



Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

May 13, 2021

The Honorable Guy Guzzone
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh
Chair
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

Re: 2020 Joint Chairmen's Report (page 103) – Report on the Increase in Psychiatric Rehabilitation Program Expenditures and Utilization

Dear Chairs Guzzone and McIntosh:

Pursuant to the requirements of the 2020 Joint Chairmen's Report (page 103), the Maryland Department of Health submits this report on the increase in psychiatric rehabilitation program expenditures and utilization.

If you have questions or need more information, please contact please contact the Director of Governmental Affairs, Heather Shek, at heather.shek@maryland.gov.

Sincerely,

Dennis R. Schrader
Secretary

cc: Aliya Jones, M.D., MBA, Deputy Secretary Behavioral Health
Heather Shek, J.D., Director, Office of Governmental Affairs



Report on the Causes for the Increase in Psychiatric Rehabilitation Program Expenditures

Submitted by the Maryland Department of Health

January 2021

Pursuant to the 2020 Joint Chairmen's Report (p. 103)

Dennis R. Schrader
Secretary of Health

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Executive Summary

In the 2020 Joint Chairmen's Report, p. 103, the Senate Budget and Taxation Committee identified concerns with the increases in psychiatric rehabilitation program (PRP) expenditures. The Maryland Department of Health (MDH) Behavioral Health Administration (BHA) is required to submit a report explaining the increases in PRP expenditures, utilization, and growth in the number of PRP providers.

In partnership with Maryland Medicaid (Medicaid), BHA analyzed PRP expenditures statewide between FY18 and FY19 and noted the following:

- PRP expenditures increased by 17% from \$231.3 million to \$271.3 million
- PRP expenditures increased in 22 of the 24 jurisdictions
- Statewide annual average per person expenditures decreased by 3.1% from \$6,189 per person to \$6,000 per person.
- There is considerable variation in expenditures across the State, ranging as low as \$4,052 in Worcester County to as high as \$10,754 in Queen Anne's County.

BHA is committed to improving the quality standards for PRP service provision, holding providers accountable, and ensuring that services target individuals in need of PRP. BHA formed a task force focused on PRPs and significant efforts are underway. These efforts, developed in collaboration with Medicaid and the Administrative Service Organization (ASO), include:

- Providing a more defined Medical Necessity Criteria and enhance Medical Necessity Screening
- Developing standards, processes, procedures, policies, and framework to guide services implementation and delivery
- Developing and implement a quality system for program implementation and management to support quality outcomes
- Developing lower-cost alternatives and adjustments to the payment structure

Through these efforts, BHA will continue to strengthen facilitating the successful participation of persons with severe mental illness in the community.

I. Overview of PRPs

PRP programs originated to address the needs of individuals with severe and persistent mental illness, the disabling secondary symptoms of which often include skills deficits and social adaptability loss. PRPs address these skills deficits and offer ongoing support. The PRP model has proven extremely effective in reducing hospital days, unnecessary ER visits, and rehabilitation to allow individuals to engage successfully in the community. It is a crucial element in maintaining and enhancing the functioning of the most individuals with disabilities in the behavioral health service sector.

II. Analysis

A. Providers

PRP models have proven to be useful for individuals with severe mental illness and others who lack the skills and support to enjoy success in the community. Over time, the service has expanded to children with mental illnesses and other groups such as individuals in substance use recovery and the homeless. This adaptability has contributed to proponents of essential services, such as daycare and social recreation, to see an opportunity to advance their service using PRP funding. Additionally, substance use treatment providers have discovered that PRP case management elements afford an additional resource to address this need in their population. While both of these services may be elements of a larger PRP model they are not the services focused on for the originally designed and funded PRP population and have contributed to the explosive growth of PRP providers and services.

Additionally, in 2016, Maryland promulgated regulations moving most community behavioral health systems to an accreditation-based licensing system (COMAR 10.63). Over time it became clear that the accreditation organizations delegated with compliance authority do not ensure regulatory compliance. The Department is reviewing possibilities for updating the regulations in the future.

The impact of the regulations and the expansion of PRP services to other target groups by providers have resulted in the increase in licensed PRP service sites, as shown in Table 1 below.

Table 1. Licensed PRP Sites

	Jul. 1, 2018	Jan. 6, 2020	Sep. 28, 2020
PRP Adult	292	484	548
PRP Minors	227	383	430
TOTAL	519	867	978

B. Utilization

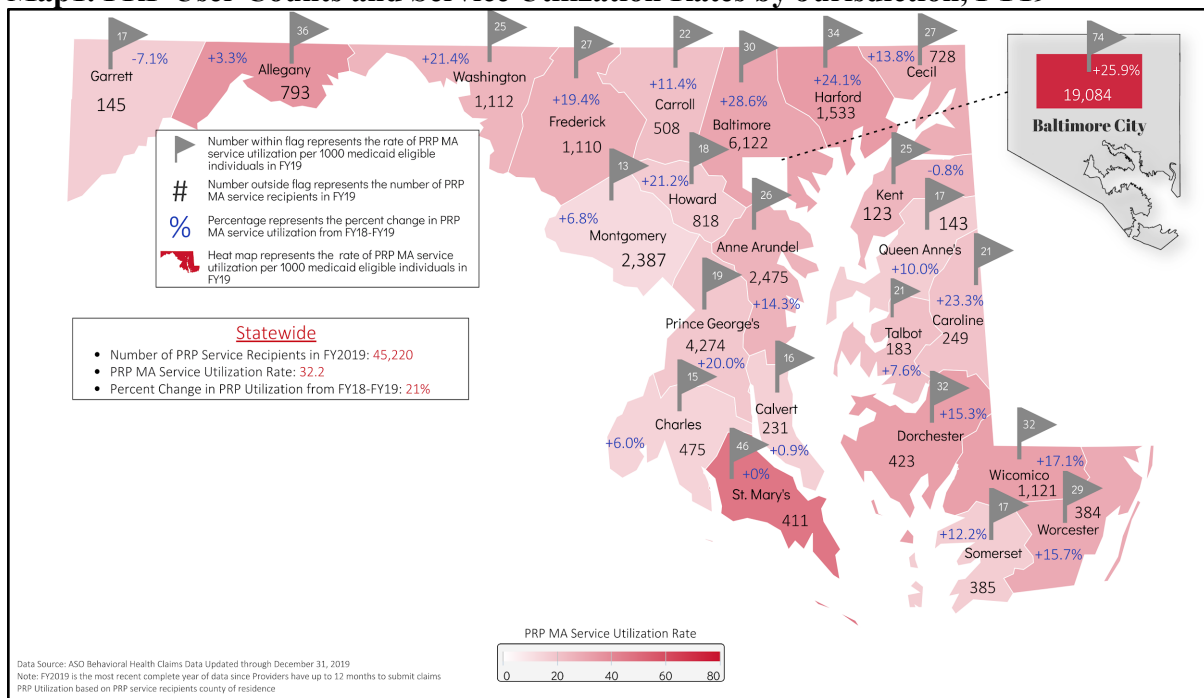
Between FY18 and FY19, PRP utilization increased by 21% statewide. Utilization increased in all but two jurisdictions (Garrett and Kent Counties). Those jurisdictions with the largest increase included Baltimore City (26%) and Baltimore (29%), Harford (24%), and Caroline (23%).

In FY19, 45,220 adults and children and youth received PRP services statewide. As shown in Map 1, PRP utilization varied across jurisdictions, ranging from a high of 19,084 in Baltimore City to a low of 123 service recipients in Kent County. Jurisdictions with the highest utilization included: Baltimore City (19,084) and Baltimore (6,122), and Prince George's (4,274) Counties, while the lowest utilization was in Kent (123), Queen Anne's (143), and Garrett (145) Counties.

An examination of PRP utilization rates per 1,000 Medicaid Eligible individuals revealed a statewide 32 PRP users per every 1,000 Medicaid Eligible individuals. PRP use rates differed substantially across jurisdictions, with the highest rates occurring in Baltimore City (74 per 1,000), St. Mary's (46 per 1,000), Allegany (36 per 1,000), and Harford (34 per 1,000) Counties. The PRP use rate in Baltimore City was twice the statewide rate. Jurisdictions with the lowest rates included Montgomery (13 per 1,000), Calvert (16 per 1,000), and Garrett (17 per 1,000).

The increase in the utilization of PRP services resulted from the expansion of PRP to populations, cost shifting to fund functions outside the original PRP model (i.e. child care, case management, etc.), and changes to regulatory standards associated with the transition to behavioral health accreditation (COMAR 10.63).

Map1. PRP User Counts and Service Utilization Rates by Jurisdiction, FY19



C. Expenditures

In partnership with Medicaid, BHA analyzed PRP expenditures statewide by user counts and the average cost per person between FY15 and FY20. The data is detailed in Table 1, showing PRP expenditures by user counts and the average cost per person.

The review of statewide PRP data between FY15 and FY19 showed an increase in PRP service utilization from 24,929 to 45,220, reflecting an 81% increase in utilization as well as a 61% increase in expenditures from \$168.6 to \$271.3 million. For adults, PRP service utilization increased by 89% from 13,449 to 22,864 between FY15 and FY19. For children and youth, there was an increase of 72% from 11,478 to 19,732. While FY20 data is not complete, available information shows lower utilization of PRP services and lower spending compared to FY19.

When disaggregated by age group, the total expenditures for adults 22 years and above were three times higher than for children and youth 21 years and younger. However, when reviewing the average per-person spending for adults 22 years and above, there has been a decrease from \$6,764 to \$6,000, reflecting an 11% decrease between FY15 and FY19 or \$765 per person.

Table 1. PRP Expenditures, User Counts and Average Cost per Person, FY15–FY19.¹

Age	2015	2016	2017	2018	2019	2020*
Expenditures						
0-21	\$36,100,240	\$41,471,218	\$47,587,013	\$55,325,188	\$68,850,035	\$35,832,818
22+	\$132,603,608	\$139,216,992	\$156,427,058	\$175,968,850	\$202,173,714	\$99,239,763
Overall	\$168,613,848	\$180,688,210	\$204,014,071	\$231,294,491	\$271,300,166	\$135,072,581
Consumer Count						
0-21	11,478	13,177	14,627	16,569	19,732	17,463
22+	13,449	15,017	17,804	20,797	25,446	22,864
Overall	24,927	28,194	32,431	37,371	45,220	40,327
Average Cost per Person						
0-21	\$3,145	\$3,147	\$3,253	\$3,339	\$3,489	\$2,052
22+	\$9,860	\$9,271	\$8,786	\$8,461	\$7,945	\$4,340
Overall	\$6,764.31	\$6,408.75	\$6,290.71	\$6,189.14	\$5,999.56	\$3,349.43

Total expenditures varied by jurisdiction between FY18 and FY19, as shown in Map 2. They ranged from a low of \$968,652 in Kent County to a high of \$95.8 million in Baltimore City. PRP expenditures increased in 22 of the 24 jurisdictions, with only Kent and Talbot Counties recording decreases. Jurisdictions with the most significant increase in expenditures included:

¹ FY2020 data based on claims paid through 12/31/2019. Data are not complete as providers have 12 months from the time of service in which to submit a claim for payment. PRP services are paid a monthly rate. To note, during the second half of FY20, PRP providers received estimated payments (not captured in Table 1 above) due to the transition to a new Behavioral Health Administrative Services Organization. MDH and providers are currently reconciling payments.

- Baltimore City (26.5%)
- Harford County (22.1%)
- Washington County (19.2%)
- Baltimore County (18.3%)

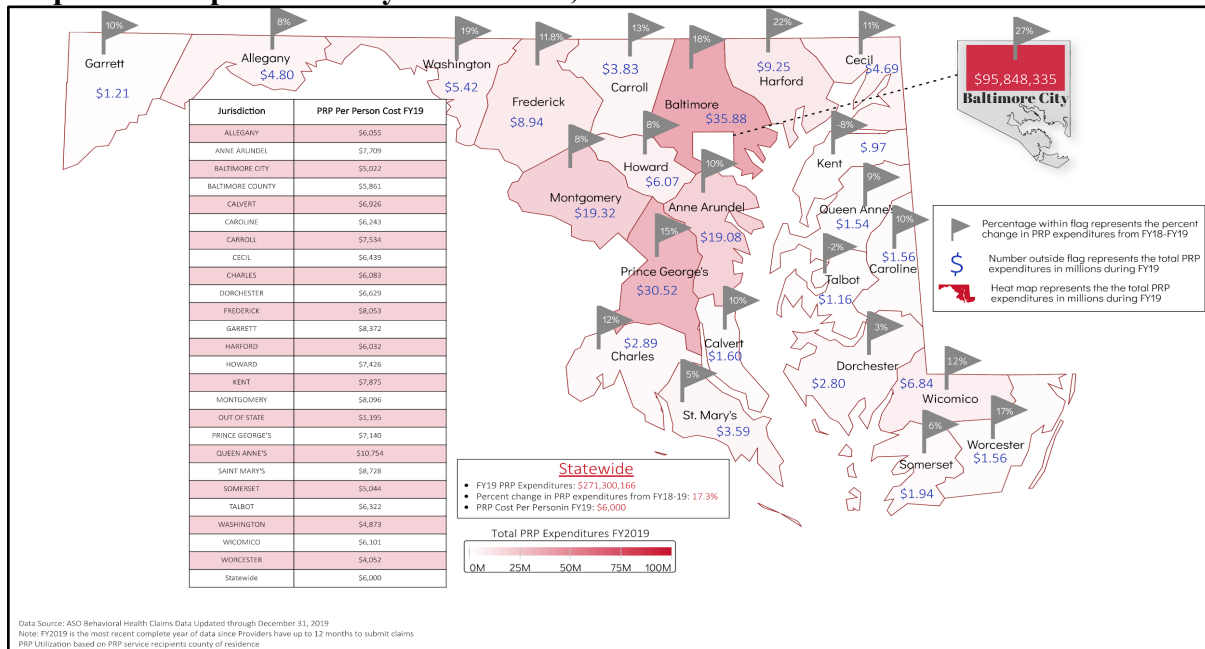
Four jurisdictions, including Baltimore City and Baltimore, Prince George's, and Montgomery Counties, accounted for 74% (\$200.6 million) of the expenditures in FY19. Baltimore City accounted for 35% (\$95.8 million) of the total spending.

Average per person expenditures decreased by 3.1% between FY18 (\$6,189) and FY19 (\$6,000); however, an examination of per-person yearly expenses in FY19 showed variation in expenditures across jurisdictions. Variations ranged from a low of \$4,052 in Worcester County to a high of \$10,754 in Queen Anne's County. Jurisdictions with the highest per-person expenditures included:

- Queen Anne's (\$10,754)
- St. Mary's (\$8,728)
- Garrett (\$8,371)
- Montgomery (\$8,095)

In contrast, the jurisdictions with the lowest included Worcester (\$4,052), Washington (\$4,873), Baltimore City (\$5,027), and Somerset (\$5,044) Counties.

Map 2 PRP Expenditures by Jurisdiction, FY18–FY19.



The increased number of PRP providers and the increase in PRP utilization have subsequently increased expenditures. PRP services are funded through Medicaid, reimbursed on a monthly case basis, and require the provider to provide a minimum number of encounters to receive reimbursement.

The set reimbursement rate was based on the understanding that the minimum number of services was a base threshold and that providers should strive to provide more than the minimum number of services. The rate becomes too high if the provider is routinely providing only the minimum number of services. For example, a PRP providing services to an individual who resides on their own is currently reimbursed \$504.81 for a minimum of three services offered on-site and off-site. That is a higher rate than if a licensed clinician provided three 45-minute therapy sessions.

A review of data finds that while most traditional PRP providers offer services far above the minimum thresholds, many new providers provide only the minimum. It is reflected in per-person costs *decreasing* as the funding pays for limited case management services provided instead of the full range of PRP services in many instances. MDH is monitoring PRP utilization to ensure that reimbursement occurs only for actual PRP services, not other services (i.e. daycare, or other non-reimbursable services). The BHA task force is planning to review the PRP reimbursement rate to determine if the monthly payments are too high or if there is a need to increase the minimum number of services.

III. Next Steps

BHA is committed to facilitating the successful participation of persons with severe mental illness in the community and is striving to ensure that all PRP participants receive high-quality, cost-effective, and evidence-based services tailored to their individual needs. Consequently, PRP participants will live successfully in the community supported by outcomes-driven programming to address living, working, and social functioning. They will have health outcomes similar to or above the surrounding community due to having increased access to health care services. They will have reduced the use of more intensive interventions.

To achieve these goals, it is clear that BHA must take measures to ensure that PRP services are:

- Successful in achieving outcomes
- Targeted to those for whom they are intended and medically necessary
- Cost-effective within budget limits

BHA has formed a task force focused on limiting PRP growth and enhancing PRP quality, both short and medium-term. Significant measures already underway, developed in collaboration with Medicaid and the ASO, are as follows:

A. Provision of a more defined medical necessity criteria and enhanced medical necessity screening

MDH provided more defined medical necessity criteria for PRP service provision and enhanced medical necessity screening commenced with the restart of the ASO Optum's Incedo Provider Portal authorizations in July 2020. Enhanced screening measures introduced include:

- Using screening forms to reduce inappropriate referrals and ensure referrals originate from qualified, independent licensed mental health professionals.
- Implementing the medical necessity criteria requirement for individuals referred for PRP services at the time of referral and throughout their stay in the PRP service.
- Limiting specific combinations of services usually inappropriate in combination with PRP and only justifiable on an additional clinical review, such as:
 - Mobile Treatment Services (MTS)/Assertive Community Treatment (ACT)—Adult
 - Adult Targeted Case Management (TCM)
 - Inpatient
 - MH-Residential Treatment Center (RTC)
 - Residential Substance Use Disorder Treatment (SUD 3.3 and higher)
 - Intensive Substance Use Disorder Treatment (SUD IOP 2.1 and 2.5)
 - Mental Health Intensive Outpatient/Partial Hospital Programs

The exceptions to these limitations include:

- Preventing imminent re-/hospitalization
- In developing plans with targeted consumers who have a record of multiple decompensations
- Transition into PRP or other lower levels of service from IOP/MTS/ACT

B. The development of standards, processes, procedures, policies, and framework to guide PRP program and services implementation statewide

The task force is working to develop standards and procedures implementation guidance that would support the implementation and quality of PRP services provided across the State.

C. Development and implementation of a quality system for program implementation and management to support quality outcomes

The task force is developing a quality system, in collaboration with stakeholders, to support quality outcomes for PRP services, with the following activities:

- The development of quality enhanced measures, training plan, and framework targeting various categories of personnel associated with the PRP program. These include PRP programs direct line staff; supervisors; administrators; Children, Adolescents, and Transition Aged Youth providers; and ASO staff.
- The enhancement of monitoring and quality of PRP services and programs by Improving the auditing of PRPs, increasing data mining activities for identification of outliers, Improving monitoring, and compliance.
- Collaboration with stakeholders for contribution and learning through the creation of a stakeholder group and learning collaborative.

D. Development of lower-cost alternatives and modifications to the payment structure

MDH is exploring options for improvements to the current PRP payment structure. This includes the enhancement of lower-cost case management and peer support services to address the current PRP program expansion trends—such as the interest of several SUD programs in PRP services because of the case management element.