Department of Legislative Services

Maryland General Assembly
2006 Session

FISCAL AND POLICY NOTE
Revised

House Bill 771 (Delegate Hubbard)
Health and Government Operations Finance

Department of Health and Mental Hygiene - Therapeutic Behavioral Services - Rate Adequacy Study

This bill requires the Department of Health and Mental Hygiene (DHMH) to conduct a study of the adequacy of rates paid to therapeutic behavioral services providers.

The bill takes effect July 1, 2006.

Fiscal Summary

State Effect: The bill's requirements could be handled with existing budgeted resources.

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: The study must:

- assess the impact of the current rates on participation of existing and potential therapeutic behavioral services providers in the Maryland Medical Assistance Program (Medicaid), the ability of providers to recruit and retain staff, the ability of DHMH to promptly refer a child for receipt of therapeutic behavioral services, and the ability of providers to deliver the requisite number of therapeutic behavioral services hours;

- take into account the impact of current rates on outcomes of care for children in need of therapeutic behavioral services; and
- be conducted jointly by Medicaid and Mental Hygiene Administration (MHA) staff.

In conducting the study, DHMH must solicit input from providers, mental health professionals, advocates, and families whose children have received or been referred for therapeutic behavioral services.

By January 1, 2007, DHMH must submit a report on the study's findings and recommendations to the Governor, the Senate Budget and Taxation Committee, the Senate Finance Committee, the House Appropriations Committee, and the House Health and Government Operations Committee.

Current Law: Medicaid is the comprehensive health insurance program for the indigent. Covered services include in-patient hospital, out-patient hospital, pharmacy, physician, nursing homes, medical day care, personal care, mental health, and substance abuse treatment.

Medicaid regulations define a therapeutic behavioral service as an intensive, short-term rehabilitative service documented in a written plan of care. A therapeutic behavioral provider is a developmental disabilities provider, an approved outpatient mental health clinic, a mental health mobile treatment unit, or a psychiatric rehabilitation program.

Chapters 109 and 110 of 2001 require DHMH to increase rates of reimbursement for community service providers to eliminate the wage disparity over a five-year period. This requirement came from concern that direct care staff employed by private providers were not being compensated at the rate of comparable employees in State residential centers.

Background: Therapeutic behavioral services provide one-to-one aides who work in the home and community with families to implement an individualized behavioral plan designed to assist children under age 21 with severe behavior problems who have diagnoses of mental illness or developmental disabilities. Only children who are at risk of needing a placement in a more restrictive living situation because of their out-of-control behaviors are eligible.

Therapeutic behavioral services are the type of lower cost community-based service that families and professionals report can prevent expensive hospitalizations, out-of-home placements, or long-term custody relinquishment.

Since 2001, providers have received a $20 hourly rate for therapeutic behavioral services. According to providers and the Maryland Disability Law Center, this rate is not sufficient to ensure an adequate array of providers and timely delivery of high quality therapeutic behavioral services.

In a 2003 report, the Governor's Council on Parental Relinquishment of Custody to Obtain Health Care recommended that DHMH complete a Medicaid rate analysis of therapeutic behavioral service aides. This study was never completed.

For the majority of health care services delivered through DHMH contracts, the department itself establishes the rates. Six separate administrations within the department set rates for and/or pay providers, each serving unique populations, providing varying services, using different rate-setting methodologies, and paying different rates.

While for some providers, including some of the major providers, rate increases in recent years have been both relatively healthy and predictable, for other providers the opposite has been true. For example, community mental health providers generally received no increase between fiscal 2002 and 2006, a time when the community mental health fee-for-service system was struggling with significant budget deficits. While some small categories of rates increased (*e.g.*, in fiscal 2003 rates for outpatient services to children and adolescents increased by an average 27.3%), other provider categories were effectively reduced (*e.g.*, the fiscal 2005 switch from fee-for-service to case rates for rehabilitation services).

The Developmental Disabilities Administration fiscal 2007 budget allowance includes $16.2 million for the fifth and final year of an initiative to increase wages for direct care workers employed by community providers, as required under Chapters 109 and 110 of 2001.

In a June 2005 report, the Community Services Reimbursement Rate Commission (CSRRC) examined the issue of payment and utilization of children's psychiatric rehabilitation services. CSRRC raised questions about the way the case rate for these services was calculated. Specifically, the report noted that the case rate had been calculated as if it were a capitation rate where providers would receive a monthly service rate but did not take into consideration that the rate would not be paid at all if the consumer did not receive the minimum service level of three services.

Similarly, the report concluded that the number of services provided to children on a monthly basis before the implementation of the case rate and afterwards fell significantly (bringing utilization costs and the case rate into approximate alignment). CSRRC also

noted that the rate did not take into account differing requirements among children and recommended that MHA consider a tiered rate for children.

However, the report did not reach any conclusion as to the impact of this change on outcomes, *i.e.,* did the case rate drive lower utilization rates and as a result outcomes suffered, or did case rates essentially limit overutilization? MHA notes that it has provided a significant rate increase for child psychiatric rehabilitation services in fiscal 2006 (30%) and slightly modified its medical necessity criteria. However, there has been no resurgence in the use of these services to date.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Department of Health and Mental Hygiene, Department of Legislative Services

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