

**Meeting Minutes of
The Governor's Council on Behavioral Health
8:30 A.M., Thursday, February 7, 2008**

The Governor's Council on Behavioral Health met at 8:30 p.m. on Thursday, February 7, 2008, in Barry Hall's Conference Room 126, 14 Harrington Road, Cranston, Rhode Island.

Members Present: Richard Leclerc, Chair; Kai Cameron; Leo Cronan; Stephanie Culhane; Sandra DelSesto; Scotti DiDonato; Mark Fields; James Gillen; Chaz Gross; Karen Kanatzar; Peter Mendoza; Anne Mulready; Noreen Shawcross; Reed Cosper; and Elizabeth Earls.

Ex-Officio

Members Present: Gene Nadeau and Lou Cerbo, Department of Mental Health, Retardation and Hospitals (MHRH); Janet Anderson, Sandy Woods, and Winsome Stone, and Linda Essex, Department of Children, Youth and Families (DCYF); Mary Ann Ciano, Department of Elderly Affairs (DEA); Craig Stenning and John Young, Department of Human Services (DHS).

Staff: Charles Williams, Mary Ann Nassa, and Elena Nicolella.

Guests: Vivian Weisman; Greg Graustein and Brooke Pastore Still of Reckitt Benckiser.

Once a quorum was established, the Chair, Richard Leclerc, called the meeting to order at 8:35 a.m. Richard entertained a motion to accept the Minutes of January 8, 2008. Peter Mendoza motioned to approve the minutes, and Scotti DiDonato seconded the motion. All were in favor, and the minutes were approved as written and submitted.

MEDICAID RULE ON TARGETED CASE MANGEMENT

Richard Leclerc introduced John Young, Director of Medicaid for the State of Rhode Island. John stated that on December 4, 2007, the Center for Mental Health Services (CMS) issued an interim final rule which differs from their normal rule-making process. The normal rule-making process sets forth their original thinking as to the content of the rule, solicits comments and input, takes those comments and input into account and then issues the rule in final form, usually months later. An interim final rule which was issued on December 4th becomes final on March 3, 2008. Therefore, while they are willing to take comment and input, they are suggesting that the rule as issued is final. The foundation for the rule is Section 6052 of the Deficit Reduction Act which states, among other things, that the use of Medicaid funding for case management will be significantly curtailed in a number of different ways. It sets forth in regulation a significantly narrower definition of case management. It further states that Medicaid funding may not be used to pay for case management activities that are the *intrinsic element* of another public program whether it is funded by that program or not; specifically, but not limited to child welfare, probation, and behavioral health. They further say that there can be one and only one case manager for any recipient. John stated that CMS favors the case managers who are employees of the single state agency responsible for the administration of Medicaid. He emphasized that this is a significant change in policy in Rhode Island since about 1987 where there was a great move to look at Medicaid as a funder to relieve the pressure from constraining programs. This is a reversal of policy and ignores hundreds of state plan amendments that have been approved, hundreds of waivers that have been approved and indicates that all will change by March 3, 2008. It sets a different bar as to what can be billed to Medicaid as a case management activity. In addition, it states that if you define yourself as being appropriately inside the rule, there is a new and abundant level of documentation required. He stated that case management must be billed in 15-minute increments. There also must be references and cross

references to treatment plans, progress notes, etc. and these are not requirements that have ever previously been set forth.

John stated that in his opinion there is true case management and there are things that have been written off to case management. He thinks that in the past things have been written off to case management because it was the simplest way to record the activity. Those practices need to be looked at, and we need to retrain how we prepare and maintain documentation and how we think about what activities we are using to support the activity.

John stated that CMS is not sure how they will enforce this other than specifically looking for this type of activity in State reviews. This also applies to all home and community-based waivers, and the first waiver up for renewal is the Aged and Disabled Waiver with CMS threatening not to approve its renewal because it includes case management as an activity.

John added that whenever we go into the State Plan, or submit a waiver amendment or an application for a new waiver, or submit any documentation to CMS, it opens the door to this type of examination. He also mentioned that CMS will send auditors to look at elements of the program and look specifically for case management following the March 3rd effective date. Between now and March 3rd, each state will be required by CMS to submit an Affirmative Attestation of Intent to Comply.

John stated that there has been some discussion about a congressional moratorium as one of the riders to the stimulus package, but that has not been successful on any of these rules; and he thinks that there is a strong commitment on the part of the administration at CMS to push this through. Based on some of their previous activity, if they don't succeed in one way, they will find another way to push this philosophy.

The Departments have been asked to look at their programs and begin to pull together what the potential financial impact is of this ruling, to see where they believe they are vulnerable or where there are opportunities for redefinition for retraining or re-documentation.

John stated that he perceives the potential impact in Rhode Island in current billable services to be valued at between 25 and 30 million dollars of All Funds. He thinks that this number could possibly be higher.

Karen Kanatzar asked John to explain how this rule impacts Title 4E. John stated that community case management for children in child welfare can no longer be billed to Medicaid. The administrative claiming for people at DCYF and state staff at MHRH may also be in jeopardy because the liberal extension is that if we are funding state staff who worked in the child welfare system or mental health system, then that runs afoul of the philosophy that has us limiting payments out in the community.

Representative Long asked if it would affect school systems and the billing of certain services provided to the students. John stated that it will affect school systems. In a separate analysis that they ran last year, they generated about 22 million dollars in funding to services in schools. His best sense, based on the rules that are current or pending, Rhode Island will lose between 6 and 7 million dollars in the next fiscal year which is not part of the 25 and 30 million dollars stated above.

The administrative burden of the rule will mean that all services and program will need to be examined and think about what is important and valuable and retrain everyone as to how they think about their services and specifically how they document them.

Craig Stenning added that the kinds of services that are normally thought of as case management services need to be tied into the treatment plan and the goals and objectives of the plan because that is what makes it eligible under a medical model. He stated that the training and the change is not necessarily an adverse thing, and it would protect a certain portion of these activities. He cautioned that it would be viewed unfavorably when there are several case manager-type services being provided to the same individual.

Karen Kanatzar asked how all of this is going to impact the changes that are trying to be accomplished here in Rhode Island in reorganizing the systems of care. John stated that the two areas should be blended together in design.

Richard Lelerc asked if there was any action on the Rehab Option. John stated that there is no new development, but it is tied up in a broad discussion about moratoria, definition, redefinition, and a lot of backroom negotiations.

Richard Lelerc asked if this rule would hold back any CMS approval or other approvals for bringing Children Intensive Services (CIS) into the plan. John stated that this issue has not come up as an obstacle towards that transition, and he hesitates to ask.

ANNUAL REPORT TO THE GOVERNOR

Charles Williams stated that the annual report was distributed with the Minutes of January 8th and that it is a requirement of the Council to submit a report to the Governor regarding its activities annually. He asked for the Council's approval for submission to the Governor's Office.

Sandra DelSesto stated that after review of the report, she felt it was absent of any actions taken by the Council. She thinks that the Council needs to revisit their role.

Richard Leclerc explained that the Council's official role is written in both state and federal statute. On the federal level, the Council's formal role is to review and approve the annual plan. On the state role, it is a planning council to review plans and to advise the Governor. Therefore, we cannot enact anything, but we can advise.

Charles pointed out that the formal recommendations are listed on Page 2 of the report. Reed Cospers suggested redrafting the report to include concerns about the Rehab Option, and concerns about the overcrowding of emergency rooms with mentally ill individuals, and concerns about shifting of Medicaid policy from the State's traditional model of mental health services into some Medicaid model. Reed motioned to redraft the report to express concerns of the behavioral health care system. Representative Long seconded the motion. Richard amended the motion to add the process of calling a subcommittee together to redraft the report. An e-mail will be forwarded with a meeting date and particulars as well as any comments received. Comments should be forwarded to Corinna Roy at croy@mhrh.ri.gov. All were in favor.

UPDATES FROM DCYF

Janet Anderson reported that DCYF is in process of reviewing proposals for the RFP for Family Care Community Partnerships (FCCP) which was issued awhile back. The evaluation committee has reviewed and scored the proposals; and their recommendations are being forwarded to the Department of Administration, Purchasing Division, to make those announcements. Negotiations will then follow, and the actual final decision and agreement are not final until negotiations are completed.

Janet reported that DCYF is working with DHS, providers, and families to look at how to best fund residential services and include all of the changes from CMS, particularly relating to the Rehab Option which has supported and reimbursed residential services by adding federal funds to the dollars within the state. DCYF has undertaken a piece of work called the "Time Study." Every residential provider in the State has been involved in the study and has completed a time study. Consultants with Medicaid expertise have evaluated staff of each residence to review how they spend their time. The reports are analyzed, and DCYF is in the process of receiving the report back that will reveal how much of that time would meet the Medicaid billable time based on the Rehab Option. Janet stated that this information will immediately be used to do training through site visits on the new Rehab Option Rule and develop good practice through documentation, treatment plan and progress notes that match and indicate where rehabilitation is occurring.

If the child has what is deemed a chronic condition, they need to look for other Medicaid waivers that can be applied for which the State has not applied for in the past.

The time study will also help to understand their present work of designing an integrated system-of-care in Rhode Island for residential services, as well as help move the dollars tied up in residential services and shift some of those dollars back into the community to provide more home and community-based services to wraparound and intensify what has been available in the community.

Janet reported that they are putting the final touches on a concept paper. The concept paper which will address the model will be available in the near future, and she will come back to discuss it when it is released.

Richard Leclerc asked what the timeframe is on the re-procurement. Janet stated spring and that they are working with DHS to examine the system. DHS has realized that much of the services for children are of social criteria, and they are looking at that as a component of the whole system which is not a medical necessity. The medical necessity of the children's system is a small piece that needs to be integrated in the whole. Janet stated that with this re-procurement DCYF is trying to set a next best step for access-to-care for children and families within the limited dollars available along with integrating the Medicaid dollars and Medicaid benefits available.

Reed Cosper asked Janet to describe what the worst case scenario is. Janet stated that the money will decrease from 100 million to possibly 50 million dollars. They are banking on relying less on residential which is more expensive, but foresee narrowing the door to access it which is difficult for DCYF because of their statutory responsibility for child welfare and the juvenile justice population.

Liz Earls stated that there is an article in the 2009 budget that caps the out-of-home residential placements. Liz asked if that includes foster care. Janet stated that it applies just to residential placement.

After much discussion about the funding loss, Janet stated that she is concerned about changes to CIS because the program has been so effective and has data to support its effectiveness; although she believes the changes in the redesign for the children's system are extremely positive. She added that the reforms that DCYF is undergoing right now look at national best practice models to shift where the money has been to better serve children and families. DCYF is committed to move ahead with the reform.

Janet stated on a positive note that the Positive Educational Partnership (PEP), which is SAMHSA funded, is helping fund the training that will be necessary for all the work being done with FCCP and wrap-around. Sandra DeSesto asked if there are any outcomes and if Janet could share them with the Council. Janet stated that she would like to bring Ginny and Frank who are the project directors to the meeting and have them do a presentation.

Liz Earls asked, in light of the reductions, where does Early Period Screening Diagnosis and Treatment (EPSDT), which is a federal requirement for children, fit in. Janet stated that it is and will continue to funnel through CEDARS.

Richard Leclerc asked Janet if she could look into getting periodic reports from DCYF submitted to the Council through Corinna Roy to support the Data Subcommittee which is looking at benchmarking and outcomes from reports from DCYF, MHRH, and DOC. Sandy Woods stated that this is in process, and they are planning to present some data at the next month.

Richard added that at the last meeting Winsome Stone reported that there was a 10 percent cut to children's residential services. Richard asked if there is a way to present a document that indicates its effect and how many fewer beds there may be, etc. Janet stated that the total reduction in dollar amount is 3.3 million. She also stated that there was a recent meeting with the residential providers indicating a loss of about 44 beds and 20 independent living slots. With the elimination of those beds, the providers were required to submit a plan about how they would transition each child. Additionally, the providers starting moving the system in a direction towards building more home and community-based capacity and submitted proposals to DCYF to add family support capacity, multi-systemic therapy which is an evidence based practice, functional family therapy which is a home-based family evidence based practice, as well as a number of different national best practices. Therefore, part of it was a reduction in bed capacity and the other is shifting dollars to a different place in the system.

UPDATES FROM MHRH

Gene Nadeau reported that the Transition from Prison to the Community Program (TPCP) went from concept to actual treatment capacity in about six months. Of inmates who have been paroled and are waiting for substance abuse treatment, there have been 42 inmates assessed and 20 are actually in treatment. There are three providers who are currently approved and providing services and three under a final evaluation. The current providers are Phoenix House, The Providence Center, Caritas House, Northern Rhode Island, and Tri-Hab. It is a combination of short-term residential, long-term residential and intensive outpatient.

Reed Cospers asked about the screening of eligible inmates for mental illness and substance abuse. Gene stated that the list of inmates received for assessments is provided by a combination of the parole board and the assessments that are ongoing within the prison. Reed asked if there is a mental health

component. Charles added that the assessment at the prison is a modification of the Addition Severity Index (ASI) and the way the bill was written and the way it is being implemented is that it is primarily substance abuse treatment. If there is a need for associated mental health services, the rates seem to be rich enough to involve that component.

Richard Leclerc asked what the capacity is after this fiscal year. Gene stated that the capacity that was originally identified in the RFP was 30, but they will plan to continue building upon that capacity as the applications are received. Lou Cerbo stated that the capacity can go up to 42.

Charles Williams reported that Dr. Westley Clark, the Director of the Center for Substance Abuse Treatment, had planned an event in Rhode Island on February 13 which has been rescheduled to March 17th from 8:30 a.m. to 12:30 p.m. and invitations are forthcoming. A government project officer will be in Rhode Island on February 13th and there will a two-hour, lunchtime, meet-and-greet and an opportunity for folks to get more information about the Access to Recovery (ATR) grant.

Charles reported that they will start seeing clients on or before February 22, 2008. They will start small with an interim paper-voucher system. They will begin at Child Protective Family Services, DCYF in Pawtucket as their initial site and will be there for no more than six weeks before they are able to open up on the electronic system. The electronic voucher management system is on pace to go up for testing at the very beginning of March and will go through a two-week testing period before being rolled out.

Within the next week or two, there should be notices posted at the Division of Purchases website for applications for continuous recruitment for clinical treatment providers and recovery support providers under the ATR. Revised applications will be posted at the MHRH Department's website. Applications will be viewable and be able to be downloaded and filled out, but cannot be submitted to the Department of MHRH. The only way to become part of the network is to go through the Division of Purchases.

Charles also stated that they will be posting a Version I of a Provider Handbook at the Department of MHRH website on or before the RFI's at the Division of Purchases.

In answer to a question raised, Charles stated that psychiatric medications are specifically excluded from the ATR program by the federal government. The ATR program will allow an individual to engage in medication assisted treatment. At this point in time, the only medication that has been approved within Rhode Island ATR for medication assistance treatment is methadone. They are looking at other medications but have not yet come up with a plan and a price. They will always have the ability to add new services into the program that would be available for individuals who are part of the ATR program.

Reed Cospers brought attention to the MHRH report and that the Department failed to mention in their report that they plan to close the Virks Unit at Eleanor Slater Hospital (ESH), which means that 50 psycho-geriatric beds taken out of the system.

Richard Leclerc stated that Dr. Ellen Nelson had planned on attending regarding many budget items that have just come out. Unfortunately, she was unable to attend but does intend to present the information at the next meeting in March.

Sandra DelSesto expressed concern about the budget and not being informed. Richard stated that Dr. Nelson has organized a number of meetings with providers and key trade associations regarding the

budget. Sandra stated that the people in prevention have been left out of this discussion. Richard stated that this issue was brought up at a meeting and that changes will be made in that regard. Charles stated that he will be working with Dr. Nelson's assistant on the master list of participants for the meetings and that names will be added to the list. Sandra requested that the budget be first on the agenda at the March meeting.

Liz Earls stated that the House Finance Committee is holding a hearing on MHRH's revised 2008 budget on Monday, February 11 at 11 a.m. at the State House.

UPDATES OF MENTAL HEALTH ADVOCATE'S OFFICE

Reed Cospere reported the consolidation of his office and the child advocate is not a proposal at this time. He stated that the idea has been taken off the table, although the other three agencies are proposed to consolidate into the Department of Elder Affairs. Those agencies would be the Commission on the Deaf and Hard of Hearing, the DD Council, and the Governor's Commission on Disabilities.

OLD/NEW BUSINESS

Craig Stenning stated on behalf of DHS he would offer to make a presentation on the Governor's Medicaid Reform Package at the March meeting.

There was no other old or new business.

ADJOURNMENT AND NEXT MEETING

There was no further business. Upon motion made and seconded, the meeting adjourned at 10:25 a.m. The next meeting of the Council is scheduled for **Tuesday, March 4, at 1:00 p.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