Community Services Reimbursement Rate Commission

Annual Report Executive Summary January 2009

Martin J. O'Malley
Governor

Theodore N. Giovanis
Chair

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COMMUNITY SERVICES REIMBURSEMENT RATE COMMISSION

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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.

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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 rates and for 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.