Community Services Reimbursement Rate Commission

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CONTENTS

Page

Community Services Reimbursement Rate Commission Membership 1

Reporting requirements 2

Executive Summary & Recommendations 3

Commission Activities 11

Future Activities 12

Developmental Disabilities Administration 13

Mental Hygiene Administration 26

Acronyms 40

Glossary of Technical Terms 41

Appendix A: Commission Biographical Sketches 43

Technical Advisory Group membership 45

Appendix B: Papers Produced by the Commission in CY 2003 46

B-1 The Financial Condition of Providers of Community Services Contracting with MHA, Fiscal Years 1999 though 2002 47

B-2 Psychiatric Rehabilitation Program Salary Survey 57

B-3 Proposed Update for DDA and MHA rates 62

B-4 The Financial Situation of Providers of Community Services Contracting with DDA, Fiscal Years 1997 through 2002 64

B-5 Wage Rate Survey of DDA Providers - 2003 75

B-6 Analysis of DDA Cost Reports 83

Appendix C: Status of CY 2002 Recommendations 87

COMMUNITY SERVICES REIMBURSEMENT RATE COMMISSION

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

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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 8 years. Each year the Commission publishes an Annual Report on its activities, findings, and recommendations. This is the eighth 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.

As a result of the Commission's concern about quality of care the December 4, 2000 meeting was devoted to quality issues in services for individuals with developmental disabilities, and the 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 was prepared and included in the 2002 Annual Report.

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 wage increases given by the providers to direct care workers have exceeded or equaled the rate increases they have received.

- 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 DDA providers has substantially improved in the past two years, but the data from the MHA providers is still inadequate.

- 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 the mid-1990s the public mental health system was expanded to serve more individuals without Medicaid who are eligible for public subsidies for selected services, but without a commensurate increase in the overall budget. Between 1998 and 2003 the number of individuals served increased

by 40%. As would be expected, MHA experienced budget shortfalls. MHA is now responding to ongoing budget overruns by cutting back on gray area eligibility and limiting rehabilitation services for gray area and Medicaid eligible adults and children. 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 often 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 although that may change with the budget cuts being made in FY 2004. Many rehabilitation providers are anticipating cuts of 10% or more in revenues. Several providers have closed programs for children and adolescents due to financial pressures. The majority of the providers contracting with DDA have a positive margin, but the mean margin dropped to about 1% in fiscal year 2001, and recovered slightly in 2002. Many 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. The Commission intends to study the changes being made in the MHA fee schedule to make it HIPAA compliant, and the effects of these changes on the financial condition of the providers.

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.

Some of the community services rates paid by MHA were increased in fiscal years 1999, 2000 and 2003. 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, all the Medicare Prospective Payment Systems include such an updating system, e.g., the nursing home, home health, and physician payment systems. The Health Services Cost Review Commission has such a system for updating the rates of the hospitals, both inpatient and outpatient, and 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 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 Commission recently received comments from MHA on its proposed updating system, and will consider changes and refinements to the proposed system to take account of these comments.

2. MHA should require the annual submission of audited financial reports[1] and should have the authority to apply financial sanctions against providers who fail to submit required reports.

Weak financial performance can impact on access to services, and the provision of quality services. Thus, it is important for MHA and the Commission to track the financial condition of the providers in a timely manner, and to respond if the financial condition looks weak. The ability to do this is restricted by the lack of availability of financial statements. To date the Commission's analysis has relied on an incomplete sample of audited financial reports gleaned from a variety of sources, MHA audit division records, CBH records, and the CSAs. This has limited the ability to draw conclusions, and made the reports much less timely than would be desirable.

Having an almost complete set of audited financial reports available in a reasonably timely manner would allow the Commission, and MHA, to assess the financial condition of the providers in general, and also to identify providers with particular problems, for whom a focused intervention might be required. This will aid in planning for changes to alleviate problems, and avoid unexpected closures of providers, which could potentially result in access problems. Once the Commission sunsets it will be important for MHA to continue the collection of audited financial reports and other data, and analyze the financial condition of the providers.

3. The Commission supports the concept, currently being explored by MHA, of paying for some types of services on an aggregated basis, provided adequate safeguards are included to maintain quality of care.

MHA is considering paying monthly case rates for selected packages of services. A change to an appropriately sized rate could provide more flexibility to providers in their provision of services, while at the same time reducing administrative costs for pre-authorization of services, both for the providers and the administration. However, paying for bundles of services can provide a financial incentive to underserve, so appropriate safeguards should be built into the reporting systems to monitor levels of services when such changes are made.

When the Commission started operations one of its first tasks was to examine the incentive structure of the payment system. At that time the issue of capitation or case rates was broached. While such payment mechanisms can provide additional flexibility to providers in how they provider services, neither the financial data or the quality monitoring mechanisms then available were considered adequate to accurately determine the appropriate case/capitation rates or to protect against potential underservice. In the interim MHA has gained experience in case rate/capitation payment systems with its ongoing demonstration with Baltimore Mental Health System, and its information

[1] Or an unaudited report with equivalent data if the provider does not have an audited financial report.

monitoring capabilities have vastly expanded through Maryland Health Partners. The time is now ripe to proceed with expansion of the use of case and/or capitation payment systems for selected services.

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 have only been applied 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 to 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, all the Medicare Prospective Payment Systems include such an updating system, e.g., the nursing home, home health, and physician payment systems. The Health Services Cost Review Commission has such a system for updating the rates of the hospitals, both inpatient and outpatient, and 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 most fiscal years, 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.

The Commission has recently received comments from DDA on its proposed updating system, and will consider changes and refinements to the proposed system to take account of these comments.

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, remain 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 and increased slightly to 1.3% in FY 2002. Over the past several years the providers have given wage increases in excess of the rate increases, and this has eroded their profit margin.

3. Additional requirements should be put in place to ensure the consistency of the wage and benefit information being submitted by the providers in response to the annual wage and salary survey.

The wage and fringe benefit information submitted by the providers is essential for monitoring the progress of the wage equalization initiative, and in observing whether the additional funds provided by DDA are being used for the purposes for which the funds were intended. Comparison of the data submitted by the providers in recent surveys suggests that there are inconsistencies in the way in which these data are being reported between years. The Commission staff and DDA have discussed these inconsistencies, and the need for additional validation of the data. Additional reviews should be implemented to allow for the required verification.

For its part, the Commission will work with DDA and MACS to improve the instructions for the wage survey, and will provide one or more training sessions on the importance of the survey information, the purposes for which the surveys are used, and how the data should be reported.

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 6, 2003
April 7, 2003
September 8, 2003
December 1, 2003
January 5, 2004
April 5, 2004
September 13, 2004
December 6, 2004

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

February 3, 2003
March 3, 2003
May 5, 2003
June 2, 2003
August 4, 2003
October 6, 2003
November 3, 2003
February 2, 2004
March 1, 2004
May 3, 2004
June 7, 2004
August 2, 2004
October 4, 2004
November 1, 2004

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 DDA and audited reports for MHA providers as available. 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 review its updating methodology and 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 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, transportation, community-supported living arrangements, residential alternative living units, and residential group homes. If medical day care is required this is paid for directly by Medical Assistance. Approximately $477 million of the Developmental Disabilities Administration's (DDA) FY 2004 budget is for community programs and $64.5 million is for institutional services. Approximately $167 million of this total budget is 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 2003 are shown in Charts 2 to 4.

The principal current DDA payment system is the Fee Payment System (FPS). $312 million is funded through the FPS. 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 were 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.

The balance of payments for community programs are made through contracts and the community supported living arrangements (CSLA) payment system (approximately $40 million). The CSLA system was commenced in fiscal year 2001 DDA. This system pays for services based on the hours and service needs identified as being required by the individual in their individual service plan. It expanded substantially between 2002 and 2003.

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 was attached as Appendix B-5 to the 2003 Annual 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 with expansions and modifications in fiscal years 2000, 2001, 2002, and 2003, with similar conclusions. The latest report on the wage survey is attached as Appendix B-5.

The governor and legislature have provided funds for a wage equalization program designed to bring the wage levels of direct care workers to comparable state levels over 5 years. The first 2 years of these funds have already been provided.

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-5 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 prepared a paper on the subject. This paper was attached as Appendix B-3 to the 2003 Annual Report, and the recommended update factor for the upcoming fiscal year is included in Appendix B-3 of this report.

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 AGC&T 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[2].

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 casts 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.

[2] 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.

Transition

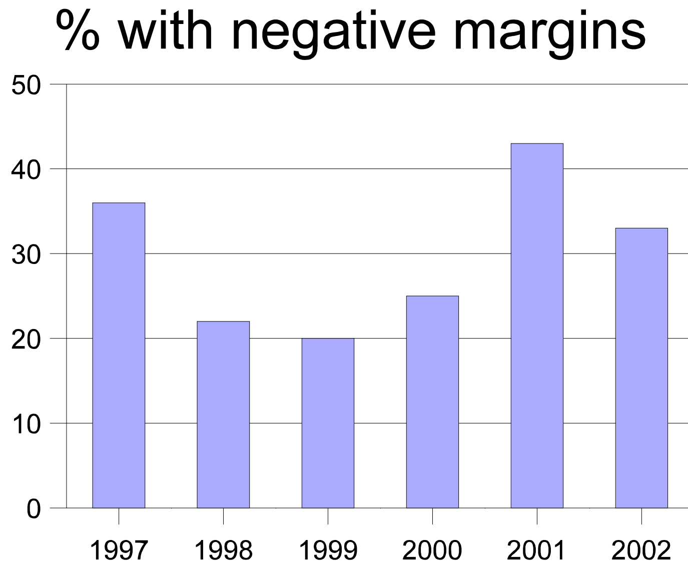
The changes to the system were phased in over a 3-year period. This appears to be a reasonable time period over which to have spread the changes, and it gave time for providers to modify their cost structure to respond to the changes in their payment stream. The Commission has analyzed the impact of 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 continues 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. The Commission has analyzed the audited financial reports for that year. This analysis shows a slight increase in the profit margin from 2001 to 2002, but the financial condition of the providers remains weak. The report on this analysis is attached as Appendix B-4 to this report. The fact that there was little change in the financial condition of the providers between 2001 and 2002 suggests that the phase-in of the change was successful in allowing the providers time to plan for, and respond to, the change in payments.

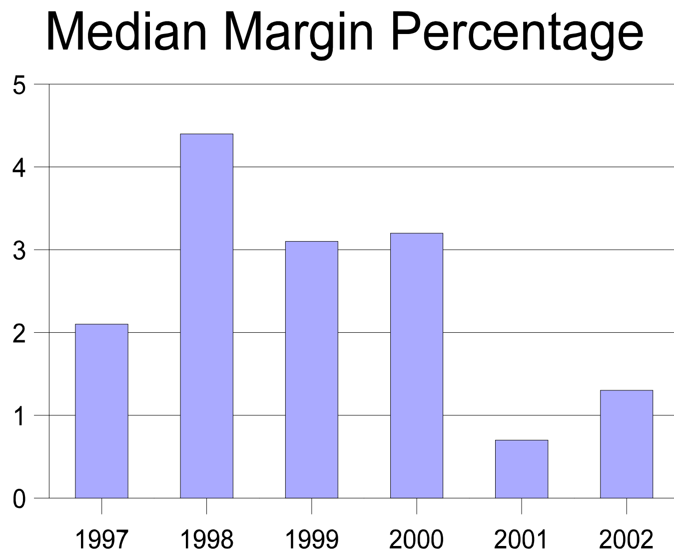
Efficiency and Effectiveness / Financial Status of Providers

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 analyzed 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 through 2002. The trends in the median margin and the percentage of providers with negative margins can be seen in the two charts.





The Commission's report on these financial analyses is attached as Appendix B-4.

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 and analyzed the Cost Reports for about 100 providers for FY 2002. These data and analyses were discussed with the DDA TAG. A report on this analysis is attached as Appendix B-6. Additional analyses are planned once the FY 2003 Cost Reports are available.

Turnover and wage levels

Based on input and advice from the Technical Advisory Group on DDA the Commission designed a wage and turnover survey. This survey has been updated and modified as necessary and mailed to the providers annually. A report summarizing the results of these surveys is attached as Appendix B-5 to this Annual Report. The analyses of these survey responses have consistently showed that direct care workers are paid substantially less than corresponding state workers, particularly when fringe benefits are taken into account. Turnover rates were around 42% for aides in 2003. Turnover rates for all categories of employees declined from 2002 to 2003, probably reflecting the general downturn in the economy, and the lack of alternative jobs.

Wage rates of direct care workers increased about 5% between fiscal year 2002 and fiscal year 2003, similar to the increase the providers received in their rates, but the wage rates are still well below the wage rates of comparable state positions. As in prior years the major sources of the additional wages were the rate increase provided, with the wage equalization fund providing some of the revenue for the wage increase in the past 2 years. In contrast with recent past years, wage increases were not subsidized by 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 with discussions in the DDA TAG of what these costs are, and whether any adjustment in rates has been made for them. A paper on this subject is in process, but is not yet complete.

Future system

The Commission staff responded to questions from DDA on the design of a special rate system for high cost users. The Commission 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 have only been applied 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 to 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, all the Medicare Prospective Payment Systems include such an updating system, e.g., the nursing home, home health, and physician payment systems. The Health Services Cost Review Commission has such a system for updating the rates of the hospitals, both inpatient and outpatient, and 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 most fiscal years, 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.

The Commission has recently received comments from DDA on its proposed updating system, and will consider changes and refinements to the proposed system to take account of these comments.

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, remain 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 and increased slightly to 1.3% in FY 2002. Over the past several years the providers have given wage increases in excess of the rate increases, and this has eroded their profit margin.

3. Additional requirements should be put in place to ensure the consistency of the wage and benefit information being submitted by the providers in response to the annual wage and salary survey.

The wage and fringe benefit information submitted by the providers is essential for monitoring the progress of the wage equalization initiative, and in observing whether the additional funds provided by DDA are being used for the purposes for which the funds were intended. Comparison of the data submitted by the providers in recent surveys suggests that there are inconsistencies in the way in which these data are being reported between years. The Commission staff and DDA have discussed these inconsistencies, and the need for additional validation of the data. Additional reviews should be implemented to allow for the required verification.

For its part, the Commission will work with DDA and MACS to improve the instructions for the wage survey, and will provide one or more training sessions on the importance of the survey information, the purposes for which the surveys are used, and how the data should be reported.

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. Almost 90,000 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. This should be contrasted with the 64,000 individuals served in 1998. The number of people served has grown by 40% from 1998 to 2003.

Chart 5 shows the distribution of MHA expenditures by type of service, and Charts 6 though 8 show the changes in MHA expenditures between fiscal years 1998 through 2003. It is of interest that the expenditures on state hospitals have been steadily increasing, in spite of slowly declining volumes of service (the average length of stay is increasing, and the number of admissions is declining), although the volume did increase slightly in FY 2003, reversing the trend. This is a similar pattern to that which was observed in the State Residential Centers funded by DDA. Expenditures on psychiatric rehabilitation services grew particularly fast, more than doubling between 1998 and 2002. In 2003 uninsured PRP services were shifted to being grant funded. Once these grants are taken into account PRP services grew by 12% from 2002 to 2003. The grants amounted to \$9,600,000 for uninsured PRP and RRP services. Outpatient expenditures grew by \$35 million between 2002 and 2003.

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. In response to HIPAA the fee schedule is currently under revision. The Commission will monitor the impact of these revisions.

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.

MHA Budget Shortfalls

MHA has experienced budget shortfalls due to expenditures on community services each year for the past several year. The Commission examined summary data from Maryland Health Partners in order to obtain a better understanding of why these shortfalls might be occurring. A major reason for the increases in expenditures is increased enrollment, particularly Medicaid enrollment, and particularly among children and adolescents. Increases in Medicaid enrollment are not within MHA's control, and so MHA should not be held accountable for the increased expenditures attributable to the enrollment increases. While MHA might have better anticipated the increases in enrollment and expenditures, and budgeted accordingly, it is not clear that their budget would have been increased sufficiently to cover the increased expenditures if they had anticipated them.

In response to the budget shortfalls MHA has imposed more restrictive utilization review criteria for authorization of services. In addition, starting in January 2004 the budget for fee-for-service community services will be reduced by $20 million in general funds. This reduction will have some impact on OMHCs, but is expected to be largely borne by the rehabilitation providers.

The number of children enrolled in Medicaid and using services paid for by MHA grew by almost 10,000, or 62%, between 1998 and 2003. The number of adolescents grew by almost 7,000, or 120%.

Average annual cost per consumer grew by 17.6% from 1998 to 2003, for an average annual growth rate of 3.3%. These increases are in keeping with general inflation over this time period.

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. MHA is working with the University of Maryland to implement their “Managing for Results” outcomes measurement system statewide. So far this project has identified domains and measurement instruments and is about to enter a pilot testing phase. MHA is also pilot testing instruments to be used as assessment tools for children needing residential treatment and less restrictive community services.

The Commission has prepared a paper on the measurement of quality and outcomes and this paper was attached as Appendix B-5 to the 2003 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) conducted studies of wage levels each year from 1998 through 2003, and summaries of the results have been included in prior Annual Reports. A summary of the results of the fiscal year 2003 study is attached as Appendix B-2 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 sent out to their providers in August. 19 responses were received to this survey. A summary of the results of that survey is included in Appendix B-6 of this Annual Report, along with the results of an analysis of audited financial reports from providers. Many of the outpatient mental health clinics (OMHCs) are in poor financial condition, with major losses. This problem is sufficiently widespread that it could result in access problems. The analysis has confirmed the financial weakness of the OMHCs, and suggests that there may be closures of additional clinics or services 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 sponsored a study on the adequacy of the rates paid for community services. This study compared the rates for the individual procedures with the costs being incurred by providers to provide these procedures. The report on the study was published in 2003.

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. Availability of more complete data would allow the Commission to perform a more comprehensive and definitive analysis, including an analysis of financial condition by region of the state.

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 prepared a paper on the subject. This paper was attached as Appendix B-3 to the 2003 Annual Report. The Commission's

recommendation on an update factor based on current inflation information is attached as Appendix B-3 to this report.

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, 2001 and 2002. Summaries of the results of these surveys were attached to previous Annual Reports. 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 four 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. The source of the additional wage increases was the profit margin of the providers, which has declined over time.

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 financial condition in FY 2000 and FY 2001 is similar to that reported for 1999. In the 2003 Annual Report the Commission predicted that changes for the worse were 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. Unfortunately, this prediction was accurate, with margins dropping by 3 percentage points to 1%.

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 current situation is reported in Appendix B-1.

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.

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, increased data availability through MHP will allow for the development and implementation of case rates for selected services.

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 with discussions in the MHA TAG of what these costs are, and whether any adjustment in rates has been made for them, or is necessary. A report on this subject is in process, but is not yet complete.

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. The Commission 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 continues to observe the performance of the "capitation" pilot demonstration[3] currently taking place in Baltimore City and is taking 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.

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

New Payment Structure Evaluation

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

RECOMMENDATIONS

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.

Some of the community services rates paid by MHA were increased in fiscal years 1999, 2000 and 2003. 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, all the Medicare Prospective Payment Systems include such an updating system, e.g., the nursing home, home health, and physician payment systems. The Health Services Cost Review Commission has such a system for updating the rates of the hospitals, both inpatient and outpatient, and 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 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 Commission recently received comments from MHA on its proposed updating system, and will consider changes and refinements to the proposed system to take account of these comments.

2. MHA should require the annual submission of audited financial reports[4] and should have the authority to apply financial sanctions against providers who fail to submit required reports.

Weak financial performance can impact on access to services, and the provision of quality services. Thus, it is important for MHA and the Commission to track the financial condition of the providers in a timely manner, and to respond if the financial condition looks weak. The ability to do this is restricted by the lack of availability of financial statements. To date the Commission's analysis has relied on an incomplete sample of audited financial reports gleaned from a variety of sources, MHA audit division records, CBH records, and the CSAs. This has limited the ability to draw conclusions, and made the reports much less timely than would be desirable.

Having an almost complete set of audited financial reports available in a reasonably timely manner would allow the Commission, and MHA, to assess the financial condition of the providers in general, and also to identify providers with particular problems, for whom a focused intervention might be required. This will aid in planning for changes to alleviate problems, and avoid unexpected closures of providers, which could potentially result in access problems. Once the Commission sunsets it will be important for MHA to continue the collection of audited financial reports and other data, and analyze the financial condition of the providers.

3. The Commission supports the concept, currently being explored by MHA, of paying for some types of services on an aggregated basis, provided adequate safeguards are included to maintain quality of care.

MHA is considering paying monthly case rates for selected packages of services. A change to an appropriately sized rate could provide more flexibility to providers in their provision of services, while at the same time reducing administrative costs for pre-authorization of services, both for the providers and the administration. However, paying for bundles of services can provide a financial incentive to underserve, so appropriate safeguards should be built into the reporting systems to monitor levels of services when such changes are made.

When the Commission started operations one of its first tasks was to examine the incentive structure of the payment system. At that time the issue of capitation or case rates was broached. While such payment mechanisms can provide additional flexibility to providers in how they provider services,

[4] Or an unaudited report with equivalent data if the provider does not have an audited financial report.

neither the financial data or the quality monitoring mechanisms then available were considered adequate to accurately determine the appropriate case/capitation rates or to protect against potential underservice. In the interim MHA has gained experience in case rate/capitation payment systems with its ongoing demonstration with Baltimore Mental Health System, and its information monitoring capabilities have vastly expanded through Maryland Health Partners. The time is now ripe to proceed with expansion of the use of case and/or capitation payment systems for selected services.

ACRONYMS

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

ASO: Administrative Services Organization

CBH: Community Behavioral Health Association of Maryland, Inc. (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

HCFA: Health Care Financing Administration

HIPAA: Health Insurance Portability and Accountability Act.

HSCRC: Health Services Cost Review Commission

MACS: Maryland Association of Community Services, Inc.

MAPSS: Maryland Association of Psychiatric Support Services, Inc.

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

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 15 years. Crossroads is a private, non-profit organization located on the Eastern Shore serving children and adults that have a mental health diagnosis. Services include day, residential, vocational, community support and case management. Mr. Plaskon received his B.S. in meteorology from Rutgers University, an M.S. in educational psychology from Texas A&M, a certificate in administrative practice from UMBC and is a graduate of Shore Leadership. He currently serves on the Boards of the Kent Island Youth Center, the Upper Shore Community Mental Health Center and the Community Behavioral Health Association of Maryland.

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 past and current 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

Tracey DeShields - DHMH
Jerry Lymas - Commissioner
John Plaskon - Commissioner
Herb Cromwell - Community Behavioral Health
Lori Doyle - Dulaney Station
Ray Lewis - MHA
Tim Santoni - MHA
Bob Pitcher - MACSA
Frank Sullivan - MACSA
Theodore Giovanis - Commissioner (ex-officio)

Technical Advisory Group on DDA issues

Tracey DeShields - DHMH
Alan Lovell - Commissioner
Jerry Lymas - Commissioner
Arthur Gold - MACS
Diane McComb - MACS
Scott Uhl - DDA
Tim Wiens - Jubilee
Theodore Giovanis - Commissioner (ex-officio)

Appendix B

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

B-1 The Financial Situation of Providers of Community Services Contracting with MHA, Fiscal Years 1999 through 2002.

B-2 Psychiatric Rehabilitation Program Salary Survey

B-3 Proposed Update for DDA and MHA Rates

B-4 The Financial Situation of Providers of Community Services Contracting with DDA, Fiscal Years 1997 through 2002

B-5 Wage Rate Survey of DDA Providers - 2003

B-6 Analysis of DDA Cost Reports

Appendix B-1

The Financial Situation of Providers of Community Services Contracting with MHA, Fiscal Years 1999 through 2002.

The Financial Situation of Providers of Community Services Contracting with MHA, Fiscal Years 1999 through 2002

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 mental health providers of community services and show trends for the fiscal years 1999, 2000, 2001 and 2002 in response to the statutory obligation.

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. A second 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 MHA payment system. Another caveat is that the set of providers reporting is not the same in each year.

Data sources

The data used for this analysis were extracted from the fiscal year 1999 through 2002 Audited Financial Reports, which were obtained from a variety of sources. The following tables shows the number of audited financial reports that were available for analysis in each year.

Year	1999	2000	2001	2002
No. of reports	19	48	47	33

The following data fields were extracted from the fiscal year 2002 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
- Receivables
- Bad debts

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 seven 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
Asset turnover:	Total revenues/Total assets
Net assets:	Total assets - Total liabilities
Days in receivables:	(Receivables/revenues) x 365
Days of cash:	(Cash/expenses) x 365

A ratio that has been used by the Commission in the past is

Return on total assets [(Total revenues - Total expenses)/Total assets].

However, this ratio has been highly variable, and was dropped from this analysis as being too volatile to be a useful indicator.

Results

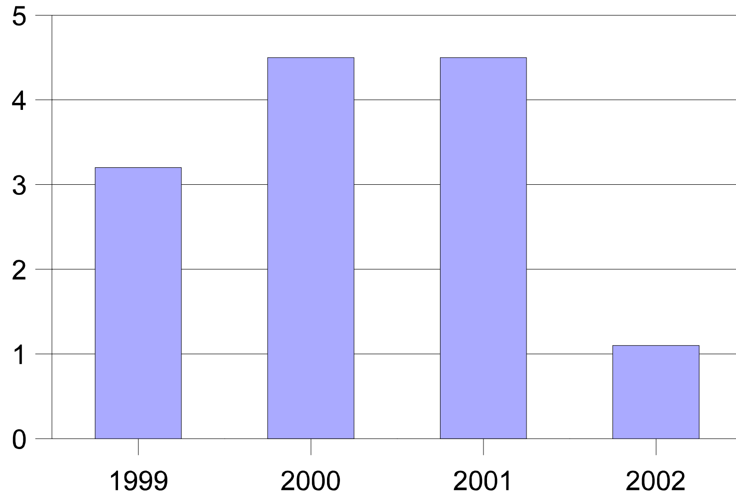
Profit Margin

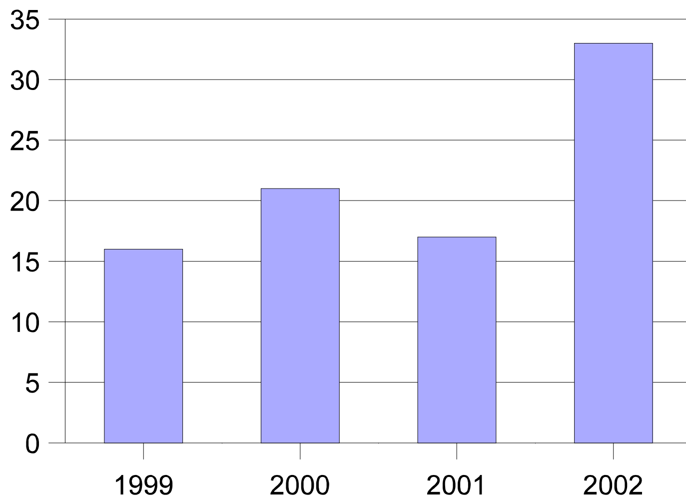
The term "profit margin" is used as it is generally understood. However, it should be noted that while most of the providers are "not-for-profit" organizations, all organizations require some level of profit in order to sustain their existence and build up funds to replace their buildings and equipment. 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 and the spread of the margins are shown in Table 1.

Table 1: Profit Margins	FY 1999	FY 2000	FY 2001	FY 2002
Maximum	14.3%	34%	26.7%	24.2%
Median	3.2%	4.5%	4.5%	1.1%
Minimum	-11.4%	-5.0%	-8.1%	-9.1%
Mean (weighted)	5.3%	6.0%	5.2%	2.3%

Of the providers of community services included in this analysis for FY 2002 11 of the 33 had negative margins (i.e., 33%). The margins were not statistically significantly correlated with the size of the provider.


Median Margin Percentage
5
4
3
2
1
0
1999
2000
2001
2002


% with negative margins
35
30
25
20
15
10
5
0
1999
2000
2001
2002

Current ratio

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

Table 2: Current ratio	FY 1999	FY 2000	FY 2001	FY 2002
Maximum	8.5	37	35	11
Median	1.6	2.0	2.4	2.1
Minimum	0.6	0.01	0.04	0.3

The providers of community services experienced an increase in their current ratio from 1999 to 2000, and a drop in 2002.

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 and receivables

Cash and investments were 12.0% of the total expenses. The cash available, thus, represents 44 days of expenses. 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.

Table 3 shows the percentage that cash and investments comprise of total expenses in recent years:

Table 3: Cash & investments	FY 1999	FY 2000	FY 2001	FY 2002
Percentage of expenses	7.1%	9.0%	7.2%	12.0%

While this table suggests a substantial improvement in the cash position of the providers in FY 2002 it should be interpreted cautiously. The set of providers included in the analysis changes between years, and only 33 providers are included in the FY 2002 analysis. Also, our ability to identify all cash and investments in the audited financial reports has improved over time.

Receivables comprised 11.0% of the total revenues, so providers had, on average, 40 days of revenue in receivables.

Net assets

Of the community service providers included in the analyses, 3 had negative net assets in FY 1999, 5 had negative net assets in FY 2000, 2 had negative net assets in FY 2001 and 2 had negative assets in FY 2002. 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.

The two providers with negative net assets in FY 2002 also had negative net assets in FY 2001 and FY 2000.

Bad debts

Bad debts are not reported uniformly by the providers in their audited financial reports, so the figures presented here are almost certainly underestimates of the amount of bad debts experienced. However, they are indicative of the order of magnitude of the bad debts, and the trends over time.

Year	1999	2000	2001	2002
Bad debt %	1.3%	1.2%	2.0%	2.4%

Situation survey results

The data reported above is for fiscal year 2002, and there was a concern that the situation may have changed in FY 2003. Audited financial reports will not be available for some time, so the Technical Advisory Group recommended that a simple survey be carried out to determine whether providers were in financial distress, and whether services were being closed or reduced in size. A simple one page survey form was prepared, and distributed through the Core Service Agency directors. Nineteen responses were received to this survey, of which 12 have OMHCs. The results are tabulated below.

Most providers (15 0f the 19) served more people in FY 2003 than in FY 2002.

Programs that experienced reductions in staffing were: Adult PRP (4), Child and Adolescent PRP (2), OMHC (2), Residential crisis for Child and Adolescent (1), and Other (1).

5 providers closed programs in FY 2002 or FY 2003, and 3 have plans to close programs in the current year. The 4 programs closed were: Horses, Child and Adolescent PRP (2) and Adult PRP. There are plans to close an Adult Residential Crisis program, OMHC and a Supported Employment program. 32% of the agencies and 42% of OMHCs lost money in FY 2003. However, very few people are being turned away due to inability to pay, and the time between intake and first visit is about a week.

Summary results of situation survey - 19 responses in total.

Question	Number of positives	Percentage of positives
Is the number of employees as of this date fewer that the number of FTEs as of this date a year ago?	6	32%
Did you close any programs in the period July 1, 2001 to June 30, 2003?	5	26%
Do you have concrete (90% probability of higher) plans to close any programs in the current year?	3	16%
Did your agency lose money in FY 2003?	6	32%
Did your agency serve more people in FY 2003 than in FY 2002?	15	80%
If you have a waiting list, or turned away people due to capacity limits, is the waiting list longer, or the number turned away higher, this year versus last?	4	21%
For OMHCs only: Count of OMHCs	12	
How many people does your clinic serve a month? Total number of people	6,585	
How many people does your clinic turn away a month due to inability to pay? Total number of people	25	
Did your clinic serve more people in FY 2003 than in FY 2002?	9	75%
What is the time between intake and the first visit?		
For children and adolescents? Average	7 days	
For adults? Average	6 days	
Did your clinic lose money in FY 2003?	5	42%

Contributions

Contributions comprise between 1 and 2% of the revenues of the providers. The contributions dropped in 2002 relative to prior years.

Year	1999	2000	2001	2002
Contributions %	1.9%	1.5%	1.8%	2.0%

Summary

The ratios examined are in a reasonable range for fiscal years 1999 through 2001. These ratios indicate that there was an improvement in overall financial condition between fiscal year 1999 and fiscal year 2000, with fiscal year 2001 being similar to fiscal year 2000, but with a deterioration in FY 2002.

	1999	2000	2001	2002
% with negative margins	16%	21%	17%	33%
Number with negative net assets	3	5	2	2
% with current ratio < 1	21%	17%	13%	22%

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.

Bad debts: Bad debts are the costs associated with services provided to clients in the expectation of payment, but for which payment was not received. Bad debts do not include contractual allowances to third party payers, but do include the costs of unpaid copayments or deductibles.

Appendix B-2

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 2003 using the results of surveys of providers performed by the Community Behavioral Health Association of Maryland, Inc. (CBH), and one of its predecessor organizations, the Maryland Association of Psychiatric Support services (MAPSS).

A separate paper on the wage rates paid by outpatient mental health clinics (OMHC) will be prepared using the results of an MHA wage survey once these are available. MHA 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

CBH recently published the results of a salary survey of psychiatric rehabilitation programs in fiscal year 2003. This survey followed the same format as surveys that were used in fiscal years 2000, 2001, and 2002, 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 had 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 1998 survey.

The survey instrument was mailed to the providers in the Fall of 2002 and reflects fiscal year 2003 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 2003 Salary Survey for Psychiatric Rehabilitation Programs", prepared by CBH staff, and dated March 2003, as well as previous such reports produced by CBH and 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 (excluding and including fringe benefits), and the State Mental Health Associate II and III wages reported (with fringe benefits imputed at 32.9%[1]). The fringe benefits paid by the providers averaged 24%, with a median value of 22%. The state gave a wage increase of 4% on January 1, 2002, i.e., in the middle of the fiscal year, and has not provided an increase since then.

	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	$26,998	$22,500	$29,835	$24,800
Rehabilitation counselor - Mean	$27,429	$22,163	$31,710	$25,576
State MHA II [2]	$31,527	$23,722	$35,234	$26,512
State MHA III [2]	$33,605	$25,286	$37,572	$28,271
Percentage by which the MHA II rate exceeds the provider median/mean[3]	17%/15%	5%/7%	18%/11%	7%/4%
Percentage by which the MHA III rate exceeds the provider median/mean	24%/23%	12%/14%	26%/18%	14%/11%

[1] 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%.

[2] These state wage rates are the average of the rates that were in effect from January 1, 2002 through FY 2003.

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

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 through 2003 to show the growth over time.

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%
FY 2003	$27,429	2.2%	$31,710	4.4%

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 through 2003 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	2.0%	$24,799	2.0%	$21,935	-0.3%	$24,523	-3.0%
FY 2003	$23,722	2.0%	$25,286	2.0%	$22,163	1.0%	$25,576	4.3%
change 1998-2003	$4,594	24%	$4,787	23%	$3,233	17%	$4,286	20%

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, and the PRP rates have not been increased since then. 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. The wages increased from 2002 to 2003, in spite of the lack of any increase in the rates.

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 17% from FY 1998 to FY 2003. 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; 3) possibly increased use of part time staff who do not receive benefits; and, 4) reductions in the operating margins.

The wage rates of the rehabilitation specialist/counselor positions continue to be lower than those of corresponding state positions. Over the 1998 to 2003 time period the state has increased their wages more than the providers. The difference in wages is in the range of 18 to 26 percent when fringe benefits are taken into account.

Appendix B-3

Proposed Update for DDA and MHA Rates

Update factor for MHA and DDA Community Service Rates

The Commission recommended that the update factor should be calculated in August, and should consist of 75% of the increase in the proxy for labor rate increases and 25% of the increase in the proxy for inflation in other costs. The proxy for other costs was to be the increase in the Baltimore-Washington Consumer Price Index (CPI) for all urban consumers (Series ID CUURA311SAO). The increase from July 2002 to July 2003 was 3.0%. The proxy for labor costs was to be the increase in mean hourly earnings of health service workers in the Baltimore Washington Metropolitan Statistical Area (MSA). Unfortunately, the Bureau of Labor Statistics BLS) has not yet published the figure for 2003.

There are a number of possible alternatives, local and national. The data on wages and other employment costs available from the BLS is produced at different levels of detail. One can obtain national data with more specific employment categories, or statewide data for very broad classes of employees. The index suggested is the national Employment Cost Index for Health Services.

Recommended update factor:

The increase in the Employment Cost Index for health services for the third quarter of 2003, as compared with the third quarter of 2002 was 3.8% and the increase in the Baltimore-Washington MSA CPI for all urban consumers for September 2003 was 2.8%. The inflation component of the update factor is thus:

0.75 x 3.8% + 0.25 x 2.8% = **3.55%**

Future modifications:

The Commission recently received comments from MHA and DDA on the updating methodology. These comments will be discussed with the TAGs, and will be taken into account in a planned revision to the paper on the updating methodology.

Appendix B-4

The Financial Situation of Providers of Community Services Contracting with DDA, Fiscal Years 1997 through 2002

The Financial Situation of Providers of Community Services Contracting with DDA, Fiscal Years 1997 through 2002

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 and show trends for the fiscal years 1997, 1998, 1999, 2000, 2001 and 2002.

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, although the increased response rate makes this less of an issue in recent years. 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 through 2002 Audited Financial Reports.

Year	1997	1998	1999	2000	2001	2002
No. of reports	55	46	84	89	94	103

Providers were required by regulation to provide their Audited Financial Reports for FY 2001 and 2002. 103 providers were available for FY 2002 out of a total possible of about 120. Of the 103 providers used for the 2002 analysis, 40 were from the Central Region, 14 from the Eastern Region, 31 from the Southern Region, and 18 from the Western Region.

The following data fields were extracted from the fiscal year 2002 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
Receivables
Bad debts

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 seven 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
Days in receivables:	(Receivables/revenues) x 365
Days of cash:	(Cash/expenses) x 365

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, FY 2001 and FY 2002 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.

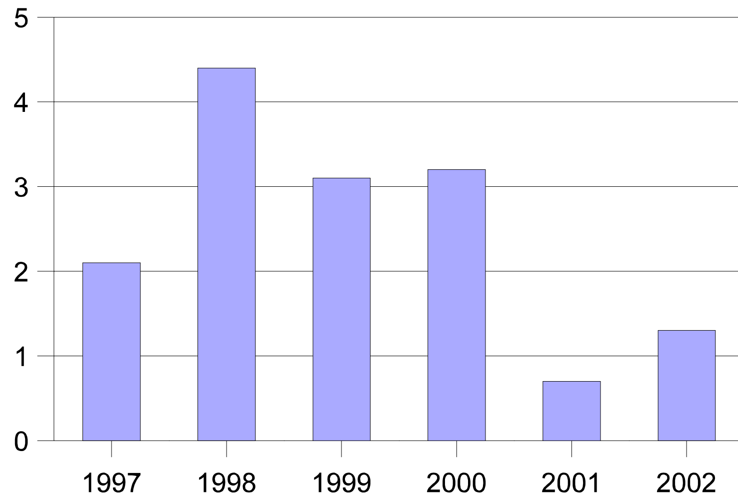
The margin (profit margin) is probably the most important indicator of the financial health of an industry (and an individual company), as it shows whether the industry is covering its costs and has the capacity to accumulate reserves for future investment. The mean margin of the providers of community 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, 0.4% in FY 2001, and 1.8% in FY 2002. The spread of the margin is shown in Table 1.

Table 1: Profit Margins	FY 1997	FY 1998	FY 1999	FY 2000[4]	FY 2001[1]	FY 2002[1]
Upper quartile	7.0%	7.8%	8.3%	8.1%	3.9%	5.6%
Median	2.1%	4.4%	3.1%	3.2%	0.7%	1.3%
Lower quartile	-2.7%	1.2%	0.0%	0.0%	-2.8%	-1.5%
Mean	2.1%	3.8%	3.2%	3.5%	0.4%	1.8%

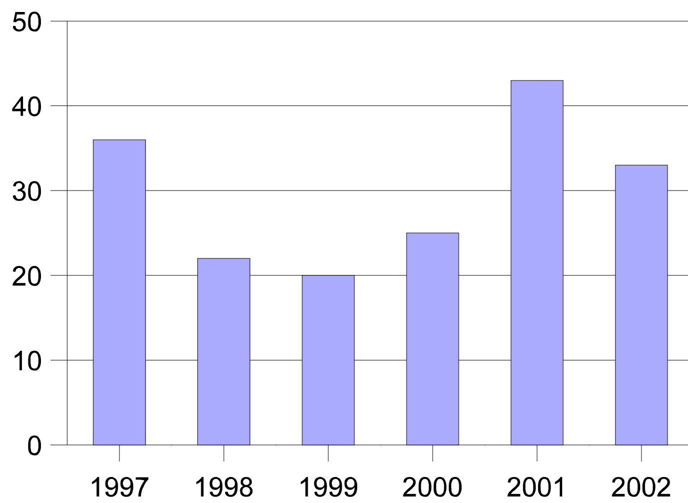
Of the providers of community services reporting to DDA for FY 2002 33 of the 103 had negative margins in FY 2002 (i.e., 32%). For each of the years the margins were not statistically significantly correlated with the size of the provider, although the small providers generally had the greatest range in their margins.

[4] Mean margin weighted by DDA payments.

Median Margin Percentage



% with negative margins



Profit margins by region of the state

Table 1A shows the mean profit margins (DDA revenue weighted for 2000, 2001 and 2002) for the providers located in the 4 DDA regions of the state for FYs 1997 through 2002* and Table 1B shows the median profit margins[5] for 1999 through 2002. These profit margins should be interpreted with caution as the number of providers involved is quite small.

* In FY 2002 contributions made up 3.2% 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[6]	2001[3]	2002[3]
Central (Baltimore & area)	0.1%	2.4%	3.0%	2.0%	0.3%	1.6%
East (Eastern Shore)	4.5%	7.8%	8.2%	5.5%	-0.5%	2.5%
South (Washington suburbs & South)	2.0%	4.3%	2.3%	5.2%	1.2%	2.9%
West (Western Maryland)	1.4%	2.9%	3.2%	3.5%	-1.3%	-0.2%
State	2.1%	3.8%	3.2%	3.5%	0.4%	1.8%

Table 1B: Median profit margin by region	1999	2000	2001	2002
Central (Baltimore & area)	2.9%	1.4%	0.2%	1.3%
East (Eastern Shore)	6.7%	3.6%	0.0%	1.6%
South (Washington suburbs & South)	2.5%	6.2%	2.7%	1.2%
West (Western Maryland)	2.6%	2.2%	-0.3%	-0.8%
State	3.1%	3.2%	0.7%	1.3%

[5] 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.

[6] Weighted by DDA payments.

Current ratio

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

Table 2: Current ratio	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002
Upper quartile	2.4	3.2	3.4	3.1	3.5	3.3
Median	1.8	1.7	1.9	1.4	1.8	1.7
Lower quartile	1.0	0.9	1.0	1.0	0.9	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 that continued in 2002.

FY 2002 median current ratio by region:

Table 2A: Current ratio	Central	East	South	West
Median	1.8	2.0	1.5	1.8

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 and receivables

Cash and investments were 27% of the total expenses. The cash available, thus, represents 98 days of expenses. 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.

Receivables comprised 11% of the total revenues, so providers had, on average, 40 days of revenue in receivables.

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	FY 2002
Upper quartile	8.3%	8.9%	10.3%	11.7%	6.9%	9.3%
Median	2.9%	5.2%	4.4%	4.7%	1.0%	1.9%
Lower quartile	-3.4%	0.5%	0.1%	0.3%	-4.1%	-1.8%

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, and similarly, the increase to FY 2002 is related to the increase in the margin in 2002..

FY 2002 median return on assets by region:

Table 3A: Return on assets	Central	East	South	West
Median	2.0%	2.9%	1.9%	-1.1%

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	FY 2002
Upper quartile	1.9	2.3	2.0	1.7	2.4	2.1
Median	1.4	1.6	1.4	1.4	1.5	1.4
Lower quartile	0.9	0.8	0.9	0.9	1.0	0.9

FY 2002 asset turnover by region:

Table 4A: Asset turnover	Central	East	South	West
Median	1.4	1.2	1.5	1.3

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, 7 had negative net assets in FY 2001 and 3 had negative assets in FY 2002. 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 3 providers with negative net assets in FY 2002, 1 also had negative net assets in FY 2001 and 2 had positive net assets in FY 2001.

Summary

The ratios examined are in a reasonable range for fiscal years 1998 through 2002. 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. The margins recovered slightly in 2002.

	1997	1998	1999	2000	2001	2002
% with negative margins	36%	22%	20%	25%	43%	32%
Number with negative net assets	4	4	3	2	7	3
% with current ratio < 1	25%	22%	23%	26%	31%	28%

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, 31% in FY 2001, and 28% in FY 2002.

The tight labor market in FY 2001 and FY 2002 resulted in providers increasing wages by more than the rate increase they received. This could explain the declines in the operating margins from the prior years.

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-5

Wage Rate Survey of DDA Providers - 2003

Wage Rate Survey of DDA Providers - 2003

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 2003. Surveys were sent to over 120 providers. 109 responses 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, provided input on the types of data available and nomenclature, 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 forms used for FY 2003 were expanded to include more detail on fringe benefits and bonuses. The survey was then mailed to over 120 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 encouraged them to complete the survey.

Data and submission problems

The preparation of this report has been delayed because many providers did not respond to the survey until many months after the due date for submission of the survey, and data problems were identified that required calls to the providers to obtain corrected data, further delaying the analysis.

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*	Base hourly rate - 2003*	% change 2002-2003
Aide	$7.44	$8.64	$8.99	$9.40	4.6%
Service worker	$8.57	$9.15	$9.43	$9.92	5.2%
1st line supervisor	$13.44	$14.83	$15.10	$15.45	2.3%
Driver - CDL[7]	$8.61	$9.45	$11.92	$12.39	3.9%
Driver- non-CDL	$8.08	$8.86	$9.34	$9.77	4.6%

* 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, 113 in the 2002 analysis, and 110 in the 2003 analysis. Corrections have been made to 2002 data, so some of the numbers differ from those reported in the prior report.

Staff turnover rates and tenure

78 providers provided information on turnover in 2002 and 94 in 2003. The turnover rates for the employees categories for all services were:

	2001	2002	2003
Aides	48%	45%	42%
Service workers	35%	44%	24%
First line supervisors	29%	28%	20%
Drivers: CDL	33%	25%	9%
Drivers: non-CDL	132%	27%	25%

The high turnover rate among aides is similar to, but slightly lower than, that found in prior years. The turnover rates of state employees are much lower than those experienced by the providers.

[7] 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.

78 providers included tenure data in 2001, 80 providers included data on staff tenure in 2002 and 86 in 2003. The average tenures of staff and the percentages of the direct care employees in each category were:

Job category	Average tenure 2001	Average tenure 2002	Average tenure 2003	% of employees in the category in 2003
Aide	26 months	39 months	30 months	33%
Service worker	29 months	45 months	40 months	53%
1st line supervisor	37 months	52 months	61 months	14%

The change in tenure from 2001 to 2002 is difficult to explain. For any given provider it would not be possible for tenure to increase by more than 12 months in a 12 month time period, and for tenure to increase by that much there would have to be no staff turnover. The large increase observed here may be indicative of a change in the set of providers reporting and included in the analysis, or, more likely, may be due to errors in the reporting. Errors were observed in the 2003 data, and some effort was put into obtaining corrected data from the providers.

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

The fringe benefit percentage reported is an overall percentage for all employees for the year, in contrast to the wage rate data, which is for specific employee categories for a pay period.

	# providers	Mean FB %	Median FB %
2000	38	19.9%	19%
2001	96	20.7%	20%
2002	97	20.5%	20%
2003	96	20.4%	20%

There was no substantial change in fringe benefit percentages in the period 2000 to 2003. However, it should be noted that, even with the percentage remaining constant, the dollar amount of fringe benefits increases as the amount of wages increases.

DDA re-surveyed providers on fringe benefits for fiscal years 2002 and 2003 because of the importance of this subject. 86 providers responded to this fringe benefit survey. The fringe benefit percentage reported for full time workers was similar for 2002 and for 2003 was slightly higher than were reported in the CSRRC wage survey. The following table summarizes the full time results from the DDA fringe benefit survey:

	Mean	Weighted mean	Median
FY 2002	20.6%	21.1%	20.4%
FY 2003	21.3%	21.6%	21.0%

It appears that in the total fringe benefit costs some providers have been including the portion of fringe benefit costs paid by the employee. The actual fringe benefit costs of the employer are, thus, likely to be less than the percentages listed in this table.

DDA has calculated the current state fringe benefit percentage to be 30.4%. This is substantially higher than that of the providers. While the fringe benefit percentage has been remarkably constant over the time period reported, the dollar amount spent on fringe benefits has increased as the dollar amount of the wages paid to the direct care employees has increased.

The reporting of the breakdown of fringe benefit costs, which was requested for the first time in this current survey, was very inconsistent, so the following numbers should be treated as rough indicators rather than as precise quantifications. The largest proportion of fringe benefits (over 40% of the total fringe benefits) was the employer proportion of FICA, and unemployment insurance. The second largest component was health and life insurance, which comprised about a third of the total. Retirement costs and retirement plan administration made up 11% of the total fringe benefit costs. Employees are contributing an additional 18% of the total employer fringe benefit costs as the employee portion of these costs.

Bonuses

Bonuses were provided by about one third of the providers, and comprised 0.7% of the base wages. The amount reported as being paid in bonuses was $1.1 million. It has been suggested, and appears plausible, that providers may be moving to paying more in bonuses, and less in wage increases, in order to provide flexibility in the future, and because they are uncertain about continuation of rate increases over the long term. However, since the bonuses were first collected in 2003 it was not possible for the Commission to determine to what extent the number of providers giving bonuses, or the amount of the bonuses, had changed.

Distribution of bonuses by job category

Job category	**% of total bonuses going to job category**
Aides	14%
Service Workers	71%
1st line supervisors	12%

Drivers	3%

Distribution of bonuses by service

Service	% of total bonuses going to the service
Individual and family services	4.6%
Day programs	7.9%
Residential - line-in	31.3%
Residential not live-in	26.9%
Employment services	21.9%
CSLA	4.0%
Transportation	3.5%

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 surveys the comparison will not be precise, although this is much less of a problem in the later years, when most providers responded to the survey. The 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, 2002 and 2003. However, it should be kept in mind that the wage levels are substantially lower than those of corresponding state workers.

Rate increases

DDA has provided the Commission with information on the rate increases provided, as a percentage of total wages and as a percentage of direct service workers wages. These data show that the rate increase from 2002 to 2003 was similar in size to the wage increase provided to the employees surveyed. Over the period 2000 to 2003 the wage increases have been substantially higher than the rate increases. It should be mentioned that in drawing this conclusion the rate increases were considered as a percentage of all wages, not just direct support wages. DDA has a different legislative responsibility in its reporting of wage increases and so may draw a different conclusion.

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%. Based on this information the Commission concluded that 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 mean margin of the providers for FY 2002 was around 2%, which is higher than the margin in FY 2001, but still low.

Summary and recommendations

The wage increases have exceeded the increases in rates.

Fringe benefits have been a relatively constant percentage of wages during the time period 2000 to 2003. However, the dollar amount spent on fringe benefits has increased as wages have increased.

In future years DDA should more actively pursue providers that do not respond to the survey in a timely manner.

DDA should require some confirmation of the reliability of the data being submitted in order to improve the quality of the data.

The Commission will hold educational sessions to inform providers of the need for accurate data, and the specific data that is required.

The implementation of the changes listed above should lead to more timely and improved quality data. This will aid the analyses of both the Commission and DDA.

Appendix B-6

Analysis of DDA Cost Reports

Analyses of DDA Cost Reports

Introduction

The CSRRC is required by its enabling legislation to:

> Review the data reported in the Developmental Disabilities Administration Annual Cost Reports and use the data to develop relative performance measures of providers.

To this end over 100 Cost Reports for fiscal year 2002 were obtained from the Developmental Disabilities Administration (DDA), key fields from these cost reports were extracted and input into a database for analysis, and the analysis described in this report was then carried out. This is the first year such an analysis has been performed, so it is likely to be subject to change and expansion over time.

To avoid any misunderstanding it will be worthwhile to discuss how the term "relative performance measures" is being interpreted for this purpose. The cost reports provide data on costs, revenues and utilization, so the performance measures that can be generated using the Cost Reports are necessarily financial and utilization measures. It will not be possible to develop outcomes measures from these data.

Questions to be addressed

Some specific questions will be addressed by this analysis. The first item will be to provide some general descriptive information regarding the range of services provided. The second will be the relative profitability of the different types of services provided, i.e., day services, residential services, employment services, and community supported living arrangements (CSLA), in total and by provider. The FPS includes two components to rates: a client component that varies depending upon client needs, and an administrative component that is a fixed amount per day for the particular service. It has been suggested that administrative costs may vary somewhat with direct care costs, so this question will be examined. The relationship between direct care costs and augmentation payments will also be examined. In response to the directive to study relative performance measures the relationship between cost per day and volume of service was explored.

Analysis and results

Descriptive statistics

The following table presents some summary statistics from the Cost Reports. There are clearly some problems with the data, with some providers appearing as outliers. For this reason medians are presented rather than means, and for the calculation of margins outliers were excluded.

	CSLA	Day	Residential	Employment
# of providers	57	50	76	20[8]
Median per diem revenue	$95	$61	$149	$46
Median per diem expense	$81	$65	$151	$48
Margin[9]	7.3%	-6.2%	-1.8%	-1.8%

These data suggest that providers are profiting substantially from the provision of CSLA services, and are generally losing money on day, residential and supported employment services. CSLA services were implemented recently, and recently enrolled clients are reported to be more profitable than clients who have been with a provider for an extended period of time.

Providers with data that looked anomalous, e.g., costs but no revenues or vice versa, or a large mismatch between costs and revenues, were discussed with the Technical Advisory Group. These providers were mostly unusual in some way, e.g., receiving a very small proportion of their payments from DDA, or having started to provide services late in FY 2002, and were dropped from the analyses.

Relationship between administrative and direct expenses

The purpose of these analyses was to determine whether there was any statistically significant relationship between the administrative expense per day and the direct expense per day for CSLA, day, supported employment and residential services. The analyses consisted of linear regression models, with the direct expense per day as the independent variable, and the administrative expense per day as the dependent variable. The regression statistics are presented in Exhibit 1.

These results indicate that there is a statistically significant positive correlation between administrative cost per day and direct expense per day for day and CSLA, i.e., per diem administrative costs increase as per diem direct care costs increase for day and CSLA services. The meaning of the regression coefficients is that : 1) for CSLA there is an increase of $0.11 in administrative costs for each $1.00 increase in direct care costs; and, 2) for day services there is an increase of $0.19 in administrative costs for each $1.00 increase in direct care expenses.

The same conclusion cannot be drawn for residential services or for supported employment. For residential services the regression suggests that administrative expenses per day decline as direct care expenses per day increase. This could be a statistical aberration, or could be indicative of an

[8] 33 providers reported costs or revenues for supported employment, but for 13 of these providers there were major problems with the data, e.g., costs but not revenues or vice versa, or revenues disproportionate to the costs. These 13 providers were dropped for this summary.

[9] For the calculation of margins providers with revenue or expense of $0, or with a day or CSLA cost or revenue per day over $400, or with a residential or employment cost or revenue per day over $600 were excluded.

cost allocation problem, or could be due to some other explanation. For supported employment the coefficient is very small, and not statistically significant.

Influence of volume on cost per day

The spread in cost per day was much wider for low volume providers than for higher volume providers, both in direct expense per day and administrative expense per day. This relationship was observed for all the services - CSLA, supported employment, day and residential. Higher costs per day could be attributed to diseconomies of scale associated with low volumes of service, but this does not explain the low volume providers with very low costs per day.

Conclusions

Providers appear to be incurring substantial losses on day programs. It was suggested that this could be due to increased transportation costs. Smaller losses were incurred on residential and employment services, and CSLA services were generally profitable.

Smaller providers tend to have a much wider spread in cost per day, both direct cost and administrative cost, than larger providers.

Revenues are highly correlated with expenses. This suggests that the current payment system has done an effective job in matching revenues to expenses within each of the service categories, or that the providers have responded to match costs to the revenues available. There are differences between service categories, however, with CSLA being relatively well paid, and the other services somewhat underpaid, particularly day services. For both CSLA and day services the administrative costs per day increase as the direct care expenses increase. This could be partly driven by differences in labor costs between regions. Further analysis is desirable to separate out the impact of differential labor wage rates in this analysis, and it would be also be desirable to carry out a similar analysis with a subsequent year's data to see if the same patterns are observed.

Exhibit 1: Correlation between revenues and expenses

An examination of the total revenues and total expenses shows a remarkably high correlation, for each of the services, and for the augmentation funds. This does not reflect upon the profitability or otherwise of the service, just on the fact that as expenses increased so did revenues. For augmentation, day services, residential services and CSLA The R-squareds were in excess of 95%, indicating that over 95% of the variation in revenues was explained by the variation in expenses. This suggests one of two conclusions: 1) the payment system has been successful in paying the expenses that are incurred by the providers; and/or, 2) the providers have constrained their expenses to fit the available revenues.

Service	Regression Coefficient	Probability level	R-squared
CSLA	0.11	0.002	0.17
Day	0.19	0.010	0.11
Residential	-0.13	0.023	0.07
Supported employment	0.02	0.75	0.01

APPENDIX C

STATUS OF 2003 RECOMMENDATIONS

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.

Status: This recommendation has not been implemented. However, in 2002 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 was attached as Appendix B-3 to the 2003 Annual Report, and the current updating recommendation is attached as Appendix B-3 to this Annual Report. DDA provided thoughtful comments on the updating recommendation, and the Commission staff is in the process of reviewing these comments, and expects to discuss them, and possible revisions to the updating recommendations, with the TAG and the Commission in the coming year.

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.

Status: The legislature did preserve the majority of the funds for the wage equalization initiative for FY 2004.

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.

Status: This recommendation has not been implemented. However, in 2002 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 was attached as Appendix B-3 to the 2003 Annual Report, and the current updating recommendation is attached as Appendix B-3 to this Annual Report. MHA provided thoughtful comments on the updating

recommendation, and the Commission staff is in the process of reviewing these comments, and expects to discuss them, and possible revisions to the updating recommendations, with the TAG and the Commission in the coming year.

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 care 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.

Status: The legislature partially addressed this issue in the 2003 session. The Medicare shortfalls will be picked up by the State for dual eligibles for whom federal matching funds are available. This is about half of the cases at issue.

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.

Status: This requirement was in budget language and was not renewed, so has effectively sunset and is no longer being applied by MHA.