

Community Services Reimbursement Rate Commission

Mental Hygiene Administration, Catonsville, Maryland

May 14, 2013

MINUTES

Present

Commissioners: Jillian Aldebron (Chair), Thomas Sizemore (Vice-Chair), Patsy Blackshear, Kia Brown, Rebecca Fuller, Timothy Wiens

MHA: Brian Hepburn, M.D., Marion Katsereles

DDA: Gerald Skaw, Frank Kirkland

Public: Herb Cromwell (CBH), Brian Frazee (MACS), Jaclin Warner Wiggins (DBM), Denise Coil (Humanim), Erin McMullen (Dept. of Legislative Svs.)

1. Proceedings

The Meeting was called to order at 6:00 p.m.; today's agenda and Minutes of March 12, 2013 were presented and approved as submitted, with an additional agenda item added for a closed discussion for Commissioners only on contractual issues. Thus, the agenda items were rearranged in order of priority and to allow time at the end of the meeting for Commissioners to have their 'closed meeting' to discuss contractor issues concerning Open Minds.

2. Updates from DDA and MHA

MHA: Dr. Brian Hepburn indicated that MHA completed their Third Quarter Projections for FY '13; Marion Katsereles stated that MHA was on target with their Appropriation. She stated, that the Appropriation was cut by the Legislature by \$12.8 million, but MHA was overall still holding their own and thus, in a good place. This includes all MHA facilities and Program 1, which is MHA administration, and Program 2 which includes uninsured and Program 3, which is the Medicaid fee-for-service budget. There is no change in FY '14. Brian Hepburn indicated that they expect a 2.54% rate increase and a significant increase in for Psychiatrists—they are projecting a 15-20% increase for evaluation and management codes. Dr. Hepburn indicated that this will be about an \$8 million increase in the total budget just for psychiatrists. Dr. Hepburn added that MHA's Office of Finance, working with Value Options, are on target. Most of the credit, however, goes to the providers keeping individuals out of the hospitals.

Dr. Hepburn stated continuing with projections for next year, in terms of how many people will be coming into the system, he indicated there will be an increase of 200,000 individuals in Medicaid expansion and 4000,000 increase in those in PAC. He added that the 'new population' will be an adult population that is healthier – with more "mild-to-moderate" mental illness and more severe substance abuse population. He stated that traditionally the Medicaid population is 18% co-occurring substance abuse, and in PAC the population there is

30% co-occurring substance abuse. In terms of the veterans' population, MHA does have veterans in their system. Traditionally, VA wants to take care of their own population—they are good with taking care of individuals with post-traumatic stress, but not so with those with severe mental illness. Thus, the PMHS has taking on the VA population that has more severe mental illness. MHA has project, Maryland's Commitment to Veterans, trying to link veterans to needed services until they can get VA services.

MHA-ADAA Integration: Dr. Brian Hepburn stated that they are in Phase 3. The model that will be used is the "Administrative Service Organization", covering mental health and substance abuse; by FY 2015 will be having an ASO doing both. MHA will be working with ADAA working to add performance risk to the ASO, performance risk to providers and consumers. Dr. Hepburn added that they will be working to improve coordination and integration at the 'clinical level' not the 'budget level'.

DATA COLLECTION: MHA determined that out of the original list of 193 providers, it was determined that 150 should submit salary surveys and 139 should submit financial information (12 Health Departments are exempt from financial). All required information was received. Dr. Hepburn stated in Phase 3 Integration, the CSRRC should be able to add some input—there is a window of opportunity from now to September to weigh in on performance risks for ASO, providers, and consumers; and on ways to incentivize.

DDA Update: Frank Kirkland provided update on the Waiver Renewal - the 2 HCBS Waivers that DDA administers are up for renewal with CMS. They expire June 30, 2013. In conjunction with the State Medicaid, DDA is planning to combine the smaller self-directed waiver (new directions) and the larger comprehensive waiver (community pathways) into one waiver with a self-directed component. DDA worked with stakeholders throughout the process and have submitted the renewal application to Centers for Medicare and Medicaid Services (CMS) at the end of March. CMS has 90 days to approve it or come back and ask questions. Frank Kirkland added that there have been some issues of quality so CMS did ask about those issues, and thus will be working with DDA to address those quality issues.

Frank stated that DDA is transitioning their case management system from a contract based model to a fee-for-service model using Targeted Case Management through Medicaid State plan. This will allow for increased federal match for people on Medicaid but not in one of our Waivers. The new model will also provide people choices of agencies. DDA solicited new case management providers and will be announcing them soon. The new system is set to go live July 1st. One of the biggest components is 'monitoring.' Mr. Kirkland stated that when a case manager logs into the system and performs updates, the system will automatically generate billing.

Fiscal Restructuring: Mr. Kirkland indicated the 1st Phase is finished, which is "as-is." DDA is planning to hold meetings with providers to get their input; the first meeting is scheduled for next week. Providers are also assisting with addressing the issues of 'better tracking.' Frank Kirkland stated that the fiscal restructuring is both a short-term and a long-term process. Mr. Kirkland suggested having this group present at the next CSRRC meeting in July. The

Committee agreed. Frank stated that they have done an exceptional job mapping out the processes, which include eligibility, dues, payments, change of services and claims.

Mr. Kirkland indicated that their budget was not as favorable as MHA's. The 3rd Quarter Projections indicate DDA is a bit over budget. Unfortunately, the current system does not capture "real-time data." They are working with DBM to help control this issue. Frank further reported on the progress of DDA's Fiscal Consultant's, Alvarez and Marsel. They have completed an initial assessment of DDA's "As-Is" fiscal and related process and will be meeting with providers to review that within the next few weeks. The consultants will then start on developing recommendations for a "to-be" fiscal structure starting later this summer with final recommendations by fall. They are also assisting DDA with some more specific tasks such as improving their process around contribution to care and identifying short term staffing needs for our fiscal operations.

Integration: DDA is continuing to work on integration/restructuring and now has a Clinical Team, lead by MHA's Dr. Lisa Hovermale. Valerie Rhoddy is now DDA's Acting Deputy Director, who will be intimately involved with the fiscal organization. Integration of supports will be the last piece. DDA will be looking for another consultant to do this; this will be tied to the fiscal restructuring. The Clinical Team will be looking at requests for service change forms and looking at policies, incidents – on line reporting. There will be several RFPs going out – (1) the BHS contracts: Dr. Hovermale will be involved with this since this is a clinical piece. Dr. Hovermale understands DDA services. She is the main presenter at the upcoming National Association of Dually Diagnosis.

New electronic models - DDA has implemented 3 new electronic modules to their web based consumer data base (PCIS2). They are a resource coordination module that will allow case managers to document their activity on behalf of people, an IP module that will allow peoples individual plans to be entered in the system, and PORI module that allows providers to enter and track reportable incidents such as abuse and neglect, deaths, injuries. Frank indicated that there has been some problems with access and uploads to the system. IT folks are working on the issues.

3. Implementation of MH provider Cost Report for FY 13

Providers feel that doing this may be a burden on them, particularly on the smaller providers. In previous cost reports, providers felt it highlighted services "above costs" not necessarily below costs, so providers feel 'why bother.' DDA feels, however, we should continue to request the information for the Cost Report. Jillian Aldebron stated that to some extent it has been illuminating for some providers. She asked about what kind of response was received previously. Flexibility in allowing providers to give us the information we want was a big issue. If providers see this as a value to them, we will get the information. It will take some time to get the cost report perfected. We should get feedback from providers on what they see as useful. Jillian Aldebron stated that we could require this with other financial reporting but it would not be an item we would penalize them for not doing, particularly since it is a learning curve. Herb Cromwell stated that the purpose of this should be clearly explained to providers and the data should be de-identifiable per agency. It was noted that providers that received a lot

of State grant dollars will be perceived as better than providers who did not with cost comparisons because they have less operating costs. It was further commented that this is a developmental process—it will take time to get it perfected; it is an exchange and if providers see that there is some value in it, they will do it. This is a dynamic that has to unfold; the prior suggestion of sending out a communication to providers to have them take another stab at this would be good to get this moving. If providers can use the information as well, rather than their seeing this as ‘just reporting’ we may get better feedback from them. Jillian indicated that collecting data over multiple years helps us look at trends. Jillian Aldebron stated that the Commission has been getting financial data for years by the agencies. If we want providers to capture data in the new format, we will need to do this now, before July 1st. If this is going to be a learning curve, we will need to provide some assistance. The request should go now indicating this to go out in the Fall. It was suggested the request come from MHA.

Action: Dr. Hepburn agreed he would send it out from MHA through the ASO, Value Options. Jeff and Tom will work together on drafting the request and developing the Cost Report format to gather the data requested. The memo will go out by June 15th.

4. Issues Raised During Advisory Groups: Did not have groups today; thus, this item can’t be discussed.

5. Annual Report timeline: Postponed; of course the report is due September 30th; tomorrow should have been the 4th White Paper, but to date, the Commission has received none. This issue directly relates to the Open Minds’ performance in meeting “contract deliverables.”

6. Review of FY 2012 DDA Raw Data, Wage and Fringe Benefits Cost Reporting: Jillian held this discussion for the “closed session.”

Adjournment: Meeting adjourned.

Minutes approved July 9, 2013.