# Community Services Reimbursement Rate Commission

## Annual Report Executive Summary January 2006

Robert L. Ehrlich, Jr.
Governor

Theodore N. Giovanis
Chair

Community Services Reimbursement Rate Commission

# ANNUAL REPORT

# January 2006

Executive Summary

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# COMMUNITY SERVICES REIMBURSEMENT RATE COMMISSION

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

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## REPORTING REQUIREMENTS

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

1. Describes its findings regarding:

   (I) The relationship of changes in wages paid by providers to changes in rates paid by the Department;
   (II) The financial condition of providers and the ability of providers to operate on a solvent basis in the delivery of effective and efficient services that are in the public interest;
   (III) The incentives and disincentives incorporated in the rate setting methodologies utilized and proposed by the Mental Hygiene Administration and the Developmental Disabilities Administration and how the methodologies might be improved;
   (IV) How incentives to provide quality of care can be built into a rate setting methodology; and
   (V) The recommended methodologies for the calculation of rate update factors and the rate update factors recommended for the next succeeding fiscal year.

2. Recommends the need for any formal executive, judicial, or legislative actions;

3. Describes issues in need of future study by the Commission; and,

4. Discusses any other matter that relates to the purposes of the Commission under this subtitle.

In addition, in the reports due on or before October 1, 2002 and October 1, 2005 the Commission was required to include its findings regarding the extent and amount of uncompensated care delivered by providers.

# Executive Summary

The State of Maryland desires an environment for citizens with developmental disabilities and mental illness that ensures quality, equity, and access to services and financial resources. The Commission believes that the State is committed to a system that provides quality care and that is fair to efficient and effective providers. As the human services and healthcare markets change and as changing demands are placed on the providers of services, it is important to ensure the continued successful operation of providers within a reasonable budgetary framework.

The Commission was established by the Maryland legislature in 1996; therefore it has been in operation for nine years. Each year the Commission publishes an Annual Report on its activities, findings, and recommendations. This is the ninth such Annual Report. The Commission consists of seven members, appointed by the Governor with the advice and consent of the Senate.

Through July 1999 the Community Services Reimbursement Rate Commission (CSRRC) met monthly to address its charges as outlined in Senate Bill 685 (1996). These charges were modified by Senate Bill 448 (1999) and further by House Bill 454 (2002) and House Bill 896 (2005). At the July 1999 meeting the Commission decided that it would be more productive to establish Technical Advisory Groups (TAG) and to replace two thirds of the formal Commission meetings with TAG meetings. The first set of TAG meetings was held in August 1999, and this structure has proved to be quite productive so the Commission has continued to use it. The topics covered in the TAG meetings have included:

- The structure of updating systems and the recommended update factor;
- The financial condition of the providers;
- Consumer safety costs and whether rates have been adjusted for such costs;
- Design of wage surveys to collect wage rate and staff turnover information from providers, and the interpretation of the data collected by these surveys;
- The measurement of quality and outcomes, and how incentives to improve quality can be built into the payment system; and,
- Transportation costs and other changes influencing provider costs.

As a result of the Commission's concern about quality of care, the December 4, 2000 meeting was devoted to quality issues in services for individuals with developmental disabilities, and the January 8, 2001 meeting to quality issues in mental health services, with presentations by invited speakers and discussions with providers. A paper discussing quality measurement and how to build incentives for quality into the payment system was prepared and included in the 2002 Annual Report.

Staff has prepared several briefing and issue papers, some of which are attached in Appendix B. This report also offers the Commission's observations with regard to funding and payment methodology, the adequacy of the rates, recommended rate updates, new system transitions, social policy, provider efficiency, and quality and outcomes. The Commission remains committed to providing constructive recommendations to the Governor, the General Assembly, and the Secretary in a timely manner. It should be noted that the recommendations have been developed in a balanced manner; the report should thus be considered as a unit rather than as a set of individual recommendations.

Key findings from the past year include the following:

- Neither the DDA nor the MHA payment systems include systematic mechanisms to adjust rates for inflation and other factors. Such adjustment mechanisms should be developed and implemented. The Commission has designed a suitable system and calculated the update factor that would result from its application. These recommended update factors are: 2.4% for DDA rates and 3.8% for MHA rates.

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

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

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

- The psychiatric rehabilitation providers paid by MHA and the providers paid by DDA have increased the wages for direct care workers over the past three years by more than the change in the rates they have received from MHA and DDA, respectively.

- The collection of uniform data on an ongoing basis is needed to monitor, compare, and evaluate the present and new payment systems in the context of the Commission's statutory authority as well as DDA and MHA responsibilities to monitor the system. The data submission from the DDA providers has substantially improved in the past three years, but the data from the MHA providers is still inadequate.

- The measurement of quality of services and of outcomes are still at a developmental stage. It would still be premature to base payments on specific measurements of quality

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

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

## Recommendations

Separate sets of recommendations are being made for MHA and for DDA related issues, although there is overlap between these two sets of recommendations. These recommendations are listed in priority order. The first two recommendations pertaining to MHA and the first recommendation pertaining to DDA have been included in previous reports, but are included again because the Commission considers them to be important, and they have not yet been implemented.

**CSRRC Recommendations Pertaining to MHA**

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

A systematic approach to adjusting rates for the reasonable impact of inflation and other factors is included in most national and state payment systems. As required by the enabling statute the Commission has prepared a paper suggesting a design for such a system, and quantifying the update factor, and has now revised that paper to take into account comments received from MHA. These recommendations should be implemented.

Some of the community services rates paid by MHA were increased in fiscal years 1999, 2000 and 2003. However, the MHA regulations and the budget process do not include any systematic approach to the updating of rates from year to year. Wages are a substantial portion of provider costs, so uncertainty in the magnitude and availability of rate increases makes it difficult for providers to plan pay raises and hiring for the subsequent year and manage their business. This may exacerbate hiring or turnover issues.

Almost all payment systems include a system for adjusting the rates to account for the impact of inflation in the prices of the goods and services purchased by the providers, among other factors. For example, all the Medicare Prospective Payment Systems include such an updating system, e.g., the nursing home, home health, and physician payment systems. The Health Services Cost Review Commission has such a system for updating the rates of the hospitals, both inpatient and outpatient, and DHMH has an updating system for the rates paid for medical day care. The Medicaid program has an elaborate system to update the rates of the Managed Care Organizations that basically holds them harmless for most changes in the prices they are paying for services. Such systems can be quite simple or relatively complex.

MHA should have some flexibility in how the rate increase is applied, so that some rates may be increased by more than the overall change, and some by less, to deal with problems of inequities in existing rates. In addition, the rates should be reviewed on a periodic basis to determine the appropriateness of the overall level of rates, and the relationship between the rates. MHA should continue to examine issues regarding individual rates or classes of services, and work to remedy these problems.

The change in rates developed through the updating system should be taken into account in the development of the MHA budget.

The recommended update factor is 3.8%.

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

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

Having an almost complete set of audited financial reports available in a reasonably timely manner would allow the Commission, and MHA, to assess the financial condition of the providers in general, and also to identify providers with particular problems, for whom a focused intervention might be required. This will aid in planning for changes to alleviate problems, and avoid unexpected closures of providers, which could potentially result in access problems. If the Commission were to sunset it would be important for MHA to continue the collection of audited financial reports and other data, and analyze the financial condition of the providers. These studies are all the more important now that the Public Mental Health system is cutting back on payment rates and eligibility levels.

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

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

3. **The Commission supports the concept, currently being implemented by MHA for psychiatric rehabilitation services, of paying for some types of services on an aggregated basis, provided adequate safeguards are included to maintain quality of care. However, the Commission believes that it is necessary to study the impact of the case rates, now that they have been implemented, to ensure that they do not disadvantage the providers caring for the most seriously and chronically ill clients. This study should be completed prior to the setting of rates for fiscal year 2007.**

As of February 2004, MHA started paying monthly case rates for psychiatric rehabilitation services. This change provides more flexibility to providers in their provision of services, while at the same time reducing administrative costs for pre-authorization of services, both for the providers and the administration. However, paying for bundles of services can provide a financial incentive to underserve, so appropriate safeguards should be built into the reporting systems to monitor levels of services when such changes are made.

When the Commission started operations one of its first tasks was to examine the incentive structure of the payment system. At that time the issue of capitation or case rates was broached. While such payment mechanisms can provide additional flexibility to providers in how they provide services, neither the financial data or the quality monitoring mechanisms available at that time were considered adequate to accurately determine the appropriate case/capitation rates or to protect against potential underservice. In the interim MHA has gained experience in case rate/capitation payment systems with its ongoing demonstration with Baltimore Mental Health System, and its information monitoring capabilities have vastly expanded through Maryland Health Partners and now APS Healthcare. The Commission supports the decision to proceed with expansion of the use of case and/or capitation payment systems for selected services.

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

**CSRRC Recommendations Pertaining to DDA**

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

In general the increases provided to DDA providers have often been tied to the cost of living increases provided to state workers and have only been applied to the wage and salary component of the provider costs. The providers have, thus, not systematically been recompensed for inflation for other components of their costs. Moreover, there is no systematic approach to providing rate increases to the providers.

Almost all payment systems include a system for adjusting the rates to account for the impact of inflation in the prices of the goods and services purchased by the providers, among other factors. For example, all the Medicare Prospective Payment Systems include such an updating system, e.g., the nursing home, home health, and physician payment systems. The Health Services Cost Review Commission has such a system for updating the rates of the hospitals, both inpatient and outpatient, and DHMH has an updating system for the rates paid for medical day care. The Medicaid program has an elaborate system to update the rates of the Managed Care Organizations that basically holds them harmless for most changes in the prices they are paying for services. Such systems can be relatively simple or quite complex.

The community services budget of DDA was increased in most fiscal years, partly for rate increases and partly because the number of people served has increased. In recent years it has also been increased under the wage equalization initiative, under which the providers are given rate increases to allow them to increase direct care wages to the equivalent state wage and fringe benefits levels. However, the DDA regulations and the budget process do not include any systematic approach to updating of rates from year to year. A systematic approach to the updating of rates is the only way to provide predictability for the providers and ensure the long term viability of these services.

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

The change in rates developed through the updating system should be taken into account in the development of the DDA budget.

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

**2. The legislature should preserve the additional funds to be provided to increase the wages and fringe benefits being paid to direct care workers.**

The Commission's wage survey confirmed that the wage rates and the level of fringe benefits of direct care workers, while greater than the nominal wage rates used by DDA to build up the payment rates, remain substantially below the wages and fringe benefits paid to corresponding state workers. The legislature, in DDA budget language a few years ago, required DDA to develop a plan to provide additional funds to the providers, with the goal of increasing the wages and fringe benefits being paid to direct care workers. The Commission believes that it is important to continue with the planned rate increases as quantified by DDA, particularly in the absence of a systematic approach to updating rates.

The Commission's most recent analysis of the financial condition of the providers is that the median margin dropped from about 3.2% in FY 2000 to about 0.7% in FY 2001 and increased slightly to 1.3% in FY 2002 then to 2.5% in FY 2003 but dropped to 1.6% in FY 2004. Over the past several years the providers have given wage increases comparable in magnitude to the rate increases provided to increase direct care worker wages, and greater than the overall change in rates.

**3. DDA should evaluate and determine whether separate rates for transportation costs should be implemented. This study should be completed before the fiscal year 2008 rates are developed.**

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

It is hoped that the transportation data submitted in the FY 2005 Cost Reports will be improved in quality, as this will be the third year that the providers have had to supply these data. An indepth analysis of transportation costs will be made once the FY 2005 Cost Reports are available. Once that analysis is complete the Commission will be in a better position to make informed recommendations on whether separate transportation payments should be made for particular services, and how these payments might be structured. For example, it may be determined that separate transportation payments are desirable for Day and Supported Employment programs, but not required for Residential and CSLA programs. The situation will be complicated by the fact that providers sometimes pick up several clients in the course of a single trip, so the clients on the trip travel different distances, and the distance traveled may not be directly related to the distance from the pick-up point to the destination.

## Social Policy Choices

The context in which social policy choices are made needs to be examined. For example, historically there have been lists of clients waiting to receive services, and providers are requesting higher rates to care for existing consumers and to make investments in quality. It was anticipated that, for DDA, this conflict between improving services to existing clients versus serving more clients would begin to be resolved by the Governor's waiting list reduction initiative. In the current fiscal year there are no funds specifically targeted for the reduction of the waiting list. DDA reports that, as of July 1, 2005, there were 15,031 individuals waiting for one or more basic services and that the number of service requests was 26,299.

In the mid-1990s, the public mental health system was expanded to serve more individuals without Medicaid who are eligible for public subsidies for selected services, but without a commensurate increase in the overall budget. Between 1998 and 2003 the number of individuals served increased by 40%. As might be expected, MHA experienced budget shortfalls. MHA responded to ongoing budget overruns by cutting back on gray area eligibility and limiting rehabilitation services for gray area and Medicaid eligible adults and children. Also, in February 2004, MHA implemented a case rate payment system for psychiatric rehabilitation services. These actions, combined with funding increases, have enabled MHA to eliminate its prior year deficits that had been rolling over from year to year. Choices, such as covering new clients, dropping clients from coverage, or ensuring stability for existing providers, need to be made consciously. MHA has described the context for its decision making in the values set forth in its 5-year plans. DDA's planning efforts are directed by the goals of its self-determination project.

The Commission will continue to look into these issues in the coming year.

## The Financial Condition of the Providers

In considering the results reported here it should be kept in mind that our assessment of the financial condition of the providers is based on available data, which often involves a lag of more than a year. In FY 2004 many rehabilitation providers experienced cuts of 10% or more in revenues. Several providers have closed programs for children and adolescents due to financial pressures.

The majority of the providers contracting with DDA have a positive margin. The mean margin dropped to about 1% in fiscal year 2001, and recovered slightly in 2002, with a further recovery in 2003 but dropped again in 2004. Many of the outpatient mental health clinics (OMHC) are losing money and have cash flow problems. Their situation is sufficiently serious that access to care could be threatened in some areas of the state. The financial condition of the OMHCs will be exacerbated by reductions in gray area eligibility, and by reductions or increases less than the impact of inflation in Medicare payments rates as well as the impact on provider costs of enforcement of the requirement that services be provided only by licensed practitioners.

In accordance with the legislative requirement to assess "the financial condition of providers and the ability of providers to operate on a solvent basis in the delivery of effective and efficient services that are in the public interest," the Commission intends to maintain a close watch on the

financial condition of the providers by obtaining updated information as soon as it becomes available, updating the analyses reported here, and reporting the results in interim work papers.

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

## COMMISSION ACTIVITIES

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

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

Commission meetings were held on, or are scheduled for, the following dates:

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

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

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