MARYLAND

COMMUNITY SERVICES REIMBURSEMENT RATE COMMISSION

an independent commission within the Maryland Department of Health and Mental Hygiene

September 30, 2013

Ms. Johanne Greer, Coordinator
Library and Information Services
Maryland General Assembly
Legislative Services Building
90 State Circle, B-00
Annapolis, MD 21401

Re: Community Services Reimbursement Rate Commission 2012 Annual Report

Dear Ms. Greer:

Md. Code Ann. Art. Health-Gen., §13-809 requires the Community Services Reimbursement Rate Commission to submit an annual report with findings and recommendations on or before October 1.

This year, the Commission has experienced delays due to a breach of contract by its technical consultant. On Sept. 13, we were able to engage the services of another contractor to review data input and perform, insofar as possible, the analyses needed to produce reliable findings and recommendations. The inability to produce an annual report did not, however, impair our ability to develop a weighted average cost structure of providers, as mandated by Md. Code Ann. Art. Health-Gen., §13-806(b) and submit this to DHMH on July 23 to incorporate into its FY 2015 budget proposal.

We expect to be able to issue an annual report before the end of the calendar year.

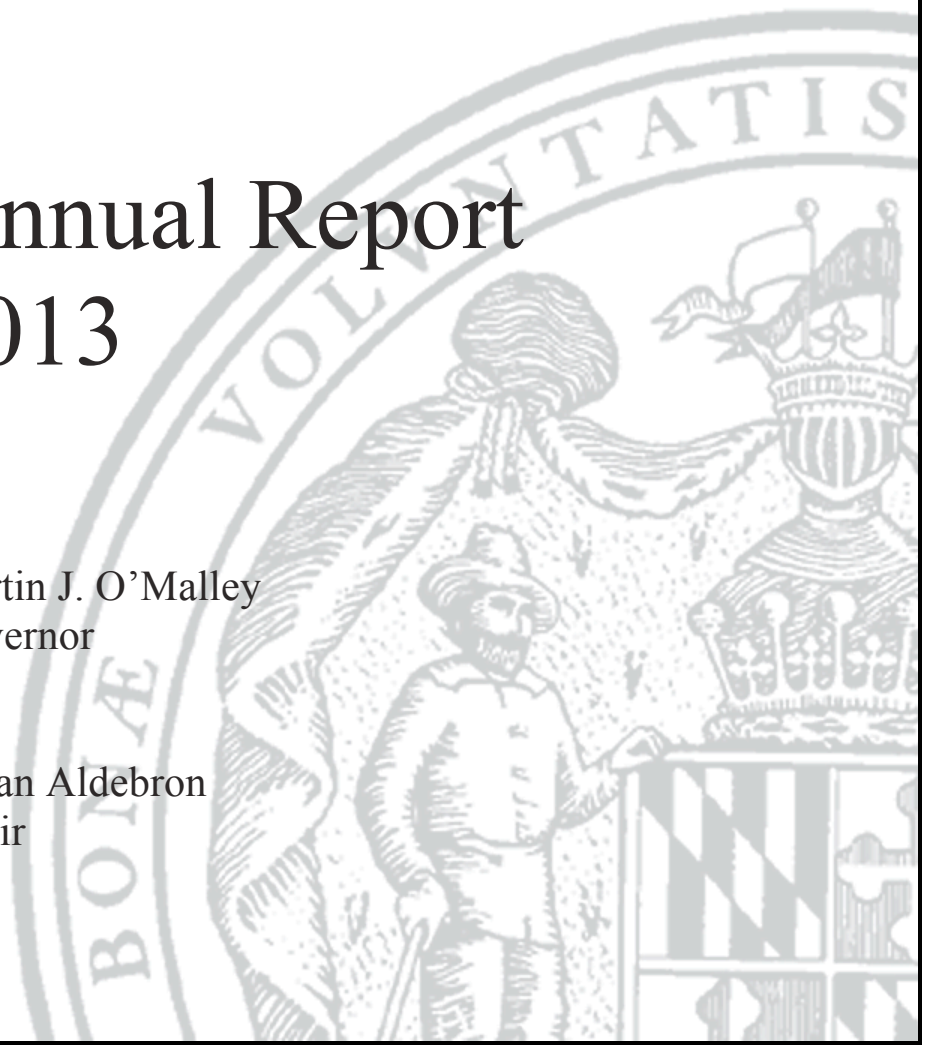
Sincerely,

Jeanne Smith (For Jillian Aldebron)

Jillian Aldebron
Chair

Community Services Reimbursement Rate Commission

Annual Report 2013



Martin J. O'Malley
Governor

Jillian Aldebron
Chair

Community Services Reimbursement Rate Commission

ANNUAL REPORT 2013

(released Nov. 26, 2013 for the period Oct. 1, 2012-Sept. 30, 2013)

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Executive Summary

The CSRRC completed the second year of its 5-year reauthorization, which took effect in October 2011 after a two-and-a half-year hiatus during which the CSRRC was authorized but inoperative. The new statute modified the CSRRC mandate by eliminating its advisory role in determining reimbursement rates: instead, the CSRRC is required to calculate a "weighted average cost structure" (WACS) using Department of Budget Management (DBM) budget categories for each of the relevant sectors; the Mental Hygiene Administration (MHA) and the Developmental Disabilities Administration (DDA) are required, in turn, to apply DBM annual budget instructions for units of state government to these WACSs and adjust rates accordingly. Unlike most state advisory commissions, the CSRRC has no dedicated staff; as a consequence, it must directly oversee the performance of data collection and analysis conducted variously by MHA, DDA, and contractors hired by the Department of Health and Mental Hygiene (DHMH) to provide expert technical services. We continue to investigate solutions for institutionalizing some functions within DHMH. The sophistication and usefulness of CSRRC reports are directly correlated with the competency of its technical consultants. This year, our findings were limited by operational constraints.

Attempts to work with DHMH on recommendations made in our 2012 Annual Report, the rate methodology study mandated by SB 633 (2010), input relevant to proposed structural changes in service delivery, and specific activities identified by MHA and DDA for collaboration had mixed results. MHA was responsive to our requests for assistance with data collection and administration outside of that already foreseen (meeting and office space, file storage and management, minutes, webpage updates, set up and monitoring of email account). On the other hand, it is clear that DHMH has no interest in collaborating with the CSRRC or acknowledging its functions. Given planned changes in the structural and payment systems for provision of community-based mental health and developmental disability services, as well as the limited mandate of the CSRRC, the General Assembly may want to reconsider whether the CSRRC continues to be relevant or useful.

This document is submitted in fulfillment of the CSRRC's annual reporting requirement under Md. Code Ann. Art. Health-Gen., § 13-809, and covers the period Oct. 2012-Sept. 2013.

Findings

Workforce

The community-based mental health sector overall appears to be satisfying its workforce needs, although some entities may have recruiting difficulties associated with provider preferences for certain geographic locations. Salaries at all professional levels are on par, and in some cases exceed, national averages. The mental health service provider salary survey was revised based on recommendations made in the CSRRC 2012 Annual Report. The new design improved clarity, eliminated inconsistencies of interpretation, and overall offered a more representative picture of the community-based provider workforce. The revised reporting requirements made it problematic to use the data for a backward looking trend analysis, but will

create a more meaningful basis for trend analysis going forward. Several issues were not addressed by the revision so as not to overburden providers with too many new requirements.

The developmental disability sector is problematic to assess because this tends to be a more transient workforce at the direct care level due in some part to the difficult nature of the work and absence of career ladder. Nonetheless, staffing appears to be adequate based on vacancy and tenure data. There is some indication that salaries of direct care workers may not be reflecting rate increases: this will have to be studied more closely in the future. The developmental disability service provider wage survey was entirely overhauled for FY 2012 reporting based on recommendations made in the CSRRC 2012 Annual Report—most notably, to reflect actual hourly wage rates instead of total payroll expenditures, segregate voluntary from mandatory fringe benefits, and establish definitions for terminology (to improve the reliability and comparability of data). The changes in reporting requirements make retrospective analysis impossible, which is why we cannot draw concrete conclusions about wage rates. Nonetheless, wages are in line with national averages as reported by the Bureau of Labor Statistics.

Discussions with mental health and developmental disability service providers last year indicated that employers were responding to financial constraints and rising health plan premiums by limiting the availability of voluntary fringe benefits or requiring greater employee contributions for the same level of coverage. To better understand this trend, the CSRRC conducted a survey among providers that focused exclusively on voluntary fringe benefits, defined broadly to encompass all types of employee benefits (e.g. health insurance, 401(k), flex time, vacation, paid sick leave, wellness programs, etc.). Some 50 providers responded across both sectors. Responses indicated that, in fact, companies on the whole are offering the same—and sometimes more generous—health benefit packages as they have in the past, in part to attract and retain staff. Whether or not employees are fully able to take advantage of the benefits offered due to affordability or other considerations was not explored.

Financial Performance

Given the slim margins characteristic of the community-based service sector, the heavy state reliance on private companies to care for Medicaid and waiver populations, and the dependence of private companies on state funds as a primary revenue source, the CSRRC decided that an examination of financial strength should focus on whether the system is stable and operationally sound, rather than on its degree of profitability. For this reason, we significantly changed our methodology this year and adopted a modified financial strength index (FSI) approach comparable to that used to gauge the performance of hospitals and other types of entities. Profitability is anyway not a proxy for the delivery of effective and efficient services, and there is no clear correlation between profits and reimbursement rates. Use of an FSI had the additional advantage of enabling us to benchmark each of the constituent financial measures within the two sectors of community-based providers in Maryland to compare the relative performance of certain groups.

The FSI methodology yielded a picture of community-based provider networks that are, on the whole, financially stable. On an individual basis, some providers—almost exclusively for-profit entities—demonstrate sufficiently poor performance to warrant concern over long-term sustainability. Most of the for-profit companies, which make up roughly half of the community-

based mental health sector, did not submit audited financial statements or much more than a balance sheet, if that. The median FSI score for mental health service providers is in the average range, as it is that for developmental disability service providers, albeit scores within the range have fluctuated over time. The developmental disability sector has fewer companies demonstrating financial vulnerability, and is almost exclusively made up of non-profits. Despite the fact that rate increases over the past six years have been minimal—nothing at all in some years for mental health service providers—the number of programs has grown from roughly 100-120 in 2007, to 193 MHA-licensed and 163 DDA-licensed companies in 2013.

Impact of the Annual Inflationary Cost Adjustment

Reporting trails budget determinations by three years: that is, providers are reporting on FY 2012 financial and workforce for consideration by the 2014 General Assembly in approving the FY 2015 budget. The first rate increase under the new statutory provision that requires DHMH to base rate adjustments on a weighted average cost structure occurred only in FY 2013, and amounted to only .88% for mental health service providers and 2% for developmental disability providers (of which 1% was a discretionary increase made by the Governor). Thus, the impact of annual rate increases cannot yet be determined.

Incentives and Disincentives in the Rate System and Quality of Care

In the mental health sector, the fee-for-service model does not incentivize provider accountability for patient outcomes. 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. 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. An annual client survey that uses quality of life indicators rates satisfaction with services, but this is not used in conjunction with rates.

Weighted Average Cost Structure

The weighted average cost structure calculation was provided to DHMH on July 23, 2013. As expected, payroll costs constitute the largest category of spending, accounting for some two-thirds of total expenditures for most community providers. The CSRRC has been unable to

get any response from DHMH, despite numerous inquiries, on whether and how the weighted average cost calculation was used to determine FY 2015 rates. We urge the General Assembly to review the budget proposal for community-based providers so as to ensure compliance with statutory and regulatory rules for annual cost-of-living rate adjustments.

Issues for Future Study

The CSRRC will concentrate especially on improving data quality through creation and implementation of a web-based reporting system hosted by DHMH. Other issues for study pertain to refining the analysis of personnel management and financial performance by adding indicators and redefining

SUMMARY OF RECOMMENDATIONS

Workforce

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

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

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

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

Financial Performance

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

2. MHA, in collaboration with the CSRRC, should support cost reporting with training and technical assistance. This new requirement is especially valuable because it will be directly

applicable to preparation of a weighted average cost structure for this sector. In addition, it will provide insights into financial operations that cannot be gleaned from a study of financial statements alone, particularly with respect to for-profit companies.

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

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

5. Policy makers have a strong interest in the sustainability of the provider network on which the public is entirely reliant for services and that is funded with tax revenue. In this regard, they may want to consider establishing minimum standards for operational soundness and conditioning authorization to receive MHA and DDA reimbursement on meeting those requirements. Some examples may be to require that all companies maintain a certain level of reserves or have a line of credit to cover recurrent debt obligations regardless of caseload fluctuations. Reimbursement rates are necessary, but not sufficient to guarantee financial health: much depends on good fiscal management. This is especially important because a significant percentage of companies are organized as for-profits that are not subject to the oversight of a board of directors with a fiduciary duty to ensure the stability of the entity.

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

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

as a marginal entity—at the very least, it needs the cooperation and collaboration of the administrations that license providers.

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

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 and regularly attend CSRRC meetings.

Although the statute empowers the CSRRC to employ staff and expend funds (Md. Code Ann. Art. Health-Gen., § 13-805(d)), in practice it is entirely dependent on DHMH to fund and administer its operations. The CSRRC is neither consulted nor informed about its annual budget allocation, nor does DHMH provide an opportunity for the CSRRC to discuss its budgetary needs. Moreover, unlike most state advisory commissions, the CSRRC has no dedicated staff support; as a consequence, it must directly oversee the performance of data collection and analysis conducted variously by MHA, DDA, and contractors hired to provide expert technical services. Despite its continuous reauthorization for successive five-year terms since its inception, the CSRRC ceased to function during the period April 2009-October 2011 because DHMH did not allocate sufficient funds to hire a technical contractor. This operational hiatus posed numerous challenges for the newly reconstituted CSRRC appointed under the 2010 5-year reauthorization that limited its ability to address some longstanding concerns (see CSRRC 2012 Annual Report for details).

The CSRRC mandate under Md. Code Ann. Art. Health-Gen., § 13-801 et seq. has been amended several times since 1996. But the most important modification made in the 2010 reauthorization was to remove its responsibility for rate recommendations. Historically, those recommendations were often disregarded, and rate updates over the life of the CSRRC averaged about 1% annually for mental health providers, although developmental disability providers have received at least double this through discretionary allocations and other payment reform mechanisms. Under the new statute, providers advocated for and obtained a modification that instead required the CSRRC to develop a weighted average cost structure in each sector using the cost categories established by the Department of Budget and Management (DBM) for units of state government (Md. Code Ann. Art. Health-Gen., § 13-806(b[3])). Beginning with the FY 2012 budget, DHMH is required to adjust rates 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

[1] "Non-rate regulated" providers are recipients of public funding whose reimbursement rates are not set by the Health Service Cost Review Commission or established by federal law.
[2] Md. Code Ann. Art. Health-Gen., §§ 13-801 to 810.
[3] The CSRRC was unable to participate in the discussion on modification of its statute because it was not functioning during the legislative session that passed the reauthorization.
[4] Also referred to as SB 633.

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 CSRRC contribution to the rate setting methodology was used for the first time in preparation of the FY 2014 budget.

The CSRRC is not authorized to study all non-rate regulated community-based mental health and developmental disability providers in Maryland, but only: "community-based agency[s] or program[s] 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)). The 193 mental health and 163 developmental disability companies (2013) fitting this definition serve the overwhelming majority of Marylanders receiving public mental health and developmental disability services. This report pertains to the subset of these providers that is required to report annually to MHA or DDA, which excludes programs run by county health departments, entities set up by parents to care for their own children, and those whose financing is inextricable from that of its hospital-system parent company.

The first meeting of the newly appointed CSRRC took place on October 28, 2011. Prior to appointment of commissioners, DHMH contracted with The Hilltop Institute 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. The lack of a consultative process in contracting constrained CSRRC objectives in the first term because contractual deliverables were pre-determined.

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.

2. Developments in 2012-2013

The CSRRC made several important operational changes in the 2012-2013 term. It terminated the technical assistance contract with Hilltop and issued an RFP seeking expertise that would be more cost effective and closely aligned with the financial and analytical competencies needed to fulfill the CSRRC mandate and vision. A contract was awarded to Open Minds, based in Gettysburg, Pennsylvania. To maximize participation from provider groups, commissioners, and public sector representatives, the CSRRC reconfigured its meeting schedule to convene bi-monthly advisory groups and full commission meetings sequentially on the same day. This had the advantage of retaining the same total number of meetings but providing improved opportunity for all Commissioners to participate in advisory group meetings and industry representatives to attend meetings of the full commission.

During this second term of its reauthorization, the CSRRC set itself an ambitious agenda to implement the recommendations proposed in its 2012 Annual Report and chart new territory in enhancing data reliability, exploring avenues of interest identified in the previous year, and collaborating closely with DHMH—where leadership changes in Behavioral Health and Developmental Disabilities, the integration of mental health and substance use disorder services, a financial overhaul of DDA (including payment system reform), and preparation to implement the Supports Intensity Scale signaled exciting opportunities. In addition, the CSRRC anticipated working with DHMH on the rate methodology study mandated by SB 633 (2010). Expectations for meaningful collaboration, however, were not completely met and have limited the potential impact of the CSRRC.

Below is a summary of progress and developments since the last annual report with respect to the proposed recommendations for DHMH, issues identified for future study, and the operational capacity of the CSRRC.

A. Progress on Recommendations Proposed in the 2012 Report

Under the statute, MHA and DDA are required to respond to recommendations offered by the CSRRC in its annual report within 30 days of submission. (Md. Code Ann. Art. Health-Gen., § 13-810) The CSRRC issued its 2012 Annual Report on Sept. 24, 2012. When a response was not forthcoming despite numerous oral queries, the CSRRC addressed a formal written request to MHA and DDA on Nov. 26, 2012. The CSRRC was eager to have a response for two reasons: first, because its work in the coming year would be guided in part by the DHMH

response; and second, it is required by law. Moreover, the CSRRC attempted to establish a more cooperative relationship with DHMH than had prevailed in the past. DHMH responded three months past the statutory deadline, on Jan. 17, 2013. What follows is a list of 2012 recommendations and outcomes.

1. 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.

    - MHA: ***partially accomplished*** due to its reluctance to demand audited financial statements (see below). Nonetheless, MHA did go back to providers several times when it was apparent that documentation was missing, and was ready to enforce penalties for noncompliance.
    - DDA: ***partially accomplished*** and required the intervention of the Deputy Secretary. Confusion in data collection and failure to forward data in a timely manner resulted in serious disruption to our work.

2. 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.

    - MHA: ***accomplished*** for the salary survey and detailed instructions provided, in conjunction with MHA staff and providers. CSRRC agreed not to change the financial survey because it intended to introduce a cost report for the next fiscal year.
    - DDA: ***accomplished*** for the wage survey and detailed instructions provided, in addition to three conference calls with providers in which DDA staff and the CSRRC participated.

3. 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.

    - ***Not accomplished***, but this was because neither the CSRRC nor the administrations had resources to devote to this issue (see B.4 below)

4. 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. Create a standardized salary and benefits survey for all providers.

    - MHA: ***accomplished***, in cooperation with MHA staff and provider input.
    - DDA: ***accomplished***, in cooperation with DDA staff and provider input.

5. Expand and refine data collection on fringe benefits, concentrating on voluntary benefits for direct support professionals and benefit quality.

    - A fringe benefit survey was conducted by the CSRRC among mental health and developmental disability service providers. This did not require the participation of MHA or DDA. (See B.7)

6. Require *audited* financial statements from all providers.

- MHA: ***Not accomplished***. Although MHA asked providers to submit audited financial statements, when they complained MHA allowed them to submit whatever they wanted. This resulted in an enormous loss of valuable data because a substantial number of the reports were incomplete, inconsistent, and did not conform to basic accounting principles. The problem is significant because roughly 50% of mental health service providers are for-profit entities organized as S-corporations or limited liability companies that do not have the same tax reporting obligations as nonprofits and their financial workings are opaque.
- DDA: This was already a requirement of developmental disability service providers, only about 16 of which are for-profit companies that tend not to prepare audited financial statements.

7. Require cost reports of all providers.
    - MHA: ***Accomplished***. During 2012-2013, the CSRRC created a cost report for mental health service providers, modeled on the statement of functional expenses and similar to that already required of developmental disability companies. This was released through ValueOptions in June 2013, in anticipation of FY 2013 data submissions.
    - DDA: Already a requirement.
8. Resolve and recover all outstanding amounts owed DDA by providers for improper use of enhanced funding under the Wage Equalization Initiative.
    - The CSRRC continues to be concerned by the lack of resolution in the case of $376,000 owed by 14 providers as repayment of FY 2005-2007 Wage Equalization Initiative funds, which were authorized based on assertions that rates did not support salary levels commensurate with recruitment and retention of a competent workforce. The improper use of these funds taints

B. Issues for Future Study Proposed in the 2012 Report

1. 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.
    - Although MHA asserted its intention to work with the CSRRC in the development of a new payment system, it has taken no steps to make this happen. In fact, the CSRRC was unable even to participate in production of the SB 633 report (which includes DDA), due in preliminary form by Dec. 1, 2012 and in final version by Jan. 1, 2013. All attempts by the CSRRC to obtain information on the progress of this study were ineffective. The CSRRC received a draft "Interim Legislative Report" responding respond to the SB 633 requirement for a rate-setting methodology study and the future role of the CSRRC on June 19, 2013. The CSRRC had no input whatsoever into development of the paper and remained ignorant of its existence until the document was received. The CSRRC submitted informal comments on the draft to DHMH on June 30, 2013 and has received no feedback on these comments.

- DDA reaffirmed the importance of the CSRRC as a partner in its efforts to develop a new algorithm for funding levels based on the SIS—particularly since this involves assessing the current rate structure. It proposed working with the CSRRC by keeping it informed regarding sample SIS assessment, seeking input on the related RFP that would reform the payment system, and other collaborative activities that would flow from implementation of the new methodologies for assessing needs. DDA has not acted to involve nor consult with the CSRRC in the development of the RFP.

2. 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.
    - Accomplished. See A.2 above.
3. 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.
    - Accomplished in part. See A.3, 4, and 7 above.
4. 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.
    - Behavioral Health and Development Disabilities and the CSRRC are actively working on development of this system and met several times over August-September, most recently with an IT expert in DHMH who is constructing the system. We hope to be able to implement it over the next reporting period. Doing so would alleviate many raw data problems and simplify the reporting process for providers.
5. Identify selected samples of MHA and DDA providers for more in-depth and longitudinal analyses of financial indicators and design and conduct analyses.
    - Because there is such a high degree of variability in data reliability, accuracy, and completeness—and because of changing reporting requirements over the years—the CSRRC has determined that such analyses are not feasible.
6. Identify meaningful financial indicators and normative standards of financial health, and develop supplemental survey methodologies to better understand the financial condition of providers.
    - The CSRRC abandoned its prior analytical methodology in favor of a more effective approach that uses validated, widely accepted concepts that define financial health in any industry but tailored to the community-based environment. By constructing "financial strength index" adapted to the public mental health and developmental disability sectors, we are able to identify the existence of operational weaknesses that indicate possible instability in the system. The use of this approach obviates the problems inherent in defining terms such as "solvency" (see Financial Analysis section below).

7. 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. Further examination of this issue would be informative, particularly in light of health insurance reform.
    - The CSRRC has taken the first step in gaining a more nuanced understanding of fringe benefits by conducting a survey among mental health and developmental disability service providers. The results, which are reported in the Workforce section, will inform future investigations.
8. 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.
    - The CSRRC has made an initial attempt to quantify unit costs of services in both the mental health and developmental disability service sectors, but this is only at a preliminary stage. Correlation of costs with satisfaction surveys and other performance indicators is still far off—not least because the performance measures are insufficiently granular (MHA) and the results of the new DDA National Core Indicators (NCI) survey in FY 2013 have not been made available. The CSRRC will continue to investigate the potential for integrating quality of care metrics into our analyses in light of the statutory requirement to assess financial condition of providers with respect to their ability to deliver "efficient and effective services" (Md. Code Ann. Art. Health-Gen., § 13-809(1)(ii)).

C. CSRRC Operating Capacity

The CSRRC continues to experience inadequate institutional support from DHMH, insufficient executive level cooperation, and an absence of control over any budget allocation for its operations—coupled with an inability to control spending. In early 2013, the Deputy Secretary acknowledged the Commission's need for operational support and to assign DHMH staff to verify data prior to submission to the CSRRC, and expressed a commitment "to identifying additional staff to help with data review." MHA has provided the CSRRC with meeting and office space, file storage and management facilities, and highly competent staff for some administrative functions. While the CSRRC is deeply appreciative of this administrative assistance, it remains an *ad hoc* arrangement. We anticipate that the Deputy Secretary for Behavioral Health, who has met with the Chair on alternating months since January 2013, and MHA will ensure the continuation of this support.

Given the mandate of CSRRC, we strongly advocate for a baseline of ongoing operational resources that would institutionalize some processes within DHMH—including those involving data collection and, perhaps, some analysis. The CSRRC is responsible for reporting to the General Assembly on the state of community-based service providers. This is accomplished through the collection and analysis of financial and workforce data, some of which is already

incorporated within DHMH administrative functions. Hence, the CSRRC recommends the institutionalization of data collection and analysis within DHMH to save on overhead fees, administrative costs, and data management inefficiencies associated with outside contracting by the CSRCC. The sophistication and usefulness of CSRRC reports are directly correlated with the competency of its technical consultants, in addition to its operational capacity. This year, challenges internal to the organization of the technical contractor forced the CSRRC to cancel advisory group meetings beginning in July and led to termination of the contract, engagement of a second consultant to perform the analyses possible with the data in hand, and delayed the submission of this report. It is important to note that because the CSRRC is not regularly staffed, the day-to-day oversight of technical consultants, data collection inter-agency liaison, administrative oversight and other organizational responsibilities fall to the Chair.

PROVIDER AND PAYMENT SYSTEM OVERVIEW

1. Community-based Mental Health Services

The MHA community-based entities under CSRRC jurisdiction served some 95,600 people in FY 2013, or about 64% of the 150,520 children and adults in the public mental health system. Another 27% of the total 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 Cost Review Commission. The remaining 9% (13,546) are among the 44,000 people who received care from the roughly 2,900 individual and private group practices that accept reimbursement from public funding sources (e.g. Medicaid).[5] Eligibility, utilization review, outcomes assessments, and claims processing is handled by Maryland's administrative service organization, currently ValueOptions.

MHA-approved community-based service models comprise outpatient mental health clinics (OMHCs), psychiatric rehabilitation providers (PRPs), residential rehabilitation services, residential crisis, mobile crisis, mobile treatment teams, assertive community treatment teams (ACT), case management, supported employment. 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. OMHCs are reimbursed at 100% of the maximum allowable Medicaid rate for physicians.[6] PRPs treat individuals with a serious emotional disturbance or a serious and persistent mental disorder. These providers are reimbursed at a flat monthly rate for the average number of face-to-face encounters based on the patient's assessed need for a minimum and maximum range of services. An itemized PRP fee schedule is published in COMAR 10.21.25.09.

In 2012, the CSRRC for the first time produced a weighted average cost structure of mental health service providers for use by MHA in determining the rate adjustment for FY 2014. This formula resulted in a 2.54% rate increase for community-based providers. Rates had effectively remained stagnant with zero or less than 1% increases since FY 2010. Separately, it is worth noting that psychiatrists also received a 15-20% increase for evaluation and management codes to put them on par with primary care physicians, whose Medicaid payments went up on Jan. 1, 2013 (a provision of the Affordable Care Act). The psychiatrist increases in Maryland's public mental health system took effect only on July 1, 2013.

Public mental health system reimbursement rates are higher than commercial rates and Medicare. This is a significant factor in the historical trend among providers to accept only Medicaid patients or those who pay cash at the time they receive services.

[5] 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.

[6] For example, an OMHC is reimbursed $185.52 for a 45-minute diagnostic interview with a child, 25% more than the physician reimbursement rate of $147.93. The same diagnostic interview with an adult is reimbursed at $166.10 for an OMHC, 12% more than the $147.72 physician rate. (COMAR 10.21.25.05 (2013))

For-profit companies make up a significant portion of the 193 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 for-profits organized as S-corporations or limited liability companies.

2. DDA Supported Community-based Services

CSRRC jurisdiction extends to 163 community-based developmental disability providers serving 15,370 people (August 2013). Another 16 serve an additional 7,644 people with resource coordination alone or behavioral support services.[7] These companies perform a range of services for people with intellectual and other developmental 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.

As of August 2013, there was a waiting list of 7,703 individuals on the waiting list for DDA-funded services, not including those on the Future Needs registry. Eighty-two percent (6,324) of these were on the "current request" 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.[8]

DDA does not "reimburse" providers in the strictest sense of the term. Rather, it pays providers in advance according to 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 within six months of the end of the year and reimburse any overpayment.

[7] DDA provides resource coordination for people who need supports regardless of the entity or program that finances their services—and even for those waiting or applying for DDA funding. As of August 2013, 7,484 people were receiving resource coordination from 12 approved agencies that also perform these functions for DDA-funded individuals. Behavioral support services are aimed at preventing institutionalization of people living in the community who have severely challenging and/or disruptive behaviors. As of August 2013, 160 people were receiving DDA-funded behavioral support services from 4 providers. Among the total number of entities authorized to received DDA funds are six micro-boards—companies formed by parents to receive state funds for caring for their own children.

[8] DDA prioritizes funding for those in most urgent need: The highest priority is those in crisis, who are eligible for ongoing services and supports. Next 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. Last are those in "current request."

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. Supported employment services are reimbursed the *per diem* rate for days on when the combined total of paid employment plus vocational supports is at least 4 hours.

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. It should be noted that FPS payments are not intended to cover the cost of all services. For example, a person receiving residential care in the community must contribute to the cost of room and board and, if financially able, the cost of care. The provider is responsible for ensuring that a private contribution provision is incorporated in the service contract and to collect the "copayment."

The prospective payment system has come under fire from the Office of the Inspector General, among others, because of its systemic inefficiencies and the difficulties it presents for fiscal management—in particular, the ability to forecast expenditures. A 2011 proposal to change to retrospective monthly payments with a small amount of upfront funding was defeated because monthly claims processing would have increased DDA administrative costs. DDA is in the midst of a reorganization aimed at improving accountability, oversight, and financial management. A forensic audit of its financial system in 2012 identified inherent weaknesses and recommended procedural changes pending total restructuring. An RFP will be issued in late 2013 for the development of a more robust financial management system intended to resolve the major underlying inefficiencies of DDA's payment and revenue structures.

In 2012, the CSRRC for the first time produced a weighted average cost structure of developmental disability service providers for use by DDA in determining the rate adjustment for FY 2014. The new rate setting formula resulted in a 2.46% rate increase for community-based providers. Unlike the mental health service sector, companies licensed to serve DDA clients received a 1.13% rate increase in FY 2012 and another 2% in FY 2013.

Some 16 developmental disability service providers (excluding the 6 micro-boards) are organized as for-profit companies.

FINDINGS

1. Community-based Provider Workforce[9]

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. Developmental disability direct care workers are generally not required to have any academic or professional credentials beyond a high-school diploma or GED and are at the lower end of the salary spectrum.[10] In the mental health sector, OMHC personnel providing direct care must have academic degrees ranging from a bachelor's (rehabilitation counselors) to a PhD (psychologists) or medical doctorate (psychiatrists), and must meet licensing requirements as well.[11] In PRPs, only the psychiatric rehabilitation specialist must have a license or certification; direct care staff need only a high school diploma and 40 hours of training.[12]

Data Collection

MHA and DDA require community-based providers to submit wage, benefit, and other workforce data to them annually for use by the CSRRC in performing its analyses. Timely completion and electronic submission of the surveys, which are in Excel spreadsheets, are mandatory.[13]

Significant improvements were made to surveys this year that produced greater consistency of format and data points across both sectors, made job titles more representative, created uniform definitions for the salary/wage ranges, and required employers in both to report only the voluntary portion of fringe benefits, among others. There are still some notable differences in the information requested from each sector; these are largely rooted in the history of this data collection: the MHA survey was developed in conjunction with the largest community-based provider association to permit comparisons by its members; the DDA survey was intended to monitor whether funds allocated over five years under the 2003 Wage Initiative were being used as intended—to increase wages paid to direct care staff. The most important difference that persists today is that developmental disability service providers are not required to report on executive level compensation and personnel characteristics. The CSRRC is considering adding this to future surveys, as well as trying to gain an understanding of the extent

[9] In fulfillment of § 13-809(1)(i). Changes in wages paid by providers to direct care workers.
[10] DDA providers also employ certified medical technicians (CMTs) in some cases.
[11] COMAR 10.21.20.10
[12] COMAR 10.21.21.10
[13] COMAR 10.21.17.06(A)(2) applies to MHA providers; COMAR 10.22.17.05(C) applies to DDA providers.

and impact of individuals performing multiple jobs and, in the mental health service sector, how ownership and salaries are related.

The MHA salary survey asks OMHCs to report information for 13 job titles, and asks PRPs to report on 7 job titles. The survey covers the full range of therapeutic staff, plus salaries and benefits for certain executives. It asks for the actual minimum and maximum salaries paid 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) 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[14] asks for payroll expenditures for two over-arching job categories—first line supervisors and direct support workers—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. Transportation salaries and other costs will receive closer examination in future because of the wide variety of transportation needs and solutions. Other data requested in the survey include the number of direct care employees, vacancies, separations, and average tenure. The most important improvement to the DDA survey this year is that it now asks for employee earnings data rather than extrapolating hourly earnings from payroll expenditures.

Data Limitations

Since its reauthorization, the CSRRC has been concerned about data integrity and quality, as these elements impact the results of its analyses and the conclusions that may be drawn from these. We continue our efforts to improve strategies and processes in this area. As previously noted, significant improvements were made to the wage and salary surveys over the last reporting period. In addition, the CSRRC for the first time conducted a fringe benefit survey and subsequent discussions with providers to broaden our understanding of compensation practices. An extensive data training and support program to assist providers in completing the surveys accurately accompanied these efforts. Nonetheless, barriers to obtaining timely, complete, and error-free submissions have limited our ability to draw conclusions about the state of the workforce, although the findings do suggest definite patterns. Moving to an electronic reporting system using a web platform hosted by DHMH would go a long way toward resolving these issues.

A. Mental Health Service Providers

A total of 145 community-based providers were required to submit FY 2012 salary surveys, including 12 county health departments. Of these, 48 are OMHCs, 47 are PRPs and 50 operate both types of programs. Because the data collection tool was modified from previous

[14] MHA and DDA title their surveys differently. This report retains the official titles.

years, trend analysis is not possible. Nonetheless, compensation levels and workforce characteristics are roughly comparable with those reported in previous years.

Table 1 shows compensation and tenure data reported by OMHCs for FY 2012. An OMHC must meet certain staffing requirements to be eligible for approval by MHA to receive state or federal funds. At a minimum, an OMHC must have a program director who is employed at least 20 hours per week and a medical director who is a psychiatrist and employed at least 20 hours per week. The medical director may also serve as the program director if employed full time. It must also ensure a multidisciplinary licensed mental health professional staff, in addition to the psychiatrist, that represents two different mental health professions, both of which are on-site during 50% of the facility's scheduled business hours.[15] Because of the significant overlap of management and clinical roles—which is further compounded by owner/employees who frequently perform administrative functions but also treat patients—compensation rates for discrete positions are difficult to discern. While **Table 1A** shows salaries reported as full time, these figures cannot be taken at face value: average hours per week were sometimes reported as less than what the entity considered a full-time workweek; in other cases, it was not clear whether an individual hired as a full-time employee served in more than one job position and the salary reported as full time reflected only the portion of total salary associated with each position. As a result, the data are not wholly reliable. When part-time salaries in **Table 1B** are converted to annualized salaries, the discrepancy with full-time salaries becomes starker. The data that most likely represent the true pay rates of administrative and professional staff in the mental health services sector are the hourly rates reported in **Table 1B**. This is because these rates are independent of terms of employment (salaried vs. contractual), number of hours work, and whether or not an individual occupies more than one position.[16]

Overtime pay for OMHC staff is not shown in **Table 1** because it was not a significant contribution to employee compensation: overtime was reported only for full-time LCSWs (mean $6,251) and LCPCs (mean $5,123). Vacancies, defined as an empty position that a company is actively seeking to fill, are also not shown because these were also relatively insignificant—especially when considered as a percentage of the total number of employees in the job category. The data indicate that workforce needs are being met overall, although certain facilities—especially in rural locations—may struggle to recruit and retain certain types of professionals. The total number of full-time and part-time vacancies reported by the 98 OMHCs that submitted salary surveys were:

	FT / PT
Adult psychiatrist	3 / 1
Child psychiatrist	1 / 7
Psychologists (PhD)	1 / 1
Psychologists (MA)	4 / 0
Nurse Practitioner	1 / 4
Nurse Psychotherapist	1 / 1
Social worker (LCSW)	20 / 14
Social worker (LGSW)	22 / 10

[15] COMAR 10.21.20.10.

[16] The U.S. Bureau of Labor Statistics constructs the mean annual salary tables in its Occupational Employment Statistics reports by multiplying the hourly mean wage by a "year-round, full-time" hours figure of 2,080. Only when the hourly mean wage is not available is the annual wage directly calculated from reported survey data.

Counselor (LCPC)	12 / 8
Counselor (LGPC)	6 / 1

It should be noted that the vacancies and salaries for medical directors, program directors, and psychiatrists have not been disentangled: that is, in some companies a single individual may simultaneously occupy some or all of these positions, particularly where administrative and/or clinical needs do not demand full-time staff. Future analyses will look at staffing strategies for these positions and how this affects compensation and vacancy levels.

Table 1A. Outpatient Mental Health Clinics, Reported Compensation and Tenure Full-Time, FY 2012

JOB TITLE	BASE SALARY		TENURE (median
	Annual Salary Min. – Max.	Median Mean	Months
Executive Director (41)	**$41,291 - 267,300**	**$103,846**	**104.5**
Non-Profit+Govt (21)	$46,353 - 267,300	$108,283	148.0
For-Profit (20)	$41,297 - 190,000	$92,500	96.0
Medical Director (21)	**$47,188 - 257,000**	**$159,135**	**60.0**
Non-Profit+Govt (11)	$55,000 - 208,000	$159,135	132.0
For-Profit (20)	$47,188 - 257,000	$156,000	13.0
Program Director (42)	**$30,418 - 125,000**	**$67,727**	**24.5**
Non-Profit+Govt (22)	$32,500 - 113,981	$64,594	34.0
For-Profit (20)	$30,418 - 125,000	$73,067	15.0
Adult Psychiatrist (11)	**$47,188 - 390,000**	**$161,733**	**36.0**
Non-Profit+Govt (7)	$48,740 - 255,000	$92,820	66.0
For-Profit (4)	$47,188 - 390,000	$178,600	3.7
Child Psychiatrist (8)	**$35,242 - 260,000**	**$158,624**	**48.0**
Non-Profit+Govt (6)	$35,242 - 260,000	$167,164	60.0
For-Profit (2)	$54,054 - 94,375	$74,215	12.0
Psychologist (PhD/PsyD) (6)	**$53,000 - 82,306**	**$64,981**	**39.0**
Non-Profit+Govt (4)	$62,000 - 82,306	$71,951	103.5
For-Profit (2)	$53,000 - 67,000	$57,500	38.0
Psychologist (MA) (5)	**$32,000 - 49,000**	**$36,000**	**12.0**
Non-Profit+Govt (3)	$34,863 - 49,000	$47,575	348.0
For-Profit (2)	$32,000 - 40,000	$35,283	8.0
Nurse Practitioner (9)	**$29,927 - 114,400**	**$82,795**	**23.2**
Non-Profit+Govt (7)	$29,927 - 114,400	$82,795	22.3
For-Profit (2)	$54,950 – 83,200	$69,075	35.0
Nurse Psychotherapist (10)	**$38,500 - 76,336**	**$62,698**	**84.0**
Non-Profit+Govt (8)	$41,074 - 76,336	$64,110	108.0
For-Profit (2)	$38,501 - 52,473	$45,742	10.0
Social Worker LCSW (41)	**$38,000 - 121,200**	**$57,017**	**38.3**
Non-Profit+Govt (27)	$38,000 - 99,044	$52,589	45.7
For-Profit (14)	$41,000 - 121,200	$60,000	12.0
Social Worker LGSW (33)	**$21,440 - 132,350**	**$45,000**	**12.0**
Non-Profit+Govt (17)	$31,928 - 96,992	$41,858	18.0
For-Profit (16)	$21,440 - 132,350	$46,500	12.0
Counselor LCPC (36)	**$28,625 - 87,520**	**$51,367**	**22.0**
Non-Profit+Govt (22)	$28,625 - 71,851	$50,267	43.4
For-Profit (14)	$35,000 - 87,520	$56,625	12.0
Counselor LGPC (16)	**$25,000 - 54,080**	**$41,028**	**12.0**
Non-Profit+Govt (8)	$27,068 - 49,859	$39,655	14.0
For-Profit (8)	$25,000 - 54,080	$42,025	12.0

Table 1B. Outpatient Mental Health Clinics, Reported Compensation and Tenure Part-Time, FY 2012

JOB TITLE	BASE SALARY				TENURE (median)
	Hourly Min. – Max.	Median Mean	Annualized Min. – Max.	Median Mean	Months
Executive Director (6)	**$27.52 - 78.43**	**$42.93**	**$57,246 - 163,136**	**$89,295**	**104.5**
Non-Profit+Govt (3)	$27.52 - 43.97	$38.19	$57,246 - 91,456	$79,434	148.0
For-Profit (3)	$28.41 - 78.43	$72.12	$59,090 - 163,136	$150,000	96.0
Medical Director (33)	**$72.19 - 200.00**	**$110.00**	**$150,150 - 416,000**	**$228,800**	**60.0**
Non-Profit+Govt (16)	$72.19 - 164.90	$112.67	$150,150 - 343,000	$234,360	132.0
For-Profit (17)	$74.04 - 200.00	$106.99	$154,000 - 416,000	$222,544	13.0
Program Director (6)	**$27.50 - 48.08**	**$40.91**	**$57,195 - 100,000**	**$85,103**	**24.5**
Non-Profi +Govt (3)	$27.50 - 44.33	$28.00	$57,195 - 92,206	$58,240	34.0
For-Profit (3)	$37.50 - 48.08	$46.15	$78,000 - 100,000	$96,000	15.0
Adult Psychiatrist (17)	**$75.00 - 200.00**	**$130.00**	**$156,000 - 416,000**	**$270,400**	**36.0**
Non-Profit+Govt (9)	$75.00 - 175.26	$123.00	$156,000 - 364,540	$255,840	66.0
For-Profit (8)	$100.00 - 200.00	$132.50	$208,000 - 416,000	$275,600	3.7
Child Psychiatrist (14)	**$38.00 - 200.00**	**$118.38**	**$79,040 - 416,000**	**$246,220**	**48.0**
Non-Profit+Govt (9)	$38.00 - 168.75	$118.75	$79,040 - 351,000	$247,000	60.0
For-Profit (5)	$90.00 - 200.00	$106.00	$187,200 - 416,000	$220,480	12.0
Psychologist (Ph/PsyD) (9)	**$31.94 - 100.00**	**$45.00**	**$66,435 - 208,000**	**$93,600**	**39.0**
Non-Profit+Govt (2)	$31.94 - 36.80	$34,47	$66,435 - 76,544	$71,490	103.5
For-Profit (7)	$35.00 - 100.00	$53.21	$72,800 - 208,000	$110,677	38.0
Psychologist (MA) (3)	**$30.95 - 45.00**	**$35.00**	**$64,367 - 93,600**	**$72,800**	**12.0**
Non-Profit+Govt (1)	$30.95 - 30.95	$30.95	$64,367 - 64,367	$64,367	348.0
For-Profit (2)	$35.00 - 45.00	$40.00	$72,800 - 93,600	$83,200	8.0
Nurse Practitioner (10)	**$24.90 - 90.00**	**$80.00**	**$51,792 - 187,200**	**$166,400**	**23.2**
Non-Profit+Govt 6)	$24.90 - 85.00	$75.00	$51,792 - 176,800	$156,000	22.3
For-Profit (4)	$53.50 - 90.00	$80.00	$111,280 - 187,200	$166,400	35.0
Nurse Psychotherapist (5)	**$20.00 - 27.73**	**$21.59**	**$41,600 - 57,678**	**$44,990**	**84.0**
Non-Profit+Govt (4)	$20.00 - 27.73	$21.86	$41,600 - 57,678	$45,407	108.0
For-Profit (1)	$21.63 - 21.63	$21.59	$44,990 - 44,990	$44,990	10.0
Social Worker LCSW (26)	**$10.86 - 65.00**	**$26.71**	**$22,589 - 135,200**	**$55,558**	**38.3**
Non-Profit+Govt (13)	$10.86 - 41.00	$25.00	$22,589 - 85,280	$52,000	45.7
For-Profit (13)	$27.00 - 65.00	$40.00	$56,160 - 135,200	$83,200	12.0
Social Worker LGSW (17)	**$15.00 - 45.00**	**$32.00**	**$31,200 - 93,600**	**$66,560**	**12.0**
Non-Profit+Govt (5)	$18.85 - 32.00	$20.00	$39,208 - 66,560	$41,600	18.0
For-Profit (12)	$15.00 - 45.00	$45.00	$31,200 - 93,600	$69,680	12.0
Counselor LCPC (19)	**$16.78 - 65.00**	**$30.00**	**$34,902 - 135,200**	**$62,400**	**22.0**
Non-Profit+Govt (6)	$16.78 - 43.40	$26.00	$34,902 - 90,272	$54,080	43.4
For-Profit (13)	$17.50 - 65.00	$37.33	$36,400 - 135,200	$77,646	12.0
Counselor LGPC (8)	**$14.27 - 45.00**	**$29.00**	**$29,682 - 93,600**	**$60,320**	**12.0**
Non-Profit +Govt (3)	$14.27 - 40.00	$28.00	$29,682 - $83,200	$58,240	14.0
For-Profit (5)	$19.00 - 45.00	$30.00	$39,520 - 93,600	$62,400	12.0

Table 2 shows compensation and tenure data reported by PRPs for FY 2012. A PRP must also meet specific staffing requirements to be eligible for approval by MHA to receive state or federal funds; these vary based on whether the program treats adults or minors, and patient volume. At a minimum, an adult PRP must have a program director, at least one psychiatric rehabilitation specialist who is licensed or certified, and direct care staff who have had 40 hours of training; the program director may also function as a psychiatric rehabilitation specialist, if qualified. Hours of employment are not specified for adult programs.[17] A PRP serving minors must employ direct care staff who have 60 hours of training and generally higher academic and experience qualifications, maintain at least a 1:6 staffing ratio (not including the program director) and meet other staffing criteria according to the number of patients enrolled:

- Fewer than 30 – a program director and a rehabilitation specialist, each employed 20 hrs/week, or a 40-hr/week program director who serves both roles but spends 20 hours performing rehabilitation specialist functions.

- 30-100 – a program director employed 20 hrs/week and a rehabilitation specialist employed 40 hrs/week, or a 40-hr/week program director who serves both roles and designates staff to carry out administrative duties 20 hours pr week.

- More than 100 – a program director employed 40 hrs/week and either 1) a rehabilitation specialist employed 40 hrs/week, 2) two 20 hr/week rehabilitation specialists, or 3) or if the program director is qualified to also serve as a rehabilitation specialist, a rehabilitation specialist employed 20 hrs/week and designated staff to carry out administrative duties for 20 hrs/week.[18]

Although they have different payment systems (discussed in the financial performance section) and different personnel characteristics, the compensation and workforce profiles of PRPs and OMHCs are fairly similar—as are the difficulties of determining accurate compensation levels. Overtime pay is not shown because it is not significant across most of the workforce.

[17] COMAR 10.21.21.10
[18] COMAR 10.21.29.09

Table 2. Psychiatric Rehabilitation Programs (Adult & Minor Combined), Reported Compensation and Tenure FY 2012

	BASE SALARY				TENURE (median)	
JOB TITLE	Full-Time		Part-Time*		Full Time	Part Time
(Full-Time/Part-Time)	Min. – Max.	Median Mean	Min. – Max.	Median Mean	Months	
Executive Director (36/4)	**$20,000 - 267,300**	**$86,220**	**$82,800 - 200,917**	**$87,500**	**132.0**	**156.0**
Non-Profit+Govt (18/2)	$42,900 - 267,300	$102,960	$82,800 - 200,917	$141,859	264.0	156.0
For-Profit (18/2)	$20,000 - 190,000	$65,000	$85,000 - 90,000	$87,500	84.0	118.0
Chief Financial Off (24/3)	**$35,500 - 156,000**	**$72,255**	**$30,000 - 65,280**	**$62,400**	**60.0**	**20.0**
Non-Profit+Govt (15/1)	$53,159 - 138,465	$73,124	$65,280 - 65,280	$65,280	72.0	23.0
For-Profit (9/2)	$35,500 - 156,000	$66,000	$30,000 - 62,400	$46,200	39.0	16.0
Chief Operating Off (18/4)	**$24,950 - 150,000**	**$87,712**	**$30,000 - 96,004**	**$96,004**	**75.0**	**36.0**
Non-Profit+Govt (6/1)	$56,876 - 150,000	$80,736	$96,004 - 96,004	$96,004	143.5	93.6
For-Profit (12/3)	$24,950 - 100,000	$73,629	$30,000 - 44,000	$30,000	27.5	24.0
Program Manager (41/6)	**$23,000 - 148,000**	**$60,000**	**$21,600 - 228,800**	**$50,707**	**50.0**	**16.5**
Non-Profit+Govt (16/3)	$36,000 - 85,537	$56,984	$59,384 - 228,800	$88,000	51.0	33.0
For-Profit (25/3)	$23,000 - 148,000	$61,576	$21,600 - 35,000	$22,000	27.0	9.0
Senior Supervisor (22/5)	**$28,000 - 90,000**	**$41,701**	**$22,880 - 59,675**	**$38,013**	**27.0**	**11.0**
Non-Profit+Govt (12/2)	$28,606 - 69,999	$41,575	$32,011 - 59,675	$45,843	36.0	158.0
For-Profit (10/3)	$28,000 - 90,000	$43,404	$22,880 - 43,680	$38,013	21.0	11.0
Rehab Specialist (31/10)	**$26,000 - 85,000**	**$47,699**	**$17,500 - 52,000**	**$27,811**	**129.5**	**14.0**
Non-Profit+Govt (12/4)	$26,000 - 73,277	$46,849	$20,800 - 40,411	$32,775	227	72.0
For-Profit (19/6)	$30,000 - 85,000	$48,000	$17,500 - 52,000	$26,250	15	8.0
Rehab Counselor (16/36)	**$19,032 - 53,826**	**$30,685**	**$18,000 - 83,200**	**$31,252**	**18.0**	**21.0**
Non-Profit (8/15)	$19,032 - 53,826	$30,321	$19,282 - 31,970	$28,621	18.0	48.0
For-Profit (8/21)	$19,600 - 45,753	$30,685	$18,000 - 83,200	$36,733	17.0	12.0

* Average number of hours/week are highly variable, ranging from 8 to 40.

Fringe benefits were redefined this year in the MHA salary survey to include only employer-paid discretionary benefits: i.e., health insurance, 401(k), pension, long/short-term disability, and others. Specifically excluded were those employer contributions mandated by federal or state law that do not accrue directly to the employee and, therefore, have no role in attracting or retaining staff—i.e., FICA, unemployment tax, and workers compensation insurance. Mandatory fringe benefits amount to roughly 12% of salary.[19] The use of contract employees—a standard practice for the more highly skilled professionals in this sector—tends to reduce overall provider expenditures for discretionary fringe. Top-level clinicians (especially psychiatrists, but also psychiatric nurse practitioners) are often hired as independent contractors, and therefore would not receive voluntary benefits. The quality of the information reported, however, was poor, showing manifest inconsistencies and errors (for example, part-time fringe

[19] 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.

benefit contributions that exceeded those for full-time staff in the same positions, or employer contributions reported as 100% of salary) that rendered it too unreliable to include in the compensation chart. A survey focusing exclusively on fringe benefits sheds more light on provider costs and uses of fringe benefits as a hiring and retention tool (see Section C. below).

Tables 1 and **2** also break out the data by corporate structure: for-profit and nonprofit, the latter of which includes county health departments. A significant percentage of mental health service providers are organized as for-profit S-corporations or limited liability companies, which makes standard compensation and workforce analyses in this sector problematic. Employees and owners (or members) are the same people in many of these entities (apart from low-level staff) and receive salaries in addition to a percentage of revenues. There is an incentive to set salaries at the lower end of the market range to minimize the company's payroll tax liability (the IRS scrutinizes salary levels of S-corporations to control tax avoidance). This will be discussed in greater detail in the section on financial performance. But here it should be noted that the corporate structure of these entities obscures actual compensation levels and the influence of staffing needs on compensation and benefits decisions. Moreover, it limits the validity of comparisons with nonprofit provider entities.

Other factors that undermine attempts to draw meaningful conclusions from the salary survey—especially regarding compensation and staffing levels—are inherent in the structure of the sector:

- As mentioned above, some one-third (50) of the entities reporting operate both OMHC and PRP programs. When run as components of a single corporate entity, these programs can benefit from economies of shared resources and a reimbursement model (PRP) that tends to result in greater profitability. A blended sample that combines stand-alone OMHC data together with that of OMHCs with PRPs internalizes distortions that cannot be identified and compensated for in the analysis.

- Where an entity has both an OMHC and PRP, it is quite possible that a single program director who meets all necessary criteria under regulation oversees both programs with a half-time position in each. This skews compensation comparisons within each program category.

- In many cases, senior program staff also occupy clinical positions: a single individual may be the executive and also a social worker, for example, and the regulations themselves provide for a medical director of an OMHC also performing clinical duties as a psychiatrist. This is frequently the case with owner/employees. o complicate matters still further, these staff may be employed full time in an executive position but also treat patients on an hourly basis, amounting to more than 1 FTE.

As shown in **Table 3** below, salaries for OMHC and PRP clinical staff are on par—and in many cases exceed—U.S. averages, despite the fact that for lower level professional positions, the Bureau of Labor Statistics standard job classifications used as comparators require greater educational qualifications.[20] It should also be noted that the increase in reimbursement rates for psychiatrists that went into effect July 1, 2013 may have some influence on the salaries that psychiatrists can demand and, ultimately, how OMHCs allocate revenue.

Table 3. Salary Comparison for Selected OMHC & PRP Positions with Regional and National Averages, 2012

Job title	Maryland Mean[21] (2012)	U.S. National Mean (2012)
Psychiatrist	$209,245	$198,290
Psychologist	$66,845	$67,650
Nurse Practitioner	$124,598	$92,510
Social Worker, LCSW	$56,288	$51,310
Professional Counselor	$56,884	$43,390
Rehabilitation Specialist	$37,755	$34,440
Rehabilitation Counselor	$30,969	$26,880

B. Developmental Disability Service Providers

DDA required 139 of a total 163 service providers to report financial and wage survey data for FY 2012.[22] As noted above, the wage survey distributed to providers was significantly revamped this year to reflect actual earnings and employer contributions for discretionary benefits. To assist providers in fulfilling the new requirements, the CSRRC, in conjunction with DDA, conducted three conference calls with providers, prepared a detailed instruction sheet with examples, and posted FAQs on the DDA website. The survey asks for actual earnings, bonuses, overtime, tenure, and vacancies for two categories of employees—"direct support worker" (which is a combination of all aide and service workers) and "first line supervisor," plus "drivers"—in each of four business lines that are funded by the FPS and CSLA, and individual and family supports (ISS/FSS), which is funded by DDA grants. Because past CSRRC analyses converted payroll expenditures into what was described as an hourly wage by dividing total expenditures by total hours paid (not a valid measure of what an employee earns per hour because reported payroll expenditures includes overtime, shift differentials, agency fees, bonuses

[20] U.S. Bureau of Labor Statistics, Occupational Employment Statistics, Occupational Employment and Wages, May 2012

[21] Calculated as the mean of mean full-time and annual part-time salaries:
- combined FT adult/child psychiatrist ($160,179) and PT adult/child psychiatrist ($258,300)
- combined FT doctoral/masters psychologist ($50,491) and PT doctoral/masters psychologist ($83,200)
- FT nurse practitioner ($82,795) and PT nurse practitioner ($166,400)
- FT LCSW ($57,017) and PT LCSW ($55,558)
- FT LCPC ($51,367) and PT LCPC ($62,400)
- FT rehabilitation specialist ($47,699) and PT rehabilitation specialist ($27,811)
- FT rehabilitation counselor ($30,685) and PT rehabilitation counselor ($31,252)

[22] Despite its best efforts, the CSRRC was unable to obtain information from DDA on the selection criteria for those required to report other than the exemption for the six micro-boards.

and potentially other types of compensation) a trend analysis with prior years is not possible.[23] The "direct support worker" category includes service workers, aides, and any other personnel whose primary responsibility (at least 50% of the time) is to provide direct care and assistance to clients. First-line supervisors do not provide direct care, but are the lowest level of supervisory oversight for direct support staff.

Table 4 shows first-line supervisor compensation by business line and how this breaks out by corporate structure. There is no correlation between salary levels and tenure, and it is possible that environment and program duties play a greater role than compensation in staff retention. Other data reported but not shown below are vacancies and overtime, which we thought may have broadened our understanding of workforce management, but turned out to have no correlation. Generally, the first-line supervisor workforce is stable, with a mean number of vacant positions at less than one. Total payroll expenditures for overtime paid to first-line supervisors amounted to just $144,212; first-line supervisors are typically exempt staff. Nonprofit entities tend to offer lower wages and higher benefits, but they also keep their first-line supervisors longer on average.

Table 4. First-Line Supervisors, Reported Compensation and Tenure by Business Line and Corporate Structure, FY 2012
(full-time only)

Business Line (no. in sample)	Minimum Hourly Wage	Maximum Hourly Wage	Median Mean Hourly Wage	Fringe (as % of wages)	Median Tenure (months)
Individual & Family Support(26)	$10.75	$52.08	$18.65		62.5
Day Service (49)	$10.30	$72.30	$17.79		82.5
Residential Live-In (11)	$9.50	$29.06	$20.00		51.3
Residential Non Live-In (59)	$9.00	$33.65	$19.52		58.0
Supported Employment (42)	$10.00	$72.28	$18.67		58.7
CSLA (38)	$11.94	$37.46	$19.44		85.0
OVERALL	**$9.00**	**$72.30**	**$18.83**	**13.2%**	**60.6**
For-Profit (8)	$9.50	$33.65	$19.50	3.6%	52.7
Nonprofit (73)	$9.00	$72.30	$18.73	14.0%	66.5

More interesting is the breakdown by quartile ranking, which is shown in **Table 5**. The results are counter-intuitive in that companies with the largest gross revenues appear to offer salaries in the lower half of the salary range. This may not tell the whole story because it fails to account for bonuses—which may not be paid out every year or reflect the same levels of generosity, but can be significant. Because of the way that bonuses are reported, it is not possible to determine an accurate per person per year average, so these do not appear in the tables. Moreover, because earnings are higher among longer-tenured staff, the relationship is likely

[23] See CSRRC 2012 Annual Report for a detailed explanation of the methodology used by the CSRRC up until this year and why it has been abandoned.

more complex: the incentive to remain with a company increases as earnings rise by virtue of pay raises that are, at least in part, based on seniority.

Table 5. First-Line Supervisors, Reported Compensation and Tenure, by Size, FY 2012
(full-time only)

Quartile	Minimum Hourly Wage	Maximum Hourly Wage	Median Mean Hourly Wage	Fringe (as % of wages)	Median Tenure (months)
Above 75th	$9.00	$35.90	$18.31	12.0%	70.0
51st - 75th	$10.13	$52.08	$18.37	18.6%	75.0
26th - 50th	$10.00	$72.30	$18.71	13.0%	53.0
Up to 25th	$9.50	$37.46	$19.90	9.5%	28.5
OVERALL	**$9.00**	**$72.30**	**$18.83**	**13.1%**	**60.5**

Table 6 shows wages for direct care workers by business line and corporate structure. Tenure of direct support workers, which ranges from roughly three to four years, does not correlate directly with wages when the data are sorted by business line and is longest among day and residential live-in program staff, and shortest among CSLA staff. In terms of corporate structure, however, nonprofits pay higher wages on average and hold on to their staff twice as long as for-profit entities. Again, these data alone are insufficient to draw conclusions about the influence of wage rates on staff retention due to the "chicken and egg" nature of wages and length of employment. Annualized average wages of direct support workers in Maryland—$23,026, exclusive of overtime and bonus—exceed the national average of $20,770 ($21,770 for residential live-in).[24]

Table 6. Direct Support Workers, Reported Compensation and Tenure by Business Line and Corporate Structure, FY 2012
(full-time/part-time)

Business Line (no. in sample)	Minimum Hourly Wage*	Maximum Hourly Wage	Median Mean Hourly Wage	Fringe (as % of wages)	Median Tenure (months)
Individual & Family Support (41/31)	$7.79/7.79	$33.19/32.23	$12.03/11.18		45.3/47
Day Service (60/25)	$7.25/7.47	$45.42/35.00	$11.42/10.89		45.5/27.9
Residential Live-In (35/8)	$7.25/7.75	$26.44/12.88	$11.60/10.39		48.8/36.7
Residential Non Live-In (78/48)	$7.25/7.25	$34.76/40.00	$10.72/10.07		39.0/30.0
Supported Employment (56/25)	$7.25/7.25	$45.42/29.43	$11.95/10.63		44.7/15.6
CSLA (57/37)	$7.25/7.25	$29.65/21.00	$11.24/11.18		36.0/21.7
OVERALL	**$7.25/7.25**	**$45.42/40.00**	**$11.07/10.37**	**13.0%**	**42.5/27.4**
For-Profit (15/4)	$7.25/7.25	$33.66/17.00	$10.39/10.19	4.0%	18.2/42.3
Nonprofit (90/57)	$7.25/7.25	$45.42/40.00	$11.30/10.35	13.1%	44.1/27.4

* Md. state minimum wage is $7.25. Wages reported below this were interpreted as erroneous entries.

[24]U.S. Bureau of Labor Statistics, Occupational Employment Statistics, Occupational Employment and Wages, May 2012. SOC 39-9021, Personal Care Aides used as comparator.

A look at compensation and tenure of direct support workers by company quartile rankings, shown in **Table 7**, indicates that unlike the case of first-line supervisors, companies with the highest gross income offer the highest average wages, although the pay range among companies with lower revenues is far wider—nearly double at the extremities. Many entities regularly pay bonuses to direct care workers (i.e., those other than first-line supervisors, professionals, or administrative staff), at varying amounts depending on the financial condition of the company. Payroll expenditure on direct support worker bonuses for FY 2012 total $1,968,402—a more than 50% increase over the FY 2011 total of $1,285,117. This is, nonetheless, in the general range of bonus expenditures reported annually since a peak of $2.2 million in FY 2005 of $2.2 million.[25]

Table 7. Direct Support Workers, Reported Compensation and Tenure, by Company Size, FY 2012

(full-time/part-time)

Quartile	Minimum Hourly Wage*	Maximum Hourly Wage	Median Mean Hourly Wage	Fringe (as % of wages)	Median Average Tenure (months)
Above 75th	$7.25/7.25	$33.19/34.78	$11.33/10.86		49.0/28.7
51st - 75th	$7.25/7.25	$34.76/32.23	$10.93/10.31		43.5/31.3
26th - 50th	$7.25/7.25	$45.42/30.00	$11.30/10.32		43.7/27.0
Up to 25th	$7.25/7.25	$32.00/40.00	$10.91/9.87		28.0/22.2
OVERALL	**$7.25/7.25**	**$45.42/40.00**	**$11.07/10.37**	**13.0%**	**42.5/27.4**

* Md. state minimum wage is $7.25. Wages reported below this were interpreted as erroneous entries.

C. Fringe Benefits

The salary and wage surveys distributed to mental health and developmental disability providers ask for information on fringe benefits and define these as being only discretionary employer contributions. Some companies, however, continue to have difficulty understanding the difference, or distinguishing between mandatory and voluntary benefits. That has made it difficult to construct analyses that can draw any reliable conclusions about the role that fringe benefits play in employee compensation and a company's ability to attract and retain staff. The question is complicated by the fact that a sizable portion of the highly skilled OMHC clinical workforce is contract labor, some percentage of direct support staff are agency hires, and the categories of owner and employee are conflated in a large number of for-profit entities—all situations where employers typically do not provide any discretionary benefits (health insurance, 401(k), long-term disability, etc.). Providers indicate, however, that fringe benefits—particularly health insurance—are a preoccupation because of the imperative to balance rising premium costs against workforce retention during a protracted period of financial constraint. Anxiety over the impact of health care reform exacerbates this concern. This year, therefore, the CSRRC conducted a survey to develop a clearer picture of the fringe benefit landscape.

[25] 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.

An online survey was distributed to all mental health and developmental disability service providers required to report to MHA or DDA. The survey, however, was not mandatory; the incentive for companies to respond was that results would be shared only with respondents, who could use them to gauge how they measured up among other companies in the sector and also, perhaps, pick up some innovative solutions. "Fringe benefits" were very broadly defined as any type of non-wage compensation offered to employees, including the full range of standard benefits but also extending to comp time, paid vacation, fitness club membership, transportation vouchers, and other perks. Fifty companies submitted complete responses to all questions, including subcomponents, of which 17 were mental health service providers and 33 were developmental disability service providers. Major findings—which should be interpreted with caution due to the low response rate, but are suggestive of the role of fringe benefits as a workforce management tool—were as follows:

- Some 80% of direct care staff are eligible for health benefits, but just 63% actually participate. Reasons for this were not explored (and indeed may not be known to employers). These could include coverage under a spouse's plan, Medicaid, and inability to afford the employee contribution, among others.

- Many employers are choosing HMO plans or are moving to one as a way of containing costs while maximizing coverage for employees.

- The median increase in health insurance premiums is 9% for the most recent renewal with a comparable plan; some increased the employee premium contribution.

- There is great concern over what health care reform will mean for employers. Responses to a question about whether the company plans to make benefit changes in light of health care reform ranged from intention to restrict employee hours to a maximum of 29.5 per week, to referring all full-time employees to the Exchange. This indicates fundamental confusion over the requirements of the law.

- Most have some kind of voluntary contribution retirement plan, just under half of which have no vesting schedule.

- It is not unusual for part-time employees to be eligible for many of the same benefits, but pro-rated or with higher employee financial contributions.

- A small percentage of employers offer wellness benefits, such as fitness club membership or have health plans that reward healthy behaviors with premium or co-pay discounts. Other types of benefits offered include paid birthday off, personal days, vacation leave, paid sick days, mileage reimbursement, bereavement days, comp time banking, tuition reimbursement, holiday gifts/bonuses, memberships in consumer clubs, financial counseling, and a range of other types of insurance at group rates, such as life, vision, disability, accidental death, etc.

D. Conclusions

Problems inherent in survey design and data collection methodology make it difficult to draw conclusions regarding wages.[26] Much of the data presents an over-simplified picture of what is a complex workforce in both the mental health and developmental disability service sectors. Changing to an electronic data collection system would improve data quality; questions that are better aligned to the personnel structures and practices unique to these sectors would permit a more refined and, therefore, more robust analysis.

On their face, survey results suggest compensation levels consistent with national averages and expected norms. This is corroborated by low vacancy rates overall. That said, the data mask difficulties in hiring and retaining certain types of professionals, especially in rural and inner city areas. They also fail to account for the influence of the recession and high unemployment—which discourages employees from changing jobs and frustrates efforts to obtain higher salaries—on staffing levels. Because reporting lags three years behind rate adjustments, it is not yet possible to assess the impact on wages of the automatic cost of living increases required by the 2010 statutory revision.

It should be note that hourly rates for developmental disability direct care workers are lower than those reported in previous years. This is at least in part due to the change in survey methodology: prior reporting included overtime and bonus payments in the hourly rate. These extra earnings are not assured and can vary greatly from year to year and from employee to employee. Including them within the hourly rate distorts comparisons across the industry, which is why the CSRRC changed its survey methodology.

Unlike the community-based mental health sector, developmental disability service providers have received small rate increases annually, whether as a result of the weighted average update method, adjustments to hold providers harmless for attendance day payment changes, or allocations made at the discretion of the Governor. There is no indication that these increases had an effect on base salaries. It may be that companies chose to use the increases for bonuses rather than raising base wage rates. This is an issue that bears investigation in the next reporting period.

[26] Importantly, the wage survey for developmental disability service providers was significantly changed from previous years, which converted total payroll expenditures into an hourly wage that was artificially inflated by the incorporation of overtime and bonuses. For FY12, providers were required to report actual base hourly wages paid to employees.

E. Recommendations

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

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

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

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

2. Financial Performance[27]

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, where these are available 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 are only snapshots and 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 the financial data of MHA- and DDA-funded providers is whether the Maryland subsidiaries of larger, multistate organizations submit financial statements for their Maryland operations only, or for the parent organization. In the latter case, Maryland operations cannot be disaggregated from those of the entire entity, making it impossible to discern the effects the Maryland payment system. A similar problem exists for large, multi-function charitable organizations that offer mental health or developmental disability services among many others; university or hospital-affiliated programs; and those with close financial ties to holding companies or umbrella entities. In such cases, public sector reimbursement rates may have minimal significance for the company's overall financial health.

Finally, there is a mix of for-profit and nonprofit service providers in both sectors, most significantly in the mental health service sector, where roughly half of all companies are organized as S-corporations or limited liability companies (LLC). These corporate forms are not taxed as separate business entities: instead, all profits and losses are passed through to the personal tax liability of owners (S-corporations) or members (LLC), just like any partnership. Therefore, recordkeeping requirements are reduced. Owners and members share profits and may also receive salaries as employees (although S corporations must pay at market rates to avoid IRS penalties). The complicated relationships and mixed incentives inherent in these structures defeat attempts to get a clear financial picture.

Cost reports submitted by developmental disability service providers offer some additional perspective on the relative financial condition of companies 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.

[27] In fulfillment of § 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.

Methodology

This year marks a significant departure from previous methodology used to examine the financial situation of community-based providers. There are no national or state benchmarks for financial performance of community-based mental health or developmental disability service providers. Because of the types of services provided, the slim margins characteristic of these enterprises, and heavy state reliance on private companies to care for Medicaid and waiver populations—and, in turn, the reliance of private companies on state funds—an examination of financial performance is more meaningful to inform policy if it focuses on whether the system is financially stable and operationally sound, rather than its degree of profitability. Profitability *per se* is contingent and obscured by the corporate structures and payment system incentives described above and, therefore, is not a proxy for stability, nor is the correlation with reimbursement rates clear. It is certainly not a proxy for the delivery of effective and efficient services. No single financial indicator can demonstrate financial health because performance measures are interrelated: an improvement in one metric will have a downward effect on another.

To capture the combined impact of individual metrics on an entity's financial condition and thereby construct a more representative and useful picture of how these sectors are faring, we have adopted a modified financial strength index (FSI) approach.[28] An FSI uses key metrics that are the component parts of a complete picture of financial strength and stability, normalizes them around an average, and produces a composite score to gauge overall performance. In this case, because there are no industry benchmarks, we created an FSI for each sector using a representative sample of Maryland providers—that is, all those that were required to report, provided complete (or capable of being completed) data sets, and were not eliminated from the sample because of exclusionary criteria (see below).

A financially strong business is one that demonstrates a capacity to remain operational—that is, it has the ability to cover short and long-term debt obligations. This is demonstrated through an analysis of selected measures of liquidity and debt leverage: current ratio, cash reserves, debt-to-net-asset ratio (nonprofits), debt-to-equity ratio (for-profits), and days in receivables. These measures are used together to develop a FSI score that is an indicator of operational soundness. The benchmark for each financial measure is the median value of the total sample. The overall condition of each sector is expressed as an FSI score that is calculated using these medians, and each mental health and developmental disability service provider can assess its own condition relative to that of the average for its respective sector. Benchmarks for selected financial measures were also calculated for FY 2009 – FY 2011 where complete data sets had been entered into spreadsheets for those years. The calculations relied on spreadsheet entries alone, it was not possible to validate the numbers entered or to accommodate modifications in reporting criteria or definitions. Therefore, these offer a general idea of trends but not an accurate measurement of change.

[28] Created by William Cheverley. Moody's uses this method to rate banks; it has been adapted to rate hospitals and large health care systems, and is used in a variety of other industries.

A. Mental Health Service Providers

MHA collects "relevant financial statements or documentation and results of a financial audit"[29] from the community-based providers in the public mental health system. Over the years, the percentage of providers complying with reporting requirements has fluctuated, and MHA historically did not use its enforcement authority. For FY 2012, 133 entities were required to submit financial information to MHA (excluding HSCRC-regulated providers and county health departments). In response to CSRRC recommendations, MHA announced that it was requiring audited financial statements for FY 2012 reporting. This requirement, however, was not enforced.

There was great variety in type and quality of data submitted by mental health service providers. Many of the financial statements were internally generated and were not presented in standardized format, nor did they follow the prescriptions of the American Institute of Certified Public Accountants or the Financial Accounting Standards Board. In a number of cases, actual expenses were confused with budgeted expenses, reported assets and liabilities did not balance with net assets/equity, and there was no match between annual net assets and income presented on a balance sheet—where a balance sheet was submitted or was sufficiently complete to allow for calculations of liquidity ratios. Where it was impossible to discern meaningful financial categories, an entity was excluded from the sample used for analysis—for example, where statements of functional expenses represented wages, fringe benefits, and payroll taxes by a single number and an examination of supplemental documents did not permit the individual components to be separated out. The validity of the financial profile also depends on having a complete data set of important indicators for a given company: in FY 2011, for example, only 49 of the 99 that reported financial information submitted complete data sets. In FY 2012, there was an attempt to compile complete data sets where supplemental documents made it possible to extrapolate this information. Finally, for-profit companies submitted reports for a calendar rather than fiscal year period; as in previous years, the calendar/fiscal year dichotomy was ignored for the purpose of analysis.

As with FY 2011 reports, the analysis excludes certain entities to avoid skewing results:

1. Less than 40% of revenue from MHA reimbursements
2. Corporate HQ outside of Maryland and no separate financial information for the Maryland operation alone
3. Closed in FY 2012 or just opened in FY 2012 and was not in operation for the entire period

After all exclusions were applied, 54 companies remained in the analysis, of which 73% are for-profits and 27% nonprofits (overall in this sector, just over half are for-profit companies). This sample, which was representative across provider types and sizes, was used to calculate median benchmarks and a FSI score for mental health service providers. The five financial ratios selected and their benchmarks are as follows:

[29] COMAR 10.21.17.06

1. ***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 without significantly depleting liquid assets. The larger the current ratio, the larger the "cushion" to meet debt obligations. Only those investments identified as current assets were used to calculate the current ratio. ***The current ratio benchmark for Maryland community-based mental health service providers, based on the median value of the sample, is 2.26***, or $2.26 in current assets for every $1 in liabilities.

2. ***Cash Reserves*:** The number of months of cash (or easily liquefied short-term investments) a company has in reserves to pay expenses in the event that it fails to achieve revenue expectations. It is calculated by dividing total current assets by average total monthly expenses. The larger the reserves, the greater the capacity to remain in business if income does not meet projections without incurring debt. Investments identified as restricted were excluded from cash reserves calculations. ***The cash reserves benchmark for Maryland community-based mental health service providers, based on the median value of the sample, is 2.90 months.***

3. ***Debt-to-Equity Ratio (Nonprofits: Debt-to-Net-Asset Ratio)*:** The ratio used to determine how extensively a company relies on debt to finance operations. It is calculated as total liabilities as a proportion of stockholder equity or net assets. It is common for companies to use borrowed funds to some extent to run the business, but a large debt-to-equity ratio can indicate an overreliance on debt. A negative ratio means that the company has continually lost money for a sustained period of time. Another factor that affects equity is the distribution of profits or dividends to stockholders or members in the case of for-profit companies. Borrowing funds also incurs interest expenses, which reduces net profits. ***The debt-to-equity/net asset benchmark for Maryland community-based mental health service providers, based on the median value of the sample, is 0.47.***

4. ***Days in Receivables*:** Accounts receivable divided by average daily revenues. This 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, but at the extreme can mean that some billings may be uncollectable. Accounts receivable from related parties were excluded in the calculation of the days in receivable ratio. The longitudinal trend in number of days in receivables may be affected by the change in ASO in FY 2010, and the significant improvements in claims processing made by ValueOptions in the ensuing years. It may also reflect the increasing tendency of providers to stop accepting commercial insurance because of low reimbursement rates and claims processing delays. ***The days in receivables benchmark for Maryland community-based mental health service providers, based on the median value of the sample, is 26.41 days.***

5. ***Margin*:** The difference between revenues from all sources and expenses expressed as a percentage. This is also known as the profit margin. Allowances for payment of income tax expenses were excluded from total expenses for this calculation. As noted above, margins are easily manipulated by variants in accounting practices. Moreover, 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 they are prudent or unwise, can propel margins up or depress them in any given year. A corporate acquisition that, in the medium or long term, will expand institutional capacity and get a bigger share of the market may be a smart business move, but it will drive profits down in that year. By the same token, a large margin can indicate insufficient investment in personnel or infrastructure that can undermine sustainability in the long run. Nonetheless, because this metric has consistently been used in the past, it has been included in the analysis and as a component of the FSI score. ***The margin benchmark for Maryland community-based mental health service providers, based on the median value of the sample, is 1.01.***

Table 8: Financial Ratios and Benchmarks – Mental Health Service Providers, FY 2012

Financial Ratio	Calculation	Benchmark (median)
Current Ratio	*Current assets ÷ Current liabilities*	2.26
Cash Reserves	*Total current assets ÷ Total liabilities × 12*	2.90 months
Debt to Equity/Net Assets	*Total liabilities ÷ Stockholder equity/Assets*	0.47
Days in Receivables	*Accounts receivable ÷ Total revenue × 365*	26.41 days
Margin	*Total revenue ÷ Total expenses*	1.01

It should be noted that bad debt was not taken into consideration, as was the case last year. 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 companies, however, do not report any bad debt at all. Moreover, because providers do not all agree on the definition of bad debt, it does not serve as a reliable proxy for uncompensated care.

The financial ratios were used to calculate an overall FSI score as follows:

$$\textbf{FSI} = \frac{\textit{Current Ratio} - 2.26}{2.26} + \frac{\textit{Cash Reserves} - 2.90}{2.90} + \frac{0.47 - \textit{Debt-to-Equity Ratio}}{0.47} + \frac{21.27 - \textit{Days in Receivables}}{26.41} + \frac{\textit{Margin} - 1.01}{1.01}$$

The FSI formula normalizes the difference of each mental health service company's calculated metric from the target value and adds those metrics together to generate a single score. A positive FSI score indicates good financial performance, which is characterized by large current ratios, sufficient cash reserves, low levels of debt, fewer days in receivables, and higher margin, as shown in **Table 9**.

Table 9: FSI Scoring Rubric – Mental Health Service Providers, FY 2012

Score	Rating	
3.0 +	Excellent	**Good Performance**
0.0 to 3.0	Average	
-2.0 to 0.0	Fair	**At Risk**
Less than -2.0	Poor	

Financially sound companies are those that are near or exceed a score of zero. Those with scores below zero should be subject to further review to determine the reason for poor performance. Their operational failures originate either in low productivity rates negatively impacting total revenue or in poor business practices, such as not having an infrastructure to ensure the collection of billings, money management, or the creation of an annual operating budget and monthly monitoring of the budget against actual income and expenditures.

Table 10 shows financial performance of mental health service providers stratified by corporate structure. Nonprofits have a lower median FSI due to smaller median margins and a greater number of days in receivables than their for-profit counterparts. But a comparison of company performance based on corporate form is not straightforward. The nonprofit median cash reserves are nearly double those of for-profits. This indicates a significant level of liquidity that mitigates the number of days in receivables. The median debt-to-net-asset ratio is slightly greater than that of nonprofits; this measure is influenced by mortgages related to building ownership, and the majority of for-profits report rented facilities.

Table 10: Financial Metrics of Mental Health Service Providers by Corporate Structure, FY 2012

Corporate Structure (no. in sample)	Median FSI	FSI > 0	Median Current Ratio	Median Cash Reserves (months)	Median Debt-to-Equity/Net Asset Ratio	Median Days in Receivables	Median Margin
For-profit (14)	1.07	64.3 %	2.52	1.77	0.47	19.09	1.02
Nonprofit (18)	0.41	55.6 %	2.26	3.10	0.48	26.35	1.00
Total	**0.60**	**59.4 %**	**2.26**	**2.90**	**0.47**	**26.41**	**1.01**

Table 11 shows financial performance of mental health service providers by type of services provided: PRP, OMHC, or both. Although the median FSI score for PRPs is less than half that of OMHCs, they demonstrate a healthy level of liquidity with a median current ratio of 2.55 and median cash reserves of 1.98 months. OMHCs show healthy median current ratios results, and some two-thirds of these entities have individual FSI scores in the "good" range. It is difficult to explain the poorer performance of companies that combine both types of services on all financial indicators.

Table 11: Financial Metrics of Mental Health Service Providers by Service Type, FY 2012

Corporate Structure	Median FSI	FSI > 0	Median Current Ratio	Median Cash Reserves (months)	Median Debt-to-Equity/Net Asset Ratio	Median Days in Receivables	Median Margin
PRP *(11)*	0.83	72.7 %	2.55	1.98	1.59	2.16	1.59
OMHC (4)	1.97	75.0 %	2.63	1.11	0.61	27.47	1.06
PRP/OMHC (17)	-0.04	47.1 %	1.68	1.08	0.60	26.40	1.01
Total	**0.60**	**59.4 %**	**2.26**	**2.90**	**0.47**	**26.41**	**1.01**

The effect of size on financial performance is demonstrated by grouping mental health service providers into quartiles by percent of total revenue, as follows:

Above 75th percentile	$5,068,134-$25,397,169
75th percentile	up to $5,068,134
50th percentile	up to $3,267,251
25th percentile	up to $1,716,226

This grouping indicates that small and medium-sized companies on average have better FSI scores, and when each of the financial metrics are examined separately, those in the 25th and 75th percentiles shows optimal performance overall. It is not surprising that the largest companies have the greatest cash reserves and may be less aggressive about billing because they can afford to float the receivables for longer periods, but this appears also to be the case for the lowest percentile.

Table 12: Financial Metrics of Mental Health Service Providers by Size, FY 2012

Size Ranking (Percentile)	Median FSI	FSI > 0	Median Current Ratio	Median Cash Reserves (months)	Median Debt-to-Equity/Net Asset Ratio	Median Days in Receivables	Median Margin
Above 75th	-0.50	50%	1.87	2.35	0.46	24.05	1.01
75th	0.80	63%	3.04	4.11	0.51	30.89	1.00
50th	-0.83	38%	2.57	1.77	0.90	16.52	1.02
25th	1.97	88%	2.70	3.72	0.34	25.63	1.00
Total	**0.60**	**59%**	**2.26**	**2.90**	**0.47**	**26.41**	**1.01**

Finally, a trend analysis looks at the same metrics over time, for the period FY 2009 – FY 2012. No FSI score was calculated for prior years because this indicator is not longitudinally comparable due to variability in the selection of constituent entities from which it would have been derived. It should be noted that these indicators will not be consistent with those reported in the 2012 Annual Report due to the exclusion in this sample of companies that did not provide complete data sets.

Table 13: Financial Metrics of Mental Health Service Providers, FY 2009 - FY 2012

Fiscal Year	Median Current Ratio	Median Cash Reserves (months)	Median Debt-to-Equity/Net Asset Ratio	Median Days in Receivables	Median Margin	Total No. in Sample
2009	2.12	2.89	0.90	30.56	1.01	30
2010	2.15	2.91	0.77	31.25	1.04	40
2011	1.50	1.90	0.38	15.42	1.03	61
2012	**2.26**	**2.90**	**0.47**	**26.41**	**1.01**	**32**

B. Developmental Disability Service Providers

DDA requires the providers it licenses to submit audited financial statements and cost reports at the beginning of the calendar year for the previous fiscal year for reconciliation of prospective payments. Roughly 120-130 developmental disability service providers, representing about 75% of those receiving FPS and CSLA funds, submitted hard copies of financial statements each fiscal year from 2009 to 2012. The same number of companies 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.

1. Less than 40% of revenue from DDA reimbursements
2. Corporate HQ outside of Maryland and no separate financial information for the Maryland operation alone
3. Closed in FY 2012 or just opened in FY 2012 and was not in operation for the entire period

After the exclusionary criteria were applied, 102 of the 132 companies that submitted all financial reports for FY 12 remained in the sample. As with the mental health service sector, there are no national or state benchmarks for financial performance of developmental disability service providers, nor do companies have to meet fiscal or operational standards to maintain certification as a service provider for DDA-funded clients. We used, therefore, an internal benchmarking methodology and development of a FSI score to analyze the financial condition of these companies. Selection of the appropriate financial ratios was based on the unique characteristics of the payment system and incentives. The more narrowly defined “operating margin” replaces “margin” in the analysis. “Days in receivables” cannot be used as an indicator because developmental disability companies are largely paid prospectively rather than retrospectively for billed services, rendering this metric meaningless.

The four financial ratios selected and their benchmarks are:

1. ***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 without significantly depleting liquid assets. The larger the current ratio, the larger the "cushion" to meet debt obligations. Only those investments identified as current assets were used to calculate the current ratio. ***The current ratio benchmark for Maryland community-based developmental disability service providers, based on the median value of the sample, is 1.51****—that is, $1.51 in current assets for each $1 in liabilities.*

2. ***Cash Reserves*:** The number of months of cash (or easily liquefied short-term investments) a company has in reserves to pay expenses in the event that it fails to achieve revenue expectations. It is calculated by dividing total current assets by average total monthly expenses. The larger the reserves, the greater the capacity to remain in business if income does not meet projections without incurring debt. Investments identified as restricted were excluded from cash reserves calculations. It should be noted that developmental disability service providers tend to have higher levels of cash reserves because of the prospective payment system. ***The cash reserves benchmark for Maryland community-based developmental disability service providers, based on the median value of the sample, is 2.56 months.***

3. ***Debt-to-Equity Ratio (Nonprofits: Debt-to-Net-Asset Ratio)*:** The ratio used to determine how extensively a company relies on debt to finance operations. It is calculated as total liabilities as a proportion of stockholder equity or net assets. It is common for companies to use borrowed funds to some extent to run the business, but a large debt-to-equity ratio can indicate an overreliance on debt. A negative ratio means that the company has continually lost money for a sustained period of time. Another factor that affects equity is the distribution of profits or dividends to stockholders or members in the case of for-profit companies. Borrowing funds also incurs interest expenses, which reduces net profits. ***The debt-to-equity/debt-to-net-asset benchmark for Maryland community-based developmental disability service providers, based on the median value of the sample, is 0.72.***

4. ***Operating Margin*:** The difference between revenue received for residential, day habilitation, vocational/supported employment, and CSLA services and corresponding direct expenses, excluding administrative costs such as executive salaries and office staff. ***The margin benchmark for Maryland community-based developmental disability service providers, based on the median value of the sample, is 1.13.***

Table 14: Financial Ratios and Benchmarks – Developmental Disability Service Providers, FY 2012

Financial Ratio	Calculation	Benchmark (median)
Current Ratio	*Current assets ÷ Current liabilities*	1.51
Cash Reserves	*Total current assets ÷ Total liabilities × 12*	2.56 months
Debt to Equity/Net Assets	*Total liabilities ÷ Stockholder equity/Assets*	0.72
Operating Margin	*Total program revenue ÷ Direct expenses*	1.13

These financial ratios were used to calculate an overall FSI score, as follows:

$$\textbf{\textit{FSI}} = \frac{\textit{Current Ratio} - 1.51}{1.51} + \frac{\textit{Cash Reserves} - 2.56}{2.56} + \frac{0.72 - \textit{Debt-to-Equity Ratio}}{0.72} + \frac{\textit{Operating Margin} - 1.13}{1.13}$$

The FSI formula normalizes the difference of each company's calculated metric from the target value and adds those metrics together to generate a single score. A positive FSI score indicates good financial performance characterized by large current ratios, sufficient cash reserves, low levels of debt, and higher operating margins that demonstrate greater budgetary control, as shown in **Table 15**.

Table 15: FSI Scoring Rubric – Developmental Disability Service Providers, FY 2012

Score	Rating	
3.0 +	Excellent	**Good Performance**
0.0 to 3.0	Average	
-2.0 to 0.0	Fair	**At Risk**
Less than -2.0	Poor	

Financially sound companies are those that are near or exceed a score of zero. Those with scores below zero should be subject to further study to determine the reason for poor performance. Their operational failures originate either in low productivity rates negatively impacting overall revenue or in unsound business practices. Because so few developmental

disability service providers are for-profit companies (16 in all), we did not compare the condition of for-profits against that of nonprofit entities.

Table 16 shows the trend across the entire sector over time, for the period FY 2009 – FY 2012. No FSI score was calculated for prior years because this indicator is not longitudinally comparable due to variability in the selection of constituent entities from which it would have been derived. It should be noted that these indicators will not be consistent with those reported in the 2012 Annual Report due to the exclusion in this sample of companies that did not provide complete data sets. Again, these measures give a general idea of changes over time, but cannot be relied upon for accuracy because definitions have been modified, reporting quality is inconsistent across entities and time, and other data validity problems.

Compared with prior years, companies appear to be holding smaller cash reserves, which dropped from a high of 5 months in FY 2011 to 2.56 months in FY 2012. This also represents a significant decrease from FY 2009 and FY 2010, which held steady at 4.25 an 4.30 months respectively. This may be, in part, due to a reduction of debt: while cash reserves decreased, the median debt-to-net-assets/equity ratio was roughly halved from FY 2011 to FY 2012, indicating that companies are using revenue to pay down debt. Operating margins have remained fairly flat. The median current ratio improved in FY 2012.

Table 16: Financial Metrics of Developmental Disability Service Providers, FY 2009 - FY 2012

Fiscal Year	Median Current Ratio	Median Cash Reserves (months)	Median Debt-to-Equity /Net Asset Ratio	Median Operating Margin	Total No. in Sample
2009	1.23	4.25	0.87	1.17	112
2010	1.27	4.30	0.65	1.23	124
2011	1.27	5.00	1.27	1.19	98
2012	**1.51**	**2.56**	**0.72**	**1.13**	**96**

Table 17 shows how the size of a developmental disability service provider in terms of revenue affects financial performance. Companies were grouped into quartiles as follows:

Above 75th percentile	$10,514,444-$41,736,629
75th percentile	up to $10,514,444
50th percentile	up to $5,754,726
25th percentile	up to $2,893,090

Larger companies, on average, do not fare better in terms of FSI score or on most financial ratios. In fact, those in the 50th percentile by revenue demonstrate the best financial performance.

Table 17: Financial Metrics of Developmental Disability Service Providers by Size, FY 2012

Size Ranking (Percentile)	Median FSI	Median Current Ratio	Median Cash Reserves (months)	Median Debt-to-Equity /Net Asset Ratio	Median Operating Margin
Above 75th	-0.70	1.44	2.88	1.14	1.11
75th	0.85	1.59	2.30	0.79	1.13
50th	1.85	2.37	2.56	0.34	1.52
25th	1.04	1.34	2.52	0.51	1.16
Total	**0.47**	**1.51**	**2.56**	**0.72**	**1.13**

Table 18 shows relative financial performance of the four programs that receive DDA FPS and CSLA reimbursements for the period FY 2009 – FY 2012. 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. This year we sought to enhance the value of this analysis by comparing ratios that together present a more meaningful picture of an entity's financial condition.

A large percentage of developmental disability companies operate two or more business lines. The analysis does not capture the affect that combinations of business lines have on overall financial performance of a company, which could be significant because of savings generated by shared administration and staffing, optimization of reimbursements, subsidization of a less profitable line by one that is more profitable, etc.

Table 18: Financial Metrics of Developmental Disability Service Providers by Business Line, FY 2009 – FY 2012

Fiscal Year (no. in sample)	Financial Metric	Median Statistics by Business Line			
		Residential Services	Day Habilitation	Vocational/ Supported Employment	Community Supported Living Arrangements
2009 (112)	Current Ratio	1.29	1.37	1.25	1.28
	Cash Reserves	4.65	4.24	3.86	4.25
	Debt Asset/Equity	0.85	0.79	0.60	1.07
	Operating Margin	1.17	1.19	1.17	1.22
2010 (124)	Current Ratio	1.27	1.43	1.45	1.23
	Cash Reserves	3.29	3.30	2.93	4.66
	Debt Asset/Equity	1.04	0.53	0.18	0.88
	Operating Margin	1.18	1.19	1.20	1.17
2011 (98)	Current Ratio	1.39	1.31	1.39	1.34
	Cash Reserves	5.54	5.00	4.89	5.09
	Debt Asset/Equity	1.45	1.29	1.12	1.50
	Operating Margin	1.22	1.21	1.16	1.20
2012 (96)	Current Ratio	1.37	1.92	1.80	1.53
	Cash Reserves	2.37	2.63	3.10	2.45
	Debt Asset/Equity	0.80	0.72	0.62	0.80
	Operating Margin	1.13	1.13	1.13	1.13

Residential, day habilitation, and vocational/supported employment services are reimbursed through the FPS payment system. FPS pays a flat per diem rate for each client that is the sum of three components:

1. Individual rate: for each program type, a client's need for supervision, support, and medical services, as determined by the "Individual Indicator Rating Scale" (IIRS) score, adjusted for the geographic region in which services are delivered (range = $17.81-$148.26).

2. Provider rate: a flat $57.40 per day per person for residential services, and $31.78 for day habilitation and vocational/supported employment services.

3. Add-ons: additional temporary needs that are reassessed annually, adjusted for geographic region (range = $17.15-$18.28 for residential; $19.18-$20.32 for day habilitation; $19.14-$20.28 for vocational/supported employment; $28.27-$30.26 for professional services).

Table 19 shows the per diem rate for an "average" client, one with an IIRS score of three (IIRS score range = 1 to 5). The per diem rate is annualized for each client and paid to the provider quarterly in advance on the following schedule: 1Q = 33%, 2Q = 25%, 3Q = 25%, 4Q = 17%. The table offers only a general guide because there are other factors that can influence total reimbursements "earned" by a provider, such as whether a client meets minimum attendance criteria on a given day; offsets from other sources of client funding (such as SSI); etc. In addition, a client may receive services from more than one program.

Table 19. Average FPS Per Diem Rate, by Business Line and Region, FY 2012

Region*	FPS Rate Component	FPS Per Diem for Average Client, by Business Line		
		Residential Services	Day Habilitation	Vocational/ Supported Employment
1, 3, 4, 6	Individual	$58.71	$33.59	$33.48
	Provider	$57.40	$31.78	$31.78
	Add-on	$17.15	$19.18	$19.14
	Total 1,3,4,6	**$133.26**	**$84.55**	**$84.40**
2	Individual	$63.34	$36.24	$36.12
	Provider	$57.40	$31.78	$31.78
	Add-on	$18.28	$20.32	$20.28
	Total 2	**$139.02**	**$88.34**	**$88.18**
5	Individual	$62.40	$35.70	$35.59
	Provider	$57.40	$31.78	$31.78
	Add-on	$18.05	$20.09	$20.25
	Total 5	**$137.85**	**$87.57**	**$87.42**

* 1 – Baltimore Metro; 2 – D.C. Metro; 3 – Rural; 4 – Allegany County (Pittsburgh Metro); 5 – Cecil County (Wilmington Metro); 6 – Washington County (Hagerstown Metro)[30]

Financial performance can also be understood in terms of actual costs incurred by a company to provide a unit of service compared to the FPS reimbursement for providing those services. It is important to note that the FPS reimbursement is not the only revenue received by a developmental disability provider to deliver services: certain clients are expected to contribute to the cost of care and housing; programs benefit from grants and funding from other state agencies; etc. Therefore, the comparison of FPS unit rates with the unit cost of service delivery is only a rough guide. The actual cost of service is calculated by dividing the total expenses reported in DDA cost reports by the actual attendance days for each business line. **Table 20** shows the average actual cost of an attendance day by FPS-reimbursed business line for all

[30] COMAR 10.22.17.06E

developmental disability service companies. While the greatest difference is in residential services, this is also the program for which there is the greatest individual contribution.[31] Companies report client contributions on their monthly claims reports, and DDA deducts these amounts from prospective payments, accordingly. *Inter alia*, Medicaid does not pay for room and board, but allows service providers to collect up to $375 per month from clients to cover these costs. DDA pays the difference (i.e., without federal match) between the actual cost of room and board and that collected from clients.

Table 20: Average FPS Per Diem Compared to Actual Cost of Attendance Day, by Business Line, FY 2012

Business Line (no. in sample)	**Average FPS Per Diem Range**	**Median Reported Daily Unit Cost**
Residential Services (92)	$133.26-$139.02	$230.30
Day Habilitation (62)	$84.55-$88.34	$89.74
Vocational/Supported Employment (64)	$84.40-$88.18	$83.17

CSLA reimbursements are calculated by multiplying a per diem rate that takes into account service criteria (awake-overnight or one-to-one) and the number of clients in a household—again, regionally adjusted—by the number of hours each week of services indicated in a client's individual plan, up to a maximum of 82 hours per week. Because these rates are subject to so many variables that are not discernible in cost reports, it is not useful to compare CSLA rates with actual costs.

C. Conclusions

The community-based mental health and developmental disability sectors appear to demonstrate relative financial stability. Despite the fact that rate increases over the past six years have been minimal—particularly for mental health service providers—the number of programs has grown from roughly 100-120 in 2007, to 193 MHA-licensed and 163 DDA-licensed companies.

The FSI reflects a major step forward by the CSRRC in constructing a maximally informative approach to assessing the financial performance of service providers. It offers a multi-dimensional perspective of performance that has positive implications for a more comprehensive review and comparison of financial management and solvency. Furthermore, it permits the CSRRC to furnish providers, on demand, with indicators for their own company so that they can compare their performance on key financial measures against the sector as a whole. The CSRRC will continue to refine the definition and application of FSI to improve the quality and saliency of these analyses.

[31] Each person's required contribution to care is calculated based on income and availability of resources. There is a maximum allowance for personal needs (deducted from income when computing the amount of contribution to care) required by federal law, which as of Oct. 2013 is $335 per month.

Of course, the validity of any study relies on rigorous screening for data errors and submission of properly and fully completed cost reports and audited financial statements. As with the wage and salary surveys, it has been a challenge to obtain sufficient, accurate financial information from providers. Only MHA and DDA have the authority to collect this information and enforce reporting requirements. Again, implementation of an electronic, web-based data collection system that is hosted by DHMH will significantly improve the quality of submissions and, therefore, the value of analyses.

D. Recommendations

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

2. MHA, in collaboration with the CSRRC, should support cost reporting with training and technical assistance. This new requirement is especially valuable because it will be directly applicable to preparation of a weighted average cost structure for this sector. In addition, it will provide insights into financial operations that cannot be gleaned from a study of financial statements alone, particularly with respect to for-profit companies.

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

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

5. Policy makers have a strong interest in the sustainability of the provider network on which the public is entirely reliant for services and that is funded with tax revenue. In this regard, they may want to consider establishing minimum standards for operational soundness and conditioning authorization to receive MHA and DDA reimbursement on meeting those requirements. Some examples may be to require that all companies maintain a certain level of reserves or have a line of credit to cover recurrent debt obligations regardless of caseload fluctuations. Reimbursement rates are necessary, but not sufficient to guarantee financial health: much depends on good fiscal management. This is especially important because a significant

percentage of companies are organized as for-profits that are not subject to the oversight of a board of directors with a fiduciary duty to ensure the stability of the entity.

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

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

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

3. Impact of the Annual Inflationary Cost Adjustment[32]

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 mental health and developmental disability service 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 and resulting in a rate hike of just .88% for mental health and a 1% for developmental disabilities service providers—albeit that the latter got an additional 1% increase from the Governor. FY 2014 was the first year that rates saw a measureable increase using the new formula.

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 rate updates under the weighted average cost structure method are having on the financial condition of providers. Even then, the fact that rates were adjusted only minimally for mental health service providers and that developmental disability service providers have been able to obtain increases outside of the rate setting formula will make it impossible to isolate the impact of the statutory adjustment.

[32] In fulfillment of § 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.

4. Incentives and Disincentives in the Rate System[33]

A. Mental Health Service Providers

As noted above, MHA uses a fee-for-service payment system. This model, as applied to 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 professional counselors 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.

B. Developmental Disability Service 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.

Residential Services

Residential programs are for 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 at a higher score or level of need). Add-on funds are meant to cover temporary (one year or less) needs for different or more intensive supports, but 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

[33] § 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.

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.

Day Habilitation

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.

Vocational/Supported Employment

Supported 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[34]

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 Appendix 1) 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.

In the mental health sector, neither the OMHC nor the PRP fee-for-service model incentivizes provider accountability for patient outcomes. 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. ValueOptions, which is the current ASO (there will be an RFP for an ASO under the carve out model planned for behavioral health implementation in FY 2015), conducts a consumer satisfaction survey and reports annually on results, which are not used at present in conjunction with the payment system. As the state looks toward more value versus volume-based purchasing from providers, initiatives such as behavioral health homes and performance-based initiatives (e.g., QuIP, a program that rewards providers that achieve improved outcomes) hold promise. It is our understanding that DHMH will be developing performance measures and quality standards, among others, that will be incorporated into new clinical models for provision of integrated behavioral health services.

While we have no information on this, we hope that payment system reform in the developmental disability sector will take care quality into account. DDA conducts an annual National Core Indicators (NCI) Survey that assesses consumer satisfaction with the services they receive by eliciting responses to quality of life questions. The survey methodology involves both in-person interviews of recipients of DDA-funded services and a written questionnaire that is completed by caregivers. Data collection was conducted in the summer of 2013, but no final report has been forthcoming, and there is no estimated date for release of the report. The stated purpose of the survey is to improve system performance and service delivery; the CSRRC has been unable to uncover any information on how the survey results have been used to date to achieve performance goals.

The CSRRC is required by statute to comment on how incentives to provide quality of care can be built into the rate-setting methodology. It does not have the budgetary resources, however, to conduct research that would enable it to propose recommendations in this regard. It should be noted that that were a number of state-sponsored entities in both sectors that bring together the regulatory agencies, providers, clients, and consumer advocates where quality of care is a central focus. Those may be more appropriate venues for consideration of this question.

[34] § 13-809(1)(iv). How incentives to provide quality of care can be built into a rate-setting methodology.

6. Weighted Average Cost Structure[35]

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 noted above, the CSRRC was consigned responsibility for developing the weighted average cost structure (WACS) in October 2011 and, in conformity with its reporting schedule, did so for the first time in its 2012 Annual Report. The calculation appearing in the 2012 Annual Report was based on the FY 2011 expenditures and used to inform the DHA and DDA budget submissions for FY 2014. This year's WACS is based on self-reported FY 2012 expenditures and is being used by MHA and DDA to prepare their FY 2015 budget submission. We used the same Department of Budget and Management (DBM) cost categories as last year. This allowed us to examine industry costs against those identified by DBM and refine the methodology to improve alignment between provider costs and DBM categories, and to identify weaknesses that make this statutorily mandated process unreliable as true indicator of the cost of services and its questionable value for budget forecasting. The major weaknesses are self-reporting, inadequate documentation, inconsistent quality of reports; the fact that the calculation lags three years behind the budget for which it is prepared also undermines the value of the WACS for determining future budget needs.

The WACS shows how much providers in each sector (mental health and developmental disabilities) report they spend, on average, in each budget category to run their businesses proportional to total operating costs for the entire sector. The "weighting" comes in because company size in terms of revenue can differ widely—from multimillion-dollar entities to businesses with an annual income of just several hundred thousand dollars. The goal is to establish a cost structure across the entire sector, and because larger entities represent a greater share of total 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 in the sector. Rather, we add together company spending across each cost category and use the totals to calculate the percentage that each category represents of total spending for the sector. The statute requires that provider budget categories correspond to the cost classifications used by DBM for units of state government. These are not always a good fit in either the mental health or development disability sector, and are not always subject to a common interpretation by accountants and finance staff.

[35] In fulfillment of § 13-809(1)(v). The recommended weighted average cost structure of providers as set forth in § 13-806.

By using a more discriminating and rigorous methodology to calculate the FY 2012 weighted average cost structures than we used in FY 2011, we were able to improve the accuracy of our calculation. This resulted, most notably, in reducing the amount of expenditures attributed to "other" by reallocating these to the correct cost category based on an examination of related financial documentation. It further resulted in a redistribution of personnel costs between salaries and health benefits in the case of mental health service providers.

For our FY 2011 calculation, we relied almost exclusively on statements of functional expenses submitted by mental health service providers and cost reports submitted by developmental disability services providers. We also established certain exclusion criteria but did not apply the same criteria across both sectors. For the FY 2012 WACS, we identified and applied the same exclusion criteria to both sectors in the interest of obtaining the most representative sector-wide estimates of spending by category and to avoid skewing due to cross subsidization of business lines and types of services by non-related corporate activities or out-of-state operations. Under our new guidelines, we included in our sample only those entities required to report that:

- Receive at least 40% of revenues from either MHA or DDA
- Are headquartered in Maryland (or, if headquartered elsewhere, were able to segregate and report the finances of their Maryland business alone)
- Have service sites in Maryland
- Provided a ***complete*** financial data set sufficient to identify expenditures for the discrete budget categories used in the cost structure

In addition, we examined reported spending for conformity with the cost categories established: for example, when an entity reported what appeared to be an inflated figure (based on previous reporting or associated financial documents) for salaries and had no entries for FICA, health insurance, pension, or other benefits, we either extracted the amount for salaries where possible, or treated this as an incomplete data set and did not incorporate it in our sample. This more rigorous methodology helps to explain some of the differences in proportional expenditures in the FY 2012 WACS compared to the FY 2011 WACS.

Producing a WACS for community-based mental health service providers continues to prove an enormous challenge. First, mental health service providers were not required to submit a cost report. This spreadsheet, which is modeled on a "statement of functional expenses," has been required of developmental disability providers for some years. While there is a degree of ambiguity and variety across the developmental disability service sector in how to construe and complete the spreadsheets, they are still more reliable than having nothing at all. A cost report for mental health service providers was developed collaboratively by the CSRRC and MHA and was distributed to providers in June 2013; hopefully, this will improve the process and reliability of the FY 2013 WACS.

Second, mental health service providers (again, unlike developmental disability services) were not required to have their financial submissions to MHA audited, despite the CSRRC recommendation that this requirement be enacted for FY 2012 reporting. As a result, the documentation received by MHA was often incomplete, of poor quality, and inconsistent; 17 entities did not submit complete data sets.

Finally, fully half of all mental health service providers required to submit financial information were for-profit businesses organized as S corporations or limited liability companies (LLC). These corporate forms are not taxed as separate business entities, but instead profits and losses are passed through the business to the personal income tax returns of members (in the case of S corporations) or shareholders (LLC). Among the myriad advantages of these types of corporate structures (and it is possible to have an LLC that is also an S corporation) are reduced record keeping and elimination of the need to prepare statements of functional expenses. Submissions from these companies reflected a patchwork of internal financial reports and tax documents that generally did not meet nationally recognized formats or respect basic accounting principles (such as total assets equaling total liabilities).

The WACS shown below were submitted to MHA and DDA on July 23, 2013 to assist those administrations in preparing their FY 2015 budget submissions.

The CSRRC will continue to refine its methodology for determining the weighted average cost structures of providers each year, in particular because the nature of these businesses does not correspond well in many cases to the defined spending categories established by DBM. Moreover, we have not yet addressed other issues that have a bearing on the WACS, such as the effect of affiliation with large provider systems on proportional spending. It should be emphasized that because the WACS are based on self-reported data, they cannot properly be used as a proxy for the cost of services. While we are limited by the strictures of the statute in our ability to deviate from DBM categories, we are nevertheless free to offer observations that may assist policy makers in developing a meaningful basis and methodology for determining reasonable reimbursement rates.

A. Mental Health Service Providers

The FY 2012 WACS shown in **Table 21** is derived from the 52 (out of 135) providers remaining after applying the exclusion criteria (as compared to 78 for the FY 2011 WACS). Comparable to the apportionment used last year, however, we included all salary (as opposed to "payroll" last year) costs for essential employees in salaries and wages, even for those hired as independent contractors. This last is significant in the mental health services sector because most of the highest salaried health care professionals—e.g., psychiatrists, psychiatric nurse practitioners—are typically contractual as opposed to permanent staff, although they are critical to the 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 **Tables 1, 2**). The "contractual services" category was used only for ancillary services needed on an occasional basis that not integral to the mission of the provider, such as accounting, legal counsel, tech support, etc. Expense data that could not be classified into one of the other categories after studying the totality of financial submissions of a given provider were added to the category "other." Again, the sum of the functional expenses in each category and the percentage each category represented of total spending was used to determine the proportionate weight of each cost category for the sector.

Table 21. FY 2012 Weighted Average Cost Structure of Mental Health Service Providers (n = 52)

DBM Cost Categories	FY 2012 Expenditures ($)	% of Total Expenditures
Salaries and Wages	94,034,105	65.67
FICA	7,905,552	5.52
Pension	199,791	0.14
Health Insurance	7,251,619	5.06
Unemployment Insurance	214,080	0.15
Workers Compensation	141,110	0.10
Telephone / Postage	1,485,613	1.04
Travel – Staff	1,347,895	0.94
Staff Development / Training	385,463	0.27
Utilities	1,918,325	1.34
Vehicle Operating / Fuel	1,742,323	1.22
Vehicle Maintenance	112,041	0.08
Vehicle Insurance	52,641	0.04
Depreciation (vehicles, equipment, building)	3,244,862	2.27
Contractual Service (legal, accounting, etc.)	2,611,009	1.82
Equipment / Supplies (non-capital)	1,306,263	.91
Medical Equipment / Supplies	48,713	0.03
Food	2,359,766	1.65
Rent	7,150,080	4.99
Insurance (excluding vehicles)	2,033,953	1.42
Interest	684,927	0.48
Other	6,968,454	4.87
Total	**$143,198,585**	**100.00%**

B. Developmental Disability Service Providers

The FY 2012 WACS shown in **Table 22** is derived from the cost reports in conjunction with the audited financial statements of the 107 (out of 139) providers remaining after applying the exclusion criteria (as compared to 111 for the FY 2011 WACS). Although the data are self-reported, there is greater consistency and reliability in this than the data from mental health service providers. 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 we did for the mental health services sector. Again, we included the salaries and wages (and only salaries and wages, not benefits) for 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 in the developmental disability sector tend to be direct support workers at the lower end of the pay scale. The category "contractual services"

represents payment for ancillary services needed on an occasional basis and not integral to the mission of the provider, such as accounting, legal counsel, tech support, etc.

Table 22. FY 2012 Weighted Average Cost Structure of Developmental Disability Service Providers (n = 107)

DBM Cost Category	FY 2012 Expenditures ($)	% of Total Expenditures
Salaries and Wages	393,164,403	62.46
FICA	29,031,497	4.61
Pension	5,893,905	0.94
Health Insurance	30,166,690	4.79
Unemployment Insurance	4,214,864	0.67
Workers Compensation	8,768,191	1.39
Telephone / Postage	4,153,155	0.66
Travel – Staff	4,148,248	0.66
Staff Development / Training	1,878,875	0.30
Utilities	10,091,492	1.60
Vehicle Operating / Fuel	10,593,568	1.68
Vehicle Maintenance	5,655,837	0.90
Vehicle Insurance	3,129,663	0.50
Depreciation (vehicles, equipment, building)	19,960,405	3.17
Contractual Services (legal, accounting, etc.)	18,326,209	2.91
Equipment / Supplies (non-capital)	9,812,885	1.56
Medical Equipment / Supplies	879,036	0.14
Food	13,088,159	2.08
Rent	20,940,763	3.33
Insurance (excluding vehicles)	3,520,572	0.56
Interest	7,947,420	1.26
Other	24,088,073	3.83
Total	**$629,453,910**	**100.00%**

7. Aligning Rates with Reasonable Costs[36]

Currently, there is no standard for what constitutes "reasonable costs" in either the mental health or developmental disability sectors. The CSRRC does not have the resources to conduct a study of the cost of service delivery, nor the authority to demand the cooperation of providers that would be necessary for such research to be performed. Payment system reforms anticipated in both sectors—and most especially in the developmental disability sector, where new baseline rates will have to be established consistent with the Supports Intensity Scale model—will likely address this issue.

[36] In fulfillment of § 13-809(1)(vi). Additional recommendations to align provider rates with reasonable costs.

NEED FOR FORMAL ACTION[37]

Throughout this report we have directed the attention of policy makers to possibilities for reinforcing the viability of the community-based provider network in order to preserve and expand access to care. We stop short of characterizing these suggestions as a "need for formal action" because there are a range of options and directions that can be taken. But we make note of them because the extensive reforms being undertaken in these service sectors offer a unique opportunity to make changes that under ordinary circumstances would be impossible to consider, most notably

- establishing fiscal requirements for licensed providers that must be met to retain licensure
- establishing staffing requirements where not currently specified that limit the number of positions that a single individual can hold as a full-time employee
- establishing best practices for fiscal management and requiring periodic training
- shifting currently misaligned incentives so as to promote care quality and efficient service delivery, including the incorporation of performance measures into reimbursement schemes

The CSRRC believes strongly that the collection and analysis of financial data from providers to assess the stability of the community-based system, the adequacy of rates, and how to align incentives with system goals should be internalized within DHMH. These are central functions of a regulatory agency and should not be relegated to an executive-level commission with no budget allocation, no inherent expertise, and no authority to affect action. Cost reports and audited financial statements are anyway required from DDA-funded entities for the purpose of annual budget reconciliation under the prospective payment system. It would be a simple matter for budget analysts within DHMH who are already familiar with the documents and experienced in extracting the relevant information to go one step further and conduct an aggregate analysis. MHA-funded entities will now be submitting cost reports and, hopefully, audited financial statements. These could be handled similarly by the same finance staff.

Barring steps to dissolve the CSRRC and subsume its role within DHMH, we would encourage the General Assembly to consider removing outdated, vague, and irrelevant language from the current CSRRC statute, and to add a requirement for a budgetary allocation and staffing support sufficient to allow the Commission to perform its duties.

[37] In fulfillment of § 13-809(2). Recommendations for formal executive, judicial or legislative action.

ISSUES FOR FUTURE STUDY[38]

The CSRRC intends to focus on some of the following initiatives in the coming year, as time and resources permit. The focus of our work may change based on continuing developments related to behavioral health integration and reforms in the developmental disability sector. As in the past, our priority will be to improve data collection.

- Engage with DHMH to develop and implement a web-based system for reporting of personnel and financial data designed to reduce errors and incomplete submissions, achieve greater consistency of interpretation, correspond more closely to prevailing management practices, and promote compliance with reporting timeframes. The system would be created and hosted by DHMH and accessed by providers through the MHA and DDA websites.

- Conduct an environmental scan of payment system reforms in other states and any lessons that can be learned from those experiences.

- Expand and refine wage and salary data to:
    - Add comparisons with state employees in comparable positions and those of other local health providers to better assess competitiveness in the local market
    - Collect segregated data on voluntary and involuntary terminations to determine turnover rates and the impact of wages on employee retention
    - Examine how staff are used in multiple positions and impact on salary analysis
    - Study the influence on salaries where employees are also owners or members of the corporation
    - Add more staff positions—in particular, management staff among developmental disability service providers and entry-level staff in the mental health sector who may not already have been included in the current survey design

- Enhance our examination of provider operations to:
    - Compare the performance of providers that are heavily reliant on MHA funding with those that have a diverse revenue base
    - Examine the difference in performance among providers with single and multiple business lines, and the impact of different programmatic combinations
    - Study entry and exit from the market and provider growth over the period 2003-2013

[38] In fulfillment of § 13-809(3). Issues in need of future study, and § 13-809(4). Any other matter that relates to the purposes of the Commission under this subtitle.

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, *Vice-Chair (2011-2014)*
Tim Wiens, MSW *(2011-2014)*

Provider Participation

(Technical advisory groups were convened only during the initial part of the year and eventually abandoned because of constraints posed by the technical contractor. The following provider representatives attended at least one advisory group and/or full meeting as an active participant.)

Denise Camp, *On Our Own of Maryland*
Denise Coll, *Humanim*
Herb Cromwell*, CBH*
Mike Drummond, *Arundel Lodge*
Brian Frazee, *MACS*
Laura Howell, *MACS*
Renae Kosmido, *MACS*
Samson Omotosho, *Optimum Health Systems*
Johnson Owoyemi, *NPHC*

Departmental and Legislative Participation

Rianna Brown, *DHMH*
Jennifer Ellick, DLS
Carolyn Ellison, DLS
Melissa Glynn, *Alvarez & Marsal (DDA)*
Daniel Harlan, *Alvarez & Marsal (DDA)*
Brian Hepburn, *MHA*
Marion Katserles, *MHA*
Frank Kirkland, *DDA*
Erin McMullen, *DLS*
Gerald Skaw, *DDA*
Jaclin Warner Wiggins (DBM)

Technical Consultant

Open Minds

[*]Appointed to vacant seats in March 2012. All terms expire September 30, 2014. Rebecca Fuller

Appendix 3

MEETING SCHEDULE 2012-2013

Commission Meetings

November 26, 2012*

January 22, 2013*

March 12, 2013*

May 14, 2013

July 9, 2013

August 27, 2013

September 10, 2013

* Mental health and developmental disability advisory groups also met on these dates.