

Community Services Reimbursement Rate Commission
Mental Hygiene Administration, Catonsville, Maryland
March 12, 2013

MINUTES

Present

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

Open Minds: Rejean Carlson, Kim Todd, Rennie Joshi

DHMH Behavioral Health: Rianna Brown

MHA: Brian Hepburn, Marion Katsereles

DDA: Frank Kirkland, Gerald Skaw

Public: Herb Cromwell (CBH), Mike Drummond (Arundel Lodge), Johnson Owoyemi (NPHC), Renae Kosmido (MACS), Denise Coll (Humanim)

Proceedings

The meeting was called to order at 6:08 p.m.; the agenda and meeting minutes from January 22, 2013 were approved.

Data Collection

DDA: Open Minds reported that 139 surveys had been submitted to date out of an expected total of 145. Warning letters were sent out to 19 providers, of which 11 returned submissions, leaving eight that face penalties unless they can resolve their noncompliance issues; a warning and offer of a resolution is required by state due process requirements. The letter went to those who were missing one of the two required submissions. It is important to note, however, that DDA did not review the submissions for completeness, correctness, or data validity—they simply accepted whatever was submitted as compliance with the statute. This will put an enormous burden on the CSRRC contractor to verify submissions with providers; it also creates a barrier to obtaining “good” data because the CSRRC alone has no regulatory authority to request resubmissions. It is advisable to start the process earlier next time. Data compilation is focusing on wages and benefits for the moment.

MHA: Surveys have been received from 149 providers out of approximately 160 required to report; 137 contained salary and benefits, 127 included financials (not every agency provided both). Warning letters have been sent. Penalty letters have been sent to seven providers. Unlike DDA, MHA has assigned Jenny Howes to review the submissions upon receipt and to go back to the providers with incomplete, incorrect, or what appears to be outlier data for clarifications and, if necessary, corrected and complete resubmissions. This process ensures that the CSRRC

receives better quality data. Ms. Howes has made a significant contribution to the efficacy and timeliness of the CSRRCs data collection and analysis.

There was broad agreement about the need to get the data requests out earlier if they are going to be substantially changed in content or format.

There was general discussion about staff working multiple jobs (some within, others outside of community-based agencies); it is not uncommon to find staff working two full-time jobs when one is a residential spanning an entire weekend. Some portion of both industries is sharing the same pool of workers. Pennsylvania released information on staff work patterns and this report may have relevance for Maryland. Entities may have to limit how much people work (because more people are working so many hours); but it is difficult because many of those who volunteer for extra work are among the best and most competent and committed. This issue is important from a risk management perspective. A recommendation was made to put together a focus group among (residential) providers to look at the issue of staff work patterns.

Data Summaries and Analysis

It was decided to convene a methodology subcommittee to determine what the summaries and analyses for salary and financial data should look like. Commissioners Fuller, who has statistical research expertise, Wiens, and Aldebron will form the committee and meet with Rejean Carlson in the coming week to put together an analysis plan.

Fringe Benefit Survey

Commissioners reviewed the proposal for an online fringe benefit survey that will be sent to all MH and DD providers. The purpose of the survey is to understand more fully the role that fringe benefits play in worker compensation and staff recruitment and retention. The questions were refined based on feedback from commissioners. The survey will be sent out tomorrow by the end of the week with revisions made as agreed and a cover email that will be signed off on by the Chair. The incentive for providers to participate will be that those who do receive aggregated results of the survey so that they can determine how their fringe benefit policies measure up with the rest of the industry.

Proposed MH Cost Report

Commissioner Sizemore drafted a proposed a cost report for MH providers similar to that already required of DD providers. It is based on DBM cost categories and will facilitate not only production of a weighted average cost structure for the industry, on which rate updates are based, but will give entities an important management tool. The format is derived from the functional expense reports that are a component of provider financial statements. The cost report was provisionally approved by the CSRRC pending revisions to reflect actual DBM cost categories (to be provided by the Chair), and feedback from CBH members (Herb Cromwell agreed to distribute to his membership).

Updates from DHMH

DDA: Frank Kirkland provided the following information

- A consultant (Alvarez and Marsal) with expertise working in PA and SC on Medicaid issues has been contracted to do the DDA fiscal restructuring. A steering committee with representatives of budget, accounting, the Deputy Secretary, and DDA staff meets bi-weekly. Definition of the “as is” process will be finished by the end of May. Recommendations for restructuring are due in October.
- DDA will meet with the providers in April to get their input
- Restructuring will include an examination of the prospective payment system and potential changes. This is separate from the issue of determining rates under SIS implementation.
- Regarding the FY14 budget, providers will be receiving a 2.4% rate update

MHA: Brian Hepburn provided the following information

- Behavioral health integration will not happen before mid 2015 at the earliest because it cannot occur before MMIS claims payment implementation in January 2015. Merger of ADAA and MHA administrations will occur earlier but is not currently proceeding due to the legislative session.
- The rate increase for PCP psychiatrists, to conform with that for PCP physicians, was approved to start July 1, 2013. The intent of the increase is to incentivize primary care.
- Community based providers will get a 2.5% rate increase in FY14.
- There is an exception to continuity of care for people using mental health services going from commercial coverage to MA (it works in the other direction). Chuck Milligan is committed to ensuring coverage, but does not want to do so through regulation or statute because of the potential cost implications.

Brian provided further information on community-based mental health services:

- There are a lot of providers in Maryland but only a small number take private insurance.
- Many providers opted out of private insurance between 2000-2002 because they were adequately compensated through the PMHS and they could avoid the administrative costs of claiming reimbursement from private insurers.
- The health home concept is moving forward on the adult side for PRPs. No developments can be expected until the fall.
- More generally, acute care hospitals are feeling increasing financial pressure because of the decrease in inpatient admissions, which is expected to continue as a result of health care reform. This will drive significant changes in the way the health care system looks and how services are delivered, including more hospitals collaborating with community providers (e.g., Arundel General providing a nurse practitioner to Arundel Lodge) and setting up their own community-based clinics.

Adjournment

The meeting adjourned at 7:42 p.m.