

**Meeting Minutes of  
The Governor's Council on Behavioral Health  
8:30 A.M., Thursday, September 11, 2008**

The Governor's Council on Behavioral Health met at 8:30 a.m. on Thursday, September 11, 2008, in Barry Hall's Conference Room 126, 14 Harrington Road, Cranston, Rhode Island.

Members Present: Richard Leclerc, Chair; Leo Cronan; Stephanie Culhane; Sandra DelSesto; Scotti DiDonato; Mark Fields; James Gillen; Chaz Gross; Mitch Henderson; Lynn Fitzgerald for Richard Hill; Karen Kanatzar, Joseph Le; Anne Mulready; Noreen Shawcross; Reed Cosper; Neil Corkery; and Liz Earls.

Ex-Officio

Members Present: Craig Stenning, Acting Director, Department of Mental Health, Retardation and Hospitals (MHRH); Denise Achin, Department of Education (DEA); Mary Ann Ciano, Department of Elderly Affairs; John Young, CEO, Eleanor Slater; Colleen Polselli, Department of Health (DOH); and Sharon Kernan and Alison Croke, Department of Human Services (DHS).

Staff: Charles Williams, Corinna Roy, Elena Nicolella, Thomas Martin, Mary Ann Nassa, Mike McAfee, and Lisa Stevens.

Guests: Vivian Weisman and Ashley Robbins, Mental Health Association;

Once a quorum was established, the Chair, Richard Leclerc, called the meeting to order at 8:40 a.m. After introductions were conducted, Richard entertained a motion to accept the Minutes of July 8, 2008. Scotti DiDonato motioned to approve the minutes, and Jim Gillen seconded the motion. All were in favor and the minutes were approved as written and submitted.

**CIS RESTRUCTURED TO CAITS AND CSHCN INTO RITE CARE**

*Sharon Kernan from the Department of Human Services* – Restructuring Child Adolescent Treatment Services (CIS) to ***Child Adolescent Intensive Treatment Services (CAITS)***: *see attachment 2*. CIS has been a DCYF program; in July of 2007 it was transferred to DHS. DHS has been mandated to reduce expenditures in this fiscal year, (which has now started), by \$11 million. This program was originally a \$24 million dollar program now reduced to a \$13 million dollar program. DHS had started meeting with (primarily mental health) provider agencies in February/March. Their goal is to preserve the essence of the program for the children they serve (birth through the age of 21) as well as focusing on short-term treatment. There will be no waiting lists for these services which is similar to CIS. Since the benefit itself is of shorter duration the cost is less per child.

The new CAITS program is a 16-week program; each child can have up to 16 weeks of this service every twelve months. The children can re-enter the program after a twelve month period if there is a medical need. The previous (CIS) length of stay ranged from up to two to three years, frequently less, averaging 6 months. The length of stay is a key part of the budget reduction as well as the reimbursement under CIS where the bulk of the children were in level 2 and 3 which were per diem reimbursements. The new program (CAITS) is now fee-based reimbursement. The providers are paid for the hours of services they provide, which will result in significant savings. Children can be referred directly to any certified case provider. There is a three day turn around at DHS for authorizing the treatment. The provider agency must then begin treatment within five business days. Intensive outpatient plans are a service that is home-based, intensive and works closely with the family and child. Community providers will be made aware of these services for dual diagnosis clients in the near future.

DHS based a time frame of 12 – 14 weeks on research of best practices and models from across the country. The skills training and development is a service that is currently provided by CIS and is provided by staff with a Bachelors degree or higher. This is provided in the home community for a maximum of 18 hours over the 16 weeks which can be flexed. Access standards for CAITS must be approved by DHS.

They have eliminated the levels that were in CIS in CAITS and have allowed the providers to flex the benefits instead. MD services are now part of CAITS but only available through Medicaid or other health plans. This service is going to go in-plan for the first calendar quarter of 2009. Health plans are working with them now to create more of a continuum where everyone is aware of what health benefits can be provided. The health plans are currently responsible for all medically necessary behavioral health care services except for those that are designated as out of plan in our current contracts. CAITS for example, is currently out of plan but will be moved in-plan. Over time, other services will be put in-plan. The out of plan services are accessed by being referred and having Medicaid or are Medicaid eligible.

DCYF will be trained on the restructure to ensure that all regional staff understand these changes and how this program can help serve their clients.

The projection is that 22% fewer children will be served with this program. As of now, we have a 50% reduction in the caseload as the summer demand usually declines. No waivers to limit this benefit regarding the cut in the days of services are in place. In-plan services are still 16 weeks per calendar year. The 1115 waiver will have to be amended. The global waiver that has been submitted does not cover the cuts in time for services.

Reed Cosper made a motion to have the Council put together a statement to the governor to voice concerns of the goal of this plan compared to our mission and our goal in government. Motion made, Neil Corkery seconded the motion, and there were no objections.

The following discussion of the issue and the motion followed: Liz Earls hopes to be able to track these children because of the many things lost in this program. She stated that many of these children may need ongoing care.

Neil Corkery mentioned that this program is being put in place at a time when Rhode Island is experiencing significant losses in funding in mental health and substance abuse in adolescent services. If it continues at this rate, people will not be able to afford to provide services. Stephanie Culhane feels that the administration is sending the wrong message that mental health services aren't as important as other services.

Liz Earls informed the committee that RIte Care will be changing to allow only generic drugs. Alison Croke feels this issue should be put on the October 7<sup>th</sup> agenda.

Reed Cosper stated that CIS was created by smart, caring, public and private sector people to solve a terrible problem. Reed feels that this is an insult to these people to see what this program has been reduced to. Reed motioned to report to the governor how the change from CIS to CAITS results in cuts of about 50% in the program, and the effects it will have on its target population.

Richard Leclerc entertained the motion to write a recommendation to the Governor not to make these substantial reductions in children's behavioral health care by moving from the CIS system to the CAITS

system, the motion passed unanimously. Richard Leclerc stated that Corinna Roy and Elizabeth Earls will work together to draft a letter for review within a couple of weeks.

**Rite Care Enrollment of Children with Special Health Care Needs, see attachment 3.** *Alison Croke, Department of Health:* There was a recent change in the budget that passed in July. Children with special health care needs are defined by DHS as: children under 21 who receive SSI; children under 21 in the Adoption Subsidy program, (John Young defined the Adoption Subsidy program as when DCYF take children who have complicated needs that are not necessarily conducive to normal adoption and are in foster care and tries to reunite them with their families or tries to find permanent homes for them); and children under 19 in the Katie Beckett coverage group. (The Katie Beckett program is for children on the pathway to Medicaid who need institutional level of care, in this program SSI looks only at the child's income vs. the household income). The budget that just passed gave DHS the authority to enroll kids on a mandatory basis within these three categories of children with special health care needs with some exemptions. In order to do this there needed to be a second health care plan contract (United Health Care in addition to Neighborhood Health Plan). This change will take place the first of October. The law passed in July and the policy was filed in the Secretary of State's office. Again, families will have two plans to choose from. Children must live in Rhode Island and have no other health plan to be eligible.

There are about 4,000 children that are enrolled in Neighborhood Health Plan who will be notified that the program is now mandatory and that they have a choice of health plans. After 90 days these children will be locked in to the health plan of their choice. There are approximately 1,700 children who are in a fee-for-service plan and eventually these children will be notified of this mandatory plan.

With United Health Care there are out-of-state providers available for children including Boston and neighboring communities such as Seekonk, etc.

All family members in a Rite Care household must be in the same plan. We cannot split family members among different plans. There should be no service disruption for kids once they are enrolled. In this plan, they will not be subjected to the generic drug rule.

### **DATA SUBCOMMITTEE**

*Corinna Roy, MHRH* – Noel reported back to Corinna that people essentially went over the measures that were already presented to this committee and received details on how they should be reported. The data was not available for that meeting and another meeting was scheduled for September 23<sup>rd</sup> at 3 PM here and at that meeting all of their data will be ready and a mass email will be sent out to the group to invite you to attend. This data will be available for discussion at the next Governor's Council meeting.

### **UPDATES FROM MHRH**

*Craig Stenning, Acting Director, MHRH* – Craig reminded all of Jim Gillen's invitation to the Recovery Waterfire event, *see attachment 1*. This event has been attended in the past by 400-500 people. This is an event to take recovery out into the public to specifically address the issue of stigma. This is a place for people in recovery to voice their stories and a place where their messages could be heard. Several public officials will be speaking at this event.

A meeting was held with the adult drug court regarding treatment and assessment costs. Almost 100% of drug court population would fit into the Access to Recovery project. The judge has accepted our assessment as the court assessment with the understanding that the magistrate will not have the ability to

change the recommendation of the assessment and that the individual has a choice of at least three agencies.

MHRH has been working with NRI and three other mental health providers in the area of police training. Reed Cosper had brought this up at a previous meeting and MHRH was concerned about this issue as well. We are in conjunction with NRI supporting a new volunteer certification program for police officers via a 'train the trainers' program so they may be able to bring the same training to their own individual police departments. We would support a small stipend to offset the cost of overtime for the police officers. This training is similar to some national models. The first session of the training is scheduled to take place at the end of this month. Stephanie Culhane questioned if this training will be recommended to the state police academies. Craig answers that this same trainer is working with new officers at the state police academies. This will be a three-day training which includes a considerable amount of case experience to deescalate a situation through role play. There will be a written test which must be passed with an 80% grade, additionally it requires that participants have at least three years of police service, must have a passing grade in the performance of the de-escalation techniques during role playing and attend at least 20 hours of critical incident response training over and above this particular 3-day training for certification. If this program works well it may put pressure on the police departments to mandate this certification program.

Craig passed out a letter *see attachment 4* regarding the initiative of moving CMAP, (Community Medication Assistance Program) which is currently supplied by the pharmacy warehouse at the Eleanor Slater Hospital to approximately 16 private pharmacies from a paper program to an electronic system utilizing RI Medicaid's pharmacy network. This program has served the clients extremely well. With this initiative, individuals will have a card, similar to a health care card, and any pharmacy could participate, which would expand their network of pharmacies from the current 16. MHRH will still control the formulary. We gain a lot of savings using samples and that would not change. This program will be in its final planning stages in the next 4-5 months.

Reorganization of MHRH – *See attachment 5*. Each state department has been given the task of coming up with reorganization on how we will conduct our business given the fact of recent and upcoming retirements that have/will occur. We face a critical period for the next two months where we will be working at little or no staff in some areas. Once the reorganization of the department is approved, and the 2010 budget is submitted, we will have the ability to hire a number of positions. What is listed on the matrix (excluding the Eleanor Slater Hospital) are the key functions of MHRH to be redesigned in the next 30 days. The 2010 budget is based on an assumption that the 2009 budget has been implemented to its fullest extent. The estimate is that we will be able to fill 50-70% of the positions that have become vacant.

Our goal is that we can ensure that we are providing the right level of service to the right number of people in the right settings at the right time in their life. Neil Corkery asked about adolescent residential services because of the cap of \$400,000 (Medicaid's share) to this population. Craig stated the state did the billing in the past essentially paying for every bed assuming that the end of the year the state would then bill for those services. Craig will meet regarding this concern.

The MHRH deficit of FY 08 was \$7 million. Sixty percent of this deficit (approximately \$4 million) seems to be an accounting problem. Medicaid utilization in Behavioral Health did increase (5%) over the previous year. The cost of medications in the CMAP program was up 12%.

Two initiatives which totaled \$2 million dollars of the remaining \$3 million discrepancy were:

1. The state withdrew co-shares 3 times from paychecks for their medical benefits where it was budgeted for only 2, which resulted in \$600,000 that had not been budgeted being taken out of our budget.
2. The assumption of 6 furlough days (a \$1.2 million dollar savings) when there were none.

### **OLD/NEW BUSINESS**

Richard Leclerc wished, on behalf of the Governor's Council, Mary Ann Nassa a wonderful, happy retirement and extended many thanks for the 17 years of service to this Council and presented her with a token of their appreciation.

### **ADJOURNMENT AND NEXT MEETING**

There was no further business. Upon motion made and seconded, the meeting adjourned at 10:20 a.m. The next meeting of the Council is scheduled for **Tuesday, October 7, at 1:00 p.m. in the first floor Conference Room 126 at the Barry Hall Building.**

Minutes respectfully recorded and written by:

Lisa Stevens  
Secretary, Governor's Council on Behavioral Health

- Attachment I:* Save the date flyer: MHRH & the Recovery Month Planning Committee event on September 20<sup>th</sup> 2-5 p.m. at Waterfire on Steeple Street. Flyer: Wilson Street Recovery Apartments Open House Celebration.**
- Attachment II:* Child & Adolescent Intensive Treatment Services (CAITS)**
- Attachment III:* Rite Care Enrollment of Children with Special Health Care Needs**
- Attachment IV:* Potential CMAP Move to Electronic System**
- Attachment V:* Six Sigma Cause & Effect Matrix MHRH**