Community Services Reimbursement Rate Commission

Annual Report January 2009

Martin J. O'Malley
Governor

Theodore N. Giovanis
Chair

Community Services Reimbursement Rate Commission

ANNUAL REPORT

January 2009

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COMMUNITY SERVICES REIMBURSEMENT RATE COMMISSION

Membership

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This report, and the appendices to the report, as well as previous Annual Reports, can be downloaded from the Commission website.

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REPORTING REQUIREMENTS

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

1. Describes its findings regarding:

    - The level of and changes in wages paid by providers to direct support workers, including the source of revenue for wages paid by providers;

    - 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 in alternative methodologies;

    - How incentives to provide quality of care can be built into a rate setting methodology;

    - The extent and amount of uncompensated care delivered by providers; and

    - The recommended methodologies for the calculation of rate update factors and recommend rate update factors 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.

[1] The Commission decided to issue its reports in January of each year to match the start of the legislative session, and so provide the information in a timely manner for budget discussions.

Executive Summary

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.

While there are other recommendations that could be added, because of the current budget environment the Commission believes that the recommendations offered are the most critical. These recommendations deal with increases in rates and the effects of mandates on costs. Over the most recent years there have been modest rate increases. In the past there were many years when these providers had no rate increases. To revert back to the ways of the past would sacrifice all of the progress that has been made to date.

Recommendations for DDA

1. Rates for fiscal year 2010 should be increased by **3.58%** to compensate for the impact of inflation on the costs of providers. The major purpose of the update adjustment is to assure that such costs increases, as estimated by objective measures of inflation, are reflected in the rates of providers.

Rationale:

The legislature, in re-enabling the Commission, instructed that an updating system should be developed, and then that an annual update should be calculated and recommended. In the 2005/2006 legislative session House Bill 98 added the requirement that the recommended update be taken into account by the Developmental Disabilities Administration in its setting of rates. The financial condition of the DDA providers indicates that such an update is necessary.

The Commission has a responsibility to make recommendations on the appropriate amount that rates should be increased to adjust for the reasonable impact of inflation on the costs incurred by providers. To carry out this requirement for a recommended update the Commission developed a methodology for calculating this adjustment which is essentially a simplified version of the methodology used by the Maryland Health Services Cost Review Commission (HSCRC) tailored to the particular providers. The result of that methodology is a calculated update for the reasonable cost of inflation of **3.58%** for FY 2010. For comparison purposes, the Medicare outpatient prospective payment system rate increase for 2009 is 3.6%, and the HSCRC provided the hospitals with inpatient rate increases of 3.81% for FY 2008 and 4.2% for FY 2009[2]. DDA increased rates by 2% for FY 2009.

[2] These are the inpatient update factors net of any allowance for case mix change.

2. The providers' costs are increased by regulations imposed by State agencies beyond those adopted by DDA. When a State agency proposes legislation or regulations that apply to providers paid by DDA that agency should be required to involve DDA in assessing the economic impact of the new legislation or regulations on the providers, and suggest how these costs should be covered.

Rationale:

State agencies adopt regulations or propose legislation that imposes additional costs on providers, often without an adequate consideration of the magnitude of these additional costs, or how they will be paid for. For example, the Commission has carried out an analysis of the impact of several requirements imposed by the Board of Nursing and found that such requirements increased the costs of DDA providers by about $5 million per year or about 1.0% of total DDA payments. When such legislation or regulations are proposed the agency proposing them should be required to involve any State agencies involved in paying affected providers and the affected providers in the assessment of the impact of the new regulations on the costs incurred by the providers, and should suggest how any increased costs should be covered. One possibility might be the reduction of other regulatory costs to offset the costs that are increasing.

Recommendations for MHA

1. Rates for fiscal year 2010 should be increased by **3.58%** to compensate for the impact of inflation on the costs of providers. The major purpose of the update adjustment is to assure that such cost increases, as estimated by objective measures of inflation, are reflected in the rates of providers.

Rationale:

The legislature, in re-enabling the Commission, instructed that an updating system should be developed, and then that an annual update should be calculated and recommended. In the 2005/2006 legislative session House bill 98 added the requirement that the recommended update be taken into account by the Mental Hygiene Administration in its setting of rates. The financial condition of the MHA providers indicates that such an update is necessary.

The Commission has a responsibility to make recommendations on the appropriate amount that rates should be increased to adjust for the reasonable impact of inflation on the costs incurred by providers. To carry out this requirement for a recommended update the Commission developed a methodology for calculating this adjustment which is essentially a simplified version of the methodology used by the Maryland Health Services Cost Review Commission tailored to the particular providers. The result of that methodology is a calculated update for the reasonable impact of inflation of **3.58%** for FY 2010. For comparison purposes, the Medicare outpatient prospective payment system update for 2009 is 3.6%, and the HSCRC provided the hospitals with inpatient rate increases of 3.81% for FY 2008 and 4.2% for FY 2009[3]. MHA increased rates by 2% for FY 2009.

2. The providers' costs are increased by regulations imposed by State agencies beyond those adopted by MHA. When a State agency proposes legislation or regulations that apply to providers paid by MHA that agency should be required to involve MHA in assessing the economic impact of the new legislation or regulations on the providers, and suggest how these costs should be covered.

Rationale:

State agencies adopt regulations or propose legislation that imposes additional costs on providers, often without an adequate consideration of the magnitude of these additional costs, or how they will be paid for. When such regulations or legislation are proposed the agency proposing them should be required to involve any State agencies involved in paying affected providers and the affected providers in the assessment of the impact of the new regulations or legislation on the costs incurred by the providers, and should suggest how any increased costs should be covered. One possibility might be the reduction of other regulatory costs to offset the costs that are increasing.

3. The providers are required by regulation to submit financial reports and wage surveys to MHA, and MHA makes these surveys available to the Commission. MHA should have the authority to apply sanctions, for example, fines or withhold of payments, to providers who are in breach of these regulations.

Less than half the providers submitted wage surveys and audited financial statements for FY 2007 in spite of the regulation and two reminder letters. This can be contrasted with the situation with DDA, which does have, and uses, the authority to fine providers for non-compliance with data reporting regulations, and where 95% compliance is experienced. Without comprehensive data neither the Commission nor MHA have a comprehensive view of the financial situation of the providers which is critical to the monitoring of the stability of the providers of services.

Note: It is important to note that while the Commission was reauthorized that reauthorization was at a significantly reduced scope than previously. This means that in the future the Commission recommendations will also be reduced. Nevertheless, the issues encountered by the providers will not change and in fact may increase given the current economic climate. Therefore, the primary burden for monitoring these critical issues will now rest solely with the state agencies themselves. In addition, the Commission's meeting schedule may be reduced to assist with budget reductions.

[3] These are the inpatient update factors net of any allowance for case mix change, and were obtained from the HSCRC staff. The published updates are higher as they include allowances for case mix change.

Introduction

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 twelve years. Each year the Commission publishes an Annual Report on its activities, findings, and recommendations. This is the twelfth 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;
- Transportation costs and other changes influencing provider costs; and
- Utilization under the case rate system for psychiatric rehabilitation services.

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 for FY 2010 (based on information gathered in 2008 and 2009)

- The 2006 legislative session produced legislation requiring that MHA and DDA take account of the Commission's recommended update factors in their rate setting. The Commission has designed an updating system for rates and calculated the update factor that would result from its application. These recommended update factors are: **3.58%** for both DDA and MHA rates.

- The average margin of the providers paid by DDA was 1.6% in fiscal year 2007, down from 2.3% the previous year. This is a relatively low margin, and is the second lowest since the Commission started calculating the margins in 1999.

- The financial condition of the MHA providers in 2007 was similar to their situation in 2006. The median margin of the providers reporting was 2.5%.

- The salary levels paid by DDA and MHA community service providers to direct care workers 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 substantially less than those of corresponding state positions. This is in spite of the fact that these providers have increased the wages for direct care workers over the past four years by more than the change in the rates they have received from DDA and MHA, 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 been quite comprehensive over the past several years, but the data from the MHA providers was inadequate in prior years. However, MHA has promulgated data submission regulations requiring the submission of wage surveys and audited financial reports to the Commission and the CSAs, and more wage surveys and audited financial reports are being received, although the submission rates are still relatively low.

- MHA, in conjunction with the University of Maryland, has implemented the Outcome Measurement System (OMS) and also several Evidence Based Practices (EBP) within the fee for service system. Incentives to promote the use of EBPs have been developed, but the financial impact of these programs on the providers is yet to be determined.

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 reported 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. As of July1, 2008 these numbers had increased to 17,959 individuals and 33,766 service requests.

Between 1998 and 2007 the number of individuals served by the Public Mental Health System increased by more than 47%. In February 2004, MHA implemented a case rate payment system for psychiatric rehabilitation services. Utilization rates dropped substantially upon the implementation of this case rate system for psychiatric rehabilitation, but subsequently recovered some of that decrease. Outpatient mental health expenditures grew by 13% from fiscal year 2006 to fiscal year 2007 and an additional 10% from 2007 to 2008.

Choices, such as covering new clients, dropping clients from coverage, or ensuring stability for existing providers, need to be made consciously. 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. However, rates for psychiatric rehabilitation services for children, and for intensive residential rehabilitation were substantially increased in FY 2005. The analysis of the financial condition of providers of community services paid by MHA is based on Audited Financial Reports. While only 48 providers were included in the study, these are generally quite large providers, so represent a substantial proportion of the revenue of the public mental health system. 25% of the providers in the study had negative margins in 2007.

The financial condition of the providers paid by DDA deteriorated in FY 2007, with 34% of the providers having negative margins, i.e., losing money. The average margin was only 1.6%.

The financial condition of the providers paid by MHA was similar in 2007 to the 2006 performance. 25% of the providers had negative margins in 2007, and the median margin was 2.5%.

In accordance with the legislative requirement to assess "the financial condition of providers and the ability of providers to operate on a solvent basis in the delivery of effective and efficient services that are in the public interest," the Commission intends to maintain a close watch on the financial condition of the providers by obtaining updated information as soon as it becomes available, updating the analyses reported here, and reporting the results in interim work papers.

Commission Activities

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

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

Commission meetings were held on the following dates:

January 7, 2008
April 7, 2008
June 2, 2008
September 8, 2008
December 1, 2008

Technical Advisory Group meetings were held on:

February 4, 2008
March 10, 2008
May 5, 2008
August 4, 2008
October 6, 2008
November 3, 2008

Commission meetings are tentatively planned for[4]:

January 5, 2009
April 6, 2009
June 1, 2009
September 14, 2009
December 7, 2009

Technical Advisory Group meetings are tentatively planned for:

February 2, 2009
May 4, 2009
August 3, 2009
October 5, 2009
November 2, 2009

[4] The Commission and TAG meeting schedule may be reduced to allow for budget reductions. Please check the Commission's website for the most recent schedule.

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 financial reports being collected by DDA and MHA. 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 continue to gather wage surveys, and to calculate the wage rates of direct care personnel. The results of these analyses will be included in the Annual Reports.

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

As of July 1, 2008 because Medical Day Care is no longer a State planned service it has been added as a service to the two DDA waivers, and is paid for directly by Medical Assistance. Approximately $708.5 million of the Developmental Disabilities Administration's (DDA) FY 2009 budget is for community programs and $68.4 million is for institutional services. In FY 2009, due to the Rosewood Center closure, DDA has opened a facility for court involved individuals. Approximately $293.5 million of this total budget are Federal funds received through the DDA's home- and community-based waiver and another $1.7 million in the Independence Plus New Directions 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 2008 are shown in Charts 2 to 4.

The principal current DDA payment system is the Fee Payment System (FPS). $556.5 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. Until recently providers completed an assessment tool, called the Individual Indicator Rating Scale (IIRS), on each consumer they served. The IIRS is now completed by MAPS-MD. The results of the IIRS are translated into a matrix score. Reimbursement is based on the matrix score of each consumer served. While the IIRS score indicates the services needed at the time, once established that score is not modified and there is no adjustment to payments unless the provider receives an augmentation grant. 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 $62.2 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 through 2007.

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.

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

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 2008 with similar conclusions.

The governor and legislature 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 last year was FY 2007 and these funds have all been provided. However, the wages of the community providers are still lower than those of state workers, particularly when fringe benefits are taken into account.

One of the charges of the Commission is to study the level of, and changes in, the wage rates paid by providers. Wage surveys performed by the Commission and DDA on an annual basis are intended to collect the data necessary to fulfill this charge. A report on the results of the wage surveys is attached as Appendix B-2 to this report.

The wage survey has been changed 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 was for FY 2005, and was due December 1, 2005. The last pay period survey was performed in February 2006. In the future, only the Annual Wage Survey that collects data for the fiscal year will be performed. The hourly wages calculated using the FY 2005 Annual Wage Survey were almost identical to those calculated using the pay period survey, so this change did not result in problems in tracking wage rate changes over time.

Updating Rates

There are two aspects to updating rates:

1. Updating 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. 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. Some additional changes were made for the update factors which are included in Appendix B-6 of this report. Legislation enacted in the 2006 legislative session required MHA and DDA to take account of the Commission's recommended update factors in their rate setting.

The Commission is recommending that an update factor of **3.58%** would be needed to maintain the purchasing power of the rates in the face of the inflation being experienced by the providers.

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[5]. Other changes have been made since that time, particularly in the areas of add-on rates and community supported living arrangements.

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[5] 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.

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 costs increase. This could be due, at least in part, to transportation costs.

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 which are in the public interest, and

- 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 2007.

The Commission's report on these financial analyses is attached as Appendix B-3.

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 has gathered and analyzed the Cost Reports for 111 providers for FY 2007. These data and analyses were discussed with the DDA TAG. A report on this analysis is attached as Appendix B-1. An analysis of transportation costs and how they vary is included in this report.

The major conclusions of the analysis are that, in general, Supported Employment programs are losing money, Residential and Day programs are about 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 described, but these are overall conclusions regarding the financial conditions of these services. These conclusions are based on analysis of data for FY 2002 through FY 2007.

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 sent to the providers annually. A report summarizing the results of these surveys is attached as Appendix B-2. The analyses of these survey responses have consistently shown that direct care workers are paid substantially less than corresponding state workers, particularly when fringe benefits are taken into account. Turnover rates were around 29% for direct care workers in 2007, down from 38% in 2004 and 34% in FY 2005, but a little higher than the 27% experienced in 2006.

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%. Between 2004 and 2005 the direct care worker wages increased by 6.3%, from 2005 to 2006 they increased 5.9%, and from 2006 to 2007 by 4.1%. 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 5 years. In addition, money paid in bonuses in prior years appears to have been used to increase wages in 2006.

The Impact of Regulatory Changes

The 2008 enabling statute requires the assessment of the impact of changes in regulations that impact on the costs of providers and whether the rates have been adjusted to provide for these costs.

The main issue raised in this regard is increased or more expensive staffing requirements imposed by the Board of Nursing. The Board of Nursing has increased the education requirements for Certified Medical Technicians, adding English and mathematics proficiency tests for new CMTs, and increasing the training requirements from 16 to 20 hours. Some assessments that were formerly performed by LPNs are now required to be performed by an RN, which clearly increases the cost. The Commission has completed a study to quantify the impact on costs of these changes. It should be emphasized that the Commission does not object to any of these changes, but is concerned that they have been added without consideration of the impact of the costs on providers. These requirements add about $5 million in additional costs, and these additional costs were not adjusted for in the rates. A report on the impact of some of the requirements imposed by the Board of Nursing was attached as Appendix B-7 to the 2008 Annual Report.

As part of this 2009 report, the Commission has made specific recommendations with regard to actions that state agencies proposing cost increasing changes should take as part of such proposals.

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-3 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 0.3% of total revenues.

Future System

The Commission will continue to review changes to the FPS, and to the system used for augmentation grants, and will comment as appropriate. In particular, the Commission is studying the level and variability of transportation costs to assist DDA with its consideration of 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 for DDA

1. Rates for fiscal year 2010 should be increased by **3.58%** to compensate for the impact of inflation on the costs of providers. The major purpose of the update adjustment is to assure that such costs increases, as estimated by objective measures of inflation, are reflected in the rates of providers.

Rationale:

The legislature, in re-enabling the Commission, instructed that an updating system should be developed, and then that an annual update should be calculated and recommended. In the 2005/2006 legislative session House Bill 98 added the requirement that the recommended update be taken into account by the Developmental Disabilities Administration in its setting of rates. The financial condition of the DDA providers indicates that such an update is necessary.

The Commission has a responsibility to make recommendations on the appropriate amount that rates should be increased to adjust for the reasonable impact of inflation on the costs incurred by providers. To carry out this requirement for a recommended update, the Commission developed a methodology for calculating this adjustment which is essentially a simplified version of the methodology used by the Maryland Health Services Cost Review Commission (HSCRC) tailored to the particular providers. The result of that methodology is a calculated update for the reasonable cost of inflation of **3.58%** for FY 2010. For comparison purposes, the Medicare outpatient prospective payment system rate increase for 2009 is 3.6%, and the HSCRC provided the hospitals with inpatient rate increases of 3.81% for FY 2008 and 4.2% for FY 2009[6]. DDA increased rates by 2% for FY 2009.

2. The providers' costs are increased by regulations imposed by State agencies beyond those adopted by DDA. When a State agency proposes legislation or regulations that apply to providers paid by DDA, that agency should be required to involve DDA in assessing the economic impact of the new legislation or regulations on the providers, and suggest how these costs should be covered.

Rationale:

State agencies adopt regulations or propose legislation that imposes additional costs on providers, often without an adequate consideration of the magnitude of these additional costs, or how they will be paid for. For example, the Commission has carried out an analysis of the impact of several requirements imposed by the Board of Nursing and found that such requirements increased the costs of DDA providers by about $5 million per year or about 1.0% of total DDA payments. When such regulations or legislation are proposed, the agency proposing them should be required to involve any State agencies involved in paying affected providers and the affected providers in the assessment of the impact of the new regulations or legislation on the costs incurred by the providers, and should suggest how any increased costs should be covered. One possibility might be the reduction of other regulatory costs to offset the costs that are increasing.

[6] These are the inpatient update factors net of any allowance for case mix change.

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. 94,000 individuals were 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 in 2008. This should be contrasted with the 64,000 individuals served in 1998. The number of people served grew by 47% from 1998 to 2007[7].

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 2008[8]. A large state hospital closed in 2004, but the total number of beds in the system remained the same. In addition to the expenditures shown in this chart, MHA spent $174 million on community inpatient and residential treatment centers.

Expenditures on psychiatric rehabilitation services grew particularly fast, doubling between 1998 and 2002. In 2003, uninsured PRP services were shifted to being contract funded. Once these contracts were taken into account, PRP services grew by 14% from 2002 to 2003. The contracts amounted to $8,000,000 for uninsured PRP and RRP services. Beginning July 2003, these contracts were built into the fee-for-service system. In February 2004, MHA shifted to case rates for the payment of psychiatric rehabilitation services. Total payments for psychiatric rehabilitation services decreased by 18% between FY 2004 and FY 2005 then increased by 13% from FY 2005 to FY 2006, and by 8% from 2006 to 2007, and stayed at a similar level in 2008. The large decrease in 2005 was mainly 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. The 8% growth in expenditures from 2006 to 2007 was half due to rate increases and half to utilization increases. Outpatient expenditures grew by 32% between FY 2002 and FY 2004, and grew 12% from FY 2004 to FY 2006, 13% from 2006 to 2007, and 10% from 2007 to 2008. There were some substantial changes in the payment system for case management, so a direct comparison of expenditures from 2007 to 2008 is difficult. Targeted case management was shifted from fee-for-service to contracts in 2007. The numbers provided in these charts include both remaining fee-for-service payments and contract payments.

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 contracts and Medical Assistance payments. However, this changed when the Maryland Medical Assistance Program (Medicaid) obtained an 1115 waiver from the Health Care

[7] In fact the growth was somewhat greater than indicated here as in July 2004 responsibility for dual Medicare/Medicaid eligibles was shifted from the MHA budget to the Medicaid budget.
[8] The data for FY 2008 are current as of the date of preparation of this report, but are expected to change a little as bills for services provided in FY 2008 continue to be processed.

Financing Administration (HCFA, the federal Medicaid agency now called the Centers for Medicare and Medicaid Services). 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 uninsured individuals who meet medical necessity and eligibility criteria, and several other specific categories of eligibility. Under the new system the reimbursement methodology has changed from contracts 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 payment 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 non-emergency care, conducts utilization review, conducts some evaluation activities, including consumer and provider surveys, 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.

MHA provided rate increases of about 4%, consistent with the Commission’s update recommendation, for FY 2007. Rates for children received smaller increases, and some evidence based practices received larger increases than the 4% average. However, due to State budget concerns the increases provided for FY 2008 were only 2%, substantially less than the 3.71% recommended by the Commission. For FY 2009, the Commission recommended an update of 4% to account for inflation, plus the shortfall of 1.71% from the previous year, but the rates were actually increased by 1.5%, and an additional 0.5% has been added based upon the performance of the lottery.

For FY 2010 the Commission is recommending an update factor of **3.58%.**

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. It is anticipated that the availability of more complete data will allow the Commission to perform a more comprehensive and definitive analysis, including an analysis of financial condition by region of the state.

Quality and Outcomes

MHA has sponsored consumer satisfaction and outcome surveys, which are an important component of the measurement of quality of care. The results of those surveys are summarized in "Maryland's PMHS: 2007 Consumer Satisfaction and Outcomes–Survey Findings". This study found that a large majority of the respondents (81% child/family, 87% adult) were satisfied with the mental health services they received, and both these percentages were up from the previous year. The most important outcome measurement question for adults is "I deal more effectively with daily problems" and in 2006 76% of the respondents agreed or strongly agreed with that statement, while this percentage increased to 81% in 2007. For children, the most important outcome question is probably "My child is better able to control his/her behavior". 52% of respondents agreed or strongly agreed with that statement in both 2006 and 2007. 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. 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 incentive to become accredited by these organizations as they would incur costs in going though the accreditation process, but would not receive many tangible benefits from being accredited. They can, however, apply for deemed status if they are 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. MHA should also consider providing incentives to providers to implement electronic medical records systems. These have substantial potential to improve quality by, for example, preventing drug errors and flagging potential drug interactions.

MHA is at the forefront of work on outcomes measurement and the adoption of Evidence-Based Practices (EBP). MHA worked with MAPS-MD and the University of Maryland to implement the Outcomes Measurement System (OMS) statewide beginning in September 2006. For adults, data are being collected on 5 outcome domains: psychiatric signs and symptoms and symptom distress; functioning, including employment; living situation; criminal justice system/legal involvement; and alcohol and substance abuse. For children, adolescents and their caregivers data are being collected on 6 outcome domains: psychiatric signs and symptoms and symptom distress; functioning, including school performance and employment; living situation; social connectedness of the caregiver; juvenile justice system/legal involvement; and alcohol and substance abuse. Current results from the OMS can be obtained from the datamart at http://mapsmdreporting.apshealthcare.com

MHA has worked with the University of Maryland in the development of EBPs. Programs in Supported Employment, Family Psycho-Education, and Assertive Community Treatment have already been implemented within the fee-for-service system. Results for 2006 suggest that the

Supported Employment EBP program has been very successful in increasing vocational outcomes. For FY 2007, MHA developed incentives in its rate structure to promote the use of this program. Further analysis is required on their financial impact. Other EBP programs are under development.

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 2007. The Commission utilized the CBH data to conduct its own evaluation and summaries of the results of the Commission's evaluations have been included in prior Annual Reports. A summary of the results of the fiscal year 2007 study is attached as Appendix B-4 of this 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 substantially 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. With the submission of Audited Financial Reports pursuant to regulations adopted by MHA in 2007, the Commission is in a better position to assess the financial condition of the providers, although the response to the regulation has not been as comprehensive as would have been desired. A report on the financial condition of the providers is attached as Appendix B-5. It is based on reports from 48 providers, and shows a financial condition in 2007 that is similar to that in 2006. Twenty five percent of the providers had expenses greater than their revenues and the median profit margin was 2.5%.

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 is recommending that an update factor of 3.58% 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 has carried out wage surveys annually from 1999 through 2007. 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-4 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 five 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.

MHA issued regulations requiring providers to submit wage surveys for FY 2007 and subsequent years. Separate survey forms were developed for Outpatient Mental Health Clinics (OMHC) and for Psychiatric Rehabilitation Programs (PRP). Usable responses were received from 39 OMHCs and 37 PRPs. The results of the analyses of these responses are included as Appendix B-4 to this report.

Efficiency and Effectiveness/Financial Status

Provider efficiency presents a different challenge under a fee-for-service payment system than under a contract-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.

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 under serve 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 community mental health 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 was 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%. There was a drop to 2.1% in FY 2004, with a recovery to 2.6% in FY 2005. The financial condition of the providers showed a general decline in 2006, with the results for 2007 being similar to those for 2006.

The small reduction in the margin in 2004 conceals, however, major changes in revenue and expenses. From providers whose reports were available for both years, revenues dropped by 5% and expenses dropped slightly less. There were major cutbacks in the payments for psychiatric rehabilitation services in FY 2005, with the total payments dropping by 18% from FY 2004 to FY 2005. Total payments for psychiatric rehabilitation services increased by 13% from 2005 to 2006, and by 8% from 2006 to 2007, but dropped by 2% to 2008. A more detailed discussion of the financial condition of the providers is included in Appendix B-5 to this report.

Case rates for psychiatric rehabilitation services were implemented effective February 1, 2004. These case rates were intended to represent a reduction in payment levels of about 10%, but to allow 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 the January 2005 Annual Report.

Data

Commission staff is working with MHA staff and the CSAs to improve the completeness of the submission of wage surveys and financial reports, and the accuracy of the wage survey data.

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 under serve, 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.

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. The requirement to study consumer safety costs has been replaced with a more specific requirement concerning changes in regulations that impact on the costs of providers.

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, bad debts in 2007 comprised 2.4% of total expenses 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. The waiver also includes 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 a population of severely and persistently mentally ill individuals, 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.

Emergency Department Diversion Project

In 2007, MHA implemented projects in conjunction with three county health departments to evaluate and triage uninsured individuals presenting at hospital emergency departments, and who are potentially at risk for admission to a State hospital. While these programs are quite new, a substantial proportion of the individuals assessed have been diverted to community services. An additional two counties were added in FY 2008.

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 the January 2005 Annual Report.

Recommendations for MHA

1. Rates for fiscal year 2010 should be increased by **3.58%** to compensate for the impact of inflation on the costs of providers. The major purpose of the update adjustment is to assure that such cost increases, as estimated by objective measures of inflation, are reflected in the rates of providers.

Rationale:

The legislature, in re-enabling the Commission, instructed that an updating system should be developed, and then that an annual update should be calculated and recommended. In the 2005/2006 legislative session House bill 98 added the requirement that the recommended update be taken into account by the Mental Hygiene Administration in its setting of rates. The financial condition of the MHA providers indicates that such an update is necessary.

The Commission has a responsibility to make recommendations on the appropriate amount that rates should be increased to adjust for the reasonable impact of inflation on the costs incurred by providers. To carry out this requirement for a recommended update the Commission developed a methodology for calculating this adjustment which is essentially a simplified version of the methodology used by the Maryland Health Services Cost Review Commission tailored to the particular providers. The result of that methodology is a calculated update for the reasonable impact of inflation of **3.58%** for FY 2010. For comparison purposes, the Medicare outpatient prospective payment rate increase for 2009 is 3.6%, and the HSCRC provided the hospitals with inpatient rate increase of 3.81% for FY 2008 and 4.2% for FY 2009[9]. MHA increased rates by 2% for FY 2009.

2. The providers' costs are increased by regulations imposed by State agencies beyond those adopted by MHA. When a State agency proposes legislation or regulations that apply to providers paid by MHA that agency should be required to involve MHA in assessing the economic impact of the new legislation or regulations on the providers, and suggest how these costs should be covered.

Rationale:

State agencies adopt regulations or propose legislation that imposes additional costs on providers, often without an adequate consideration of the magnitude of these additional costs, or how they will be paid for. When such regulations or legislation are proposed the agency proposing them should be required to involve any State agencies involved in paying affected providers and the affected providers in the assessment of the impact of the new regulations or legislation on the costs incurred by the providers, and should suggest how any increased costs should be covered. One possibility might be the reduction of other regulatory costs to offset the costs that are increasing.

3. The providers are required by regulation to submit financial reports and wage surveys to MHA, and MHA makes these surveys available to the Commission. MHA should have the authority to apply sanctions, for example, fines or withhold of payments, to providers who are in breach of these regulations.

Less than half the providers submitted wage surveys and audited financial statements for FY 2007 in spite of the regulation and two reminder letters. This can be contrasted with the situation with DDA, which does have, and uses, the authority to fine providers for non-compliance with data reporting regulations, and where 95% compliance is experienced. Without comprehensive data neither the Commission nor MHA have a comprehensive view of the financial situation of the providers which is critical to the monitoring of the stability of the providers of services.

[9] These are the inpatient update factors net of any allowance for case mix change, and were obtained from the HSCRC staff. The published updates are higher as they include allowances for case mix change.

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:	Centers 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
EBP:	Evidence Based Practice
FPS:	Fee Payment System
HCFA:	Health Care Financing Administration (now CMS)
HIPAA:	Health Insurance Portability and Accountability Act.
HSCRC:	Health Services Cost Review Commission
MACS:	Maryland Association of Community Services, Inc.
MAPS-MD:	The ASO currently contracted by MHA to assist in administering the PMHS
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
OMS:	Outcome Measurement System
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 Centers 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.

MAPS-MD: The statewide mental health carve-out for Medicaid and uninsured enrollees administered by APS Healthcare.

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

Lynn Garrison, M.B.A.

Lynn Garrison is a retired governmental employee with over 30 years of experience in health care. He worked at the Maryland Health Services Cost Review Commission as the Associate Director of Hospital Regulation, the Maryland Health Care Commission as Program Manager for the Certificate of Need Program, and as a Medicare hospital audit manager for the Hospital Cost Analysis Service. Mr. Garrison received an M.B.A. in finance from Loyola College in Baltimore.

Theodore N. Giovanis, FHFMA, M.B.A.

Theodore Giovanis is President of T. Giovanis & Company, LLC, a consulting firm specializing in legislative, regulatory, and strategic consulting with an emphasis on health care policy at the federal and state levels. 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.

Jeanette M. Martin, B.S.

Jeanette M. Martin is a Management Analyst with the District of Columbia Department of Corrections. In that capacity she works in the Director's office, and is responsible for report generation for the Red Book on Front Burner Issues for the Mayor's office. Ms. Martin has over

15 years experience in project management and evaluation.

Ms. Martin received her B.S. and M.S. (pending) from the School of Human Ecology and Allied Sciences, Howard University.

Jeff Richardson, MBA, LCSW-c

Mr. Richardson is the Executive Director of Mosaic Community Services (MCS), a position he has held for 14 years and has over twenty years of experience in Behavioral Health Services. MCS has an annual budget of $25 million serving over 6,000 consumers in the Baltimore Metropolitan Area.

Mr. Richardson is a licensed psychotherapist and holds Master Degrees in Social Work from University of Maryland and Business Administration from Loyola College. He is also a Professor in the graduate program in Healthcare Studies at Towson University. He has been involved in nonprofits boards, state task forces, and academic positions to further support the cause of community mental health.

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 its 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
Herb Cromwell - Community Behavioral Health
Lori Doyle - Mosaic Community Services
Jeff Richardson - Commissioner
Frank Sullivan – MACSA
Michael Luginbill - MACSA
Theodore Giovanis - Commissioner (ex-officio)

Technical Advisory Group on DDA issues

Tracey DeShields – DHMH
Lynn Garrison - Commissioner
Alan Lovell - Commissioner
Arthur Gold - MACS
Dennis Kokoskie – DDA
Mona Vaidya – DBM
Audrey Waters - 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 2007 DDA Cost Reports

B-2 Wage Rate Survey of DDA providers–2007

B-3 The Financial Situation of Providers of Community Services Contracting with DDA, Fiscal Years 1997 through 2007

B-4 Mental Health Program Salary Survey–FY 2007

B-5 The Financial Situation of Providers of Community Services Contracting with MHA

B-6 Updates for MHA and DDA Rates

APPENDIX B-1

Analyses of FY 2007 DDA Cost Reports

Analyses of FY 2007 DDA Cost Reports

Executive Summary

Providers appear to be consistently incurring losses on day and supported employment programs. These losses may be due to increased transportation costs. Residential services generally operated at a slim positive margin in 2003 and 2006, and a slim negative margin in 2004, 2005 and 2007. Community Supported Living Arrangements (CSLA) services were generally profitable in 2007, as was the case in prior years. It should be noted that these results are in aggregate, and that individual providers may be losing money on a service when the aggregate result is a profit, and vice versa.

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 111 Cost Reports for fiscal year 2007 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 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.

Table 1: Summary statistics, fiscal year 2007

	CSLA	Residential	Day	Employment
# of providers	64	86	60	63
Median Margin 2006	9.33%	0.54%	-0.20%	-5.20%
Median Margin 2007	7.65%	-0.97%	-2.67%	-4.43%
Median Cost/Day	$77.71	$204.40	$77.42	$66.51
Percentage of revenue	9%	61%	19%	11%

These data suggest that providers are profiting from the provision of CSLA services, and are generally losing money on supported employment services. These results are generally consistent with the results found for fiscal years 2002 through 2006. CSLA services were implemented relatively 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 9% 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 data reported the analysis of transportation costs was delayed. The quality of the transportation data did appear to be somewhat improved in the FY 2004 Cost Reports, although there were still some obvious problems. The survey forms and instructions were substantially revised for the FY 2005 survey to reduce any ambiguity as to what should be reported. The FY 2007 Cost Report used the same forms as the FY 2005 and 2006 Cost Reports. While the data have improved over time, there are clearly inconsistencies in the ways in which the transportation cost data are being reported, so the results presented below should be interpreted with caution.

The following tables provide summaries of the transportation costs per day and per mile.

Table 2: Transportation cost per client per day

	Day	Supported Employment	CSLA	Residential
Median FY 2006	$11.99	$8.94	$2.92	$6.77
Median FY 2007	$11.85	$9.11	$3.51	$7.09

Table 3: Transportation cost per mile

	Day	Supported Employment	CSLA	Residential
Median FY 2006	$1.58	$1.02	$0.72	$0.61
Median FY 2007	$1.71	$0.92	$0.72	$0.73

Caveats and comments

Transportation costs may be an issue for day and supported employment services. For residential services providers, the transportation requirements are smaller, and more varied in their nature, with transportation of residential clients to day programs generally being provided by the day program.

The data still show substantial variation between providers in the costs. By reporting medians the impact of these variations is reduced, but not eliminated. The Commission encourages DDA and the providers to try to improve the quality of the data reporting on transportation, and to continue to study the issue.

The capital cost for vehicles is based on depreciation. This underestimates the real cost in that it does not account for inflation. Also, many providers are likely to have vehicles that are fully depreciated so are not contributing any depreciation cost.

Conclusions

Providers appear to be incurring losses on day and employment programs. These losses may be due to increased transportation costs. Residential services operated at a slim positive margin in 2003 and 2006, and a slim negative margin in 2004, 2005 and 2007. CSLA services were generally profitable. Even in services in which the median margin is positive there are still a substantial number of providers with negative margins, and conversely for services in which the median margin is negative.

APPENDIX B-2

Direct-Support Worker Wage Rates of DDA Providers
Fiscal Year 2007

Direct-Support Worker Wage Rates of DDA Providers– Fiscal Year 2007

Executive Summary

The results reported in this paper are based on wage surveys of providers contracting with DDA. The data on wages were for the entire fiscal year 2007, as well as from pay period and annual surveys from prior years. The data reported have been checked by DDA and CSRRC staff. In addition, the providers have been required, since 2004, to have the data attested to by their independent auditors.

The mean wage rates of Direct-Support Workers increased by 4.1% from FY 2006 to FY 2007. The mean wage rates of First-line supervisors increased by 4.2% from FY 2006 to FY 2007[10]. However, the mean wages of community Direct-support workers, at $11.42 per hour, are still about **4.7% below** the $11.95 per hour paid to the corresponding state Direct-support workers, and more when fringe benefits are taken into account.

DDA reports that the weighted average fringe benefit percentage has increased steadily over the period 2003 through 2006, and this survey shows little change between 2006 and 2007 in the percentage of fringe benefits, although the dollar amount increased by $8.8 million. The amounts paid as bonuses were basically unchanged between 2004 and 2005, but the amount paid in bonuses decreased by about 50% in 2006, then increased in 2007.

The turnover rate for Direct-support employees was 29% and that for First-line supervisors was 20% in 2007.

[10] The wage equalization initiative was not intended to fund wage increases for first line supervisors.

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. Surveys were sent to 120 providers and 110 of these providers responded to the FY 2007 survey.

Annual Wage Surveys are due December 1 following the end of the fiscal year. These Annual Wage Surveys have replaced the February pay period surveys that were used through 2006.

This paper reports the results and conclusions from the FY 2007 Annual wage survey, and provides data on trends in the wage rates, fringe benefit percentages, staff turnover rates, and vacancy rates.

Design and testing of the survey instrument

The first step in the design of the survey instrument was a review of survey instruments previously used to collect data from these providers. The design of the survey instrument was done in conjunction with the Technical Advisory Group on DDA issues, who reviewed the instrument, provided input on the types of data available and nomenclature, and suggested changes. The instrument used in FY 2000 had been field tested by two providers, and modified based on their input prior to its use. Based on the response to that survey, and the FY 2001 survey, additional minor changes were made to the FY 2002 survey form. The survey forms used for FY 2003 were expanded to include more detail on fringe benefits and bonuses. The survey, without the fringe benefit form, and with some minor editorial changes was used again in FY 2004. For FY 2005 the survey form was simplified by combining Aides and Service Workers into a Direct-Support Worker category and the same form was used for FY 2006 and FY 2007. Prior to the due date for the FY 2005 survey three educational sessions were provided to instruct providers on the purposes of the survey and how the forms should be completed.

The Annual Wage Survey form was based on the survey instrument used for the pay period survey, but was somewhat simplified, as the reporting of base and overtime wages and hours were combined.

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. Starting in 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. This requirement has resulted in some corrections being filed when the auditors check the data. Data on bonuses and fringe benefits are also gathered in December.

Trends in full time hourly wages

The following table shows the trends in the hourly wage rate of full time Direct-support workers (excluding fringe benefits):

Wage category	Direct-Support Worker mean wage rate[11]	% increase from prior year
FY 2001	$8.96	
FY 2002	$9.31	3.9%
FY 2003	$9.69	4.1%
FY 2004	$9.75	0.6%
FY 2005	$10.36[12]	6.3%
FY 2006	$10.97[13]	5.9%
FY 2007	$11.42	4.1%
Change from 2001-2007	$2.37	27.5%

The mean wages of drivers increased from $10.84 in 2006 to $11.46 in 2007, an increase of 5.7%.

The mean wages of First line supervisors increased from $16.94 in 2006 to $17.65 in 2007, an increase of 4.2%.

State Direct-support workers received wage increases from 2001 to 2006 of about 10.8%. In comparison the Direct-support workers in community providers received 27.5% in wage increases over the period 2001 to 2007. However, the mean wages of community Direct-support workers, at $11.42 per hour, are still about **4.7% below** the $11.95 per hour paid to the corresponding state Direct-support workers, and more when fringe benefits are taken into account.

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.

[11] The wage rate reported here is the weighted mean wage, weighted by number of hours.
[12] The $10.36 was the result in both the pay period the Annual surveys conducted for FY 2005.
[13] The $10.97 result is from the Annual survey for FY 2006.

Staff turnover rates and tenure

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

	2004	**2005**	**2006**	**2007**
Direct Support Worker	38%	34%	27%	29%
First Line Supervisor	19%	18%	20%	20%

These turnover rates are substantially lower than the 50% rate experienced by the providers when this survey was started in the 1990s. The literature documents turnover rates nationally for providers of services to individuals with developmental disabilities from a low of 40% to over 75%. The general trend of reduction in turnover in Maryland may be due, in part, to the increase in the wage rates, but may also be influenced by the downturn in the economy and workforce development issues.

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

The average tenures of staff in each category were:

Job category	Average tenure 2004	Average tenure 2005	Average tenure 2006	Average tenure 2007
Direct-support worker	42 months	44 months	44 months	39 months
First-line supervisor	61 months	68 months	73 months	72 months

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 percentage reported is an overall percentage for all employees for the year, in contrast to the wage rate data reported here, which is for specific employee categories. The following table summarizes the weighted mean fringe benefits percentages calculated by DDA from the current and prior year surveys.

Fringe benefit percentage by fiscal year:

Fiscal Year	# providers	Weighted Mean FB %	Median FB %
2003[14]	108	19.5%	20.0%
2004	111	20.5%	19.2%
2005	112	21.2%	19.8%
2006	118	22.8%	20.1%
2007	110	22.2%	20.0%

The weighted mean fringe benefit percentage steadily increased over the period 2003 to 2006. The dollar amount of fringe benefits increased by $51.9 million between 2004 and 2006[15]. The 110 providers included reported that they had increased fringe benefits by $8.8M between FY 2006 and FY 2007.

DDA has calculated the current state fringe benefit percentage to be 35.5%. This is substantially higher than that of the providers.

In FY 2007, the two items comprising the largest proportions of fringe benefits were health insurance (43%) and the employer proportion of FICA(33%) . Retirement costs and retirement plan administration made up 12% of the total fringe benefit costs. Employees are contributing an additional 23% of the total fringe benefit costs as the employee portion of these costs.

Bonuses

In both 2004 and 2005 the amount reported as being paid in bonuses to Direct-support workers was $2.2 million. In 2006 bonuses amounted to $1.2 million and in 2007 to $1.4 million.

[14] Data for 2003 were not audited.
[15] 2004 was the first year in which the data were audited.

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, 2006 (i.e., for FY 2007) under the wage equalization initiative sufficient to increase direct support worker wage expenditures by 3.2%, and with an equal amount to increase fringe benefits. The increase in Direct-support worker wages measured in the Annual survey, at 4.1%, is greater than the rate increase that was provided by DDA[16].

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 2006 to 2007 the increases in direct-support wages, as measured in the Annual Survey, were similar in magnitude to the overall rate increase. The wage equalization initiative provides funds to allow providers to increase the wage rates of direct-support workers, with the intent of bringing these wages to the level of corresponding state Direct-support workers.

The main source of funds for the wage increase is the wage equalization funds that provided the rate increase.

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-support 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 mean wage rates of Direct-support workers increased by 4.1% from FY 2006 to FY 2007 in the Annual Wage Survey. The mean wage rates of First-line supervisors increased by 4.2%.

Bonuses remained constant in dollar terms between 2004 and 2005, but dropped in half in 2006 then increased in 2007.

[16] DDA calculated their rate increases as 3.7% for residential services, 3.4% for day and supported employment services, 4.1% for add-ons. The rate increase for CSLA was much smaller than these.

Fringe benefits increased by $8.8 million and remained relatively constant as a percentage of wages.

APPENDIX B-3

The Financial Situation of Providers of Community Services Contracting with DDA, Fiscal Years 1999 through 2007

The Financial Situation of Providers of Community Services Contrating with DDA, Fiscal Years 1999 through 2007

Executive Summary

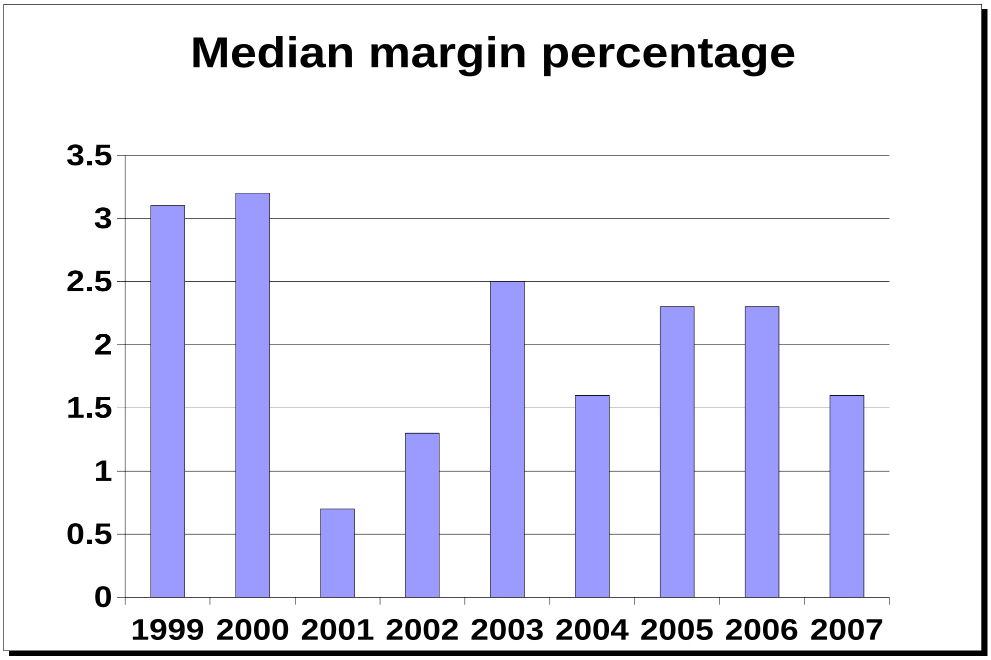
The ratios examined are in a reasonable range for fiscal years 1999 through 2007. These ratios indicate that fiscal years (FY) 1999 and 2000 were similar, but with a deterioration in FY 2001. The margins recovered slightly in 2002 and further in 2003, declined in 2004, but margins recovered in 2005 and 2006 to almost the 2003 level. **The indicators in Table 1, combined with the drop in the weighted mean margin, show a slightly weakening trend in the financial condition of the providers from 2005 to 2006 with further deterioration to 2007.**

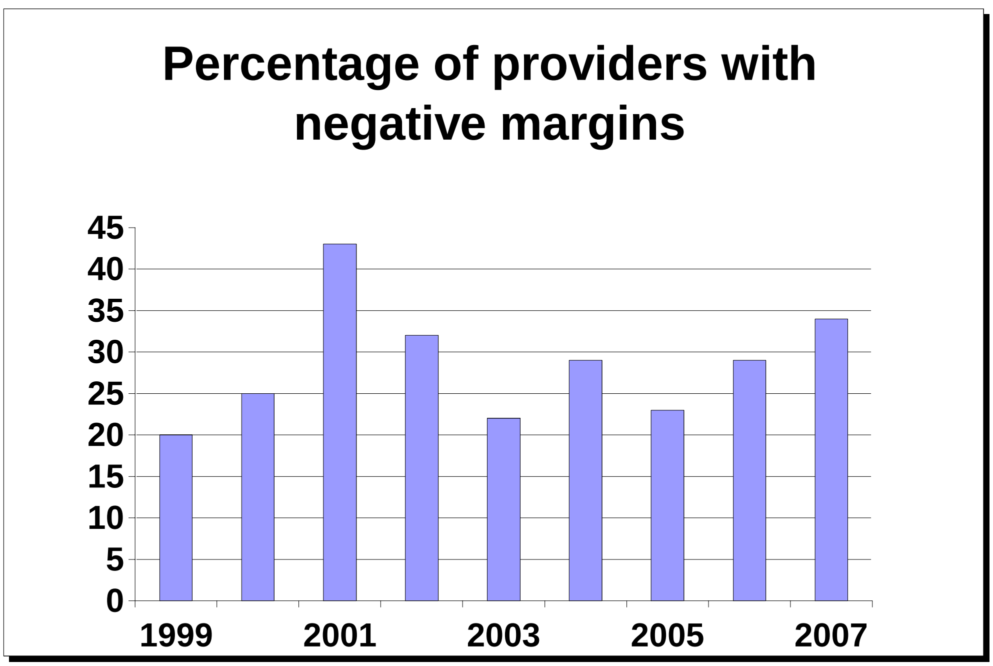
Table 1	1999	2000	2001	2002	2003	2004	2005	2006	2007
% with negative margins	20%	25%	43%	32%	22%	29%	23%	29%	34%
Median margin	3.1%	3.2%	0.7%	1.3%	2.5%	1.6%	2.3%	2.3%	1.6%
Median current ratio	1.9	1.4	1.8	1.7	1.8	1.7	1.7	1.4	1.4
Number with negative net assets	3	2	7	3	3	6	5	5	9
% with current ratio < 1	23%	26%	31%	28%	20%	24%	27%	27%	30%

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

Margins declined slightly from 2005 to 2006 and then more to 2007, and the percentage of providers with negative margins increased, suggesting a deterioration in the overall financial situation of the providers.

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 2005 2006 2007


Percentage of providers with negative margins
45
40
35
30
25
20
15
10
5
0
1999 2001 2003 2005 2007

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 2007.

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 several 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.

2. Data sources

The data used for this analysis were extracted from the fiscal year 1999 through 2007 Audited Financial Reports.

Table 2: Number of reports included in the analysis

Year	1999	2000	2001	2002	2003	2004	2005	2006	2007
No. of reports	84	89	94	103	104	106	102	100	102

Providers are required by regulation to provide their Audited Financial Reports. Usable financial reports from 102 providers were available for FY 2007 out of a total possible of about 120. Of the 102 providers used for the 2007 analysis, 38 were from the Central Region, 18 from the Eastern Region, 27 from the Southern Region, and 19 from the Western Region.

The following data fields were extracted from the fiscal year 2007 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 Community Supported Living Arrangements (CSLA), Fee Payment System (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.

Most providers are on the accrual basis of accounting for their financial records, which recognizes revenues and expenses as they occur throughout the reporting period. This is different from the relative levels of cash providers have, which is influenced by the increases or decreases in accounts receivable and accounts payable. Implicitly, the provider's cash position is affected by its payor mix and how quickly its largest payor is billed by the provider and in turn how quickly the payor pays those bills. Accordingly, both profit margin and cash position are important determinants of a provider's financial position.

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, 1.6% in FY 2004, 1.9% in FY 2005, 1.5% in FY 2006, and 1.0% in FY 2007. The mean, median, and spread of the margins are shown in Table 3. The margins (as well as the other ratios examined) in 1999, 2000, and 2001 could have been affected by the phase-in of the FPS, which was completed in FY 2001.

Table 3: Profit Margins	**1999**	**2000**[17]	**2001**[1,18]	**2002**[1]	**2003**[1]	**2004**[1]	**2005**[1]	**2006**[1]	**2007**[1]
75th percentile[19]	8.3%	8.1%	3.9%	5.6%	6.7%	4.6%	5.2%	4.7%	4.6%
50th percentile (Median)	3.1%	3.2%	0.7%	1.3%	2.5%	1.6%	2.3%	2.3%	1.6%
25th percentile	0.0%	0.0%	-2.8%	-1.5%	0.1%	-0.3%	0.0%	-0.5%	-0.8%
Mean	3.2%	3.5%	0.4%	1.8%	2.5%	1.6%	1.9%	1.5%	1.0%

Of the providers of community services included in this study for FY 2007, 35 of the 102 had negative margins in FY 2007 (i.e., 34%). For each of the years the margins were not statistically

[17] Mean margin weighted by DDA payments.

[18] 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.

[19] 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.

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 through 2007) for the providers located in the 4 DDA regions of the state for FYs 1999 through 2007* and Table 3B shows the median profit margins[20] for 1999 through 2007.

* In FY 2007 contributions made up 2.9% 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 3A: Mean profit margin by region	**1999**	**2000[21]**	**2001[5]**	**2002[5]**	**2003[5]**	**2004[5]**	**2005[5]**	**2006[5]**	**2007[5]**
Central (Baltimore & area)	3.0%	2.0%	0.3%	1.6%	1.3%	0.2%	1.1%	-0.2%	0.7%
East (Eastern Shore)	8.2%	5.5%	-0.5%	2.5%	6.2%	4.5%	2.6%	3.0%	4.4%
South (Washington suburbs & Southern tri-county area)	2.3%	5.2%	1.2%	2.9%	4.0%	2.9%	2.7%	2.7%	2.0%
West (Western Maryland)	3.2%	3.5%	-1.3%	-0.2%	1.1%	1.0%	2.3%	2.6%	1.8%
State	3.2%	3.5%	0.4%	1.8%	2.5%	1.6%	1.9%	1.5%	1.0%

[20] 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.

[21] Weighted by DDA payments.

Table 3B: Median profit margin by region	1999	2000	2001	2002	2003	2004	2005	2006	2007
Central (Baltimore & area)	2.9%	1.4%	0.2%	1.3%	2.5%	1.1%	2.2%	2.0%	0.1%
East (Eastern Shore)	6.7%	3.6%	0.0%	1.6%	6.7%	3.5%	2.8%	4.4%	4.6%
South (Washington suburbs & Southern tri-county area)	2.5%	6.2%	2.7%	1.2%	1.1%	3.1%	1.7%	1.8%	3.6%
West (Western Maryland)	2.6%	2.2%	-0.3%	-0.8%	2.2%	0.8%	3.7%	2.8%	2.9%
State	3.1%	3.2%	0.7%	1.3%	2.5%	1.6%	2.3%	2.3%	1.6%

Table 3C: Profit margin percentiles by region, FY 2007	25th percentile	50th percentile (Median)	75% percentile	Number of providers
Central (Baltimore & area)	-2.3%	0.1%	3.8%	38
East (Eastern Shore)	-2.4%	4.6%	7.9%	18
South (Washington suburbs & Southern tri-county area)	-0.4%	3.6%	5.4%	27
West (Western Maryland)	0.5%	2.9%	5.0%	19
State	-0.8%	1.6%	4.6%	102

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	1999	2000	2001	2002	2003	2004	2005	2006	2007
75th percentile	3.4	3.1	3.5	3.3	3.1	3.3	3.2	2.6	2.6
50th percentile (Median)	1.9	1.4	1.8	1.7	1.8	1.7	1.7	1.4	1.4
25th percentile	1.0	1.0	0.9	0.9	1.1	1.0	0.9	1.0	0.9

The providers of community services reporting to DDA experienced an increase in their current ratio from 1997 to 1999, a drop in 2000, and a recovery in 2001 that was stable through 2005, but with a drop in 2006.

FY 2006 median current ratio by region:

Table 4A: Current ratio	Central	East	South	West
Median	1.1	2.9	1.4	2.0

4.4 Days in cash and investments

Cash and investments are closely related to the current ratio. They represent money that is available to the provider in the short term. Cash and investments represented 25% of the total expenses. The cash and investments, thus, represent 91 days of expenses in FY 2007. 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.

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 10% of the total revenues (down from 12% the previous year, and the same as the 10% in the year before that), so providers had, on average, 36 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 0.3% of the total revenues, down from 0.4% the previous year. The low level of bad debt is understandable given the nature of the services provided and the fact that the State is the major payer for these services.

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, 6 had negative net assets in 2004, 5 in 2005 and 2006, and 9 in 2007. The providers with negative net assets in FY 2007 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-4

Mental Health Program Salary Survey
FY 2007

Wage Survey of Community Mental Health Providers

Executive Summary

The Community Services Reimbursement Rate Commission (CSRRC) has a responsibility to report on the wage rates of community providers of mental health services. Two wage survey forms were prepared, one for Outpatient Mental Health Clinics (OMHC) and one for Psychiatric Rehabilitation Providers (PRP), based on the survey forms that had been used by CBH, but adding some additional data elements. MHA posted these forms on its website. The first of these surveys was required by April 1, 2008 and requested data for FY 2007. This report summarizes the results of the wage surveys that were returned in response to the regulation.

Outpatient Mental Health Clinic Wage Rates and Tenure

Position	Current salary – no fringe	Current salary – with fringe	Average tenure – in years	Fringe benefit %[22]
Psychiatrist – Adult	$148,115	$163,173	4.9	16%
Psychiatrist – Child	$153,212	$175,949	2.4	7%
Psychologist	$64,163	$81,259	7.2	21%
Nurse Psychotherapist	$60,791	$70,687	6.5	24%
Social Worker – LCSW-c	$42,865	$47,318	5.4	21%
Professional Counselor	$43,504	$48,924	4.8	15%

[22] For some providers and positions the workers are paid under a contract or on a fee-for-service basis, and no fringe benefits are provided. This can distort the fringe benefit numbers, and, in particular, is the reason the fringe benefits for child psychiatrists are so low.

Psychiatric Rehabilitation Provider Wage Rates and Tenure

Position	Current salary – no fringe	Current salary – with fringe	Average tenure – in years	Calculated fringe %
Program Manager/Director	$56,564	$66,033	5.6	16%
Senior Supervisor	$38,228	$46,647	4.0	17%
Rehabilitation Counselor/Specialist	$25,954	$31,287	0.3	21%

Introduction

The Community Services Reimbursement Rate Commission has a responsibility to report on the wage rates of community providers of mental health services. In prior years this responsibility was met using wage surveys provided by members of the Community Behavioral Health Association of Maryland (CBH). While the Commission is grateful for the data supplied by CBH, this did not provide as complete and representative selection of providers as would have been desired. In 2008 the Mental Hygiene Administration (MHA) published regulations requiring that community mental health providers contracting with MHA submit wage surveys annually. Two wage survey forms were prepared, one for Outpatient Mental Health Clinics (OMHC) and one for Psychiatric Rehabilitation Providers (PRP), based on the survey forms that had been used by CBH, but adding some additional data elements. MHA posted these forms on its website. The first of these surveys was required by April 1, 2008 and requested data for FY 2007. This report summarizes the results of the wage surveys that were returned in response to the regulation.

Data collection form

The OMHC form requested data for the following positions:

Executive Director*
Medical Director*
Clinical Director*
Psychiatrist – Adult
Psychiatrist – Child
Psychologist
Nurse psychotherapist
Social Worker – LCSW-c
Professional Counselor
Other

The PRP form requested data for the following positions:

Executive Director*
Chief Financial Officer*
Chief Operating Officer*
Program Manager/Director
Senior Supervisor
Rehabilitation Counselor/specialist

*The MHA regulations specify the reporting of administrative positions as well as direct care positions. However, since the Commission is concerned about the wage rates of personnel providing services, as opposed to administrative salaries, this report does not include the administrative positions.

The fields that were requested for each position were:

Number of Full Time Equivalent personnel (FTE)
Average tenure
Current Salary with no fringe benefits
Salary range minimum
Salary range maximum
Fringe benefit percentage
Current salary including fringe benefits
Number of employees
Number of terminations
Number of days any position was vacant

OMHC results

The following results are based on 39 surveys.

Outpatient Mental Health Clinic Wage Rates and Tenure

Position	Current salary – no fringe	Current salary – with fringe	Average tenure – in years	Fringe benefit %[23]
Psychiatrist – Adult	$148,115	$163,173	4.9	16%
Psychiatrist – Child	$153,212	$175,949	2.4	7%
Psychologist	$64,163	$81,259	7.2	21%
Nurse Psychotherapist	$60,791	$70,687	6.5	24%
Social Worker – LCSW-c	$42,865	$47,318	5.4	21%
Professional Counselor	$43,504	$48,924	4.8	15%

The MHA wage survey requested the minimum of the salary range and the maximum of the salary range for each position, without fringe benefits. However, this field was not completed by some providers. The following tables present the medians of the minimum and maximum salaries reported. In other words, the median minimum salary is the minimum salary which lies in the middle of the minimum salaries reported by the providers that reported this field.

Position	**Median Minimum Salary**	**Median Maximum Salary**
Psychiatrist: adult	$110,100	$167,800
Psychiatrist: child	$137,500	$181,700
Psychologist	$48,900	$70,000
Nurse psychotherapist	$47,750	$67,900
Social worker LCSW-c	$37,850	$56,750
Professional counselor	$35,000	$45,400

[23] For some providers and positions the workers are paid under a contract or on a fee-for-service basis, and no fringe benefits are provided. This can distort the fringe benefit numbers, and, in particular, is the reason the fringe benefits for child psychiatrists are so low.

PRP results

The following results were based on 37 surveys.

Psychiatric Rehabilitation Provider Wage Rates and Tenure

Position	Current salary – no fringe	Current salary – with fringe	Average tenure – in years	Calculated fringe %
Program Manager/Director	$56,564	$66,033	5.6	16%
Senior Supervisor	$38,228	$46,647	4.0	17%
Rehabilitation Counselor/Specialist	$25,954	$31,287	0.3	21%

The MHA wage survey requested the minimum of the salary range and the maximum of the salary range for each position, without fringe benefits. However, this field was not completed by some providers. The following tables present the medians of the minimum and maximum salaries reported. In other words, the median minimum salary is the minimum salary which lies in the middle of the minimum salaries reported by the providers that reported this field.

Position	**Median Minimum Salary**	**Median Maximum Salary**
Program Manager/Director	$48,000	$67,700
Senior Supervisor	$31,250	$45,150
Rehabilitation Counselor/Specialist	$20,850	$34,000

Data qualifications and proposed changes

The data provided on number of terminations and the number of days any position was vacant was too sparse to allow for any meaningful analysis. This field should be dropped from future surveys.

The forms were intended to collect the total current wages for each position, with and without fringe benefits. However, many providers gave the average current salary, with and without fringe benefits. This could be ascertained by comparing the actual salary with the salary range, so corrections were made to make the reporting consistent. In future years the instructions should be changed to request the average current salaries, since this is what most providers gave.

There were some minor formatting problems with the forms, which should be corrected in the versions issued for the FY 2008 salary survey.

Several providers asked whether Social Worker – LGSW should be included with Social Worker LCSW. They were told to group the two categories. The instructions should be changed to reflect this.

Several providers gave hourly wages for some positions. These were converted to annual figures using 2,080 hours per FTE.

APPENDIX B-5

The Financial Situation of Providers of Community Services Contracting with MHA, Fiscal Years 1999 through 2007

The Financial Situation of Providers of Community Services Contracting with MHA, Fiscal Years 1999 through 2007

Executive Summary

The financial condition of the providers of community services contracting with MHA generally deteriorated from 2005 to 2006, with a drop in the median margin and an increase in the proportion of providers losing money, but this trend reversed in 2007 to about the 2005 levels.

Bad debts represent 2.4% 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 sample of providers, so may not provide a complete picture of the financial condition of the providers of mental health services. Also, the set of providers included for 2007 was larger than that used in previous years.

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 2007 in response to this 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 2007 Audited Financial Reports. Up through 2006 these reports were all provided by the Community Behavioral Health Association of Maryland (CBH). For 2007 reports were received from CBH and also from MHA. The following table 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, but a substantial proportion of the total revenue of the mental health system, since the providers included in the analysis tend to be the larger ones. However, the analysis does not produce a complete picture of the financial condition of the providers.

Year	1999	2000	2001	2002	2003	2004	2005	2006	2007
No. of reports	19	48	47	33	30	31	34	32	48

The following data fields were extracted from the fiscal year 2007 Financial Reports (definitions of the terms is included in Attachment 1) where they were available, but for 6 providers only the revenues and expenses were available.

Total expenses
Total revenues
Current assets
Total assets
Current liabilities
Long term liabilities
Total liabilities
Contributions
Cash and investments
Receivables
Bad debts

Most providers are on the accrual basis of accounting for their financial records, which recognizes revenues and expenses as they occur throughout the reporting period. This is different from the relative levels of cash providers have, which is influenced by the increases or decreases in accounts receivable and accounts payable. Implicitly, the provider's cash position is affected by its payor mix and how quickly its largest payor is billed by the provider and in turn how quickly the payor pays those bills. Accordingly, both profit margin and cash position are important determinants of a provider's financial position.

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

Most providers are on the accrual basis of accounting for their financial records, which recognizes revenues and expenses as they occur throughout the reporting period. This is different from the relative levels of cash providers have, which is influenced by the increases or decreases in accounts receivable and accounts payable. Implicitly, the provider's cash position is affected by its payor mix and how quickly its largest payor is billed by the provider and in turn how quickly the payor pays those bills. Accordingly, both profit margin and cash position are important determinants of a provider's financial position.

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	1999	2000	2001	2002	2003	2004	2005	2006	2007
Highest	14.3%	34%	26.7%	24.2%	20.4%	28.1%	15.0%	24.8%	26.1%
Median	3.2%	4.5%	4.5%	1.1%	2.5%	2.0%	2.5%	1.4%	2.5%
Lowest	-11.4%	-5.0%	-8.1%	-9.1%	-8.3%	-14.8%	-11.9%	-20.0%	-18.7%
Mean (wgted)	5.3%	6.0%	5.2%	2.3%	2.9%	2.1%	2.6%	5.4%[24]	3.5%[25]

Of the providers of community services included in this analysis for FY 2007, 12 of the 48 had negative margins (i.e., 25%). Chart 1 shows that the losses tend to be concentrated in the smaller providers, although a couple of larger providers had substantial losses in 2007. A majority of the providers with losses operated Outpatient Mental Health Clinics.

For comparison purposes, a similar analysis of providers contracting with DDA showed a median margin of 1.6% and a weighted mean margin of 1.0%. The Health Services Cost Review Commission in their Financial Disclosure Reports dated September 10, 2008 and July 18, 2007 reported that hospital profits in Maryland were 5.2% for fiscal year 2007, 4.5% for fiscal year 2006, and 4% for fiscal year 2005.

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. It is an indicator of 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.

[24] The mean in 2006 was heavily influenced by 2 large providers with substantial margins.
[25] The weighted mean margin would be lower if 2 outliers in terms of margin were to be removed from the data.

Table 2: Current ratio	1999	2000	2001	2002	2003	2004	2005	2006	2007
Highest	8.5	37	35	11	13	17.6	20	38	39
Median	1.6	2.0	2.4	2.1	2.1	2.8	2.6	2.7	2.5
Lowest	0.6	0.01	0.04	0.3	0.4	0.6	0.5	0.6	0.2

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 22% of the total expenses. The cash available, thus, represents 81 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 can fluctuate from year to year, with changes in the stock market and 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	2005	2006	2007
Percentage of expenses	7%	9%	7%	12%	25%	19%	17%	22%	22%

While this table suggests a substantial improvement in the cash position of the providers in FY 2006, holding steady to 2007, it should be interpreted cautiously. The set of providers included in the analysis changes between years, and some of the reports do not allow for the identification of cash and investments. Also, our ability to identify all cash and investments in the audited financial reports has improved over time.

Receivables comprised 8.4% of the total revenues, so providers had, on average, 31 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, 1 in 2004, 1 in 2005, none in 2006, and 1 in 2007.

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	2005	2006	2007
Bad debt %	1.3%	1.2%	2.0%	2.4%	1.8%	3.0%	3.4%	1.7%	2.4%

4.6 Contributions

Contributions were 3.9% of the revenues of the providers, but this relatively high number was mainly due to a couple of providers with high levels of contributions.

Year	1999	2000	2001	2002	2003	2004	2005	2006	2007
%	1.9%	1.5%	1.8%	2.0%	0.6%	0.8%	0.8%	1.5%	3.9%

5 Summary

The percentage of providers with negative margins decreased from 2006 to 2007. The pattern of change from 2006 to 2007 was mixed, possibly due to the larger number of providers included in the 2007 analysis. The best summary is that there was no substantial change in the financial position of the providers between 2006 and 2007.

	1999	2000	2001	2002	2003	2004	2005	2006	2007
% with negative margins	16%	21%	17%	33%	30%	35%	26%	31%	24%
Number with negative net assets	3	5	2	2	1	1	1	0	1
% with current ratio < 1	21%	17%	13%	22%	18%	11%	19%	6%	15%

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).

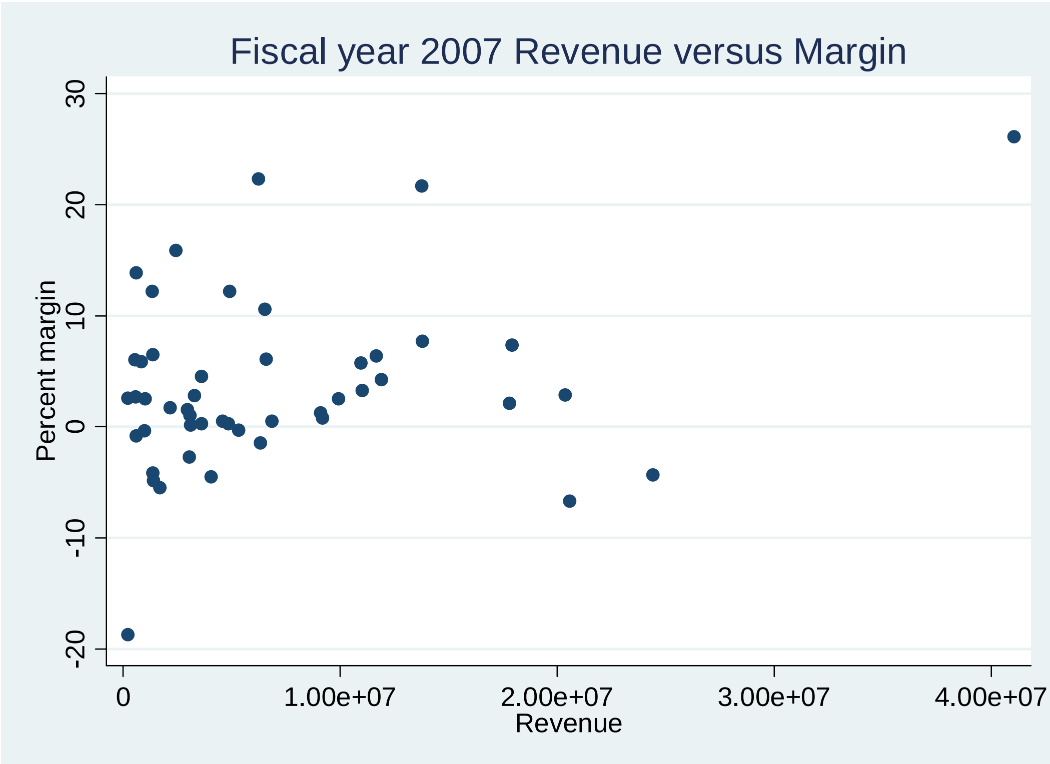
Current liabilities: Payment due from the provider in the near future. These include payables and current mortgage payments.

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.

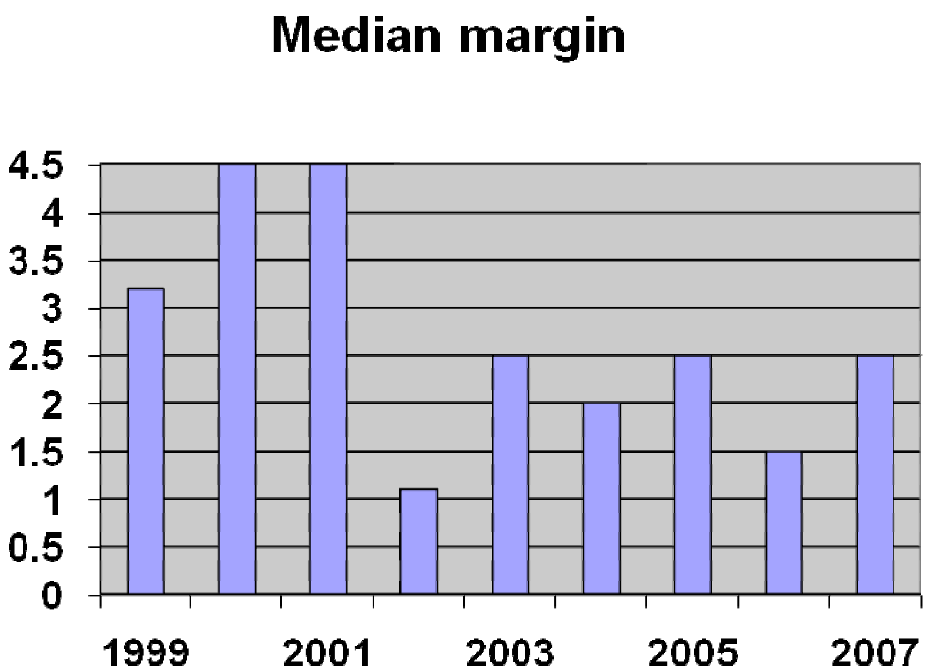
Total liabilities: The sum of the current and the long term liabilities.

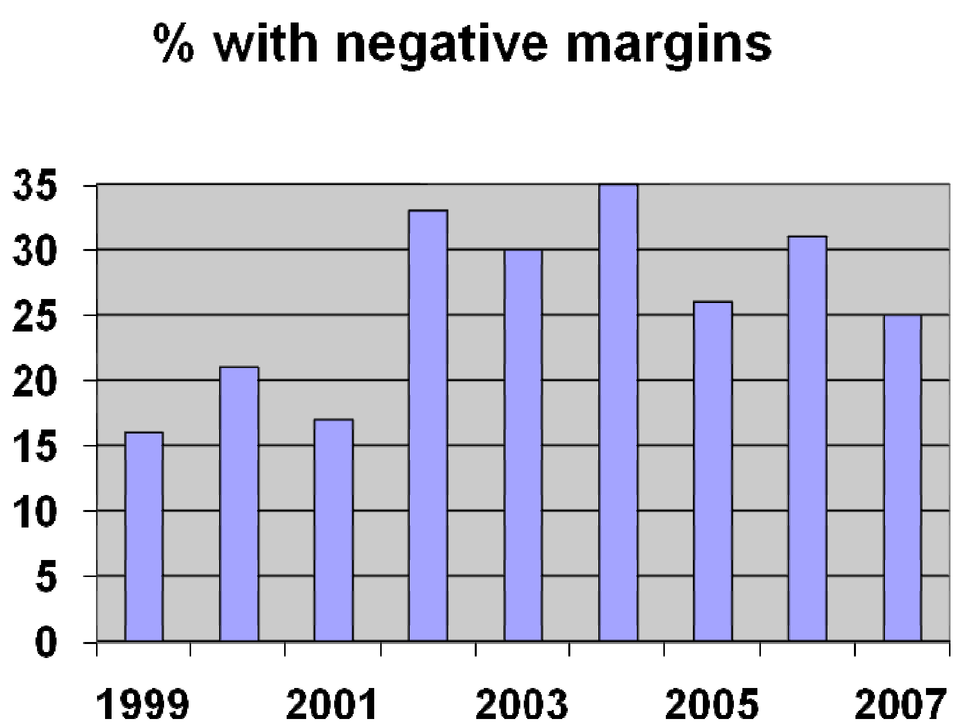
Bad debts: Bad debts are the costs associated with services provided to clients in the expectation of payment, but for which payment was not received. Bad debts do not include contractual allowances to third party payers, but do include the costs of unpaid copayments or deductibles.

Chart 1: Scatter plot of revenue versus margin



This chart illustrates that the smaller providers tend to have the largest spread in their margins, although a couple of larger providers had substantial losses in 2007.


Median margin
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
1999
2001
2003
2005
2007


% with negative margins
35
30
25
20
15
10
5
0
1999
2001
2003
2005
2007

APPENDIX B-6

Recommended update factors for FY 2010

Community Services Reimbursement Rate Commission
Recommended update factor for FY 2010

Date: September 9, 2008

The recommended updates factors for FY 2010 MHA and DDA rates have been calculated using the same methodology as was applied for the FY 2009 recommended update factor, i.e., the methodology adopted for MHA rates in September 2004, and adopted by the Commission for DDA rates last year, and used data from the Bureau of Labor Statistics for the year ending June 2008 for the Employment Cost Index and July 2008 for the CPI[26].

Recommended update factor for DDA and MHA rates:

80% of the increase in the Employment Cost Index for health[27], plus 20% of the increase in the Baltimore-Washington MSA CPI for all urban consumers[28]:

$$0.2 \times 4.70\% + 0.8 \times 3.3\% = 3.58\%$$

The recommended update factor for both MHA and DDA rates for FY 2010 is 3.58%.

Underfunding in previous years:

For FY 2009 the CSRRC recommended an update factor of 4.0%, but the actual increase provided was 1.5%, with an additional amount of up to 1.5% contingent upon the performance of the lottery. For FY 2008 the CSRRC recommended an update factor of 3.71% for MHA and 3.87% for DDA, and the actual increase provided was 2% for each.

[26] These were the most recent data available on August 22 when the data were retrieved from the www.bls.gov website.
[27] The BLS Series ID is: CIU1016200000000A (K)
[28] The BLS Series ID is: CUURA311SA0

APPENDIX C

Status of 2008 Recommendations

2008 Recommendations for DDA

1. Rates for fiscal year 2009 should be increased by a total of 5.87% to compensate for the impact of inflation on the costs of providers (4% for FY 2009), plus the 1.87% of the previously recommended update that was not funded for FY 2008. The major purpose of the update adjustment is to assure that such costs increases, as estimated by objective measures of inflation, are reflected in the rates of providers.

A rate update of 1.5% was provided effective July 1, 2008, plus an additional 0.5% based upon the performance of the lottery for a total increase of 2%.

2. The providers' costs are increased by regulations imposed by State agencies beyond those adopted by DDA. When a State agency proposes regulations that apply to providers paid by DDA that agency should be required to involve DDA in assessing the economic impact of the new regulations on the providers, and suggest how these costs should be covered.

The CSRRC enabling legislation passed in the 2008 session requires that the Board of Nursing inform the Commission whenever it promulgates regulations that would have an impact on the costs of providers. The Commission has written to the Board of Nursing to bring this requirement to their attention. DDA stated that it is in agreement with this recommendation.

2008 Recommendations for MHA

1. Rates for fiscal year 2009 should be increased by a total of 5.71% to compensate for the impact of inflation on the costs of providers (4% for FY 2009), plus the 1.71% of the previous recommended update that was not funded for FY 2008. The major purpose of the update adjustment is to assure that such cost increases, as estimated by objective measures of inflation, are reflected in the rates of providers.

A rate update of 1.5% was provided effective July 1, 2008, and an additional amount of 0.5% was provided based upon the performance of the lottery, for a total increase of 2%.

2. The providers' costs are increased by regulations imposed by State agencies beyond those adopted by MHA. When a State agency proposes regulations that apply to providers paid by MHA that agency should be required to involve MHA in assessing the economic impact of the new regulations on the providers, and suggest how these costs should be covered.

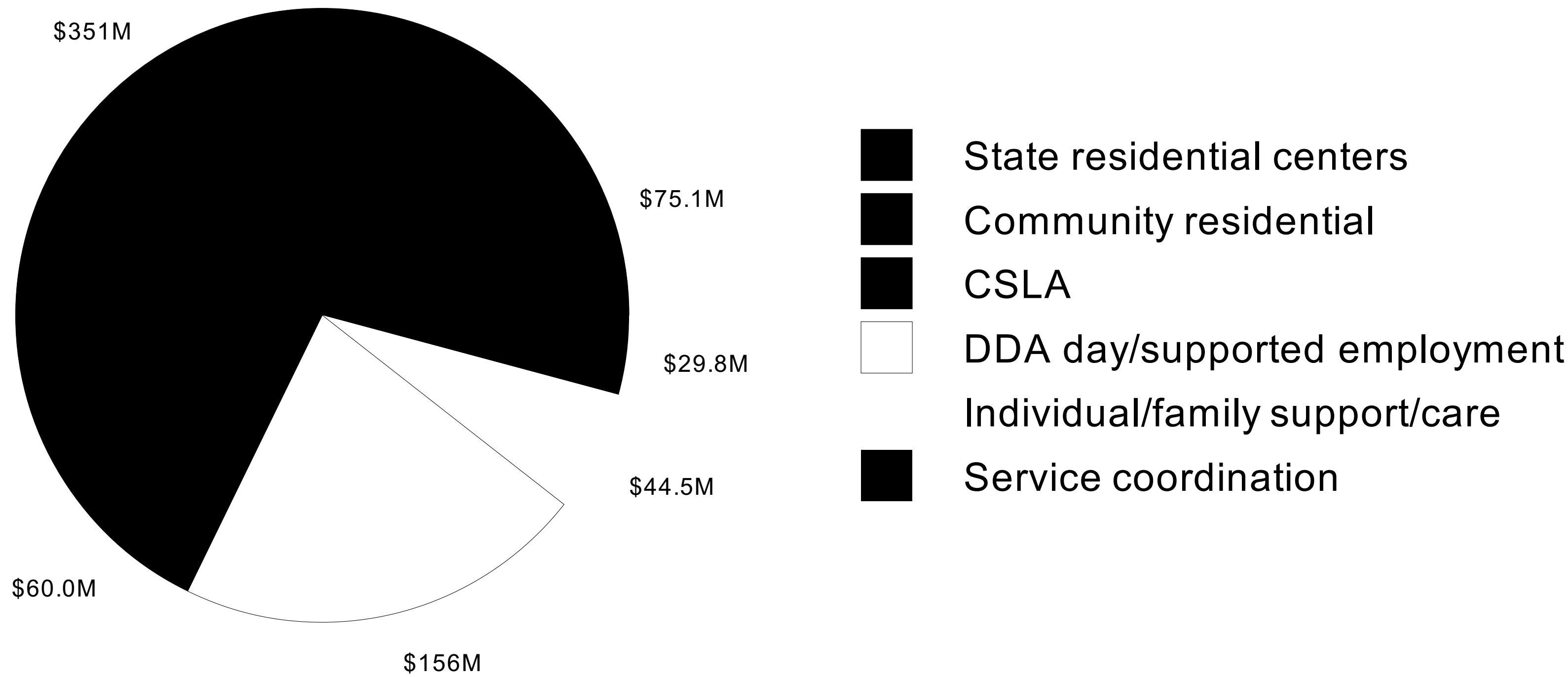
The CSRRC enabling legislation passed in the 2008 session requires that the Board of Nursing inform the Commission whenever it promulgates regulations that would have an impact on the costs of providers. The Commission has written to the Board of Nursing to bring this requirement to their attention.

Appendix D

Charts

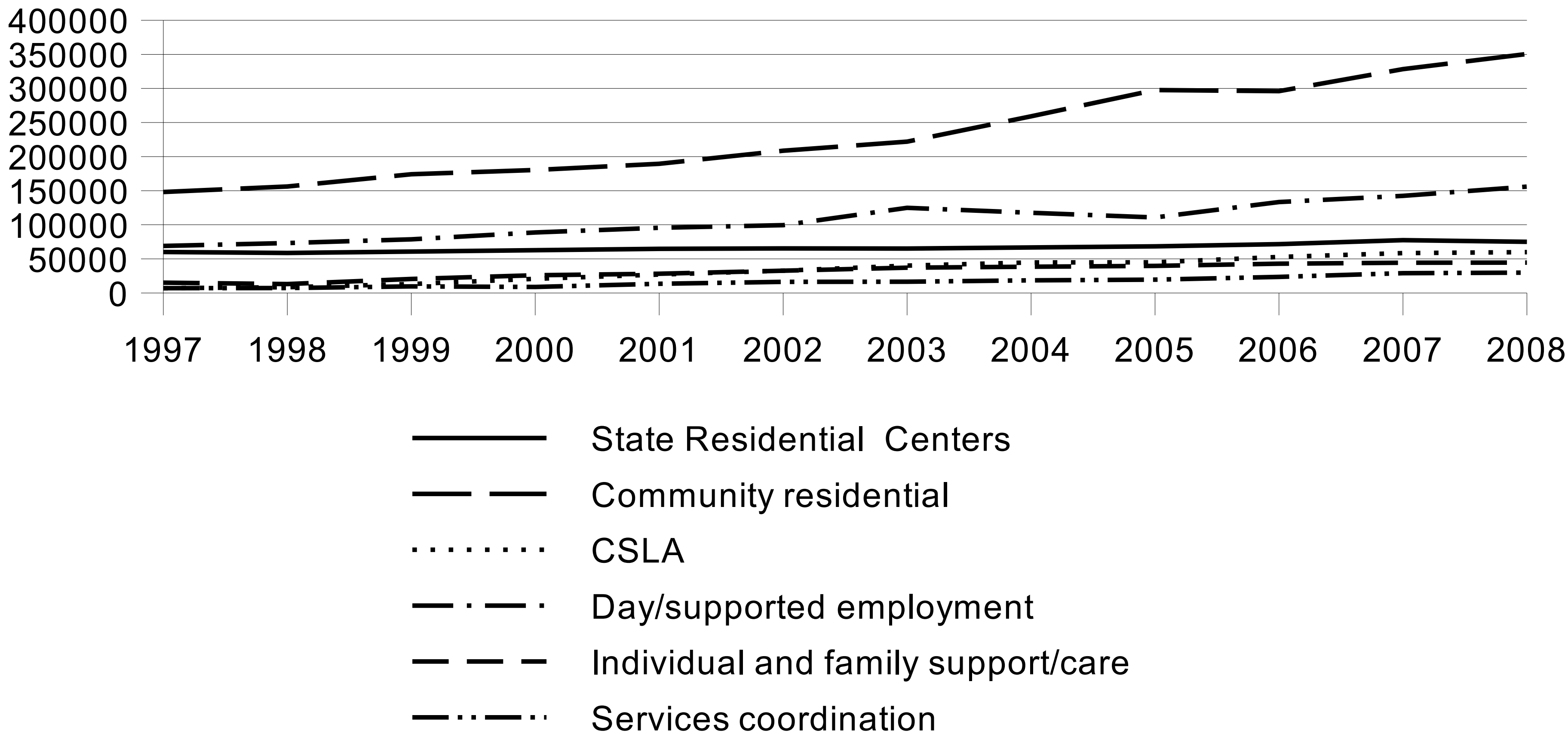
1. Distribution of DDA expenditures

Fiscal year 2008

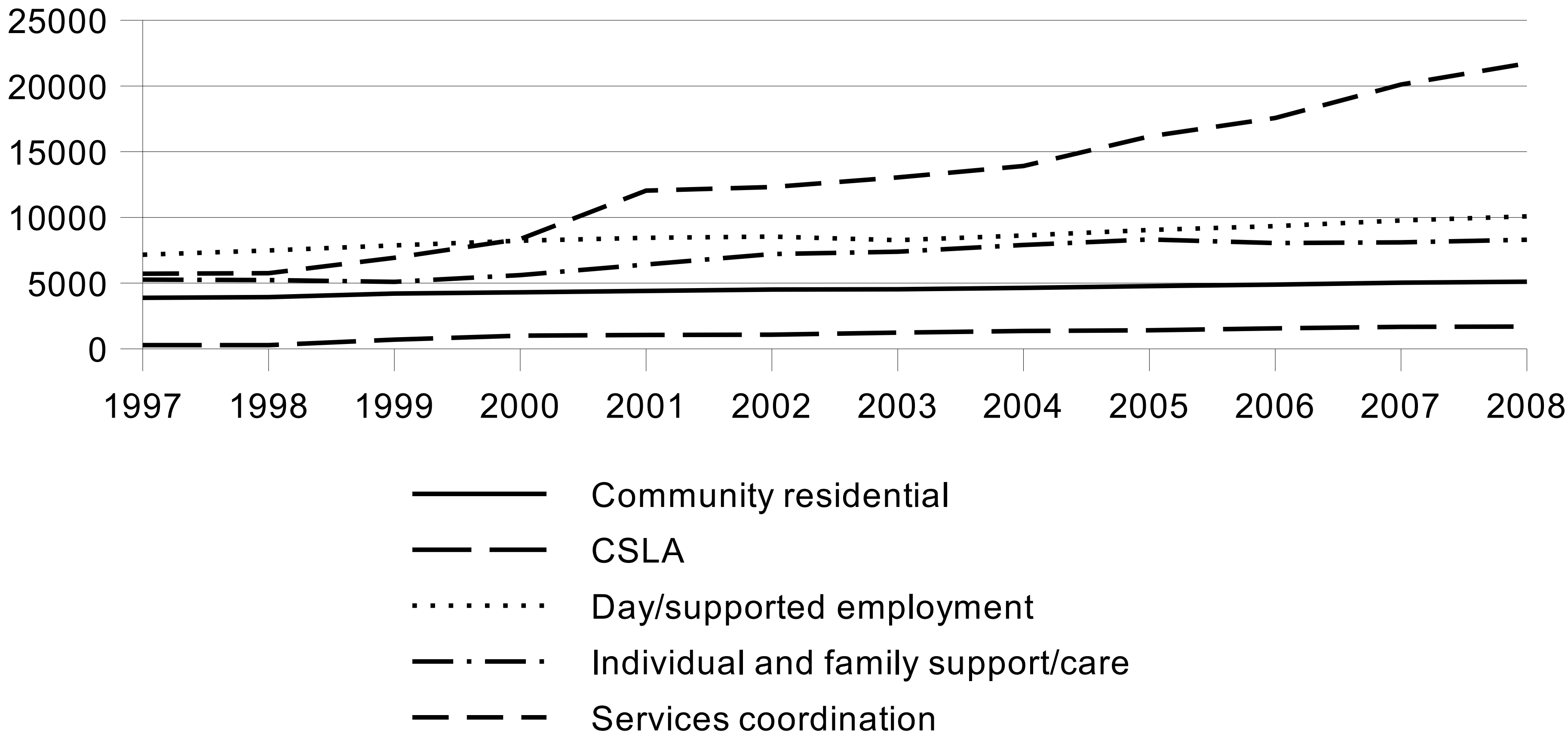


2. DDA Expenditures: FY 1997-2008

Amounts in thousands of $s.

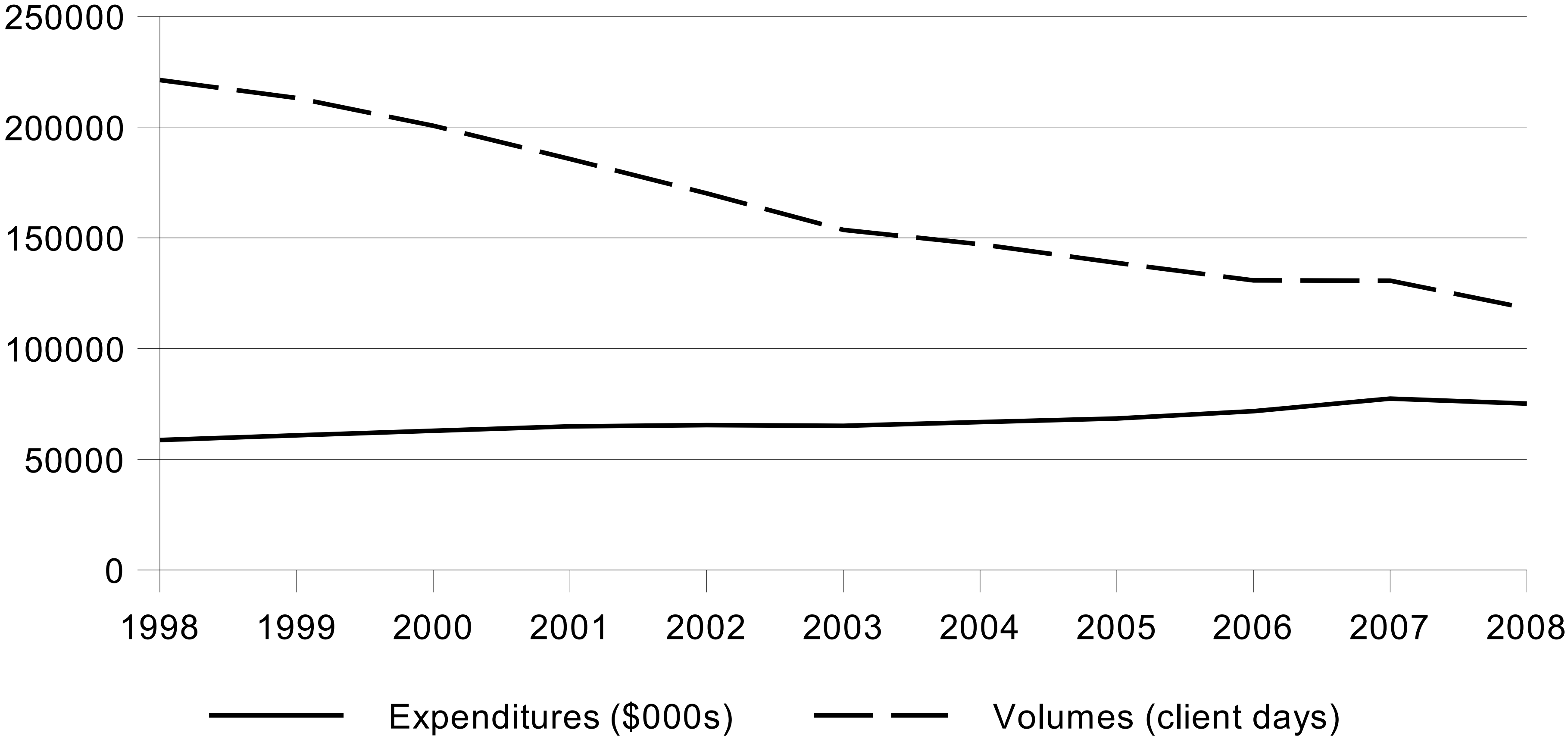


3. DDA: Community service volumes



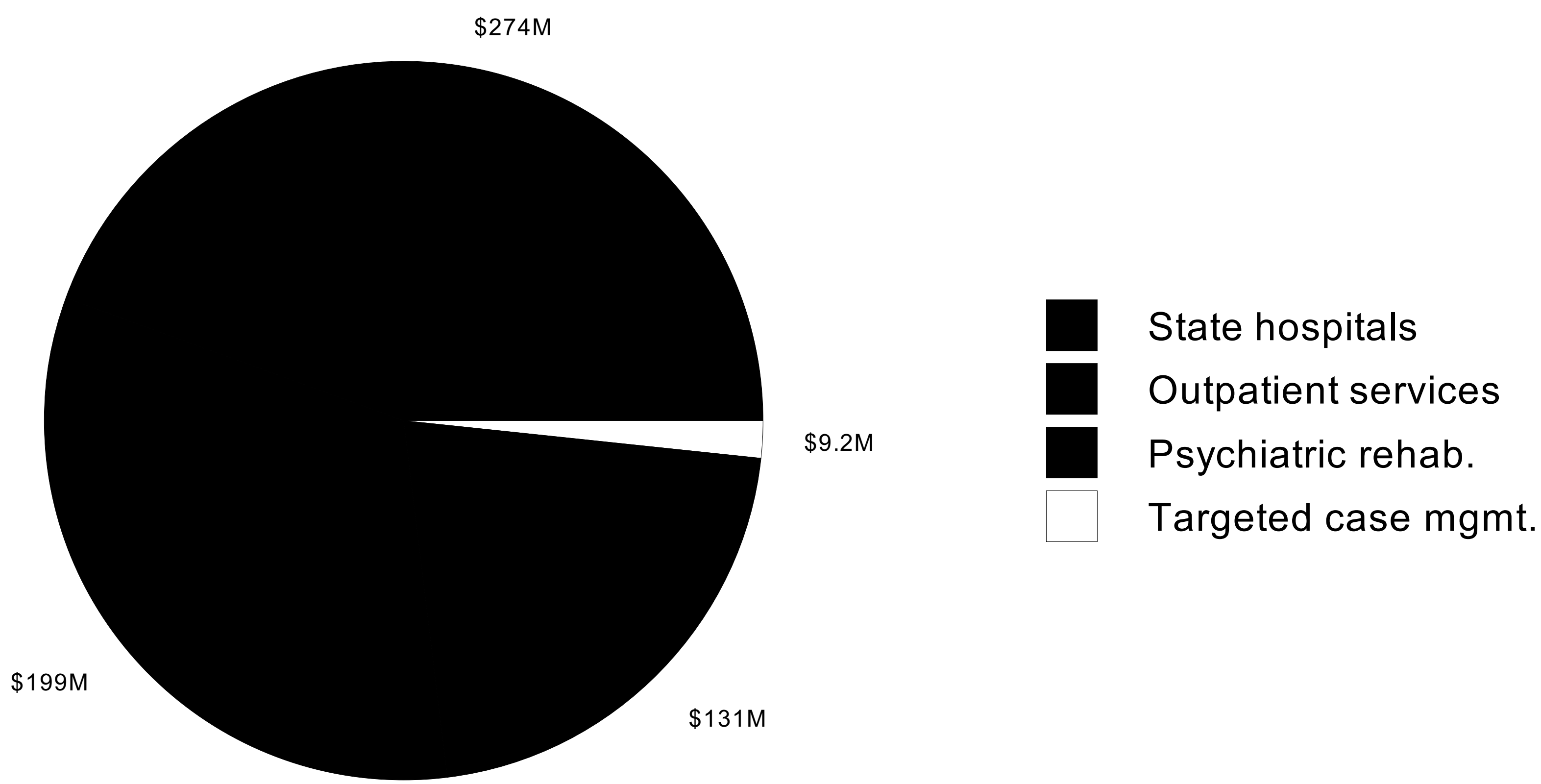
4. State Residential Centers: DDA

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



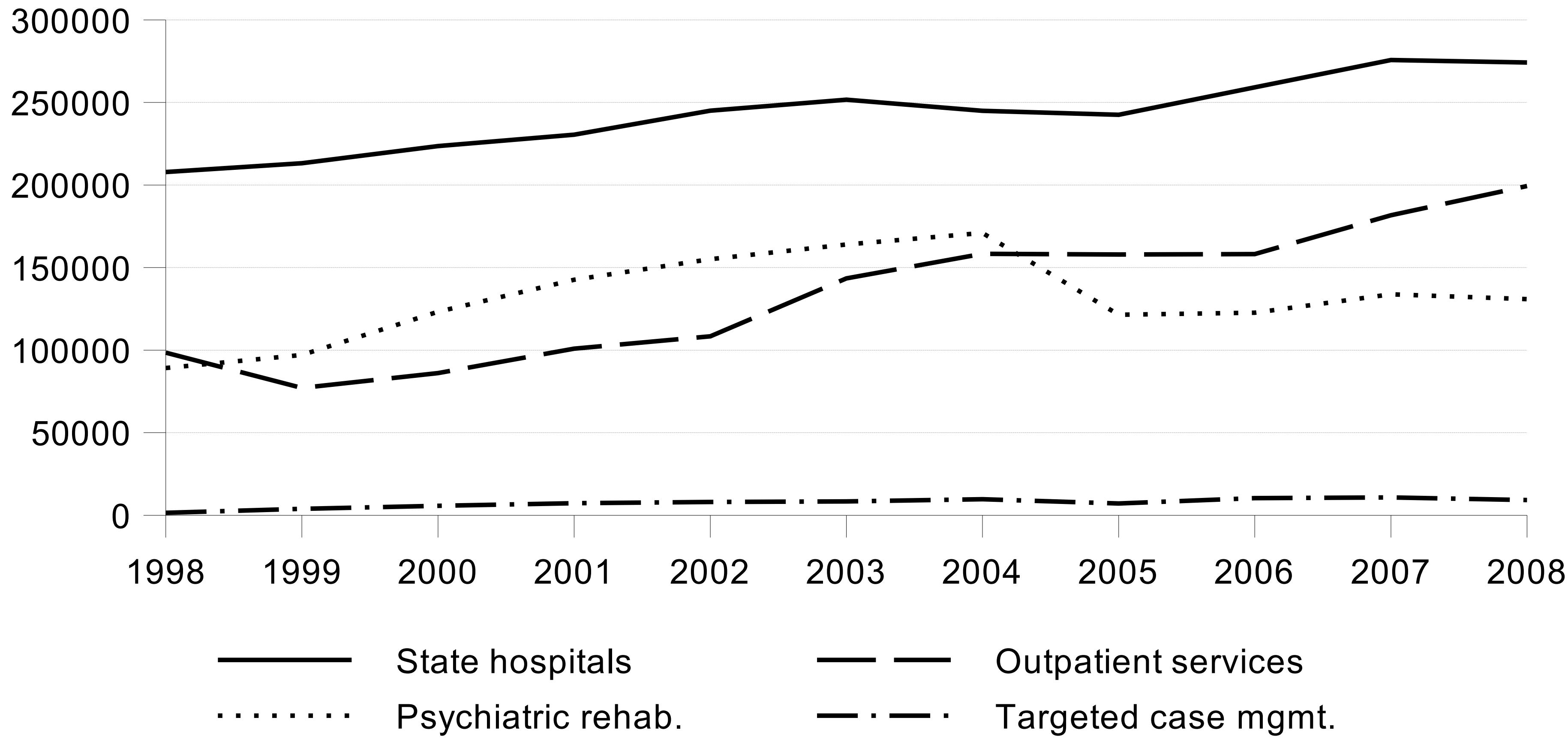
5. Distribution of MHA expenditures

Fiscal year 2008



6. MHA Expenditures: FY 1998-2008

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



7. State Hospitals: Mental Health

Expenditures ($000s) and volumes