



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

January 30, 2014

Ms. Jillian Aldebron, Chair
Community Services Reimbursement Rate Commission
55 Wade Avenue, Dix Building
Catonsville, MD 21228

RE: Department of Health and Mental Hygiene Response to the Community Services
Reimbursement Rate Commission Report – HG § 13-810

Dear Ms. Aldebron:

In accordance with Health-General Article § 13-810, the Department of Health and Mental Hygiene's (DHMH) Developmental Disabilities Administration (DDA) and Mental Hygiene Administration (MHA) have reviewed the 2013 Annual Report submitted by the Community Services Reimbursement Rate Commission (CSRRC) and the recommendations contained therein. The Department appreciates the efforts of the CSRRC and was able to collaborate with the Commission to achieve some of the recommendations contained in its 2013 Annual Report.

The Department has provided responses to relevant recommendations provided in the CSRRC's Annual Report. These responses correlate with two specific areas contained in the report – workforce and financial performance. Below are the recommendations with specific responses from MHA and DDA:

Workforce

1. MHA and DDA, in conjunction with the CSRRC, should support the development and implementation of a secure, electronic web-based reporting system hosted by DHMH that reduces errors, facilitates compilation and analysis, and is more reflective of the personnel structures of provider entities. Institution of this system should be accompanied by information sessions and technical assistance for providers.

DDA Response: DDA supports the plan to innovate the reporting process and looks forward to supporting implementation through providing information sessions and training as appropriate.

MHA Response: MHA is very supportive of the development and implementation of an electronic, web-based reporting system. MHA staff has been working with the CSRRC Chair and relevant DHMH staff to develop and test this system. Once the system is ready for launch, MHA staff will provide information sessions and technical assistance to MHA providers.

2. MHA and DDA should ensure full compliance with reporting requirements by taking prompt enforcement action and refusing to make exceptions that are not justified by extraordinary circumstances.

DDA Response: DDA has implemented a revised timeline and penalty process to address any non-compliance with providers associated with submission of cost reports.

MHA Response: MHA has implemented a penalty process that allows the Administration the flexibility to work with providers to ensure full compliance in the submission of salary surveys, audited financial statements, and cost reports.

3. The payment system for community-based developmental disability services will soon undergo a transformation due most notably to implementation of the Supports Intensity Scale and a study of the cost of providing services. Currently, it is unclear if a system for automatic cost of living adjustments will be built into the new payment system. Whether or not this is the case, policy makers should consider whether or not they want to require apportionment of rate increases across certain budget categories. In the past, some companies have maintained that low reimbursement rates put them at a competitive disadvantage when trying to recruit staff, lead to higher turnover, and could undermine access to services or quality of care. Providers may also consider examining the distribution of administrative and operational expenditures. If the relationship between wages and rates is not a matter of concern, there is no reason to monitor compensation or to require reporting on related indicators.

DDA Response: As noted by the Commission's report, DDA is embarking on several efforts which will significantly impact the individual's funding plans and provider rate structures. As part of the planned rate study, administrative costs will be closely examined, as will the recommendation to review which budget categories are increased with any raises in rates.

4. The issue of misspent Wage Equalization Initiative funds, which were intended to boost the compensation and benefits of DDA direct care workers to the same levels as those in the public sector by FY 2007, continues to cast a shadow over employee compensation in the developmental disability sector. Expeditious resolution of this matter, which has now dragged on for at least seven years, is in the mutual interest of providers and DDA. As of fall 2011, DDA estimates that \$365,000 is still owed by as many as 14 providers.

DDA Response: DDA is working with DHMH to resolve the issue of misspent funds under the Wage Equalization Initiative. DDA is currently verifying which providers are still subject to the recovery of misspent Wage Equalization Initiative funds. DDA intends to recoup the remaining funds by the end of FY 2014.

Financial Performance

1. As noted in the workforce section, MHA and DDA, in conjunction with the CSRRC, should support the development and implementation of a secure, electronic web-based reporting system hosted by DHMH that reduces errors, simplifies compilation and analysis, and promotes compliance. The implementation of such a system is facilitated by introduction of a cost report for mental health service providers. The system could be set up to permit attachment of electronic copies of audited financial statements, creating a paperless process that would reduce the associated administrative workload and storage issues for MHA and DDA. Regardless of the type of reporting system used, MHA and DDA must assert their enforcement authority for data collection to be successful.

DDA Response: DDA has changed timelines and a process associated with cost reporting and appreciates the approach taken by the CSRRC to improve the cost report submission process for community providers. DDA agrees that the statute associated with cost report submissions requires enhanced enforcement efforts and it has adopted internal and external processes to support increased accountability by providers.

MHA Response: As noted previously, MHA is supportive of the web-based reporting system. The system will be set up to collect salary information, audited financial statements, and the newly-developed cost report. This new system will enhance MHA's ability to collect the required information in a timely manner.

2. MHA, in collaboration with the CSRRC, should support cost reporting with training and technical assistance. This new requirement is especially valuable because it will be directly applicable to preparation of a weighted average cost structure for this sector. In

addition, it will provide insights into financial operations that cannot be gleaned from a study of financial statements alone, particularly with respect to for-profit companies.

MHA Response: MHA concurs and will be instituting a cost report this year. The cost report will be part of the web-based reporting system and training and technical assistance will be made available once the system is active.

3. DHMH should internalize data collection and analytical functions that the CSRRC currently assumes. This would create operational and management efficiencies and save on overhead fees, administrative costs, and data management associated with outside contractors employed by CSRRC.

DHMH Response: DHMH has been working with the CSRRC to develop a secure, web-based reporting system that will allow MHA and DDA providers to submit their salary surveys, audited financial statements, and cost reports on-line, thereby streamlining the reporting process and ensuring greater compliance with reporting. Once data are collected, they may be extracted into the appropriate format for analysis by a designated entity. DHMH has covered the full IT and administrative costs associated with this project.

4. MHA and DDA should provide the CSRRC with historical data on the provider network over the period 2003-2013 that indicates the names of all entities licensed to receive MHA and DDA funds and number of clients served in each year. This formation can be cross-referenced with the financial records in CSRRC files to provide a picture of how the sectors have evolved in terms of size, geographical coverage, and access to services, and how rates changes have affected the system overall.

DDA Response: DDA will provide historical information regarding licensed entities and numbers of clients.

MHA Response: MHA will be able to make historical data related to the names of licensed providers and number of clients served available to the CSRRC.

5. Policy makers have a strong interest in the sustainability of the provider network on which the public is entirely reliant for services and that is funded with tax revenue. In this regard, they may want to consider establishing minimum standards for operational soundness and conditioning authorization to receive MHA and DDA reimbursement on meeting those requirements. Some examples may be to require that all companies maintain a certain level of reserves or have a line of credit to cover recurrent debt obligations regardless of caseload fluctuations. Reimbursement rates are necessary, but

not sufficient to guarantee financial health: much depends on good fiscal management. This is especially important because a significant percentage of companies are organized as for-profits that are not subject to the oversight of a board of directors with a fiduciary duty to ensure the stability of the entity.

DDA Response: DDA concurs and continues to work with the Department’s Office of Health Care Quality to improve licensing standards, including the development of business plan requirements for new providers.

MHA Response: MHA will work with relevant DHMH entities (Medicaid and the Office of Health Care Quality) to consider establishing standards.

6. Because the CSRRC has no statutory appropriation, it depends entirely on DHMH for funds to carry out its mandate. The amount of money DHMH is willing to set aside for CSRRC activities is neither disclosed to nor discussed with commissioners. This leaves us with no ability to plan, to organize the types of in-depth studies that would enhance the value of our analyses, to hire the level of expertise necessary. The CSRRC cannot function under such circumstances: indeed, its two-year lapse prior to the reauthorization was the direct result of DHMH slashing the budget to its current level. The Commission has been able to operate over the past two years only because its members have been willing to contribute many uncompensated hours of time performing work usually conducted by staff. The time commitment vastly exceeds that expected of any other executive-level commission. DHMH must engage with the CSRRC in a transparent, structured, cooperative process to develop a realistic budget that is sufficient to satisfy our technical and administrative needs.

DHMH Response: The Department has worked in conjunction with the CSRRC to establish a budget that meets the CSRRC’s needs. That budget is based on the Commission’s original technical support contract. The Commission’s budgeted appropriation and actual expenditures to date are shown below.

	Fiscal 2012	Fiscal 2013	Fiscal 2014
Appropriation	\$139,998	\$139,998	\$139,998
Expenditures	\$93,149	\$87,272	\$3,000
Unspent Funds	\$46,849	\$52,726	\$136,998

Although the Commission has indicated that its current funding level is insufficient, each year it has failed to spend its full appropriation. At the time of this writing, the State is in the third quarter of fiscal 2014; however, only 2 percent of the Commission’s appropriation has been expended.

The Department respects the independence of the Commission. Therefore, the technical consultant that supports the CSRRC's activities is selected by the Commission – not the Department – and the CSRRC chair serves as the contract monitor. As the contract monitor, the chair meets with DHMH budget staff to review contract specifications and budgeted funding levels. The Department has not interfered with the CSRRC's decision to terminate its two previous technical consultants, and has approved all procurement requests and short-term contracts to support the CSRRC's activities. Moreover, the Department has provided additional resources - at no cost - to assist with the Commission's activities. These resources include: space on the MHA server and Administrative (MHA and DDA) and IT staff.

7. DDA is expected to issue an RFP in March 2014 for a comprehensive review of rates and costs to develop a new rate structure. The CSRRC should be included among the stakeholders collaborating on the content of the RFP, as well as the payment system reforms that will flow from this study. It is noteworthy that the October 2013 report on DDA progress and plans (Developmental Disabilities Administration: Moving Forward) omits any reference to the CSRRC whatsoever, even in the sections on communications and stakeholder engagement. In fact, it received no notification of the leadership changes in DDA. The CSRRC cannot function as a marginal entity—at the very least, it needs the cooperation and collaboration of the administrations that license providers.

DDA Response: Currently, DDA is conducting research on other states' rate development, to assist with DDA's statement of work for the contract. The Administration anticipates working with CSRRC to review a draft statement of work prior to its release to potential vendors.

8. DHMH has been unwilling to include the CSRRC in its deliberations, planning, or meetings with the provider community. The Department is always willing to meet privately with the CSRRC chair, but there is no follow up. To date, DHMH has refused to collaborate on the SB 633 report, and the CSRRC is not aware of anything that may have been submitted to the General Assembly in this regard. It has refused to acknowledge the weighted average cost structure provided for preparation of its FY 2015 budget submission. As noted above, DHMH did not inform the CSRRC of DDA management developments and has not assigned anyone to collaborate with the CSRRC at a technical level to replace the prior liaison. Absent a willingness on the part of DHMH to work with the CSRRC on matters related to its mandate, the General Assembly should reevaluate the practical utility of continued authorization of the Commission.

DDA Response: DDA has been undergoing a period of transformation, particularly in fiscal operations. Currently, the Administration is recruiting for the Chief and Deputy Financial Officer positions. DDA's historical practice and intention going forward is to have the Chief Financial Officer serve as the liaison with the CSRRC. Additionally, DDA is currently recruiting a new Executive Director. Accordingly, additional management changes are anticipated over the coming months.

DHMH Response: DHMH's Office of the Deputy Director for Behavioral Health and Disabilities, as well as the Administrations it oversees, will continue to work with the CSRRC to assist the Commission in meeting its mandate.

If you have any further questions or concerns regarding the Administrations' response, please contact me at 410-767-3167.

Sincerely,

A handwritten signature in black ink, appearing to read 'G Jordan-Randolph', with a stylized, cursive script.

Gayle Jordan-Randolph, M.D.
Deputy Secretary
Behavioral Health and Disabilities

cc: Joshua M. Sharfstein, M.D.
Patrick Dooley
Allison Taylor
Senator Thomas M. Middleton
Senator Edward J. Kasemeyer
Senator James N. Robey
Delegate Peter A. Hammen
Delegate Norman H. Conway
Delegate Mary-Dulany James
Sarah Albert, DLS, MSAR #8817