Managing the Utilization and Quality of Psychiatric Rehabilitation Programs (PRPs)

White Paper | June 21, 2023

This white paper uses Psychiatric Rehabilitation Programs (PRPs) to illustrate structural problems with BHA's oversight processes beginning with leadership changes in 2015. BHA's challenges played out against a targeted rise in PRP utilization and licensing of new providers. As BHA implemented a global, rather than targeted, response to these problems, its actions demonstrate the limitations of its current approach to oversight and policy-making. CBH offers policy and oversight recommendations below. While this paper addresses these problems specific to PRP context, similar challenges exist for the addiction treatment benefit managed by BHA, as well as the continuum of specialty services for children.

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Contextualizing Oversight, Policies and Results at BHA

1. 2015 – 2019: Oversight weaknesses coincide with targeted spikes.

As noted in a 2020 OLA audit, BHA failed to exercise adequate oversight of LBHAs and the ASO from 2015 through 2019.[1] Specifically, BHA failed to oversee these agencies in their roles managing the provider network from authorizations to overpayments and provider corrective action plans. BHA cited personnel changes as one reason for its failures during this period.[2]

Concurrently, DLS budget analysts in 2020 noted a spike in both PRP licenses and utilization during the same period that OLA auditors found weakened oversight. BHA has cited the adoption of 10.63 regulations as the main driver of the PRP license and utilization growth, reporting that the regulations are too vague to support effective compliance.

The DLS budget analysis did not support BHA's narrative because the problems didn't occur system-wide in either licensing or utilization growth, as one may expect with a regulatory failure. Instead, DLS analysts identified concentrated growth in licenses. In CY2019 alone, the number of licensed PRP sites grew by 19% - and ***nearly two-thirds of that growth occurred in Prince George's County and Baltimore City***.[3]

> DLS analysts found that PRP growth was driven by rising utilization among ACA-eligible single adults, not the categorically-eligible disabled adults or foster children traditionally receiving PRP.

As new PRP licenses proliferated in two jurisdictions, PRP utilization also spiked. By the end of FY2019, PRP utilization was 71% higher than the beginning of FY2016.[4] Just as licensing growth was concentrated, DLS budget analysts also concluded that the rise in PRP costs appeared to be associated an influx of new patients. The utilization spike was driven by the Medicaid expansion population, whose utilization of PRP grew at a rate almost five times higher than disabled adults, youth in foster care, or other traditional eligibility categories.[5] In other words, ***the patients driving the PRP spike have an identifiable eligibility category and different diagnostic profile than traditional PRP recipients***.

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[1] Office of Legislative Audits, "Maryland Department of Health – Medical Care Programs Administration – Administrative Service Organization for Behavioral Health," at p. 8 (Jan. 13, 2020) ("BHA relied on designated county or multi-county authorities, referred to as Core Service Agencies and Local Addiction Authorities (generally local health departments or private contractors), to review the plans and ensure the providers implemented the necessary corrective actions. Neither MCPA nor BHA performed any oversight of this process. As a result, there is a lack of assurance that the deficiencies were properly resolved.").

[2] *Id*. at p. 6.

[3] Department of Legislative Services, "Behavioral Health Administration FY2021 Operating Budget Analysis," p. 25 (March 2, 2020).

[4] *Id*. at p. 2.

[5] *Id*. at Exhibit 13, p. 22.

Because most CBH members were in business prior to 2019 and because they concentrate in serving categorically eligible populations like disabled adults and foster children, DLS findings suggest that CBH providers and their clients may be distinct from those organizations and clients driving the utilization and licensing spikes. While the DLS analysis from 2020 has not been repeated, its findings may explain the disparate impact that BHA's subsequent efforts to restrict PRP have had on CBH members compared to the public behavioral health system as a whole.

2. 2020 – 2023: Oversight collapses, while policies reduce access to PRP.

BHA never responded to the DLS findings to strengthen its oversight of the eligibility categories and jurisdictions identified as driving the problem. Instead, as oversight weaknesses accelerated into a collapse under the new ASO vendor, BHA undertook a series of policy changes that restricted access to PRP for all eligibility categories.

BHA's oversight weakness accelerated with the launch of Optum as ASO vendor in January 2020. Optum has failed to routinely or adequately perform key functions historically managed by the ASO, such as provider audits. From a provider perspective, it is unclear how or if utilization management is occurring at the ASO level. Optum's oversight of overpayments and provider corrective actions has been deficient.

Meanwhile, since Optum's launch in January 2020, BHA modified PRP medical necessity criteria twice to make it more restrictive.[6] BHA also restricted authorization policies through Provider Alerts on eight separate times in the last three years.[7] Two additional policy changes to PRP were communicated to providers via an unannounced update to an FAQ document[8] and through a recurring PRP training.[9]

Since Optum's launch in January 2020, BHA modified PRP medical necessity criteria twice to make it more restrictive. BHA also restricted PRP authorization policies through Provider Alerts on eight separate times in the last three years.

[6] See Optum, "State of Maryland Medical Necessity Criteria," at pp 15-20 (effective July 1, 2020). The publication date has not been updated to reflect the second MNC change, made in March 2021.
[7] Optum, "Provider Alert: Updates to PRP Forms" (January 7, 2021); "Provider Alert: Adults Authorization Requests" (March 9, 2021); "Provider Alert: Update to Administrative Denials Checklist (April 20, 2021); Provider Alert: TAY PRP and Schools" (April 28, 2023); "Provider Alert: PRP Service Site and Telehealth" (September 15, 2021); "Provider Alert: PRP Clinical Service Form Update" (December 20, 2021); "Provider Alert: Changes to … PRP Clinical Request Forms" (August 3, 2022); "Provider Alert: Retraction" (August 11, 2022); "Provider Alert: Changes to … PRP Clinical Request Forms" (May 11, 2023).
[8] *See, e.g.,* Optum, "FAQs PRP" at Q1 (Oct 2021) (first announcement for four visit threshold).
[9] Compare same-day exclusion list in Optum, "Provider Alert: Updates to MNC for PRP-M" (March 1, 2021) with Optum, "Provider Training: Psychiatric Rehabilitation Program – Minors"(undated although url indicates March 2023 publication date).

3. Impact of PRP restrictions and oversight collapse

BHA's actions have reduced access to care for the eligibility categories traditionally served by CBH members – including children in foster care and disabled adults – but do not appear to have not alleviated PRP growth as a whole. BHA continues to implement PRP-wide restrictions, without evaluation of its results and possible strategy modficiations to improve the efficacy of its actions.

DLS analysts found targeted sources of PRP growth, and BHA undertook PRP-wide policy solutions, while its compliance oversight process collapsed. The disparate impacts of BHA's policies on CBH members compared to the PBHS as a whole suggest that BHA's actions may have reduced access to care for the categorically-eligible disabled adults and foster children, but may not have effectively reduced utilization growth among ACA-eligible adults, who were identified by DLS analysts as driving the problem.

Licenses. BHA has not taken action since 2019 to increase barriers to new provider licensing through a licensing moratorium, regulatory changes, or targeted improvements in the two jurisdictions driving the licensing spike.

BHA's failure to correct its oversight problems means that the proliferation of PRP licenses continues, even as its system-wide crackdown to reduce access to PRP continues. Since 2019, BHA data indicates that the number of PRP sites has increased 58%, while the number of PRP sites among CBH membership shrank by 12% as CBH members closed programs. The rate of CBH membership among PRP providers has fallen nearly in half.[10]

Table 1 - BHA-Reported PRP Site Licenses

	2019 PRP Licensed Sites			2023 PRP Licensed Sites		
	All	CBH	CBH share	All	CBH	CBH share
Programs for Minors (PRP-M)	409	109	27%	640	91	14%
Programs for Adults (PRP-A)	518	159	31%	820	146	18%
Total	927	268	29%	1,460	237	16%

Utilization. It is unclear whether BHA's MNC and auth changes reduced utilization for PRP services as a whole. BHA has not published adult utilization data for FY2022, while BHA's data indicate that children's utilization dropped 18% from pre-pandemic levels,[11] despite a 22% increase in Medicaid enrollment.[12]

[10] Behavioral Health Administration licensing data on file with CBH.
[11] BHA has not published program-level utilization data for FY2022 publicly but shared a file with children's data with CBH. Data on file with CBH.
[12] See Kaiser Family Foundation monthly Medicaid enrollment data; BHA utilization data emailed to CBH.

Table 2 - Medicaid Enrollment and BHA PRP Utilization Data

	FY2019	FY2020	FY2021	FY2022	Change FY19 to FY21	Change FY19 to FY22
Medicaid Enrollment	1,322,426	1,377,552	1,523,891	1,611,601	15%	22%
PRP Utilization						
Ages 0-17	17,608	19,156	16,743	14,468	-5%	-18%
Ages 18-26	4,719	5,215	4,655	4,319	-1%	-8%
Ages 27+	22,892	25,095	23,125	unknown	1%	unknown
Total	45,219	49,466	44,523	unknown	-2%	unknown

By contrast, CBH members, who concentrate in serving categorically eligible disabled adults, foster children, and other traditional eligibility groups, report a steeper decline in PRP utilization than BHA reports as a whole. Data from CBH members indicates that the average monthly rate of new admissions to adult PRP programs shrank by 24% between January 2020 and December 2022, while child PRP utilization was reported to fall over 30%.

The disparity between system-wide results and CBH-reported results may reflect the continuation of a trend previously identified by DLS analysts.[13] If DLS analysts' past findings continue to hold true, then the erosion of CBH-reported licenses and utilization suggests that disabled adults, foster youth and other critical eligibility categories are losing access to PRP while ACA-eligible adults may continue to drive growth.

If this is correct, it means ***BHA's policy actions are achieving the exact opposite of their desired effect***. BHA is not effectively restricting access among the population identified as driving growth, but is restricting access among the population that is not driving growth. Three years into BHA's ongoing PRP-wide crackdown, no evaluation of the results or modifications to the approach have occurred at BHA.

Restricting Access for Disabled/Foster Youth Coincides with Sharp LOS Increase in Institutional Settings. Data indicates that BHA's policies restricting access to PRP may be having an unintended consequence of increasing ED utilization and institutional lengths-of-stay.

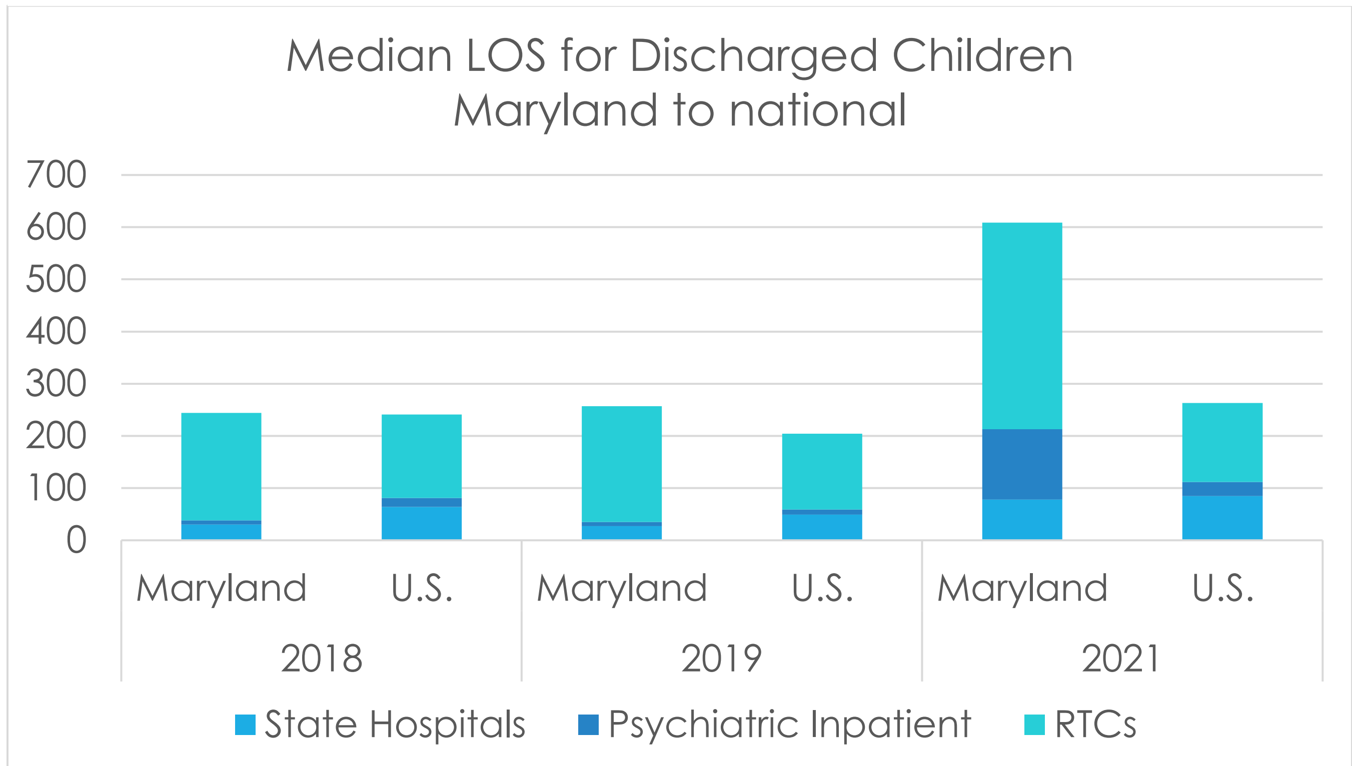
SAMHSA data indicates that the median length-of-stay in psychiatric hospitals, state hospitals, and residential treatment centers grew rapidly for adults and exploded for children in 2021 (see Table 3 below).[14] Nationally, the median length-of-stay for children in these institutional settings grew 29%, a likely reflection of challenges associated with the pandemic and workforce crisis. In Maryland, however, the median length-of-stay for children exploded 153%, suggesting state-specific challenges in 2020 may account for Maryland's differential spike.

[13] *See* note 4 *supra*.

[14] *Compare* SAMHSA, "Maryland 2019 Mental Health National Outcome Measures (NOMS)" at page 17 (Appropriateness Domain: Length of Stay in State Psychiatric Hospitals, Other Psychiatric Inpatient and Residential Treatment Centers) with "Maryland 2021 Mental Health National Outcome Measures (NOMS)" at page 13 (Appropriateness Domain: Length of Stay in State Psychiatric Hospitals, Other Psychiatric Inpatient and Residential Treatment Centers).

BHA's restriction in PRP access occurred concurrently with the onset of Maryland's spike and may be a potential driver of it. The very populations – disabled adults and foster children – who appear to be losing access to PRP services are also those at higher risk for hospitalization.

Table 3 - SAMHSA Length-of-Stay Median for Children in Institutional Settings



CBH Recommendations

1. Adopt "gold card" authorization policies

In January 2023, CBH urged BHA to adopt PRP prior authorization policies that impose higher scrutiny on poor performing providers in lieu of further restrictions to PRP as a whole. BHA indicated that such solutions were "challenging" to implement "[i]n a fee for service environment in which … rules are standardized for all providers."[15] CMS has encouraged the use of such policies – called "gold carding" – and is considering broader adoption of them,

[15] Email from Marshall Henson to Shannon Hall (June 16, 2023) ("In a fee for service environment in which a basic requirement is that rules are standardized for all providers, it can be a challenge to develop measures that adequately differentiate high and low performing providers without regulatory description of outcomes.")

including in fee-for-service Medicaid programs.[16] Some states have already adopted gold carding authorization policies.[17]

If provider performance data is too difficult to produce with the current ASO vendor, BHA could consider differentiating authorization burden for traditional eligibility categories and ACA-eligibility categories. CBH recommends that BHA immediately rework its PRP authorization policy to adopt gold card standards based either on patient eligibility categories or provider performance.

2. Create single document with accessible, durable format capable of clear updates for subregulatory guidance

Currently, subregulatory guidance is disseminated by the ASO vendor, without control numbers to clearly identify superceded policies. BHA has changed PRP MNC and auth policies twelve times in the past three years.[18] Provider compliance is dependent on reading all 12 communications published in three separate venues.

New providers are not necessarily able to synthesize evolving policy requirements when they are communicated in this manner, and access to the evolving policy statements disappears with every ASO vendor change. Effective compliance programs don't remind providers to comply with decade-old policies that are no longer accessible;[19] instead, they make compliance standards available.

CBH recommends that BHA develop and publish a policy manual, housing all of the subregulatory policy guidance for PBHS in one document. Each policy should have a number and reference date, which can be updated if the policy is superceded. A wealth of examples from other states exists.[20]

Moreover, published policies are not accessible when the ASO vendor changes, as it does every five years. Auditors, stakeholders, and providers often demonstrate confusion about what rules are in force under the current system.[21] A clear publication will improve provider compliance and strengthen BHA's ability to effectively audit programs.

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[16] Kaiser Family Foundation, "CMS Prior Auth Proposal Aims To Streamline the Process and Improve Transparency" (Feb 21, 2023).

[17] See, e.g., NM Administrative Code Part 31, Texas, Vermont.

[18] See notes 6-8 supra.
[19] See, e.g., Optum, "Provider Alert: TAY PRP and School Systems" (April 28, 2021) ("This is a reminder of the original MDH transmittal sent Wednesday, November 13, 2002, to Child and Adolescent PRP providers detailing revised PRP guidelines.")
[20] D.C. Dept. of Behavioral Health, "Policies and Notices," Magellan of Pennsylvania, "Quality Improvement: Provider Performance Standards."
[21] CBH, "10.63 Regulatory Confusion" (March 28, 2023).

3. Create effective oversight workflow between BHA, ASO, and LBHAs

The BHA oversight problems identified in the 2020 OLA audit remain ongoing. It is not clear from a provider perspective whether BHA has actualized oversight of LBHA performance and has the capacity to hold LBHAs accountable. Nor is it clear whether BHA has clarified responsibilities for managing provider deficiencies between the ASO, state, and local authorities.

The 2020 audit also identified BHA's failure to audit the quality of the ASO vendor's MNC decisions. [22] This too remains an ongoing problem. Providers have repeatedly described Optum's staff and technology failures as contributing to a higher rate of inappropriate authorization denials, and 69% of providers felt that Optum did not make the correct auth decision almost all the time.[23] BHA has not required the ASO to report auth denials in a way that allows oversight of its performance; an auth denial checklist that was intended to offer denial reasons to providers is reportedly often incomplete or insufficient to fill that purpose. Without reliable data on Optum's auth performance, it is unclear how BHA can audit the quality of Optum's work.

In short, a compliance framework does not exist to ensure that the state, local authorities and ASO vendor are effectively performing the activities expected of them. A workflow with clearly defined expectations of each party, performance transparency, and accountability for performance failures does not exist.

4. Revamp fraud prosecution pipeline

In the last year, the DC Office of Inspector General announced three convictions for Medicaid fraud arising out of substance use or mental health treatment in the DC Medicaid program,[24] despite being far smaller in scale than Maryland's public behavioral health system. During the same period, zero convictions or indictments for fraud or abuse in Medicaid behavioral health services could be identified on the Maryland Attorney General's website. This suggests that compliance processes to elevate fraud concerns from BHA, LBHAs or ASO level to state prosecuting authorities may also benefit from process improvements. BHA has cited the vagueness of 10.63 regulatory standards as a barrier to prosecution, but DC is securing indictments on blatant fraud and abuse, not regulatory violations. The disparate results

[22] Office of Legislative Audits, "Maryland Department of Health – Medical Care Programs Administration – Administrative Service Organization for Behavioral Health," at p. 8 (Jan. 13, 2020)
[23] CBH, "Authorization Experience Survey and Recommendations" (August 27, 2021).
[24] See D.C. Office of Inspector General, "Former Mental Health and Community Residence Facility Director Sentenced for Financial Exploitation of a Vulnerable Adult and Elderly Person" (May 12, 2023); "Maryland Man Sentenced for Defrauding the D.C. Medicaid Program" (May 11, 2023); "D.C. Doctor Arrested for Unlawfully Distributing Opioids" (April 12, 2023); "Owners and Former Employee of Heath Care company Facing Federal Charges for Allegedly Paying Kickbacks to Homeless Patients and Fraudulently Billing Medicaid" (April 2, 2021); "District Woman Sentenced to 24 Months in Prison on Federal Mail Fraud Charge, Admits Her Role in Embezzlement Scheme" (Jan. 16, 2020).

between DC and Maryland suggest that BHA's oversight framework is failing to locate and document active Medicaid fraud or abuse of vulnerable persons.

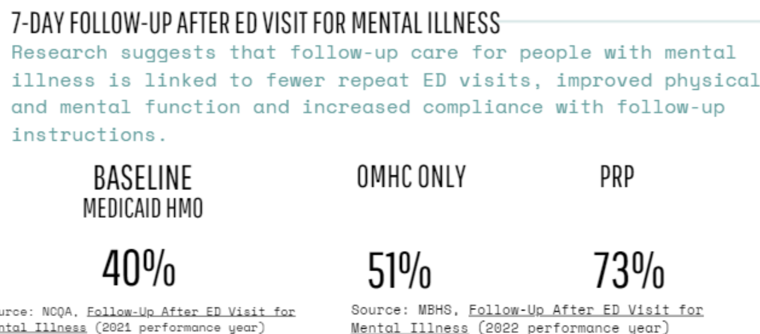
5. Create a Plan-Do-Study-Act or similar change management framework for policy implementation

BHA does not have an effective change management framework in place. Policies are changed without goals being articulated. It's not clear whether evaluation of policy change occurs at BHA level. This may result in inefficient change and lost opportunities to make small modifications to improve policy efficacy. Ensuring that BHA policy-makers follow standard change management framework would be beneficial to ensuring the agency can better achieve its desired results.[25]

6. Performance incentives for PRP

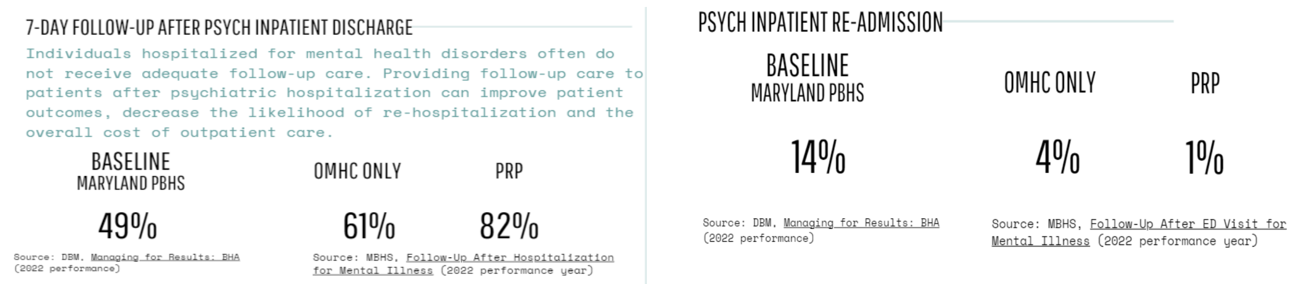
The Community Behavioral Health Association of Maryland recommends the use of value-based purchasing contracts or pay-for-performance incentives for PRP. By measuring outcomes – such as improved social connection or reduced hospital utilization – and correctly incentivizing provider performance, MDH can preserve access to treatment while improving the quality of care.

There is a direct link between access to high-performing PRPs and reduced hospital utilization. The MBHS provider network's data demonstrates the critical role that effective PRP providers play in reducing hospital utilization and speeding access to care following hospital discharges. Within the MBHS network, 73% of clients linked to PRP received a follow-up mental health visit within 7 days of an ED visit for mental illness, compared to 40% for Medicaid HMOs.



[25] See, e.g., Cardiff University, "How to use the PDSA model for change management"

Maryland measures its PBHS performance on 7-day follow-up after psychiatric inpatient discharge and psychiatric inpatient re-admission. Within the MBHS network, clients enrolled in PRP demonstrate 7-day follow up at nearly double the rate of the PBHS as a whole, while readmissions are one-tenth of the PBHS performance.



The MBHS network data indicates that PRP is an essential tool to help high-risk individuals with serious mental health conditions access appropriate care. When BHA's policies restrict access to PRP as a whole, rather than targeting problem providers, Maryland increases strain on its hospitals.

7. RFP Modification: Use ASO vendor to create compliance culture

It is normal practice in healthcare to use a variety of subregulatory tools to ensure provider quality.[26] Key elements of a compliance culture that are currently missing from BHA and its ASO vendor's work include subregulatory strategies such as:

- Articulating goals or desired results of program interventions through published provider materials;
- Articulating clear performance standards for programs through published provider materials;
- Publishing compliance newsletters on a monthly or quarterly basis;
- Publishing self-audit standards and reporting policies to providers, and creating incentives that reward provider self-audits and disclosures;

CBH offers a robust annual compliance training to its members, and has offered to host annual compliance trainings for PBHS providers, but BHA has not taken steps on this offer or other actions to promote a culture of compliance among its provider network.

CBH Recent Publications on PRP

CBH's recent communications with the Department of Health on PRP utilization include:

- Policy Response: Feedback on Adult PRP Authorization Forms (June 9, 2023).
- 10.63 Regulatory Confusion (March 28, 2023)
- Letter to BHA on Rehab Specialist Staffing (Oct 28, 2021)
- CBH: Child Utilization Since the Pandemic | Troubling Questions Raised (Sept 23, 2021)
- Provider Survey: Optum Authorization Experiences (August 27, 2021)
- Letter to BHA on PRP-M Service Combo Exclusions (March 16, 2021)
- MHAMD Children's BH Coalition Letter to BHA on PRP-M/TCM Exclusions (March 16, 2021)
- Letter to BHA on PRP Medical Necessity Criteria (Oct. 21, 2020)
- Comments: Proposed Behavioral Health State Plan (August 14, 2020)
- Informal Comments: Proposed 10.63 Regulations (July 30, 2020)
- PRP Medical Necessity for Minors (July 7, 2020)

[26] See, e.g., Magellan Behavioral Health of Pennsylvania, "Psychiatric Rehabilitation Program Performance Standards" ("These performance standards should not be interpreted as regulations, but instead add to the foundation provided by current licensing guidelines and regulations. It is Magellan's expectation that providers apply these performance standards when developing internal quality and compliance monitoring activities. Magellan will use this document as a guide when conducting quality and compliance reviews.")