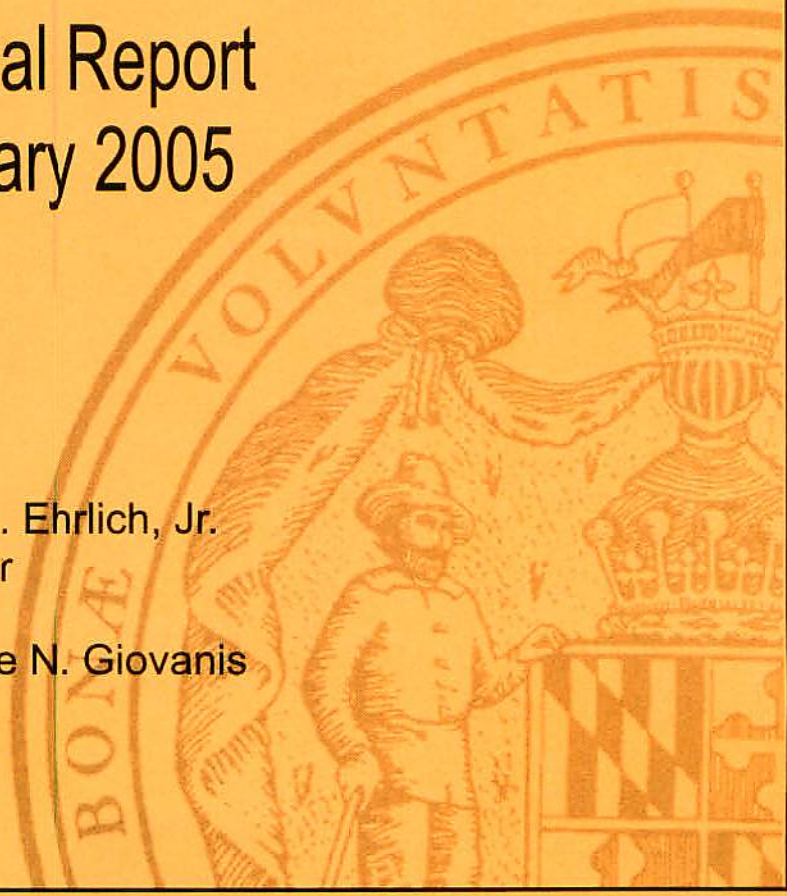
Community Services Reimbursement Rate Commission

Annual Report
January 2005



Robert L. Ehrlich, Jr.
Governor

Theodore N. Giovanis
Chair

Community Services Reimbursement Rate Commission

ANNUAL REPORT

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COMMUNITY SERVICES REIMBURSEMENT RATE COMMISSION

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This report, and the appendices to the report, can be downloaded from the Commission website.

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REPORTING REQUIREMENTS

On or before October 1st 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 healthcare 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, therefore it has been in operation for eight 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 seven members, appointed by the Governor 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:

- The structure of updating systems and the recommended update factor;
- The financial condition of the providers;
- Consumer safety costs and whether rates have been adjusted for such costs;
- Design of wage surveys to collect wage rate and staff turnover information from providers, and the interpretation of the data collected by these surveys; 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, recommended 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. These recommended update factors are: 2.9% for DDA rates and 4.1% for MHA rates.

- The mean margin of the providers paid by DDA was 2.5% in fiscal year 2003.

- The rate structures of MHA and DDA appear to provide sufficient flexibility to ensure that services essential for client safety can be paid for. However, due to budget constraints choices have been and/or will have to be made among various needs which compete for available funding, such as: paying for services for more clients, not reducing eligibility levels as much as might otherwise be required to meet budget limitations, and increasing funding levels (including safety costs) for services to existing clients. As a result there are clients who require additional supports, but are not receiving the funding for those supports.

- The salary levels paid by DDA providers and in a number of MHA community service employment categories continue to be lower than the corresponding salaries of State employees, particularly when fringe benefits are taken into account. For example, the wages and fringe benefits of community mental health rehabilitation counselors are about 20% less than those of corresponding state positions, and the wages of direct care workers providing services to individuals with developmental disabilities are about 23% less than those of corresponding state workers.

- 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.

- 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 three 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.

Both MHA and DDA have promulgated regulations requiring the submission of wage surveys and other data. However, MHA does not currently have the authority to apply sanctions against providers who do not respond, and the responses have been inadequate.

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 enabling statute the Commission has prepared a paper suggesting a design for such a system, and quantifying the update factor, and has now revised that paper to take into account comments received from MHA. 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 the 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. The Medicaid program has an elaborate system to update the rates of the Managed Care Organizations that basically holds them harmless for most changes in the prices they are paying for services. 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 recommended update factor is 4.1%.

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. If the Commission were to sunset it would be important for MHA to continue the collection of audited financial reports and other data, and analyze the financial condition of the providers. These studies are all the more important now that the Public Mental Health system is cutting back on payment rates and eligibility levels.

Based on prior experience of both the Commission and MHA, many providers will not comply with the data submission requirements unless MHA has the authority and the will to apply financial sanctions against providers that do not comply. Making the submission of required data a condition of participation is one possible approach, but dropping a provider from participation in the Public Mental Health System is a fairly severe penalty, with consequences for care to clients, and so MHA is likely to apply such a severe sanction only in extreme situations. It should be mentioned that Medicare does have, and use, this sanction, and that in order to avoid it a provider just has to provide the required data. Giving MHA the power to fine providers, or withhold payments, for failure to comply with regulations regarding data submissions is more likely to be used in practice. It should be mentioned in this context that DDA currently has such authority.

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

3. **The Commission supports the concept, currently being implemented by MHA for psychiatric rehabilitation services, of paying for some types of services on an aggregated basis, provided adequate safeguards are included to maintain quality of care. However, the Commission believes that is in necessary to study the impact of the case rates, now that they have been implemented, to ensure that they do not disadvantage the providers caring for the most seriously and chronically ill clients.**

As of February 2004, MHA started paying monthly case rates for psychiatric rehabilitation services. This change provides 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 provide services, neither the financial data or the quality monitoring mechanisms available at that time 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 and now APS Healthcare. The Commission supports the decision to proceed with expansion of the use of case and/or capitation payment systems for selected services.

Within any case or capitation payment system the method used to classify enrollees to determine the appropriate level of payment is critical. If this classification system is not sufficiently refined it is possible that providers caring for the most seriously and chronically ill clients could be underpaid relative to the level of services required for these clients, and conversely, the providers with clients who fall at the low end of service requirements within the classes could be overpaid. The Commission plans to continue its data collection and analysis on this subject, and if the Commission sunsets this activity it should be taken over by MHA. This study will require the use of data from multiple sources: 1) the utilization patterns of providers prior to the implementation of case rates; 2) the utilization patterns under case rates; and 3) financial reports.

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 systematically been recompensed for inflation for other components of their costs. Moreover, there is no systematic approach to providing rate increases to the providers.

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. The Medicaid program has an elaborate system to update the rates of the Managed Care Organizations that basically holds them harmless for most changes in the prices they are paying for services. 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. In recent years it has also been increased under the wage equalization initiative, under which the providers are given rate increases to allow them to increase direct care wages to the equivalent state wage and fringe benefits levels. However, the DDA regulations and the budget process do not include any systematic approach to updating of rates from year to year. A systematic approach to the updating of rates is the only way to provide predictability for the providers and 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 recommended update factor is 2.9%.

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 DDA budget language a few years ago, 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 as quantified by DDA, particularly in the absence of a systematic approach to updating rates.

The Commission's most recent analysis of the financial condition of the providers that 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 then to 2.5% in FY 2003. Over the past several years the providers have given wage increases comparable in magnitude to the rate increases provided to increase direct care worker wages, and greater than the overall change in rates.

3. DDA should evaluate and determine whether a separate payment for transportation costs should be built into the FPS payment system.

Currently an allowance for transportation costs is built into the FPS payment rates. This allowance is not specific to a given provider or client, but the transportation requirements vary greatly from one region of the state to another, and from one provider to another. DDA added detail on the costs of transportation, miles traveled, and number of clients transported, to the FY 2003 Cost Report. A review of these data suggest that there are major differences between providers in the transportation requirements of the clients they serve, so that differential payments for transportation would be a fairer mechanism by which to recompense the providers for transportation costs.

It is expected that the transportation data submitted in the FY 2004 Cost Reports will be improved in quality, as this will be the second year that the providers have had to supply these data. An indepth analysis of transportation costs will be made once the FY 2004 Cost Reports are available. Once that analysis is complete the Commission will be in a better position to make informed recommendations on whether separate transportation payments should be made for particular services, and how these payments might be structured. For example, it may be determined that separate transportation payments are desirable for Day programs, but not required for Residential programs. The situation will be complicated by the fact that providers sometimes pick up several clients in the course of a single trip, so the clients on the trip travel different distances, and the distance traveled may not be directly related to the distance from the pick-up point to the destination.

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 might 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. Also, in February 2004, MHA implemented a case rate payment system for psychiatric rehabilitation services. 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 made in FY 2004. Many rehabilitation providers experienced 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. The mean margin dropped to about 1% in fiscal year 2001, and recovered slightly in 2002, with a further recovery in 2003. 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 or increases less than the impact of inflation in Medicare payments rates. The Commission reviewed the changes made in the MHA fee schedule to make it HIPAA compliant, and will monitor the effects of these changes, as well as the shift to case rates for psychiatric rehabilitation services 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, updating the analyses reported here, and reporting the results in interim work papers.

COMMISSION ACTIVITIES

Commission meetings and Technical Advisory Group (TAG) meetings are generally held the first Monday of each month unless it is a holiday. Commission meetings generally run from 1 p.m. to 3 p.m. The Mental Hygiene Administration TAG meetings run from 1 p.m. to 3 p.m. and the Developmental Disabilities Administration TAG meetings run 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 5, 2004
April 5, 2004
September 13, 2004
December 6, 2004
January 3, 2005
April 4, 2005
June 6, 2005
September 12, 2005
December 5, 2005[2]

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

February 2, 2004
March 1, 2004
May 3, 2004
June 7, 2004
August 2, 2004
October 4, 2004
November 1, 2004
February 7, 2005
March 7, 2005
May 2, 2005
August 1, 2005
October 3, 2005[2]
November 7, 2005[2]

[2] This meeting is contingent upon re-authorization of the Commission. If the Commission is not re-authorized it will sunset at the end of September 2005.

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 1st of 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 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 $519.5 million of the Developmental Disabilities Administration's (DDA) FY 2005 budget is for community programs and $69.4 million is for institutional services. Approximately $196.5 million of this total budget are 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 2004 are shown in Charts 2 to 4.

The principal current DDA payment system is the Fee Payment System (FPS). $406.5 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. Each agency submits reports on the functional severity levels and corresponding support requirements of its client mix. Reimbursement is based on the matrix scores of the clients served. 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. An additional payment is made to cover transportation costs for clients who use wheel chairs. In addition, add-on rates provide for clients with particular needs not covered in the base rates. These needs were formerly paid though augmentation payments.

The balance of payments for community programs are made through contracts and the community supported living arrangements (CSLA) payment system (approximately $44.5 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 and continued to grow in 2004.

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 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.

Wage Rates and Wage Rate Increases Compared with Rate Increases

One of the Commission's early activities was to perform a survey of the wage rates paid to direct care workers and compare these 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, 2003, and 2004, 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 3 years of these funds have already been provided.

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 and DDA 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 over the time period for which the Commission has relatively complete data the wage increases have been comparable to 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. Based on consideration of comments from the Administrations and other parties the Commission decided that changes in the proposed updating framework were advisable. The modified updating system and the recommended update factor for the upcoming fiscal year are 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.

The Commission is recommending that an update factor of 2.9% would be needed to maintain the purchasing power of the rates in the face of the inflation being experienced by the providers.

Geographic Variation in Rates

The individual component of the rates varies by areas of Maryland, with the areas being:

Baltimore Metropolitan area: Baltimore City and Baltimore, Anne Arundel, 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 major changes included: (1) the payment for the provider component of the rate was changed from being based on the actual costs of the individual provider with limits to flat rates for residential and day services; and, (2) the individual component of the rates of the rural areas was increased to the Baltimore level. The first change improved the incentives embodied in the payment system, making it a management decision to determine to what extent AGC&T costs and other costs should be substituted for one another[3]. Other changes have been made since that time, particularly in the areas of add-on rates and community supported living arrangements.

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

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

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 reported in Appendix B-1 casts light on both these issues. It appears that for day programs the administrative costs increase as the direct care costs increase. This could be due, at least in part, to transportation costs, and the Commission plans to study transportation costs in more detail in the coming year.

Transition

The changes to the system implemented in 1999 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 changes 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 2001. That year represents a low point in the profit margins of the providers. Subsequently there was a slight increase in the profit margin from 2001 to 2002, and the margins continued to improve in 2003. The report on this analysis is attached as Appendix B-4 to this report. The Commission will analyze the financial situation of providers in fiscal year 2004 as soon as the required reports are available. This should be early in 2005.

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 2003.

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 over 110 providers for FY 2003. These data and analyses were discussed with the DDA TAG. A report on this analysis is attached as

Appendix B-1. Additional analyses, including a detailed analysis of transportation costs and how they vary, are planned once the FY 2004 Cost Reports are available.

The major conclusions of the analysis are that Day programs, in general, are losing money, Residential programs, in general, are breaking even, and CSLA programs, in general, are making profits. These conclusions do not, of course, mean that every providers with a particular service is performing in the manner, but these are overall conclusions regarding the financial conditions of these services. These conclusions are now based on analysis of data for both FY 2002 and FY 2003.

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 2004. 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 increase in 2004 was smaller, about 0.6%. 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 increases provided, with the wage equalization fund providing much of the revenue for the wage increase in the past 2 years.

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 discussed with the DDA TAG the issue of what these costs are, and whether any adjustment in rates has been made for them. Discussion was also held with representatives of DDA regional offices and providers. A paper on this subject was prepared and discussed at several TAG meetings. It is attached as Appendix B-6 to this report. The overall conclusion was that the system provides flexibility to pay for necessary consumer safety costs, but that budget constraints have prevented the funding of some services that are documented to be necessary in some client care plans.

Uncompensated Care

The Commission is required to report on the extent and amount of uncompensated care delivered by providers. Since uncompensated care is reported in the Audited Financial Statements of the providers, and has an effect on the financial status of the providers, the commission determined that the appropriate place to include this analysis is in the report on the financial condition of the providers, Appendix B-4 to this report. The majority of the providers reported no bad debts or charity care in their audited Financial Statements, and the bad debts reported comprised 0.42% of total revenues.

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. In particular, the Commission is studying the level and variability of transportation costs to assist DDA with its consideration whether a separate payment should be made to cover such costs, which are currently simply included in the FPS rate.

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 systematically been recompensed for inflation on other components of their costs. Moreover, there is no systematic approach to providing rate increases to the providers.

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. The Medicaid program has an elaborate system to update the rates of the Managed Care Organizations that basically holds them harmless for most changes in the prices they are paying for services. 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. In recent years it has also been increased under the wage equalization initiative, under which the providers are given rate increases to allow them to increase direct care wages to the equivalent state wage and fringe benefits levels. However, the DDA regulations and the budget process do not include any systematic approach to updating of rates from year to year. A systematic approach to the updating of rates is the only way to provide predictability for the providers and 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 recommended update factor is 2.9%.

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 DDA budget language a few years ago, 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 as quantified by DDA, particularly in the absence of a systematic approach to updating rates.

The Commission's most recent analysis of the financial condition of the providers that 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 then to 2.5% in FY 2003. Over the past several years the providers have given wage increases comparable in magnitude to the rate increases provided to increase direct care worker wages, and greater than the overall change in rates.

3. DDA should evaluate and determine whether a separate payment for transportation costs should be built into the FPS payment system.

Currently an allowance for transportation costs is built into the FPS payment rates. This allowance is not specific to a given provider or client, but the transportation requirements vary greatly from one region of the state to another, and from one provider to another. DDA added detail on the costs of transportation, miles traveled, and number of clients transported, to the FY 2003 Cost Report. A review of these data suggest that there are major differences between providers in the transportation requirements of the clients they serve, so that differential payments for transportation would be a fairer mechanism by which to recompense the providers for transportation costs.

It is expected that the transportation data submitted in the FY 2004 Cost Reports will be improved in quality, as this will be the second year that the providers have had to supply these data. An indepth analysis of transportation costs will be made once the FY 2004 Cost Reports are available. Once that analysis is complete the Commission will be in a better position to make informed recommendations on whether separate transportation payments should be made for particular services, and how these payments might be structured. For example, it may be determined that separate transportation payments are desirable for Day programs, but not required for Residential programs. The situation will be complicated by the fact that providers sometimes pick up several clients in the course of a single trip, so the clients on the trip travel different distances, and the distance traveled may not be directly related to the distance from the pick-up point to the destination.

Chart 1

Distribution of DDA expenditures

Fiscal year 2004

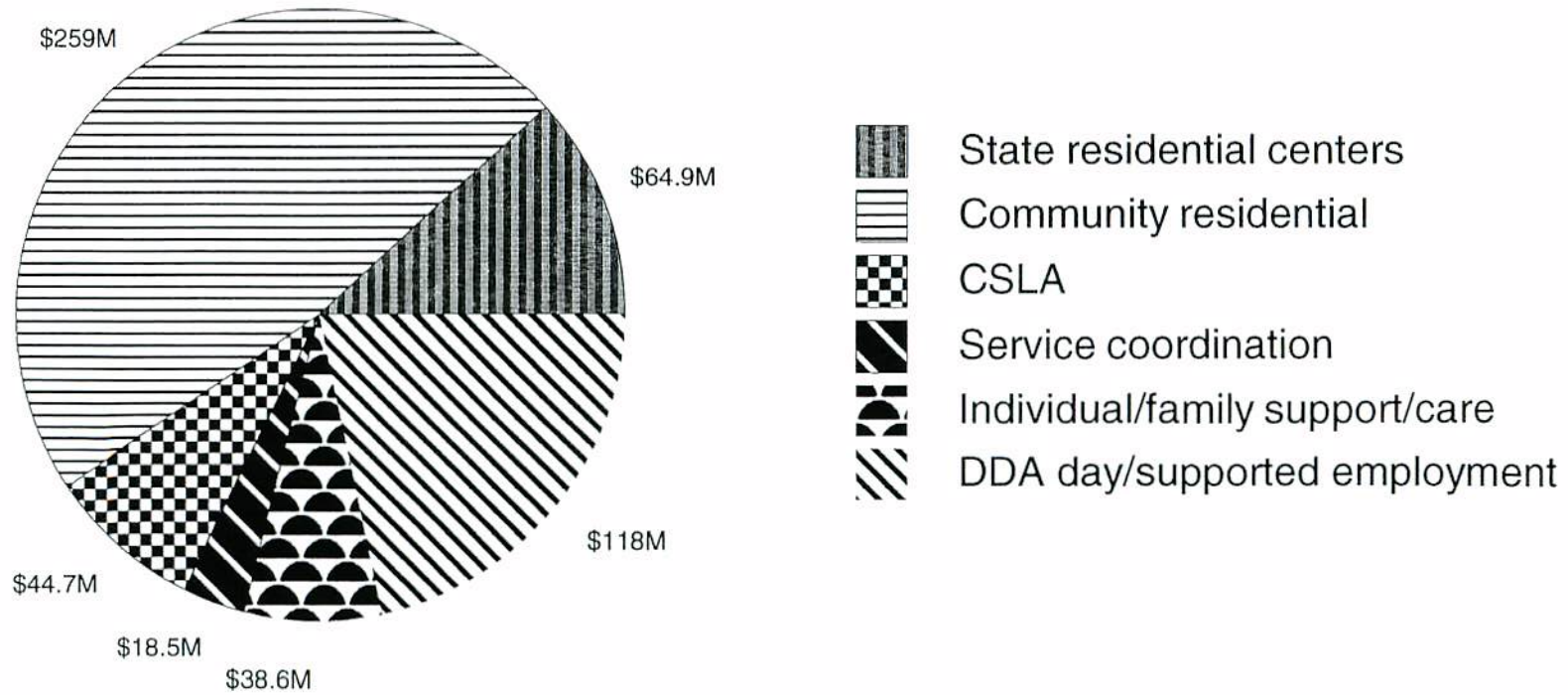


Chart 2

DDA Expenditures: FY 1997-2004

Amounts in thousands of $s.

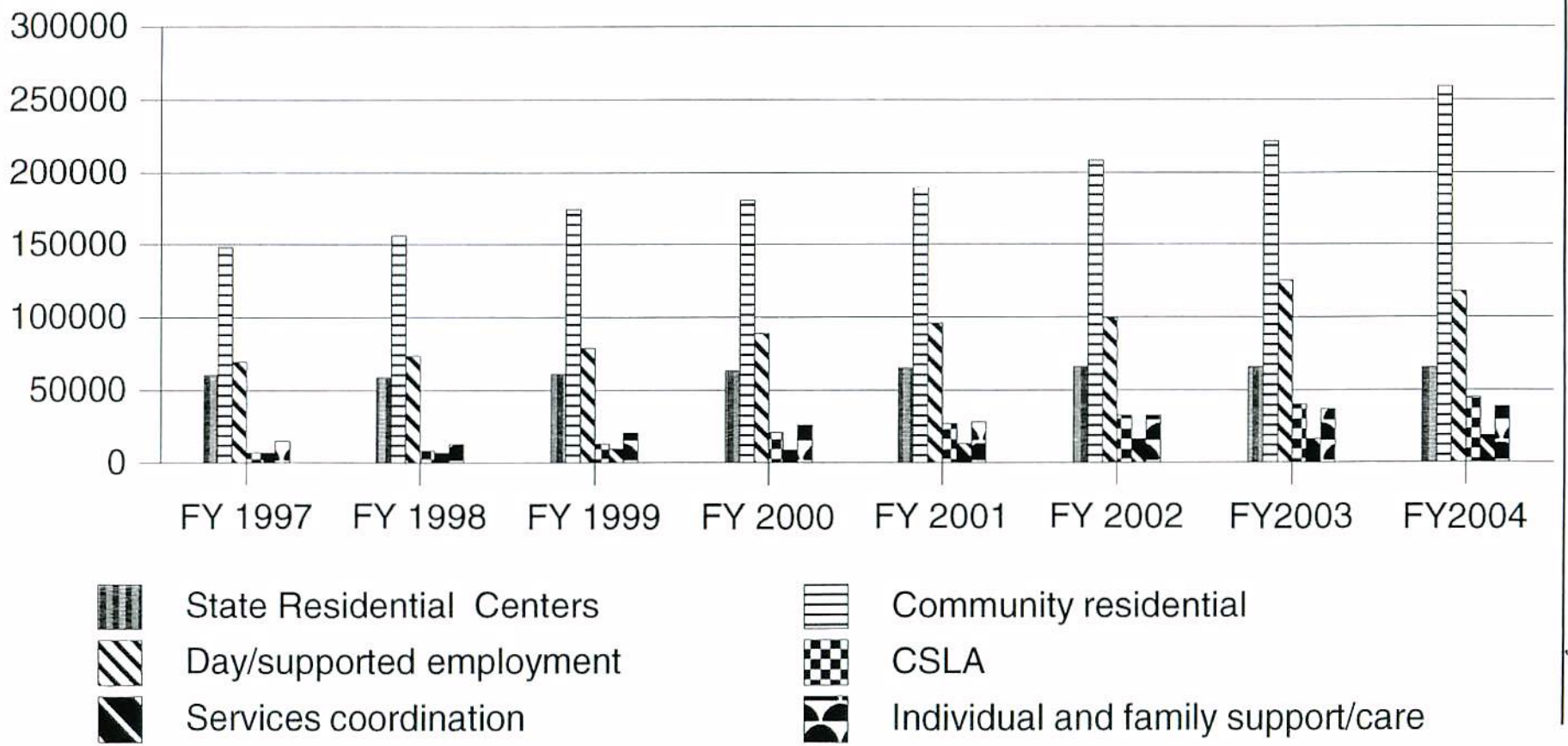


Chart 3

DDA: Community service volumes

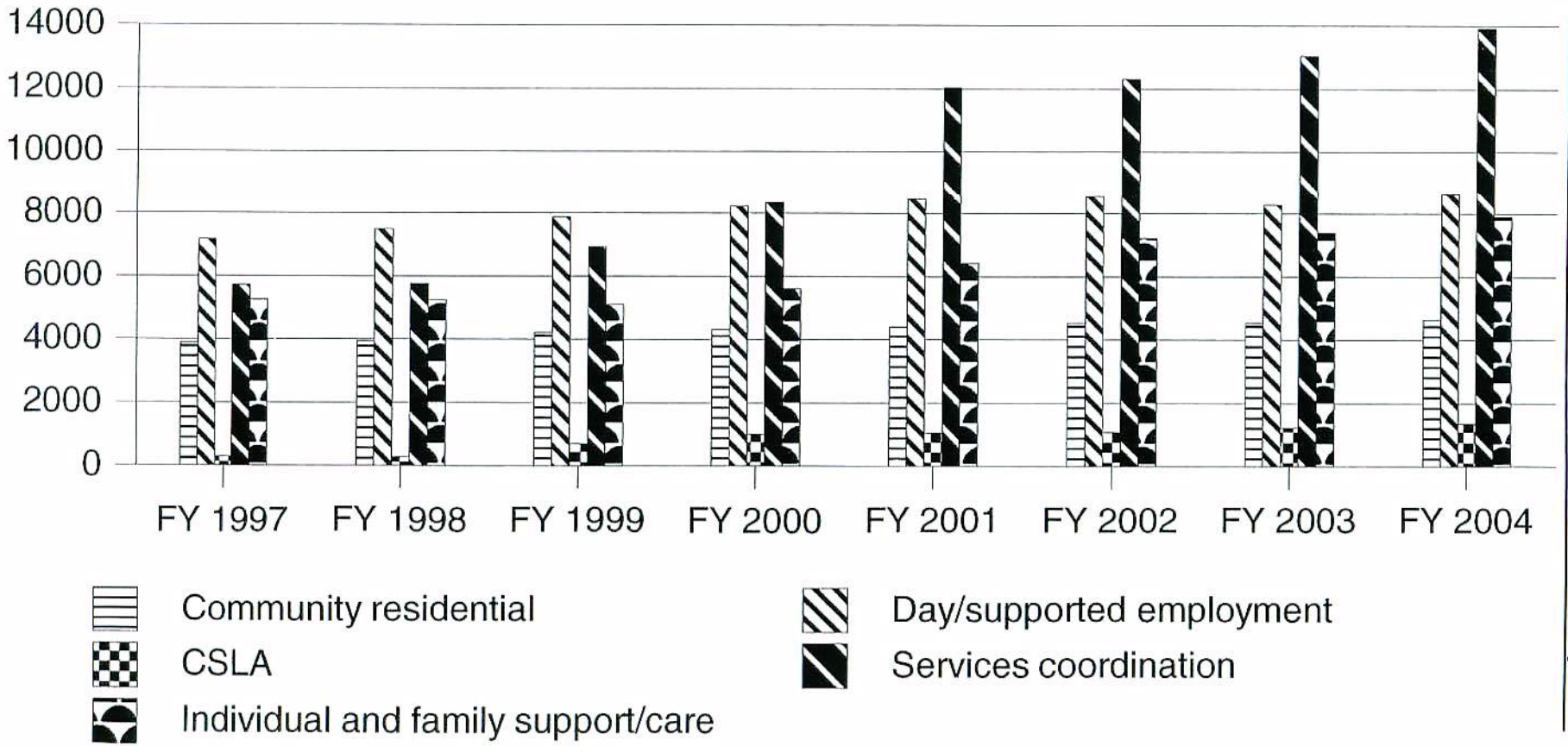
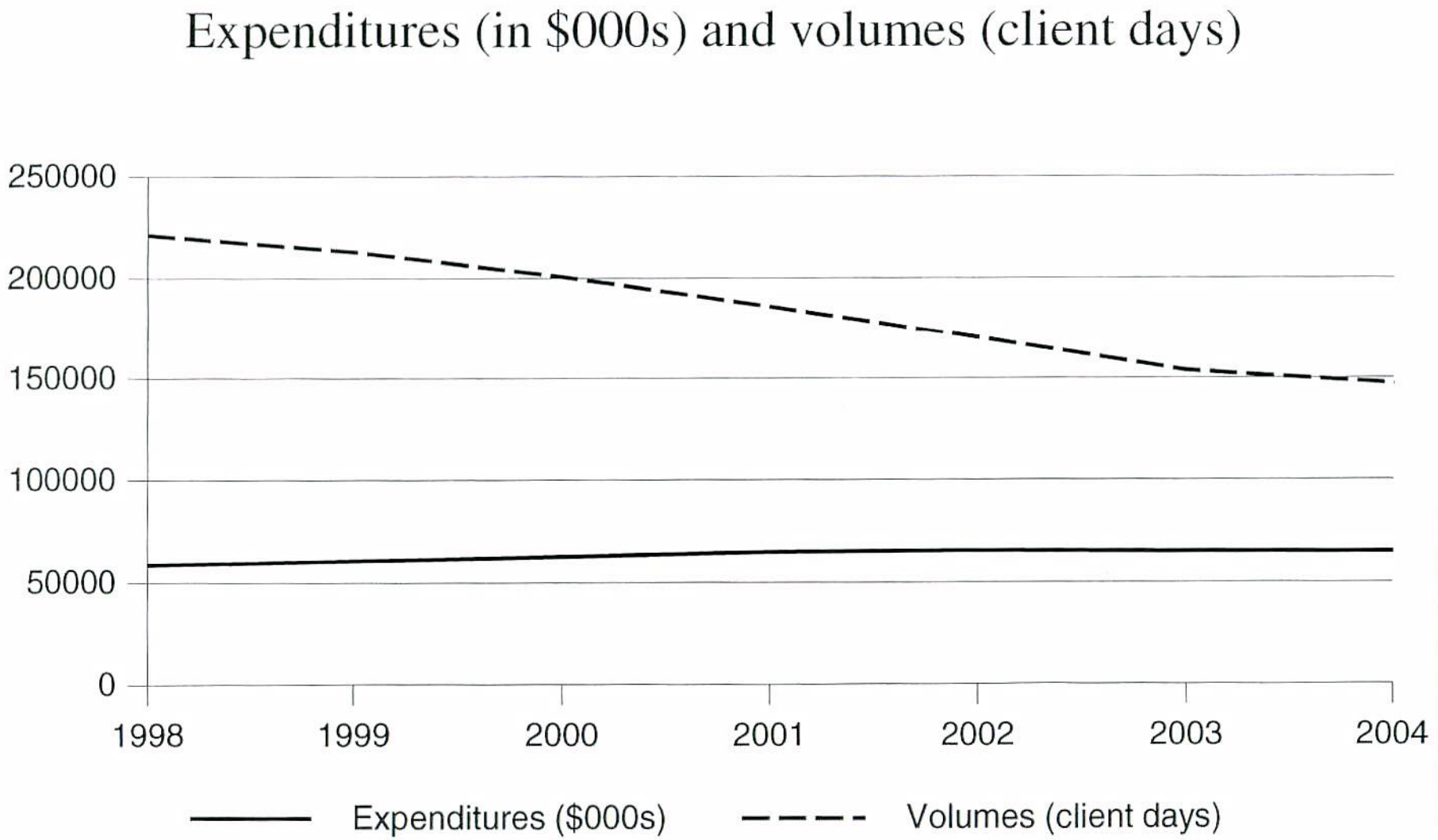


Chart 4

State Residential Centers: DDA



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 2004.

Chart 5 shows the distribution of MHA expenditures by type of service, and Charts 6 and 7 show the changes in MHA expenditures between fiscal years 1998 through 2004. The expenditures and number of services provided by State hospitals had been growing steadily through FY 2003, but both dropped in FY 2004, mainly due to the closure of a large state hospital.

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 $12,000,000 for uninsured PRP and RRP services. In February 2004 MHA shifted to case rates for the payment of psychiatric rehabilitation services. Total payments for these services fell by 12% between 2003 and 2004. This was partly due to restrictions on eligibility for services, but is also partly due to the change in the rate system to case rates and an associated reduction in rates of about 10%. Outpatient expenditures grew by $19 million between 2002 and 2003 then by another $12 million from 2003 to 2004[4].

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 zone" 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. Case rates for psychiatric rehabilitation services were implemented in February 2004. Modifications were made in FY 2005 to make the

[4] Data for 2004 are not yet complete as of the time of writing.

system HIPAA compliant. These modifications were mainly to the codes, but there were also some small changes in rates. The Commission will monitor the impact of these revisions.

MHA uses an administrative services organization (ASO) to help administer the system. This ASO was Maryland Health Partners (MHP), but was replaced by APS Healthcare effective September 1, 2004. The ASO provides 24-hour screening and helps determine if the individual is eligible for publicly funded services. The ASO 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 have been largely resolved. The Commission intends to monitor carefully the impact of the change in the ASO in 2004.

MHA Budget Shortfalls

MHA has experienced budget shortfalls due to expenditures on community services each year for the past several years. 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.

The number of children (ages 0 to 21) served in outpatient clinics increased steadily from 24,941 in FY 1998 to 46,963 in FY 2004; an 88% increase. The number of adults served in outpatient clinics increased from 36,490 in FY 1998 to 44,478 in FY 2003, then declined to 36,283 in FY 2004. The number of children served in psychiatric rehabilitation services increased from 1,595 in FY 1998 to 10,193 in FY 2003, then declined to 9,870 in FY 2004.

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 was reduced by $20 million in general funds. This reduction had some impact on OMHCs, but was largely borne by the rehabilitation providers.

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 measurements 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 2004, and summaries of the results have been included in prior Annual Reports. A summary of the results of the fiscal year 2004 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 2003. 19 responses were received to this survey. A summary of the results of that survey is included in Appendix B-6 of the 2004 Annual Report, along with the results of an analysis of audited financial reports from providers. Many of the outpatient mental health clinics (OMHCs) were 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. Related to this are changes to encourage the use of particular services, and discourage the use of other services.

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. This paper was revised and refined to include consideration of comments received from the Administrations and other parties. The revised updating methodology and the Commission's recommendation on an update factor based on current inflation information are attached as Appendix B-3 in this report.

The Commission is recommending that an update factor of 4.1% would be needed to maintain the purchasing power of the rates in the face of the inflation being experienced by the providers.

Turnover and Wage Levels

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

1. Nationally turnover for direct care staff was around 20%.
2. In Maryland the turnover of direct care staff was 29%.
3. Turnover in Maryland was higher than that reported in the literature, so it is important to address the issue.
4. There is a correlation between pay levels and turnover. 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. A similar situation prevails for 2004.

CBH carried out wage surveys in the falls of 1999, 2000, 2001, 2002 and 2003. Summaries of the results of these surveys were attached to previous Annual Reports, and the summary of the most recent survey is attached as Appendix B-2 in this report. The Commission is required to compare the increases in the rates paid to providers with the increases in the wage rate paid by providers. The results of the survey show that over the past four years the Psychiatric Rehabilitation Providers (PRPs) have provided wage increases for their direct care workers which are higher than the rate increases they have received over the same time period. The source of the additional wage increases was the profit margins of the providers, which have declined over time, and possibly improvements in efficiency and economies of scale as volumes of service have increased.

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. To commence a study on this issue the Commission obtained some data from Maryland Health Partners prior to their losing the ASO contract. Once APS Healthcare has dealt with the immediate operational issues the Commission intends to meet with them to start a flow of data for ongoing analysis.

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 had 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 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 were being made in gray area eligibility, with additional reductions in FY 2004. In addition, other required changes in the payment system have been overshadowed by the budget shortfalls. The need for a systematic updating system for rates is an example. Case rates for psychiatric rehabilitation services were implemented effective February 1, 2004. These case rates represented a reduction in payment levels of about 10%, but allowed more flexibility to the providers. The Commission intends to study the impact of the change to case rates on the utilization of services, and on the financial condition of providers once sufficient data are available.

Data

The Commission is instructed in the new enabling legislation to work with MHA to expand the use of the billing data collected by the ASO 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. A summary report by provider was received from MHP prior to their ceasing to be the ASO. The Commission plans to request ongoing similar data from the new ASO once they have settled into their new role and have their data bases, historical and current, operational.

Integration of Payment Modalities

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

The case rate payment system provides more flexibility to providers in how services are provided, and also incorporates better incentives for effective provision of services. However, with the implementation of case rates for psychiatric rehabilitation services the Commission considers it important to track utilization patterns over time and across providers. This will have two roles: 1) to ensure that service levels remain adequate; and, 2) to detect whether providers with high proportions of heavy care clients are financially disadvantaged as a result of their clients' needs.

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 considered this issue and discussed with the MHA TAG what these costs are, and whether any adjustment in rates has been made for them, or is necessary. A report on this subject has been prepared and is attached as Appendix B-6 to this report.

Uncompensated Care

The Commission is required to report on the extent and amount of uncompensated care delivered by providers. Since uncompensated care is reported in the Audited Financial Statements of the providers, and has an effect on the financial status of the providers, the commission determined that the appropriate place to include this analysis is in the report on the financial condition of the providers. Appendix B-1 to the January 2004 Annual Report includes a discussion of bad debts. Some of the providers did not report any bad debts or charity care in their Audited Financial Statements, and the sample of Audited Financial Reports available is incomplete. However, it appears that bad debts have been increasing, and in 2002 they comprised 2.4% of total revenues for the providers reporting.

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[5] 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.

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. The adoption of case rates for Psychiatric Rehabilitation Services on February 1, 2004 was a move in that direction, and the impact of that change is being observed and studied by the Commission.

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

RECOMMENDATIONS

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

A systematic approach to adjusting rates for the reasonable impact of inflation and other factors is included in most national and state payment systems. As required by the enabling statute the Commission has prepared a paper suggesting a design for such a system, and quantifying the update factor, and has now revised that paper to take into account comments received from MHA. 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. The Medicaid program has an elaborate system to update the rates of the Managed Care Organizations that basically holds them harmless for most changes in the prices they are paying for services. 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 recommended update factor is 4.1%.

2. MHA should require the annual submission of audited financial reports[6] 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. If the Commission were to sunset it would be important for MHA to continue the collection of audited financial reports and other data, and analyze the financial condition of the providers. These studies are all the more important now that the Public Mental Health system is cutting back on payment rates and eligibility levels.

Based on prior experience of both the Commission and MHA, many providers will not comply with the data submission requirements unless MHA has the authority and the will to apply financial sanctions against providers that do not comply. Making the submission of required data a condition of participation is one possible approach, but dropping a provider from participation in the Public Mental Health System is a fairly severe penalty, with consequences for care to clients, and so MHA is likely to apply such a severe sanction only in extreme situations. It should be mentioned that Medicare does have, and use, this sanction, and that in order to avoid it a provider just has to provide the required data. Giving MHA the power to fine providers, or withhold payments, for failure to comply with regulations regarding data submissions is more likely to be used in practice. It should be mentioned in this context that DDA currently has such authority.

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

3. **The Commission supports the concept, currently being implemented by MHA for psychiatric rehabilitation services, of paying for some types of services on an aggregated basis, provided adequate safeguards are included to maintain quality of care. However, the Commission believes that is in necessary to study the impact of the case rates, now that they have been implemented, to ensure that they do not disadvantage the providers caring for the most seriously and chronically ill clients.**

As of February 2004 MHA started paying monthly case rates for psychiatric rehabilitation services. This change provides 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 available at that time 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 and now APS Healthcare. The Commission supports the decision to proceed with expansion of the use of case and/or capitation payment systems for selected services.

Within any case or capitation payment system, the method used to classify enrollees to determine the appropriate level of payment is critical. If this classification system is not sufficiently refined, it is possible that providers caring for the most seriously and chronically ill clients could be underpaid relative to the level of services required for these clients, and conversely, the providers with clients who fall at the low end of service requirements within the classes could be overpaid. The Commission plans to continue its data collection and analysis on this subject, and if the Commission sunsets this activity should be taken over by MHA. This study will require the use of data from multiple sources: 1) the utilization patterns of providers prior to the implementation of case rates; 2) the utilization patterns under case rates; and 3) financial reports.

Chart 5
Distribution of MHA expenditures

Fiscal year 2004

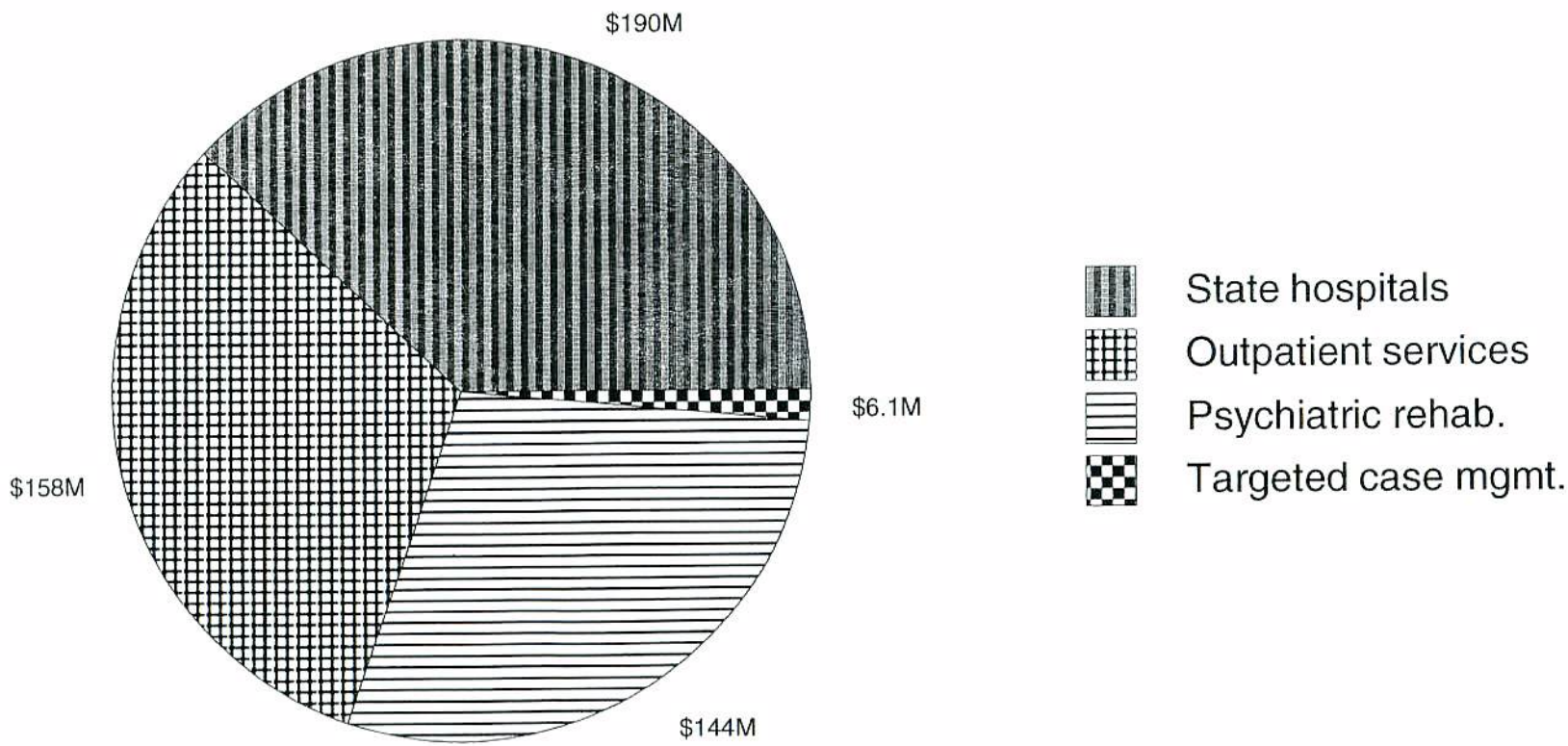


Chart 6

MHA Expenditures: FY 1998-2004

Excludes grant payments, which increased $10M from 1998 to 1999. Amounts in thousands of $s.

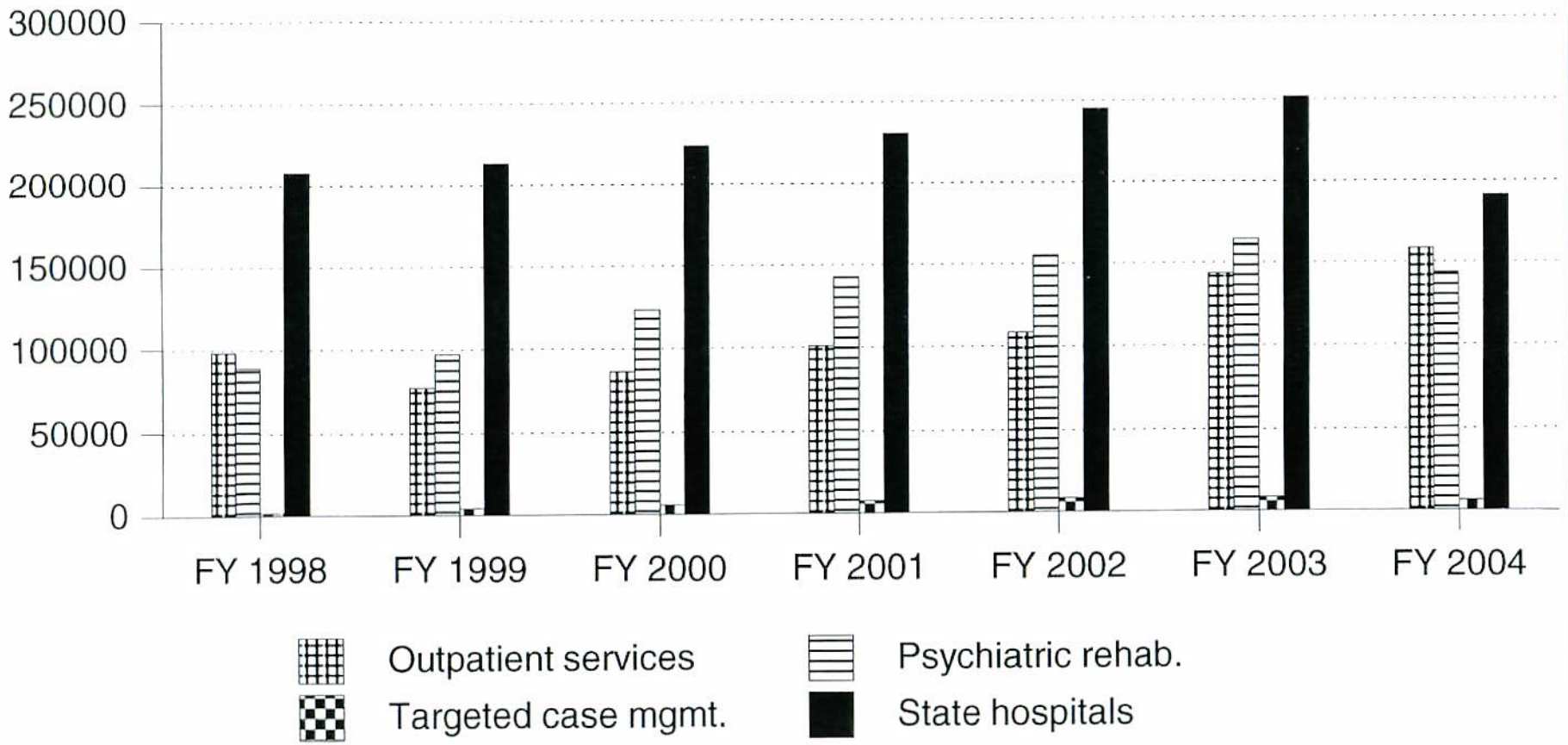
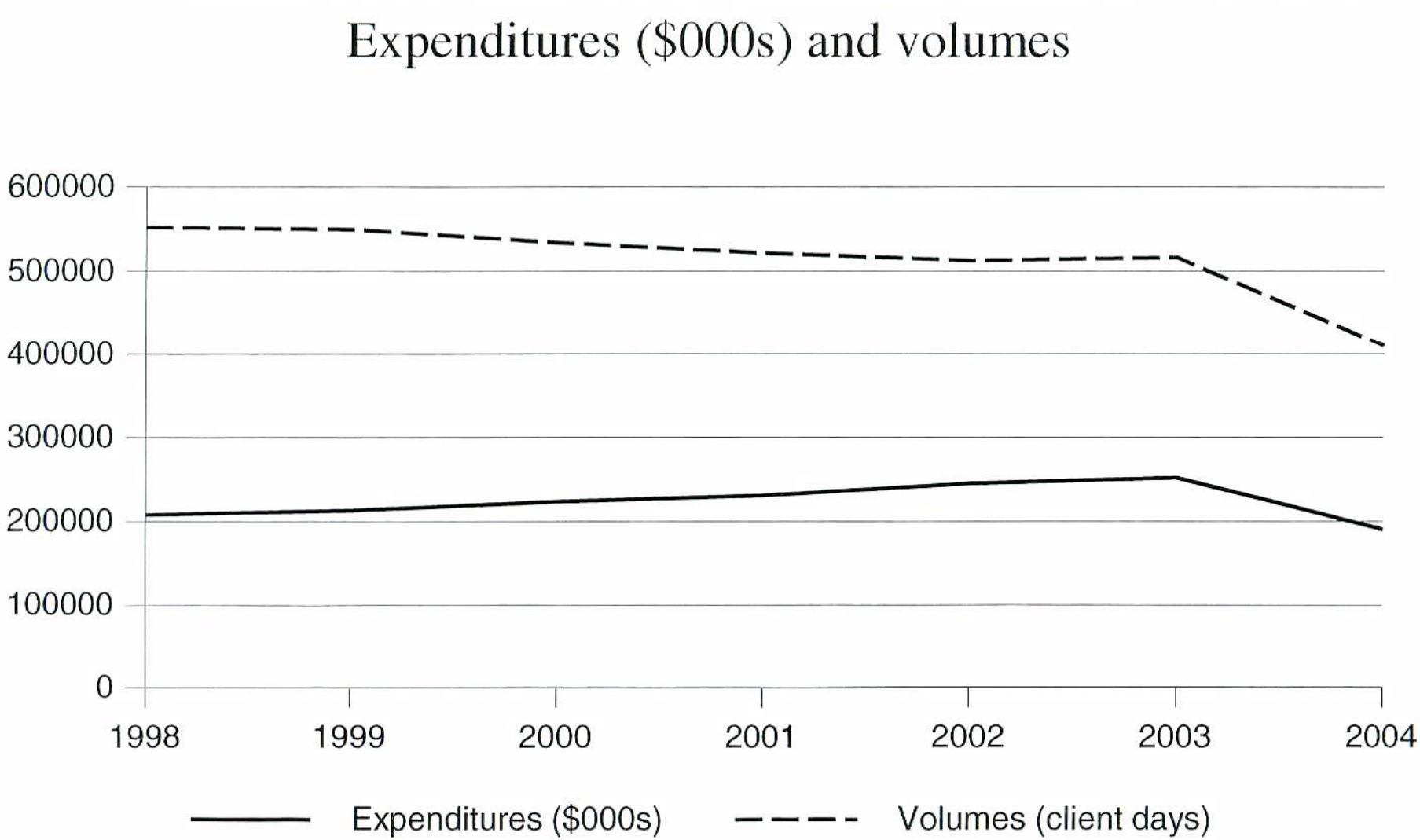


Chart 7

State Hospitals: Mental Health



ACRONYMS

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

APS Healthcare: The ASO currently administering the Public Mental Health System.

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.

Co-payment: 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 of Maryland 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 (CSRRC) 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 consulting experience in health care finance, 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, as Assistant Chief of the Maryland Health Services Cost Review Commission and as a health system Chief Financial Officer.

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 individuals with disabilities and their families. 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 13 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 16 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 and the Upper Shore Community Mental Health Center.

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. Ms. Somerville had spent fifteen years at Vantage Place and over seven as the Executive Director. She is a graduate of Leadership Howard County and currently serves on the board of Children of Separation and Divorce. Ms. Somerville'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.

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

List of Members of the Technical Advisory Groups

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

Technical Advisory Group on MHA issues

Tracey DeShields - DHMH
Jerry Lymas - Commissioner
Herb Cromwell - Community Behavioral Health
Lori Doyle - Mosaic Community Services
Ray Lewis - MHA
Frank Sullivan - MACSA
Theodore Giovanis - Commissioner (ex-officio)

Technical Advisory Group on DDA issues

Tracey DeShields - DHMH
Alan Lovell - Commissioner
Queenie Plater - Commissioner
Arthur Gold - 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 Analysis of DDA Cost Reports

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 2003

B-5 Wage Rate Survey of DDA Providers - 2004

B-6 Consumer Safety Costs

APPENDIX B-1

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 113 Cost Reports for fiscal year 2003 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 only the second 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. Accordingly, the measures that result are comparisons of providers with one another. As such they do not represent comparison with some objective standard. 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. In this table medians are presented rather than means as they are less influenced by outliers. The median per diem payment for Residential Services was $164, for CSLA was $87, for Employment Services was $61 and for Day Services was $60.

Table 1: Summary statistics, fiscal year 2003

	CSLA	Residential	Day	Employment
# of providers	62	88	53	55
Median Margin	8.0%[1]	0.02%[1]	-1.7%[1]	-2.9%[1]

These data suggest that providers are profiting from the provision of CSLA services, and are generally losing money on day and supported employment services. These results are consistent with the results found for FY 2002. 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. The payments for CSLA comprise only about 10% of the total expenditures on community services.

Relationship Between Administrative and Direct Expenses

It was suggested by a provider that providers with a high proportion of clients with heavy service requirements might have higher administrative costs as well as higher direct care costs, and that the payment for administration, general, capital and transportation costs would not account for that. The purpose of these analyses was to test that hypothesis by determining whether there was any statistically significant relationship between the administrative expense per day and the direct expense per day separately for each of 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 data were trimmed to remove outliers[2].

These results for both FY 2002 and 2003 indicate that there is a statistically significant positive correlation between administrative cost per day and direct expense per day for day and CSLA, but not for residential or employment programs.

The CSLA payment system is sufficiently flexible that it can take account of such costs. Combining this flexibility with the relative profitability of CSLA services, the conclusion is that no adjustment is required to the CSLA payment system to take account of this phenomenon.

[1] The median margin was calculated by first calculating the margin for each provider, then calculating the median of these margins. It is not calculated from the median revenue and median expense.

[2] Providers that reported either a cost or revenue of $0 for a service were excluded for this analysis for the service. Residential providers were dropped if the administrative cost per day exceeded $100. For Day and supported employment programs the threshold for administrative cost was $40 per day. CSLA providers were dropped if their administrative costs per day exceeded $400 or their direct cost per day exceeded $1,000 per day.

For Day and Employment programs the effect could be due, as least in part, to transportation costs. As a result, as well as for other reasons, the Commission plans to engage in a more intensive study of transportation costs when data from the FY 2004 Cost Reports are available.

Transportation Costs

The FY 2003 Cost Report was the first in which detailed data on transportation costs and utilization were collected. These data were examined and large differences among providers in transportation costs were noted. However, due to problems with the detailed analysis of transportation costs, the analysis was delayed pending availability of the FY 2004 Cost Reports.

Conclusions

Providers appear to be incurring losses on day and employment programs. It was suggested that this could be due to increased transportation costs. Although residential services appear to be operating at a slim margin in 2003 almost half the providers (48%) are operating at a deficit. 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. There are differences between service categories, however, with CSLA being relatively well paid, and the other services somewhat underpaid, particularly day services.

Additional study of transportation costs for Day and Employment programs should be performed once the FY 2004 data are available.

APPENDIX B-2

CSRRC Summary of the 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 2004 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 2004. This survey followed the same format as surveys that were used in fiscal years 2000, 2001, 2002, and 2003 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 winter of 2003/2004 and reflects fiscal year 2004 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 2004 Salary Survey for Psychiatric Rehabilitation Programs", prepared by CBH staff, and dated April 2004, 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%[3]). The fringe benefits paid by the providers averaged 22.6%, with a median value of 22.5%. 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	$26,831	$22,000	$30,008	$24,558
Rehabilitation Counselor - Mean	$26,937	$21,964	$30,209	$24,610
State MHA II [4]	$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[5]	18%/17%	8%/8%	17%/17%	8%/8%
Percentage by which the MHA III rate exceeds the provider median/mean	25%/25%	15%/15%	25%/24%	15%/15%

[3] 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%.

[4] These state wage rates are the average of the rates that were in effect from January 1, 2002 through FY 2004.

[5] 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 2004 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%
FY 2004	$26,937	–1.8%[6]	$30,209	-4.7%[4]

[6] The Commission does not believe that wage rates of staff were actually reduced. There were, however, substantial reductions and turnover in staff, loss of higher paid staff, and reduction in the type of benefits offered and a reduction in the employer share of benefits. Also, different sets of providers responded to the surveys in different years.

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 2004 to show the growth over time, along with the state MHA II and MHA III starting salaries (excluding benefits), and the increase in the Washington-Baltimore Consumer Price Index, 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.	CPI Wash-Balt. % 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%	1.8%
FY 2000	$21,931	7.5%	$23,377	7.4%	$20,420	5.3%	$23,309	5.6%	2.5%
FY 2001	$22,809	4.0%	$24,313	4.0%	$21,998	7.7%	$25,272	8.4%	3.3%
FY 2002	$23,265	2.0%	$24,799	2.0%	$21,935	-0.3%	$24,523	-3.0%	1.8%
FY 2003	$23,722	2.0%	$25,286	2.0%	$22,163	1.0%	$25,576	4.3%	3.3%
FY 2004	$23,722	0.0%	$25,286	0.0%	$21,964	-0.9%	$24,610	-3.8%	2.2%
change 1998-2004	$4,594	24%	$4,787	23%	$3,034	16%	$3,320	16%	16%

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 a small increase in selected psychiatric rehabilitation rates, and the PRP rates have not been increased since then. The rates were adjusted slightly, generally downwards, in conjunction with the implementation of HIPAA coding requirements, and then rates were reduced by about 10% on average, with the implementation of case rates. The dramatic changes in the payment structure with the shift to case rates, and coding changes associated with HIPAA, make it impossible to calculate an exact rate change. However, it is fair to say that PRP rates are currently at a lower level than they were in 1998.

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.

[7] The CPI increase is from January to January. Data from the Bureau of Labor Statistics, May 6, 2004.

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, but appear to have declined from 2003 to 2004. This may be reflective of a generally tighter financial situation.

It would be useful if CBH and MHA could revisit the issue of the equivalency between state and community positions.

Conclusion

The psychiatric rehabilitation providers have increased starting wages for rehabilitation specialist/counselors by 16% from FY 1998 to FY 2004. This is equal to inflation in the general economy, but less than the increases in state starting wages. The Consumer Price Index for the Washington-Baltimore area rose by 16% from January 1998 to January 2004. Over this same time period the fee schedule rates for psychiatric rehabilitation services were adjusted, but did not receive any general rate increases. The implementation of case rates on February 1, 2004 was intended to implement a rate reduction of about 10%. The wage increases provided were substantially greater than any rate increases received by the providers, and rates are effectively lower now than they were in 1998. 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 2004 time period the state has increased their wages more than the providers. The difference in wages is in the range of 17 to 25 percent when fringe benefits are taken into account.

APPENDIX B-3

Proposed Update System for DDA and MHA Rates

Proposed Update System for DDA and MHA Rates

Background

A fundamental component of the design of most health care payment systems is a systematic method for updating rates. However, the payment systems used by the Developmental Disabilities Administration (DDA) and the Mental Health Administration (MHA) do not include such a component. Failure to have such a component leads to a lack of predictability for providers and the government and over time can undermine the service structure that the payments are intended to support. As a result the CSRRC has undertaken a review of the approaches taken to updating rates in several payment systems.

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

Almost all payment systems include a system for adjusting the rates to account for the impact of inflation in the prices of the goods and services purchased by the providers. For example, the Health Services Cost Review Commission (HSCRC) has such a system for updating the rates of the hospitals, and all the Medicare Prospective Payment Systems include such a system. DHMH has an updating system for the rates paid for medical day care which bases the update on the increase in the medical care component of the Consumer Price Index (CPI). Such systems can be quite simple or relatively complex.

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

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

This paper starts with a brief discussion of the updating systems used by the HSCRC and by Medicare, then continues with a discussion of some options for systems for the DDA and the MHA rates. The HSCRC and Medicare discussions are provided as background, and are not

intended to suggest that the MHA or the DDA should use such systems for setting rates.

HSCRC Updating System

The HSCRC hospital payment system establishes the rates of individual hospitals using the costs of a group of similar hospitals, adjusting for some factors that are specific to the particular provider, and then using the resulting adjusted costs to develop rates. Once the rates have been established they are updated annually using an Inflation Adjustment System (IAS) and hospitals may go for long periods without having their base rates reviewed. The HSCRC compares the charges of the hospitals after adjusting for factors for which they do not consider it appropriate to hold the hospitals accountable. These factors include: geographical differences in wage rates, case-mix and payer mix, outlier cases (cases with an unusually high charge), highly specialized and expensive services (e.g., the burn center at Hopkins Bayview Medical Center, the trauma center at University of Maryland Medical System, and some organ transplants), and the reasonable level of uncompensated care experienced by the hospital. If a hospital is found to have high adjusted charges under this comparison it is either subject to detailed review of its rates, or agrees to accept a reduced inflation adjustment each year until it achieves some target.

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

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

Medicare Updating Systems

The Medicare Inpatient Hospital Prospective Payment System (PPS) is used to pay hospitals for inpatient services, but many of the factors involved apply equally to Medicare payments to other providers, e.g., skilled nursing facilities, outpatient hospital services, physicians. Inpatient cases are classified into Diagnosis Related Groups (DRG). A payment rate is set by Medicare for each hospital for a DRG with a weight of 1 by standardizing the rates for the various adjustment factors included in the system. The payment for any particular case is calculated by multiplying the weight for the case by that rate. The payment for the particular hospital varies for factors such as the geographical location of the provider, the level of graduate medical education, and the proportion of indigent patients. There are separate components for operating and capital costs. Geographical adjustments are based on the Metropolitan Statistical Area in which the hospital is located, and geographical adjustments apply to the labor costs, and to capital costs (the adjustment factors are different for labor and capital), but not to the other costs. The rates were originally calculated based on actual average costs, but are not rebased to actual costs.

Additional payments are made for very high cost cases through "outlier payments". An update to the rates is provided each year, and this update is often specified by Congress in legislation. However, the basis of the update factor is usually studies performed by CMS/HCFA and the Medicare Payment Advisory Commission (MedPAC), who look at the impact of input price changes, technology improvement, changes in coding practices, changes in case mix, and improvements in productivity, on hospital costs. This creates a framework for determining the update, but does address the issue of evaluating base rates. Medicare is moving forward with a quality initiative. Eventually providers will receive lower rates if they rank low on a relative quality comparison. To encourage participation in the quality initiative the Medicare Drug Bill provides a lower rate update for providers that are not participating in the quality initiative.

A second aspect of updating is the review of the weights used for different categories of patients. Annually Medicare considers factors such as changes in medical practices, introduction of new technology, technology diffusion, then reclassifies types of cases among the DRGs and recalculates the weights associated with the DRGs. The recalculation of weights is performed in a budget neutral manner, i.e., based on the number and mix of cases seen in the prior year and the HCFA model of payments and as a result the change in weights does not change the total payments. However, the total payments by Medicare are permitted to increase based on, among other factors, increases in volume or case mix, as well as the update factor.

The Medicare physician payment system also includes an updating system, with an allowance for the impact of inflation, but is complicated by an additional adjustment based on the change in total payments. If the total payments for physician services increase above a certain level, then the rate for subsequent years is reduced to remove the payments above the limit. However, in recent years Congress has provided small increases instead of the reductions that would have been required if this formula were strictly applied. The Medicare physician payment system is very similar to the MHA payment system for physicians and clinics. Both are based on the CPT-4 coding system for procedures, and set a rate for each CPT-4 code.

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

1. Decide upon the update to rates.

2. Use the prior year's volume and case mix data with the update factor to calculate projected aggregate payments at prior year volume/case mix.

3. Make changes in the treatment of outliers, calculate new weights, and other changes that are required to be done in a budget neutral manner.

4. Use prior year's data to model the impact of the changes listed in step 3.

5. Use the results of the modeling in step 4 to make budget neutrality adjustments so that the new aggregate payment level at prior year volume/case mix calculated in step 2 is not exceeded.

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

Options for the DDA and the MHA

The Commission believes that the rate systems of the DDA and the MHA should include a systematic approach to updating rates. However, based on a review of the comments received from the MHA and the DDA to the previous version of this paper, the Commission is now recommending different approaches for these updating systems.

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

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

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

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

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

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

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

The legislature has specified that additional funds should be made available to the DDA providers to allow for the wage rates to be brought up to the level of corresponding state wages. The adjustment to the base rates was intended to bring the base rates up to a target level. The amount of adjustment required was calculated using the state employee compensation for similar positions as the target wage rate. However, once the base rates are equalized between community

service direct care workers and corresponding state employees a policy decision is required. That decision is whether the direct care wage component of the rates should be increased in lock-step with state wage increases, or whether the updates can be separated at that point. It has been argued that no allowance is needed for inflation in wages and fringe benefits currently because the additional funds provided through the wage equalization program can be expected to reduce turnover, and result in savings in recruitment, training, and overtime expenses. While this seems plausible, no studies have been done to quantify such effects, or verify that they are occurring.

Recommended Approach and Update Factor for the DDA

The update factor recommended by the Commission last year was constructed as follows:

- Costs were assumed to be 75% labor related and 25% non-labor related.
- The recommended update factor for labor related costs was the increase in Employment Cost Index (ECI) for health services.
- The recommended update factor for the non-labor component was the increase in the Baltimore-Washington MSA CPI for all urban consumers.
- In addition, adjustments should be made for the estimated impact on costs of any significant state or federally mandated changes in staffing, or other aspects of the delivery of care, or for any substantial costs changes that impacted on providers differently from the manner in which they impacted on the indices specified above.

The DDA commented that an inflation update for the non-labor portion of costs was appropriate, but not feasible given the current financial situation. They pointed out that the use of an index of the type being suggested for the labor proportion of costs was inconsistent with the law that requires wage equalization between direct care workers and corresponding state workers. The logical index given that law is the increase in the wages of state workers. The DDA also suggested that the providers should be experiencing cost reductions due to savings in turnover, recruitment, training and overtime costs as a result of being able to pay higher wages.

Only the wages of direct care workers are covered by the wage equalization program, and these comprise about 60% of the total costs. The recommended update factor is therefore:

- Costs are assumed to be 60% direct care labor related and 40% other costs.
- The recommended update factor for labor related costs for direct care workers is the increase in the wages and fringe benefits of state direct care workers.
- The recommended update factor for the Other component is the increase in the Baltimore-Washington MSA CPI for all urban consumers.
- In addition, adjustments should be made for the estimated impact on costs of any significant state or federally mandated changes in staffing, or other aspects of the delivery of care, or for any substantial costs changes that impacted on providers differently from the manner in which they impacted on the indices specified above.

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

Another issue that was discussed in the previous version of this paper was the relative weights in the client matrix, and how often these should be updated. The DDA points out in their comments that adjusting these weights would be complicated, contentious, and disruptive. Given these comments and the results of the Commission's analysis of the DDA Cost Reports, the Commission agrees that the recalibration of the FPS would not be a good use time and resources.

Comment

The Commission understands the current budget situation, but would point out that the majority of health care providers paid by the state are provided with automatic rate updates based on inflation proxies barring a conscious decision to modify the update. For example, the medical day care providers receive an update of the medical care component of the consumer price index barring legislative action to the contrary, nursing homes receive an automatic increase, and the hospitals have received increases in excess of general inflation in recent years. The MHA and DDA payments systems are unusual in not having such a system. In the long term the Commission considers such a system to be extremely important to the financial viability of providers, as well as being important to provide predictability to the providers.

The Commission does not expect that the update would be applied uniformly to all rates, or that it would necessarily be provided in full in years in which the state was experiencing major budget problems. The administration should have flexibility in these aspects of the application of an update system. However, it is important that the impact of inflation on the costs being incurred by providers is recognized, and accounted for both in the rates paid to the providers, and the budgets of the two administrations. The default situation should be a rate increase commensurate with the inflation being experienced by the providers, rather than no increase, as is the current situation. The budgets of the administrations should also be adjusted for changes in projects enrollment and utilization.

Recommended Approach and Update Factor for the MHA

The update factor recommended by the Commission last year was constructed as follows:

- Costs were assumed to be 75% labor related and 25% non-labor related.
- The recommended update factor for labor related costs was the increase in Employment Cost Index (ECI) for health services.
- The recommended update factor for the non-labor component was the increase in the Baltimore-Washington MSA CPI for all urban consumers.
- In addition, adjustments should be made for the estimated impact on costs of any significant state or federally mandated changes in staffing, or other aspects of the delivery of care, or for any substantial costs changes that impacted on providers differently from the manner in which they impacted on the indices specified above.

The MHA commented that the costs of the providers are largely labor related, and so an inflation index that was tied purely to labor cost increases would be more appropriate. The Commission considers understands that the majority of the costs incurred by the providers are for labor, but certainly there are some non-labor costs. As a result the recommendation is being modified to assume that the costs are 80% labor related and 20% other costs. Once detailed cost data are available from providers a study should be performed to determine what proportion of the costs are labor related, and whether that varies by type of provider.

The MHA suggested that it may not be appropriate to increase all rates by the same amount, and that it may be appropriate to increase some rates to encourage these services, and to reduce other rates. The Commission agrees that such flexibility is desirable, did not intend to suggest that all rates should be uniformly increased each year, and, in fact, included in its recommendation a suggestion that such flexibility should be provided. The idea of trying to encourage services that have been demonstrated to be effective, and discourage those that have been demonstrated to be ineffective, is laudable, as is moving the mental health system in the direction of evidence based practice models.

The MHA also discusses the budget problems that it has experienced over the past several years, and the trade-off between increasing rates and maintaining coverage. While the Commission understands this trade-off, it considers it important to ensure that the rates are fair and adequate. Adjusting the rates for inflation is an important component in ensuring that the rates continue to be fair, and if rates are not adjusted for inflation they will inevitably become inadequate.

The Commission agrees with the MHA that it is important to collect financial information on the providers to track the impact of rates and rate changes, and has encouraged the collection of such information in its recent Annual Reports. However, it is not necessary to have such information in advance of implementing an updating system. The following approach to the development of the MHA budget for community services might serve to address the concerns of the Commission and some of the concerns raised by the MHA.

1. Start with community service expenditures for the prior year.

2. Update this amount for the reasonable impact of inflation.

3. Adjust for projected changes in volume and service mix.

4. Reallocate the amount calculated in step 3 among the rates based on desired changes in service patterns, and evidence based practice.

5. Develop the rates.

This approach has the benefit that the starting point is the prior year's expenditures, adjusted for inflation and volume change, rather than having to start from the prior year's expenditures and then justify all increases, including those for inflation and volume change.

Comment

The Commission understands the current budget situation, but would point out that the majority of health care providers paid by the state are provided with automatic rate updates based on inflation proxies barring a conscious decision to modify the update. For example, the hospitals have received increases in excess of general inflation in recent years, the medical day care providers receive an update of the medical care component of the consumer price index barring legislative action to the contrary, and nursing homes receive an automatic increase. The MHA and DDA payments systems are unusual in not having such a system. In the long term the Commission considers such a system to be extremely important to the financial viability of providers, as well as being important to provide predictability to the providers.

The Commission does not expect that the update would be applied uniformly to all rates, or that it would necessarily be provided in full in years in which the state was experiencing major budget problems. The administration should have flexibility in these aspects of the application of an update system. However, it is important that the impact of inflation on the costs being incurred by providers is recognized, and accounted for both in the rates paid to the providers, and the budgets of the two administrations. The default situation should be a rate increase commensurate with the inflation being experienced by the providers, rather than no increase, as is the current situation. The budgets of the administrations should also be adjusted for changes in projects enrollment and utilization.

Comparison of updating components of payment systems:

Factor	HSCRC rates	Medicare PPS	DDA PPS	MHA	CSRRC position
Base costs	Initial base year. No current costs used unless full review.	Initial base year costs. No current costs used to rebase system.	Initial base year costs.	Fee-for-service system 7/1/97, first based on projected costs, then market prices for some services.	
Current cost data	Cost reports annually.	Cost reports annually.	Cost reports annually.	No current cost data collected.	
Rebasing[8]	More current peer group cost used in full rate review.	No rebasing. Current costs used to monitor system only.	No rebasing. Current costs used to monitor system only.	Base remains constant. Rates may be added or updated.	
Complexity adjustments	Charges and DRGs.	DRGs.	25 categories,	Fee-for-service by CPT-4 code.	
Update weights	Updated based on charges.	Updated annually using charges.	No.	No.	
Update rates	Annual inflation, productivity, etc. adjustment.	Annual inflation, net of productivity	Subject to budgetary constraints.	Subject to budgetary constraints.	Annual update required
High cost cases	Implicitly included, as charges are the basis of payments	Extra payment for high cost cases - "outliers"	Accomplished through "Augmentation grants".	Implicit, as fees increase with increased services.	
Capital costs	Blend of hospital specific and peer group, after review.	Standardized rate. Varies by MSA	Partly through Start-up grants. Statewide average for balance.	Average costs implicit in the rates.	
Geographic adjustments	County level adjustments for wage/salary costs only.	By MSA for wages/capital. Different rates for large and small urban/rural areas.	By region for client portion. No adjustment to AGC&T portion.	No geographic adjustment	

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

Memorandum

To: CSRRC Commissioners

From: Graham Atkinson

Date: December 7, 2004

Regarding: Recommended update factors

At the September meeting the Commission approved a revised update methodology. The recommended updates factors for MHA and for DDA rates have been calculated using that methodology, and the most recently available data from the Bureau of Labor Statistics as of the date of this memorandum.

Recommended update factor for MHA rates:

80% of the increase in the Employment Cost Index for health, plus 20% of the increase in the Baltimore-Washington MSA CPI for all urban consumers:

$$0.8 \times 4.4\% + 0.2 \times 3.1\% = 4.1\%$$

Recommended update factor for DDA rates:

60% of the increase in state direct care worker wages[9], plus 40% of the increase in the Baltimore-Washington MSA CPI for all urban consumers:

$$0.6 \times 2.8\% + 0.4 \times 3.1\% = 2.9\%$$

[9] State workers were provided an increase of $752 independent of wage level. This converted to percentage wage increases for community workers of 3.3% for aides, 2.7% for service workers, and 2.3% for first line supervisors. The weighted average was 2.8%. These percentages were calculated by dividing $752 by the annual average wage for the wage category determined from the 2004 wage survey of the community providers.

APPENDIX B-4

The Financial Situation of Providers of Community Services Contracting with DDA, Fiscal Years 1997 through 2003

The Financial Situation of Providers of Community Services Contracting with DDA, Fiscal Years 1997 through 2003

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 through 2003.

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 2003 Audited Financial Reports.

Year	1997	1998	1999	2000	2001	2002	2003
No. of reports	55	46	84	89	94	103	104

Providers were required by regulation to provide their Audited Financial Reports starting with FY 2001. 104 providers were available for FY 2003 out of a total possible of about 120. Of the 104 providers used for the 2003 analysis, 42 were from the Central Region, 17 from the Eastern Region, 28 from the Southern Region, and 17 from the Western Region.

The following data fields were extracted from the fiscal year 2003 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 the 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
Total 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 profits or losses, but only a small proportion of their business is with Maryland DDA. In order to adjust for this starting in FY 2000 the mean ratios were calculated weighting the results by the total Maryland DDA payments to the provider. These payments included CSLA, FPS, and 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, 1.8% in FY 2002 and 2.5% in FY 2003. The spread of the margin is shown in Table 1. The margins, and so many of the other ratios examined, could have been affected by the phase-in of the FPS, which was completed in FY 2001.

Table 1: Profit Margins	FY 1997	FY 1998	FY 1999	FY 2000[10]	FY 2001[11]	FY 2002[1]	FY 2003[1]
Upper quartile	7.0%	7.8%	8.3%	8.1%	3.9%	5.6%	6.7%
Median	2.1%	4.4%	3.1%	3.2%	0.7%	1.3%	2.5%
Lower quartile	-2.7%	1.2%	0.0%	0.0%	-2.8%	-1.5%	0.1%
Mean	2.1%	3.8%	3.2%	3.5%	0.4%	1.8%	2.5%

Of the providers of community services reporting to DDA for FY 2003 23 of the 104 had negative margins in FY 2003 (i.e., 22%). 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.

To place these margins in a context, it will be useful to list recent margins of two related sets of providers: Nursing facilities and Home Health Agencies. The Centers for Medicare and Medicaid Services (CMS) reported that in 2002 the mean net income margin (profit margin) for 7 large for-profit nursing home chains was 2.2%. The American Association of Homes and Services for the

[10] Mean margin weighted by DDA payments.

[11] FY 2001 represents a low point in the profit margins, and this coincides with the last year of the phase-in of the FPS. In FY2001 several providers experienced negative adjustments to their rates as a result of this phase-in, but none received positive adjustments.

Aging[12] estimated that the mean total margin for not-for-profit freestanding Medicare certified SNFs was 1.8%. CMS calculated that the median operating margin of publicly traded Home Health Agencies was 2.2% in 2002. Thus, the margins experienced by the DDA providers in 2003 are similar to, but slightly higher than, those recently experienced by for-profit nursing homes and Home Health Agencies.

Profit Margins by Region of the State

Table 1A shows the mean profit margins (DDA revenue weighted for 2000, 2001, 2002 and 2003) for the providers located in the 4 DDA regions of the state for FYs 1997 through 2003* and Table 1B shows the median profit margins[13] for 1999 through 2003.

* In FY 2003 contributions made up 4% 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[14]	2001[5]	2002[5]	2003[5]
Central (Baltimore & area)	0.1%	2.4%	3.0%	2.0%	0.3%	1.6%	1.3%
East (Eastern Shore)	4.5%	7.8%	8.2%	5.5%	-0.5%	2.5%	6.2%[15]
South (Washington suburbs & South)	2.0%	4.3%	2.3%	5.2%	1.2%	2.9%	4.0%
West (Western Maryland)	1.4%	2.9%	3.2%	3.5%	-1.3%	-0.2%	1.1%
State	2.1%	3.8%	3.2%	3.5%	0.4%	1.8%	2.5%

[12] Susan Polniaszek, MPH, American Association of Homes and Services for the Aging, October 2002.

[13] 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.

[14] Weighted by DDA payments.

[15] This result includes data for 17 providers.

Table 1B: Median profit margin by region	1999	2000	2001	2002	2003
Central (Baltimore & area)	2.9%	1.4%	0.2%	1.3%	2.5%
East (Eastern Shore)	6.7%	3.6%	0.0%	1.6%	6.7%[16]
South (Washington suburbs & South)	2.5%	6.2%	2.7%	1.2%	1.1%
West (Western Maryland)	2.6%	2.2%	-0.3%	-0.8%	2.2%
State	3.1%	3.2%	0.7%	1.3%	2.5%

It is interesting to note the difference in the trend in median margins in the Southern region from 2001 to 2003. This contrasts with the overall trend, and with the trend in mean margins. The mean margins are influenced more strongly by a small number of providers with large margins, which could be due to capital grants.

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	FY 2003
Upper quartile	2.4	3.2	3.4	3.1	3.5	3.3	3.1
Median	1.8	1.7	1.9	1.4	1.8	1.7	1.8
Lower quartile	1.0	0.9	1.0	1.0	0.9	0.9	1.1

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 has been stable through 2003.

FY 2003 median current ratio by region:

Table 2A: Current ratio	Central	East	South	West
Median	1.8	2.1	1.7	1.8

Cash and investments are closely related to the current ratio so will be discussed under this

[16] This result includes data for 17 providers.

heading. They represent money that is available to the provider in the short term.

Days in Cash and Investments

Cash and investments were 14% of the total expenses. The cash available, thus, represents 51 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, but this has dropped substantially in recent years, with the downturn in the stock market, and the lowering of interest rates.

Days in cash is an important measure as it indicates a provider's ability to pay their bills, and to deal with delays or interruptions in their income stream. 45 to 60 days is a reasonable level.

Days in Receivables

Receivables comprised 12% of the total revenues, so providers had, on average, 44 days of revenue in receivables. Receivables are the total charges associated with bills that have been sent out, but not yet paid. The days in receivables measure the average delay in payment. 44 days is a reasonable level.

Bad Debts

Bad debts do not appear to be an issue for the providers contracting with DDA. The majority of the providers reported no bad debts, and the total bad debts reported were only 0.42% of the total revenues. This low level of bad debt is understandable given the nature of the services provided; the services are long term.

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	FY 2003
Upper quartile	8.3%	8.9%	10.3%	11.7%	6.9%	9.3%	9.4%
Median	2.9%	5.2%	4.4%	4.7%	1.0%	1.9%	2.9%
Lower quartile	-3.4%	0.5%	0.1%	0.3%	-4.1%	-1.8%	0.2%

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 and then to FY 2003 is related to the increase in the margins.

FY 2003 median return on assets by region:

Table 3A: Return on assets	Central	East	South	West
Median	2.7%	9.2%	2.2%	1.9%

Total Asset Turnover

Total 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 total asset turnover is shown in Table 4.

Table 4: Asset turnover	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003
Upper quartile	1.9	2.3	2.0	1.7	2.4	2.1	1.9
Median	1.4	1.6	1.4	1.4	1.5	1.4	1.3
Lower quartile	0.9	0.8	0.9	0.9	1.0	0.9	0.9

FY 2003 total asset turnover by region:

Table 4A: Asset turnover	Central	East	South	West
Median	1.4	1.3	1.4	1.1

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 and FY 2003. 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 3 providers with negative net assets in FY 2003 also had negative net assets in FY 2002. Their 2003 margins showed small profits in 2 cases and a small loss in the other. The distribution of these providers by region was as might be expected given the number of providers reporting in each region - 2 were from the central region and 1 from the Southern region.

Total DDA Community Services Revenues

It is important to note that total volumes of services and DDA payments to Community Service providers have increased substantially over the past several years. Between 1998 and 2003 the total payments increased from $260 million to $441 million, an increase of 71%. The largest percentage increases were in CSLA and Individual support, which both increased by more than 350%.

Summary

The ratios examined are in a reasonable range for fiscal years 1998 through 2003. 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 and further in 2003.

	1997	1998	1999	2000	2001	2002	2003
% with negative margins	36%	22%	20%	25%	43%	32%	22%
Number with negative net assets	4	4	3	2	7	3	3
% with current ratio < 1	25%	22%	23%	26%	31%	28%	20%

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, 28% in FY 2002 and 20% in FY 2003.

In previous papers reporting the results of the Commission's wage surveys the Commission concluded that providers had increased wages by a greater percentage than the percentage rate increase they received. This could explain the declines in the operating margins observed in these years. The wage equalization funds provided by DDA in FY 2003 may have contributed towards the improvement in the margin seen in 2003.

The Commission continues to find that bad debts are not an issue of concern for these providers.

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.

Contributions: Revenue from contributions and donations. This includes United Way funding.

Cash and investments: Cash and investments reported in the assets section of the audited financial statement.

Receivables: The dollar amount of accounts receivable, as reported in the assets section of the audited financial statement.

Bad debts: Any amounts reported as being written off as bad debts or listed as bad debts in the Statement of Functional Expenses of the audited financial statement.

APPENDIX B-5

Wage Rate Survey of DDA Providers - 2004

Wage Rate Survey of DDA Providers - 2004

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 2004. Surveys were sent to over 120 providers. 114 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 FY 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, without the fringe benefit form, and with some minor editorial changes was used again in FY 2004. The survey was mailed to over 120 providers. Two educational sessions were provided to instruct providers on the purposes of the survey and how the forms should be completed.

The data were checked extensively once received. Overall reasonableness checks were made by both DDA and CSRRC staff, and the data were compared with the corresponding data submitted in the prior year. Where errors were found the provider was asked to resubmit corrected data. Most of the corrections submitted based con this review were to the data submitted for FY 2003. 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, and assisted in obtaining clarification or corrections from providers when the data appeared suspect.

Starting for FY 2004 the providers are required by DDA to have their auditor certify the data provided in the survey form. This certification was due to DDA December 1, 2004. About a third of the providers refiled corrected reports, either in response to queries or after the review by the auditors.

Results of the Survey

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

Wage category	Base hourly rate - 00*	Base hourly rate - 01*	Base hourly rate - 02*	Base hourly rate - 03*	Base hourly rate - 04*	% change 03-04	% chg 01-04[17]
Aide	$7.44	$8.64	$8.99	$9.24	$9.24	0.0%	6.9%
Service worker	$8.57	$9.15	$9.43	$10.00	$10.03	0.3%	9.6%
1st line supervisor	$13.44	$14.83	$15.10	$15.72	$16.76	6.6%	13.0%
Driver - CDL[18]	$8.61	$9.45	$11.92	$12.29	$10.63	-13.5%	12.5%
Driver-non-CDL	$8.08	$8.86	$9.34	$9.54	$9.70	1.7%	9.5%

* The set of providers responding differed among the years, with 47 providers included in the 2000 analysis, compared with over 115 in the 2001 analysis, 113 in the 2002 analysis, 110 in the 2003 analysis, and 114 in the 2004 analysis. Because of the small number of providers reporting in 2000 the change in the last column was measured from 2001.

The reported proportion of Aides to Service Workers decreased substantially from 2003 to 2004. This may be due to a change in the way in which positions were classified in the two surveys. If the two categories are combined the increase in the wage rate is 0.6%.

[17] Because of the small number of surveys available for 2000 the change from 2001 is being measured.

[18] 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.

Staff Turnover Rates and Tenure

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

	2001	2002	2003	2004
Aides	48%	45%	41%	37%
Service workers	35%	44%	27%	35%
First line supervisors	29%	28%	21%	18%
Drivers CDL	33%	25%	17%	11%
Drivers - non-CDL	132%	27%	28%	29%

The turnover rates of state employee categories are much lower than those experienced by the providers.

80 providers included data on staff tenure in 2002, 86 in 2003, and 111 (of the 114) in 2004. The average tenures of staff and the percentages of the direct care employees in each category were:

Job category	Average tenure 2002	Average tenure 2003	Average tenure 2004	% of employees in the category in 2004
Aide	39 months	30 months	38 months	32%
Service worker	45 months	40 months	44 months	56%
1st line supervisor	52 months	61 months	62 months	12%

The large changes observed here may be indicative of changes in the set of providers reporting and included in the analysis, or, more likely, may be due to errors in the reporting in prior years.

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.

Fringe Benefits

The fringe benefit survey for 2004 will be collected in conjunction with the submission of the Annual Cost Reports in December, since the providers will then have complete data on their fringe benefit expenses for 2004. The data presented in this section is from prior surveys.

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. The following table summarizes the results from prior year CSRRC surveys.

Fringe benefit percentage by fiscal year

Year	# providers	Mean FB %	Median FB %
2000	38	19.9%	19.0%
2001	96	20.7%	20.0%
2002	97	19.7%	19.6%
2003	119	20.3%	20.0%

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, but it should be noted that this effect is budgeted for in the $80 million wage initiative.

DDA re-surveyed providers on fringe benefits for fiscal years 2002 and 2003 because of the importance of this subject. 119 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	19.7%	20.7%	19.6%
FY 2003	20.3%	21.3%	20.0%

DDA has calculated the current state fringe benefit percentage to be 30.4%. This is substantially higher than that of the providers.

The reporting of the breakdown of fringe benefit costs, which was requested for the first time in the 2003 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 (about 40% of the total fringe benefits) was the employer proportion of FICA. 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

In 2003 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. In 2004 57 providers reported paying bonuses, with a total of $2.1 million, or 1.2% of the base wages.

Distribution of bonuses by job category (for the reported job categories)

Job category	% of total bonuses going to job category
Aides	16%
Service Workers	67%
1st line supervisors	14%
Drivers	3%

Bonuses paid in FY 2004 will be reported along with the FY 2004 Cost Reports. These data will be reviewed and an updated version of this paper will be produced once the results are complete.

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 2001 survey described in this report was intended to provide a base from which wage rate increases in the future could be calculated. The wage increases are greater than the rate of increase in the Consumer Price Index between 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. The rate increase from 2002 to 2003 was similar in size to the wage increase provided to the employees surveyed, but the rate increase from 2003 to 2004 was greater than the increase in direct care wage rates. Over the period 2000 to 2004 the wage increases have been similar in magnitude to the rate increases. It should be mentioned that the Commission, in drawing this conclusion considered the rate increases as a percentage of all wages, not just direct support wages.

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 margins of the providers for FY 2002 was around 2%. In FY 2003 the mean margin increased to 2.5%.

Data Quality Caveats

There appear to be inconsistencies in the way in which employees were classified within providers from year to year. While it would be expected that there will be some changes in which services/job category include employees from year to year, one would not expect a large number of such changes. The 2003 and 2004 surveys were compared to see which services/job categories included employees in one year but not in the other. There were 112 instances where providers reported having no employee in the service/job category in 2003 but reported employees in 2004, and 94 instances where employees were reported in 2003, but none were reported in 2004. While this could represent the closure or opening of a service in some instances, the large number of such situations suggests that some providers may have classified of employees as aides, service workers, or first line supervisors differently in the two years.

The reviews by DDA and CSRRC staff identified data elements that were clearly in error, and the providers were asked to resubmit these data. Hourly wage rates that were unreasonably high or low, tenures that appeared unreasonable or impossible, and other such aberrations, were identified. The corrected surveys replaced the original data in the analysis. Additional errors were identified by the auditors in their review, and resulted in re-filed surveys. This paper includes all corrections received as of December 15, 2004.

Summary

Wages rates for aides and service workers appear to be unchanged between FY 2003 and FY 2004. The wage rates of Service Workers increased by 0.3%, and for the two categories combined by 0.6%[19]. The wages for first line supervisors increased by 6.6%. Bonuses increased by about 0.5 percentage points between 2002 and 2003.

[19] The increase for the two categories combined is greater than that for either of the individual categories because there was a shift in employees from the Aide category to the Service Worker Category.

APPENDIX B-6

Consumer Safety Costs

Introduction

The Community Services Reimbursement Rate Commission (CSRRC) is required to assess the impact of consumer safety costs, and to determine whether such costs have been included in the rates paid by the Mental Hygiene Administration (MHA) and the Developmental Disabilities Administration (DDA). The purpose of this paper is to respond to this requirement by describing the discussions and conclusions reached regarding such costs. The paper starts by quoting the applicable statutory language, then continues to describe the discussions that took place. Separate discussions for DDA and MHA rates are then followed by a summary and conclusions section.

Statutory Language

"CONSUMER SAFETY COSTS" MEANS THE COSTS INCURRED BY A PROVIDER FOR CARE THAT IS PROVIDED TO COMPLY WITH ANY REGULATORY REQUIREMENTS IN THE STAFFING OR MANNER OF CARE PROVIDED, INCLUDING:

(1) 24-HOUR OVERNIGHT AWAKE SUPERVISION; AND

(2) OTHER COST FACTORS RELATED TO HEALTH AND SAFETY THAT ARE STATED IN THE CARE PLAN REQUIRED FOR AN INDIVIDUAL.

The Commission shall assess:

THE IMPACT OF CONSUMER SAFETY COSTS AND WHETHER THE RATES HAVE BEEN ADJUSTED TO PROVIDE FOR CONSUMER SAFETY COSTS.

Background

The issue of what is meant by consumer safety costs, and the extent to which they are or are not included in the rates, was discussed with the Technical Advisory Groups on several occasions, as well as with representatives of providers and DDA regional offices. This paper summarizes the results and conclusions from these discussions.

DDA Rates

The base costs of providing services are included in the standard Fee Payment System (FPS) rates, and these adjust for behavioral and medical needs by means of the rate schedule matrix, which includes 5 levels in each dimension. The matrix score is calculated when an individual is first placed with a provider, and is then normally left fixed, even if the service needs change. This provides appropriate incentives to provide care effectively, and means that a provider is not penalized by a reduced rate if they are successful in fostering more independence on the part of the individual. If an individual's service needs are greater than are paid for by the standard FPS rate then the provider can apply for an add-on rate, and if an add-on is provided for a year or more then the matrix level is re-assessed. However, the approval of add-on payments is subject to budget constraints, is not, and should not be, guaranteed. However, this mechanism does provide a safety

valve to pay for services that are necessary to ensure safety.

If a balance exists between clients with decreasing matrix levels and clients with increasing matrix levels then the providers would be kept whole, on average. As clients enter the system the payment levels appear to be set appropriately. However, it is reported that existing clients are aging in place, and so are requiring more services. Examples of the types of concerns that have been raised include:

- Increased medical needs as clients get older.
- Individuals with Down's Syndrome often experience an earlier onset of Alzheimer's disease than others, with concomitant increases in supervision requirements.
- The death or debility of relatives who have been providing support results in greater costs of care for the provider.

To some extent these effects are diluted by the death of clients and the entry into the system of new clients. However, this issue is worthy of additional study. The re-engineered PCIS system may serve as a valuable tool for further analysis, provided sufficient client specific information is collected, and it is collected in a format that allows for analysis extensive reading of narrative text fields.

The residential FPS rates for level 5/5 include payments for 58 hours of supervision per person per week, and add-on grants are provided for awake overnight when necessary and funds are available.

The conclusion from this discussion is that there are situations in which increased costs are incurred due to increasing care requirements, and that DDA is working with the provider community to take these into account.

There are situations in which the FPS does not fully cover the costs incurred to provide services to clients, but these tend to be short term situations related to particular medical or behavioral issues. If a client who is normally in a day program cannot participate in that program due to medical or behavioral issues, and, as a result, requires additional supervision, this is not automatically covered. A provider can apply for an add-on to rates to pay for the additional services required. The system of add-on rates, while it cannot cover all the requests due to budget constraints even when it is agreed by all parties that the services are required, does appear to provide flexibility to ensure that funds are available to provide essential services required to ensure consumer safety.

MHA Rates

MHA pays for many services on a fee for service basis, and so to the extent the clients' needs involve more authorized services, they will automatically be paid for. Most of the mandated training requirements, e.g., CPR, blood borne pathogens, first aid, drivers education for employees transporting clients, were in place when the fee for service system was implemented in 1997. Thus, their costs can be considered to have been included in the rates. Some grants are provided to provide services to high risk individuals. There is an enhanced supervision rate to cover the costs associated with clients who require substantially more than the usual amount of supervision, and this can be considered to be one way in which consumer safety costs have been taken into account. There may be additional costs incurred in caring for clients on conditional release from state

institutions. However, there have been reports that turnover of staff is increasing, which in turn increases training costs and raises concerns about continuity of care.

MHA is engaged in an active enforcement review of providers, and several providers have been delicensed for inadequate staffing.

Some providers incur costs to become accredited by national accrediting organizations. These could be considered to be costs associated with safety.

The rates were originally set based on assumptions of staffing requirements, staffing costs, and productivity, but were subsequently adjusted upwards based on market rates. Given that the rates are now market based it does not make much sense to ask whether specific cost elements are or are not included in the rates. It does, however, make sense to look at the overall financial situation of the providers, and to examine what specific issues are resulting in financial problems for providers. The Commission has done that, and continues to monitor the situation of providers. The conclusion that has been reached from these analyses is that the outpatient mental health clinics are in a weak financial situation, but that this is largely due to issues other than the MHA rates. Uncompensated care is an issue, including unpaid Medicare copayments, and the relatively low Medicare payment rates is causing problems for providers with a substantial Medicare client base.

When clients require enhanced supervision the rate structure allows for up to 10 hours to be paid, but does not allow for 24 hour supervision 7 days a week. In the discussions regarding consumer safety costs a related issue was mentioned, namely, employee safety costs. In some areas staff safety requires that staff work in pairs or are escorted. The rates do not allow for the additional costs incurred due to this duplication of staff.

The implementation of case rates for psychiatric rehabilitation services may increase the importance of tracking consumer safety costs. The Commission intends to monitor utilization patterns under case rates to identify changes.

Summary and Conclusions

The rate structures of MHA and DDA appear to provide sufficient flexibility to ensure that services essential for client safety can be paid for. However, due to budget constraints choices have been and/or will have to be made among various needs which compete for available funding, such as: paying for services for more clients, not reducing eligibility levels as much as might otherwise be required to meet budget limitations, and increasing funding levels (including safety costs) for services to existing clients. As a result there are clients who require additional supports, but are not receiving the funding for those supports.

The Commission will continue to monitor the systems, particularly when changes in the rate structure alter the financial incentives on the providers, or the resources available to provide services.

APPENDIX C

Status of 2004 Recommendations

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.

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. MHA provided thoughtful comments on the updating recommendation, and the Commission took these into account in the revision of the updating paper that is attached as Appendix B-3 to this report.

2. MHA should require the annual submission of audited financial reports[20] 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.

Status: This recommendation has not yet been implemented. The Commission understands that MHA is attempting to obtain regulatory authority to require the submission of audited financial reports from providers that have them, and strongly encourages the adoption of this regulation.

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.

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

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 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.

Status: MHA implemented case rates for psychiatric rehabilitation services effective February 1, 2004. The Commission is monitoring the impact of this new rate system.

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.

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. DDA provided thoughtful comments on the

updating recommendation, and the Commission took these into account in the revision of the updating paper that is attached as Appendix B-3 to this report.

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.

Status: The legislature did preserve the majority of the funds for the wage equalization initiative for FY 2005.

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.

Status: The Commission staff, in conjunction with DDA, provided a training session on the wage survey. In addition, DDA has required that the auditors provide an opinion on the wage and fringe benefit survey data. This opinion is to be filed with the provider's Cost Report. The Commission is receiving a large number of corrected surveys are a result of this requirement.