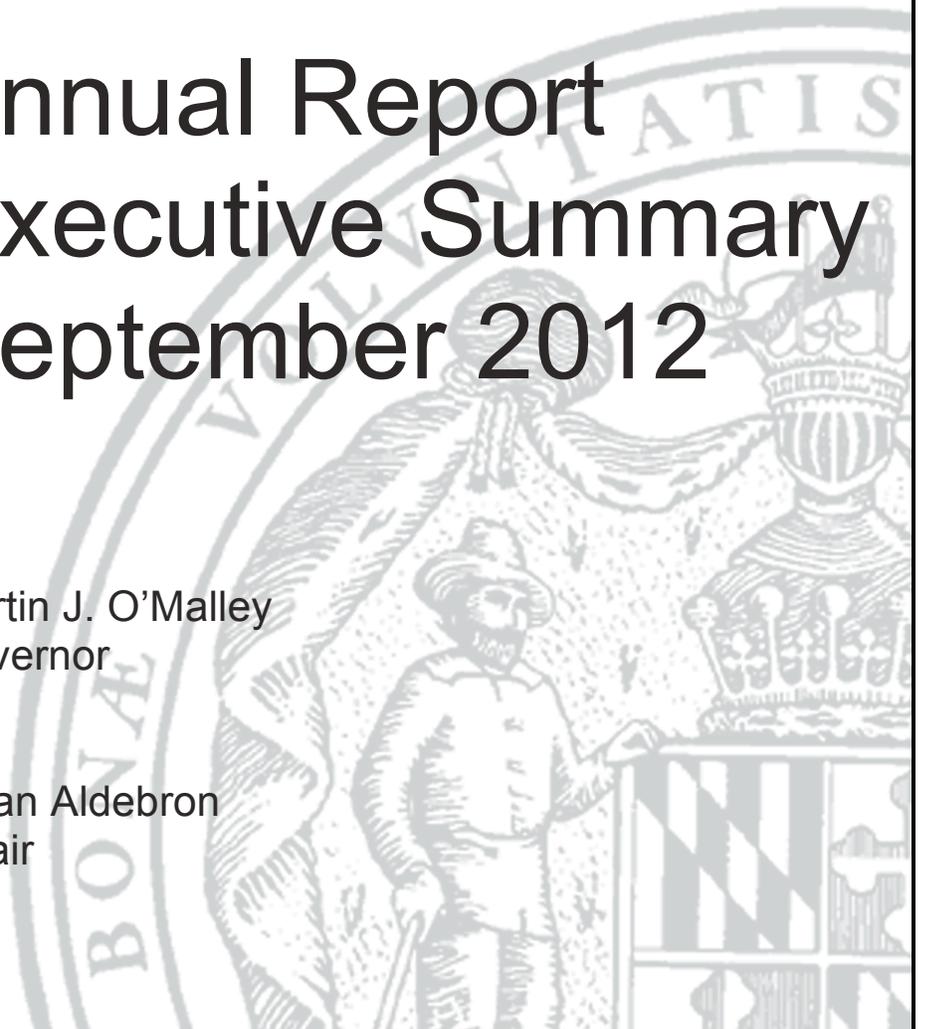


Community Services Reimbursement Rate Commission

Annual Report Executive Summary September 2012

Martin J. O'Malley
Governor

Jillian Aldebron
Chair



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ANNUAL REPORT
Executive Summary

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COMMUNITY SERVICES REIMBURSEMENT RATE COMMISSION

Membership

Jillian Aldebron, JD, MA, *Chair (non-affiliated, 2011-2014)*
Patsy Baker Blackshear, PhD (*non-affiliated, 2012-2014*)*
Kia Brown, MS (*non-affiliated, 2011-2014*)
Rebecca L. M. Fuller, PhD (*non-affiliated, 2012-2014*)*
Jeff Richardson, MBA, LCSW-C (*2011-2014*)
Tom Sizemore, MBA, CPA (*2011-2014*)
Tim Wiens, MSW, *Vice-Chair (2011-2014)*

Technical Advisory Group (TAG) Members

Mental Health Technical Advisory Group

Jillian Aldebron, *CSRRC (chair)*
Denise Camp, *On Our Own of Maryland*
Herb Cromwell, *CBH*
Rebecca Fuller, *CSRRC*
Brian Hepburn, *MHA*
Jeff Richardson, *CSRRC*
Donna Wells, *CSA, Howard County Mental Health Authority*
Frank Sullivan, *CSA, Anne Arundel County Mental Health Agency*

Developmental Disability Technical Advisory Group

Tim Wiens, *CSRRC (chair)*
Patsy Baker Blackshear, *CSRRC*
Kia Brown, *CSRRC*
Laura Howell, *MACS*
John Dumas, *Service Coordination, Inc.*
Frank Kirkland, *DDA*
Bette Ann Mobley, *DHMH*
Thomas Sizemore, *CSRRC*
Gerald Skaw, *DDA*

Technical Consultant

The Hilltop Institute
University of Maryland Baltimore County

*

These commissioners were appointed to vacant seats in March 2012. All terms expire September 30, 2014.

EXECUTIVE SUMMARY

The CSRRC resumed activity in October 2011 after a more than two-year hiatus (April 2009-October 2011). Since its inception in 1996, the CSRRC has assessed various aspects of the payment system used by the Mental Hygiene Administration (MHA) and the Developmental Disabilities Administration (DDA) to reimburse community-based providers of mental health and developmental disability services. The authorizing statute has been amended several times over the years to modify the scope of CSRRC responsibilities. Beginning in 2011, the CSRRC no longer recommends inflationary adjustments to rates, but instead is responsible for developing a weighted average cost structure for use by MHA and DDA in calculating rate updates for their annual budget submissions.

This document is submitted in fulfillment of the CSRRC's annual reporting requirement under Md. Code Ann. Art. Health-Gen., § 13-809.

Findings

Workforce: wages, benefits, and turnover

Because many MHA providers responded inconsistently, incompletely, or not at all to requests for wage information, and MHA did not enforce compliance with reporting requirements prior to FY 2011, the data presented here is only a general indication of salaries, fringe benefits, and vacancy rates. *It cannot be used to interpret a trend in wages or other workforce characteristics.* Vacancy rates appear highest among those professionals who can prescribe medication: psychiatrists and psychiatric nurse practitioners. Fringe benefits (defined in existing surveys as including mandatory employer contributions e.g., FICA) reported as a percentage of salary range between a median of 10% and 21%, depending on the job position and the year. Psychiatrists and other highly compensated clinical staff receive a lower percentage of benefits on average because they are often employed as independent contractors.

Among DDA providers, mean expenditures on direct care worker salaries declined 4.4% in FY 2011 over FY 2010. This may be related to an effective 1.5% rate cut in FY 2010. It is unclear how decreased provider earnings were spread over the entire workforce and other operational expenditures. Nonetheless, mean turnover rates for direct care workers decreased over this same period, while mean tenure in months increased, possibly an effect of the recession and tight job market.

Anecdotal evidence in both sectors points to employers limiting the availability of voluntary fringe benefits or requiring greater employee contributions. Providers have used this as a strategy to compensate for the rising cost of health insurance premiums during a period when reimbursement rates shrank or remained flat. This will be an avenue of future investigation.

Financial Performance

The majority of MHA and DDA providers appear “solvent” according to standard measures of financial performance, although a significant percentage show poor performance on many of the financial indicators typically used to gauge solvency. But a review of the data collected by MHA

and DDA does suggest a number of points to be mindful of in this and future CSRRC assessments:

- “Financial solvency” in any industry is a concept without strict parameters, although measures such as negative margins, fewer than 30 days of cash reserves, current ratios below 1.0, and negative net assets are indicators of an entity’s financial vulnerability. There is no normative definition of solvency for community-based mental health or developmental disability providers. Monitoring the performance measures of these providers over time, using conforming and complete data, and identifying those demonstrating consistently poor financial performance, is the best way to assess solvency in these sectors.
- It is unlikely that any public funding system can ensure solvency for all providers given the budgetary challenges faced by public agencies, which tend to constrain rates, and given the wide range of size, composition of services, the profile of the population served, and business acumen among providers. Successful providers will develop effective operational strategies and find efficiencies in how they deliver services within funding system parameters. Others will fare poorly, as reflected in their financial indicators.
- The CSRRC governing statute implies that “the delivery of efficient and effective services” must be considered in the assessment of financial solvency. (Md. Code Ann. Art. Health-Gen., § 13-809(1)(ii).) There is no definition or common understanding of “efficient and effective” service delivery in the community-based mental health and developmental disability sectors for the CSRRC to use as a guide. And while the concept of “effective” is incorporated in the outcome and satisfaction surveys used by ValueOptions and DDA for their respective constituencies, the data on financial performance are not correlated with the outcome measures of a given entity.

These concerns will persist even after implementation of community-based service payment system reforms anticipated by the Department of Health and Mental Hygiene (DHMH). We will try to address them in the coming years, both inside and outside our collaboration with DHMH on structural changes.

With respect to developing relative performance measures of DDA providers, current methods of data collection do not permit us to do more than compare profit margins among the business lines that are eligible for rate-based payments. Business lines funded through the Fee Payment System (FPS) show losses in most years; CSLA programs show profits every year, although the margin has declined.

Impact of the Annual Inflationary Cost Adjustment

Rates remained essentially stagnant for MHA community-based providers in FY 2010 and FY 2011. DDA providers saw an effective rate cut of 1.5% in FY 2010 and no change in rates for FY 2011.

The new methodology meant to result in an annual inflationary cost adjustment went into effect for the first time in the FY 2012 budgeting process and was implemented by DHMH with no input from the CSRRC in FY 2012 and FY 2013. Because there is a two-year lag time in the availability of financial data (i.e., the FY 2013 update was based on FY 2011 financial data, which preceded the new rate setting methodology), we cannot yet determine the impact of these adjustments. We identified several problems with the way MHA and DDA applied the DBM update factors to the cost structures in FY 2013.

Incentives and Disincentives of the Payment System and Quality of Care

In the mental health sector, neither the OMHC nor the PRP fee-for-service model incentivizes provider accountability for patient outcomes, a major flaw with this type of system. Moreover, because reimbursement rates are not cost based, they have a varied financial impact on providers depending on the service mix, size of the entity, and the entity's infrastructure. Direct fee-for-service reimbursements to OMHCs encourage providers to maximize revenues by providing as many services as possible. The case rate system for reimbursing PRPs has the effect of encouraging providers to limit services above a minimum to optimize earnings by reducing costs. Neither payment system takes quality of care into consideration. Quality is monitored and evaluated through external mechanisms (e.g., ValueOptions Outcomes Measurement System) but it is not financially incentivized.

In the developmental disability sector, FPS design provides an incentive to serve people with less complex support needs in day programs because they are more likely to show up, and absences are not compensated; it also incentivizes providers to serve people who already have employment skills in supported employment programs because they require less assistance but the provider can claim the same rate. In residential programs, there is an incentive to help people who do not qualify for add-ons achieve a higher level of independent living, which reduces provider costs. There is a disincentive to promote greater independence among people who receive add-on funding because the rate supplement would then disappear.

The payment system will be modified for MHA providers as a result of behavioral health integration and DDA providers in conjunction with adoption of the Supports Intensity Scale (SIS) assessment tool. It is anticipated that quality of care considerations will be incorporated in these processes.

Weighted Average Cost Structure

DHMH determined the weighted average cost structure of providers for the FY 2012 and FY 2013 budgets. For FY 2014, we made a certain number of changes to the methodology used by MHA and DDA, most importantly 1) using the statements of functional expenses of all MHA providers instead of a sample of 10 or 11, and 2) assigning costs for permanent contract staff who are essential to the mission of the entity to the salaries and wages category.

The CSRRC will continue to refine its methodology for establishing the weighted average cost structures of providers each year. This will be facilitated by improved data collection. In particular, because the "other" category is the second largest spending category after salaries in

both sectors, we will need to determine if it is possible and appropriate to reapportion some or all of these costs.

Issues for Future Study

The CSRRC intends to address the following areas over the coming years, as time and resources permit. The focus of our work may change based on developments related to behavioral health integration and use of the SIS. But our main focus for 2013 will be on improving data collection.

- Advise MHA on how to integrate payment incentives for provider solvency, efficiency, and quality as part of integrating mental health and substance use disorder service delivery. Assist DDA with the payment system reforms that are expected to result from implementation of the SIS.
- Work with MHA and DDA to clarify the terminology used in financial and wage reporting and to develop information guides and other supports that promote correct and complete submissions.
- Develop new formats and inputs for reporting financial and wage data to MHA and DDA (including cost reports and wage surveys), and standardize these insofar as possible across both sectors. Take into consideration the need to identify costs in terms of DBM classifications for purposes of determining rate updates.
- Investigate the potential for adopting and implementing a secure and private centralized electronic system for submitting financial and wage survey information in standardized formats to MHA and DDA.
- Identify selected samples of MHA and DDA providers for more in-depth and longitudinal analyses of financial indicators and design and conduct analyses.
- Identify meaningful financial indicators and normative standards of financial health, and develop supplemental survey methodologies to better understand the financial condition of providers.
- Develop and implement a method for examining voluntary fringe benefit trends and the role these play in compensation for MHA and DDA employees who provide direct care. In the DDA sector especially, some lower level employees choose to decline certain employment benefits because their own contribution is too costly. It would be interesting to look at this issue, and to see how this changes for health insurance as the Health Benefit Exchange becomes operational.
- Develop relative performance measures of DDA providers that incorporate information on the people served to benchmark performance while adjusting for risk. This would identify when provider costs in a given category deviate from the norm, regardless of whether people are more or less costly to serve. We may be able to develop comparable performance measures for MHA providers based on introduction of a cost report.

Summary of Recommendations

Over the next term, the CSRRC will focus on improving the quality, quantity, and type of data collected from MHA and DDA providers, and on refining and supplementing its data analysis. In this regard, we make the following recommendations for MHA and DDA consideration:

- Rigorously enforce full compliance of MHA and DDA providers with regulations on annual financial and wage submissions. Submissions that are incomplete should not be accepted as demonstrating compliance: they should be returned to providers for resubmission.
- Clarify the terminology used in financial and wage surveys and provide more extensive and complete definitions in the instruction sheets, with sufficient details to reduce confusion and erroneous data entry; it may be helpful to conduct information sessions or offer other assistance to providers to improve the quality of submissions.
- Improve the format of electronic data submissions to make them useable without excessive need to transpose information. This would greatly facilitate data analysis and reduce errors.
- Refocus the DDA Wage and Benefits Survey to provide more useful information on employee earnings rather than provider expenditures, and to emphasize direct support professionals. Revise the MHA Salary Survey and align with DDA survey to the extent possible.
- Expand and refine data collection on fringe benefits, concentrating on voluntary benefits for direct support professionals and benefit quality.
- Create a standardized salary and benefits survey for all providers.
- Require *audited* financial statements from all providers.
- Require cost reports of all providers.
- Resolve and recover all outstanding amounts owed DDA by providers for improper use of enhanced funding under the Wage Equalization Initiative.