Community Services Reimbursement Rate Commission

ANNUAL REPORT

Executive Summary

January 2008

COMMUNITY SERVICES REIMBURSEMENT RATE COMMISSION

Membership

Theodore N. Giovanis, FHFMA, M.B.A., Chairman
Alan C. Lovell, Ph.D., Vice Chairman
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Jeanette M. Martin, B.S., M.S.
Jeff Richardson, MBA, LCSW-c
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(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.

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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 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. The Commission actually includes information on uncompensated care in each of its Annual Reports, in the discussion of the financial condition of the providers.

[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 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.

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 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 put 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 4.0% for FY 2009. For comparison purposes, the HSCRC provided the hospitals with inpatient update factors of 5.25% for FY 2008 and 3.56% for FY 2007.

The Commission recommended an update factor of 3.87% for FY 2008, but the actual increase provided was only 2%. The shortfall of 1.87% should be built into the rate update provided 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 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.

Rationale:

State agencies adopt regulations that impose 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 they increased the costs of DDA providers by about $5 million per year or about 1.0% of total DDA payments. When such regulations are proposed the agency proposing them should be required to involve any State agencies involved in paying 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.

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.

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.

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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 eleven years. Each year the Commission publishes an Annual Report on its activities, findings, and recommendations. This is the eleventh 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 2008

- 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: 4.00% for both DDA rates and for MHA rates. These should be augmented by the shortfalls in the rate increases for fiscal year 2008 relative to the Commission recommended update. These shortfalls were: 1.87% for the DDA rates and 1.71% for the MHA rates.

- The average margin of the providers paid by DDA was 1.5% in fiscal year 2006, down from 1.9% the previous year. This is a relatively low margin, and is the second lowest since the Commission started calculating the margins in 1999.

- 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 three 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 is still inadequate. It is anticipated that the Commission will receive more complete data now that MHA has promulgated data submission regulations requiring the submission of wage surveys and audited financial reports to the Commission and the CSAs.

- 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, 2007 these numbers had increased to 16,356 individuals and 29,532 service requests.

Between 1998 and 2007 the number of individuals served by the Public Mental Health System increased by more than 44%. 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.

In the past year the Centers for Medicare and Medicaid Services (CMS) objected to the monthly case rate payment system for targeted case management services. They requested a change to a service time based rate. After evaluating the potential impact of such a change on providers, MHA decided to retain the current system and forego federal match on the funds paid for targeted case management.

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 from members of CBH. While only 32 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. 31% of the providers in the study had negative margins in 2006.

The financial condition of the providers paid by DDA deteriorated in FY 2006, with 29% of the providers having negative margins, i.e., losing money. The average margin was only 1.5%.

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 are scheduled for the following dates:

January 7, 2008
April 7, 2008
June 2, 2008
September 8, 2008
December 1, 2008 (contingent on reauthorization)

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

February 4, 2008
March 10, 2008
May 5, 2008
August 4, 2008
October 6, 2008 (contingent on reauthorization)
November 3, 2008 (contingent on reauthorization)

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.

Jeanette M. Martin, B.S., M.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. 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 12 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
Dennis Kokoskie – DDA
Mona Vaidya – DBM
Audrey Waters - DDA
Tim Wiens - Jubilee
Theodore Giovanis - Commissioner (ex-officio)