increase provided in rates. The providers have given wage increases greater than the rate increases they were provided. This was also the situation in FY 2001. An analysis of the financial condition of the providers in FY 2001 showed a substantial decline in their mean operating margin from 3.5% to 0.4%. The Commission concludes that

[6] The fringe benefits requested do not include leave.

providers have funded some or all of the increase in wages in excess of the rate increase by a reduction in their operating margins. The data on wage increases presented in this report suggests that an additional deterioration in the financial condition of the providers is to be expected in FY 2002. The Commission will be obtaining the data necessary to check this hypothesis early in 2003.

Summary and conclusions

- The providers appear to have given wage increases to their workers for 2002 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.

- The fact that the providers gave wage increases substantially in excess of the rate increases they received is probably due to the tight labor market, and this may have contributed to the deterioration in their financial performance in FY 2001.

- Turnover rates have remained high, and are in the same range as is reported for similar providers nationally.

- Fringe benefits continue to be about 20% of wages.

Appendix B-3

Proposed Update System for DDA and MHA Rates

Proposed Update System for DDA and MHA Rates

Background

A fundamental component of the design of most health care payment systems is a systematic method for updating rates. However, the payment systems used by the Developmental Disabilities Administration (DA) and the Mental Health Administration (MHA) do not include such a component. As a result the CSRRC has undertaken a review of the approaches taken to updating rates in several payment systems.

A systematic approach to adjusting rates for the reasonable impact of inflation and other factors is included in most national and state payment systems. The Maryland legislature has recognized this fact in requiring that the Community Services Reimbursement Rate Commission develop such a methodology and recommend update factors on an annual basis. The purpose of this paper is to present options and recommendations for the design of the updating methodology, and to provide the update factors that would be generated by this methodology given current information.

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 (HSCRC) 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 which bases the update on the increase in the medical care component of the Consumer Price Index (CPI). Such systems can be quite simple or relatively complex.

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 and 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.

This paper starts with a brief discussion of the updating systems used by the HSCRC and by Medicare, then continues with a discussion of some options for a system for DDA and MHA rates. It concludes with a recommendation for a system to be used.

HSCRC updating system

The HSCRC hospital payment system establishes the rates of individual hospitals using the costs of a group of similar hospitals, and adjusting for some factors that are specific to the particular provider. Once the rates have been established they are updated annually using an Inflation

Adjustment System (IAS) and hospitals may go for long periods without having their base rates reviewed. The HSCRC compares the charges of the hospitals after adjusting for factors for which they do not consider it appropriate to hold the hospitals accountable. These factors include: geographical differences in wage rates, case-mix and payer mix, outlier cases (cases with a charge of over $70,000), highly specialized and expensive services (e.g., the burn center at Hopkins Bayview Medical Center, the trauma center at University of Maryland Medical System, and some organ transplants), and the reasonable level of uncompensated care experienced by the hospital. If a hospital is found to have high adjusted charges under this comparison it is either subject to detailed review of its rates, or agrees to accept a reduced inflation adjustment each year until it achieves some target.

The detailed review compares the approved inpatient charge per case and outpatient charges of the target hospital, adjusted for the factors discussed above, with the corresponding adjusted charges of peer group hospitals. The rates developed do not include any allowance for profit margin, and apply a 2% reduction for expected improvements in productivity.

The IAS is used to update the rates of the hospitals from year to year. These adjustments are not dependent on geographical location. They are intended to account for the increases experienced in the input prices of hospitals (as measured by various proxies external to the hospital industry), changes in uncompensated care and payer mix, unusual costs, and changes in technology and productivity in the industry as a whole. The HSCRC calculates an estimate of the impact of inflation on hospital input prices, and uses that, along with estimates of how changes in net revenue per discharge in Maryland compare with the corresponding national changes to arrive at an update factor to be provided in rates.

Medicare updating systems

The Medicare Inpatient Hospital Prospective Payment System (PPS) is used to pay hospitals for inpatient services, but many of the factors involved apply equally to Medicare payments to other providers, e.g., skilled nursing facilities, outpatient hospital services, physicians. Inpatient cases are classified into Diagnosis Related Groups (DRG). A payment rate is set by Medicare for each hospital for a DRG with a weight of 1 by standardizing the rates for the various adjustment factors included in the system. A simple example of the payment calculation is provided in Appendix A. The payment for any particular case is calculated by multiplying the weight for the case by that rate. The payment for the particular hospital varies for factors such as the geographical location of the provider, the level of graduate medical education, and the proportion of indigent patients. Geographical adjustments are based on the Metropolitan Statistical Area in which the hospital is located, and geographical adjustments apply to the labor costs, and to capital costs (the adjustment factors are different for labor and capital), but not to the other costs. The rates were originally calculated based on actual average costs, but are not rebased to actual costs. Additional payments are made for very high cost cases through “outlier payments”. An update to the rates is provided each year, and this update is often specified by Congress in legislation. However, the basis of the update factor is usually studies performed by CMS/HCFA and the Medicare Payment Advisory Commission (MedPAC), who look at the impact of input price changes, technology improvement, changes in coding practices, changes in case mix, and improvements in productivity, on hospital costs. This creates a framework for determining the update, but does address the issue of evaluating base rates.

A second aspect of updating is the review of the weights used for different categories of patients. Annually Medicare considers factors such as changes in medical practices, introduction of new

technology, technology diffusion, then reclassifies types of cases among the DRGs and recalculates the weights associated with the DRGs. The recalculation of weights is performed in a budget neutral manner, i.e., based on the number and mix of cases seen in the prior year and the HCFA model of payments and as a result the change in weights does not change the total payments. However, the total payments by Medicare are permitted to increase based on, among other factors, increases in volume or case mix. In some ways this is similar to the different weights used by DDA in its 5x5 matrix of client characteristics, except that weights in the DDA matrix have not been updated recently.

The Medicare physician payment system also includes an updating system, with an allowance for the impact of inflation, but is complicated by an additional adjustment based on the change in total payments. If the total payments for physician services increase above a certain level, then the rate for subsequent years is reduced to remove the payments above the limit. For 2002 this latter adjustment has resulted in a decrease in the Medicare physician fee schedule of about 5%. The Medicare physician payment system is very similar to the MHA payment system for physicians and clinics. Both are based on the CPT-4 coding system for procedures, and set a rate for each CPT-4 code.

In summary, the Medicare process can be characterized by the following steps:

1. Decide upon the update to rates.
2. Use the prior year's volume and case mix data with the update factor to calculate projected aggregate payments at prior year volume/case mix.
3. Make changes in the treatment of outliers, calculate new weights, and other changes that are required to be done in a budget neutral manner.
4. Use prior year's data to model the impact of the changes listed in step 3.
5. Use the results of the modeling in step 4 to make budget neutrality adjustments so that the new aggregate payment level at prior year volume/case mix calculated in step 2 is not exceeded.

Such a process provides structure to the process of changing rates each year.

Options for DDA and MHA

The Commission believes that the rate systems of DDA and MHA should move toward a system/framework similar in concept to Medicare's system, in that it should plan a periodic review of all aspects of the payment system, including base rates, weights, coverage of CPT codes, etc.

The major question to be addressed is how simple or complicated to make the updating system. Because this is the initiation of the process it seems prudent to begin the process by deciding on the applicable growth factor for updating the rates, similar to step 1 in the Medicare process described above. The process described could then be used for budgeting the aggregate expenditures expected.. The determination of the growth factor could be made very simple by adopting some published measure of costs and simply specifying that each year the rates will be increased by the recent annual increase in this measure. This is the approach that the state has adopted for medical day care, where the increase in the medical care component of the Consumer Price Index is used. Alternatively, an inflation measure specific for the types of providers being paid could be developed. The majority of the costs incurred by the providers are for labor, so one natural component could be the increase in the wages of service workers, as reported by the Bureau of Labor Statistics.

If the more detailed approach is selected then the steps in the process of designing the updating system would be:

1. Decide what components of costs will be used. A natural breakdown might be: 1) wages, salaries and wage related costs; 2) supplies and contracted services; and, 3) capital costs.

2. Decide what inflation proxies to adopt for each of the components.

3. Calculate weights for each of the components using cost reports or audited financial reports, and decide whether these weights will be updated, and with what frequency.

4. Decide whether any other factors will be taken into account in the updating factor, e.g., improvements in productivity, changes in technology, changes in the nature of the clients being treated, unusual cost changes that impact the providers differently from the inflation proxies used, or costs due to state or federal mandates.

5. Decide when the update factor will be applied, and when it will be calculated. There are advantages to having the update factor as current as possible, but it is also desirable to give the providers advance notice of the update factor so that they can take it into account in their budgeting process.

The legislature has specified that additional funds should be made available to the DDA providers to allow for the wage rates to be brought up to the level of corresponding state wages. The adjustment to the base rates was intended to bring the base rates up to a target level. Part of the reason this is required is because rates were not properly updated for inflation in the past. The amount of adjustment required was calculated using the state employee compensation for similar positions as the target wage rate. This standard was used because of the history of the DDA rate system. However, once the base rates are adjusted and a process for updating the rates is in place there is not need to link inflation in the salary component of rates to state employees.

Recommended Approach and Update Factor (tentative)

The medical care component of the CPI would be the simplest measure of inflation that might be suitable, but it does not reflect the actual mix of labor and non-labor resources used by the providers. The approach that is recommended is, therefore, slightly more complicated. A baseline study of the costs of the providers should be performed to determine the split between labor costs and other costs. The labor cost portion should be increased by the increase in the hourly wage rates of service workers, and the balance of the costs should be increased by the increase in the CPI for urban consumers in the Washington-Baltimore MSA. The update factor should be calculated each year, to provide adequate notice to the providers and to allow for its inclusion in the state budgeting process. An estimate should be calculated in August, for inclusion in the Governor's budget, with a final calculation in November based on more recent data.

Estimated update factor:

Assume that the costs are 75% labor related and 25% non-labor related. The increase in mean hourly earnings of health service workers in the Baltimore Washington MSA for the year ended April 2002 was 3.0% and the increase in the Baltimore-Washington MSA CPI for all urban consumers for May 2002 was 2.5%. The inflation component of the update factor would be calculated as follows:

0.75 x 3.0% + 0.25 x 2.5% = 2.9%

In addition, adjustments should be made for the estimated impact on costs of any significant state or federally mandated changes in staffing, or other aspects of the delivery of care, or for any substantial costs changes that impacted on providers differently from the manner in which they impacted on the indices specified above.

It is possible to start with a relatively simple system, and then refine it over time. What is important is that a sound framework and process be developed and put in place. This framework might include a market basket adjustment and some or all of the other adjustments:

- An estimate of the impact of inflation on the prices of the goods and services being purchased by the providers - this is often referred to as a "market basket" increase.
- Other adjustments
  - changes in mandated staffing requirements
  - delivery system changes, such as the site or mode of care
  - expected productivity improvements
  - significant costs changes, such as for malpractice insurance
  - the impact of regulatory changes that increase or decrease costs

It is important to note that in this type of payment system adjustments for inflation in input costs are separate from increases for new technology, or changes to the base rates. For example, the salary differential adjustment that is being phased in to the DDA payment system represents an adjustment to the base rate that is separate and apart from the impact of inflation and other factors on the rates.

It should be noted that this paper is presenting the Commission's initial ideas on the design and implementation of a systematic updating system, and it is expected that these ideas will be subject to further refinement over time. It should also be noted that the increase required in the budget, while it should be estimated using the update factor, may be substantially different from the update factor since it must account for changes in enrollment, utilization of services, etc..

Comparison of updating components of payment systems:

Factor	HSCRC rates	Medicare PPS	DDA PPS	MHA	CSRRC position
Base costs	Initial base year. No current costs used unless full review.	Initial base year costs. No current costs used to rebase system.	Initial base year costs.	Fee-for-service system 7/1/97, first based on projected costs, then market prices for some services.	
Current cost data	Cost reports annually.	Cost reports annually.	Cost reports annually.	No current cost data collected.	
Rebasing[7]	More current peer group cost used in full rate review.	No rebasing. Current costs used to monitor system only.	No rebasing. Current costs used to monitor system only.	Base remains constant. Rates may be added or updated.	
Complexity adjustments	Charges and DRGs.	DRGs.	25 categories,	Fee-for-service by CPT-4 code.	
Update weights	Updated based on charges.	Updated annually using charges.	No.	No.	
Update rates	Annual inflation, productivity, etc. adjustment.	Annual inflation, net of productivity	Subject to budgetary constraints.	Subject to budgetary constraints.	Annual update required
High cost cases	Implicitly included, as charges are the basis of payments	Extra payment for high cost cases - "outliers"	Accomplished through "Augmentation grants".	Implicit, as fees increase with increased services.	
Capital costs	Blend of hospital specific and peer group, after review.	Standardized rate. Varies by MSA	Partly through Start-up grants. Statewide average for balance.	Average costs implicit in the rates.	
Geographic adjustments	County level adjustments for wage/salary costs only.	By MSA for wages/capital. Different rates for large and small urban/rural areas.	By region for client portion. No adjustment to AGC&T portion.	No geographic adjustment	

[7] I.e., using a subsequent year's costs to recalculate rates.

Appendix A

Simple example of Medicare PPS payment calculation

Consider a hospital in an urban location, with an inpatient case with a DRG weight of 1.5. Suppose that the standard payment for a case with a weight of 1.0 in an urban hospital is $2,000[8], that the wage index for the hospital is 1.1, and that wages and salaries comprise 70% of total costs. Assume no other adjustments to the rates.

Adjusting for the wage index, the standard payment rate for this hospital for a case with a DRG weight of 1 would be:

(1.1 x $2,000 x 0.7) + ($2,000 x 0.3) = $2,140

Since the weight for the particular case is 1.5, this standard payment would be multiplied by 1.5 to arrive at the payment for that case:

Payment for case = 1.5 x $2,140 = $3,210.

[8] Under the Medicare system the base rate was developed from the actual costs of all hospitals in a particular "base year", updated to the current year for inflation and other factors. The differing case complexity of hospitals was neutralized by dividing that each hospital's cost per case by its average case mix score, creating an average cost for a theoretical case of 1.0 case mix complexity. After that initial calculation based on costs the rates are updated using update factors that are averages, and not hospital specific. Thus the system divorces the payment rate from cost, except from some particular adjustments.

Appendix B-4

Psychiatric Rehabilitation Program Salary Survey

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 2002 using the results of a survey of providers performed by the Community Behavioral Health Association of Maryland, Inc. (CBH). In future years a more detailed analysis may be possible using the results of a survey done by the Mental Health Administration (MHA). MHA has collected baseline salary information for fiscal year 2001 for several categories of direct care workers in outpatient mental health clinics and psychiatric rehabilitation providers. Subsequent surveys will allow for the calculation of changes in wage rates.

Data source

The CBH (formerly the Maryland Association of Psychiatric Support Services, Inc. (MAPSS)) recently published the results of a salary survey of psychiatric rehabilitation programs in fiscal year 2002. This survey followed the same format as surveys that were used in fiscal years 2000 and 2001, 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 in the Fall of 2001 and reflects fiscal year 2002 salaries.

The CBH 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 "CBH FY 2002 Salary Survey", prepared by CBH staff, and dated February 2002, 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 following table shows the comparison of the salary results reported in the CBH study (including fringe benefits), and the State Mental Health Associate II and III reported (again including fringe benefits, imputed at 32.9%[9]). The fringe benefits paid by the providers averaged 21%. The state gave a wage increase of 4% on January 1, 2002, i.e., in the middle of the fiscal year. The state wage rates used to calculate the percentage differences in the table are the mean of the wage rate prior to January 1 and the wage rate that went into effect on January 1.

	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	$26,168	$22,000	$29,760	$24,501
Rehabilitation counselor - Mean	$26,827	$21,935	$30,373	$24,523
State MHA II [10]	$30,920	$23,265	$34,557	$26,002
State MHA III [2]	$32,958	$24,799	$36,849	$27,727
Percentage by which the MHA II rate exceeds the provider median/mean[11]	18%/15%	6%/6%	16%/14%	6%/6%
Percentage by which the MHA III rate exceeds the provider mean/median	26%/23%	13%/13%	24%/21%	13%/13%

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.

[9] 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%.

[10] These state wage rates are the average of the rates that were in effect for the first 6 months of the fiscal year and the rates that were in effect for the second 6 months of the fiscal year. The state wages were increased by 4% on January 1, 2002. The Rehabilitation Counselor wage rate was based on wage rates for July 1, 2001, for fiscal year 2002.

[11] 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%
FY 2002	$26,827	0.1%	$30,373	-1.6%

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, 2001, and 2002 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	$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%
FY 2002	$23,265	2%	$24,799	2%	$21,935	-0.3%	$24,523	-3.0%
change 1998-2002	$4,137	22%	$4,300	21%	$3,005	15.9%	$3,233	15.2%

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, but between FY 2001 and FY 2002 the wage rates of the providers were basically unchanged, as were the rates. The apparent decreases in wages between FY 2001 and FY 2002 are not significant, and are probably due to a difference in the providers that responded to the surveys in the two years, but may also be reflective of a declining financial position within community mental health programs and the poorer situation of the general economy. It would be useful if CBH and MHA could revisit the issue of the equivalency between state and community positions.

Conclusion

The psychiatric rehabilitation providers have increased starting wages for rehabilitation specialist/counselors by 16% from FY 1998 to FY 2002. 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 the providers to increase the wages more than the increase in the rates 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 2002 time period the state has increased their wages more than the providers. The difference is in the range of 16 to 27 percent when fringe benefits are taken into account.

Appendix B-5

Quality Measurement for Behavioral Health

Quality Measurement for Behavioral Health Care

1. Introduction

This paper discusses the current state of quality measurement for behavioral health. It includes a discussion of what is meant by quality, the measurement tools that are available, the strengths and weaknesses of some of these tools, and the difficulty in coming up with an objective measure of quality that can be used across multiple settings. It then discusses the current state of quality measurement in Maryland, both for mental health and developmental disabilities services.

The Community Services Reimbursement Rate Commission (CSRRC) has a responsibility to report on quality measures that are available, and upon ways in which incentives for quality can be built into the payment system. The following two sections address the first of these two responsibilities. The second responsibility is then addressed in section 4.

The general structure for quality measurement was established by the seminal work by Avedis Donabedian[12]. Donabedian proposed measuring quality in three different dimensions: structure, process, and outcomes[13]. The structure dimension involves insuring that facilities are safe and appropriate for the services being provided, that staffing levels are adequate, the staff are appropriately trained and qualified, etc.. The process dimension involves insuring that the process by which care is provided is appropriate. For example, that care is subject to a plan, that different aspects of care are properly coordinated, that the care being provided is appropriate for the situation of the client, that there is a process for handling adverse events and complaints, and that that process is actually followed. The measurement and assessment of outcomes is still at a developmental stage, and in many circumstances it is difficult to define exactly what is a good outcome, since that is very much dependent upon the situation and desires of the particular client.

Quality assessment is closely tied to the licensing and certification activities engaged in by the state, and the review activities of national accreditation agencies such as the Joint Commission on Accreditation of Health Care Organizations (JAHCO), the Commission on the Accreditation of Rehabilitation Facilities (CARF), and the Council on Quality and Leadership in Services for individuals with developmental disabilities. Until recently these various organizations concentrated their activities in the structure and process dimensions. However, they are now becoming much more concerned with the assessment of outcomes, and it is the assessment of outcomes that will be a major focus of much of the discussion that follows.

Outcomes can be split into a number of components: clinical outcomes, consumer satisfaction, adverse occurrences, and general functioning. The efficiency and effectiveness of treatment are also aspects of the measurement of outcomes. For each of the aspects it is necessary to consider what factors are to be measured, what variables are to be quantified to accomplish that measurement, and what values of these variables constitute desirable outcomes. The major problem in this activity is that a particular result may be a desirable outcome for one individual but an undesirable one for another, depending on the particular desires and goals of the individual

[12] Donabedian A, "The seven pillars of quality", Arch Pathol Lab Med, 1990 Nov; 114(11): 1115-8

[13] Donabedian A, "Quality assurance: Structure, process, outcome", Nurs Stand 1992 Dec 2-8;7(11 Suppl QA)

in question.

2. Quality Measurement Tools

A wealth of literature exists on quality measurement, with numerous articles that compare and contrast data collection instruments, or summarize the results of studies carried out using these instruments. It is not the intention in this paper to provide a complete catalog of such instruments, but to simply point the reader in the directions of some of the most salient books or papers and to provide a flavor of the work that has been done. A couple of useful starting points for the reader who wants to get into this subject in more depth are: "Mental Health, United States, 1998"[14], and subsequent editions of that publication. Of particular interest is the Mental Health Statistics Improvement Program (MHSIP) sponsored by the Center for Mental Health Services. This project has as an output a consumer oriented mental health report card based on survey data, and using measures that are of particular interest to consumers.

The book, "The Measurement and Management of Clinical Outcomes for Mental Health"[15] contains an extensive discussion of the issues of measurement, including an inventory of the tools available, with a summary of their key features.

General functioning

There are a number of data collection instruments designed to gather data on the general functioning of consumers. One of the earliest such, and one still in use, is the Global Assessment Scale (GAS)[16]. A useful overview and comparison of the tools that are available is contained in "Assessing Clinical Outcomes: The Community Functioning of Persons with Serious Mental Illness"[17].

Consumer satisfaction

Consumer satisfaction surveys are fairly widely used as one component of quality measurement. Many states, including Maryland, have surveys of consumers which include questions on satisfaction. An overview of the issue of consumer involvement in quality assessment can be found in "Consumerism, Outcomes, and Satisfaction: A Review of the Literature"[18].

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[14] "Mental Health, United States, 1998", U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration.

[15] Johns S. Lyons, Kenneth I Howard, Michael T O'Mahoney, Jennifer D Lish, "The Measurement and Management of Clinical Outcomes in Mental Health", Wiley, 1997.

[16] Husby R, "Short-term dynamic psychotherapy: 5. Global Assessment Scale as an instrument for description and measurement in 33 neurotic patients", Psychotherapy and Psychosomatics, 1985, 43, 28-31.

[17] Faith B Dickerson, "Assessing Clinical Outcomes: The Community Functioning of Persons With Serious Mental Illness", Psychiatric Services, July 1997, Vol. 48, N0.7, 897-902.

[18] Jean Campbell, "Consumerism, Outcomes, and Satisfaction: A Review of the Literature", Chapter 2, Mental Heath, United States, 1998, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration.

Clinical and personal outcomes

Clinical outcomes can be assessed using self-reported data, medical record data, or claims data submitted by providers. All of these data sources have their strengths and weaknesses. On the mental health side a comprehensive discussion of clinical outcomes is included in "The Measurement and Management of Clinical Outcomes in Mental Health"[19]. The issues are somewhat different in regard to the provision of services to individuals with developmental disabilities, and the topic of personal outcomes in that area is discussed in "Personal Outcomes and Measures of Quality"[20].

Efficiency and effectiveness

Efficiency and effectiveness are being addressed though the development of treatment protocols and the assessment of the relative effectiveness of different treatments for specific conditions. It is important that the findings from such research be disseminated and used, or the research becomes simply an academic exercise. Unfortunately, many of the practitioners working in the field find it difficult or impossible to keep up with the flood of literature.

Summary

The intent in this section was simply to provide an overview of the activity in the area on quality assurance, and provide pointers to key literature for the reader wanting to get into the subject in greater depth. A key activity, which is likely to strongly influence the direction of quality assessment in the country over the next decade, is a project sponsored by the American College of Mental Health Administration, in conjunction with 5 of the major accreditation agencies. The Accreditation Organization Workgroup has issued "A Proposed Consensus Set of Indicators for Behavioral Health"[21]. The indicators are divided into those that are applicable for comparison purposes, and those that are more suitable for use internally within provider organizations for quality improvement. This report includes a comprehensive discussion of the rationale for the endeavor, lists the measures being proposed, and discusses potential sources for the data. The broad representation on the Workgroup, and the fact that all the major accreditation organizations are involved, is likely to make this report one of the most important drivers of how quality is measured, and how the data for that measurement are collected.

[19] Johns S. Lyons, Kenneth I Howard, Michael T O'Mahoney, Jennifer D Lish, "The Measurement and Management of Clinical Outcomes in Mental Health", Wiley, 1997.

[20] James F Gardner, Sylvia Nudler, Michael S Chapman, "Personal Outcomes as Measures of Quality", Mental Retardation, August 1997, Vol. 35, No. 4, 295-305.

[21] Accreditation Organization Workgroup, "A Proposed Consensus Set of Indicators for Behavioral Health", 2001, American College of Mental Health Administration, www.acmha.org.

3. Quality Measurement in Maryland

The Office of Health Care Quality is responsible for the assessment of the quality of care of the services provided by providers. As mentioned earlier, most of the measures used are structure and process measures, although there is starting to be more of an emphasis on outcomes. Both the Mental Hygiene Administration (MHA) and the Developmental Disabilities Administration (DDA) sponsor annual consumer satisfaction surveys.

Most providers are currently collecting some outcome data, but there is little consistency in the factors collected, or in the measurement tools used, so it is difficult to aggregate and compare the measures. In addition, certain Core Service Agencies (CSAs) are developing outcome measurement tools that they consider to be practicable for their providers. Examples include consumer satisfaction surveys, and quantitative measures for the major domains. In the employment domain the measure might be the percentage of consumers who a competitively employed, and a goal might be established prospectively. In the residential domain the measure might be the percentage of consumers that move to a less restrictive environment.

At the statewide level, the "Managing for Results" Task Force was formed in December 2001 with the goal of developing an outcome evaluation system for the public mental health system. The Task Force includes broad representation and is supported by consultants from the National Association of State Mental Health Program Directors and the Systems Evaluation Center at the University of Maryland. An initial paper was produced in April 2002 listing the life domains to be included in the evaluation, and potential measures for each domain, with a discussion of their advantages and disadvantages. The 13 domains are: psychiatric symptoms, psychiatric symptom distress, functioning, daily role, school performance, housing situation, natural supports, substance abuse, re-hospitalization, criminal and juvenile justice involvement, recovery, consumer-centered approach, and access to somatic care. The tasks to be completed for each domain include the definition of the factor to be measured, identification of suitable data sources, and the population to be sampled, and design of the data analysis and dissemination plan. The Task Force is now in the process of refining this paper and selecting a small number (1 to 3) of standard outcome measures to be collected on a state-wide basis. Broader sets of measures may be tested on a pilot basis. One end product of the Task Force's activities will be a set of consistently defined and collected measures. Achieving the goal of developing a broadly based outcome evaluation system is clearly a major undertaking, and will take some time to complete.

The Baltimore Mental Health System, Inc. (BMHSI), under a contract with MHA, has been engaged in a capitation demonstration project for a group of severely and persistently mentally ill clients since 1994. As part of this project quantitative outcome measures have been established, and the clients who enrolled in this project are surveyed regularly to determine how the project is performing relative to these measures. Outcome measures have ben defined, with separate outcomes for the major services, e.g., adult psychiatric rehabilitation, and mobile treatment, and goals have been established for these measures. More detail on this innovative project, including the data collection forms used for outcome reporting can be found on the BMHSI web site, www.bmhsi.org.

The DDA is operating under a consent decree that resulted from, and settled, the court suit alleging inadequate quality of care that was filed by the Maryland Disability Law Center. Under the terms of the consent decree DDA is required to undertake specified quality improvement functions, and to have these overseen by an independent consultant. The cost reports filed by the providers contain information on the cost and volume of services being provided and this

information may be useful for some efficiency and effectiveness comparisons. The Self-Determination Project is another major activity being pursued by DDA. This project allows clients and their families more choice in the services they receive and how they are provided. This is a major contributor to quality of care as clients can easily change their provider if they are dissatisfied with the quality or nature of the services they are receiving.

Both DDA and MHA engage in consumer surveys to assess patient satisfaction and outcomes. Reports on the results of these surveys are available from the respective administrations.

In addition to the activities being undertaken by State agencies, the provider organizations have independent initiatives, or initiatives in collaboration with the state, to improve the measurement of quality and outcomes. The Maryland Association of Community Services for Persons with Developmental Disabilities, Inc. (MACS) is working with the Council on Quality and Leadership to encourage more community providers to become accredited by the Council. Several Core Service Agencies, as part of a broader MHA workgroup on outcomes, are working with psychiatric rehabilitation providers to pilot the collection of outcome data related to employment, housing, and other indicators of independence. Data is being reported on a quarterly basis, and includes the number of consumers served in the quarter, the number of consumers who earned at least the minimum wage, various measures of independence in housing, and the number of consumers hospitalized.

The MHA deems that providers have satisfied certain state licensing requirements if they are accredited by a national accreditation organization. This gives the providers an incentive to become accredited. Maryland Health Partners (MHP) is the administrative organization responsible for management of the community mental health services, authorizing services when this is required, processing claims filed by the providers, and paying these claims. The claims database provides a potential wealth of information on the relative utilization patterns of different providers and clients. This database provides a valuable source of information for assessing the relative efficiency and effectiveness of the services being provided. However, to date little of this potential has been explored.

4. Mechanisms to Improve Quality

It is important that the quality improvement activities currently undertaken by MHA and DDA be continued and expanded. Specifically, the consumer surveys sponsored by both of these agencies should continue to be done annually, and should be expanded to include as many providers as possible. However, it should be understood that it may not be feasible to collect sufficient data on a large enough number of consumers to provide statistically valid results at the individual provider level.

The cost report data collected by DDA and the billing data collected by MHA though MHP should be explored for their potential to develop measures of efficiency and effectiveness of treatment.

A good mechanism to improve quality could be a system that allows the providers as much flexibility in the way in which they provide services, within reasonable financial constraints, while ensuring that the clients have multiple choices of providers, and understand that they can move to different providers if they are dissatisfied with the services they are receiving. This may require modifying the MHA payment system to one that uses larger bundles of services, and adjusting the DDA payment system so that the payment is less dependent upon the actual services

provided.

At a minimum such system changes should be explored in an analytical context. Even if a new payment system is not developed and implemented, in all probability the analyses will suggest improvements to the current system. These ideas are in keeping with the current research findings, and the direction being suggested by the Substance Abuse and Mental Health Services Administration (SAMHSA).

5. Summary

Quality is one of those intangible concepts that is easy to understand at a basic level, but very difficult to define precisely. The discussion in this paper is intended to provide the reader with the basic concepts and structure of quality measurement, with an emphasis on the various dimensions of quality that exist, an understanding of the impossibility of coming up with a single measure of quality, and to point out some key references for the reader wishing to study the subject in greater depth.

Because of differences in desires, expectations, and conditions, care that might be high quality for one client may be unsatisfactory for another. At this time, a good way to ensure quality is through a multi-dimensional approach that:

1) continues to have licensing and certification standards that review the safety and appropriateness of the facilities and staffing, and encourages the Office of Health Care Quality to continue and expand its focus on consumer and program goals, and whether these are being achieved;

2) encourages providers to become accredited by third party accrediting organizations by making available funding for the costs associated with becoming accredited.

3) allows clients to choose their providers, and move between providers, so that a good match is achieved. In this way providers will have an incentive to ensure that the services being provided are those that are valued by the clients;

4) gathers and analyzes data so that effective and efficient practices can be identified, and the knowledge of them disseminated to other providers. As part of this program the existing consumer satisfaction surveys should be continued and expanded; and,

5) allows providers flexibility in the manner in which they provide care, subject to reasonable constraints.

The design of a flexible framework to implement 5) should be commenced in the near future, and adequate lead time should be allowed for its study, design, and implementation.

Appendix A

Minutes of Meeting: Quality Measurement in Mental Health

Community Services Reimbursement Rate Commission
Meeting Summary, Monday January 8, 2001

The meeting was called to order at 1:15 pm by Chairman Theodore Giovanis. Present at this meeting were: Commissioners Theodore Giovanis, Lloyd Bowser, Joan Peterson Clement, Patsy Blackshear, Alan Lovell and consultants Graham Atkinson and Elham-Eid Alldredge.

Approximately 55 members of the general public were present.

Mr. Giovanis welcomed everyone to the meeting and reiterated that the focus was on quality and outcomes in mental health services. He then introduced the first speaker, Ron Manderschied, Ph.D., from the US Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA).

Dr. Manderscheid shared some publications with the group and distributed an order form. He especially noted Chapter 12 of *Mental Health US 1998* where data are presented that are of great use to this group. He mentioned that the 2000 report will be available shortly and can be downloaded from the Web.

His presentation was divided into two major areas: Trends in behavioral health care and quality measures. As an introduction, he presented data from the World Health Organization and the US Mental Health 1998 to show that although mental health issues have intensified and the costs have gone up, the resources have dwindled. The top causes of disability have to do with behavioral health such as: depression, bipolar disorders, and alcohol use. In addition, depression ranked 4th in 1990 as a cause of disability and in 2020 is projected to rank 2nd.

Trends in Behavioral Health Care

- Integrated delivery systems. Indications are: the increase in Employee Assistance Programs, the integration of primary care and mental health, and the emergence of community support services. However, the public systems for mental health, substance abuse, and vocational rehabilitation are still separate.

- Role of new technologies. Indications are: patients communicate with their physicians via e-mail (replacing the phone), web sites offer mental health for purchase over the internet, the emergence of self-help groups (e.g., 300-400 discussion/chat groups exist for depression), and smart systems that operate 24/7 where patients interact with a computer, via the internet. The largest issue here is that this cannot be regulated.

- Confidence in purchasing care. Practice guidelines are needed, however, the questions are: do we have them? What are they? If we do not have these guidelines then chaos results. In the future it will be possible to pay for outcomes rather than process. In this case there will be no need for managed care since consumers/payers pay for results rather than processes.

- Commodification. This is taking goods and translating them into commodities. Two factors hinder this: having the experiences but not the resources, and not having tools to measure quality.

- Consumer and Family Revolution. The trend over the past 5-10 years has shown an increase in power for consumers and family. This will continue.

Quality

Quality measures include report cards for payers such as the National Committee on Quality Assurance"s (NCQA) HEDIS and the American Managed Behavior Healthcare Association's PERMS, and report cards for consumers such as VISTA, Institute for Behavioral Health Care-Industry Indicator, and CMHS/ MHSIP which is a Federal agency measure. Report cards for consumers are based on customer satisfaction surveys. These surveys cover domains such as: access, appropriateness of care, prevention, and clinical outcomes. Outcomes measures are what really happened not just what the consumer perceives. SAMHSA has grants to work on these.

Some outcomes for adults are: housing, drug use, employment, and involvement with criminal justice. Some outcomes for children are: living situation, being in school, drug use, involvement with juvenile justice.

Dr. Manderscheid left the group with several items/questions to look for:

– will the consumer and family perspective prevail?
– will the field have accepted quality tools?
– will the field find prevention and intervention (with teenagers and in the workplace)?
– what will be the role of bio-, neuro-, and genetic engineering?
– will the field exist in 10 years?

Mr. Giovanis then introduced the second speaker, Faith Dickerson, Ph.D.

Dr. Dickerson described a project at Sheppard Pratt Hospital dealing with Quality and Outcome Measures for Mental Health.

Dr. Dickerson's presentation covered the following topics:

< Types of Measures to Assess Quality and Outcome
  - Utilization and intensity of services (which is a basic measure)
  - Adverse events such as suicide or re-hospitalization. Discussion ensued about situations where a re-admission is not necessarily an adverse event
  - Consumer ratings of satisfaction with services. Although not aggregated, the project looks at general comments provided by consumers.
  - Consumer ratings of satisfaction with their lives, although quality of life measures do not correlate with objective measures.
  - Functional status (e.g., living independently, having a job, etc. This does not tell you how well consumers are doing)
  - Global ratings of functioning (GAF which provides an overview of the individual, but many domains are measured together so that a rating of 40 for one person does not mean the same as a rating of 40 for another)
  - Measures of symptoms or social functioning (BPRS which measures symptoms not functional status or satisfaction, and MCAS–details below)
  - Best practices for disorders
  - Assessment of needs and unmet needs. These are used extensively in the United

Kingdom and their scales are not practical to use across the board, however, these scales are good for research purposes.

< Goals of Outcome Measurement

- Describe and compare groups of clients
- Determine outcomes of interventions
- Investigate degree to which services meet specified standards

< The Many Challenges of Measuring Outcomes of Persons with SMI

- Serious mental illnesses are associated with various symptoms and problems
- Community services are complex and multi-faceted
- Populations and programs may be difficult to compare
- The culture of mental health services may not be receptive to outcomes measurement

< The Multnomah Community Ability Scale (MCAS)

- 17 item clinician rated instrument (Dr. Dickerson then listed these items)
- Each item is rated on 1-5 severity scale (1= very infrequently; 2= fairly infrequently; 3= occasionally; 4= Fairly frequently; 5= very frequently)
- Taps domains which are relevant to adults with SMI who receive community-based mental health services

< Pluses and Minuses of the MCAS

Pluses
- Face valid
- Easy to administer
- Used by other states
- Provides "snapshot" of individual client

Minuses
- Limited anchor points
- Not established as change measure or program evaluation tool
- No standardized way to use data
- Viewpoint of consumer is not included
- No follow-up if consumer leaves one facility to another

< Sheppard Pratt MCAS Project

- More detailed MCAS anchor points to increase reliability among raters
- Structured interview to elicit information necessary to make MCAS ratings
- Study underway to evaluate interview and expanded anchors

< Recommendations to the Commission

- Understand the limitations of outcome and quality measures that you select
- Ensure that data are practical to collect and that implementation plan is realistic
- Determine in advance how you will analyze and use the information

- Exchange feedback with programs and provides about data which are collected

Dr. Dickerson mentioned that the data have not yet been published.

Mr. Giovanis then introduced the third speaker, Ms. Joan Clement from the International Association of Psycho-Social Rehabilitation Services (IAPSRS). Ms. Clement introduced the IAPSRS, its mission, principles and values. Then she spoke of IAPSRS's commitment to quality of life and quality of services.

The organization provides mechanisms for defining and evaluating quality on various levels: program, practitioner, and system levels.

Program Level

C Accreditation with one of the several nationally recognized accreditation bodies, CARF, JCAHO, Council on Quality and Leadership, Council on Accreditation, and ICCD.

C Adherence to standard for the field of psychiatric rehabilitation set by IAPSRS including: a registry for Psychiatric Rehabilitation Practitioners; code of ethics for PRP practitioners; practice guidelines; multicultural principles, standards, and indicators; PRP training standards; PRP organizational codes of ethics; and PRP referral guidelines.

C Measuring program outcomes using IAPSRS Outcome Toolkit or another method. The kit includes the following domains: hospitalization, residential, employment, education, financial, legal, and consumer satisfaction.

Practitioner Level

With high staff turnover, accreditation alone cannot assure quality service provision. Therefore, IAPSRS supports accreditation standards for credentialing staff.

C A registry (RPRP) of practitioners established by IAPSRS in 1996 with 1,038 practitioners registered.

C A certification program (CPRP) to begin February 2002 which will test the knowledge and skills needed to perform tasks identified by field tested job analysis as being important, critical and relevant to the practice of psychiatric rehabilitation. In addition, it includes a criminal background check and a continuing education component.

C Working with states to endorse the certification program. The organization has already begun discussions in Maryland. Virginia is requiring all their practitioners to be certified while discussion are under way in Texas and Louisiana to require that 25% of practitioners be certified. The same applies to Pennsylvania and New York.

System Level

Ms. Clement mentioned several items under system level services:

< Increase the availability of community-based services through increased funding
< Encourage the use of IAPSRS PRP referral guidelines

- < Increase the accountability to payers, consumers, families, and the general public through certification, accreditation, grievance procedures, etc.
- < Increase linkages with academic and research institutions especially regarding training
- < Develop public policies that support consumer empowerment and choice
- < Provide voluntary services in the least restrictive environment and without coercion.
- < Find resources to meet basic survival needs and social needs along with mental health needs in an integrated manner.

Ms. Clement concludes her presentation by providing recommendations to the Commission for incentives in rate structure and funding regulations to assure quality. Her recommendations were as follows:

- < Provide financial incentives to programs which become accredited
- < Provide a higher reimbursement to programs that have a high percentage of certified practitioners
- < Provide funding to cover the cost of certification
- < Include RPRP/CPRP designation in the list of Qualified Mental Health Professionals (QMHP's) in state Medicaid regulations
- < Dialogue with local colleges and universities regarding the development of psychiatric rehabilitation curricula
- < Discuss with the insurance commission to mandate insurance reimbursement for psychiatric rehabilitation in the private sector. Quality cannot be assured if services are not reimbursed.

The fourth speaker was Mr. Steve Baron of the Baltimore Mental Health Systems (BMHS). His presentation was on the Baltimore Demonstration Capitation Project.

The project started in April of 1994 as a demonstration project to provide community-based services to 300 individuals with a serious and persistent mental illness who have not been served by the community mental health system.

They established clear criteria for admission. The individuals served by the program have to have had state hospital stays of at least six consecutive months and have been high users of Medicaid services. Services are provided by two providers, Bayview Medical Center and North Baltimore Center; both are monitored by BHMS. The programs are evaluated annually on their performance in meeting certain outcomes. These are process variables such as: numbers of clients seen, number disenrolled, hospital bed use, aggregate use of jail days; aggregate use of homeless shelters or days of homelessness; housing acquisition and number attaining and retaining independent housing; number in skills training; number of clients with jobs, the timely submission of accurate data reports; the creative use of existing services, the success of the program in fulfilling client needs; and the involvement of clients and families in planning and policy-making decisions. These are mostly process variables. They do interview clients in their homes every year for evaluation purposes. They interview about 50 percent of the total, that is 150 clients. Mr. Baron mentioned that the program is for adults but he would like to try it with children.

Mr. Baron showed an example of their rating system using housing as an example. The variable is "housing acquisition." If 100 percent of the clients acquire housing they (the programs) get a rating of excellent; if 95-99% acquire housing, the programs get a rating of good; if 90-94% acquire housing the rating is satisfactory; and if less than 90% of clients acquire housing then the

rating is unsatisfactory. The percentages vary with the variable. Another example is independent housing. Here if 70-100% of clients secure independent housing, the program get a rating of excellent.

Mr. Giovanis introduced the last speaker, Karen Oliver, Ph.D., from the Maryland Health Partners. Dr. Oliver presented data from two surveys regarding consumer satisfaction with mental health services.

Initially, Dr. Oliver talked about the data warehouse and the CSA Performance Indicator Reports project. Components of this project were: a cultural competency survey, coordination with academia in Baltimore, recommendations for system quality improvement activities, and tracking of national quality.

The consumer survey initiatives involve two surveys: one of adult consumers asking them to rate mental health services received through the Maryland Public Mental Health System. Consumers were asked to rate various services such as outpatient, inpatient, rehabilitation, etc. Statements were presented to them and they were asked to rate certain items on a 5-point scale of agree/disagree. The second survey was of caregivers on behalf of children receiving mental health services through the public system. The two surveys were very similar in construction. & surveys have been completed to date, 4 basic surveys, with 3 follow-up surveys.

Dr. Oliver distributed a small number of the survey reports and encouraged attendees to obtain them from the MHP website.

Mr. Giovanis thanked everyone for coming and for participating and reminded everyone about next month's meeting. The meeting was adjourned at 4:20 pm.

Appendix B

Minutes of Meeting: Quality Measurement in the Provision of Services to Individuals with Developmental Disabilities

Community Services Reimbursement Rate Commission Meeting
December 4, 2000

Meeting Minutes

The meeting was called to order at 1:20 p.m. by Chairman Theodore Giovanis. Present at this meeting were Commissioner Theodore Giovanis and consultants Graham Atkinson, Elham-Eid Alldredge, and Amy Tsou.

The main agenda items were the presentations by three guest speakers - Ms. Lauren Young, Ms. Sarah Basehart, and Mr. Michael Chapman - on current quality measurement activities within their respective organizations.

Mr. Theodore Giovanis began by discussing the statute and making reference to the mention of quality in two places within the statute. He said that, first of all, one should look for how quality is integrated into the rate system and whether or not there is a way to build in incentives for quality. Secondly, an effort must be made to assure that, in general, quality services are provided.

He stated that about a year ago, the commission had discussed the quality issue in a more general way but that this time, more focused sessions would occur. The topic of today's focus session is quality of care in the provisions of services to individuals with developmental disabilities. The topic of the January 8th meeting will be quality of care in the provision of mental health services.

Mr. Giovanis explained that the commission hoped to learn about the status of quality from these focus sessions - what is quality? how can it be measured? can it be built into a rate system? and are there other issues of which the commission should be aware? He told the meeting participants that three speakers had been invited to facilitate the focus session and introduced the first speaker, Ms. Lauren Young, from the Maryland Disability Law Center.

Ms. Young introduced herself as the Legal Director of the Maryland Disability Law Center and explained that the Center has been the protection and advocacy organization for the state of Maryland for 20 years and represents people across disabilities.

She applauded the work being done by the Commission and explained that she would touch on three areas during the meeting, 1) the recommendations made in the April 2000 report, 2) the Wasserman or quality assurance case, and 3) issues that need action by the Commission.

She touched on the first area by stating that the recommended increase in the hourly rate for persons under the fee payment system is an obvious need and the Commission should be more forceful in arguing for the increase. Service providers are continually asked to do more and more in the provision of services and they have not been thanked in a way that they can feel in their pockets. Ms. Young requested that this recommendation be worded in a way that makes it a priority for the Commission. She explained that the service provision system is currently damaged and that the MDLC is quite aware of the extent to which the licensing regulations have changed and how people are increasingly being asked to do more. The MDLC is sensitive to the changes because the organization is very involved in those regulations especially since they were required under the MDLC quality assurance lawsuit. The state spent a long time developing the regulations and they represent a significant improvement in the way that individuals are offered service. They focus on individual choice, satisfaction and maximization of personal growth and

personal outcomes.

These foci are supported in the research field for individuals with developmental disabilities and the MDLC has moved away from the more prescriptive licensing regulations. However, such an approach requires a lot of independent judgement, creativity and flexibility by the providers. It is not realistic to expect that staff continue to change the way they operate, get more training, and offer services to a variety of people and not be compensated in a way that allows them to maintain their activities.

Providers have moved away from offering services where all participants are expected to fit into an established routine. It is unkind to the client and does not represent quality care. People should be able to voice their needs; direct care staff then has to juggle these differing individual needs. Quality of service is greatly improved by the provision of individualized care.

Ms. Young continued by explaining how the state used to review individualized habilitation plans and always joke about how, for example, people had to learn to brush their teeth as a goal. The DDA uses that example in their training to say, "Move away from these things and let's look at socialization, do people have friends, what makes a difference? It's good that we've done all those things but if the individual plans are really going to look different, they need to be implemented differently. Then again, direct care staff is juggling more things. How do we expect them to do that without continued incentives for employment, without continued training to retain them."

There is no disagreement among the Commissioners about the goal of increasing the direct care wages but it needs to be reiterated and made stronger as a statement to legislature and the Governor. States are always complaining to the federal government about funding; that now we must have requirements for certified nurses assistants, must go through all this training, must go through the licensing process but how are we going to pay for it?

And we know what happens when you don't pay for it. Very briefly, to address two other of your recommendations; one is recommendation number four which states that the Commission is supportive of moving individuals from state facilities to a community setting when this is in the best interest of the individual. And that as such shifts occur the current rate system might not be adequate due to the individual's complex and high care requirements.

Two assumptions then must to be examined. One is that we only support moving individuals from institutions to community centers when it is in their best interest. I think the Supreme Court very clearly stated that there was a different standard and that we cannot just decide on a person's best interest, but in fact, it was the law that people have the right to live in a more community integrated setting.

It is better to be in the community in an integrated setting; people cannot be kept in an institution if they can live in the community, unless the people themselves object. These are very different standards from simply stating that "it is in their best interest." Ms. Young stated that her organization believes that there is no need for the level of state residential centers that exist and that the standard is different than is stated in the report. Also the assumption that people in the residential centers are going to cost a lot more and have particularly high care requirements

should be examined more carefully.

She gave the example of people who have come out of institutions some of whom are very vocal self-advocates who don't need particularly complex services and who do not cost more than people who came out of institutions several years ago. She cited the Great Oaks Center, one of the state residential facilities that closed. The Great Oaks Center was a program, as are all our institutions, that accepted people based on geographic distribution, not complexity of needs. The MDLC is asking the Commission to check the assumption that people in institutions need more money. In fact, the rate of institutional cost of care is so high that if that money that you would recommend could follow the individual, we think you'd find that people would be served well and that eventually there would be savings that could go to the community for start up funds and other costs to deliver quality care.

Ms. Young highlighted recommendation six because of the vital importance of collecting data that allow for an assessment of outcomes. Because outcomes change there needs to be a way to design data collection processes to serve the varied information needs and to examine the quality of data being provided. Independent review of data quality must also exist. Their organization brought a lawsuit in the 1980's against DDA after feeling they had the legal evidence to show that there was a substantial problem with the quality of care being provided to persons with developmental disabilities. The lawsuit resulted in a consent decree, signed by all the parties in 1994, that mandated several things to occur, some of which were new regulations, implementation of new licensing survey tools, and generation of new reportable incident policies. Some kind of consumer satisfaction guarantee was mandated in the lawsuit; quality assurance plans had to be developed by all providers and approved by the state.

In terms of assessing the success of the Wasserman case, Ms. Young was uncertain if it had been a success or not. She explained that as in any major case, you see some phases of completed work and others that are still being operationalized. She gave a brief picture of the status of the quality assurance case and stated that she felt that the big picture was being missed. Assuming that money changes everything, Ms Young asked the Commission to look at the bigger picture and continue with their recommendations to suggest how the community may better serve their population; one way would be getting more money.

She continued by saying "Let's examine how we can use the system we have with the funding streams we have now to use more money in better ways. I'd like to give a couple of examples of problems that I see that perplex me with the funding stream and may help support this recommendation for more money. The increase in money doesn't need a lot of verbal advocacy for me; clearly the rates need to go up. The Governor's initiative served a lot of people but the waiting list has ballooned again so that there are more people waiting for services again. People in institutions need to come out and the rates need to go up. We should refer to David Braddock's reports about Maryland's position in spending money and compare the per capita income and the amount spent on persons with developmental disabilities. The fact that we rated 38 in the country is an embarrassment.

There are people with dual diagnoses who are stuck in state psychiatric hospitals who are ready to be discharged. Whether that number at any one given time is 30, 40, or 60, there's a significant number of people in state psychiatric hospitals who have dual diagnoses. There is no federal

financial participation going to those people. We don't have a funding stream that moves those folks out into the community. And so we spend a ridiculously high amount of money for them to stay in state psychiatric hospitals. We don't get federal financial participation when the majority of these folks are determined by their treatment teams to be able to live in the community. It's illegally incarcerating them. So what's the problem? There isn't a funding stream; they are caught between two administrations and this needs to change.

We see a number of children that should be able to, through the medical assistance program, draw down all kinds of federal match money for a variety of services, but are not able to get those services. For children under 21, there is a separate programmatic requirement for Medicaid which basically is a universal health care insurer for children. If you have a treatment need then you are supposed to get that need met. So if children need behavioral aids, if children need personal care services, they're supposed to get those services and not be limited by certain hours or caps that the adult system places. But our system is not really set up to provide that. So there are children who come onto the Governor's waiting list initiative on the DD side; waiver slot are used and DD funds are used when they should receive these services under medical assistance from the Medicaid program and not use the scarce DDA resources and waiver slots. But that doesn't happen in part because we don't have a fully developed Medicaid system for children. We have this waiting list for the waiver that says, get in line and we'll try to fund you."

Graham Atkinson stated that while the number of residents in the state facilities has been declining, the operational costs have not declined proportionately. There was concern that the funds were staying with the institution without following the patient.

Mr. Giovanis introduced the next speaker, Ms. Sara Basehart, from the ARC of Maryland who had been invited to discuss the ASK ME! Project which started five years ago. Ms. Basehart discussed one of the stipulations from the lawsuit against the DDA which mandated that a consumer satisfaction survey project be done. The Consumer Satisfaction Quality of Life Survey Project was completed with actual individuals who received services. Ms. Basehart explained, "We began working with DDA, other stakeholders, and people who were really interested in this area of quality assurance. The first thing that the group had to do was to come up with a survey to use. We originally looked at a survey by Bob Shalock, who has been a long time member of AAMR including the past president and have used that survey for the last couple of years. In copyrighting our survey we realized that we were violating some laws so we developed our own survey designed completely by focus groups of People on the Go members.

The survey is divided into 8 dimensions and asks people questions about their material and physical well-being, their community integration, their personal development, their personal interrelationships with other people, transportation, and social activities – quality of life issues. What is very important about the quality measurement activities is face-to-face interviews. People who received DDA funds are randomly selected from participating agencies. This results in having people of all types of disability levels and who receive all kinds of services. The face-to-face interviews are completed by interviewers who have developmental disabilities themselves. It is a real peer-to-peer interview and we have an excellent response rate because there are only 18-20% of people that aren't able to answer the questions.

Several of our interviewers have been with us the whole time and are experienced. Once a year we have a huge training where we talk about the qualities of good interviewers and review all the survey questions. We have ongoing trainings, recommended by Charlie Lakin, who's very well known in the quality assurance field.

The ASK ME! Project has three major goals. The first one is meeting the requirements of the lawsuit. Ms. Basehart supports DDA in complying with the suit. The second goal is to provide the information that we gather from consumers to parents, family members, and other consumers. The third goal is to support provider agencies by offering technical assistance. They are trained annually to learn how to understand the data-oriented information.

Ms. Basehart answered several questions from the audience, examples of which are listed below:

Which agencies normally participate in the survey?
At the beginning it was just predominantly the people who had been involved with developing the survey, people who had expressed interest. We also, quite honestly, wanted very easy agencies our first year. We didn't want to have to fight to get interviewing done, which we haven't run into a lot of but have had happen sometimes. But each year we're typically seeking agencies in certain areas. For example, we've been really focused on the Eastern Shore and Western Maryland the last couple of years so we've really been increasing the number of agencies there. We've also been trying to increase the number of agencies that support people who are deaf because we are working on a very good survey tool for people who are deaf. Also, we have had agencies that request the Ask Me! Survey for the coming year; we try to comply with the request but we cannot interview everybody. At times the quality assurance person at an agency would come to a presentation, hears about the project and takes the information back to the agency. Then they call us. So there various ways agencies join the program.

Has anybody ever refused that you come to an agency?
An entire agency would have already committed before we show up there, but absolutely people still have the right to refuse. Agency staff generally approach the person first, is this something that you're interested in? No, that's fine. We do try to talk to people who say no instantly and explain to them, since they sometimes think this is one more group of people they have to talk to. And certainly that's their right. They can refuse, their guardian can refuse if they don't want the person they are guardian for to be interviewed. Sometimes we even have people come and sit down, ready to be interviewed and then they refuse. We respect that even though it is frustrating.

What is the major limit of the number of agencies?
Certainly the funding is a limit. This is an expensive project. We have $300,000 this year from DDA to interview 1,000 people. Also, the researcher wants us to interview a good percentage of people to get a real feel for the agency and for the information to be useful to an agency. We have come up with a number which is 28.5. Therefore, we typically try to get about 30 people at every agency and I think that gives agencies a good perspective. Clearly an agency that only supports 40 people, that's very different than an agency that supports 4,000. So small agencies are only interviewed every couple of years cause we interview most everyone when we go there and then large agencies, such as BARC and Chimes, will be interviewed every year so that we're interviewing 30 new people every year. But again the money is a limitation. Also we do what is physically possible. We work with an agency in order to interview their people but sometimes

they are receiving services from a different agency in the same county, so we cannot interview them.

Do you routinely do any kind of cross sectional analysis about how people are answering the same question across the agencies?

Absolutely, and that is presented in our final report. In fact, that's a lot of what the final report is - comparing across Maryland what people are saying. Agencies also receive data from their agency as well as aggregate data from all Maryland.

Mr. Giovanis introduced Dr. Michael Chapman, Vice President of the Council on Quality and Leadership in Support for People with Disabilities. Mr. Chapman explained that he is responsible for accreditation and evaluation in the organization. He continued, "in order to address the quality issue it is important to know where we come from as that tells a lot about who we are today and where we see the future in quality and quality assessment in the United States and abroad. The Council has a long history of looking at quality measurement. We are an international organization that sets us apart from our colleagues. There are 4 major accreditation bodies in the United States and us – the Council on Quality and Leadership. What sets us apart is that we accredit organizations – not programs. So the standards that we apply, apply to the organization, and not to a program.

For example, I used to work at McKenna and Creek and our Early Childhood Programs and our Service Coordination Programs had been accredited by different standards that applied to those different programs. With the Council, there is only one set of standards that applies to all programs. This is important. However, all accrediting bodies ask 3 questions: What is quality? How do you measure quality? And how do you go about improving quality?

That is what accrediting organizations do. They set up criteria for an independent 3rd party view of organizations that have nothing to do with the organization. The Council establishes the definition of quality and then seeks to apply that definition through the accreditation process.

What makes up the Council? The Council is a 26-member board that includes representation from the major disability groups in the United States. For example, the United Association on Mental Retardation, the American Psychological Association, and the Epilepsy Foundation of America send representatives. Those people and others make up the Council. And through their work they focus very heavily on "What is quality and how do you go about measuring it?"

A very popular item these days is that of outcomes. Most national conferences cover Outcomes and Outcomes Measurement. That word has become overused and misunderstood. It is very important when we talk about quality and quality management that we have a common language and a common definition of the word 'outcome.'

There are over 200 different measurements of outcomes - management outcomes, fiscal outcomes, programmatic outcomes, personal, functional, and medical outcomes. And every one of those has a different meaning to each individual, especially when it comes to the measurement of quality.

Clinical outcomes usually mean certain symptoms - a person has depression, or has epilepsy or has limited range of motion in their arms, etc. Those are clinical types of outcomes. With clinical types of outcomes the emphasis is on decreasing them. How do we then measure quality when it comes to clinical outcomes? We tend to do that through record review to see the affects of the services on the clinical outcomes of people.

When we talk about functional outcomes, we refer to people's activities of daily living. Typically, we want to increase functional outcomes, that is, how well a person feeds himself, bathes himself, uses the restrooms, eats – all types of daily activities. There are several types of norms- reference and criteria-reference tests to understand peoples' functions to the point where it proved troublesome.

Personal outcomes are very different because they focus on peoples' dreams and aspirations. There is no test for peoples' dreams. There is no test to understand what is important for people in this life. So there is no measurement system personal outcome in terms of a formalized system; the only way to test personal outcome is by talking to people, which is critical in our service system.

Dr. Chapman gave some examples to illustrate his point. He explained that it was important for direct support staff to be aware of the language they use in describing the people they serve. "If we talk about our clients or our consumers, we're creating a mindset for people in terms of what we are doing or should be doing for people. When you go back to your programs, listen to the language. How are people being described? That will indicate the mindset of your organization and what they see as their primary mission – whether they see their people as being at the clinical outcome, functional outcome or personal outcome levels.

At the Council, we believe very strongly that we need good clinical measures. We need to demonstrate the effectiveness of our occupational therapists, of our physical therapists, of our psychiatrists, and of our physicians. We need good functional outcomes for people. People need to learn how to feed themselves, how to dress themselves, how to use the restroom. We still need to teach those types of skills to people. However, we would say that absent a personal definition, forcing those types of things on people, is a waste of time, energy and resources. So we want to be very clear about the context in which we have talked about services and supports to people.

The Council has 35 years of experience in defining quality and figuring out systems for measuring quality. In the early part of our history we had 754 organizational process measures that were used to define quality. So the accreditation review under our old system consisted primarily of walking into a conference room, greeting our host, then spending 3 or 4 days poring over records and policies and procedures, looking to make check marks on 754 organizational process measures. Is there a mission statement? Are there policies and procedures? Is there a policy on abuse and neglect? Is there a policy on the passing of medications? Each individual has a single plan. The Council, in its effort to be very proactive, in its effort to be very contemporary, indicated a need for an item that focused on people having single plans.

In 1971, I was a direct care worker in an institution in North Carolina. What did we do back in 1971 if we needed a feeding protocol for somebody? We would go through the files and pull out the drawer under "F" and we would go to "F" for "Feeding" and there was a task analysis already

written - suggestions for reinforcement strategy and a data sheet already attached to it. All I had to do then was fill in the person's name and there was her plan.

The Council, at one of its meetings decided that the process did not work and it should be replaced with individual plans; therefore Item #441 requires individual plans that are written so all concerned can understand them. The assessment process is about people understanding information written about themselves so the plans should be written by the person who is being evaluated or assessed and by direct support staff, as well as other physicians.

We then looked at what was going on 3 to 6 months before the actual accreditation review. Services stopped being provided because we had to chase the paperwork around; somebody find that mission statement, put it in a file, label it in big letters so that when the team arrived, someone can check off item #111. What does the mission statement say? Who cares; that didn't matter. Just check off that the organization had a mission statement and put the file back. That was the purpose because the definition of quality rested on organizational process measures that was defined by a group of professionals that come together for the purpose of defining and measuring quality. The whole idea behind accreditation was uniformity and consistency so that each organization has a mission statement, procedures, and organizational charts. Consistency and uniformity across programs was quality.

In 1990, the Council held a series of focus groups around the United States and in Canada. We brought together thousands of people with disabilities and asked them to tell us what quality measure they would look for? The consensus was that not one person with disabilities cared about a mission statement, policy manual or organizational chart

As vice president of Kennedy Krieger Institute, where I ran a residential programs I needed a mission statement. That mission statement said who we are as an organization. We needed to share that mission statement with consumers - the people that we were trying to support - with the state, with family members, with whomever else was important to us. We need good mission statements to manage and run our organizations. We also need policies and procedures and organizational chart to have a good organization. However, these things mean nothing in terms of quality.

Also, the definition of the word "quality" varies depending on who is defining it – consumers or professionals. When consumers in our focus groups defined quality, they did not mention a single item that matched any of the 754 organizational process measures that were developed by professional consensus. If you want a quality driven system, quality has to be defined by the service users, the people whom we are funding and supporting. By professional consensus, quality was measured by looking at organizational processes. By consumer consensus, quality was measured by looking at the effects of services and by providing the best resources for people to have a meaningful life. Twenty-five simple statements reflect the consumer viewpoint. Examples of these are: I choose my own personal goals; I choose my own goals; I choose where and with whom I live; I choose where I work; I am satisfied with services; and I am satisfied with my personal life situations.

Trying to implement such a change created the greatest challenge to service providers because the service system is not set up for this. Furthermore, the state became uncomfortable with the idea

that people could make their own goals. Professionals felt that they were better educated and qualified; whereas consumers felt it was vital that they choose their own daily routines. When consumers are asked what they want, the first thing they say is a real job, the second is money, real earnings, not the wages they earn in the day centers, and the third is friendships, meaningful relationships. The challenge we have is in providing services where these things can be achieved.

From the 25 measures of quality, we look closely at two things in particular. First, we can derive how an individual defines the term outcome. For example, one of the outcome measurements says that people should have friends. How many friends should people with disabilities have? Recently, I came back from a meeting from a state that had just mandated to every service provider that each person that they support must have 4 friends; it is unbelievable.

The accreditation review is no longer looking at paper; it is looking at the effects of that paper on people's lives. So we do that by literally going out and interviewing and talking to people receiving services; much like the Ask Me! Project. Dr. Chapman gave an example of the response he got from two women when he asked if they had friends - one didn't want any friends because they were an emotional burden to her and the other rattled off ten names. Whether or not the outcome of having friends is present various depends on individual definitions of what friendships means to them. And that's very critical to understand.

The second thing that we look at - given the definition of what is important to each person for each of the 25 outcomes – is what does an organization do about it. We have proven that when the focus of an organization is on individual support quality of service exists."

Mr. Chapman ended his presentation by sharing some data with the meeting participants and answering some questions.

The meeting adjourned at 4:00 p.m. Mr. Giovanis thanked the participants and informed them that the next Commission meeting would be held on January 8th, 2001. The topic will be MHA quality measurement.

APPENDIX C

STATUS OF 2002 RECOMMENDATIONS

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.

Status: The legislature mandated that MHA must pay for gray area services by means of grants or contracts, and not through the fee-for-service system. This has resulted in administrative complications for the providers, MHA and MHP, and is the subject of a recommendation in this report. The levels of authorized services have been reduced.

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.

Status: This recommendation has not been implemented. However, the legislature did modify the Commission's enabling legislation to require that the Commission design an updating system, and recommend annually an update factor. The required paper is attached as Appendix B-3 to this Annual Report.

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.

Status: MHA has had a consultant examining rates, with particular emphasis on children's rates, and is currently engaged in a detailed cost study to determine the adequacy of the rates. Substantial increases were provided in certain rates effective July 1, 2002 to deal with the type of problems discussed above. No progress has been made on dealing with the issue of low levels of payment for dual eligible Medicare/Medicare beneficiaries. Reductions in gray area eligibility are likely to further exacerbate the uncompensated care problems.

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.

Status: The legislature required that MHA collect financial reports. MHA has requested that the CSAs provide the financial reports of their providers to the CSRRC so that an analysis of financial condition can be undertaken. To date about 40 financial reports have been made available and CSRRC staff is analyzing data extracted from these reports. MHA has engaged a consultant to survey providers, and study their rates and costs. MHA has provided technical support to some providers.

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.

Status: No reductions to DDA rates or payments were made. In fact, rates were increased effective July 1, 2002.

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.

Status: This recommendation has not been implemented. However, the legislature did modify the Commission's enabling legislation to require that the Commission design an updating system, and recommend annually an update factor. The required paper is attached as Appendix B-3 to this Annual Report.

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.

Status: The providers have the flexibility to apply the additional funds to direct care wages or fringe benefits. No other flexibility has been provided.

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.

Status: Data collection for assessment of outcomes is being undertaken. The Commission staff have obtained copies of Cost Reports from DDA and are currently conducting an analysis of these reports.