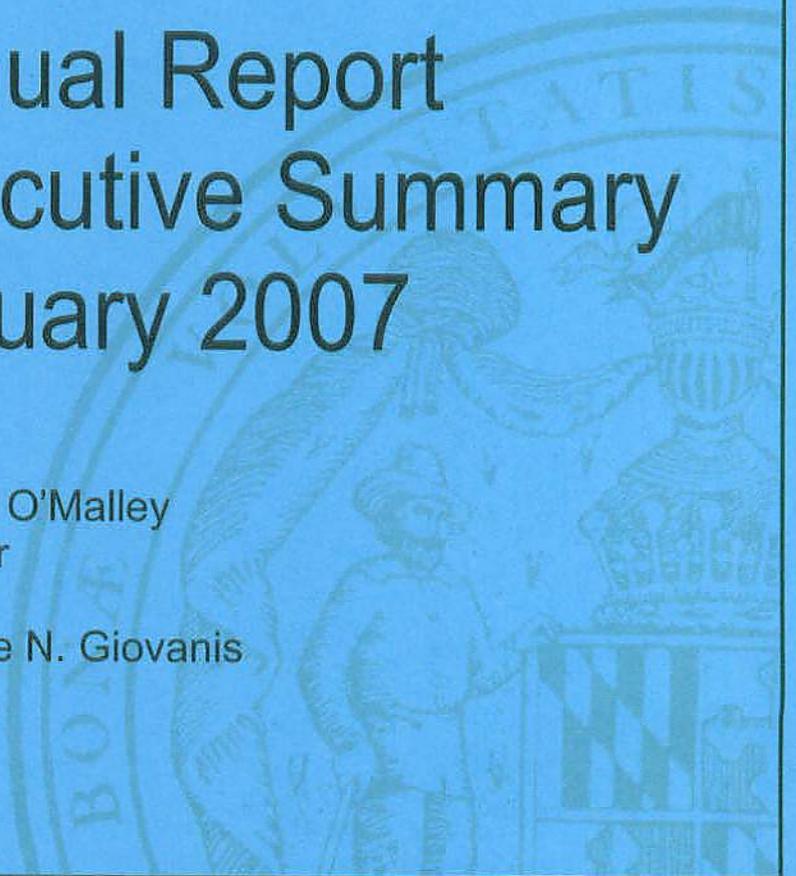


Community Services Reimbursement Rate Commission

Annual Report Executive Summary January 2007

Martin J. O'Malley
Governor

Theodore N. Giovanis
Chair



Community Services Reimbursement Rate Commission

ANNUAL REPORT
Executive Summary

January 2007

COMMUNITY SERVICES REIMBURSEMENT RATE COMMISSION

Membership

Theodore N. Giovanis, FHFMA, M.B.A., Chairman
Alan C. Lovell, Ph.D., Vice Chairman
Lynn Garrison, MBA
Jeff Richardson, MBA, LCSW-c
Lori Somerville, B.S., M.S.
(Note: Biographical sketches are included as Appendix A)

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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.

Administrative and Data Consultant:

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REPORTING REQUIREMENTS

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

1. Describes its findings regarding:
 - ! The relationship of changes in wages paid by providers to changes in rates paid by the Department;
 - ! The financial condition of providers and the ability of providers to operate on a solvent basis in the delivery of effective and efficient services that are in the public interest;
 - ! The incentives and disincentives incorporated in the rate setting methodologies utilized and proposed by the Mental Hygiene Administration and the Developmental Disabilities Administration and how the methodologies might be improved;
 - ! How incentives to provide quality of care can be built into a rate setting methodology; and
 - ! The recommended methodologies for the calculation of rate update factors and the rate update factors recommended for the next succeeding fiscal year.
2. Recommends the need for any formal executive, judicial, or legislative actions;
3. Describes issues in need of future study by the Commission; and,
4. Discusses any other matter that relates to the purposes of the Commission under this subtitle.

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

Executive Summary

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

The Commission was established by the Maryland legislature in 1996; therefore it has been in operation for ten years. Each year the Commission publishes an Annual Report on its activities, findings, and recommendations. This is the tenth 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:

- ! The 2006 legislative system 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: 3.87% for DDA rates and 3.71% for MHA rates.
- ! The mean margin of the providers paid by DDA was 1.9% in fiscal year 2005.
- ! 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 substantially 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. It is expected that this situation will improve once MHA promulgates the data submission regulations it is currently developing.
- ! The measurement of quality of services and of outcomes is 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.

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.

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. However, rates for psychiatric rehabilitation services for children, and for intensive residential rehabilitation were substantially increased in FY 2005.

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, dropped again in 2004 but recovered a little in 2005.

The analysis of the financial condition of providers of community services paid by MHA is based on Audited Financial Reports from members of CBH. While only 34 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.

The median margin in 2005 was 2.5% and the weighted mean margin was 2.6%. The financial condition of the providers was relatively unchanged between 2004 and 2005.

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.

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.

Recommendations for DDA

1. Rates for fiscal year 2008 should be increased by 3.87% to compensate for the impact of inflation on the costs of providers.

Rationale: 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. The Commission developed a methodology for calculating this adjustment, and has calculated that the impact is 3.87%.

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.

2. The wage equalization initiative should be continued until wage parity with state employees is achieved.

Rationale: The goal of the wage equalization initiative was to allow providers to raise the wage rates of direct care workers to equivalent state wage levels. The results of the Commission’s most recent wage survey show that this has not yet been achieved. This may be in part due to wage increases that have been provided to state employees since the amount of the original wage equalization initiative was calculated. Continuing the wage initiative would allow the community providers to increase their wage rates to be close to state wage levels.

3. DDA, in cooperation with the Commission, should continue to work on improving the method used to pay for transportation costs, with a target of implementing the new system for fiscal year 2009.

Rationale: DDA and the Commission have been studying transportation costs using the data reported by the providers in their DDA Cost Reports. However, the variability exhibited by this transportation data is such as to make it unusable for purposes of developing a transportation payment method. As a result the Commission is suggesting a delay of one year in making changes to the transportation payment system from its previous recommendation of fiscal year 2008.

A more focused study, involving interviews with selected providers to determine how transportation is organized, travel distances, costs, staffing levels, and other factors influencing the costs, is likely to be required.

Recommendations for MHA

1. Rates for fiscal year 2008 should be increased by 3.71% to compensate for the impact of inflation on the costs of providers.

Rationale: 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. The Commission developed a methodology for calculating this adjustment, and has calculated that the impact is 3.71%.

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.

2. The Commission continues to have a concern that having a single case rate for PRP services to children could make it difficult to place children with heavy care requirements, or could disadvantage providers with clients with particularly heavy care needs. MHA, in cooperation with the Commission, should study whether the case rate for psychiatric rehabilitation services to children should involve more than the current single payment level. If a multi-level rate is determined to be appropriate it should be implemented for fiscal year 2009.

Rationale: MHA implemented case rates for psychiatric rehabilitation program (PRP) services in February of 2004. The case rate is paid in months in which the child receives 3 or more PRP services. There is no payment if a child receives only 1 or 2 services in the month, and there is no difference in the payment for a child who receives 3 services as compared with a child who receives 8 services in a month.

3. MHA should promulgate regulations requiring the submission of audited (or best available if audited reports are not available) financial reports and wage data. MHA should have, and use, authority to sanction providers who do not submit the required data in a timely manner. If legislation is required to give MHA the

authority to fine providers for non-compliance with data regulations then MHA should seek such legislation.

Rationale: MHA does not routinely collect audited financial reports or wage surveys from all providers. Because of the lack of this information it is not possible to assess the overall financial condition of the providers of public mental health services. Such an assessment would be invaluable, particularly to assess whether the providers of specific services are experiencing financial difficulties. The Commission would find comprehensive wage survey data invaluable in responding to its legislative mandate to relate increases in the wage rates to the increases in rates. It is understood that regulations to this effect are under development, but they have not yet been promulgated, and the Commission understands that they will not include the option of fining providers who fail to submit the data in a timely manner. Without such fining authority it will be difficult to enforce compliance with the data submission requirements.

DDA does have, and use, the authority to fine providers for failure to submit required reports. Legislation was required in order to allow DDA to do this. MHA should examine the DDA legislation, and seek similar legislation to allow it to enforce its data submission regulations.

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 9, 2006
April 3, 2006
June 5, 2006
September 11, 2006
December 4, 2006
January 8, 2007
April 2, 2007
June 11, 2007
September 10, 2007
December 3, 2007

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

February 6, 2006
March 6, 2006
May 1, 2006
August 7, 2006
October 16, 2006
November 6, 2006
February 5, 2007
March 5, 2007
May 7, 2007
August 6, 2007
October 1, 2007
November 5, 2007

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, a consulting firm specializing in legislative, regulatory, and strategic consulting with an emphasis on health care policy. He has served as a technical resource for congressional staffs and the Administration. In addition to extensive consulting experience in health care finance, regulation, and policy, he has served as Director of the Health Care Industry Services of Deloitte & Touche, Director for Regulatory Issues of the Healthcare Financial Management Association, as Assistant Chief of the Maryland Health Services Cost Review Commission and as a health system Chief Financial Officer.

Mr. Giovanis received an M.B.A. in management from The University of Baltimore and is a fellow in the Healthcare Financial Management Association (HFMA). He is also certified in managed care.

Alan C. Lovell, Ph.D.

Alan C. Lovell is currently the Chief Executive Officer of CHI Centers, Inc., “supporting people with disabilities since 1948,” a multi-purpose, community-based organization serving individuals with disabilities and their families. He has served in numerous leadership positions, including President and Chair with the Maryland Association of Community Services, the Maryland state Developmental Disabilities Council and the Montgomery County Interagency Coordinating Committee for People with Developmental Disabilities (InterACC/DD).

Dr. Lovell received his Ph.D. in public administration from Kensington University.

Jeff Richardson, MBA, LCSW-c

Mr. Richardson is the Executive Director of Mosaic Community Services (MCS), a position he has held for 11 years and has over twenty years of experience in Behavioral Health Services. MCS has an annual budget of 18 million serving over 5,000 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
Theodore Giovanis - Commissioner (ex-officio)

Technical Advisory Group on DDA issues

Tracey DeShields – DHMH
Lynn Garrison - Commissioner
Alan Lovell - Commissioner
Arthur Gold - MACS
Scott Uhl – DDA
Mona Vaidya - DBM
Tim Wiens - Jubilee
Theodore Giovanis - Commissioner (ex-officio)