

**Meeting Minutes of  
The Governor's Council on Behavioral Health  
1:00 P.M., Tuesday, April 11, 2006**

The Governor's Council on Behavioral Health met at 1:00 p.m. on Tuesday, April 11, 2006, in Barry Hall's Conference Room 126, 14 Harrington Road, Cranston, Rhode Island.

Members Present: Neil Corkery, Acting Chair; Carrie Blake; Sandra DelSesto; Mitch Henderson, Joseph Le, Peter Mendoza, and H. Reed Cosper.

Ex-Officio Carol Fox, DCYF; John Young, DHS; Craig Stenning and Gene Nadeau, MHRH;  
Members Present: and Denise Achin, Department of Education.

Guests: Jill Beckwith, Rhode Island Kids Count; and Karen Smashe.

Staff: Corinna Roy, Charles Williams and Mary Ann Nassa.

The Acting Chair, Neil Corkery, called the meeting to order at 1:05 p.m. After introductions were conducted, Neil entertained a motion to accept the Minutes of March 9, 2006. Gene Nadeau motioned to accept and Carrie Blake seconded the motion. All were in favor, and the minutes were approved as written.

Neil Corkery introduced John Young in his role as Medicaid Director of Health and Human Services (DHS) who distributed the presentation, *Health Care Delivery System Options for Adults with Disabilities in Medicaid (See Attachment I)*. John Young stated that the Department of Human Services is the Medicaid agency for the State of Rhode Island and RIte Care. John stated that there has been a lot of discussion over the last ten years about managed care as a service delivery vehicle and what it does for budgets. He stated that while a great deal of attention has been placed on expenditures for RIte Care, the largest area of spending growth has been within a relatively small population of adults with disabilities. Further, it has been for those people who are eligible for Medicaid only, which typically is a temporary condition. Most adults served by Medicaid in Rhode Island, with the exception of those who are eligible only under RIte Care, are dually eligible for Medicare. As a result, most of the treatment expenses are borne by Medicare, and Medicaid becomes a wrap-around coverage for co-payments and deductibles and for treatment and for services that Medicare doesn't offer. Historically it has covered nursing facilities, home and community-based supports, and pharmaceuticals.

John reviewed the distributed material. The first slide described a breakdown of people with disabilities and the elderly. Two-thirds, 61 percent, of them are dual eligible and about a third, 30 percent, of them are Medicaid only eligible. John stated that last year the General Assembly sent a directive that authorized and directed the development of a system of "managed care" for adults with a disability who are not eligible for Medicare. The purpose of that system was to ensure that those adults had access to quality and affordable health care. It was intended to integrate an efficient financing mechanism with quality service delivery; provide a "medical home," which is a term used in healthcare to assure appropriate care and deter unnecessary, inappropriate care; and to emphasize prevention and primary care. John stated that about four years ago RIte Care enrolled foster children and now offers it as an option to families who have children with special health care needs. He stated that those efforts have been reasonably successful and he is particularly happy with the special needs children enrollment because it was offered on a voluntary basis and has been taken up by about 80 percent of the people who are eligible.

John stated that a 100-page proposal will be available on the DHS website by the end of this week for everyone's review. DHS is proposing two delivery system options. The first is a Comprehensive Health Plan similar to Blue Chip or United or NHP. The State specifies its expectations for this comprehensive health plan, and that is what gets delivered. Therefore, it is not a conventional and commercial product because most commercial plans would not feature either the types of benefits or the level of benefits that need to be brought to bear for this population. The second option is called Connect CARRE Choice which is a primary care nurse/case management model. The current delivery system for all adults with disabilities in Rhode Island, as it exists today, is Fee-for-Service which pays for all of the conventional medical supports as well as paying for community supports. There are two options that exist today. The first is a small disease management program called Connect Care which has approximately 200 people enrolled; it is a very intensive nurse/case manager model. It has been tremendously effective in moving people to more appropriate levels of care in a more natural manner. As of the first of this year, there is a fully managed and integrated care model for the elderly called PACE which is a Program of All-inclusive Care for the Elderly. It is small and it consolidates all of the medical and long-term care supports in Medicaid and all of the medical supports in Medicare. It is the only model of integrated Medicare/Medicaid managed care that CMS recognizes. It is a model that serves at-risk individuals and at last count there were 19 members enrolled.

John stated that community supports are something that are intended to be included in this planning because one of the challenges is not so much how to better manage medical care, but how to connect the medical model to the system of community supports that is just as necessary to keep folks where they need to be. Community Supports are Medicaid-covered services or "waiver" services that allow people to continue living in the community. Some examples of community supports are: case management, respite care, homemaker services to keep individuals out of nursing facilities or other institutional settings, environmental modifications, and special medical equipment.

John stated once again that this general population is the highest driver of expenditure growth, which had an 8 percent increase in expenditures per person from 2003 to 2004. This is largely because the choices available to people in the system are not good, so they are going where they can receive care, which, unfortunately, is always in the most expensive and most acute setting. There has been some positive experience with Connect CARRE and RIte Care for children with special health care needs demonstrating that managed care can improve quality and access and achieve savings. This group is comprised of about 15,000 people and their needs have been examined for a couple of years.

John reported that in 2002 a focus study was conducted regarding adults with disabilities and unmet health care needs and the following issues were identified: oral health, vision service (eyeglasses), mental health/behavioral health services, information and education on health conditions, physical and occupational therapy, peer support and guidance and service coordination.

John stated that discussions have been held with consumers, providers of all types, advocacy groups, and State agencies, with the greatest challenge being to engage this population. A series of community forums were held that were advertised and not many people came who had disability and there were not that many people that had connections with persons with disability that came to any of the meetings.

John believes that there is an isolated group of people for whom engagement is going to be a challenge, and suggests that this is something to be considered as the final design to implementation process approaches. He explained that the option being considered is a phased-in approach consisting

of three phases over 2006. July would be Phase 1, Program Development and Planning. John stated that there are approximately 150 children a year who are enrolled in RItE Care and by old rules age out by age 21 but are still eligible for Medicaid. Previously these children have been disenrolled into a disorganized system; and when enrolled in an organized system, they were content with continuing to have that option. When RItE Care was started, it was agreed that disabled members of RItE Care households would not be enrolled in the health plan. There are approximately 400 parents of RItE Care households that have not been allowed that opportunity and that will change in Phase 2. People will now be afforded an opportunity to make a choice about how their health care is delivered.

John stated that it is necessary to think about how to implement two things that don't exist: The first is a comprehensive health plan model (not an off-the-shelf product) for people with disabilities that address their needs. The second is Connect CARRE Plus. John recalled that ten years ago there was RICover which was an effort to integrate behavioral health and primary care by forging a partnership between the primary care community centers and the mental health centers. That is one version of how Connect CARRE Plus could roll out. He reported that there are several discussions going on right now in the community between primary and behavioral healthcare providers. The Providence Center and Providence Ambulatory Health are looking at partnering to meet the needs of clients by offering holistic care management. The Allied Advocacy Group has been encouraging private primary care sites to integrate services with behavioral health. John stated that this is largely a budget-neutral kind of proposal, which typically troubles people because of how that will play out with the distribution of limited resources.

John explained that there is a population of 15,000 people who are not eligible for RItE Care, not eligible for Medicare and not eligible for commercial insurance, these people account for all of the fee-for-service hospital expenditures of over one hundred billion dollars. John stated that it is not hard to imagine how some of that service use can be diverted to a more natural setting, more primary care without reducing the quality of services. John stated that for that hospital experience, about 25 percent of the admissions had a diagnostic reference that was behavioral on either the primary or secondary level. Therefore, it is the decision not to provide services to people who have depression and anxiety and perhaps some other issues that have not risen to the standard of being severely and persistently mentally ill that causes this fairly large expenditure.

There was discussion regarding the specifics about the different needs of the individuals within the population being described above. John stated that what they are eligible for and what they access is the problem. He stated that most of the people who come through this system will become Medicare eligible. A portion of the 15,000 may be permanently eligible, but not all. John stated that within this population there are clusters of folks that have very disparate needs and there is no insurance coverage that will meet all of their needs. Therefore, it must be clear that that level of difference be accommodated by providing more than one option, and these options must be sensitive to the balance of services individuals are getting through Medicaid.

Reed Cospers stated that he is troubled that the 15,000 includes the segment of mentally ill people within the system who are not contributing at all to the problem. Reed suggested that the people on Medicaid and the people within the mental health system who are not part of the problem should not be enrolled in this program.

John stated that when you look at Connect CARRE, which is a small program, a good percent of those people have intersection with the community mental health system. Connect CARRE is not meant to replace that, it is meant to augment it. John stated that the problem with the community mental health center case management system is that while it is competent to refer and order mental health services, it can't do anything about medical services.

Reed reported that everybody in the mental health system has case management that connects them to primary care. John stated that the only actionable option in Medicaid to date is to go to the emergency department, which is the most expensive way to receive the care of a physician. John stated that the Connect CARRE case managers can work with the community mental health center case managers and produce a better overall result because they can order different services.

### **UPDATE ON STATEWIDE NEEDS ASSESSMENT FOR STRATEGIC PLAN**

Corinna Roy distributed information *Rhode Island Foundation (See Attachment II)* reporting that she has spoken with Claude Elliott of The Rhode Island Foundation regarding funding available for this project. Corinna stated that it is necessary to have a letter of intent/application packet in by May 1 to qualify for the annual strategy grants that would be distributed some time in December 2007.

Neil Corkery requested a motion for the Council to work with Corinna in submitting the letter of intent. Gene Nadeau motioned to submit the letter of intent and Carrie Blake seconded the motion. All were in favor. The motion was so moved.

### **ANNUAL REPORT TO THE GOVERNOR**

Corinna distributed the Annual Report to the Governor which was included with the Minutes of March 9. Corinna reviewed the report which is part of the Council's statutory requirements and describes what the Council has been doing.

### **BLOCK GRANT AMENDMENT**

Corinna stated that this amendment was included with the Minutes of March 9. Corinna reported that the overall block grant funding decreased by approximately 1.1 percent and for Rhode Island it was 2.6 percent, more than double the average. If the difference in funding to a State is 1 percent or more, either plus or minus, SAMHSA requires the State to submit an amendment to the block grant application. Corinna stated that this should only have implications on the fiscal outcome targets which have been revised. In terms of the other impacts that it would have on services, this is an ongoing struggle, but it will not affect any specific targets that could be identified.

### **OLD/NEW BUSINESS**

Corinna distributed a *letter written to Governor from the Council (See Attachment III)* requesting him to advocate to rescind the proposed budget cuts. Neil Corkery requested a motion be made to ratify the letter that was sent to the Governor. Reed Cosper made motion to ratify and Peter Mendoza seconded the motion. All were in favor and the motion was accepted.

Corinna also requested volunteers or nominations for the National Association of Mental Health Planning and Advisory Councils (NAMHPAC) who are looking for new members. Corinna requested that if anyone is interested in nominating someone who is on the planning council, to please submit the 2006 Nomination Form which she distributed by April 21, 2006 to the Nominating Committee c/o Stephanie Townsend, NAMHPACE, 2001 N. Beauregard Street, 12<sup>th</sup> Floor, Alexandria, VA 22311 or Fax it to (703) 684-5968.

Charles Williams reported that Jim McNulty resigned to take another position and his last day is officially Friday, April 14<sup>th</sup>. Charles stated that his position will be filled but there is presently no candidate.

Neil Corkery requested that a motion be made to thank Jim McNulty for his contribution not only to this Council but also to mental health advocacy in the State for many years. Gene Nadeau motioned for the above and Carrie Blake seconded the motion. All were in favor to send a letter thanking Jim for all his contributions.

**ADJOURNMENT AND NEXT MEETING**

There was no further business. Upon motion made and seconded, the meeting adjourned at 2:15 p.m. The next meeting of the Council is scheduled for **Thursday, May 11 at 8:30 a.m. in the first floor Conference Room 126 at the Barry Hall Building.**

Minutes respectfully recorded and written by:

Mary Ann Nassa  
Secretary, Governor's Council on Behavioral Health

***Attachment I: Health Care Delivery System Options for Adults with Disabilities in Medicaid***

***Attachment II: Rhode Island Foundation***

***Attachment III: Letter to Governor from the Council***