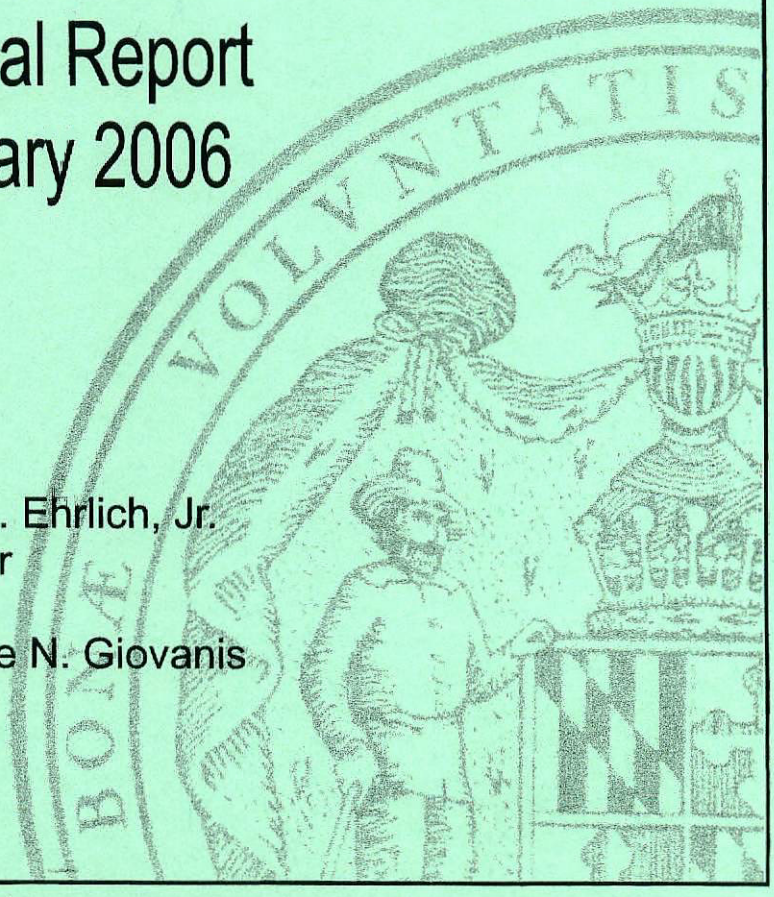
Community Services Reimbursement Rate Commission

Annual Report
January 2006



Robert L. Ehrlich, Jr.
Governor

Theodore N. Giovanis
Chair

Community Services Reimbursement Rate Commission

ANNUAL REPORT

January 2006

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COMMUNITY SERVICES REIMBURSEMENT RATE COMMISSION

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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:

    - The relationship of changes in wages paid by providers to changes in rates paid by the Department;
    - 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 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;
    - How incentives to provide quality of care can be built into a rate setting methodology; and
    - 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 reports due on or before October 1, 2002 and October 1, 2005 the Commission was required to 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 nine years. Each year the Commission publishes an Annual Report on its activities, findings, and recommendations. This is the ninth 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) and House Bill 896 (2005). 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;
- The measurement of quality and outcomes, and how incentives to improve quality can be built into the payment system; and,
- Transportation costs and other changes influencing provider costs.

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: 2.4% for DDA rates and 3.8% for MHA rates.

- The mean margin of the providers paid by DDA was 1.6% in fiscal year 2004.

- 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.

- 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 still be premature to base payments on specific measurements of quality

and outcomes, although some progress is being made on the collection of outcome measure data.

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 to date 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. The first two recommendations pertaining to MHA and the first recommendation pertaining to DDA have been included in previous reports, but are included again because the Commission considers them to be important, and they have not yet been implemented.

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 3.8%.

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, in regulation or legislation, 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 uses, this sanction, and that in order to avoid it a provider just has to provide the required data. Giving MHA the authority 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, has displayed a willingness to use it, and as a result receives data from all providers.

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

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 it is 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. This study should be completed prior to the setting of rates for fiscal year 2007.

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.

CSRRC 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 2.4%. In the absence of the wage equalization initiative the recommended update factor might be higher.

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 is 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 but dropped to 1.6% in FY 2004. 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 separate rates for transportation costs should be implemented. This study should be completed before the fiscal year 2008 rates are developed.

Currently, an allowance for transportation costs is built into the DDA 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 hoped that the transportation data submitted in the FY 2005 Cost Reports will be improved in quality, as this will be the third year that the providers have had to supply these data. An indepth analysis of transportation costs will be made once the FY 2005 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 and Supported Employment programs, but not required for Residential and CSLA 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. In the current fiscal year there are no funds specifically targeted for the reduction of the waiting list. DDA reports that, as of July 1, 2005, there were 15,031 individuals waiting for one or more basic services and that the number of service requests was 26,299.

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 responded 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. These actions, combined with funding increases, have enabled MHA to eliminate its prior year deficits that had been rolling over from year to year. 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.

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. 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 but dropped again in 2004. 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 as well as the impact on provider costs of enforcement of the requirement that services be provided only by licensed practitioners.

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.

The Commission, at the request of MHA, studied the case rates being paid for child psychiatric rehabilitation services and for intensive residential rehabilitation services. Specific concerns were raised, and some changes were recommended. MHA has responded to these concerns by substantially increasing both sets of case rates, and setting up a program to monitor difficulties in placement of individuals in need of the most intensive care.

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 3, 2005
April 4, 2005
June 6, 2005
September 12, 2005
December 5, 2005
January 9, 2006
April 3, 2006
June 5, 2006
September 11, 2006
December 4, 2006

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

February 7, 2005
March 7, 2005
May 2, 2005
August 1, 2005
October 3, 2005
November 7, 2005
February 6, 2006
March 6, 2006
May 1, 2006
August 7, 2006
October 16, 2006
November 6, 2006

Future Activities

- The Commission will continue to schedule meetings in advance to fulfill 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 as necessary 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, transportation costs, 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 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 other support services. These services include family and individual supports and community supported living arrangements that enable an individual to stay in his or her own home, day programs, supported employment, resource coordination/case management, behavioral support services, transportation, residential alternative living units, and residential group homes. If medical day care is required, this is paid for directly by Medical Assistance. Approximately $519.4 million of the Developmental Disabilities Administration's (DDA) FY 2005 budget is for community programs and $70.1 million is for institutional services. Approximately $198.4 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 2005 are shown in Charts 2 to 4.

The principal current DDA payment system is the Fee Payment System (FPS). $408.5 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. Providers complete an assessment tool, called the Individual Indicator Rating Scale (IIRS), on each consumer they serve. The results of the IRRS are translated into a matrix score. Reimbursement is based on the matrix score of each consumer served. The FPS includes regional rate adjustments that increase the individual component 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 and scooters. In addition, add-on rates provide for clients with particular needs not covered in the base rates. These needs were formerly paid though augmentation contracts.

The balance of payments for community programs are made through contracts and the community supported living arrangements (CSLA) payment system (approximately $45.0 million). The CSLA system was commenced in fiscal year 2001. 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, but stabilized in 2005.

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 through 2005 with similar conclusions.

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 4 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.

Plans are being implemented to shift from a survey of wages paid in a pay period in February to a survey of wages and hours for the entire fiscal year. The first such survey of annual data will be for FY 2005, and was due December 1, 2005. The pay period survey will continue to be performed in February 2006, but it is expected that it will then be discontinued.

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 were included as Appendix B-3 of the January 2005 report. The current recommended update factors are included in Appendix B-3 of this report.

The Commission is recommending that an update factor of 2.4% 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; and

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[2]. 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 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 of the January 2005 report casts light on both these issues. It appears that for day programs the administrative costs increase as the direct care

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

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.

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 2004.

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 119 providers for FY 2004. 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 2005 Cost Reports are available.

The major conclusions of the analysis are that Day programs, in general, are losing money, Supported Employment and Residential programs, in general, are losing a little, but close to breaking even, and CSLA programs, in general, are making profits. These conclusions do not, of course, mean that every provider 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 FY 2002, FY 2003, and FY 2004.

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 34% for direct care workers in 2005, down from 38% in 2004.

Wage rates of direct care workers increased about 5% between FY 2002 and FY 2003, similar to the increase the providers received in their rates, but the increase in 2004 was smaller, about 0.6%. However, between 2004 and 2005 the direct care worker wages increased by 6.3%. 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 3 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 was attached as Appendix B-6 to the January 2005 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. The Commission intends to continue to monitor this issue.

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 0.8% 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.

DDA received a waiver to commence its New Direction project effective July 1, 2005. This waiver is under the Independence Plus 1915(c) Home and Community Based Waivers for Individuals with Developmental Disabilities program. The project will provide support to individuals living in their own home, or their family home, to direct some of their own services, using support brokerage and a financial management service. Services that can be self-directed under this program are: Respite, Supported Employment, Personal Support Transportation, Environmental Accessibility Adaptations, Family and Individual Support services, Assistive Technology, and Adaptive Equipment. The Arc of Anne Arundel County and MedSource have been selected to act as the two Fiscal Management Services providers.

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 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 2.4%. In the absence of the wage equalization initiative the recommended update factor might be higher.

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 but dropped to 1.6% in FY 2004. 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 separate rates for transportation costs should be implemented. This study should be completed before the fiscal year 2008 rates are developed.

Currently an allowance for transportation costs is built into the DDA 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 hoped that the transportation data submitted in the FY 2005 Cost Reports will be improved in quality, as this will be the third year that the providers have had to supply these data. An indepth analysis of transportation costs will be made once the FY 2005 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 and Supported Employment programs, but not required for Residential and CSLA 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.

MENTAL HYGIENE ADMINISTRATION
Current Reimbursement System

Description of the Current Payment System

Community services for individuals with severe and persistent mental illness are provided by community agencies, which are mostly nonprofit corporations. Over 92,000 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 grew 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 2005. The expenditures and number of services provided by State hospitals had been growing steadily through FY 2003, but both dropped in FY 2004 and continued to decline slightly to FY 2005. A large state hospital closed in 2004, but the total number of beds in the system remained the same.

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 $10,000,000 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 decreased by 14.5% between 2003 and 2004 and dropped by 22.4% between FY 2004 and FY 2005. This was largely due to the change in the rate system to case rates and an associated reduction in rates of about 10%, but was also contributed to by more intensive utilization review. Outpatient expenditures grew by 32% between FY 2002 and FY 2004, but were basically unchanged in FY 2005.

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 system HIPAA compliant. These modifications were mainly to the codes, but there were also some small changes in rates. The Commission has monitored 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 October 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. The Commission monitored the impact of the change in the ASO in 2004, but the problems involved in that switch were much more limited, and were quickly resolved.

MHA Budget Shortfalls

MHA 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 was 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. These budget problems appear to have been resolved, with the implementation of case rates and reductions in eligibility.

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. The MHA expenditures for psychiatric rehabilitation services dropped by about $50 million, or 29%, between FY 2004 and FY 2005.

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 2005, and summaries of the results have been included in prior Annual Reports. A summary of the results of the fiscal year 2005 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 about 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 Commission requires more comprehensive data from OMHCs in order to fully evaluate their financial situation.

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 then current inflation information are attached as Appendix B-3 in the January 2005 report. The current recommendation on an update factor is included as Appendix B-3 of this report.

The Commission is recommending that an update factor of 3.8% 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 that 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 prevailed for 2004.

CBH carried out wage surveys in the falls of 1999, 2000, 2001, 2002, 2003 and 2004. 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. In 2004 revenues and expenses both dropped.

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.

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%. However, the situation improved in FY 2003, with the mean margin increasing to 2.9%, and there was a drop to 2.5% in FY 2004.

This small reduction in the margin conceals, however, major changes in revenue and expenses. For providers from whom reports were available in both years, revenues dropped by 5% and expenses dropped slightly less. More detailed discussion of the financial condition of the providers is included in Appendix B-8 to this report. There were major cutbacks in the payments for psychiatric rehabilitation services in FY 2005, with the total payments dropping by 29% from FY 2004 to FY 2005. As a result, the Commission is particularly interested in evaluating the financial condition of the providers in FY 2005.

The survey of OMHCs discussed in the previous section showed that the providers responding were generally in very poor financial condition. A survey performed by Community Behavioral Health (CBH) showed that the financial condition of the OMHCs continued 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 2002 Annual Report.

The MHA experienced budget shortfalls in recent years but now appears to have overcome these problems. 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 studied two particular sets of case rates, that for intensive residential rehabilitation programs and the one used to pay for most psychiatric rehabilitation services for children. Reports on these studies are attached as Appendices B-6 and B-7 to this report.

The Commission found a problem with the manner in which the rate for the child psychiatric rehabilitation programs had been set. MHA has since substantially increased that rate. The intensive RRP rate was being supplemented for clients with particularly high service needs, but the approach used to determine the supplements did not appear to be fair to all providers. The Commission recommended retaining some of the funds used to make supplemental payments to facilitate placement of clients with particularly high resource needs, but to use the majority of the funds to increase the intensive RRP rate. This had the advantage that the funds used to increase the rates became eligible for a federal match, increasing the amount of money available to raise the rates.

Data

The Commission is instructed in its 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 now that 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. In addition, because the classifications in the payment system do not differentiate clients much based on the level of care required they provide an incentive to avoid enrolling clients with particularly high care requirements within the categories. This is of particular concern for intensive RRP services, as they are expensive. MHA is collecting data and planning a study to ensure that the most clients with the most intensive needs do not have difficulty in finding placements.

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 was prepared and was attached as Appendix B-6 to the January 2005 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 2004 they comprised 2.9% 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 currently taking place in Baltimore City, a program that uses case rates for an intensely ill population, 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. As part of that monitoring, and at the request of MHA, the child psychiatric rehabilitation rates and the intensive residential rehabilitation rates were studied, and these studies resulted in the reports attached as Appendices B-6 and B-7 to this report.

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 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 3.8%.

2. MHA should require the annual submission of audited financial reports[3] 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, in regulation or legislation, 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 uses, this sanction, and that in order to avoid it a provider just has to provide the required data. Giving MHA the authority 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, has displayed a willingness to use it, and as a result receives data from all providers.

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

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

disadvantage the providers caring for the most seriously and chronically ill clients. This study should be completed prior to the setting of rates for fiscal year 2007.

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.

1. 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

RRP: Residential Rehabilitation Program

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. This sometimes also referred to as a Section 1915 waiver.

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

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 14 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 17 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 Upper Shore Community Mental Health Center Citizens Advisory Board.

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 FY 2004 DDA Cost Reports

B-2 Psychiatric Rehabilitation Program Salary Survey

B-3 Updates for DDA and MHA Rates

B-4 The Financial Situation of Providers of Community Services Contracting with DDA, Fiscal Years 1997 through 2004

B-5 Wage Rate Survey of DDA Providers - 2005

B-6 Review of the Intensive Residential Rehabilitation Program (RRP) Case Rates

B-7 Children's Psychiatric Rehabilitation Program Case Rates

B-8 The Financial Situation of Providers of Community Services Contracting with MHA, Fiscal years 1999 through 2004

APPENDIX B-1

Analysis of DDA Cost Reports

Analyses of FY 2004 DDA Cost Reports

Executive Summary

Providers appear to be incurring losses on day, residential and employment programs. For day and employment services the losses may be due to increased transportation costs. Residential services operated at a slim positive margin in 2003 and a slim negative margin in 2004. However, almost half the providers (48%) operated at a deficit on residential services in 2003 and over half (53%) in 2004. CSLA services were generally profitable.

The mean per diem payment for Residential Services was $153.18, for CSLA was $90.41 for Employment Services was $57.47 and for Day Services was $55.52.

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 119 Cost Reports for fiscal year 2004 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.

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. In response to the directive to study transportation costs the transportation costs and mileages will be studied.

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 mean per diem payment for Residential Services was $153.18, for CSLA was $90.41 for Employment Services was $57.47 and for Day Services was $55.52.

Table 1: Summary statistics, fiscal year 2004

	CSLA	Residential	Day	Employment
# of providers	69	92	57	64
Median Margin	8.6%[1]	-1.4%[1]	-1.9%[1]	-4.3%[4]

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 fiscal years 2002 and 2003. 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.

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 was delayed pending availability of the FY 2004 Cost Reports. The quality of the transportation data does appear to be somewhat improved in the FY 2004 Cost Reports, although there are still some obvious problems.

Given that the transportation data is clearly being reported inconsistently, that the survey forms and instructions have been revised for the FY 2005 survey and that the FY 2005 survey is due in December further analysis will be deferred pending the availability of that survey with, hopefully, more reliable data. Given the complexity of this issue, and the various ways in which transportation is provided, it may be necessary to perform a smaller focused survey of a sample of providers.

Conclusions

Providers appear to be incurring losses on day, residential and employment programs. For day

[4] 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.

and employment services the losses may be due to increased transportation costs. Residential services operated at a slim positive margin in 2003 and a slim negative margin in 2004. However, almost half the providers (48%) operated at a deficit on residential services in 2003 and over half (53%) in 2004. 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.

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 2005 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 once sufficient data become available for 2 successive years. CBH surveyed the OMHCs in 2005 and MHA has adopted regulations to collect wage survey data from the OMHCs.

Data source

CBH recently published the results of a salary survey of psychiatric rehabilitation programs (PRP) and outpatient mental health clinics in fiscal year 2005. The PRP survey followed basically the same format as surveys that were used in fiscal years 2000 through 2004 and collected data on the starting and 3 year salaries and fringe benefits for several 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 2004/2005 and reflects fiscal year 2005 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 Salary Survey Summary for Psychiatric Rehabilitation Programs and Outpatient Mental Health Clinics", prepared by CBH staff, and dated April 2005, 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 30.4%[1]). The fringe benefits paid by the providers averaged 21.5%, with a median value of 22.0%. The state gave a wage increase of 4% on January 1, 2002, i.e., in the middle of the fiscal year, and an increase of $752 on July 1, 2004. This is equivalent to an increase of about 3%. No increments were allowed in the state system for fiscal years 2003 and 2004, which has the effect of slightly reducing mean wage rates.

	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	$27,279	$22,000	$30,663	$25,138
Rehabilitation counselor - Mean	$27,163	$22,353	$30,472	$25,064
State MHA II	$31,914	$24,474	$35,552	$27,264
State MHA III	$33,954	$26,038	$37,846	$29,023
Percentage by which the MHA II rate exceeds the provider median/mean[2]	17%/17%	11%/9%	16%/17%	8%/9%
Percentage by which the MHA III rate exceeds the provider median/mean	24%/25%	18%/16%	23%/24%	15%/16%

[1] This was the figure used by DHMH in a report to the General Assembly. The figure used in previous reports as the State fringe benefit percentage was 32.9%.

[2] 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 2005 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%[3]	$30,209	-4.7%[3]
FY 2005	$27,163	0.8%	$30,472	0.9%
Change 2001 to 2005	$364	1.4%	-$393	-1.3%

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 2005 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

[3] 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. 82% of the agencies responding to the CBH survey in April 2005 reported staff layoffs or unfilled vacancies in the past year and 68% reported fringe benefit cuts. Different sets of providers responded to the surveys in different years.

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. [4]
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%
FY 2005	$24,474	3.1%	$26,038	3.0%	$22,353	1.8%	$25,064	1.8%	3.6%
change 1998-2005	$5,326	28%	$5,539	27%	$3,423	18%	$3,774	18%	20.1%
Change 2001-2005	$1,665	7.3%	$1,725	7.1%	$355	1.6%	-$208	-0.8%	11.3%

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 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.

[4] The CPI increase is from January to January. Data from the Bureau of Labor Statistics.

The increase in the wages of rehabilitation counselors from FY 2000 to FY 2001 was greater than the rate increase that was received by the providers between these two years, but between FY 2001 and FY 2002 the wage rates of the providers were basically unchanged, as were the rates. The apparent decreases in wages between FY 2001 and FY 2002 are not significant, and are probably due to a difference in the providers that responded to the surveys in the two years, but may also be reflective of a declining financial position within community mental health programs and the poorer situation of the general economy. The wages increased from 2002 to 2003, in spite of the lack of any increase in the rates, but appear to have declined from 2003 to 2004 and then increased slightly to FY 2005. The rehabilitation counselor wages rates in 2005 are very similar to those in 2001, whereas the state wages increased by over 7% over that same time period. This may be reflective of a generally tighter financial situation.

Conclusion

The psychiatric rehabilitation providers have increased starting wages for rehabilitation specialist/counselors by 18% from FY 1998 to FY 2005. This is 2 percentage points below inflation in the general economy, and less than the increases in state starting wages. The Consumer Price Index for the Washington-Baltimore area rose by 18% from January 1998 to January 2005. 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%, but in practice resulted in a much larger decrease. 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) reductions in staffing; 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. There was a decrease in the fringe benefits provided.

The wage rates of the rehabilitation specialist/counselor positions continue to be substantially lower than those of corresponding state positions. Over the 1998 to 2005 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. The difference is particularly noticeable for the period 2001 through 2005, in which the state wage rates increased over 7%, while the rehabilitation counselor wage rates were relatively constant.

APPENDIX B-3

Updates for DDA and MHA Rates

Updates for DDA and MHA Rates

At the September 2004 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:

$$0.8 \times 3.8\% + 0.2 \times 3.8\% = 3.8\%$$

Recommended update factor for DDA rates:

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

$$0.6 \times 1.5\% + 0.4 \times 3.8\% = 2.4\%$$

The update factor for DDA rates is calculated using the increase in state direct care worker wages in order to be consistent with the philosophy underlying the wage equalization initiative. Under the previous methodology used by the Commission to calculate update factors the wage component of this update factor used the same Employment Cost Index as the MHA update factor.

APPENDIX B-4

The Financial Situation of Providers of Community Services Contracting with DDA, Fiscal Years 1997 through 2004

The Financial Situation of Providers of Community Services Contracting with DDA, Fiscal Years 1999 through 2004

Executive Summary

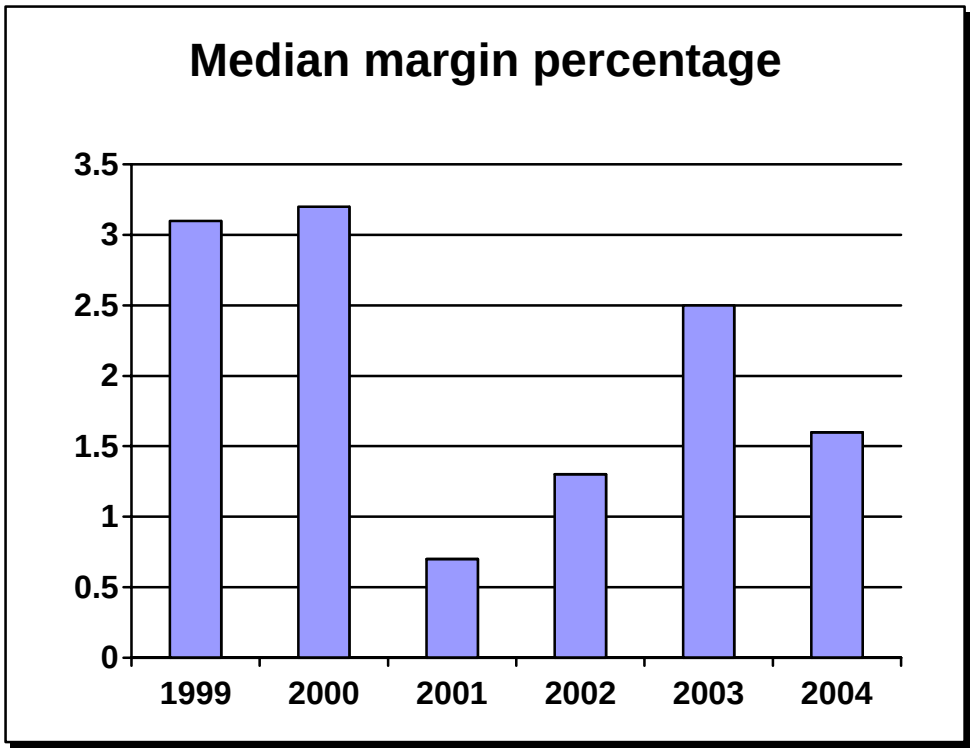
The ratios examined are in a reasonable range for fiscal years 1999 through 2004. These ratios indicate that fiscal years 1999 and 2000 were similar, but with a deterioration in FY 2001. The margins recovered slightly in 2002 and further in 2003, but declined in 2004. The indicators in Table 1 show a generally weakening trend in the financial condition of the providers from 2003 to 2004.

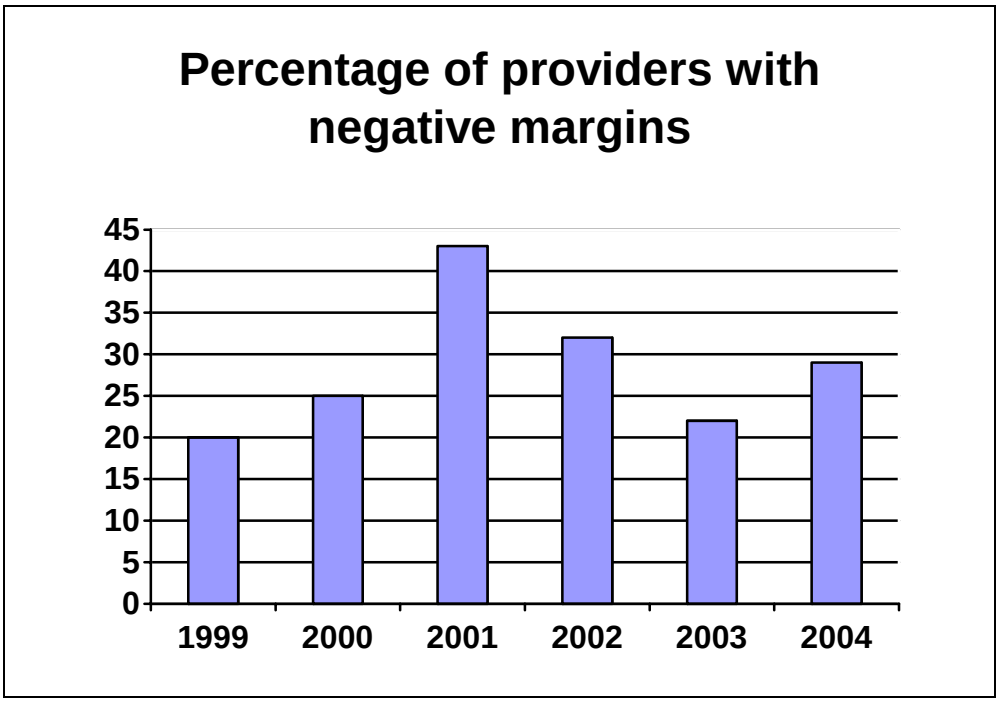
Table 1	1999	2000	2001	2002	2003	2004
% with negative margins	20%	25%	43%	32%	22%	29%
Median margin	3.1%	3.2%	0.7%	1.3%	2.5%	1.6%
Median current ratio	1.9	1.4	1.8	1.7	1.8	1.7
Number with negative net assets	3	2	7	3	3	6
% with current ratio < 1	23%	26%	31%	28%	20%	24%

A more detailed discussion of the results can be found in Section 4 of this paper.

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.


Median margin percentage
3.5
3
2.5
2
1.5
1
0.5
0
1999
2000
2001
2002
2003
2004


Percentage of providers with negative margins
45
40
35
30
25
20
15
10
5
0
1999
2000
2001
2002
2003
2004

1. 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 1999 through 2004.

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.

The paper starts with a summary of the most important results, then continues with a description of the data sources, and a more detailed presentation of the results of the analysis.

Two ratios that were included in previous reports have been dropped from this report. These ratios are: return on assets and asset turnover. They have been found to be somewhat erratic, and due to the different ways in which providers obtain facilities, with some providers owning their facilities and others renting most of their sites, they were not good indicators of financial performance.

2. Data sources

The data used for this analysis were extracted from the fiscal year 1999 through 2004 Audited Financial Reports.

Table 2: Number of reports included in the analysis

Year	1999	2000	2001	2002	2003	2004
No. of reports	84	89	94	103	104	106

Providers are required by regulation to provide their Audited Financial Reports. Financial reports from 106 providers were available for FY 2004 out of a total possible of about 120. Of the 106 providers used for the 2004 analysis, 44 were from the Central Region, 17 from the Eastern Region, 27 from the Southern Region, and 18 from the Western Region.

The following data fields were extracted from the fiscal year 2004 Financial Reports (definitions of the terms are 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

3. 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 five 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
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.

4. Results

4.1 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 3.2% in FY 1999, 3.5% in FY 2000, 0.4% in FY 2001, 1.8% in FY 2002, 2.5% in FY 2003,and 1.6% in FY 2004. The spread of the margin is shown in Table 3. The margins in 1999, 2000 and 2001, and the other ratios examined, could have been affected by the phase-in of the FPS, which was completed in FY 2001.

Table 3: Profit Margins	FY 1999	FY 2000[5]	FY 2001[1,6]	FY 2002[1]	FY 2003[1]	FY 2004[1]
75th percentile[7]	8.3%	8.1%	3.9%	5.6%	6.7%	4.6%
50th percentile (Median)	3.1%	3.2%	0.7%	1.3%	2.5%	1.6%
25th percentile	0.0%	0.0%	-2.8%	-1.5%	0.1%	-0.3%
Mean	3.2%	3.5%	0.4%	1.8%	2.5%	1.6%

Of the providers of community services reporting to DDA for FY 2004 31 of the 106 had negative margins in FY 2004 (i.e., 29%). For each of the years the margins were not statistically significantly correlated with the size of the provider, although the small providers generally had the greatest range in their margins.

4.2 Profit margins by region of the state

Table 3A shows the mean profit margins (DDA revenue weighted for 2000, 2001, 2002, 2003

[5] Mean margin weighted by DDA payments.

[6] 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 FY 2001 several providers experienced negative adjustments to their rates as a result of this phase-in, but none received positive adjustments.

[7] The 75th percentile is that level at which 75% of the providers have values below this level, and 25% has values above this level. This, together with the 25th percentile, provide a measure of the spread in the values being reported.

and 2004) for the providers located in the 4 DDA regions of the state for FYs 1999 through 2004* and Table 3B shows the median profit margins[8] for 1999 through 2004.

Table 3A: Mean profit margin by region	1999	2000[9]	2001[4]	2002[4]	2003[4]	2004[4]
Central (Baltimore & area)	3.0%	2.0%	0.3%	1.6%	1.3%	0.2%
East (Eastern Shore)	8.2%	5.5%	-0.5%	2.5%	6.2%	4.5%
South (Washington suburbs & Southern tri-county area)	2.3%	5.2%	1.2%	2.9%	4.0%	2.9%
West (Western Maryland)	3.2%	3.5%	-1.3%	-0.2%	1.1%	1.0%
State	3.2%	3.5%	0.4%	1.8%	2.5%	1.6%

*In FY 2004 contributions made up 2.7% 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 3B: Median profit margin by region	1999	2000	2001	2002	2003	2004
Central (Baltimore & area)	2.9%	1.4%	0.2%	1.3%	2.5%	1.1%
East (Eastern Shore)	6.7%	3.6%	0.0%	1.6%	6.7%	3.5%
South (Washington suburbs & Southern tri-county area)	2.5%	6.2%	2.7%	1.2%	1.1%	3.1%
West (Western Maryland)	2.6%	2.2%	-0.3%	-0.8%	2.2%	0.8%
State	3.1%	3.2%	0.7%	1.3%	2.5%	1.6%

Table 3C: Profit margin percentiles by region, FY 2004	25th percentile	50th percentile (Median)	75% percentile
Central (Baltimore & area)	-0.5%	1.1%	3.4%
East (Eastern Shore)	-1.2%	3.5%	5.0%
South (Washington suburbs & Southern tri-county area)	0.2%	3.1%	6.9%
West (Western Maryland)	-2.2%	0.8%	4.9%
State	-0.2%	1.6%	4.6%

[8] 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.

[9] Weighted by DDA payments.

4.3 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 4.

Table 4: Current ratio	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004
75th percentile	3.4	3.1	3.5	3.3	3.1	3.3
50th percentile (Median)	1.9	1.4	1.8	1.7	1.8	1.7
25th percentile	1.0	1.0	0.9	0.9	1.1	1.0

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 2004.

FY 2004 median current ratio by region:

Table 4A: Current ratio	Central	East	South	West
Median	1.5	2.6	1.4	1.9

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

4.4 Days in cash and investments

Cash and investments represented 19% of the total expenses, up from 14% the previous year. The cash and investments, thus, represent 69 days of expenses in FY 2004. 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 and investments 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. The higher the number of days of cash and investments the better.

4.5 Days in receivables

Receivables represented 11% of the total revenues (down from 12% the previous year), so providers had, on average, 40 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 and 45 days is a reasonable level. The lower the number of days in receivables the better.

4.6 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 0.8% of the total revenues, up from 0.4% the previous year. The low level of bad debt is understandable given the nature of the services provided: the services are long term.

4.7 Net assets

Net assets are an important indicator of financial condition. The net assets are the total assets minus the total liabilities. Having negative net assets means that the provider has more liabilities than it has assets, and so is a major concern.

Of the community service providers reporting to DDA, 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, 3 had negative assets in FY 2002 and FY 2003, and 6 had negative net assets in 2004. 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 with negative net assets in 2003 continued to have negative net assets in 2004, 2 with positive net assets in 2003 lost sufficient to turn their net assets negative in 2004, and the other provider did not report in 2003. 5 of the 6 providers with negative net assets in 2004 were in the central region, and one was in the southern region. They varied in size.

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 - 2005

Wage Rate Survey of DDA Providers - 2005

Executive Summary

The results reported in this paper are from a survey of providers contracting with DDA . The data on wages were for a pay period in February 2005. All the providers surveyed responded to the survey, and the data reported has been checked by DDA and CSRRC staff, and attested to by independent auditors.

The wage rates of Direct Care Workers increased by 6.3% from FY 2004 to FY 2005. The wage rates of first line supervisors increased by 7.8%.

Data on the increase in bonuses in FY 2005, as well as fringe benefits, will be available early in calendar year 2006. Bonuses increased by about 1.1 percentage points between 2003 and 2004. Through FY 2004 fringe benefits remained relatively constant at 20% of wages.

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 each year, in cooperation with DDA, carries out a survey of these providers. The survey instrument asked for information on wages paid during a pay period in February 2005. Surveys were sent to 118 providers and all these providers responded to the survey. Four of the responses were not usable for purposes of this analysis, so 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 instruments previously used to collect data from these providers. The design of the 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. For FY 2005 the survey form was simplified by combining Aides and Service workers into a Direct care worker category. The survey was mailed to 118 providers. Three 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. 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 were required by DDA to have their auditor certify the data provided in the survey form. These certifications are due to DDA December 1 following the date of the survey.

Data on bonuses and fringe benefits are naturally reported on an annual basis, not for a pay period, so are gathered in December. As a result the data for FY 2005 on bonuses and fringe benefits are not yet available, and the data provided for these elements are for FY 2004.

Results of the survey

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

Wage category	Direct Care Worker	1st line supervisor
FY 2001	$8.96	$14.82
FY 2002	$9.31	$15.17
FY 2003	$9.69	$15.73
FY 2004	$9.75	$16.50
FY 2005	$10.36	$17.78
% change from 2001-2005	15.6%	20.0%
% change from 2004-2005	6.3%	7.8%

Corrections were received to prior year surveys, so the figures listed in the table above may differ from those reported in previous reports on the wage survey.

The wages of drivers increased from $9.77 in 2004 to $10.26 in 2005, an increase of 5%.

Staff turnover rates and tenure

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

	2004	2005
Direct care workers	38%	34%
First line supervisors	19%	18%

These turnover rates are substantially lower than those experienced by the providers when this survey was started in the 1990s. At that time the turnover rate in Maryland was around 50%. The literature documents turnover rates nationally from a low of 40% to over 75%.

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

The average tenures of staff and the percentages of the direct care employees in each category were:

Job category	Average tenure 2004	Average tenure 2005	% of employees in the category in 2005
Direct care worker	42 months	44 months	88%
1st line supervisor	61 months	68 months	12%

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 fiscal year 2005 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 FY 2005. 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

Fiscal Year	**# providers**	**Mean FB %**	**Median FB %**
2001	96	20.7%	20.0%
2002	97	19.7%	19.6%
2003	111	20.4%	20.0%
2004	114	20.4%	19.3%

There was no substantial change in fringe benefit percentages in the period 2000 to 2004. However, 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 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 two items comprising the largest proportions of fringe benefits (almost 40% of the total fringe benefits each) were the employer proportion of FICA and health insurance. Retirement costs and retirement plan administration made up 10% of the total fringe benefit costs. Employees are contributing an additional 23% of the total employer fringe benefit costs as the employee portion of these costs.

Bonuses

In 2004 the amount reported as being paid in bonuses was $2.2 million. It has been suggested, and appears plausible, that providers may be moving to paying more in bonuses, and less in wage increases, partly due to concerns about uncertainty in the revenue and a desire to provide incentives for training and retention.

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 rates were increased effective July 1, 2004 under the wage equalization initiative sufficient to increase direct support worker wage expenditures by 3.7%, and with an equal allowance to increase fringe benefits. The increase in direct care worker wages, at 6.3%, is greater than the 3.7%. The fringe benefit increase in fiscal year 2005 will not be available until after December 2005. However, the percentage that fringe benefits comprise of total wages has been relatively constant through 2004. While the dollar expenditures on fringe benefits have increased as the wage rates have increased, the wage equalization program intended that the fringe benefits would increase as a percentage of total wages, and this does not appear to have occurred. Fringe benefits have remained relatively constant at about 20% of wages and salaries. DDA reported that the dollar amount of fringe benefits paid to workers in residential, CSLA, day and supported employment services, as reported in the FY 2003 and FY 2004 Cost Reports, increased by $7,746,750 from 2003 to 2004.

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. From 2004 to 2005 the increases in direct care wages were greater than the rate increase. The wage equalization initiative provides funds to allow providers to increase the wage rates of direct care workers, with the intent of bringing these wages to the level of corresponding state direct care

workers. Direct care worker wages comprise about 60% of the total costs of providers, so increased funding sufficient to increase direct care workers wages by 5% results in an overall rate increase of about 3%. In making the comparison between rate increases and wage increases the Commission usually compares the wage increases with the overall rate increase. This is done because the providers are experiencing increases in their other costs, as well as the wages paid to direct care workers.

Data quality caveats

In prior years there appeared to be inconsistencies in the way in which employees were classified within providers from year to year. Two actions were taken to reduce or eliminate these, and other, problems: 1) starting in FY 2004 the providers were required to have their surveys attested to by an independent CPA; and, 2) the wage surveys through 2004 split the workers into three categories, aides, service workers, and first line supervisors. For the FY 2005 survey the aide and service workers categories were combined into a single category designated Direct Care Workers.

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.

Summary

The wage rates of Direct Care Workers increased by 6.3% from FY 2004 to FY 2005. The wage rates of first line supervisors increased by 7.8%.

Bonuses increased by about 1.1 percentage points between 2003 and 2004.

There was no substantial change in fringe benefit percentages in the period 2000 to 2004. However, 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.

APPENDIX B-6

Review of the Intensive Residential Rehabilitation Program (RRP) Case Rate

Review of the Intensive Residential Rehabilitation Program (RRP) Case Rate

Background

This study was performed because of concerns raised by the providers regarding the case rate for intensive RRP services, and the payments being made for enhanced client support for clients receiving these services. The Commission, in its January 2005 Annual Report, had raised questions regarding the adequacy of the rate for clients in need of constant supervision, and the providers have raised similar concerns. Currently the Mental Hygiene Administration (MHA) pays about $3.8 million per year for enhanced client support to a number of providers. These funds were intended to facilitate the placement of clients with heavy care requirements in the community and are allocated on a case by case basis. There is a concern that some providers with equally care-intensive clients are not similarly funded, and that the providers currently receiving this funding cannot rely on the level of funding into the future. In addition, the funds are currently state only, and so are not subject to federal matching. If they were expended as Medicaid funds there would be federal matching available. However, Medicaid is an entitlement program, so shifting the payment to Medicaid results in a reduction in the ability of MHA to control the level of the expenditures.

Conclusions and caveats

The clients have widely differing care requirements, and the single rate for intensive RRP does not account for these differing requirements, and could result in underpayment of providers who service a set of consumers with above average care requirements and conversely overpayments for providers with consumers with below average care requirements. MHA should consider refining the payment system to include multiple levels of case rates. However, it is understood that defining different levels would be difficult, and if this is done the authorization process should ensure that only clients who require a much heavier intensity of services are approved for the higher rates, otherwise the expenditures could increase substantially above the budgeted amount. Given this it is not recommended that the rate category be split into subcategories in the short term.

The encounter level data for the period post implementation of case rates should be studied on an ongoing basis to better understand the changes in utilization patterns, if any, that have occurred, and their impact on outcomes and quality. The Commission will continue to monitor this.

While the encounter level data for the period subsequent to implementation of the case rates does not appear to be complete, it is suggestive that the providers are continuing to provide a high level of care to the clients in intensive RRP.

Provider suggestion and comments on that suggestion

Community Behavioral Health, Inc. (CBH) has suggested that the funds be used to increase the intensive RRP rate for all providers. The funds would then become Medicaid expenditures, and so be eligible for federal matching, which would increase the amount of money available for the rate increase.

One concern with shifting the funds to increase Medicaid payments is that Medicaid is an entitlement program, and so the expenditure levels are more difficult to control. However, this is mitigated in this instance because there is a moratorium on increasing the number of intensive RRP beds, and the existing beds are fairly fully occupied, so there is little scope to increase the number of services provided in this category.

A second concern is that MHA uses some of the funds, approximately $300,000, to pay for short term placements, and the need for these placements will continue. It is suggested that MHA reserve some portion of the funds for continued use for short term placements, and other special requirements such as enhanced payments to assist with the placement of individuals coming out of state facilities. MHA should specify how much will be required for these purposes.

The third concern is that providers may have different mixes of intensity of client needs. Some providers are currently receiving funds for enhanced client support to enable them to serve clients with particularly heavy care requirements, and the level of funding for these providers would probably decrease. The level of funding to other providers, some of which may not be serving the heaviest care clients, would increase, whether the increase was needed or not.

Another option

Another option would be to define a higher level within intensive RRP to include clients who require a particularly high level of supervision, and to use the funds to pay a higher rate for the eligible clients.

Advantages:

This option would have the advantages of providing an incentive to providers to enroll the heavy care clients, and would spread the funds more equitably than at present. It would not pay additional funds to providers who were not caring for the heaviest care clients.

Disadvantages:

It would be difficult to define objective criteria to qualify for the higher rate. This approach would require a modification to the State Plan, which would delay implementation. As a result, this option is not likely to be feasible in the short term.

Suggested approach

MHA should reserve some portion of the funds for placement of new clients in need of enhanced client support. These funds would be used for enhanced client support on behalf of specific identified clients. The remaining funds, expected to be $2.5 million or more, would be used to increase the intensive RRP rate. At the same time, a monitoring system should be established for tracking discharges from intensive RRP beds, and for tracking difficulties in placement of clients in need of intensive RRP. At the end of a year the data from these monitoring systems should be studied to make a determination whether this increased payment should be continued. This determination would include evaluating whether clients in need of the highest level of care had been differentially discharged or had particular difficulty in finding placements, or total or with particular providers. If such problems are observed then work should commence on defining criteria for a high level intensive RRP rate and a regular intensive RRP rates. The high level rate would be funded using all or part of the funds under discussion.

This approach has the advantages that it allows for the rate to be increased quite quickly, without requiring a change to the State Medicaid Plan, will increase the rate to close to the level being paid prior to the implementation of the case rate, and will allow MHA to monitor for potential placement problems, and modify the approach, if necessary.

APPENDIX B-7

Children's Psychiatric Rehabilitation Program Case Rates

Children's Psychiatric Rehabilitation Program Case Rates

Introduction

The Mental Hygiene Administration (MHA) paid for psychiatric rehabilitation (PRP) services on a fee-for-service basis until February 2004, at which time they shifted to case rates for these services. The case rates are paid in any month in which a consumer receives 3 or more services, and does not vary by the number of services received after that threshold is achieved[10]. The case rate for PRP services for individuals living with a responsible adult (mostly children) is $297, and the case rate for individuals living independently (mostly adults) is $667, and the rates for individuals living in residential rehabilitation programs are substantially higher. For convenience in the rest of this paper the $297 rate for individuals living with a person legally responsible for them will be referred to as the child rate.

Providers of PRP services to children have expressed concern about the level of the rates and have reported having to lay off substantial numbers of staff in order to operate with the approved rates. The situation is confounded by the fact that changes were made to the medical necessity criteria for authorization of services prior to the implementation of the case rates, and MHA also determined that they had been paying for certain services in schools that they considered should be more appropriately funded by the school system.

The Commission was asked to review the children's PRP rates and agreed to do so. This paper is the result of that review.

The definition of what comprises a service has changed under case rates. Under the fee-for-service system the services were defined by time and the nature of the service, and there could be multiple services in a given day. For example, there were different rates for children's on-site services of 1-3 hours, and over 3 hours, and for offsite services of 60-90 minutes, and over 2 hours. Under the case rates the providers have greater flexibility in what comprises a service, which could be as short as 15 minutes for off-site and 60 minutes for on-site services, but there is only considered to be one service per day.

Background

MHA provided to the Commission data for fiscal years 2002 and 2003 that had been used in the calculation of the case rates, and also summary data on the utilization for the period after the implementation of the case rates. The Commission staff used these data to study the utilization patterns, changes in utilization patterns, and the appropriateness of the case rate. In addition, Commission staff discussed this issue with representatives of Community Behavioral Health, Inc., MHA, the Maryland Disability Law Center, and several providers of services.

[10] There are some additional payments for consumers who require very intensive services, but these are not relevant for the current discussion. Providers in the transitional age youth program receive grant payments in addition to the case rates.

The data received for the post-implementation period was summary data with average child encounters per month by provider.

Calculation of the case rate

The community client case rate was calculated by summing all the payments for community client PRP services in fiscal year 2003, counting the number of consumers in that year, dividing the total payments by the number of consumers to obtain the payment per consumer for the year, then dividing that amount by 12 to arrive at a rate per month. This was reduced by 7% to produce the $297 rate. This rate is then paid for each month in which a consumer receives 3 or more services. The same methodology was used to calculate the various other PRP rates.

Problems with the rate calculation/implementation

The rate calculation described above is appropriate to develop a capitation rate to be paid each month, and would have provided a payment approximately 7% under the previous year fee-for-service had it been paid every month. However, it provides much less revenue than the prior year payments if it is only paid for months in which a consumer receives 3 or more services. This is best illustrated by means of a simplified example:

Example:

Suppose in the base year there was only one consumer, and that consumer received $500 of services in each of 6 months, for a total of $3,000 for the year.

The base year cost per month was $3,000/12 = $250.

For simplicity, assume this case rate is used without the 7% reduction.

If in the rate year the consumer again receives services sufficient to justify the case rate payments in 6 months the total payments would be:

6 x $250 = $1,500.

The total payments are half what was actually paid in the base year.

Results of the analysis

The FY 2003 data received from MHA contained 9,968 children, and they received services, on average, in 6.2 months. If attention is restricted to consumers who received 3 or more services in some months, and only to the months in which they received 3 or more services, there were

9,280 consumers, and they received services, on average in 6.0 months. In the months in which they received services they received such services on an average of 11.3 days, and received 1.1 services on average in each of these days. In 2002 the patterns of utilization were quite similar to those found in 2003. The payment per service in 2003 was about $60 on average.

The number of days in the month on which consumers received services ranged from 1 to 31, with the mode (i.e. the most common number of days) being 12. There were about 160 consumer/months in which the consumer received services on every day of the month.

Restricting attention to children aged 16 and under, they received 1.1 services in the days in which they received services, received services 10.1 days in the months in which they received services, and received services in 5.6 months of the year.

The summary data for the period subsequent to the implementation of the case rates showed an average of just under 4 encounters per month for the children not in the transitional age youth program. There was considerable variability among providers. This suggests that providers have substantially reduced the number of services being provided in response to the child PRP case rate. This is consistent with the information received in discussion with provider representatives. The transitional age youth program participants were receiving, on average, in excess of 20 services per month. Payments for transitional age youth involve grant payments, which can be as high as $80,000, in addition to the case rate payments.

Conclusions and caveats

The child PRP rate was calculated as if it were a capitation rate, i.e. a rate that would be paid for every month in which a child was eligible for services, but was paid as a case rate only in months in which the child received 3 or more days of service. This resulted in the payments being about half of the expected payment. It was reported in discussions that the providers have reduced staffing levels substantially, and reduced the number of services being provided per month. Thus, while the payments are about half the previous payments, the costs and utilization have also been reduced. Accordingly, it is possible that the costs of current utilization now approximate the case rate.

The eligible children have widely differing care requirements, but the single rate does not account for these differing requirements, and could result in underpayment of providers who service a set of consumers with above average care requirements and conversely for providers with consumers with below average care requirements. MHA should consider refining the payment system to include multiple levels of case rates. However, if this is done the authorization process should ensure that only children who require a heavier intensity of services are approved for the higher rates, otherwise the expenditures could increase substantially above the budgeted amount.

Given the reported reduction in the number of consumers being served, the FY 2003 consumer population used for the calculation of the case rate may not be representative of the population of consumers being served currently. This could result in under or overpayments, and should be

reviewed once encounter level data are available from APS Healthcare, the new system administrator.

Using the original base year data and adjusting the case rate to account for the number of months in which 3 or more services are provided using the same data used for the development of the case rates would be expected to double the current MHA payments for child PRP services. However, the utilization of services has been dramatically reduced under the case rate system. In addition, some providers have reduced or eliminated their provision of child PRP services because of the level of payment. Providing a higher rate may encourage these providers to return to providing child PRP services, so may prompt an increase in utilization from current levels, either more individuals or more services for individuals already being served, which would further increase total payments for child PRP services.

There appear to have been reductions in utilization levels to match the reduction in payments experienced with the shift to case rates. It would be important to understand what impact, if any, this has had on the outcomes of care. The current rate may be, on average, close to the rate required for the number of services currently being provided, but a final determination of that would require financial data that will not be available for some time.

If the hypothesis discussed above is correct MHA expenditures for child PRP services should have reduced dramatically under case rates as compared with expenditures under the fee-for-service system.

The encounter level data for the period post implementation of case rates should be studied on an ongoing basis to better understand the changes in utilization patterns that have occurred, and their impact on outcomes and quality. The Commission will continue to monitor this.

Additional questions that remain unanswered are whether: 1) the utilization rates under the former fee-for-service system were too high; 2) the current utilization rates are too low; 3) a combination of the two; and, 4) what impact, if any, have the reductions in utilization had on outcomes of care.

Recommendations

Given the dramatic changes in utilization that have occurred since the implementation of case rates it may not be appropriate to simply recalculate the case rates using the base year 2003 payments and utilization, and correcting for the number of months that children are receiving services. Doing so would overpay providers relative to the services currently being provided. MHA should study and determine the appropriate utilization level and recalculate the rate based on that level, taking account of the outcomes of care. This could increase the case rate, and so increase the expenditures on child PRP services. In addition, a higher case rate may encourage existing providers to enroll (or re-enroll) more children or other providers to enter (or re-enter) the system, which would further increase the total expenditures. Any changes made should take account of the MHA budget.

MHA should study the consumer population to determine whether consumers can be classified by level of care required, so that multiple tiers of case rates could be established within the community client category. However, any such change should take account of the incentives to shift children to categories with higher payment rates, and provide adequate protections to limit such shifts.

The Commission would be happy to provide assistance with these activities.

APPENDIX B-8

The Financial situation of Providers of Community Services Contracting with MHA, Fiscal Years 1999 through 2004

The Financial Situation of Providers of Community Services Contracting with MHA, Fiscal Years 1999 through 2004

Executive Summary

The financial condition of the providers of community services contracting with MHA deteriorated from fiscal year 2003 to fiscal year 2004, with the profit margin dropping by 0.5% to 2.0% (see Section 4.1), and the proportion of providers with negative margins increasing to 35% (see Section 4.1). The relatively small drop in the profit margin conceals, however, major changes in the revenues. For providers for which data were available in both 2003 and 2004 the total revenues dropped by 2%. This was probably due to a combination of the change in payments for psychiatric rehabilitation services with a change to case rates effective February 1, 2004, and a reduction in the total payments at that time, and a new rules limiting the ability of outpatient mental health clinics to bill for certain combinations of services in the same day. These factors are expected to have an even greater impact on revenues in fiscal year 2005, when they will be in effect for the entire year.

Bad debts have been increasing, and now represent 3% of total expenses (see Section 4.5).

Receivables and cash and investments are at a reasonable level (see Section 4.3).

It should be noted that this analysis is based on a relatively small sample of providers, so may not provide a complete picture of the financial condition of the providers of mental health services.

1. Introduction

The enabling statute of the Community Services Reimbursement Rate Commission (CSRRC) requires that the Commission, in its evaluation of rates, consider "the existing and desired ability of providers to operate on a solvent basis in the delivery of effective and efficient services that are in the public interest". The analysis reported here is intended to examine the financial status of the mental health providers of community services and show trends for the fiscal years 1999 through 2004 in response to the statutory obligation.

A number of caveats need to be made to avoid reading too much into this data. The first is that there is no single financial measure that gives a complete picture of the financial situation of a provider. Therefore, it is necessary to examine several indicators to obtain an overall picture. A second is that the expenses and payments are not just those associated with services paid for by the state, so this is not simply an analysis of the impact of the MHA payment system. Another caveat is that the set of providers reporting is not the same in each year.

2. Data sources

The data used for this analysis were extracted from the fiscal year 1999 through 2004 Audited Financial Reports, which were obtained from a variety of sources. The following tables shows the number of audited financial reports that were available for analysis in each year. It should be noted that these represent a small proportion of the total number of providers, so do not produce a complete picture of the financial condition of the providers.

Year	1999	2000	2001	2002	2003	2004
No. of reports	19	48	47	33	30	31

The following data fields were extracted from the fiscal year 2004 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

3. Financial ratios calculated

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

The data were used to calculate seven financial ratios or indicators several of which 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
Net assets: Total assets - Total liabilities
Days in receivables: (Receivables/revenues) x 365

Days of cash:	(Cash/expenses) x 365
Bad debts	Bad debt expenses/Total expenses
Contributions	Contributions/Total revenue

4. Results

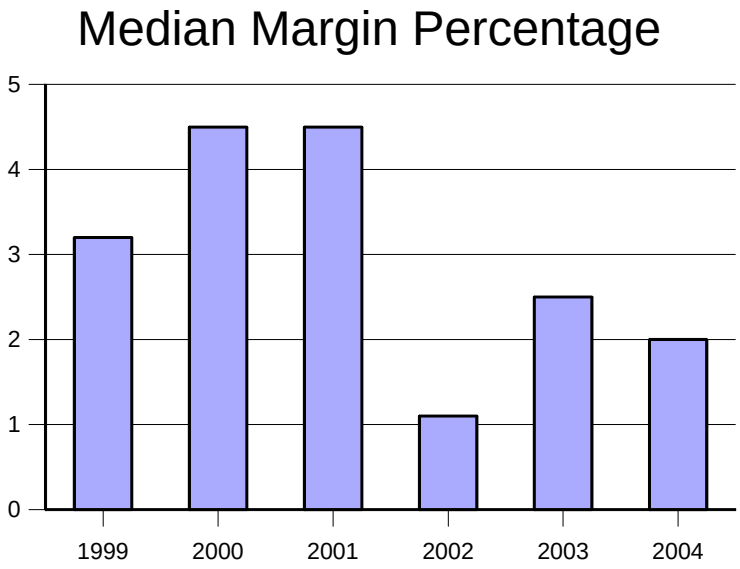
4.1 Profit Margin

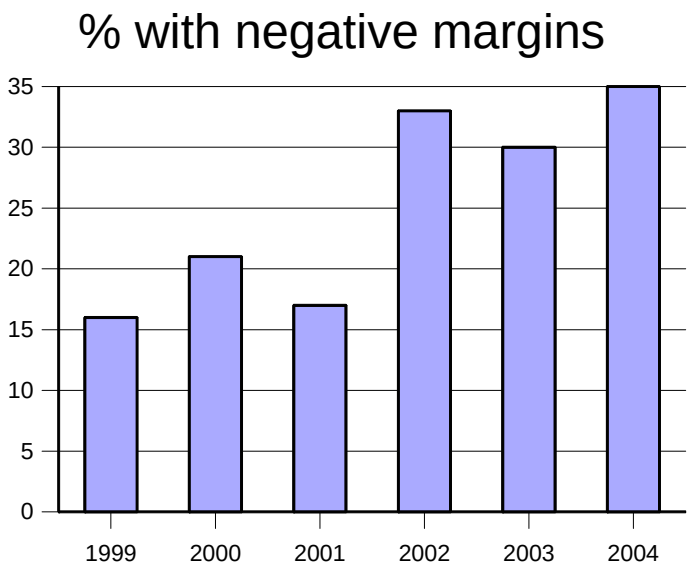
The term "profit margin" is used as it is generally understood. However, it should be noted that while most of the providers are "not-for-profit" organizations, all organizations require some level of profit in order to sustain their existence and build up funds to replace their buildings and equipment.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

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

Table 1: Profit Margins	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004
Maximum	14.3%	34%	26.7%	24.2%	20.4%	28.1%
Median	3.2%	4.5%	4.5%	1.1%	2.5%	2.0%
Minimum	-11.4%	-5.0%	-8.1%	-9.1%	-8.3%	-14.8%
Mean (weighted)	5.3%	6.0%	5.2%	2.3%	2.9%	2.1%

Of the providers of community services included in this analysis for FY 2004 11 of the 31 had negative margins (i.e., 35%).


Median Margin Percentage
5
4
3
2
1
0
1999
2000
2001
2002
2003
2004


% with negative margins
35
30
25
20
15
10
5
0
1999
2000
2001
2002
2003
2004

4.2 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	1999	2000	2001	2002	2003	2004
Maximum	8.5	37	35	11	13	17.6
Median	1.6	2.0	2.4	2.1	2.1	2.8
Minimum	0.6	0.01	0.04	0.3	0.4	0.6

4.3 Cash and investments and receivables

Cash and investments represent money that is available to the provider in the short term. Cash and investments were 19.1% of the total expenses. The cash available, thus, represents 70 days of expenses. Some of this cash may be restricted or allocated for specific capital projects and so may not be available for operations. Revenue from investments is often an important source of revenue for the providers, and this has dropped substantially in recent years, with the downturn in the stock market, and the lowering of interest rates.

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

Table 3: Cash & investments	1999	2000	2001	2002	2003	2004
Percentage of expenses	7.1%	9.0%	7.2%	12.0%	25.5%	19.1%

While this table suggests a substantial improvement in the cash position of the providers in FY 2003 and 2004 it should be interpreted cautiously. The set of providers included in the analysis changes between years, and only 27 providers are included in the FY 2004 analysis for this variable. Also, our ability to identify all cash and investments in the audited financial reports has improved over time.

Receivables comprised 10.2% of the total revenues, so providers had, on average, 37 days of revenue in receivables.

4.4 Net assets

Of the community service providers included in the analyses, 3 had negative net assets in FY 1999, 5 had negative net assets in FY 2000, 2 had negative net assets in FY 2001, 2 had negative assets in FY 2002, 1 had negative net assets in 2003 and 1 in 2004. 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.

4.5 Bad debts

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

Year	1999	2000	2001	2002	2003	2004
Bad debt %	1.3%	1.2%	2.0%	2.4%	1.8%	3.0%

4.6 Contributions

Contributions comprise less than 2% of the revenues of the providers. The contributions dropped in 2003 and 2004 relative to prior years.

Year	1999	2000	2001	2002	2003	2004
Contributions %	1.9%	1.5%	1.8%	2.0%	0.6%	0.8%

5. Summary

The median margin declined from 2003 to 2004, and the percentage of providers with negative margins increased. However, the margin itself does not give the full picture. For the 22 providers for which data were available in 2003 and 2004 there was a decline of about 1.7% in revenues, but an increase of 1.2% in expenses.

	1999	2000	2001	2002	2003	2004
% with negative margins	16%	21%	17%	33%	30%	35%
Number with negative net assets	3	5	2	2	1	1
% with current ratio < 1	21%	17%	13%	22%	18%	11%

Attachment 1: Definitions of terms

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

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

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

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

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

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

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

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

APPENDIX C

Status of 2005 Recommendations

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%.

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 the January 2004 Annual Report.

2. MHA should require the annual submission of audited financial reports[11] 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.

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 also the submission of data on wage rates, and strongly encourages the adoption of this regulation.

[11] 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.

Status: MHA implemented case rates for psychiatric rehabilitation services effective February 1, 2004. The Commission is monitoring the impact of this new rate system. The Commission performed studies on the case rates largely applicable to children, and those for intensive residential rehabilitation services. Based in part on these studies, these rates have been increased, and a monitoring system has been established to ensure that individuals with particularly heavy care requirements are not having difficulty in finding placements.

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%.

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 the January 2005 Annual 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 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.

Status: The legislature did preserve the majority of the funds for the wage equalization initiative for FY 2006.

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.

Status: The quality of the transportation data reported in the FY 2004 Cost Reports was not sufficient to allow for the study of these costs. Based on the problems observed in these data DDA has revised the instructions for the collection of the transportation data for the FY 2005 Cost Reports to reduce any ambiguity.

Appendix D

Charts

Chart 1

Distribution of DDA expenditures

Fiscal year 2005

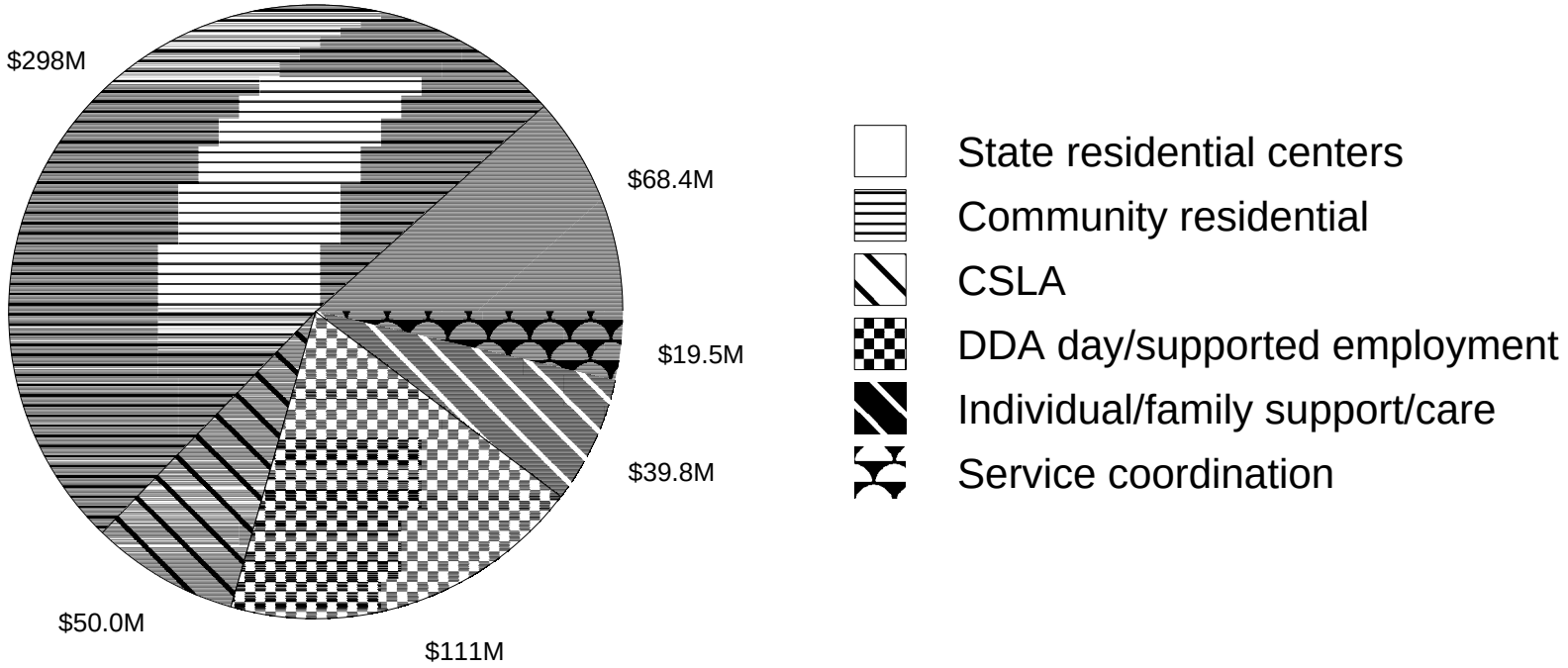


Chart 2

DDA Expenditures: FY 1997-2005

Amounts in thousands of $s.

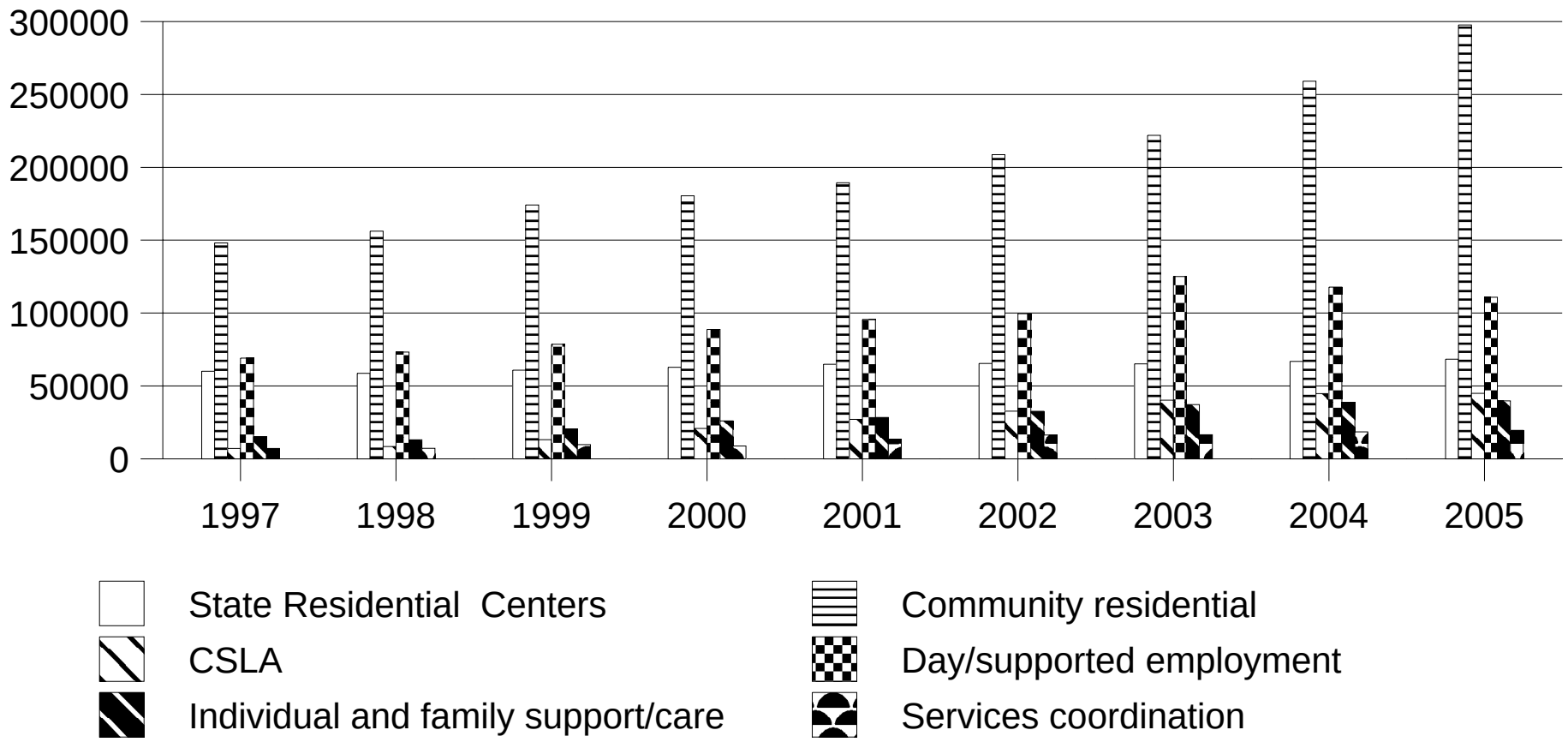


Chart 3

DDA: Community service volumes

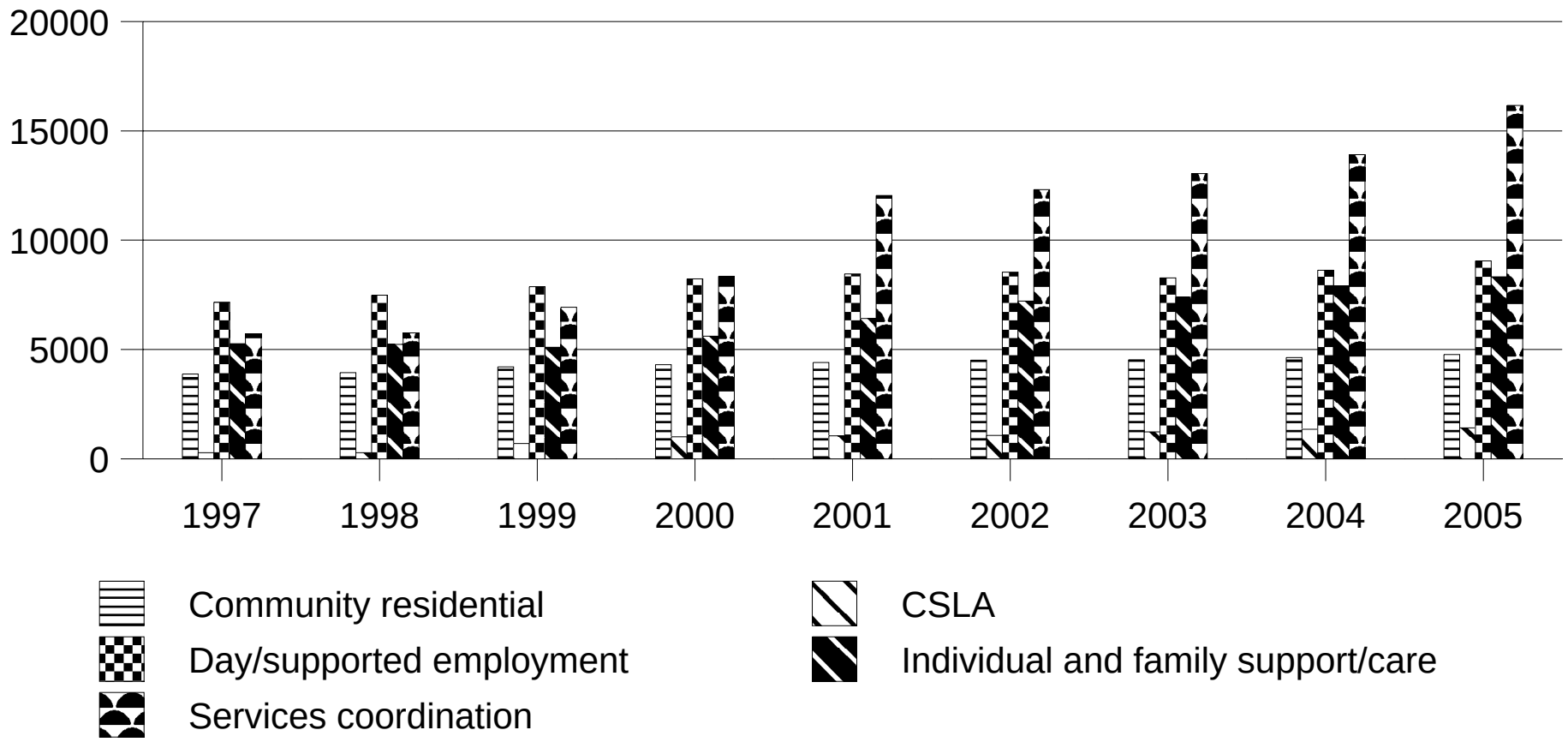


Chart 4

State Residential Centers: DDA

Expenditures (in $000s) and volumes (client days)

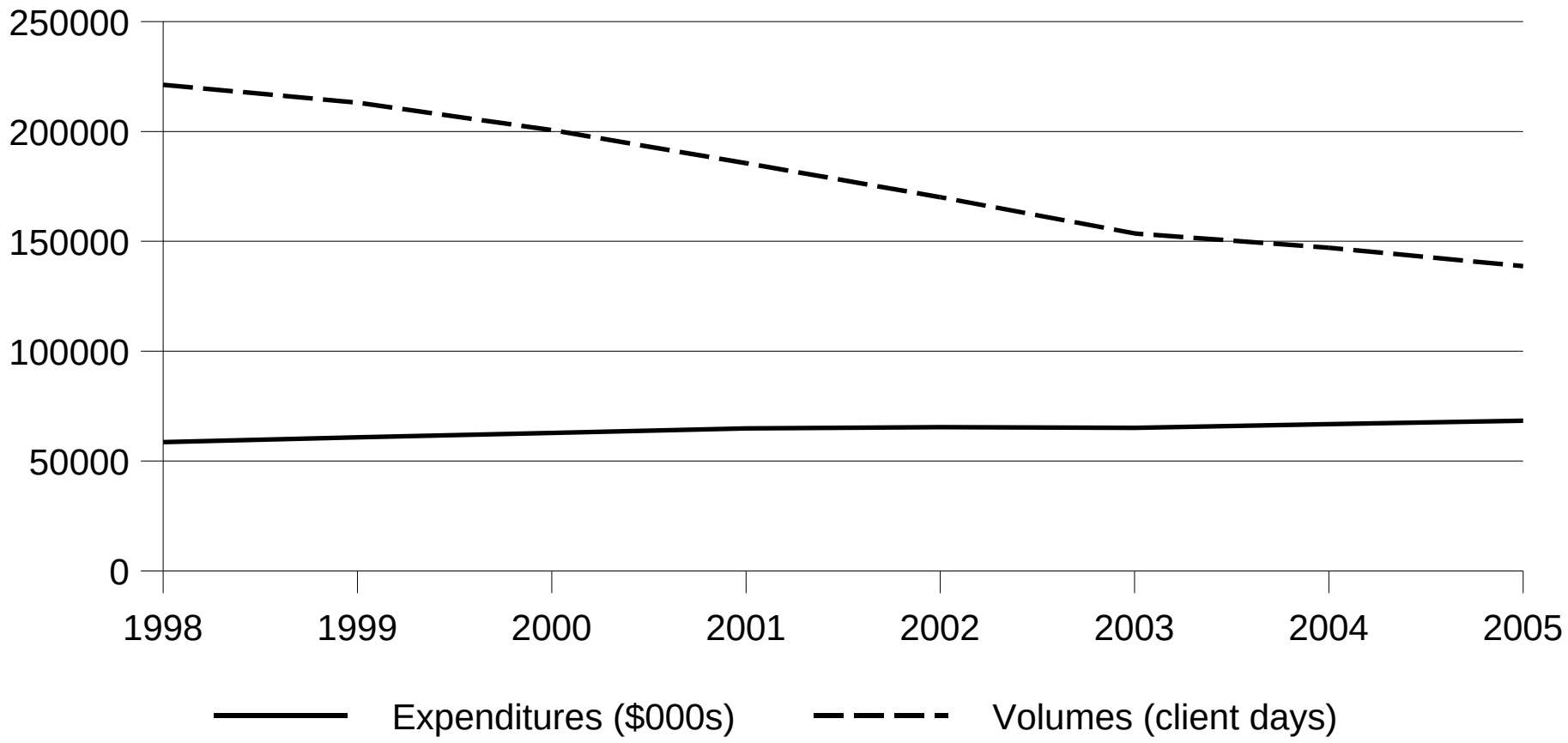


Chart 5

Distribution of MHA expenditures

Fiscal year 2005

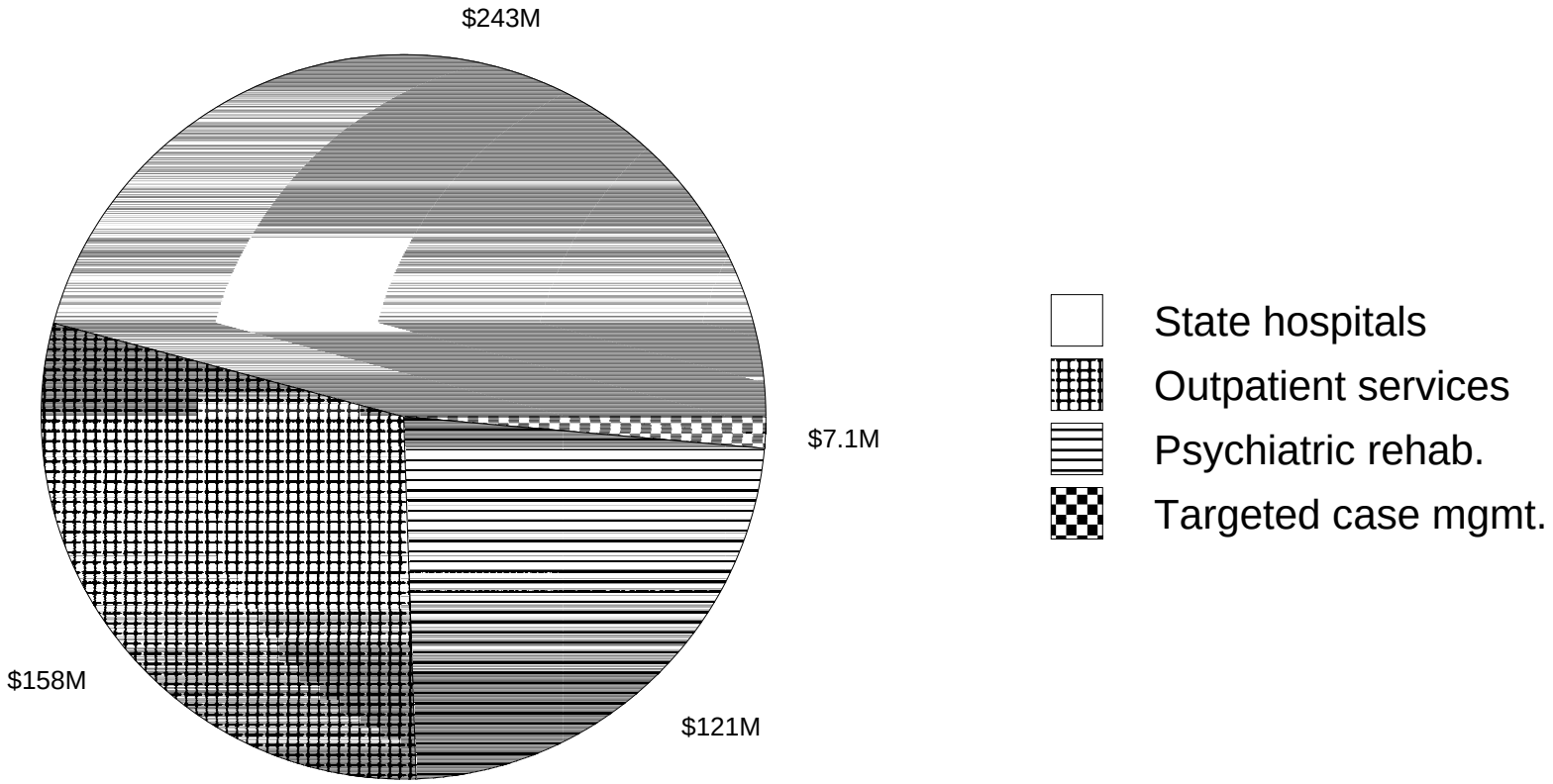


Chart 6

MHA Expenditures: FY 1998-2005

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

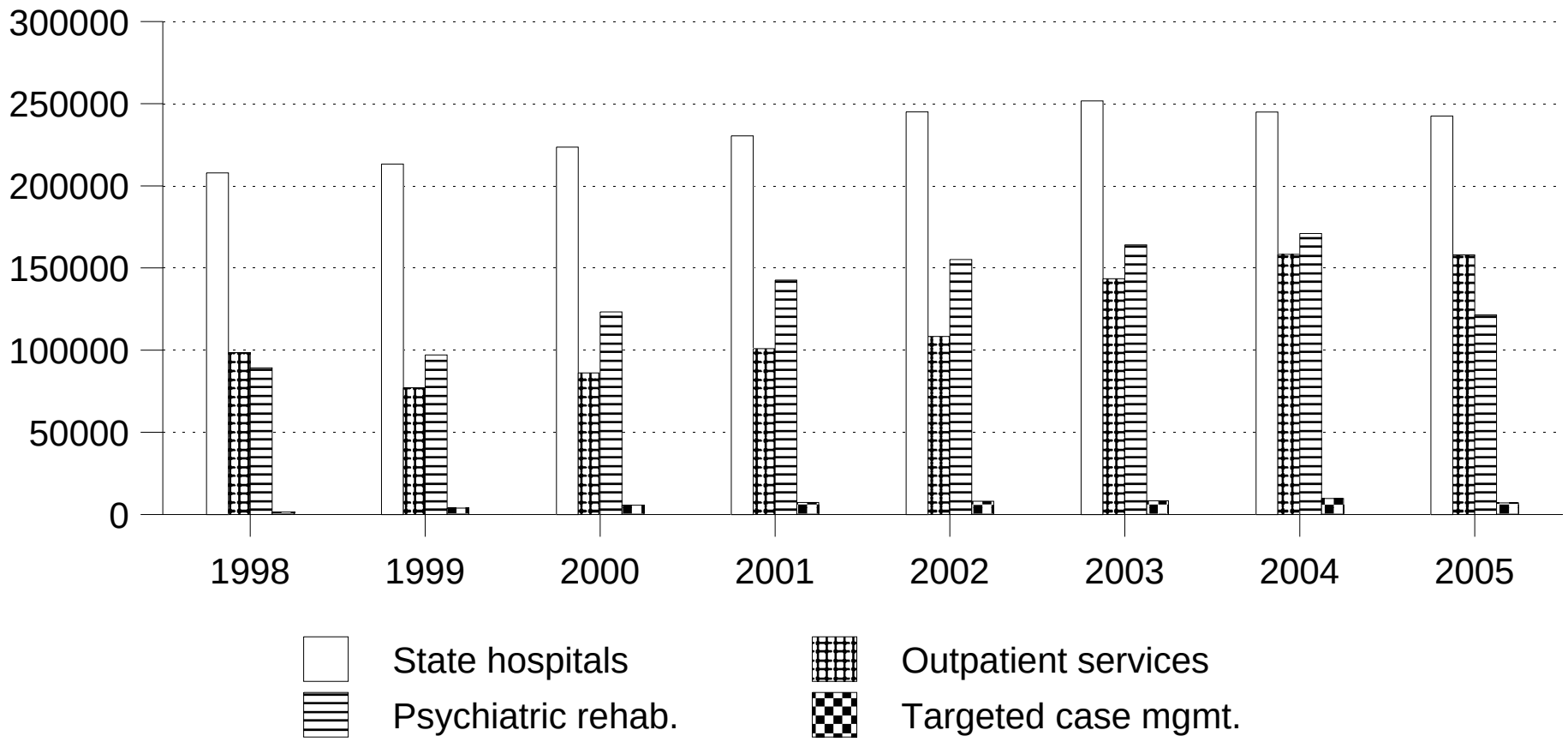


Chart 7

State Hospitals: Mental Health

Expenditures ($000s) and volumes