STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

September 9, 2013

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, MD 21401

The Honorable Michael E. Busch
Speaker of the House
H-101 State House
Annapolis, MD 21401

RE: HB1034, Chapter 498 and SB0633, Chapter 497 of the Acts of 2010

Dear President Miller and Speaker Busch:

Pursuant to House Bill 1034 and Senate Bill 633 (Chapters 498 and 497 of the Acts of 2010), the Department of Health and Mental Hygiene respectfully submits this preliminary report on its recommendations for a plan to develop and implement a rate-setting methodology for community developmental disabilities and mental health services providers.

If you have any questions regarding this report, please contact Ms. Marie L. Grant, Director of Governmental Affairs, at (410) 767-6480.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

cc: Ms. Sarah Albert, MSAR# 8247
Patrick Dooley, M.A.
Marie L. Grant, J.D.
Brian Hepburn, M.D.
Gayle Jordan-Randolph, M.D.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

INTERIM LEGISLATIVE REPORT

Rate-Setting Methodology for Community Services Providers

Senate Bill 633, Chapter 497 and House Bill 1034, Chapter 498 of the Acts of 2010 requires the Department of Health and Mental Hygiene (DHMH) to conduct a study for the 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. DHMH has begun the process of conducting this study, and is submitting this interim report to provide an update of our preliminary findings and recommendations. We expect to complete this study, after consulting with the appropriate stakeholders, by the summer of 2014.

Among other things, the final study will include an analysis of:

- the operating costs of community services providers;
- the ability of community services providers to attract and retain a high quality work force;
- any appropriate and feasible incentives for high quality performance of community services providers;
- any capital infrastructure needs of community services providers;
- transportation costs of community services providers; and
- any other issues related to the efficient and effective provision of community services.

One aspect of the final study required by the legislation is to include an analysis of the appropriate future role of the Community Services Reimbursement Rate Commission (CSRRC). Since its inception in 1996, CSRRC has reinforced various aspects of the payment systems used by the Developmental Disabilities Administration (DDA) and the Mental Hygiene Administration (MHA). DHMH is supportive of the role of CSRRC and has found the input of CSRRC useful in the development of rates for community services providers.

DEVELOPMENTAL DISABILITIES ADMINISTRATION

DDA provides direct services to individuals in two State Residential Centers (SRC) and through a coordinated service delivery system that supports the integration of individuals into the community. Services provided in the community are a combination of federal, general, and special funds. Since the majority of the individuals that receive services are Medicaid-eligible, the State receives federal matching funds for services provided to individuals receiving services through the Home and Community Based Services waiver. DDA has four regional offices that assist with administrative oversight, coordination, and management of these services.

Overview of Current Rate-Setting Process

Currently, DDA has two systems to pay providers –a contracts and grants system for non-rate based services and the Fee Payment System (FPS) for rate-based services. While federal, general and special funds support the contracts and grants based programs and FPS, providers also receive income from client contributions (including copayments), contracts for professional and vocational services, other government revenue streams (e.g., via Division of Rehabilitation Services), grants, and donations. Moreover, Senate Bill 633/House Bill 1034 of 2010 mandated that the Governor include an annual cost of living adjustment for community providers in the DDA and MHA systems equivalent to the increase in the Executive Branch for certain cost centers. For FPS and contract and grant services, cost of living adjustment is applied to the entire rate if authorized by the State. In accordance with Senate Bill 633/House Bill 1034 of 2010, the fiscal 2014 budget includes a 2.46% rate increase for DDA providers.

Contracts and Grants System

The contracts and grants systems covers the following services: family support services, individual support services, individual family care, New Directions (self-directed services), purchase of care, summer programs, low intensity support services, and behavioral support services. Contracts and grants for these services are negotiated with individual providers. At the beginning of each fiscal year, contracts are renewed and updated to reflect the number of individuals served by a provider and to apply the statutory rate increase.

Fee Payment System

DDA's current payment methodology for rate-based services - the prospective payment system - was adopted in 1987 and was subsequently codified in 1994. In accordance with Health - General Article § 7-306.1, DDA does not "reimburse" providers in the strictest sense of the term. Rather, it pays providers quarterly prospective payments based on projected earnings. The prospective payment is made with State funds, of which a portion is reimbursed with federal funds for Medicaid waiver recipients, based upon allowable costs. Payments to providers are made on the following schedule: a four-month advance at the beginning of the first fiscal quarter, three-month advances for each of the second and third quarters, and a two-month advance for the fourth quarter. Providers must reconcile payments received with actual services delivered at the end of the fiscal year and reimburse DDA for any overpayment in services. Likewise, if actual costs for the provider were greater than the prospective payments received, DDA must reimburse the provider.

FPS was developed in 1998 by using the prospective payment system as a base. FPS covers five programs— Community Supported Living Arrangements (CSLA), day, residential, supported employment, and resource coordination. FPS also covers "add-ons" to accommodate temporary changes in client needs (usually for a period under one year, but can be extended), and 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.

The rates used for FPS services are historical in nature and outlined in *Code of Maryland Regulations* (COMAR) 10.22.17.06 through 10.22.17.13. FPS rates are computed using the following three components:

1. The individual component, which assesses the service needs of the individual as determined by his or her matrix score, using an assessment tool called the Individual Indicator Rating Scale (IIRS). This component also includes regional rate adjustments that increase for certain high-cost areas of the State.

2. The provider component, which accounts for the indirect costs of providing care. These are fixed, Statewide per diem rates, with separate scales for day and residential programs.

3. The add-ons component, which addresses additional service needs that were not covered under the IIRS matrix score. Add-ons are negotiated at the regional level with each provider. It is important to note that not all individuals require add-ons but the majority of individuals do have add-ons included in their FPS rates.

Efforts to Improve DDA's Rate Setting Methodology are Ongoing

For nearly 30 years, DDA has used IIRS to assess the need of individuals receiving DDA-funded services. However, this assessment tool does not adequately assess the needs of people who require more intense supports. Accordingly, DDA supplements individual budgets, as they have been determined by the IIRS, with add-ons. In 2010, DDA saw the need to change the assessment tool and established a stakeholder group to assist in the process. That group identified the Supports Intensity Scale (SIS) as a more appropriate tool.

SIS is an individual client assessment and planning tool developed by the American Association on Intellectual and Developmental Disabilities. It is already in use by a number of states and Canadian provinces. Some states are utilizing SIS measures as a basis for payment of providers. The SIS is distinguished from other measurement tools because it is used to identify the needs of a client in order to be as high functioning as possible, rather than to measure a client's weaknesses. DDA is committed to implementing SIS as a means to better align service payments with costs and incentivizing effective and efficient service delivery.

DDA has already begun piloting the application of the SIS and is planning to hire a consulting firm to develop a resource allocation formula (algorithm) based on the sample assessments. DHMH will initiate a procurement to obtain a consultant to analyze the sample of SIS assessments. A second consultant will then be procured in the fall of 2013 to recommend a new rate-setting methodology. DDA will continue to seek input on this process with the SIS workgroup and other stakeholders in addition to its collaboration with CSRRC. Additionally, CSRRC will provide DDA and consultants with relevant data that will be used to assist in the development of the new resource allocation methodology.

Next Steps – SIS Implementation and Financial Restructuring

SIS Implementation: The use of SIS and a new resource allocation formula will coincide with a financial restructuring effort that is ongoing within DDA. The DDA financial restructuring effort includes: tasking an independent consultant to provide recommendations for a new financial services platform with a focus on assessing current payment methodologies, developing payment rates, interfacing with Medicaid's payment platform, and determining the viability of the current DDA data platform for the next 10 years. The following timeline for deliverables has been developed for the SIS implementation:

- Initiate procurement process for SIS Consultant (Fall 2013).
- Develop specifications for consultant solicitation for rate-setting methodology, with assistance from Alvarez and Marsal (A&M) (DDA - Fall 2013).
- SIS Consultant will be selected and will receive Notice to Proceed. (Late Fall/Early winter2013).
- Identify best procurement strategies and issue solicitation for rate-setting consultant (Winter 2014).
- Award rate-setting contract (Spring 2014).
- Rate-setting consultant to engage with stakeholders (Summer/Fall 2014).
- Final recommendations of consultant to be completed (Summer 2015).

Financial Restructuring: Throughout fiscal year 2013, DDA has sought to strengthen its fiscal structure to better ensure that providers are adequately reimbursed for services and that clients are provided high-quality care. Among other things, DDA selected Alvarez and Marsal (A&M) in November of 2012 as the consultant to support the financial restructuring of DDA. The DDA financial restructuring contract proposal was approved by the Board of Public Works on January 2, 2013 and a Notice to Proceed was issued. A&M has completed Phase I, which includes the documentation of current fiscal management processes. This review of current processes highlighted the need to make changes to certain protocols immediately instead of waiting for Phase II to commence, which includes the development of To-Be processes and recommendations. A&M is currently assisting DDA in implementing critical processes identified for immediate change in order to improve DDA's operations. Delivery of the To-Be processes and the associated recommendations for improvements are expected in Fall 2013.

MENTAL HYGIENE ADMINISTRATION

MHA provides services to individuals in a variety of settings. MHA headquarters coordinates the delivery of mental health services throughout Maryland, whether in institutional or community-based settings. Community mental health services are available to individuals who are Medicaid-eligible and to those who, because of the severity of their illness and their financial need, qualify to receive State-subsidized services. Primary mental health services are delivered through a managed care structure, while specialty mental health services to Medicaid enrollees are carved out and funded through the public mental health system. The carve-out system is overseen by MHA; however, it contracts with an administrative services organization (ASO) – Value Options – to administer the system. Core Service Agencies (CSA) work with MHA to coordinate and deliver mental health services at the county level. CSAs contract for services that are not reimbursed through the fee-for-service system (FFS), such as peer support programs and training. MHA also operates State-run psychiatric facilities, including five hospitals and two Residential Treatment Centers (the Regional Institutions for Children and Adolescents).

Services provided in the community are financed with a combination of federal, general, and special funds. The majority of the individuals who receive services are Medicaid-eligible, and the State receives federal matching funds for services provided to Medicaid-enrolled individuals.

Overview of Current Rate-Setting Process

There are two community mental health services models financed by MHA: outpatient mental health clinics and psychiatric rehabilitation providers. Outpatient mental health clinics conduct assessments and evaluations, as well as provide individual, family and group therapy. These clinics are reimbursed on a FFS basis. Outpatient mental health clinic fees are outlined in COMAR 10.21.25.05 to 10.21.25.08. Outpatient mental health clinics are reimbursed at 100% of the maximum allowable Medicaid rates for physicians, regardless of the kind of provider who delivers the services.

Psychiatric rehabilitation providers treat individuals with serious emotional disturbances or a serious and persistent mental health disorders. Psychiatric rehabilitation providers are reimbursed for face-to-face patient encounters at a monthly rate, based on a person's assessed need, for a minimum and maximum range of services. These rates are published in

COMAR 10.21.25.09. Eligibility, utilization review, outcomes assessments, and claims processing is handled by Value Options.

In accordance with Senate Bill 633/House Bill 1034 of 2010, MHA continues to use a weighted average cost structure established by CSRRC and implemented by DHMH's Budget Management Office and the Department of Budget and Management. The fees paid to the community mental health services providers for services rendered to eligible individuals are adjusted annually. For fiscal year 2014, a 2.54% rate increase was applied to both outpatient mental health clinic and psychiatric rehabilitation provider rates.

Behavioral Health Integration

A recent focus at MHA has been Behavioral Health Integration. In early 2012, DHMH established a Steering Committee, led by the Deputy Secretary for Health Care Financing, to review options for the financing of integrated care for individuals with behavioral health disorders. Membership included representatives from all key programmatic units at DHMH, including Medicaid, MHA, the Alcohol and Drug Abuse Administration, and the Office of the Chief Medical Examiner. During 2012, DHMH held a series of large public stakeholder meetings regarding the selection of a financing model. After considering all input, on November 1, 2012, the Steering Committee issued a report recommending a specialty behavioral health carve-out using an ASO, with significant and meaningful performance risk at the ASO and behavioral health provider levels. MHA will continue to use the weighted cost average methodology and will work with CSRRC while a new finance plan is implemented as a result of the decision on the model.

Collaboration with CSRRC

DHMH will continue to strive to improve our progress to implement a rate-setting methodology for community developmental disabilities and community mental health services. Both MHA and DDA have been collaborating with CSRRC to implement meaningful and normative standards to accurately measure provider financial health. MHA is also working with CSRRC to develop supplemental survey methodologies to better understand and measure the financial condition of MHA providers.

It is anticipated that a final report of the Department's plan to develop a rate-setting methodology for community developmental disabilities and mental health services providers will be available in the summer of 2014. DHMH appreciates the Maryland General Assembly's continued support for people in the public mental health system and people with developmental disabilities.