Draft Meeting Summary
Psychiatric Services Clinical Advisory Group Meeting
Wednesday, November 6, 2019
Maryland Health Care Commission (MHCC)
4160 Patterson Avenue, Baltimore, MD 21215

Workgroup Attendees

Jeffrey Bracken (phone)
Anthony Chico, D.O. (phone)
Sarah Edwards, D.O. (phone)
Elias Shaya, M.D.
Todd Peters, M.D. (phone)
Joe Petrizzo, M.S.W. (phone)
Nancy Praglowski
Corneliu Sanda, M.D. (phone)
Steve Rainone, N.P. (phone)
Bob Wisner-Carolson, M.D.

MHCC Staff Attendees

Ose Emasealu, Program Manager, Acute Care Policy and Planning
Eileen Fleck, Chief, Acute Care Policy and Planning
Paul Parker, Director, Center for Health Care Facilities Planning and Development
Ben Steffen, Executive Director
Suellen Wideman, Assistant Attorney General

Other Attendees

Pat Cameron, MedStar Health

Eileen Fleck commenced the meeting, and members of the clinical advisory group (CAG) introduced themselves. Ms. Fleck then explained that MHCC staff are in the process of updating Certificate of Need regulations for acute psychiatric services and thought additional clinical expertise could be helpful. She explained that a Certificate of Need (CON) is required in order to establish a psychiatric unit within a general hospital or a psychiatric hospital. As part of the CON review process, the Commission considers whether a project is needed, financial feasible, cost-effective, consistent with the applicable State Health Plan chapter, and meets other criteria. Ms. Fleck also noted that CON regulations for acute psychiatric services have not been updated in over two decades. As a result, even though there is a need projection methodology for CON reviews, it is not applied.

A work group was convened by MHCC staff to facilitate updating the CON regulations for acute psychiatric services, and two members of the CAG are members of that work group too (Stephanie Knight, M.D. and Joe Petrizzo). The work group includes some clinicians, but MHCC staff concluded that it would be beneficial to have more clinical expertise and broader representation of some of the other staff that serve acute psychiatric patients. Ms. Fleck noted that

the CAG may be able to provide guidance on additional analysis that should be undertaken by MHCC as well as feedback on specific issues raised by the work group.

Ms. Fleck stated that before this meeting, MHCC staff asked for feedback on populations who need acute psychiatric services that are difficult to serve. Some types of patients were already identified by the work group, and MHCC staff asked about additional types of patients that may be difficult to serve, either placing them for treatment or discharging after treatment. Ms. Fleck next explained that the tables in the handout include additional information and analysis of some of the types of patients identified by CAG members and work group members. Table 1 has the breakdown by categories of primary psychiatric diagnoses over time. The categories are based on the ICD-9 coding system and mapping the corresponding ICD-10 codes to these categories, in order to keep the number of categories manageable.

Ms. Fleck noted that boarding in emergency departments is a concern that has been raised, and this is seen as an indication that acute psychiatric bed capacity is lacking. Ms. Fleck then explained the way that data is captured by the Health Services Cost Review Commission (HSCRC) for administrative purposes. If a patient has an emergency department visit that does not result in admission or that results in admission to a different hospital than the one where the initial ED visit occurred, then the ED visit is captured in the HSCRC outpatient data set. When a patient has an ED visit and is admitted to the same hospital, then the visit is captured in the HSCRC discharge abstract data, as part of the same record for the inpatient admission. MHCC staff relied on the HSCRC data sets for its analysis of acute psychiatric service utilization in Maryland hospitals.

Ms. Fleck explained that Table 2 includes the estimated time that psychiatric patients spent in emergency departments over time. Table 2 shows that it is a relatively small number of patients who are boarding over 20 days, but it is still concerning that any patients are boarding for that period of time. The number of patients with longer boarding times has increased over time. For example, she noted that the number of ED visits with an estimated boarding time of four to eight days increased from 139 in 2010 to 870 in 2018. Ms. Fleck also clarified that the data in Table 2 is for patients who are not admitted to a hospital or admitted to a different hospital. The estimated boarding times for psychiatric patients admitted to the same hospital from an ED is not captured in the HSCRC discharge abstract data. Ms. Fleck estimated that 75% of psychiatric ED visits are captured in Table 2. The next set of tables shows the same type of information for specific age groups (children, adolescents, and adults). Ms. Fleck quickly reviewed these tables and noted that the same trend appears across these age groups, with more psychiatric patients having longer boarding times over the period calendar year 2010 through calendar year 2018.

In Table 6, the trends in the volume of psychiatric ED visits that resulted in admission and length of stay are shown. Elias Shaya, M.D. asked for clarification on Table 6, specifically whether the length of stay reflected time boarding in an ED. Ms. Fleck responded that the length of stay information in Table 6 refers to time in the hospital as an admitted patient. Dr. Shaya asked if there information on the length of stay in an ED apart from the length of the hospital stay. Ms. Fleck explained that the information is available for patients who are not admitted to the same hospital where they initially showed up in the ED. Ms. Fleck estimated that about 75% of psychiatric patients who are admitted to a hospital are admitted to different hospitals than the

hospitals for their initial ED visits. This may occur because a hospital does not have acute psychiatric services or because a bed is not available.

Bob Wisner-Carlson, M.D. commented that a lack of capability and not just capacity is an issue. Some patients need a specialized psychiatric program. He runs the inpatient adult neuropsychiatry unit that is primarily for patients with severe intellectual disabilities and autism. The patients may wait days or weeks in emergency departments until space is available in his program.

Ms. Fleck noted that work group members had mentioned that placing psychiatric patients with intellectual disabilities and autism is a concern. For this reason, MHCC staff created some tables with statistics for this population, including estimated boarding times in EDs and length of stay in hospitals. Dr. Carlson noted that discharge delays are part of the problem because patients need to then get into residential services following discharge, and these services are usually funded by the Maryland Department for Developmental Disabilities. He noted that there are also problems with discharging children who have developmental disabilities because multiple agencies are involved, including education boards.

Ms. Fleck noted that another person from Sheppard Pratt Health System contacted her prior to the meeting and mentioned the same issue. She followed up with the Maryland Developmental Disabilities Administration, and it mentioned working together with Sheppard Pratt to try and address the problem for adults.

Dr. Carlson commented that for families of children with developmental disabilities and an acute psychiatric problem it is very challenging to get the right care. A family may be forced to keep their child in an emergency department in order to maintain their child's priority position for a specialized bed, even though it is a challenging environment. MHCC staff responded that the same concern has previously been raised by others. Ms. Fleck asked for feedback on how to address the issue. She asked whether emergency departments should be designed differently to accommodate those particular patients.

Ben Steffen commented that MHCC is limited in what in can do to address some aspects of the problem. Mr. Steffen noted that operational concerns have been raised that are not within the scope of MHCC's authority. MHCC regulates the establishment of services. He asked what can be done in terms of MHCC's regulations and planning for those acute psychiatric patients with developmental disabilities. Nancy Praglowski commented that Johns Hopkins Hospital does not have beds for that population. Sheppard Pratt has 12 beds for this population, and those are the only beds for them in the State.

Dr. Carlson commented that Maryland is unique in having a neurodevelopmental unit available. There are very few in the country. There is an opportunity for Maryland to be a leader for serving those with autism and developmental disabilities. Todd Peters, M.D. agreed with Dr. Carlson. There are only seven or eight programs in the country, and Maryland has two programs. However, he also noted that other programs have better reimbursement for the costs. There may be children with staffing that is a two to one ratio. There is also specialized equipment and training. There needs to be more recognition of the costs. Often patients can be stabilized within a couple

of weeks or months, but the average length of stay is longer because of discharge barriers when patients will not be returning home. Often multiple agencies have to coordinate their efforts, and the waiting can result in decompensation of patients.

Dr. Carlson commented that keeping patients boarded in an ED is not consistent with Maryland statute. A patient may be non-verbal and have a guardian and have to be involuntary patients. These patients may have spent an excessive amount of time in an ED, and then may be released on technicalities by a judge, even though it is not consistent with what the family wants. Dr. Shaya commented that because of how challenging the process is, a patient may be kept several days in an emergency department which results in further deterioration of the patient's condition. It is a disservice to the population. Ms. Fleck asked if the technical violations can be addressed or is the law written in a way that is necessary to cover a broad range of patients and changing the law is not part of the solution. Dr. Carlson responded that he wants the Commission to be educated about the severity of the problem and how it hits many different areas, as solutions are considered.

Ms. Praglowski explained that being boarded in an ED means sitting in a small empty room for days without anything to do. Mr. Steffen asked about moving patients to observation space instead. Dr. Shaya explained that observation space is more of a status for patients and not a dedicated physical space. There is not another safe space for the psychiatric patients who are boarding in an ED to wait.

Anthony Chico, M.D. commented that once a patient is not seen as an emergency patient, then it becomes less urgent to get them into a psychiatric bed. Ms. Fleck asked for feedback on how the Commission can be part of the solution. Should there be another neurobehavioral unit for children, even though it seems like it is not financially appealing and discharge barriers often exist. Ms. Praglowski responded that both more acute care beds and long term care beds for children and adults would be helpful. Ms. Fleck asked for clarification on the long term care setting referenced. Ms. Praglowski stated that usually patients are released to residential treatment facilities. There are few in the state of Maryland though.

Dr. Peters commented that preventative measure should be taken, especially for those patients that do not qualify for Medicare or Medicaid. Private insurance often may not cover some services that would be very helpful. There need to be wrap around services to allow physicians to feel comfortable releasing some patients. Having more of those services available regardless of insurance coverage would be helpful. Mr. Steffen asked what wrap around services are essential.

Dr. Peters noted that Maryland has 14 non-public school settings that often cater to autism specter disorders. Those services really help. Without them, problem would be much worse. Many children might be hospitalized regularly without those program. Other services that would helpful are day hospital services. Some of those services are provided in schools, but for those people over age 21, it would be helpful to have more high fidelity programs that are not just day care or a respite provider. Applied behavioral analysis (ABA) services may be helpful, especially in-home ABA services. Getting out of the house can be hard for families. Telepsychiatry services would be helpful, but regulations are prohibitive in Maryland. Other states have revised their regulations to allow for more telepsychiatry.

Dr. Chico agreed with Dr. Peters. If there were more options for a back door, then inpatient hospitalization may be avoided. Often focus on symptoms. If day programs were available, that would be helpful. Sarah Edwards, D.O. commented that she strongly agreed with the importance of telepsychiatry as a tool to address the needs of both children and adults. Using innovative technology would help to reduce ED visits.

Dr. Edwards asked if a representative from the Kennedy Krieger Institute (KKI) was a part of the meeting, and staff responded that it was not represented at the meeting. Dr. Edwards emphasized that KKI plays an important role in the region that should be included. She mentioned that some states have specific crisis programs for individuals with neurodevelopmental conditions. There is a program called START, which is intended to reduce the need for emergency departments for individuals with developmental disabilities. If there was an opportunity to partner with KKI and State funding for an initiative that would be significant. Dr. Wisner-Carlson noted that the Maryland Developmental Disabilities Administration and Bernie Simons, Deputy Secretary for the Administration, already have a contract with START. A pilot project is planned in the Southern Region that will cover Montgomery County and Prince George's County. He also agreed with other comments; more flexibility for other services provided to those with developmental disabilities would be very helpful.

Mr. Steffen asked if limitations on telepsychiatry are in the COMAR regulations for Medicaid. Dr. Peters confirm that is correct. The regulations only allow for point of service brick and morter. He mentioned that New York relaxed its regulations to allow for telepsychiatry. Issues may fester that otherwise could be addressed more quickly.

Dr. Chico commented that when Rosewood closed many patients went to small unstructured group homes. Staff at group homes cannot provide medication periodically, as-needed basis. Staff cannot do any hands on de-escalation. State should consider that training and those requirements. Staff seem unaware of what they can do and how they can help. Dr. Wisner-Carlson agreed with Dr. Peters. Ms. Fleck commented that she spoke with staff at Maryland Developmental Disabilities Administration and asked about staff training. The Developmental Disabilities Administration indicated that training is adequate. There seemed to be a disconnect between its perception of staff training at group homes and the perception of physicians who treat psychiatric patients with developmental disabilities in hospitals.

Dr. Wisner-Carlson noted that the regulations are intended to protect the rights of individuals. He said that family could administer medication as needed, but staff for group homes cannot administer medication as needed, so the only alternative is an emergency room. It is a level of complication that may be beyond that charge of the CAG, but it highlights the complexity of the issue, and it becomes very cumbersome for EDs. Ms. Fleck asked if a clinician could come to the group home to administer medication, instead of a taking an individual to an ED. Dr. Peters commented that it is too late at that point. A patient may try to run out of a group home. He also added that it would be helpful to have more tools to de-escalate a situation instead of needing to go to a crisis center.

Ms. Fleck asked if it would be beneficial to change the configuration of an ED to better meet the needs of psychiatric patients with a developmental disability. Dr. Shaya responded that

each hospital can decide, but it could put them at risk for not meeting certain requirements. Dr. Shaya also pointed out that the problems for the population of patients with a developmental disability are problems that other populations face as well. He suggested that it would be helpful to have tables for the population over age 60 with psychiatric issues that show estimated boarding times and lengths of stay for hospital admissions.

Dr. Shaya asked for more description on what is within the Commission's control. Mr. Steffen asked Paul Parker to review the services that are subject to CON regulations. Mr. Parker stated that psychiatric hospitals, psychiatric units at general hospitals, bed capacity, and residential treatment centers. Outpatient programs for behavioral health are not regulated. Sometimes a hospital may be developing a range of psychiatric services and facilities, including acute psychiatric services. The whole project is reviewed, even though only acute psychiatric services may be subject to CON review. Mr. Parker also noted that intermediate care facilities, which are for drug treatment, are subject to CON regulations.

Dr. Shaya asked if post acute hospitals are subject to CON regulations. He asked specifically about Levindale Hospital, as an example. Mr. Parker responded that Levindale has three separate licenses for services that are all subject to CON regulations. It has a chronic unit, a rehabilitation unit, and a nursing home (comprehensive care facility). Establishing any of those special facilities requires a CON. Dr. Shaya asked about whether intensive day programs are subject to CON regulations. Mr. Parker responded that those services are not subject to CON regulations. The program would only be reviewed if it was part of a larger project that is subject to CON regulations.

Ms. Fleck commented that it would be helpful to have feedback on how the need for acute psychiatric services should be evaluated. She asked, what the signs are that there is a need for a service or a particular population; should the State encourage the development of programs for a particular population; and is there data that should be collected that would be helpful to evaluate the need for acute psychiatric services. For example, she asked whether capturing the intensity of staffing would be valuable. Although MHCC does not control rates for psychiatric services, it could potentially highlight an issue, like a lack of financial reimbursement, and make recommendations to the HSCRC.

Dr. Shaya commented that for non-psychiatric hospital patients, there are more levels of care with different staffing requirements. For psychiatry, it is one rate. It would be helpful to have recognition in the rates with stratification for the intensity of resources required. It would better reflect the reality and create greater parity among services. Dr. Peters agreed with Dr. Shaya's point. There needs to be rate reimbursement commiserate with the level of care. He also suggested that more geriatric psychiatric beds could be helpful and identified this population as one that requires greater resources. Mr. Steffen asked if anyone was aware of a state that has tried to tackle offering different levels of reimbursement for psychiatric patients. No one knew of another state tackling this issue.

Ms. Fleck commented that the lack of recognition of the intensity of resources required for some patients has previously been raised. She noted that often MHCC staff evaluates the occupancy rates for psychiatric beds to determine if there is a need for more beds. Very high

occupancy rates may be an indication that more psychiatric beds are needed. She noted that occupancy rates are not currently extremely high, despite reported problems with a lack of beds and boarding of patients. MHCC staff was told that for semi-private rooms with two beds, it may only be possible to have only one patient in the room, due to the level of staffing required. If that is the case, then occupancy rates may not be a good indicator of need.

Dr. Peters commented that everyone to some extent may be treating psychiatric patients with developmental disabilities. Everyone to some extent works with children and adults who are psychiatric patients with developmental disabilities. He noted that treating this population can result in less efficient use of resources, if there is not a program in place for them, which can then impact the resources available for other patients. Ms. Fleck mentioned that the idea of encouraging more private rooms came up. Dr. Shaya responded that it is both rooms and staffing. If there is two to one staffing, which may be required occasionally or even three staff members, then fewer patients may be accepted to a psychiatric unit. Ms. Fleck responded that she understood, but she wanted to know if encouraging the development of more private rooms would be helpful. Dr. Shaya responded that it would be helpful.

Dr. Shaya stated that another challenge is patients who are not helped by treatment. The result may be prolonged time in an acute psychiatric bed for two or three months. Ideally, these patients would be in a long term facility, but State beds are not available anymore. There should be a better solution. Ms. Fleck asked if there is a way to identify those patients specifically. She noted that there is a code for homelessness, but other subpopulations of psychiatric patients may be harder to identify.

Dr. Shaya stated that the patient population that may need a long term care facility are those with severe psychoses that have not been helped by treatment in the hospital or who have not been adherent to medication treatment. Many of those patients wind up back on the streets. There is not a good alternative. The patients are too dysfunctional, and the process for getting guardianship and civil commitment cannot be carried out. These patients are often then discharged with a relatively safe plan, but not a good plan. State hospital beds are not available. We need to recognize that for the small percentage of patients who are not helped by treatment in an acute hospital setting, it may be more appropriate to place the patient in a long term facility.

Ms. Fleck asked whether more specialized programs are needed and whether a critical number of patients is needed for them or whether spreading the burden around makes sense and raising expectations for staff, in terms of their ability to treat a range of patients. Dr. Wisner-Carlson commented that it would be better to concentrate patients. If staff has the skills for handling patients with developmental disabilities, then the time that it takes to stabilize a patient may be much quicker. Dr. Chico commented that sometimes there is too much emphasis on getting into a specialized unit, when one is not needed or it is preferable to have treatment sooner rather than boarding in an ED. Mr. Steffen suggested that it may be more equitable to spread high cost patients among hospitals, if the HSCRC rates do not account for the full range of costs for treating some patients.

Dr. Shaya commented that the way patients are handled who are not responding to treatments is to increase the staffing ratio in order to keep all patients safe. It may be more efficient

to have all units to have some baseline ability to respond to high intensity needs for some patients, similar to the expectations for medical surgical units.

Ms. Fleck asked whether travel time should be a consideration in defining reasonable access to acute psychiatric services. She noted that it could be a different standard for different age groups. Dr. Wisner-Carlson commented that his program gets inquiries from all over the state and many would come from outside the state, if they had the opportunity. Dr. Shaya commented that facilitating access for families and community based providers would be helpful. Ms. Fleck explained that sometimes travel outside of a health planning region is regarded as an indication of a lack of access. She asked for feedback on what the criteria should be for adequate access.

Dr. Peters commented that there are behavioral health 'deserts' outside of the Baltimore and District of Columbia regions, such as on the Eastern Shore and out on the panhandle. Although the focus of MHCC is on the acute level of psychiatric care, having more services along the continuum of care would help with inpatient diversion and better utilization of acute psychiatric beds. It will continue to be hard to assess the number of beds needed, until better use is made of the existing beds. Both are needed, but helping the throughput is important. Dr. Shaya pointed out that in Table 9, the percentage of patients with a developmental disability that stayed over 20 days was 2.3% in 2010 compared to six percent in 2018. He also noted that the number of psychiatric patients admitted who are homeless doubled between 2010 and 2018. Clearly, there has been a change over time.

Dr. Wisner-Carlson commented that the units at Sheppard Pratt are for those with autism and extreme challenges due to a developmental disability. He noted that the autism codes do not capture very well those with severe problems. The more severe group really needs specialty services. It is hard to imagine putting another program in other parts of the State if there was not a real financial commitment to it. He mentioned that he is board certified psychiatrist and board certified neuropsychiatrist. There are few of the latter in the country. He specializes in developmental neuropsychiatry. He seemed skeptical about putting a unit on the Eastern Shore for those with the most severe problem, but he agreed that better access to services for those with less severe problems makes sense.

Ms. Praglowski commented that when children are in an emergency department waiting for a psychiatric bed, the family does not want to go more than ten miles away and would prefer to wait. Sometimes this has to do with transportation concerns, time away from work, and the ability to be part of the treatment team. Ms. Fleck commented that she understood the family preferences, and she asked how often that situation arises. She also asked for feedback on solutions. Ms. Praglowski commented that it often arises, and a family would rather wait a day instead of going to a hospital in the District of Columbia.

Dr. Shaya noted that acute psychiatric services are not that different from other kinds of medical services, like bone marrow transplants and heart surgery. These services are not available in every hospital and not every hospital needs to provide those services. The majority of patients, they can be served in community hospitals, but for those who need highly specialized services the right balance is needed. Ms. Fleck asked if there is a way to define the need. She noted how challenging it is to address that when access to other services on the continuum affect the need for

acute psychiatric services, and access to some of those other services may not improve, even if a need has been identified.

Dr. Shaya suggested that a pragmatic approach be taken. The focus should be on what MHCC can do, and the goal should be to take one step forward. It would be better not to be overly ambitious and try to improve the system just a little bit. In his view, a graduated reimbursement rate could help improve capacity and improve care.

Ms. Fleck noted that the HSCRC discharge data has a field for capturing one-on-one staffing, but HSCRC does not do anything with the information, and the field is often blank. However, if it is important to capture that information and use it, then maybe there needs to be a change. She also noted that the existing fields may be inadequate, if sometimes staffing must be even higher, at two to one or three to one.

Dr. Shaya commented that every unit in a hospital has a budget and must be mindful of it. The psychiatric unit tries to do the best for patients, but that can mean that a patient is left waiting in an emergency room because the acuity on the unit is too high to accept another patient. Dr. Peters commented that even if staffing is not specifically two to one for a given patient, the staffing on the unit may be higher due to patient acuity. Even if nurse staffing is not high for patients, routine additional staffing may be required for certain programs.

Dr. Peters commented that better compensation for care will be helpful, but it should not just be based on nursing staff. Ms. Fleck responded that she expects that it may be easier to account for costs for a psychiatric hospital as compared to a psychiatric unit within an acute care general hospital which has a global budget that covers multiple types of hospital services.

Mr. Steffen commented that MHCC has been a participant in multiple meetings of different bodies, and the boarding issue has been raised in all of them. He asked about tracking of ED boarding and whether hospitals compare themselves to each other. Mr. Steffen commented that people wanting to be close to home makes sense, but in some cases, it seems like families will only accept placement is one hospital and do not want to leave ED until that hospital has an opening. He asked about how much education is done for families to discourage that approach. Dr. Shaya agreed that education should be done. However, he noted that apart from that issue, there is boarding and will continue to be boarding.

Dr. Shaya then also commented that he did not think it was common for boarding to occur because a family only wanted to go to Sheppard Pratt Hospital. Dr. Wisner-Carlson commented that his perspective is skewed, but based on his perspective, it happens all the time. Families recognize specialty care is needed. Dr. Shaya clarified that he had in mind patients with less specialized needs and did not think those patients spent excessive time boarding because of family preferences for a specific hospital. Dr. Chico commented that they do not let families board in the ED due to hospital preferences. Families are informed upfront and asked to sign a form. Unless there is a specific reason that specialized care is need, patients cannot board due to a hospital preference. Dr. Chico also commented that boarding times have doubled in the past five years.

Joe Petrizzo commented that parents' preferences do not dictate where children and adolescent go for acute psychiatric treatment. However, for patients with a developmental disability, when the hospital tries to get the patient into a psychiatric unit at another hospital, the hospital is told that the other hospital cannot treat the patient, and then the patient may be boarded for several weeks until placement at Sheppard Pratt Hospital is possible. Dr. Chico commented that is also what happens at Greater Baltimore Medical Center. Mr. Petrizzo commented that the focus is on finding a bed and patients will be sent anywhere in the region where one can be found. Mr. Steffen commented that at other meetings concerns have been raised by some families about the placement options presented.

Mr. Steffen returned to the topic of telehealth. He asked what should be done to make the diffusion of telepsychiatry more effective. Although it is not a CON issue, MHCC has some credibility on it. Dr. Shaya commented that revising the regulations, as proposed earlier in the meeting would be helpful. Dr. Shaya also commented that there is data validating the benefits of telepsychiatry in North Carolina. Dr. Peters agreed that data supports the use of telepsychiatry. He noted that he works on the Committee of Telepsychiatry for the American Academy of Child and Adolescent Psychiatry. The data shows that treatment through telepsychiatry is just as good as psychiatry services provided in-person. States that have revised their regulations have benefited from those changes. Dr. Peters offered to provide more data if it would be helpful. Mr. Steffen responded that MHCC staff would reach out directly for it.

Ms. Fleck asked if anyone had any final comments. No one did. Ms. Fleck mentioned that a tentative meeting was scheduled for November 20, 2019 at 1:00 p.m. Dr. Shaya suggested synthesizing the discussion and having action plan for this meeting. Ms. Fleck asked if the date and time would be acceptable for CAG members. No one objected. Mr. Steffen asked if anyone remembered when HSCRC last reviewed facility reimbursement for behavioral health services, but no one did. Mr. Steffen indicated that he would reach out to HSCRC directly to find out. Ms. Fleck let everyone know that the meeting had been recorded and she would be providing a detailed meeting summary.