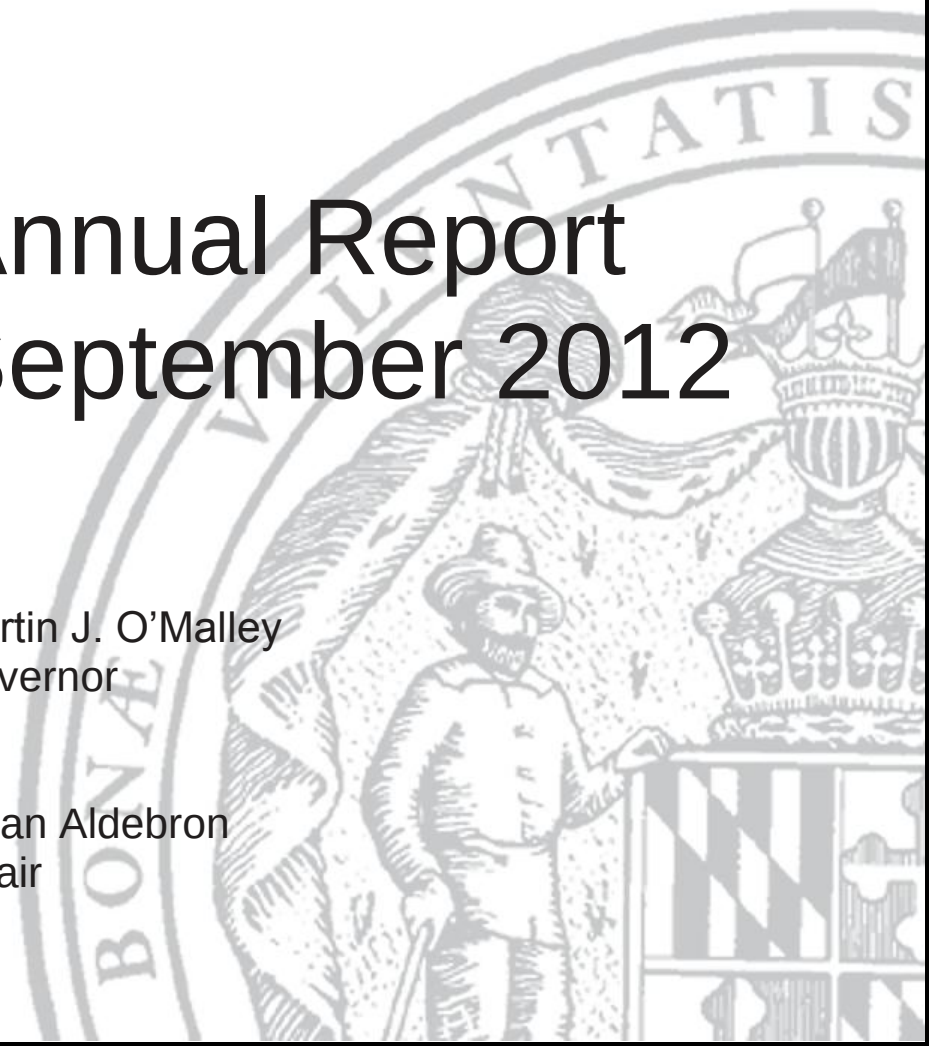
# Community Services Reimbursement Rate Commission

# Annual Report September 2012



Martin J. O'Malley
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## Community Services Reimbursement Rate Commission

# ANNUAL REPORT

## September 2012

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# Executive Summary

The CSRRC resumed activity in October 2011 after a more than two-year hiatus (April 2009-October 2011). Since its inception in 1996, the CSRRC has assessed various aspects of the payment system used by the Mental Hygiene Administration (MHA) and the Developmental Disabilities Administration (DDA) to reimburse community-based providers of mental health and developmental disability services. The authorizing statute has been amended several times over the years to modify the scope of CSRRC responsibilities. Beginning in 2011, the CSRRC no longer recommends inflationary adjustments to rates, but instead is responsible for developing a weighted average cost structure for use by MHA and DDA in calculating rate updates for their annual budget submissions.

This document is submitted in fulfillment of the CSRRC's annual reporting requirement under Md. Code Ann. Art. Health-Gen., § 13-809.

## Findings

### Workforce: wages, benefits, and turnover

Because many MHA providers responded inconsistently, incompletely, or not at all to requests for wage information, and MHA did not enforce compliance with reporting requirements prior to FY 2011, the data presented here is only a general indication of salaries, fringe benefits, and vacancy rates. ***It cannot be used to interpret a trend in wages or other workforce characteristics***. Vacancy rates appear highest among those professionals who can prescribe medication: psychiatrists and psychiatric nurse practitioners. Fringe benefits (defined in existing surveys as including mandatory employer contributions e.g., FICA) reported as a percentage of salary range between a median of 10% and 21%, depending on the job position and the year. Psychiatrists and other highly compensated clinical staff receive a lower percentage of benefits on average because they are often employed as independent contractors.

Among DDA providers, mean expenditures on direct care worker salaries declined 4.4% in FY 2011 over FY 2010. This may be related to an effective 1.5% rate cut in FY 2010. It is unclear how decreased provider earnings were spread over the entire workforce and other operational expenditures. Nonetheless, mean turnover rates for direct care workers decreased over this same period, while mean tenure in months increased, possibly an effect of the recession and tight job market.

Anecdotal evidence in both sectors points to employers limiting the availability of voluntary fringe benefits or requiring greater employee contributions. Providers have used this as a strategy to compensate for the rising cost of health insurance premiums during a period when reimbursement rates shrank or remained flat. This will be an avenue of future investigation.

### Financial Performance

The majority of MHA and DDA providers appear "solvent" according to standard measures of financial performance, although a significant percentage show poor performance on many of the financial indicators typically used to gauge solvency. But a review of the data collected by MHA

and DDA does suggest a number of points to be mindful of in this and future CSRRC assessments:

- "Financial solvency" in any industry is a concept without strict parameters, although measures such as negative margins, fewer than 30 days of cash reserves, current ratios below 1.0, and negative net assets are indicators of an entity's financial vulnerability. There is no normative definition of solvency for community-based mental health or developmental disability providers. Monitoring the performance measures of these providers over time, using conforming and complete data, and identifying those demonstrating consistently poor financial performance, is the best way to assess solvency in these sectors.

- It is unlikely that any public funding system can ensure solvency for all providers given the budgetary challenges faced by public agencies, which tend to constrain rates, and given the wide range of size, composition of services, the profile of the population served, and business acumen among providers. Successful providers will develop effective operational strategies and find efficiencies in how they deliver services within funding system parameters. Others will fare poorly, as reflected in their financial indicators.

- The CSRRC governing statute implies that "the delivery of efficient and effective services" must be considered in the assessment of financial solvency. (Md. Code Ann. Art. Health-Gen., § 13-809(1)(ii).) There is no definition or common understanding of "efficient and effective" service delivery in the community-based mental health and developmental disability sectors for the CSRRC to use as a guide. And while the concept of "effective" is incorporated in the outcome and satisfaction surveys used by ValueOptions and DDA for their respective constituencies, the data on financial performance are not correlated with the outcome measures of a given entity.

These concerns will persist even after implementation of community-based service payment system reforms anticipated by the Department of Health and Mental Hygiene (DHMH). We will try to address them in the coming years, both inside and outside our collaboration with DHMH on structural changes.

With respect to developing relative performance measures of DDA providers, current methods of data collection do not permit us to do more than compare profit margins among the business lines that are eligible for rate-based payments. Business lines funded through the Fee Payment System (FPS) show losses in most years; CSLA programs show profits every year, although the margin has declined.

## Impact of the Annual Inflationary Cost Adjustment

Rates remained essentially stagnant for MHA community-based providers in FY 2010 and FY 2011. DDA providers saw an effective rate cut of 1.5% in FY 2010 and no change in rates for FY 2011.

The new methodology meant to result in an annual inflationary cost adjustment went into effect for the first time in the FY 2012 budgeting process and was implemented by DHMH with no input from the CSRRC in FY 2012 and FY 2013. Because there is a two-year lag time in the availability of financial data (i.e., the FY 2013 update was based on FY 2011 financial data, which preceded the new rate setting methodology), we cannot yet determine the impact of these adjustments. We identified several problems with the way MHA and DDA applied the DBM update factors to the cost structures in FY 2013.

## Incentives and Disincentives of the Payment System and Quality of Care

In the mental health sector, neither the OMHC nor the PRP fee-for-service model incentivizes provider accountability for patient outcomes, a major flaw with this type of system. Moreover, because reimbursement rates are not cost based, they have a varied financial impact on providers depending on the service mix, size of the entity, and the entity's infrastructure. Direct fee-for-service reimbursements to OMHCs encourage providers to maximize revenues by providing as many services as possible. The case rate system for reimbursing PRPs has the effect of encouraging providers to limit services above a minimum to optimize earnings by reducing costs. Neither payment system takes quality of care into consideration. Quality is monitored and evaluated through external mechanisms (e.g., ValueOptions Outcomes Measurement System) but it is not financially incentivized.

In the developmental disability sector, FPS design provides an incentive to serve people with less complex support needs in day programs because they are more likely to show up, and absences are not compensated; it also incentivizes providers to serve people who already have employment skills in supported employment programs because they require less assistance but the provider can claim the same rate. In residential programs, there is an incentive to help people who do not qualify for add-ons achieve a higher level of independent living, which reduces provider costs. There is a disincentive to promote greater independence among people who receive add-on funding because the rate supplement would then disappear.

The payment system will be modified for MHA providers as a result of behavioral health integration and DDA providers in conjunction with adoption of the Supports Intensity Scale (SIS) assessment tool. It is anticipated that quality of care considerations will be incorporated in these processes.

## Weighted Average Cost Structure

DHMH determined the weighted average cost structure of providers for the FY 2012 and FY 2013 budgets. For FY 2014, we made a certain number of changes to the methodology used by MHA and DDA, most importantly 1) using the statements of functional expenses of all MHA providers instead of a sample of 10 or 11, and 2) assigning costs for permanent contract staff who are essential to the mission of the entity to the salaries and wages category.

The CSRRC will continue to refine its methodology for establishing the weighted average cost structures of providers each year. This will be facilitated by improved data collection. In particular, because the "other" category is the second largest spending category after salaries in

both sectors, we will need to determine if it is possible and appropriate to reapportion some or all of these costs.

## Issues for Future Study

The CSRRC intends to address the following areas over the coming years, as time and resources permit. The focus of our work may change based on developments related to behavioral health integration and use of the SIS. But our main focus for 2013 will be on improving data collection.

- Advise MHA on how to integrate payment incentives for provider solvency, efficiency, and quality as part of integrating mental health and substance use disorder service delivery. Assist DDA with the payment system reforms that are expected to result from implementation of the SIS.

- Work with MHA and DDA to clarify the terminology used in financial and wage reporting and to develop information guides and other supports that promote correct and complete submissions.
- Develop new formats and inputs for reporting financial and wage data to MHA and DDA (including cost reports and wage surveys), and standardize these insofar as possible across both sectors. Take into consideration the need to identify costs in terms of DBM classifications for purposes of determining rate updates.
- Investigate the potential for adopting and implementing a secure and private centralized electronic system for submitting financial and wage survey information in standardized formats to MHA and DDA.
- Identify selected samples of MHA and DDA providers for more in-depth and longitudinal analyses of financial indicators and design and conduct analyses.
- Identify meaningful financial indicators and normative standards of financial health, and develop supplemental survey methodologies to better understand the financial condition of providers.
- Develop and implement a method for examining voluntary fringe benefit trends and the role these play in compensation for MHA and DDA employees who provide direct care. In the DDA sector especially, some lower level employees choose to decline certain employment benefits because their own contribution is too costly. It would be interesting to look at this issue, and to see how this changes for health insurance as the Health Benefit Exchange becomes operational.
- Develop relative performance measures of DDA providers that incorporate information on the people served to benchmark performance while adjusting for risk. This would identify when provider costs in a given category deviate from the norm, regardless of whether people are more or less costly to serve. We may be able to develop comparable performance measures for MHA providers based on introduction of a cost report.

## Summary of Recommendations

Over the next term, the CSRRC will focus on improving the quality, quantity, and type of data collected from MHA and DDA providers, and on refining and supplementing its data analysis. In this regard, we make the following recommendations for MHA and DDA consideration:

- Rigorously enforce full compliance of MHA and DDA providers with regulations on annual financial and wage submissions. Submissions that are incomplete should not be accepted as demonstrating compliance: they should be returned to providers for resubmission.
- Clarify the terminology used in financial and wage surveys and provide more extensive and complete definitions in the instruction sheets, with sufficient details to reduce confusion and erroneous data entry; it may be helpful to conduct information sessions or offer other assistance to providers to improve the quality of submissions.
- Improve the format of electronic data submissions to make them useable without excessive need to transpose information. This would greatly facilitate data analysis and reduce errors.
- Refocus the DDA Wage and Benefits Survey to provide more useful information on employee earnings rather than provider expenditures, and to emphasize direct support professionals. Revise the MHA Salary Survey and align with DDA survey to the extent possible.
- Expand and refine data collection on fringe benefits, concentrating on voluntary benefits for direct support professionals and benefit quality.
- Create a standardized salary and benefits survey for all providers.
- Require *audited* financial statements from all providers.
- Require cost reports of all providers.
- Resolve and recover all outstanding amounts owed DDA by providers for improper use of enhanced funding under the Wage Equalization Initiative.

# BACKGROUND

## 1. History of the CSRRC

The Maryland General Assembly established the Community Services Reimbursement Rate Commission (CSRRC) in 1996 to provide guidance on reimbursement for non-rate regulated[1] community-based mental health and developmental disability providers.[2] It is a non-expert body consisting of seven members—three from the relevant provider sectors, four unaffiliated with providers—whose decisions are informed by technical consultants contracted by DHMH and the contributions of stakeholders who participate in ad hoc advisory groups assembled by the CSRRC.

Although it has been continuously reauthorized for successive five-year terms since its inception, the CSRRC ceased to meet during the period April 2009-October 2011 due to insufficient funds to hire a technical contractor. Because of this operational hiatus, the CSRRC appointed in October 2011 under a new statute faced a number of challenges:

- An incomplete slate of commissioners for the first six months of the 2011-2012 term.
- A lack of institutional memory and expertise due to the fact that all but one commissioner was new to the body, and virtually no files or historical documentation existed beyond some of the annual reports available on the CSRRC website.
- An inability to make hiring decisions: the technical expert was selected and the scope of work defined by DHMH before the CSRRC was seated.
- An absence of administrative and logistical support.
- A backlog of several years of financial and wage data that needed to be compiled and analyzed in order to determine trends that would cover the "gap" years.
- An inability to influence data collection and analysis methodologies because of the timing of CSRRC authorization (with respect to regulatory deadlines for data submission).

That said, the CSRRC is greatly indebted to Theodore Giovanis, former CSRRC chair, and J. Graham Atkinson, former CSRRC technical consultant, for their generosity of time, advice, and material assistance in helping to reestablish and guide the Commission in initial stages. The CSRRC must also acknowledge the willingness of Secretary Joshua Sharfstein to engage with the CSRRC and his commitment to resolve problems and ensure that going forward the CSRRC has the resources necessary to be effective as an independent unit within DHMH. The CSRRC is

[1] Non-rate regulated providers are recipients of public funding whose reimbursement rates are determined by the Health Service Cost Review Commission or established by federal law.
[2] Md. Code Ann. Art. Health-Gen., §§ 13-801 to -810.

also grateful to the Maryland Association of Community Services (MACS) for providing it with meeting space and logistical support at no charge.

The first meeting of the CSRRC took place on October 28, 2011. For this initial term, the CSRRC retained the technical advisory group structure of previous commissions: a Mental Health Technical Advisory Group (MH TAG) and a Developmental Disabilities Technical Advisory Group (DD TAG), both bringing in the participation of state and industry stakeholders, along with several commissioners (see Appendix 2 for TAG membership). An effort was made to involve patient/client advocates, but this proved unsuccessful. The full Commission and TAGs met on alternating months (see Appendix 3 for meeting schedule). The Hilltop Institute was contracted by DHMH to provide technical expertise to the CSRRC that consisted of data collection, advising on methodology, data analysis, participation in all CSRRC and TAG meetings, and production of draft minutes and reports.

Section § 13-809 of the CSRRC statute requires submission of an annual report to the Governor, the Secretary, and the General Assembly on or before October 1 of each year that

> (1) Describes its findings regarding:
>
> (i) The changes in wages paid by providers to direct care workers;
>
> (ii) The financial condition of providers, the ability of providers to operate on a solvent basis in the delivery of effective and efficient services that are in the public interest, and the impact of the annual inflationary cost adjustment as set forth in § 16–201.2(c) of this article, on the financial condition of providers;
>
> (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;
>
> (v) The recommended weighted average cost structure of providers as set forth in § 13–806 of this subtitle, for the next succeeding fiscal year; and
>
> (vi) Any additional recommendations regarding rate–setting methodologies to align provider rates with reasonable costs;
>
> (2) Recommends the need for any formal executive, judicial, or legislative action;
>
> (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.

The report herein is submitted in fulfillment of this requirement.

It should be noted that the CSRRC mandate does not encompass the universe of non-rate regulated community-based mental health and developmental disability providers in Maryland. Rather, the CSRRC authorizing statute defines "provider" as "a community–based agency or program funded (1) by the Developmental Disabilities Administration to serve individuals with developmental disabilities; or (2) by the Mental Hygiene Administration to serve individuals with mental disorders" (§ 13-801(c)). There are some 187 mental health and 175 developmental disability entities fitting this definition that are authorized to receive public funding by the respective agencies. This report pertains exclusively to this group.

## 2. Recent Developments in Rate-Setting

The CSRRC mandate under Md. Code Ann. Art. Health-Gen., § 13-801 et seq. has been amended several times since 1996. The most important modification made to the 2010 reauthorization was to remove responsibility for rate recommendations.[3] Instead, the CSRRC must develop a weighted average cost structure of providers in each sector guided by the cost categories used by the Department of Budget and Management (DBM) for units of state government. Beginning with the FY 2012 budget, DHMH is required to adjust reimbursements for inflation based on the weighted average cost structure proposed by the CSRRC (Md. Code Ann. Art. Health-Gen., § 16-201.2(c), enacted 2010).[4]

MHA and DDA prepared their own weighted average cost structures of providers to determine inflationary adjustments for the FY 2012 and FY 2013 budget cycles because the CSRRC was either not functioning (FY 2012) or was appointed too late to provide input (FY 2013). The rate updates derived from this new formula came on the back of stagnant or regressive budgeting to compensate for shortfalls consequent to the recession. For example, although the proposed FY 2010 budget foresaw a 0.9% rate increase for DDA providers, the Board of Public Works rescinded this in July 2009 as part of measures to close a state budget deficit. Additional cuts went into effect in October 2009, including a 2% decrease for DDA providers through the rest of that fiscal year—effectively cutting FY 2010 rates by 1.5%. To avoid imposing a similar 1.5% rate cut on its providers in FY 2010, MHA drew savings from restricting eligibility and coverage for non-Medicaid fee-for-service mental health care, which is funded entirely by the state with no federal match. Cost containment measures have slashed the number of uninsured patients in the public mental health system, but total enrollment has continued to grow 9% annually from FY 2007-FY 2011, in part due to Medicaid expansion and the effects of the recession.

MHA providers saw no rate change in FY 2011. In FY 2012, the first year that the new rate-setting method went into effect, they netted a cost-of-living adjustment of only 0.29%. The new

[3] This change enhances rather than diminishes CSRRC contributions to the rate-setting process. In the past, CSRRC was responsible for *recommending* rate updates, but these could be ignored. In practice, CSRRC recommendations were seldom implemented. Under the new formula, DHMH is *required* to implement a cost-of-living increase based on the CSRRC weighted average cost structure so long as units of state government receive one. Thus, providers are guaranteed at least equal treatment with state agencies (but cannot be subjected to a rate reduction) in the DHMH budget proposal. Whether it is appropriate to compare community-based providers to state units of government for budgetary purposes is not considered here, but is something that the legislature may want to revisit in the future.
[4] Sometimes referred to as SB 633.

methodology itself yielded a 1.13% increase (split between the MHA and DBM budgets), the same increase as that foreseen for DDA providers. But this coincided with a simultaneous provision for a 2.5% rate cut in the MHA FY 2012 budget. Passage of the $10 million supplemental budget added back 1.66% to MHA provider rates, resulting in a net increase of 0.29%. This was a rather inauspicious beginning for the new rate setting process. In FY 2013, MHA providers were allocated a .88% increase based on the cost structure method. It should be noted that MHA sampled just 11 providers in FY 2012 and 10 providers in FY 2013 to establish the cost structure used for rate setting.

DDA providers received no rate update in FY 2011 either. FY 2012 saw DDA rate increases meant in part to hold providers harmless for a change in absence day policy, but that also included a 1.38% inflationary factor for some programs. The result was an overall net increase of 1.13% based on the new rate setting method.[5] In FY 2013, DDA providers received a total 2% increase (1.03% based on the new rate setting process, and 0.97% granted at the Governor's discretion). In its FY 2013 budget analysis, the Department of Legislative Services noted that because the CSRRC had been inactive for more than two years, it was unclear whether the financial condition of DDA providers justified the 2% increase for FY 2013.[6] Unfortunately, persistent data collection weaknesses, which are detailed throughout this report and that we hope to resolve in coming years, make it difficult to draw any conclusions in this regard.

The weighted average cost structure prepared by the CSRRC (see below) was delivered in advance of this annual report to MHA and DDA for use in calculating FY 2014 cost-of-living increases for community-based providers. As such, it represents the first time that the 2010 provisions of § 13-806(b)(1) and § 16-201.2(c) will be fully implemented.

# 3. Provider and Payment System Overview

## A. MHA Supported Community-Based Services

The MHA community-based entities under CSRRC jurisdiction serve some 80,000 people, or about 60% of patients in the public mental health system, which numbered 135,000 children and adults in FY 2011. Another 34% of this patient population is being served by federally qualified health centers (which have payment rates set by federal regulation), residential treatment centers operated by the state, and hospital-based programs regulated by the Maryland Health Services

[5] Prior to FY 2012, providers received the standard daily rate for FPS programs even on days when a person did not attend, although the state could not claim federal matching funds for those days. Beginning in FY 2012, DDA stopped paying for absences in day and supported employment programs, and paid no more than 33 bed hold days in residential programs. To compensate providers for potential revenue losses, DDA increased rates for day (15.6%), supported employment (15.4%), residential (1.7%) and add-on (1.7%) services. These amounts were calculated to keep FY 2012 earnings for these programs at least at the level of FY 2010. CSLA, individual support (ISS), family support (FSS), and resource coordination (including those served through New Directions) rates received a 1.38% cost-of-living adjustment.

[6] Analysis of the FY 2013 Maryland Executive Budget, 2012, p. 24.

Cost Review Commission. The remaining 6% receive care from the roughly 2,900 individual and private group practices that accept reimbursement from public funding sources (e.g. Medicaid).[7]

There are two MHA-approved community-based service models: outpatient mental health clinics (OMHCs), and psychiatric rehabilitation providers (PRPs). OMHCs conduct assessments; evaluations; and individual, family, and group therapy. OMHCs are reimbursed on a fee-for-service basis (e.g., an hour of therapy by a licensed therapist). An itemized fee schedule that includes OMHC rates is published in COMAR 10.21.25.05 to 10.21.25.08. It should be noted that OMHCs are reimbursed at 100% of the maximum allowable Medicaid rate for physicians, regardless of the kind of provider who delivers the services. That is, they are reimbursed anywhere from 12% to 25% more than physicians in solo or private group practices who perform the same services for Medicaid patients.[8] PRPs treat individuals with a serious emotional disturbance or a serious and persistent mental disorder. These providers are reimbursed for face-to-face patient encounters on a monthly rate based on a person's assessed need for a minimum and maximum range of services. An itemized PRP fee schedule is published in COMAR 10.21.25.09. Eligibility, utilization review, outcomes assessments, and claims processing is handled by Maryland's administrative service organization, currently ValueOptions.

For-profit entities make up a significant portion of the 187 mental health service providers under CSRRC jurisdiction; the others are independent non-profits, university affiliates, or county or local health departments. More PRPs than OMHCs are organized as for-profit businesses.

## B. DDA Supported Community-Based Services

The vast majority of the 175 community-based developmental disability providers, with some 15,079 people served (July 2012), fall under CSRRC jurisdiction. They perform a range of services for people with intellectual and physical disabilities that include day programs, residential programs, supported employment (job skills), individual and family supports, assistance that enables people to remain in their own homes, transportation, resource coordination, and behavioral services. The DDA Fee Payment System (FPS) covers three programs—day, residential and supported employment—plus "add-ons" to accommodate temporary changes in an individual's needs usually lasting under one year (but these can be extended). It also pays for one-time supplemental costs for special equipment, assistive technology, accessibility modifications to structures, and other needs that are not covered by Medicaid, private insurance, or any other state or federal health program. There is a separate system for reimbursing community-supported living arrangements (CSLA). Medicaid and state general funds pay for FPS and CSLA programs. Providers also receive income from people served (including copayments), vocational and professional contracts, other government revenue streams (e.g., Division of Rehabilitation Services), grants, and donations.

[7] These are defined as those practices that filed at least one claim for reimbursement from the public mental health system in the past year. Many solo practitioners and private group practices do not accept Medicaid or even private insurance and they tend to serve a lower-risk patient population.

[8] For example, an OMHC is reimbursed $183.90 for a 45-minute diagnostic interview with a child, 25% more than the physician reimbursement rate of $146.63. The same diagnostic interview with an adult is reimbursed at $164.65 for an OMHC, 12% more than the $146.63 physician rate. (COMAR 10.21.25.05.)

As of July 2012, there was a waiting list of 7,403 individuals seeking DDA-funded services. Eighty percent (5,892) of these were on the "current request" waiting list, defined as those who will likely need services within three years due to deteriorating condition or because family providers will no longer be able to shoulder sole responsibility for care.[9]

DDA does not "reimburse" providers in the strictest sense of the term. Rather, it pays providers quarterly advances based on projected earnings on the following schedule: a four-month advance at the beginning of the first fiscal quarter, three-month advances for each of the second and third quarters, and a two-month advance for the fourth quarter. Providers must reconcile payments received with actual services delivered at the end of the year and reimburse any overpayment.

FPS rates are computed as the sum of three components:

- The service needs of the individual as determined by their matrix score on the Individual Indicator Rating Scale (IIRS);
- The indirect costs of providing services; and
- The regional location of the services, which incorporates cost-of-living variations.

The provider component is made up of four cost centers: administrative, general, capital, and transportation (this last with a higher rate for people who use wheel chairs or scooters); these are fixed, statewide *per diem* rates, with separate scales for day and residential programs. The rate schedule and terms for the FPS and professional contracts are set out in COMAR 10.22.17.06 to 10.22.17.13; update notices are issued annually.

Beginning in 2012, the FPS method of compensating supported employment was changed to pay providers the *per diem* rate for days when the total hours of paid employment ***plus*** vocational supports equaled at least 4 hours. The prior rule required individuals to be engaged in paid employment alone for at least 4 hours. CSLA is the only program reimbursed on an hourly rate, which is based on the number of individuals served at a site and the service needs of those individuals.

Some 15% of DDA providers are organized as for-profit entities.

[9] DDA prioritizes funding for those in most urgent need: First served are those in crisis, who are eligible for ongoing services and supports. Second are those identified for crisis prevention, who are eligible for individualized short-term (up to 3 months) supports that help them resolve immediate crisis needs or triggers so they can remain in their own homes. Third are those in "current request." Revenue from the Alcohol Tax was dedicated to funding a $15 million Waiting List Initiative in FY 2012 that was used to provide community-based supports for 287 individuals on the crisis resolution list, and 1,180 individuals on the crisis prevention list. Because this left 607 people eligible for supports still on the crisis prevention list, DHMH made additional funding available so that all those on the list received the supports they needed.

# FINDINGS

## 1. Wages and Benefits

***§ 13-809(1)(i). Changes in wages paid by providers to direct care workers.***

Direct care workers, also referred to as direct support workers or direct support professionals, are defined here as employees who spend more than 50% of their work time providing hands-on care and assistance (as opposed to administrative, logistical, care coordination, or advocacy services) to people with mental health or developmental disability needs. Ordinarily, this nomenclature applies only to the developmental disability sector. The CSRRC, however, has continued to interpret its mandate to review wage data broadly to encompass mental health professionals as well, and at all levels. It should be noted that developmental disability direct care workers are generally not required to have any credentials beyond a high-school diploma or GED and are at the lower end of the salary spectrum.[10] In the mental health sector, however, all those providing direct care must have academic degrees ranging from a bachelors (rehabilitation counselors) to a medical doctorate (psychiatrists), and most must meet licensing requirements as well.

### *Methodology*

MHA and DDA collect wage and benefits information annually from providers for use by the CSRRC in conducting its analyses. Timely completion and electronic submission of the surveys, which are in Excel spreadsheets, are mandatory.[11]

The MHA and DDA surveys, however, are not in the same format, nor do they ask similar questions or cover similar professional categories. The MHA Salary Survey asks OMHCs to report information for 12 specified job titles, and asks PRPs to report on six specified job titles. The survey covers the full range of therapeutic staff, plus salaries and benefits for certain executives. It asks for a minimum and maximum salary range for each position and the current salary (usually interpreted as the average current salary if there is more than one employee with that job title) with and without fringe benefits. The way the survey is constructed makes it possible to quantify the base earnings of mental health therapists and executives. The MHA survey includes other data that help shape a fuller picture of the workforce: mean FTEs, average tenure, mean number of employees, terminations, and the number of vacancies.

By contrast, the DDA Wage and Benefits Survey[12] asks for payroll expenditures for two job categories—direct support workers and first line supervisors—in each of five business lines: individual and family supports, day programs, residential programs (live-in and not live-in), supported employment, and CSLA. It also asks for payroll expenditures for drivers in a "transportation" category. The survey format has evolved over the years to eliminate separate reporting on fringe benefits for direct support workers (FY 2004), to combine "aides" and

[10] DDA providers also employ certified medical technicians (CMTs) in some cases.
[11] COMAR 10.21.17.06(A)(2) applies to MHA providers; COMAR 10.22.17.05(C) applies to DDA providers.
[12] MHA and DDA title their surveys differently. This report retains the official titles.

"service workers" into a single "direct support worker" job category (FY 2005), and to annualize data rather than providing it by pay period, as was done prior to FY 2007.[13] The Maryland General Assembly allocated funds for a five-year wage initiative, beginning in FY 2003, whose purpose was to achieve parity in compensation for private sector direct care workers with those employed by the state. The DDA Wage and Benefits Survey was designed, in part, to monitor whether the increased payments were used as intended to increase the wages of direct support workers.

Nevertheless, the format of the DDA Wage and Benefits Survey makes it impossible to compare private and public sector compensation because it looks at employer expenditures rather than at employee wage ranges or earnings. Because reported expenditures combine base pay, overtime, shift differentials, agency fees, and bonuses, the totals cannot be converted into a base hourly wage for a given position. The survey also asks for fringe benefit expenditures for all personnel rather than just direct care workers, and in a format that makes it impossible to isolate the portion of expenditures devoted to that subset of employees. Other data requested in the survey include the number of direct care employees, vacancies, separations, and average tenure.

## A. MHA Providers

A total of 135 MHA providers reported FY 2011 financial and wage data, including some county health departments (although these are not required to report). In order to minimize bias from subsidization of mental health care by other more lucrative lines of business or from outliers, we excluded the following MHA providers from our FY 2011 wage analysis:

- Those headquartered outside of Maryland
- Those with less than 40% of revenue derived from treatment of mental health patients
- University hospital system affiliation
- County health department

This left a cohort of 81 community-based OMHCs and PRPs. We had anticipated comparing these private sector salaries with those of public sector employees as published in the DBM salary plan and job specifications for the relevant fiscal year. But after many attempts to design a valid methodology, we concluded that direct comparisons using the data at our disposal would not be instructive. To conduct a meaningful comparison would require 1) actual earnings data on individual state employees (rather than rate tables), which is difficult to gather; 2) even if such data collection were not unduly burdensome, it would be impossible to discern and account for differences in qualifications, experience, tenure, etc.—not to mention the range and variation of roles and responsibilities—that factor into a given employee's compensation; and finally 3) there are ancillary influences on compensation unique to one sector or another (e.g., public sector cost containment goals that have kept civil servants concentrated in the lower steps of the salary scale). We should emphasize, however, that our review of the workforce data submitted by MHA providers gives us no reason to believe that their staff are either under or over compensated.

**Table 1** shows the changes in OMHC wages and workforce characteristics for FY 2009-FY 2011. The data is presented as a general indication of compensation rates: ***it cannot be***

[13] CSRRC Annual Report 2009, p. 44; CSRRC Annual Report 2008, p. 43.

***interpreted as a trend***. Only 65 providers submitted financial and salary survey data in each of FY 2009 and FY 2010. Of these, 35 (55%) did not report in both years. MHA used its enforcement authority to gain better compliance for FY 2011. But an exclusion screen was applied to the FY 2011 data, again limiting the longitudinal value of the data set. Therefore, conclusions about trends are not possible. The FY 2008 data set appeared so unreliable on its face that we decided to exclude it altogether.

The mean number of full time equivalent (FTE) employees refers to the average number of 40-hour-per-week positions in a job category. The mean number of employees is the average number of actual people in those categories; because it includes part-time, full-time, and partial-year staff, this number is always greater than the number of FTEs. Some entities may have reported zero FTEs for certain positions, especially in senior management. Reasons for reporting an FTE of less than one include a vacancy in the position, labeling the highest officer something other than "executive director," (such as chief operating officer), or that the entity is too small to require a full-time person in the role. Past CSRRC reports did not include salaries for executive positions, but we have done so here for completeness since this is collected by MHA.

Psychiatrists and medical directors are invariably the most highly compensated OMHC employees. Providers typically employ one or two psychiatrists and larger numbers of social workers and counselors. Providers tell us that psychologists and nurse psychotherapists are being hired less frequently, but the percentage of psychiatric nurse practitioners (who can perform these functions in addition to many of the functions of psychiatrists) in the workforce is rising. Vacancy rates appear highest among those professionals with prescriptive authority: psychiatrists and psychiatric nurse practitioners. The vacancy rate, however, has to be approached with caution because there is no way to know how many of these positions are "live"—that is, entities are actively recruiting for them, as opposed to preserving a budget line for the future. Nonetheless, the higher vacancy rates among child and adult psychiatrists and psychiatric nurse practitioners would support information gleaned from discussions with providers, which indicates an attempt to develop a more flexible workforce that optimizes availability of needed professional expertise while reducing payroll costs.[14]

Fringe benefits reported as a percentage of salary range between medians of 10% and 21%, depending on the position and year. The survey defines fringe benefits as including both employer contributions for mandatory benefits (e.g., Social Security and Medicare (FICA)) and the employer-paid portion of voluntary benefits (e.g., health insurance and retirement). Some mandatory employer contributions do not accrue directly to individual employees, such as federal and state unemployment tax and workers compensation insurance, but they are included in the fringe benefit category. The employer-paid portion of mandatory benefits accounts for about 8% of the total percentage of fringe reported.[15] Where providers report fringe benefit

[14] Psychiatrists are medical doctors who specialize in psychiatry. Psychiatric nurse practitioners have a master's degree or doctorate in psychiatric-mental health nursing and board certification, and they must work in collaboration with a medical doctor. Their job functions often include psychotherapy, counseling, and primary care, which psychiatrists do not perform, but which overlap with psychologists, social workers, and counselors.

[15] Per employee: FICA is 7.65% of the first $106,800 of salary (2011); federal unemployment tax (FUTA) is effectively, after credits, 0.8% of the first $7,000 of salary ($56); state unemployment tax (SUTA) is on average 2.4% of the first $8,500 of salary ($205); and workers compensation premiums vary by industry, job, and claims history and are calculated per $100 of payroll.

percentages of less than 8% for salaried employees (as opposed to contract employees), it indicates that some may be misinterpreting instructions to include all required cost categories in this field. It should be noted that top-level clinicians (especially psychiatrists, but also psychiatric nurse practitioners) are often hired as independent contractors, and therefore would not receive voluntary benefits or trigger mandatory contributions. In addition, a number of providers list actual salaries outside the salary range reported for the same job title. The medians calculated for each field are based only surveys in which the relevant field was completed; not all respondents completed all fields. For this reason the median salaries with and without benefits, as reported in Table 1, may exceed the reported ranges of salaries for that position. MHA providers should be instructed to pay closer attention to the instructions supplied with the salary survey to avoid these errors and omissions, and to resubmit corrected reports when errors and omissions are discovered.

## Table 1. MHA OMHC Salary Survey Summary, FY 2009 – FY 2011

| Position | MEAN Number of FTEs | Average tenure in years MEAN | MEDIAN CURRENT SALARY without fringe benefits, for a full time employee | SALARY RANGE: MINIMUM (no fringe) MEDIAN | SALARY RANGE: MAXIMUM (no fringe) MEDIAN | MEDIAN FRINGE BENEFITS (AS % OF OVERALL SALARY) | MEDIAN TOTAL CURRENT SALARIES INCLUDING FRINGE BENEFITS | Mean Number of Employees | Mean VACANCY RATE[16] (%) |
|---|---|---|---|---|---|---|---|---|---|
| **Executive Director** | | | | | | | | | |
| FY 2011 | 1.00 | 13.29 | $99,979 | $77,500 | $110,504 | 17 | $112,985 | 1.06 | 0 |
| FY 2010 | 0.89 | 11.84 | $87,788 | $72,500 | $99,990 | 18 | $103,188 | 1.50 | 0 |
| FY 2009 | 0.87 | 11.98 | $90,000 | $70,000 | $106,159 | 20 | $104,256 | 0.96 | 0 |
| **Medical Director** | | | | | | | | | |
| FY 2011 | 1.09 | 7.38 | $159,903 | $130,000 | $173,313 | 13 | $166,635 | 1.03 | 3 |
| FY 2010 | 0.82 | 6.80 | $140,895 | $135,000 | $170,328 | 15 | $158,600 | 1.04 | 0 |
| FY 2009 | 0.76 | 7.08 | $144,800 | $130,000 | $175,000 | 15 | $152,958 | 1.01 | 2 |
| **Clinical Director** | | | | | | | | | |
| FY 2011 | 1.22 | 7.66 | $73,000 | $62,327 | $81,393 | 15 | $84,301 | 1.22 | 0 |
| FY 2010 | 1.07 | 8.11 | $69,889 | $60,000 | $75,000 | 20 | $81,560 | 1.22 | 0 |
| FY 2009 | 1.02 | 7.63 | $68,196 | $60,000 | $80,000 | 20 | $79,175 | 1.23 | 7 |
| **Psychiatrist: Adult** | | | | | | | | | |
| FY 2011 | 1.36 | 6.03 | $166,832 | $135,514 | $185,800 | 14 | $164,865 | 2.55 | 8 |
| FY 2010 | 1.48 | 4.73 | $147,177 | $131,000 | $163,602 | 12 | $152,143 | 2.40 | 23 |
| FY 2009 | 1.27 | 5.52 | $149,879 | $123,363 | $170,000 | 12 | $143,000 | 2.25 | 11 |

[16] The vacancy rate is defined as the number of vacancies at some fixed point in time divided by the number of budgeted positions.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Psychiatrist: Child** | | | | | | | | | |
| FY 2011 | 0.95 | 5.20 | $155,513 | $139,675 | $160,980 | 21 | $203,910 | 1.77 | 11 |
| FY 2010 | 1.08 | 7.77 | $141,532 | $120,000 | $165,000 | 18 | $161,476 | 1.52 | 38 |
| FY 2009 | 0.73 | 6.44 | $152,833 | $128,017 | $165,700 | 11 | $158,496 | 1.42 | 2 |
| **Psychologist** | | | | | | | | | |
| FY 2011 | 0.56 | 3.51 | $67,000 | $58,500 | $70,604 | 16 | $76,639 | 1.23 | 0 |
| FY 2010 | 2.18 | 10.51 | $60,725 | $56,449 | $72,000 | 21 | $65,000 | 1.75 | 0 |
| FY 2009 | 0.71 | 4.81 | $43,539 | $27,571 | $36,270 | 10 | $51,519 | 1.58 | 1 |
| **Psychiatric nurse practitioner** | | | | | | | | | |
| FY 2011 | 0.98 | 4.61 | $80,000 | $75,587 | $85,010 | 10 | $69,090 | 1.91 | 14 |
| FY 2010 | 0.88 | 2.67 | $83,036 | $79,040 | $80,000 | 11 | $94,848 | 1.27 | 0 |
| FY 2009 | 0.45 | 4.23 | $74,464 | $65,137 | $74,500 | 15 | $60,792 | 1.10 | 0 |
| **Nurse psychotherapist** | | | | | | | | | |
| FY 2011 | 1.41 | 10.73 | $58,685 | $38,037 | $61,102 | 20 | $61,414 | 2.46 | 0 |
| FY 2010 | 1.29 | 7.98 | $57,957 | $51,000 | $63,167 | 23 | $72,240 | 2.00 | 0 |
| FY 2009 | 1.23 | 6.46 | $54,169 | $37,567 | $60,000 | 21 | $58,825 | 1.71 | 0 |
| **Social Worker - LCSW-C** | | | | | | | | | |
| FY 2011 | 5.31 | 4.35 | $52,076 | $41,983 | $60,000 | 19 | $62,260 | 6.95 | 5 |
| FY 2010 | 5.07 | 4.84 | $51,089 | $44,200 | $57,372 | 19 | $60,970 | 6.28 | 11 |
| FY 2009 | 5.35 | 6.99 | $48,500 | $41,074 | $60,000 | 22 | $57,249 | 6.55 | 10 |
| **Social Worker - LGSW** | | | | | | | | | |
| FY 2011 | 3.92 | 3.02 | $42,962 | $39,000 | $48,260 | 19 | $49,662 | 7.18 | 5 |
| FY 2010 | 4.23 | 3.16 | $42,000 | $39,250 | $48,170 | 18 | $48,750 | 4.90 | 16 |
| FY 2009 | 4.38 | 9.10 | $44,532 | $37,000 | $51,781 | 21 | $51,526 | 6.07 | 4 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Professional Counselor-LCPC** | | | | | | | | | |
| FY 2011 | 3.40 | 5.19 | $51,659 | $41,750 | $52,190 | 19 | $60,600 | 3.92 | 2 |
| FY 2010 | 3.09 | 4.66 | $48,485 | $41,309 | $55,232 | 14 | $56,882 | 3.43 | 11 |
| FY 2009 | 2.54 | 4.58 | $49,313 | $41,037 | $55,000 | 21 | $57,776 | 2.92 | 4 |
| **Professional Counselor-LGPC** | | | | | | | | | |
| FY 2011 | 2.08 | 2.53 | $40,977 | $38,550 | $43,793 | 17 | $45,242 | 2.20 | 5 |
| FY 2010 | 1.87 | 2.98 | $37,500 | $36,750 | $48,000 | 19 | $48,625 | 2.10 | 14 |
| FY 2009 | 1.62 | 2.34 | $40,587 | $39,500 | $49,850 | 15 | $48,274 | 2.43 | 5 |
| **Other**[17] | | | | | | | | | |
| FY 2011 | 3.59 | 5.15 | $32,920 | $28,468 | $45,131 | 19 | $38,876 | 3.96 | 3 |
| FY 2010 | 2.58 | 5.19 | $33,071 | $28,368 | $41,967 | 18 | $43,015 | 3.38 | 0 |
| FY 2009 | 3.18 | 4.53 | $38,286 | $32,000 | $47,000 | 21 | $47,201 | 3.94 | 8 |

[17] Consists primarily of administrative support personnel

**Table 2** shows PRP wages and workforce characteristics for FY 2009-FY 2011. Again, the same caveat regarding trends applies to PRP data. The majority of employees are rehabilitation counselors or specialists, whose median salary has remained at about $30,000 over the three years of survey data available. Vacancy rates among rehabilitation counselors as well as program managers are relatively high compared to the rates among other PRP positions.

Fringe benefit percentages vary less than those of OMHC employees, ranging around 19% to 21% percent. PRPs appear to make greater use of salaried employees rather than contract staff.

**Table 2. MHA PRP Salary Survey Summary, FY 2009 – FY 2011**

| Position | MEAN Number of FTEs | Average tenure in years MEAN | MEDIAN CURRENT SALARY without fringe benefits, for a full time employee | SALARY RANGE: MINIMUM (no fringe) MEDIAN | SALARY RANGE: MAXIMUM (no fringe) MEDIAN | MEDIAN FRINGE BENEFITS (AS % OF OVERALL SALARY) | MEDIAN TOTAL CURRENT SALARIES INCLUDING FRINGE BENEFITS | Mean Number of Employees | Mean VACANCY RATE[18] (%) |
|---|---|---|---|---|---|---|---|---|---|
| **Executive Director** | | | | | | | | | |
| FY 2011 | 0.95 | 14.88 | $ 95,903 | $ 70,000 | $101,732 | 20 | $114,114 | 0.96 | 0 |
| FY 2010 | 0.89 | 14.35 | $102,500 | $ 77,500 | $105,000 | 21 | $120,048 | 0.98 | 0 |
| FY 2009 | 0.89 | 13.64 | $ 97,240 | $ 77,500 | $106,522 | 20 | $114,085 | 0.96 | 0 |
| **Chief Financial Officer** | | | | | | | | | |
| FY 2011 | 0.80 | 8.77 | $ 70,995 | $ 64,014 | $80,000 | 20 | $86,614 | 0.89 | 0 |
| FY 2010 | 0.79 | 7.61 | $ 67,538 | $ 68,750 | $90,000 | 21 | $91,600 | 0.97 | 1 |
| FY 2009 | 0.82 | 7.76 | $ 73,932 | $ 70,000 | $84,298 | 20 | $89,063 | 0.95 | 0 |
| **Chief Operating Officer** | | | | | | | | | |
| FY 2011 | 0.81 | 8.20 | $ 65,000 | $ 66,500 | $80,500 | 20 | $74,834 | 0.85 | 6 |
| FY 2010 | 0.87 | 7.91 | $ 72,600 | $ 70,000 | $88,500 | 19 | $92,100 | 0.97 | 0 |
| FY 2009 | 0.83 | 6.93 | $ 73,104 | $ 62,400 | $72,922 | 21 | $81,504 | 0.88 | 5 |
| **Program Manager/Director** | | | | | | | | | |
| FY 2011 | 1.97 | 8.38 | $ 58,314 | $ 46,608 | $66,500 | 20 | $67,700 | 2.15 | 3 |
| FY 2010 | 2.17 | 8.02 | $ 58,816 | $ 48,000 | $65,000 | 21 | $69,428 | 2.34 | 13 |
| FY 2009 | 2.34 | 7.49 | $ 58,718 | $ 48,500 | $65,000 | 21 | $66,874 | 2.83 | 11 |

[18] The vacancy rate is defined as the number of vacancies at some fixed point in time divided by the number of budgeted positions.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Senior Supervisor** | | | | | | | | | |
| FY 2011 | 4.02 | 6.68 | $ 40,000 | $ 35,500 | $49,600 | 20 | $48,089 | 4.35 | 2 |
| FY 2010 | 3.79 | 5.97 | $ 41,186 | $ 33,969 | $48,800 | 21 | $50,860 | 4.11 | 1 |
| FY 2009 | 5.08 | 6.21 | $ 40,272 | $ 33,004 | $50,000 | 21 | $47,306 | 7.33 | 3 |
| **Rehabilitation counselor/ specialist** | | | | | | | | | |
| FY 2011 | 29.52 | 3.91 | $ 29,497 | $ 24,000 | $36,960 | 20 | $35,265 | 43.02 | 7 |
| FY 2010 | 22.67 | 3.72 | $ 30,785 | $ 24,178 | $38,700 | 21 | $37,248 | 30.10 | 13 |
| FY 2009 | 23.03 | 3.62 | $ 29,964 | $ 23,856 | $40,000 | 21 | $35,000 | 26.81 | 15 |

## B. DDA Providers

Only DDA providers based in Maryland were included in the FY 2011 analysis. DDA providers that had profit margins with an absolute value of greater than 20% were excluded to reduce outliers. This left a cohort of 104 out of 152 providers, or about 68% of the total reporting, that met the criteria for inclusion and supplied sufficient wage data.

As previously noted, the DDA Wage and Benefits Survey requests total payroll expenditures and total annual hours paid for two categories of employees—"direct support worker" (which is a combination of all aide and service workers) and first line supervisor—in each of four business lines plus transportation that are funded by the FPS and CSLA, as well as individual and family supports (ISS/FSS), which is funded by DDA grants. Past CSRRC analyses converted payroll expenditures into what it described as an hourly wage by dividing total expenditures by total hours paid. Because reported payroll expenditures includes overtime, shift differentials, agency fees, bonuses and potentially other types of compensation, however, this method of conversion does not accurately represent average hourly base wages. Therefore, in the trend analyses that follow, we have used the data collected but changed the terminology to make it clear that we are looking at *average hourly payroll expenditures* and not *average hourly earnings*. This analysis complies literally with the statutory requirement to describe "changes in wages paid by providers," but it does not speak to wages from the perspective of determining whether compensation is sufficient to attract and retain the workforce needed to meet the demand for services. The CSRRC was reactivated too late to consider and propose revisions to the way DDA collects wage data for the current term, but will be working with DDA to incorporate changes that will improve our understanding of employee earnings and benefits in future years.

It is also important to note that the DDA Wage and Benefit Survey defines "full time" as being "30 or more hours per week." This has implications for benefits and hours eligible for overtime pay, among others.

Direct care workers receive bonuses, but these are not guaranteed and the amounts vary from year to year depending on the financial condition of the entity. In FY 2011, providers paid out a total of $1,285,117 in bonuses to direct care workers (i.e., not including first line supervisors, professionals, or administrative staff). This is consistent with annual bonus payments reported since FY 2005, when they peaked at $2.2 million.[19]

**Table 3** shows mean employer hourly payroll costs for DDA direct care workers over the period FY 2004-FY 2011. Mean hourly payroll costs rose through FY 2007, then declined slightly in FY 2008, but rebounded in FY 2009 and FY 2010.[20] FY 2011, however, saw a steep drop of

[19] FY 2005 figures reported in the 2009 CSRRC Annual Report. It is not possible from the data collected to determine the number of employees receiving bonuses in any given year.

[20] The Wage Equalization Initiative was passed in 2001 to bring wages and benefits of private sector direct care workers up to the level of those employed in state institutions. It required DHMH to increase reimbursement rates over five years to eliminate the disparity by FY 2007. Providers could only use the increase to boost wages and benefits and not for any other purpose. Three successive Office of Legislative Audits reports in 2003, 2007, and 2009, found that there had been inadequate controls over the way providers spent the enhanced funding and that DDA had dragged its feet on recovering amounts that had not been used for the intended purpose. DDA's own investigations identified $3.6 million in improperly used funds. Subsequent cost reviews that revised the amount

4.4% to pre-FY 2007 levels. Discussions with providers on the reason for this suggest that it was related to the 1.5% rate cut made by DDA in FY 2010. This showed up only in FY 2011 payroll expenditures because it took time for providers to accommodate the revenue loss, and they may have done so by turning to the budget category with the most flexibility: payroll. Expenditure reductions may have come from limiting overtime eligibility and other strategies to lower personnel costs. To the extent that employers shifted expenditure patterns in light of earnings losses, payroll cuts needed to exceed the size of the rate reduction to compensate for fixed costs over which they had little control, such as rents, vehicle operation, and utilities.

misspent downward, coupled with DDA action to recoup funds, reduced the outstanding debt to $365,000 owed by as many as 14 providers at the end of 2011.

**Table 3. DDA Provider Mean Hourly Payroll Costs for Direct Care Workers FY 2004 – FY 2011**

| Fiscal Year | Mean Hourly Payroll Cost ($) | % Change from Previous Year |
|---|---|---|
| 2004 | 9.75 | -- |
| 2005 | 10.36 | 6.3 |
| 2006 | 10.97 | 5.9 |
| 2007 | 11.42 | 4.1 |
| 2008 | 11.40 | -0.2 |
| 2009 | 11.67 | 2.3 |
| 2010 | 11.90 | 2.0 |
| 2011 | 11.37 | -4.4 |

**Table 4** shows DDA mean hourly payroll expenditures for direct care workers by business line in FY 2010 and FY 2011. The drop in expenditures occurred exclusively among residential live in (8.2%), residential not live in (4.3%), and CSLA (7.1%) workers.

**Table 4. DDA Provider Mean Hourly Payroll Costs for Direct Care Workers by Business Line, FY 2004 – FY 2011**

| Type of Service | FY 2010 ($) | FY 2011 ($) |
|---|---|---|
| Individual & Family Support | 14.06 | 14.07 |
| Day Service | 11.62 | 11.63 |
| Residential Service (live-in) | 12.08 | 11.09 |
| Residential Service (not live-in) | 11.39 | 10.90 |
| Employment Service | 13.68 | 13.74 |
| Community Supported Living Arrangement (CSLA) | 12.35 | 11.47 |

**Table 5** shows employer-paid fringe benefits as a percentage of salaries for all employees—not just direct care workers—over the period FY 2004-FY 2011. These consist of both mandatory employer contributions and the employer paid portion of voluntary benefits (including administrative costs). The median fringe benefit percentage has hovered at 19%-20%. The weighted mean, which shows the proportion of employer-paid benefit contributions across the whole industry, has been rising since FY 2009 to nearly one-fourth of payroll. It was not possible to isolate expenditures for fringe benefits associated with direct care workers because of the way the data is collected by DDA. In any event, total fringe benefit costs mask changes in the quality of the voluntary benefits received by employees—e.g., reduced health care coverage, employees responsible for a greater share of premiums or copayments, etc. Also, most part-time and contract direct care workers do not receive benefits, and because they are paid at the lower end of the spectrum may not be able to afford to buy coverage on their own. These are issues that should be explored in the future.

**Table 5. DDA Provider Fringe Benefits as a Percentage of Total Payroll for Full Time Employees, FY 2004 – FY 2011**

| Fiscal Year | % Median Fringe Benefit | % Weighted Mean Fringe Benefit | Number of Providers Reporting |
|---|---|---|---|
| 2004 | 19.2 | 20.5 | 111 |
| 2005 | 19.8 | 21.2 | 112 |
| 2006 | 20.1 | 22.8 | 118 |
| 2007 | 20.0 | 22.2 | 110 |
| 2008 | 19.7 | 22.1 | 127 |
| 2009 | 19.2 | 19.9 | 123 |
| 2010 | 19.4 | 23.1 | 127 |
| 2011 | 20.0 | 24.5 | 104 |

**Table 6** shows the mean turnover rate and mean tenure in months for direct care workers and first line supervisors. Mean turnover rates for direct care workers decreased from 38% in FY 2004 to 27% in FY 2011. During the same time period, mean tenure for direct care workers rose from 42 to 57 months. Mean turnover rates for first line supervisors stayed between 19%-22% over the same period, but tenure in months rose from 61 to 84. The data suggest that the workforce has become more experienced. Economic uncertainty

over this period may have contributed to lower turnover rates and layoffs would likely have affected workers with the shortest tenure first.

**Table 6. Mean Turnover Rates and Mean Tenure (in Months) for Direct Care Workers and First Line Supervisors, FY 2004 – FY 2011**

| | Direct Care Workers | | First Line Supervisors | |
|---|---|---|---|---|
| **Fiscal Year** | **Mean Turnover Rate (%)** | **Mean Tenure (months)** | **Mean Turnover Rate (%)** | **Mean Tenure (months)** |
| 2004 | 38 | 42 | 19 | 61 |
| 2005 | 34 | 44 | 18 | 68 |
| 2006 | 27 | 44 | 20 | 73 |
| 2007 | 29 | 39 | 20 | 72 |
| 2008 | 32 | 51 | 22 | 84 |
| 2009 | 28 | 50 | 22 | 78 |
| 2010 | 26 | 65 | 16 | 83 |
| 2011 | 27 | 57 | 19 | 84 |

## C. Conclusions

Because many MHA providers responded inconsistently, incompletely, or not at all to requests for wage information, and MHA did not enforce compliance with reporting requirements prior to FY 2011, the data presented here is only a general indication of salaries, fringe benefits, and vacancy rates. ***It cannot be used to interpret a trend in wages or other workforce characteristics***. Vacancy rates appear highest among those professionals who can prescribe medication: psychiatrists and psychiatric nurse practitioners. Fringe benefits (defined in existing surveys as including mandatory employer contributions e.g., FICA) reported as a percentage of salary range between a median of 10% and 21%, depending on the job position and the year. Psychiatrists and other highly compensated clinical staff receive a lower percentage of benefits on average because they are often employed as independent contractors.

Among DDA providers, mean expenditures on direct care worker salaries declined 4.4% in FY 2011 over FY 2010. This may be related to an effective 1.5% rate cut in FY 2010. It is unclear how decreased provider earnings were spread over the entire workforce and other operational expenditures. Nonetheless, mean turnover rates for direct care workers decreased over this same

period, while mean tenure in months increased, possibly an effect of the recession and tight job market.

Anecdotal evidence in both sectors points to employers limiting the availability of voluntary fringe benefits or requiring greater employee contributions. Providers have used this as a strategy to compensate for the rising cost of health insurance premiums during a period when reimbursement rates shrank or remained flat. This will be an avenue of future investigation.

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, but it is continuing to investigate whether this amount is correct.

## D. Recommendations to Improve Wage Data Quality and Analytical Value

- ***Rigorously enforce full compliance with regulations on annual data submissions.***

  MHA obtained the authority to penalize noncompliant providers in 2009, but acted on this only in 2012 at the urging of the CSRRC. The results were dramatic: virtually all community-based providers required to submit annual wage data did so.[21] As previously noted, in FY 2009 and FY 2010 by contrast the response rate was so low and inconsistent as to undermine efforts to understand what was going on in this sector and to perform trend analyses. DDA has had comparable authority to fine providers for noncompliance for some time, but could improve its enforcement to get a better response rate.

- ***Clarify data terminology and conduct information sessions for providers to promote correct and complete submissions.***

  Respondents could benefit from MHA and DDA taking a more hands-on approach to data collection in terms of training and oversight of submissions, with an iterative process that requires respondents to correct errors. In both the mental health and developmental disability sectors, respondents do not always agree on how to define key terms used in surveys or financial reports—this despite instruction sheets provided by MHA and DDA with all forms. Both sectors had individual respondents that reported inconsistently from others, such as reporting total wage expenditures when wage expenditures per job category were requested. Validation of data to the extent possible demanded an inordinate amount of time and resources. But some inaccuracies and anomalies may have gone undetected because an entry fell in the "reasonable" range. In addition, some respondents failed to complete all questions--yet another factor that distorts calculations and analyses.

[21] County health departments, for example, are not required to complete MHA financial and wage surveys.

- ***Standardize and improve electronic data submissions.***

  MHA and DDA should require wage data in an Excel format that is easy to aggregate and analyze. This would impose no additional burden on providers, but would significantly improve data collection and analysis. Currently, some data are submitted electronically, other data are submitted in paper format. Even when there are electronic submissions, sometimes these are in PDF files or in locked spreadsheets from which data must be extracted and re-entered into spreadsheets that permit data manipulation This process is needlessly staff intensive, time consuming, and multiplies the potential for data entry errors at each stage. DDA and MHA may want to explore the possibility of a central electronic data submission Internet portal that would eliminate the need to transpose data between electronic formats.

- ***Revise the DDA wage survey to improve its value for policy making.***

  The weaknesses of the data currently being collected from DDA providers have been amply noted. The DDA surveys should be redesigned to to obviate aforementioned flaws. Most importantly, the new survey should make it possible to compare private and public sector employee compensation for similar positions. In addition to already noted areas for revision, the survey should distinguish among categories of employees who require some sort of certification or licensing.

- ***Expand and refine data collection on fringe benefits.***

  The issue of fringe benefits is not adequately explored in the MHA and DDA wage surveys as they are currently constructed. Providers have indicated to the CSRRC that while wages have remained fairly constant over recent years, there have been reductions in the quality and range of voluntary fringe benefits such as health insurance, pension, etc. It is also important to understand, in particular, how these changes are affecting direct care workers and clinical professionals, as opposed to administrative and executive staff. Finally, there is some percentage of lower level employees that does not choose to take certain employment benefits because their own contribution is too costly. It would be interesting to look at this issue, and to see how this changes for health insurance as the Health Benefit Exchange becomes operational.

- ***Revise and coordinate the wage survey between the two agencies.***

  Before data are collected for FY 2012, the instructions for the MHA wage survey should be reviewed to make it clear what sorts of data need to be provided. The DDA survey, modified as suggested above, should show overtime hours separately since these are an important component of employee compensation in this sector, and indicate which employees are contract workers. MHA and DDA wage data should also indicate which employees are being paid as independent contractors. Making the surveys for both sectors more consistent will facilitate collection, analysis, and technical support to providers.

- Resolve and recover all outstanding amounts owed DDA by providers for improper use of enhanced funding under the Wage Equalization Initiative.

# 2. Financial Performance

***§ 13-809(1)(ii). Financial condition of providers and indicators of their ability to operate on a solvent basis in the delivery of effective and efficient services in the public interest.***

No single measure can reliably represent the financial condition of individual providers or of groups of providers; nor can solvency be evaluated through simple measurements. Instead, an assessment of financial condition requires a balanced analysis of a set of indicators, comparisons over time and among similar providers, discussions with providers to clarify interpretation of data, and research to identify and account for contextual and ancillary influences. Even audited financial statements (MHA notably does not require that financial submissions be audited) raise questions because 1) accounting practices are subject to variation in how data are categorized and reported (e.g. how assets and liabilities are classified, the degree to which functional expenses are itemized, etc.); 2) there is no general agreement on the meaning of certain terminology (e.g. bad debt); and 3) margins can fluctuate widely from year to year based on the timing of reporting, major capital expenditures, mergers, and other factors. This is made clear when one considers the number of providers that consistently report negative margins, which raises the issue of how they continue to make payroll—not to mention how they stay in business.

Another source of concern in analyzing MHA and DDA provider financial data is whether the Maryland subsidiaries of larger, multistate organizations provide financial statements for their Maryland operations only, or for the parent organization. In the latter case, financial information on Maryland operations is conflated with an entity's out-of-state operations, making it difficult to discern what effects the Maryland payment system has on a provider's financial condition. A similar problem exists for providers of MHA or DDA services that are also large, multi-function charitable organizations; that are part of universities or hospitals; or that have close financial affiliations with holding companies or umbrella entities. In such cases the effect of MHA and DDA reimbursement rates on an entity's finances is overwhelmed by the influence of the parent or larger organization.

Cost reports submitted by DDA providers offer additional perspective on the relative financial condition of providers by allocating expenditures and revenues to each of the four business lines that DDA reimburses under FPS and CSLA (that is, funded only through Medicaid and state general funds). This is not to say that gray areas do not exist where the allocation of expenditures to a given business line is subject to some discretion. This is particularly true for the allocation of administrative costs shared across some or all business lines. The fact that an entity's cost report is expected to reconcile with its financial statement mitigates but does not entirely resolve the problem.

## *Methodology*

MHA collects "relevant financial statements or documentation and results of a financial audit"[22] of its providers beginning in March for the previous fiscal year. A large number of providers submitted financial data in FY 2008, when regulations were first adopted authorizing MHA to assess fines for noncompliance. But numbers dropped off in FY 2009 and 2010. FY 2011 data

[22] COMAR 10.21.17.06

was collected between March and June 2012, with virtually all providers complying when MHA threatened enforcement of the penalty provision. These data were submitted in hard copy and scanned into PDF files by MHA. Input of the data into Excel spreadsheets was needed in order to perform calculations and analysis.

DDA requires that providers submit financial statements and cost reports at the beginning of the calendar year for the previous fiscal year. Roughly 120-130 DDA providers, representing roughly 75% of all providers receiving FPS and CSLA funds, submitted hard copies of financial statements each year from 2008 to 2011. The same number of providers submitted cost reports in the form of Excel spreadsheets that were locked into fixed table formats and had to be converted to text files and then back to Excel spreadsheets for calculation and analysis.

Because of the timing of CSRRC reauthorization, data collection constraints, and the backlog of data to be analyzed going back to FY 2008, the CSRRC has relied on the data as collected by MHA and DDA, and largely retained the analytical methodology used by the CSRRC in prior years. We hope to improve upon data collection and our methodological approach in future years. In particular, the CSRRC hopes to obtain audited financial statements and cost reports from MHA providers; these are already being collected from DDA providers.

**Financial indicators and definitions**

Certain financial indicators were selected for analysis because they appeared in past CSRRC analyses and are typically used to evaluate the financial health of businesses in various industries. These are:

***Margins*:** The difference between revenues from all sources and expenses expressed as a percentage. This is also known as the profit margin. The tables summarize individual provider margins in two ways:

- The *median margin* across the industry or within an analysis group. The median is the level at which 50% of all the objects measured exceed the measurement, and 50% are less than the measurement. The median measures the central tendency of the distribution of measures, but unlike the mean or average level, it is less affected by outlying values that distort the calculation.

- The percentage of providers with negative margins shows the proportion of providers that spend more money than they take in, i.e. they are not breaking even on the services they provide.

In general, a neutral or positive margin shows that an entity has income sufficient to cover its costs. Margin can be an important indicator of financial health, but it should not relied upon as the sole measure, either for an individual entity or for an industry as a whole. This is because business decisions—such as, the level of executive compensation, investment to shore up financial stability, a large capital expenditure (say, for building renovation)—regardless of whether the decisions are prudent or unwise, can push margins down in a given year. So can a corporate acquisition that, in the medium or long term, will expand institutional capacity and get a bigger share of the market. By the same token, a large margin

can indicate insufficient investment in personnel or infrastructure that can undermine sustainability in the long run. Unfortunately, there is no baseline by which to assess the acceptability of community-based provider mental health service provider margins as being healthy or not. At the very least, margins need to be considered over time, and any attempt to derive trends from the data we have is undermined by factors previously discussed. Nevertheless, some comparisons with similar industries may provide context. For example, the Health Services Cost Review Commission has reported Maryland hospital margins ranging from 1.54% in FY 2003 to 2.96% in FY 2011.

***Current ratio*:** A measure of liquidity defined as current assets divided by current liabilities. It measures the extent to which the provider has available resources to meet short-term obligations. Ideally, the current ratio should be 1.0 or greater, which occurs when current assets are greater than or equal to the amount of current liabilities. The tables below show the median current ratio and the percentage of providers with current ratios less than 1.0.

***Net assets*:** A measure of the overall net worth of the entity, obtained by subtracting all current and long-term liabilities from current and long-term assets. The tables show *median net assets* as an indicator of the typical net worth of providers. Although providers with negative net assets in a single year may be able to improve their situation, providers with consistently negative net assets are seen as being in financial trouble. The tables show the percentage of providers with negative net assets. But as previously noted, because different providers reported in different years, this may not represent an actual trend in industry performance.

***Days of cash on hand*:** The amount of assets in cash or cash-equivalent investments divided by average daily expenses. This measure indicates how many days the entity can continue to operate if receipts suddenly ceased. Median days of cash are shown in the table; the greater the number of days, the better a provider's financial position. If the provider has fewer than 30 days of cash it could be a warning sign of insufficient liquidity. It should be noted that DDA providers have an advantage in the measure of cash on hand because they are paid prospectively (in advance of service delivery) and reconciliation their budgets at the end of the year, at which time they must return any overpayments to DDA.

***Days in receivables*:** Accounts receivable divided by average daily revenues. This indicator measures the amount of revenues locked up in extended terms to debtors, as well as how efficiently the company works to collect receivables (how quickly they bill). Higher numbers of days in receivables indicate that the provider has greater flexibility in receiving payment. The measures reported in the financial data tables include median days in receivables and the percentage of providers with greater than 30 days in receivables. The number of days in receivables may also be affected by the change in ASO in FY 2010, and the significant improvements in claims processing made by ValueOptions in the ensuing years.

***Bad debt*** was not used as an indicator. Section 13-806(a)(1) of the CSRRC statute requires assessment of the amount of uncompensated care delivered by providers. The only measure of uncompensated care currently available is bad debt, which is reported in financial statements either as functional expenses or in statements of cash flow. The vast majority of

providers, however, do not report any bad debt at all. Moreover, because there is providers do not all agree on the meaning of bad debt, it does not serve as a reliable proxy for uncompensated care. Therefore, we decided to abandon past practice and not to consider bad debt among the financial indicators.

## A. MHA Providers

The same exclusion criteria used for the wage analysis were applied to analysis of financial condition:

- Based outside of Maryland
- Less than 40% of revenue derived from treatment of mental health patients
- University hospital system affiliation
- County health department

These rules left the same 81 entities included in the wage analysis. Sector-wide financial results were also broken down into the following subgroups to see what influence certain characteristics played on financial performance:

- OMHC and PRP
- For-profit and non-profit status
- Percentile of total revenues

Again, data here cannot be used to deduce trends. As previously noted, a significant percentage of MHA providers reported financial data in FY 2008, but only about 65 submitted financial statements for FY 2009 and FY 2010, and more than 50% of these did not report in both years. In FY 2011 nearly all providers submitted reports. Inclusion criteria were applied to providers reporting in FY 2011, but not in previous years. The data below is provided for purposes of completeness and to get a general feel for the sector, but should not be relied upon to show a trend.

**Table 7** shows selected financial indicators for MHA providers over the period FY 2008-FY 2011. Relatively high median margins in FY 2011 may be a good sign, although 25% of providers show negative margins. The fact that over one-fourth of providers in that year had negative net assets is troubling.

## Table 7. MHA Provider Financial Indicators, FY 2008 – FY 2011

| Year | Median Margins (%) | Percentage with Margins <0 | Median Current Ratio | Percentage with Current Ratio <1.0 | Median Net Assets | Percentage with Negative Net Assets | Median Days of Cash | Percentage with <30 Days of Cash | Median Days in Receivables | Percentage with >30 Days in Receivables | Total Reporting |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2008 | 2.09 | 27.8 | 1.55 | 28.6 | $63,945 | 8.7 | 16.9 | 64.7 | 9.4 | 29.1 | 103 |
| 2009 | 2.04 | 34.9 | 1.92 | 23.1 | $486,048 | 13.8 | 35.0 | 45.5 | 29.6 | 48.5 | 65* |
| 2010 | 2.41 | 26.0 | 1.96 | 26.5 | $756,775 | 11.9 | 39.8 | 42.9 | 28.2 | 52.4 | 65* |
| 2011 | 2.37 | 25.0 | 1.49 | 39.0 | $69,073 | 28.2 | 20.1 | 61.4 | 10.8 | 12.7 | 81** |

*May not be representative of the provider community as a whole due to low reporting rate.
**After applying exclusion criteria.

## *Comparison among subgroups in FY 2011*

### For-profits vs. Non-profits

**Table 8** shows the differences between for-profit and non-profit MHA providers in FY 2011. For-profit providers (59% of the 81 used in our analysis) had a higher median net margin than non-profit providers (3.3% compared to 1.6%). For-profits had a slightly smaller percentage of entities with negative net margins (22.9% of for-profits compared to 27.3% of non-profits). They did less well on other financial indicators, however. The median current ratio of for-profits was considerably lower (0.71 to 1.97), and the percentage of for-profits with a current ratio below 1.0 was two and a half times that of non-profits (52.9% versus 20.0%). Non-profits had substantially larger median net assets than for-profits, and the percentage of non-profits with negative net assets was about half that of for-profits (17.2% versus 35.7%).

The cash position of for-profits was also considerably worse than that of non-profits. For-profits had just 8.1 median days of cash, compared to non-profits with 46.8 median days. In addition, 82.1% of for-profits had less than 30 days of cash on hand, compared to 35.5% of non-profits. For-profit providers had 0 days in receivables, while non-profits had a median of 22.8 days in receivables.

Overall, financial indicators for for-profit providers show a tendency toward greater risk and, therefore, less stability than non-profit providers, albeit for-profit provider margins are significantly higher.

### OMHCs vs. PRPs

**Table 9** compares PRPs (37% of the total), OMHCs (16% of the total), and those providing both services (47%). Providers offering both types of services had lower margins than those specializing in either PRP or OMHC. PRPs had a higher median margin (2.9%) than OMHCs (2.0%), but 26.7% of PRPs had negative median margins, compared to just 15.4% of OMHCs. OMHCs, however, did less well on other indicators: they had the lowest median current ratio (0.59), the highest percentage with current ratio less than 1.0 (62.5%), the highest percentage with negative net assets (44.4%), and the worst cash position (10.1 median days of cash, with 63.6% of providers having less than 30 days of cash on hand).

The generally unfavorable financial indicators reported by OMHCs may be a consequence of size: median net assets for OMHCs were only $5,808, compared to $73,915 for PRPs and $88,395 for providers offering both services.

**Table 8. FY 2011 Financial Indicators for MHA Providers by For-Profit/Non-Profit Status**

| Type and number | Median Margin (%) | Percentage with Negative Margins | Median Current Ratio | Percentage with Current Ratio < 1.0 | Median Net Assets | Percentage with Negative Net Assets | Median Days of Cash | Percentage with < 30 Days of Cash | Median Days in Receivables | Percentage with > 30 Days in Receivables |
|---|---|---|---|---|---|---|---|---|---|---|
| For-profit (48) | 3.3 | 22.9 | 0.71 | 52.9 | $33,525 | 35.7 | 8.1 | 82.1 | 0.0 | 5.6 |
| Non-profit (33) | 1.6 | 27.3 | 1.97 | 20.0 | $1,758,239 | 17.2 | 46.8 | 35.5 | 22.8 | 22.2 |
| **Total** | **2.4** | **25.0** | **1.49** | **39.0** | **$69,073** | **28.2** | **20.1** | **61.4** | **10.8** | **12.7** |

**Table 9. FY 2011 Financial Indicators for MHA Providers by Type of Services Provided**

| Type and number | Median Margin (%) | Percentage with Negative Margins | Median Current Ratio | Percentage with Current Ratio < 1.0 | Median Net Assets | Percentage with Negative Net Assets | Median Days of Cash | Percentage with < 30 Days of Cash | Median Days in Receivables | Percentage with > 30 Days in Receivables |
|---|---|---|---|---|---|---|---|---|---|---|
| PRP (30) | 2.9 | 26.7 | 1.76 | 31.3 | $73,915 | 23.1 | 23.3 | 57.7 | 6.31 | 8.7 |
| OMHC (13) | 2.0 | 15.4 | 0.59 | 62.5 | $5,808 | 44.4 | 10.1 | 63.6 | 18.94 | 0.0 |
| Both PRP & OMHC (38) | 1.1 | 26.3 | 1.49 | 37.1 | $88,395 | 27.8 | 17.2 | 64.7 | 18.17 | 19.4 |
| **Total** | **2.4** | **25.0** | **1.49** | **39.0** | **$69,073** | **28.2** | **20.1** | **61.4** | **10.8** | **12.7** |

**Size by Revenue**

The effect of size on financial indicators is striking when providers are grouped according to percentile of total revenue, as follows:

- Above 75th percentile ($3,000,001-$35,000,000)
- 75th percentile ($1,500,001-$3,000,000)
- 50th percentile ($750,001-$1,500,000)
- 25th percentile ($150,000-$750,000)

**Table 10** shows financial indicators by quartile. The largest entities, above the 75th percentile, had more favorable indicators overall than the other groups, although they did not have the highest margins.

A review of the financial indicators suggests that smaller providers, for-profit providers, and OMHC-only providers achieve higher margins. But, again, margins are not a perfect proxy for financial health or stability, as discussed earlier. Margins may be reduced if the provider invests in infrastructural capacity that expands market share and increases future revenue. Margins may also be low if income is directed to paying down liabilities from past investments. So it is not possible to draw conclusive inferences about the financial health of a provider from this data alone.

**Table 10. FY 2011 Financial Indicators for MHA Providers, by Percentile of Revenue**

| | Median Margin (%) | Percentage with Negative Margins | Median Current Ratio | Percentage with Current Ratio < 1.0 | Median Net Assets | Percentage with Negative Net Assets | Median Days of Cash | Percentage with < 30 Days of Cash | Median Days in Receivables | Percentage with > 30 Days in Receivables |
|---|---|---|---|---|---|---|---|---|---|---|
| Above 75th Percentile ($3,000,001-$35,000,000) | 2.2 | 23.8 | 1.98 | 16.7 | $2,975,476 | 10.0 | 50.7 | 25.0 | 23.07 | 29.4 |
| 75th Percentile ($1,500,001-$3,000,000) | 0.5 | 30.0 | 1.90 | 31.3 | $149,076 | 16.7 | 21.0 | 63.2 | 15.42 | 0.0 |
| 50th Percentile ($700,001-$1,500,000) | 3.8 | 20.0 | 0.50 | 61.5 | $24,591 | 37.5 | 4.2 | 86.7 | 0.00 | 7.7 |
| 25th Percentile ($150,000-$750,000) | 5.8 | 25.0 | 0.68 | 70.0 | $(1,013) | 52.9 | 15.8 | 81.3 | 0.00 | 12.5 |
| **Total** | **2.4** | **25.0** | **1.49** | **39.0** | **$69,073** | **28.2** | **20.1** | **61.4** | **10.8** | **12.7** |

## B. DDA Providers

### i. Financial Condition of Providers

As with the wage survey analysis, the sole exclusion criteria applied to DDA entities in FY 2011 were 1) headquartered out-of-state, and 2) a margin exceeding 20% in absolute value (positive or negative). This left 111 providers in the analysis of FY 2011 financial statements in FY 2011. Because financial statements from DDA providers are available only in hard copy, the number included in this analysis could vary from the number of DDA providers reporting other data due to misfiling or misplacement.

DDA providers were also grouped by region, however, since unlike reimbursement to MHA providers, rates differ based on cost-of-living variation in different labor markets across Maryland.

**Table 11** shows the financial indicators for DDA providers as reported on their FY 2008-FY 2011 financial statements. Median margins that were under 1% in 2008 and 2009 rose to a high of 1.81% in FY 2010 before falling slightly to 1.38% in FY 2011. The percentage of providers with negative margins showed a similar pattern. Providers with negative margins declined to their lowest level in FY 2010, at 24.1%, but increased in FY 2011 to 31.9%. This could be due to the delayed effect of the FY 2010 rate cut whose effects on DDA direct care provider expenditures was discussed early.

The median current ratio and the percentage of providers with current ratios less than 1.0 improved steadily over the FY 2008-FY 2011 period. This indicates that a greater number of providers improved their ability to fund current liabilities with their current assets and therefore were at less financial risk.

Median net assets reached a peak in FY 2011, after falling in FY 2010. Again, the FY 2010 rate cut may have affected this pattern, as providers could react quickly to the cut by spending down liquid assets like cash on hand in order to maintain operations.

Since the FPS pays providers prospectively, DDA entities tend to have fewer days in receivables than MHA providers. Compared to MHA providers, they may have a relatively large number of days of cash on hand for this same reason. In FY 2011, median days of cash on hand reached a peak of 133 days, and only 6% of providers had fewer than 30 days of cash on hand. Providers may have been rebuilding cash assets after having spent them down in FY 2010.

## Table 11. DDA Provider Financial Indicators, FY 2008 – FY 2011

| Fiscal Year | Median Margin (%) | Percentage with Negative Margins | Median Current Ratio | Percentage with Current Ratio < 1.0 | Median Net Assets | Percentage with Negative Net Assets | Median Days of Cash | Percentage with < 30 Days of Cash | Median Days in Receivables | Percentage with > 30 Days in Receivables | Total Reporting |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2008 | 0.86 | 42.1 | 1.11 | 42.7 | $1,626,421 | 8.6 | 96.7 | 21.3 | 16.5 | 24.5 | 95 |
| 2009 | 0.91 | 36.4 | 1.22 | 36.4 | $1,935,095 | 14.6 | 98.2 | 17.3 | 15.4 | 22.7 | 110 |
| 2010 | 1.81 | 24.1 | 1.27 | 35.3 | $1,648,350 | 14.5 | 96.5 | 21.2 | 16.5 | 23.3 | 124 |
| 2011 | 1.38 | 31.9 | 1.27 | 22.8 | $2,897,205 | 6.9 | 133.0 | 6.0 | 10.8 | 15.3 | 111* |

*****Number remaining after applying exclusion rules

## *Comparisons among subgroups for FY 2011*

### By Region

FPS and CSLA payment rates include a regional component. The six regions defined in DDA regulations are perceived to draw direct care workers from different labor markets with different costs of living. These are:

Region 1: Baltimore metro (Baltimore City, Baltimore County, Anne Arundel, Harford, Howard Carroll, Queen Anne's)
Region 2: Washington D.C. metro (Calvert, Frederick, Prince George's, Montgomery, Charles)
Region 3: Rural (St. Mary's, Caroline, Garrett, Dorchester, Kent, Somerset, Talbot, Wicomico, Worcester)
Region 4: Pittsburgh metro (Allegany)
Region 5: Wilmington metro (Cecil)
Region 6: Hagerstown metro (Washington)[23]

Region 2 has the highest rates, followed by Region 5. Regions 1, 3, 4, and 6 all have the same, lower rates.

**Table 12** shows financial indicators by region. Region 2 (Washington D.C. metro) had the highest median margins (and the highest rates); it also had the lowest percentage of providers with negative margins. Region 1 (Baltimore metro), which gets the lowest rates along with regions 3, 4, and 6, was close behind the Washington D.C. area in median margin and percent of providers with negative margins. Although the median current ratio of providers was about the same, Region 1 had a significantly greater percentage of providers with current ratios less than 1.0 than did Region 2. Other measures of financial health were not remarkably different between the two regions. Both had slightly more than 9% of providers with negative net assets, compared to no providers with negative net assets in the other regions.

Regions 4 (Allegany) and 6 (Hagerstown) had the lowest margins; regions 3 (rural) and 6 had a very high percentage of providers with negative margins. By contrast, Region 5 (Cecil County) had no providers with negative margins and a median margin of similar to those of Regions 1 and 2. Region 5, which qualifies for the second highest rates, had a median current ratio of 4.02, roughly three times that of the other regions, and no providers with a negative current ratio. The other five regions performed similarly in terms of current ratios and median days of cash on hand.

Because only a handful of providers operate in Regions 4, 5, and 6, the analysis for those regions is especially sensitive to the individual performance of any given entity.

[23] COMAR 10.22.17.06(E)

## Table 12. DDA Provider Financial Indicators by Region, FY 2011

| Region (number of providers ) | Median Margin (%) | Percentage with Negative Margins | Median Current Ratio | Percentage with Current Ratio < 1.0 | Median Net Assets | Percentage with Negative Net Assets | Median Days of Cash | Percentage with < 30 Days of Cash | Median Days in Receivables | Percentage with > 30 Days in Receivables |
|---|---|---|---|---|---|---|---|---|---|---|
| Region 1 (49) | 1.54 | 29.2 | 1.22 | 27.3 | $2,355,371 | 9.1 | 128.2 | 6.8 | 11.6 | 13.6 |
| Region 2 (33) | 2.22 | 24.2 | 1.20 | 18.8 | $2,425,663 | 9.4 | 141.2 | 9.7 | 14.8 | 17.2 |
| Region 3 (17) | 1.19 | 43.8 | 1.39 | 30.8 | $3,321,294 | 0.0 | 159.4 | 0.0 | 10.4 | 23.1 |
| Region 4 (4) | 0.91 | 25.0 | 1.56 | 0.0 | $1,004,920 | 0.0 | 148.6 | 0.0 | 7.1 | 0.0 |
| Region 5 (3) | 1.96 | 0.0 | 4.02 | 0.0 | $2,894,946 | 0.0 | 203.2 | 0.0 | 8.5 | 0.0 |
| Region 6 (5) | 0.27 | 50.0 | 1.37 | 25.0 | $ 881,787 | 0.0 | 140.2 | 0.0 | 3.6 | 0.0 |
| **All Regions (111)** | **1.38** | **31.9** | **1.27** | **22.8** | **$2,897,205** | **6.9** | **133.0** | **6.0** | **10.83** | **15.3** |

## Size by Revenue

Providers were ranked by total reported revenue, as follows:

- Above 75th percentile ($10,500,001-$60,000,000)
- 75th percentile ($5,750,001-$10,500,000)
- 50th percentile ($2,750,001-$5,750,000)
- 25th percentile ($150,000-$2,750,000)

**Table 13** shows financial indicators for each of the four quartiles of providers. The two middle quartiles show better performance based on margins than the lowest and highest quartiles. For example, median margins at the two extremes are far lower, and the percentage of providers with negative margins is far greater. It is difficult to explain this pattern. In general, however, smaller providers tend not to fare as well as the larger entities.

## Table 13. DDA Provider Financial Indicators by Percentile of Revenues, FY 2011

| Revenues | Median Margin (%) | Percentage with Negative Margins | Median Current Ratio | Percentage with Current Ratio < 1.0 | Median Net Assets | Percentage with Negative Net Assets | Median Days of Cash | Percentage with < 30 Days of Cash | Median Days in Receivables | Percentage with > 30 Days in Receivables |
|---|---|---|---|---|---|---|---|---|---|---|
| Above 75th Percentile ($10,500,001-$60,000,000) | 0.91 | 39.3 | 1.26 | 21.4 | $4,765,553 | 3.57 | 83.1 | 7.14 | 16.98 | 28.57 |
| 75th Percentile ($5,750,001-$10,500,000) | 1.96 | 7.4 | 1.39 | 19.2 | $3,396,524 | 0.00 | 150.9 | 3.85 | 11.72 | 3.85 |
| 50th Percentile ($2,750,001-$5,750,000) | 2.25 | 29.6 | 1.50 | 20.0 | $1,781,784 | 4.00 | 145.7 | 4.17 | 7.45 | 12.50 |
| 25th Percentile ($150,000-$2.750,000) | 0.72 | 42.3 | 1.09 | 33.3 | $ 159,558 | 23.81 | 136.7 | 9.52 | 6.03 | 10.53 |
| **All Percentiles** | **1.38** | **31.9** | **1.27** | **22.8** | **$2,897,205** | **6.9** | **132.99** | **6.0** | **10.83** | **15.31** |

### ii. Relative Performance of Business Lines

Section 13-806(b)(2) requires the CSRRC to "review the data reported in the Developmental Disabilities Administration annual cost reports and use the data to develop relative performance measures of providers." Cost reports contain only financial and utilization data. Therefore, past annual reports have fulfilled this requirement by comparing the margins of business lines. We have continued this practice.

**Table 14** below shows the trend in median margins for FY 2008-FY 2011. Because the DDA cost reports require providers to allocate expenditures and revenues across four programs supported with FPS and CSLA funds, it is possible to measure and compare the margins of individual lines of business by dividing the difference between revenues and expenditures within each category by revenues.

**Table 14. DDA Provider Median Margins by Line of Business, FY 2008-FY2011**

| Fiscal Year | Median Margins by Business Line (%) (FPS- and CSLA-Supported Programs[24]) | | | | Total Margin (%) | Number Reporting |
|---|---|---|---|---|---|---|
| | Residential | Day | Supported Employment | Community Supported Living Arrangements | | |
| 2008 | -1.46 | -0.28 | -3.67 | 3.25 | -0.83 | 117 |
| 2009 | -1.26 | -1.67 | -0.28 | 4.36 | -0.50 | 109 |
| 2010 | 0.04 | -3.82 | -3.92 | 3.21 | -0.47 | 125 |
| 2011 | -0.17 | -2.26 | -5.41 | 4.18 | -0.17 | 111* |
| | *Number of People Served (July 2012)* | | | | | |
| | *5,696* | *7,237* | *4,782* | *2,069* | | |
| | *Percentage of Expenditures FY 2011* | | | | | |
| | 61% | 19% | 11% | 9% | | |
| | *Numbers of Providers FY 2011* | | | | | |
| | 94 | 75 | 69 | 76 | | |

*Number reporting after applying exclusion criteria.

Overall, median margins related to FPS- and CSLA-supported programs were negative, but improved from -0.83% in FY 2008 to -0.17% in FY 2011. The only program to show consistently positive margins has been CSLA, whose margins grew from 3.25% in FY 2008 to 4.18% in FY 2011. Residential services, which cost more than the other three business lines combined and account for nearly two-thirds of total expenditures for these programs, had a slightly negative margin in FY 2011 (-0.17%), after having a barely positive margin in FY 2010

[24] Includes other sources of revenue that supplement FPS and CSLA funding for these services, e.g., grants, contracts, fundraising, and copayments, among others.

(0.04%). It will be interesting to see how the FY 2012 change in policy for supported employment reimbursements affects the margin for this business line.

DDA providers show positive net margins across the entire entity because they engage in other program activities that benefit from other sources of revenue. These may include services funded through block grants (e.g., individual support (ISS) and family support (FSS)), fundraising, vocational and professional (DDA or other) contracts, other state agencies, and individual copayments, among others. We did not look at transportation costs, which are a significant expense and an area highlighted in previous reports, due to insufficient time and resources to conduct the necessary analyses. We will include these in future reports.

## C. Conclusions

Financial indicators show that the majority of MHA and DDA providers are performing moderately well, although poor performance among some of the providers pulls down the median measures. This information, by itself, does not permit us to make judgments about the adequacy of reimbursement rates.

"Financial solvency" in any industry is a concept without strict parameters, although measures such as negative margins, fewer than 30 days of cash reserves, current ratios below 1.0, and negative net assets are indicators of an individual entity's financial vulnerability. There is no normative definition of solvency for community-based mental health and developmental disability providers. Monitoring the performance measures of MHA and DDA providers over time, using conforming and complete data, and identifying those providers with consistently poor financial performance measures, is the best way to assess solvency in these industries.

But a review of the data collected by MHA and DDA does raise a number of important questions that bear further study:

- When defining "solvency" in the community-based mental health and developmental disability sectors what do we expect the financial profile of a "healthy" industry to look like? Does the definition change if an entity provides only a single type of service (e.g., OMHC, day care), is entirely dedicated to MHA and/or DDA services, or offers a wide range of programs besides those funded by MHA or DDA (e.g., large multifaceted organizations such as Catholic Charities and Jewish Social Services)?

- A significant percentage of MHA and DDA providers show poor performance on many of the financial indicators typically used to gauge "solvency." For example, many have negative margins, fewer than 30 days of cash reserves, current ratios below 1.0, and negative net assets. For those with year on year negative margins and net assets, it is difficult to understand how they are staying in business. Does this reflect problems with the data, problems with financial management, variations in accounting methodologies, or other factors?

- It is unlikely that any public funding system can ensure solvency for all providers given the budgetary considerations faced by public agencies that constrain rates, and given the wide range of size, composition of services, profile of the population served, and business acumen among providers. Successful providers will develop effective operational strategies and find efficiencies in how they deliver services within funding system parameters. Others will fare poorly, as reflected in their financial indicators. Do we expect public funds to cover the entire cost of business lines that receive rate-based reimbursements from DHMH? As a corollary, do we need to refine our expectations based on 1) percentage of the population requiring services population who are eligible for state support, 2) the DHMH funding mechanism (e.g., rates, grants, or contracts), and 3) other state funding sources?

- How do we define "the delivery of efficient and effective services" and correlate this with an assessment of financial solvency, as implied by Md. Code Ann. Art. Health-Gen., § 13-809(1)(ii)? This question is beyond the scope of data collection conducted and reviewed by the CSRRC to date.

These concerns will persist even after implementation of community-based service payment system reforms anticipated by the Department of Health and Mental Hygiene (DHMH). We will try to address them in the coming years, both inside and outside our collaboration with DHMH on structural changes.

With respect to developing relative performance measures of DDA providers, current methods of data collection do not permit us to do more than compare profit margins among the business lines that are eligible for rate-based payments. Business lines funded through the Fee Payment System (FPS) show losses in most years; CSLA programs show profits every year, although the margin has declined.

## D. Recommendations to Improve Financial Data Quality and Analytical Value

The financial data being collected from providers needs to be 1) refined, and 2) supplemented by more sophisticated research. Many of the recommendation proposed for wages surveys applies equally to financial statements and associated reporting. These are: 1) rigorously enforce full compliance with regulations that require annual financial reporting; 2) clarifying terminology and taking a more proactive approach to ensuring that providers understand and complete requests for financial information; 3) standardizing and improving electronic submissions so that data can be collected and manipulated more easily and reliably. In addition, we recommend the following:

- ***Require audited financial statements of all providers.***

  MHA requests "...relevant financial statements or documentation and results of a financial audit."[25] Because *audited* financial statements are not required, the quality of

[25] COMAR 10.21.17.06(A)(1)

financial data received from MHA providers varies greatly. This issue is less serious among DDA providers, which are required to file audited financial statements. Nevertheless, even DDA data can be inconsistent because individual auditors have their own preferences for categorizing data. Audited statements combined with standardized formats and terms would greatly improve data validity.

- ***Require cost reports that can more readily be aligned with DBM cost classifications for all providers.***

  Cost reports from all providers in both sectors offer a parallel set of information that could greatly enhance our understanding of the financial condition and performance of the industries—and to the extent that they can align expenditures with DBM cost classifications, could improved the accuracy of weighted average cost structures. The current DDA cost report should be modified so as to address questions raised by the CSRRC over the course of this term, and a new report developed for MHA providers.

- ***Study stratified samples of providers over time.***

  By identifying stratified samples of providers and studying the financial indicators of these same providers over time, we can obtain a more accurate picture of the financial condition of the community-based mental health and developmental disability sectors. This strategy will also inform our understanding of how factors such as size, location, service mix, profile of the population needing services, and others affect the financial health of providers. An important outcome would be to develop normative standards for financial indicators among these providers and how to identify providers in trouble.

## 3. Impact of the Annual Inflationary Cost Adjustment

***§ 13-809(1)(ii). Impact of the annual inflationary cost adjustment as set forth in § 16-201.2(c) on the financial condition of providers.***

The provisions of § 16-201.2(c) went into effect for the first time during the FY 2012 budget cycle. As noted earlier, DHMH complied with the requirements of the statute by proposing an update for MHA and DDA providers using a weighted average cost structure based on DBM cost categories, with rate increases that for the most part reflected DBM budget instructions. The General Assembly, however, is not bound to approve the inflationary cost adjustment as set forth in statute, in large part due to the balanced budget requirement. Thus, in FY 2012, the MHA budget contained an inflationary cost adjustment of 0.49% for providers but offset this with a 2.5% rate cut for those same providers. FY 2013 marked the first time that a rate update using the § 16-201.2(c) formula was implemented.

FY 2013 financial data will not become available until the beginning of calendar year 2014, at the earliest. Therefore, we cannot yet determine the impact that the rate updates calculated under the new method are having on the financial condition of providers.

That said, because MHA and DDA retain responsibility under §16-201.2(c) for applying line item adjustments to the weighted average cost structures furnished by the CSRRC, it is important to clarify interpretation of two provisions of the statute that we identified as having caused some confusion in FY 2013.

- **Use of DBM cost adjustments** – Section 16-201.2(c)(2) states: "The Department shall establish an annual inflationary cost adjustment for providers that shall be aligned with the annual cost adjustments for units of State government in the Governor's proposed budget." In FY 2013 DHMH internally reduced its budget for vehicle insurance, and MHA and DDA applied this reduction to the corresponding line item in provider weighted average cost structures. This was improper because DBM did not instruct state units of government to apply an adjustment to vehicle insurance. This had a negligible impact on the rate update for FY 2013 because vehicle insurance is such a small part of provider budgets.

- **Negative adjustments** – Section 16-201.2(c)(4) states: "The annual inflationary cost adjustments for categories of costs for units of state government used to establish the annual inflationary cost adjustment for providers may not be less than 0%." Again, with respect to vehicle insurance, MHA and DDA both applied negative adjustments (-4.4%) to this line item in FY 2013. Even if DBM had instructed other units of state government to adjust their budgets downward, it would have been improper to apply the negative adjustment to community-based providers because an adjustment "may not be less than 0%." Fortunately, providers did not feel the impact of this error.

# 4. Incentives and Disincentives in the Rate System

***§ 13-808(1)(iii). Incentives and disincentives incorporated in the rate-setting methodologies utilized and proposed by MHA and DDA and how these might be improved.***

## A. MHA Providers

As previously discussed, MHA uses a fee-for-service payment system. This model, as traditionally applied with OMHC reimbursements, creates an incentive to increase the volume of services and face-to-face encounters and to optimize billable staff time. In other words, therapists

ranging from psychiatrists to licensed counselors and clinical social workers are more efficiently used, in a financial sense, the more services they provide that can be billed to payers. There is little incentive to coordinate activities with other providers because there is no way to bill for the time spent; the same is true of services for which providers cannot bill, regardless of their clinical desirability or functional importance. For example, there is no incentive to perform case

management, although it may be vital to ensure effective care of the whole person and improve patient outcomes.

PRPs are reimbursed on a modified fee-for-service model that employs stratified case rates. In this system, a patient is determined to be eligible for a minimum and a maximum number of clinical encounters per month. Providers are reimbursed a flat case rate for treating these patients. The case rate is calculated as the average (rather than the actual) number of monthly face-to-face encounters the patient requires. Providers qualify for reimbursement if they see the patient at least the minimum number of times. The incentive here is reversed: providers earn more by limiting services to the minimum necessary to qualify for payment.

Neither the OMHC nor the PRP fee-for-service model incentivizes provider accountability for patient outcomes, a major flaw with this type of system. In addition, reimbursement rates are not cost based, so they have a varied financial impact on providers depending on the service mix, size of the provider entity and its infrastructural capacity. This can result in inconsistent consumer experience with the public mental health system across providers.

Maryland has piloted a capitation project since 1996. The program has established single points of accountability for identified patients that has shifted incentives toward more efficiently integrated services that meet the complex needs of people who were once viewed by hospitals as unable to live and function in the community. To be eligible, a person must be either 1) an inpatient at a state psychiatric hospital for a minimum of six months or 2) a high user of psychiatric services (i.e., have at least four psychiatric inpatient hospitalizations or at least seven psychiatric emergency room visits in the previous two years). The project has a current capacity of 354 patients at any point in time.

Cost and patient outcomes have been positive since its implementation. The average annual cost of care for a Medicaid recipient in the capitation project is $25,973,[26] while the estimated average annual cost of care for a patient treated at Spring Grove Hospital is almost four times that amount, or $100,504.[27] Data from the most recent evaluation (FY 2010) indicate that 62% of project participants were living in independent housing and there was a 90% retention rate for independent housing.

## B. DDA Providers

As previously discussed, the DDA FPS compensates providers for day, residential, and supported employment programs, plus add-ons and supplemental services. These are fixed per diem rates that account for individual needs, indirect costs, and region of the state. DDA compensates CSLA services on a per person per hour rate that depends on the number of individuals served in the same dwelling, the number of hours per week of service, and the region of the state.

[26] Source: ValueOptions. Based on claims paid through September 30, 2011. Run Date: October 3, 2011.
[27] Mental Hygiene Administration, November 9, 2011.

### *Day Services*

Day programs are for people who reside elsewhere but attend the facility during daytime hours. There is an incentive to serve people under the day program rather than the supported employment program, whether or not they have good job skills. This is because compensation for day services depend only on attendance; supported employment requires people to engage in paid work, which puts an added burden on individual performance and external factors like the availability of a suitable job. There is also an incentive to serve people with less complex support needs because they are more likely to attend on a regular basis, and DDA does not pay for days on which a person is absent.

### *Residential Services*

Residential programs are for full-time (up to 24 hours, in some cases0 services in a group home or alternative living unit. Under the current system, once a person's matrix score is established and a rate generated, the individual is generally not re-evaluated and the rate remains unchanged. Those who later need additional services can apply for add-on funding, even if they have a relatively low matrix score (rather than being reassessed for a higher matrix score or level of need). Add-ons are meant to accommodate temporary (one year or less) needs for different or more intensive supports, but they can be extended.

For people assigned a rate without add-ons, service providers have an incentive to help them achieve a higher level of independent living and to be more efficient in the way they deliver services. This is because an improvement in a person's dimensions of need reduces the cost of providing services, but the FPS rate is unchanged since it is based on the initial matrix score. There are, however, disincentives in the current system because a substantial proportion of people receiving services require add-ons. This formula discourages providers from promoting greater independence because eliminating the need for add-ons eliminates the extra rate component and, therefore, reduces provider compensation.

### *Supported Employment*

Supportive employment programs help individuals gain job skills and employment opportunities in an environment suited to their particular needs. Prior to FY 2012, providers were only paid for days when a person performed paid work for at least 4 hours. This changed in FY 2012, when the time spent engaged in a supported employment activity was included in the 4-hour minimum. The incentive in this system is to get people into jobs with employers that help promote and sustain the individual's success because this ensures continued employment and reduces costs for the provider. There is also an incentive to choose to serve people who are likely to be successful in jobs. Conversely, there is a disincentive to serve people who don't start with good employment skills because they will require more services until they can engage in combined employment and support activities for at least 4 hours a day to qualify for reimbursement. There is also a disincentive to serve people who are more dependable because payment relies on meeting the minimum hour requirement.

***Community Supported Living Arrangements***

A therapeutic team determines the number of hours of service per week that an individual needs. The hours can be increased or decreased if the team decides this is appropriate. Service need determinations and changes are contingent on DDA regional office approval. DDA conducts audits of the hours provided to each person in CSLA, and funding for hours of service not provided must be refunded.

As the number of hours per week increase, the rate per hour drops; the hourly rate is also reduced with each additional individual receiving services at the same dwelling. There is, however, a financial incentive to serve two or more persons living together—provided that none of them needs one-on-one assistance. Although the hourly rate is decreased for each additional person, the number of hours reimbursed is multiplied by the number of people served at the same location, resulting in higher compensation overall. Because the current rate system links level of funding to the number of hours of support needed, however, there is a disincentive for providers to scale back hours of support as an individual's needs lessen.

# 5. Incentives to Provide Quality of Care

***§ 13-809(1)(iv). How incentives to provide quality of care can be built into a rate-setting methodology.***

DHMH has already begun to consider opportunities for payment reform in the mental health sector in conjunction with behavioral health integration, and in the developmental disability sector in conjunction with adoption of the Supports Intensity Scale to replace the current IIRS matrix. Moreover, the provisions of Chapter 497 (see below) require DHMH to conduct a study that would lead to recommendations for a payment system that would promote quality of care along with the financial stability of providers. Therefore, it is useful to consider the incentives and disincentives built into the current payment systems as a guide, but there is little point in suggesting improvements to existing methodologies that are slated for change.

## A. Behavioral Health Integration

Since 1997, when DHMH moved Medicaid to managed care under Health Choice, mental health services have been carved out and managed through an ASO. In early 2011, DHMH began to consider integrating mental health, substance use, and general health services under the Medicaid managed care system. The first phase of this process, combining mental health and substance use into a single state administrative operation is already underway. In the second phase, also underway, a new service delivery model will be selected. The three options under consideration are: 1) moving mental health under MCOs as a protected "carve in;" 2) integrating substance use and mental health services under a Behavioral Health Organization; or 3) a population carve out for individuals with severe mental illness and/or severe substance use disorders who would be

served by a behavioral health MCO (BHMCO) that would also provide somatic care. The selection of a model is expected for late 2012—after submission of this report. Once the service delivery model is chosen there will be a third phase to design the new system (e.g., establishing areas of shared risk, integration of care, and identifying deliverables). The CSRRC hopes to be able to offer its support, expertise, and recommendations to DHMH during this third phase.

If behavioral health services are delivered as a carve-in under MCOs or as a carve-out to a BHMCO, the need for a regulatory fee schedule will be eliminated. Instead, payments would be negotiated between MCO plans and providers. The CSRRC would have a role in evaluating the system for how capitation payments are developed. Capitation payment systems have inherent disincentives to provide services, which has implications for care quality and patient outcomes. These disincentives will need to be counter-balanced with the development of performance indicators and payment adjustments that take these into account.

## B. DDA and the Supports Intensity Scale

The Supports Intensity Scale (SIS) is an individual assessment and planning tool developed by the American Association on Intellectual and Developmental Disabilities. It is already in use by a number of states and Canadian provinces. Some states are going still further by using the SIS measures as a basis for payment of providers.[28] The SIS is distinguished from other measurement tools by identifying the needs of a person to achieve the highest degree of independence possible, rather than measuring a person's deficiencies.

DDA has already begun piloting application of the SIS and is planning to hire a consulting firm to perform the evaluations. The adoption of SIS does not demand payment system reform, but there are advantages to using it in this way. Incorporating the SIS in a new payment system methodology offers potential for better aligning payments with costs and incentivizing effective service delivery. For example, it would require identifying the mean and variance of costs of people at various assessment levels. By accounting for variability in costs for each person served, the system reduces the risk of over-payment or under-payment for significant numbers of people in the classification system.

[28] http://www.oregon.gov/dhs/DD/rebar/Pages/st-rate-info.aspx and Human Services Research Institute *Developing Reimbursement Levels Using the Supports Intensity Scale (SIS) in Louisiana*, June 9, 2009

# 6. Weighted Average Cost Structure

***§ 13-809(1)(v). The recommended weighted average cost structure of providers as set forth in § 13-806.***

Md. Code Ann. Art. Health-Gen., § 13-806, in pertinent part, requires the CSRRC to:

> (1) Determine a weighted average cost structure of providers by:
> (i) Studying the categories of costs used by the Department of Budget and Management in the budgets of units of State government; and
> (ii) Assessing the average cost structure of providers using the categories of costs used by the Department of Budget and Management for units of State government;

As mentioned earlier, the CSRRC was consigned responsibility for developing the weighted average cost structure of providers with its reauthorization, effective October 2011. Because our data sources and funding were limited, we used as our point of departure the categories of costs selected previously by DHMH and verified them against the categories in the Accounting Procedures Manual published by the Maryland Comptroller for use by state agencies, including the Department of Budget and Management. That said, our methodology corrects for a number of flaws identified in the process used for FY 2013, as discussed in the relevant sections below.

The weighted average cost structure shows how much providers spend, on average, in each budget category to run their businesses proportional to their total operating costs. In this case, the statute requires that budget categories correspond to the cost classifications used by DBM for units of state government, which is why we defined the categories as we did. The "weighing" comes in because the size of providers, in terms of revenues, differs vastly, from multimillion dollar entities to businesses with annual incomes of just several hundred thousand dollars. We want to establish a cost structure across the entire industry, and because larger entities represent a greater share of total industry expenditures, we need to give them greater proportional "weight" when we calculate percentage spending by budget category. We do this by accounting for the relative contribution of each provider to the whole in each category when we compute the average. That is, we do not calculate an individual cost structure profile for each entity and use the sum of these to get the average percentage of expenditures by budget category for all providers. Rather, we add together all provider spending across each line item and use those totals to calculate the percentage that each category represents of total expenditures for the industry.

The CSRRC will continue to refine its methodology for determining the weighted average cost structures of providers each year. In particular, because the “other” category is the second largest spending category after salaries in both sectors, we will need to determine if it is possible and appropriate to reapportion some or all of these costs.

We would like to emphasize the absence of reference to these cost structures in our recommendations to DHMH. This is because the following cost structures are not

recommendations for DHMH consideration in preparation of its budget (Md. Code Ann. Art. Health-Gen., § 13-810). They are the mandated basis for rate updates equivalent to those given to units of state government (Md. Code Ann. Art. Health-Gen., § 16-201.2(c)).

## A. MHA Providers

The weighted average cost structure is based on the annual "statement of functional expenses" that is included in the financial statements required by MHA. The functional expense statements are not standardized, and as a result they evidence variations in interpretation of certain expense categories and in completeness. Moreover, the categories of expenditures do not conform to the cost classifications used by DBM. It was necessary, therefore, to create a crosswalk between the categories used in the functional expense statements and the DBM cost classifications.

The resulting weighted average cost structure shown in **Table 15** is derived from the 78 providers left after applying the exclusion criteria that submitted sufficiently detailed data for all categories of expenditures.

The difference between the methodology we used for FY 2014 and that used by MHA for FY 2013 was that 1) MHA prepared its weighted average cost structure based on the submissions of 10 select providers, and 2) for FY2014, the CSRRC included all payroll costs for essential employees in salaries and wages, even for those hired as an independent contractors. This last is significant in the mental health sector because an important percentage of the highest salaried professionals—e.g., psychiatrists, psychiatric nurse practitioners—are typically employed as contractors rather than as permanent staff, although they are critical to the service mission of the entity. The vast majority of these professionals are, for all intents and purposes, long-term staff members, as is clear from their average tenure (see Table 1). The "contractual services" category was used only for ancillary services needed on an occasional basis and not integral to the mission of the provider, such as accounting, legal services, tech support, etc. Expense data that could not be classified into one of the categories were added to the category "other." The sum of the functional expenses in each category and the percentage each category represented of the total was used to determine the proportionate weight of each expenditure category across all providers.

**Table 15. MHA Provider Weighted Average Cost Structure Based on FY 2011 Expenditures**

| Cost Classifications | FY 2011 Expenditures ($) | % of Total Expenditures |
|---|---|---|
| Salaries and Wages | 170,045,765 | 69.0 |
| FICA | 13,394,741 | 5.4 |
| Pension | 792,174 | 0.3 |
| Health Insurance | 5,358,273 | 2.2 |
| Unemployment Insurance | 446,180 | 0.2 |
| Workers Compensation | 574,474 | 0.2 |
| Telephone/Postage | 2,172,715 | 0.9 |
| Travel-Staff | 1,591,428 | 0.6 |
| Staff Development/Training | 517,988 | 0.2 |
| Utilities | 2,811,466 | 1.1 |
| Vehicle Operating/Fuel | 1,414,644 | 0.6 |
| Vehicle Maintenance | 107,305 | 0.0 |
| Vehicle Insurance | 44,320 | 0.0 |
| Depreciation (vehicles, equipment, building) | 6,031,898 | 2.6 |
| Contractual Services (legal, accounting, etc.) | 2,548,602 | 1.0 |
| Equipment/Supplies (non-capital) | 4,395,686 | 1.8 |
| Medical Equipment/Supplies | 107,948 | 0.0 |
| Food | 2,481,840 | 1.0 |
| Rent | 11,015,637 | 4.5 |
| Insurance (excluding vehicles) | 2,346,953 | 1.0 |
| Interest | 2,260,004 | 0.9 |
| Other | 15,964,622 | 6.5 |
| | | |
| **Total Expenses** | **$246,424,662** | **100.0** |

## B. DDA Providers

FY 2011 cost reports were used to inform the weighted average cost structure for DDA providers shown in **Table 16**. Although the data are self reported, this methodology is valid as a straight forward representation of the distribution of expenditures and has the advantage of facilitating data consistency across providers because of the standard reporting form. Each provider reported component costs separately for day, residential, supported employment, and CSLA, but the totals reported had to match expenditures and revenues on the providers' audited financial statements. The business lines were summed across, as was done by DDA for its FY 2013 weighted average cost calculation. The only difference between the method we used and that used by DDA was to

ensure that salaries and wages included all essential employees, even if the employees were hired through contracts with temporary employment agencies or as independent contractors. Unlike the mental health sector, contract employees tend to be direct support workers at the lower end of the pay scale. The category "contractual services" corresponds to ancillary services needed on an occasional basis and not integral to the mission of the provider, such as accounting, legal services, tech support, etc.

**Table 16. DDA Provider Weighted Average Cost Structure Based on FY 2011 Expenditures**

| Cost Classifications | FY 2011 Expenditures ($) | % of Total Expenditures |
|---|---|---|
| Salaries and Wages | 411,345,644 | 61.5 |
| FICA | 28,711,947 | 4.3 |
| Pension | 7,177,981 | 1.1 |
| Health Insurance | 32,599,157 | 4.9 |
| Unemployment Ins. | 9,203,859 | 1.4 |
| Workers Comp | 7,681,880 | 1.1 |
| Telephone/Postage | 4,100,097 | 0.6 |
| Travel-Staff | 3,780,062 | 0.6 |
| Staff Development/Training | 2,200,317 | 0.3 |
| Utilities | 12,364,940 | 1.8 |
| Vehicle Operating/Fuel | 8,612,925 | 1.3 |
| Vehicle Maintenance | 5,211,587 | 0.8 |
| Vehicle Insurance | 3,391,322 | 0.5 |
| Depreciation (vehicles, equipment, building) | 20,951,083 | 3.1 |
| Contractual Services (legal, accounting, etc.) | 13,709,428 | 2.0 |
| Equipment/Supplies (non-capital) | 9,395,499 | 1.4 |
| Medical Equipment/Supplies | 829,003 | 0.1 |
| Food | 14,261,899 | 2.1 |
| Rent | 21,508,626 | 3.2 |
| Insurance (excluding vehicles) | 3,819,549 | 0.6 |
| Interest | 7,867,099 | 1.2 |
| Other | 40,671,531 | 6.1 |
| | | |
| **Total** | **$669,395,436** | **100.0** |

# 7. Aligning Rates with Reasonable Costs

***§ 13-809(1)(vi). Additional recommendations to align provider rates with reasonable costs***

In view of the integration of behavioral health services and SIS implementation, both of which will involve changes to the associated payment systems, we have no additional recommendations at this time. We would, however, like to call attention to the terminology "reasonable costs," which is not defined by statute or convention—presumably this issue will be addressed through the ongoing structural reforms.

# NEED FOR FORMAL ACTION

***§ 13-809(2). Recommendations for formal executive, judicial or legislative action.***

The CSRRC believes that recommendations for formal executive, judicial, or legislative action at this time would be premature. For one, it is not certain what the MHA and DDA payment systems will look like in FY 2014 or 2015: the new service delivery model has yet to be selected for mental health/substance use disorder; changes to individual assessments and incorporating this into the payment model for DDA providers are expected to roll out some time in FY 2014.

Moreover, a non-codified provision of the 2010 Laws of Maryland, Chapter 497 (see Appendix 1) foresees modification of the rate-setting methodology for community-based providers in both sectors. Section 2 of the law requires, in pertinent part, that DHMH work with the Maryland Association of Community Services (MACS) and the Community Behavioral Health Association of Maryland (CBH) on a study to recommend "a plan to develop, and a timeline to implement, a rate-setting methodology for community developmental disabilities and mental health services providers" that would promote quality of care and financial stability. Among other requirements of this study, it is to analyze "the appropriate future role of the Community Services Reimbursement Rate Commission." DHMH is required to report its preliminary findings and recommendations to the General Assembly by December 1, 2012 (after submission of this annual report) and issue its final report by January 1, 2013.

The CSRRC has expressed a strong interest in participating in this process. We have been informed by MHA and DDA that this work will be conducted as part of impending structural changes of their respective systems. It should be noted that some models under consideration for delivery of mental health and substance use disorder services would preclude any role for the CSRRC.

# ISSUES FOR FUTURE STUDY

***§ 13-809(3). Issues in need of future study.***
***§ 13-809(4). Any other matter that relates to the purposes of the Commission under this subtitle.***

## 1. Collaboration with MHA and DDA on Systemic Reforms

As described earlier, DHMH is in the process of combining mental health and substance use into a single administrative organization, and studying service delivery options that will have implications for payment methodologies in the coming years. The CSRRC will assist MHA in its efforts to develop a new payment system.

DDA will contract with a consultant to develop a new algorithm for funding levels based on a person's needs as determined by the SIS. This process will also involve assessing the current rate structure that DDA has for all services, which makes the CSRRC an important partner in this effort. DDA has proposed working with the CSRRC on this major systems change in the following ways:

- Provide updates to the CSRRC on progress in completing the sample SIS assessments.
- Seek input from the CSRRC on development of a solicitation for the consultant to develop the new formula and in assessing the current DDA rate structure.
- Once selected, the consultants and DDA will collaborate with the CSRRC on the development of recommendations for a new resource allocation methodology and provide the CSRRC with regular reports on progress.
- The CSRRC will provide DDA and consultants with relevant data that will be used to assist in the development of the new resource allocation methodology.

DDA will also continue to seek input on this process with the SIS work group and other stakeholder groups as in addition to its collaboration with the CSRRC.

## 2. Data Collection and Analysis

The CSRRC intends to address the following areas of interest in the coming year and beyond, as time and resources permit. The focus of our work may change based on developments related to behavioral health integration and the implementation of SIS. But our priority for the forthcoming year will be on improving data collection.

- Advise MHA on how to integrate payment incentives for provider solvency, efficiency, and quality as part of integrating mental health and substance use disorder service delivery. Assist DDA with the payment system reforms that are expected to result from implementation of the SIS.
- Work with MHA and DDA to clarify the terminology used in reporting financial and wage reporting and to develop information guides and other supports that promote correct and complete submissions.
- Develop new formats and inputs for reporting financial and wage data for MHA and DDA providers (including cost reports and wage surveys), and standardize these insofar as possible across both sectors. Take into consideration the need to identify costs in terms of DBM classifications for purposes of determining rate updates.
- Investigate the potential for adopting and implementing a secure and private centralized electronic system for submitting financial and wage survey information in standardized formats to MHA and DDA.
- Identify selected samples of MHA and DDA providers for more in-depth analysis of income and expenditure trends derived from historical data.
- Develop and implement a method for examining voluntary fringe benefit trends and the role these play in compensation for MHA and DDA employees who provide direct services. In the DDA sector in particular, there is some percentage of lower level employees that does not choose to take certain employment benefits because their own contribution is too costly. It would be interesting to look at this issue, and to see how this changes for health insurance as the Health Benefit Exchange becomes operational.
- Develop relative performance measures of DDA providers that incorporate information on people served so as to benchmark performance while adjusting for risk. This would make it possible to identify when provider costs in a given category deviate from the norm. We may be able to develop comparable performance measures for MHA providers based on introduction of a cost report.

# SUMMARY OF RECOMMENDATIONS

Over the next term, the CSRRC will focus on improving the quality, quantity, and type of data collected from MHA and DDA providers, and on refining and supplementing its data analysis. In this regard, we make the following recommendations for MHA and DDA consideration, and looks forward to working with the agencies to realize them:

- Rigorously enforce the full compliance of MHA and DDA providers with regulations on annual financial and wage submissions. Submissions that are incomplete should not be accepted as regulatory compliance: they should be returned to providers for resubmission.
- Clarify the terminology used in financial and wage surveys and provide more extensive and complete definitions in the instruction sheets, with sufficient details to reduce confusion and erroneous data entry; it may be helpful to conduct information sessions or offer other assistance to providers to improve the quality of submissions.
- Improve the format of electronic data submissions to make them useable without excessive need to transpose information. This would greatly facilitate data analysis and reduce errors.
- Refocus the DDA Wage and Benefits Survey to provide more useful information on employee earnings rather than provider expenditures, and to emphasize direct care professionals. Revise the MHA Salary Survey and align with DDA survey to the extent possible.
- Expand and refine data collection on fringe benefits, concentrating on voluntary benefits for direct care professionals and benefit quality.
- Create a standardized salary and benefits survey for all providers.
- Require *audited* financial statements from all providers.
- Require cost reports of all providers.
- Resolve and recover all outstanding amounts owed DDA by providers for improper use of enhanced funding under the Wage Equalization Initiative.

# Appendix 1

# RELEVANT PROVISIONS OF LAW

## MARYLAND HEALTH-GENERAL CODE ANNOTATED
## TITLE 13. MISCELLANEOUS HEALTH CARE PROGRAMS
## SUBTITLE 8. COMMUNITY SERVICES REIMBURSEMENT RATE COMMISSION

**§13–801. Definitions** [Subtitle subject to abrogation]

(a) In this subtitle the following words have the meanings indicated.

(b) "Commission" means the Community Services Reimbursement Rate Commission.

(c) "Provider" means a community–based agency or program funded:

(1) By the Developmental Disabilities Administration to serve individuals with developmental disabilities; or

(2) By the Mental Hygiene Administration to serve individuals with mental disorders.

(d) "Rate" means the reimbursement rate paid by the Department to a provider from State general funds, Maryland Medical Assistance Program funds, other State or federal funds, or a combination of those funds.

**§13–802. Established; function** [Subtitle subject to abrogation]

(a) There is a Community Services Reimbursement Rate Commission.

(b) The Commission is an independent unit that functions in the Department.

**§13–803. Members; requirements; terms; vacancies** [Subtitle subject to abrogation]

(a) The Commission shall consist of seven members appointed by the Governor with the advice and consent of the Senate.

(b) Of the seven members, four shall be individuals who do not have any connection with the management or policy of any provider.

(c) Each member appointed to the Commission shall be interested in ensuring high quality community–based services for individuals with developmental disabilities or mental disorders.

(d) (1) The term of a member is 3 years.

(2) If a vacancy occurs during the term of a member, the Governor shall appoint a successor who will serve until the term expires.

(3) Except as provided in paragraph (4) of this subsection, a member who serves two consecutive full 3–year terms may not be reappointed for 3 years after completion of those terms.

(4) The Governor may, with the advice and consent of the Senate, appoint up to two members serving on the Commission as of January 1, 2008, to serve a fifth consecutive 3–year term beginning October 1, 2008.

**§13–804. Chairman; vice chairman** [Subtitle subject to abrogation]

Each year, from among the members of the Commission:

(1) The Governor shall appoint a chairman; and

(2) The chairman shall appoint a vice chairman.

**§13–805. Quorum; meetings; compensation and expenses; staff** [Subtitle subject to abrogation]

(a) A quorum of the Commission is four members.

(b) The Commission shall meet at least four times a year at the times and places that it determines.

(c) A member of the Commission:

(1) May not receive compensation for duties performed as a member of the Commission; but

(2) Is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(d) The Commission may employ staff and expend funds to carry out its duties and responsibilities under this subtitle in accordance with the State budget.

**§13–806. Duties** [Subtitle subject to abrogation]

(a) The Commission shall assess:

(1) The extent and amount of uncompensated care delivered by providers;

(2) The level of and changes in wages paid by providers to direct support workers, including the source of revenue for wages paid by providers;

(3) The ability of providers to operate on a solvent basis in the delivery of effective and efficient services that are in the public interest;

(4) The incentives and disincentives:

(i) Incorporated in the rate setting methodologies utilized and proposed by the Mental Hygiene Administration and the Developmental Disabilities Administration; and

(ii) In alternative methodologies;

(5) How incentives to provide quality care can be built into a rate setting methodology; and

(6) The impact of changes in regulations that impact on the costs of providers and whether the rates have been adjusted to provide for any increased costs associated with the regulatory changes.

(b) The Commission shall:

(1) Determine a weighted average cost structure of providers by:

(i) Studying the categories of costs used by the Department of Budget and Management in the budgets of units of State government; and

(ii) Assessing the average cost structure of providers using the categories of costs used by the Department of Budget and Management for units of State government;

(2) With respect to the Developmental Disabilities Administration, review the data reported in the Developmental Disabilities Administration annual cost reports and use the data to develop relative performance measures of providers; and

(3) Evaluate proposed regulatory changes by the Department, the Developmental Disabilities Administration, and the Mental Hygiene Administration that affect the rates paid or the rate structure.

**§13–806. // EFFECTIVE JUNE 30, 2016 PER CHAPTERS 497 AND 498 OF 2010 // // EFFECTIVE UNTIL SEPTEMBER 30, 2016 PER CHAPTER 94 OF 2011 //**

(a) The Commission shall assess:

(1) The extent and amount of uncompensated care delivered by providers;

(2) The level of and changes in wages paid by providers to direct support workers, including the source of revenue for wages paid by providers;

(3) The ability of providers to operate on a solvent basis in the delivery of effective and efficient services that are in the public interest;

(4) The incentives and disincentives:

(i) Incorporated in the rate setting methodologies utilized and proposed by the Mental Hygiene Administration and the Developmental Disabilities Administration; and

(ii) In alternative methodologies;

(5) How incentives to provide quality care can be built into a rate setting methodology; and

(6) The impact of changes in regulations that impact on the costs of providers and whether the rates have been adjusted to provide for any increased costs associated with the regulatory changes.

(b) The Commission shall:

(1) Develop or refine methodologies for calculating rate update factors for rates paid by the Developmental Disabilities Administration and the Mental Hygiene Administration and recommend annual rate update factors that use the methodologies that are developed;

(2) With respect to the Developmental Disabilities Administration, review the data reported in the Developmental Disabilities Administration annual cost reports and use the data to develop relative performance measures of providers; and

(3) Evaluate proposed regulatory changes by the Department, the Developmental Disabilities Administration, and the Mental Hygiene Administration that affect the rates paid or the rate structure.

**§13–807. Powers** [Subtitle subject to abrogation]

(a) In addition to the powers and duties provided elsewhere in this subtitle, the Commission may:

(1) Recommend the adoption of regulations to carry out the provisions of this subtitle;

(2) Create committees from among its members;

(3) Appoint advisory committees that may include individuals and representatives of interested public and private organizations;

(4) Publish and distribute information that relates to the financial aspects of community–based developmental disability or mental health services; and

(5) Subject to the limitations of this subtitle, exercise any other power that is reasonably necessary to carry out the purposes of this subtitle.

(b) The Commission shall have timely access to information from the Executive Branch required to fulfill the responsibilities of the Commission under this subtitle, including information from the Developmental Disabilities Administration and the Mental Hygiene Administration.

**§13–808. Authority of Secretary of Health and Mental Hygiene** [Subtitle subject to abrogation]

(a) The power of the Secretary over plans, proposals, and projects of units in the Department does not include the power to disapprove or modify a decision or determination that the Commission makes under authority specifically designated to the Commission by law.

(b) The power of the Secretary to transfer by rule, regulation, or written directive any staff, function, or funds of units in the Department does not apply to any staff, function, or funds of the Commission.

**§13–809. Annual Report** [Subtitle subject to abrogation]

On or before October 1 of each year, the Commission shall issue a report to the

Governor, the Secretary, and, subject to § 2–1246 of the State Government Article, the General Assembly that:

(1) Describes its findings regarding:

(i) The changes in wages paid by providers to direct care workers;

(ii) The financial condition of providers, the ability of providers to operate on a solvent basis in the delivery of effective and efficient services that are in the public interest, and the impact of the annual inflationary cost adjustment as set forth in § 16–201.2(c) of this article, on the financial condition of providers;

(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;

(v) The recommended weighted average cost structure of providers as set forth in § 13–806 of this subtitle, for the next succeeding fiscal year; and

(vi) Any additional recommendations regarding rate–setting methodologies to align provider rates with reasonable costs;

(2) Recommends the need for any formal executive, judicial, or legislative action;

(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.

**§13–809. // EFFECTIVE JUNE 30, 2016 PER CHAPTERS 497 AND 498 OF 2010 // // EFFECTIVE UNTIL SEPTEMBER 30, 2016 PER CHAPTER 94 OF 2011 //**

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

(1) Describes its findings regarding:

(i) The changes in wages paid by providers to direct care workers;

(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 action;

(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.

**§13–810. Findings and recommendations** [Subtitle subject to abrogation]

(a) The findings and recommendations of the Commission shall be considered each year in the development of the budgets of the Department, the Developmental Disabilities Administration, and the Mental Hygiene Administration.

(b) (1) The Mental Hygiene Administration and the Developmental Disabilities Administration shall respond to the recommendations of the Commission in writing within 30 days after the report required in § 13–809 of this subtitle has been issued.

(2) The written response of the Mental Hygiene Administration and the Developmental Disabilities Administration shall include:

(i) An explanation of the actions being taken to implement the recommendations of the Commission; or

(ii) An explanation of why no action has been taken on the recommendations of the Commission.

(c) (1) The Mental Hygiene Administration and the Developmental Disabilities Administration shall provide to the Commission, in advance of or at the same time as they are provided to the public, copies of any new or revised regulations regarding payment rates for community services.

(2) The Board of Nursing shall provide to the Commission, in advance of or at the same time as they are provided to the public, copies of any new or revised regulations that would be expected to impact on the costs incurred by providers of community services that are paid for by the Mental Hygiene Administration or the Developmental Disabilities Administration.

## MARYLAND HEALTH-GENERAL CODE ANNOTATED
## TITLE 16. REIMBURSEMENTS AND COLLECTIONS
## SUBTITLE 2. GENERAL PROVISIONS

**§16–201.2 Cost-of-living adjustment** [Amendment subject to abrogation]

(a) Definitions. --

(1) In this section the following words have the meanings indicated.

(2) "Community developmental disabilities services provider" means a community-based developmental disabilities program licensed by the Department.

(3) "Community mental health services provider" means a community-based mental health program approved by the Department or an individual practitioner who contracts with the Department or the appropriate core service agency.

(4) "Core service agency" has the meaning stated in § 10-1201 of this article.

(5) "Eligible individual" means a Medicaid recipient or an individual who receives developmental disabilities services or mental health services subsidized in whole or in part by the State.

(b) Reimbursement for approved services. -- Notwithstanding the provisions of this subtitle, the Department shall reimburse a community developmental disabilities services provider or a community mental health services provider for approved services rendered to an eligible individual as provided in this section.

(c) Factors used for adjustment. --

(1) Beginning in fiscal year 2012 and in each fiscal year thereafter, the Department shall adjust for inflation the fees paid to a community developmental disabilities services provider and a community mental health services provider for approved services rendered to an eligible individual.

(2) The Department shall establish an annual inflationary cost adjustment for providers that shall be aligned with the annual cost adjustments for units of State government in the Governor's proposed budget.

(3) Subject to paragraphs (4) and (5) of this subsection, the Department shall ensure that the annual inflationary cost adjustment for providers is equivalent to the annual inflationary cost adjustments for categories of costs for units of State government in the Governor's proposed budget by using the weighted average cost structure set forth in § 13-806(b)(1) of this article.

(4) The annual inflationary cost adjustments for categories of costs for units of State government used to establish the annual inflationary cost adjustment for providers may not be less than 0%.

(5) The annual inflationary cost adjustment for providers may not exceed a maximum adjustment of 4%.

(6) Annual adjustments shall be funded with due regard to the expenditures necessary to meet the needs of individuals receiving services.

**§16-201.2. Cost-of-living adjustment.** (Abrogation of amendment effective June 30, 2016)

(a) Definitions. --

(1) In this section the following words have the meanings indicated.

(2) "Community developmental disabilities services provider" means a community-based developmental disabilities program licensed by the Department.

(3) "Community mental health services provider" means a community-based mental health program approved by the Department or an individual practitioner who contracts with the Department or the appropriate core service agency.

(4) "Core service agency" has the meaning stated in § 10-1201 of this article.

(5) "Eligible individual" means a Medicaid recipient or an individual who receives developmental disabilities services or mental health services subsidized in whole or in part by the State.

(b) Reimbursement for approved services. -- Notwithstanding the provisions of this subtitle, the Department shall reimburse a community developmental disabilities services provider or a community mental health services provider for approved services rendered to an eligible individual as provided in this section.

(c) Factors used for adjustment. --

(1) Subject to the limitations of the State budget, beginning in fiscal year 2008 and in each fiscal year thereafter, the Department shall adjust for inflation the fees paid to a community developmental disabilities services provider and a community mental health services provider for approved services rendered to an eligible individual using the update factor recommended by the Community Services Reimbursement Rate Commission.

(2) Annual adjustments shall be funded with due regard to the expenditures necessary to meet the needs of individuals receiving services.

(3) The annual rate of change for the fees may not exceed a maximum rate of 5%.

## 2010 Laws of Maryland

# Chapter 497

**(Senate Bill 633)**

AN ACT concerning

**Community Services Reimbursement Rate Commission – Developmental Disabilities and Community Mental Health Services – Rate Adjustments**

FOR the purpose of requiring the Community Services Reimbursement Rate Commission to ~~develop a certain update formula for determining rates paid to developmental disabilities service providers and community mental health services providers~~ *determine a weighted average cost structure of certain developmental disabilities service providers and community mental health services providers in a certain manner*; requiring the Commission to include in a certain existing annual report an analysis of the impact of a certain ~~update formula~~ *annual inflationary cost adjustment* on the financial condition of certain providers; requiring the Department of Health and Mental Hygiene to make a certain adjustment for inflation of the fees paid to certain providers ~~using a certain update formula~~ beginning in a certain fiscal year; *requiring the Department to ensure that a certain annual inflationary cost adjustment is equivalent to certain other annual inflationary cost adjustments by using a certain weighted average cost structure; providing that certain annual inflationary cost adjustments used to establish a certain annual inflationary cost*

*adjustment may not be less than a certain percentage; providing that a certain annual inflationary cost adjustment may not exceed a certain percentage;* establishing the formula for the annual inflation rate adjustment for certain providers; requiring the Department to conduct a certain study in consultation with certain stakeholders and to report its findings and recommendations to the General Assembly on or before ~~a~~ certain ~~date~~ *dates; providing for the termination of this Act*; and generally relating to the Community Services Reimbursement Rate Commission and provider rate adjustments.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 13–806, 13–809, and 16–201.2
Annotated Code of Maryland
(2009 Replacement Volume)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

**Article – Health – General**

13–806.

(a) The Commission shall assess:

(1) The extent and amount of uncompensated care delivered by providers;

(2) The level of and changes in wages paid by providers to direct support workers, including the source of revenue for wages paid by providers;

(3) The ability of providers to operate on a solvent basis in the delivery of effective and efficient services that are in the public interest;

(4) The incentives and disincentives:

(i) Incorporated in the rate setting methodologies utilized and proposed by the Mental Hygiene Administration and the Developmental Disabilities Administration; and

(ii) In alternative methodologies;

(5) How incentives to provide quality care can be built into a rate setting methodology; and

(6) The impact of changes in regulations that impact on the costs of

providers and whether the rates have been adjusted to provide for any increased costs associated with the regulatory changes.

(b) The Commission shall:

(1) ~~Develop [or refine methodologies for calculating rate update factors for rates paid by the Developmental Disabilities Administration and the Mental Hygiene Administration and recommend annual rate update factors that use the methodologies that are developed]~~ **AN UPDATE FORMULA THAT IS EQUIVALENT TO THE COST ADJUSTMENTS FOR UNITS OF STATE GOVERNMENT IN THE GOVERNOR'S PROPOSED BUDGET BY** ***DETERMINE A WEIGHTED AVERAGE COST STRUCTURE OF PROVIDERS BY*****:**

**(I) STUDYING THE CATEGORIES OF COSTS USED BY THE DEPARTMENT OF BUDGET AND MANAGEMENT IN THE BUDGETS OF UNITS OF STATE GOVERNMENT;** ***AND***

**(II) ASSESSING THE AVERAGE COST STRUCTURE OF PROVIDERS USING THE CATEGORIES OF COSTS USED BY THE DEPARTMENT OF BUDGET AND MANAGEMENT FOR UNITS OF STATE GOVERNMENT;** ~~**AND**~~

~~**(III) DETERMINING A WEIGHTED AVERAGE FORMULA BASED ON THE AVERAGE COST STRUCTURE OF PROVIDERS TO ALIGN ANNUAL COST ADJUSTMENTS FOR PROVIDERS WITH COST ADJUSTMENTS FOR UNITS OF STATE GOVERNMENT IN THE GOVERNOR'S PROPOSED BUDGET;**~~

(2) With respect to the Developmental Disabilities Administration, review the data reported in the Developmental Disabilities Administration annual cost reports and use the data to develop relative performance measures of providers; and

(3) Evaluate proposed regulatory changes by the Department, the Developmental Disabilities Administration, and the Mental Hygiene Administration that affect the rates paid or the rate structure.

13–809.

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

(1) Describes its findings regarding:

(i) The changes in wages paid by providers to direct care workers;

(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**, AND THE IMPACT OF THE ~~UPDATE FORMULA~~ *ANNUAL INFLATIONARY COST ADJUSTMENT* AS SET FORTH IN § ~~13–806~~ *16–201.2(C)* OF THIS ~~SUBTITLE~~ *ARTICLE*, ON THE FINANCIAL CONDITION OF PROVIDERS**;

(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]~~ **UPDATE FORMULA**, ***WEIGHTED AVERAGE COST STRUCTURE OF PROVIDERS*** **AS SET FORTH IN § 13–806 OF THIS SUBTITLE,** for the next succeeding fiscal year; **AND**

**(VI) ANY ADDITIONAL RECOMMENDATIONS REGARDING RATE–SETTING METHODOLOGIES TO ALIGN PROVIDER RATES WITH REASONABLE COSTS;**

(2) Recommends the need for any formal executive, judicial, or legislative action;

(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.

16–201.2.

(a) (1) In this section the following words have the meanings indicated.

(2) "Community developmental disabilities services provider" means a community–based developmental disabilities program licensed by the Department.

(3) "Community mental health services provider" means a community–based mental health program approved by the Department or an individual practitioner who contracts with the Department or the appropriate core service agency.

(4) "Core service agency" has the meaning stated in § 10–1201 of this article.

(5) "Eligible individual" means a Medicaid recipient or an individual who receives developmental disabilities services or mental health services subsidized in whole or in part by the State.

(b) Notwithstanding the provisions of this subtitle, the Department shall reimburse a community developmental disabilities services provider or a community mental health services provider for approved services rendered to an eligible individual as provided in this section.

(c) (1) **[**Subject to the limitations of the State budget, beginning**] BEGINNING** in fiscal year **[**2008**] 2012** and in each fiscal year thereafter, the Department shall adjust for inflation the fees paid to a community developmental disabilities services provider and a community mental health services provider for approved services rendered to an eligible individual ~~using the update~~ **[**~~factor~~**] FORMULA SET FORTH IN § 13–806 OF THIS ARTICLE** ~~recommended by the Community Services Reimbursement Rate Commission~~.

***(2) THE DEPARTMENT SHALL ESTABLISH AN ANNUAL INFLATIONARY COST ADJUSTMENT FOR PROVIDERS THAT SHALL BE ALIGNED WITH THE ANNUAL COST ADJUSTMENTS FOR UNITS OF STATE GOVERNMENT IN THE GOVERNOR'S PROPOSED BUDGET.***

***(3) SUBJECT TO PARAGRAPHS (4) AND (5) OF THIS SUBSECTION, THE DEPARTMENT SHALL ENSURE THAT THE ANNUAL INFLATIONARY COST ADJUSTMENT FOR PROVIDERS IS EQUIVALENT TO THE ANNUAL INFLATIONARY COST ADJUSTMENTS FOR CATEGORIES OF COSTS FOR UNITS OF STATE GOVERNMENT IN THE GOVERNOR'S PROPOSED BUDGET BY USING THE WEIGHTED AVERAGE COST STRUCTURE SET FORTH IN § 13–806(B)(1) OF THIS ARTICLE.***

***(4) THE ANNUAL INFLATIONARY COST ADJUSTMENTS FOR CATEGORIES OF COSTS FOR UNITS OF STATE GOVERNMENT USED TO ESTABLISH THE ANNUAL INFLATIONARY COST ADJUSTMENT FOR PROVIDERS MAY NOT BE LESS THAN 0%.***

***(5) THE ANNUAL INFLATIONARY COST ADJUSTMENT FOR PROVIDERS MAY NOT EXCEED A MAXIMUM ADJUSTMENT OF 4%.***

~~**(2) THE ANNUAL INFLATION RATE ADJUSTMENT FOR DEVELOPMENTAL DISABILITY AND MENTAL HEALTH COMMUNITY PROVIDERS SHALL BE EQUIVALENT TO THE COST ADJUSTMENTS FOR CATEGORIES OF COSTS FOR UNITS OF STATE GOVERNMENT IN THE GOVERNOR'S PROPOSED BUDGET.**~~

**[**(2)**]** ~~**(3)**~~ ***(6)*** Annual adjustments shall be funded with due regard to the expenditures necessary to meet the needs of individuals receiving services.

**[**(3) The annual rate of change for the fees may not exceed a maximum rate of 5%.**]**

SECTION 2. AND BE IT FURTHER ENACTED, That the Department of Health and Mental Hygiene shall:

(a) *(1)* conduct a study, in consultation with community services stakeholders, including the Maryland Association of Community Services and the Community Behavioral Health Association of Maryland, ~~to evaluate whether the role of the Community Services Reimbursement Rate Commission and its reporting requirements should be modified as a result of the changes in §§ 13–806, 13–809, and 16–201.2 of the Health – General Article enacted by Section 1 of this Act; and~~ *for purposes of recommending a plan to develop, and a timeline to implement, a rate–setting methodology for community developmental disabilities and mental health services providers that would:*

*(i) promote the fiscally sound and efficient operation of community services providers; and*

*(ii) promote the highest level of quality of care for individuals with developmental disabilities and mental illness;*

*(2) include in the study an analysis of:*

*(i) the operating costs of community services providers;*

*(ii) the ability of community services providers to attract and retain a high quality work force;*

*(iii) any appropriate and feasible incentives for high quality performance of community services providers;*

*(iv) any capital infrastructure needs of community services providers;*

*(v) transportation costs of community services providers;*

*(vi) the appropriate future role of the Community Services Reimbursement Rate Commission and other entities involved in State rate–setting processes; and*

*(vii) any other issues related to the efficient and effective provision of community services; and*

*(b) (1) on or before December 1, 2012, report its preliminary findings and recommendations to the General Assembly, in accordance with § 2–1246 of the State Government Article; and*

~~(b)~~ *(2)* on or before January 1, ~~2011~~ *2013*, report its findings and recommendations to the General Assembly, in accordance with § 2–1246 of the State Government Article.

SECTION ~~2.~~ 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2010. *It shall remain effective for a period of 5 years and 9 months and, at the end of June 30, 2016, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.*

**Approved by the Governor, May 20, 2010.**

# Appendix 2

# ORGANIZATIONAL STRUCTURE

## Commissioners

Jillian Aldebron, JD, MA, *Chair (non-affiliated, 2011-2014)*
Patsy Baker Blackshear, PhD *(non-affiliated, 2012-2014)*[*]
Kia Brown, MS *(non-affiliated, 2011-2014)*
Rebecca L. M. Fuller, PhD *(non-affiliated, 2012-2014)*[*]
Jeff Richardson, MBA, LCSW-C *(2011-2014)*
Tom Sizemore, MBA, CPA *(2011-2014)*
Tim Wiens, MSW, *Vice-Chair (2011-2014)*

## Technical Advisory Group (TAG) Members

### *Mental Health Technical Advisory Group*

Jillian Aldebron, *CSRRC (chair)*
Denise Camp, *On Our Own of Maryland*
Herb Cromwell, *CBH*
Rebecca Fuller, *CSRRC*
Brian Hepburn, *MHA*
Jeff Richardson, *CSRRC*
Donna Wells, *CSA, Howard County Mental Health Authority*
Frank Sullivan, *CSA, Anne Arundel County Mental Health Agency*

### *Developmental Disability Technical Advisory Group*

Tim Wiens, *CSRRC (chair)*
Patsy Baker Blackshear, *CSRRC*
Kia Brown, *CSRRC*
Laura Howell, *MACS*
John Dumas, *Service Coordination, Inc.*
Frank Kirkland, *DDA*
Bette Ann Mobley, *DHMH*
Thomas Sizemore, *CSRRC*
Gerald Skaw, *DDA*

## Technical Consultant

The Hilltop Institute
University of Maryland Baltimore County

[*]These commissioners were appointed to vacant seats in March 2012. All terms expire September 30, 2014.

# Appendix 3

# MEETING SCHEDULE 2011-2012

## Commission Meetings

October 28, 2011

December 20, 2011

February 15, 2012

April 24, 2012

June 12, 2012

August 14, 2012

August 27, 2012

September 18, 2012

## Mental Health TAG

November 29, 2011

January 31, 2012

March 20, 2012

May 15, 2012

July 17, 2012

## Developmental Disability TAG

December 1, 2011

January 6, 2012

March 5, 2012

May 7, 2012

July 30, 2012