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COMMISSION ON MENTAL HEALTH AND ADDICTION

Legislative Services Agency
200 West Washington Street, Suite 301
Indianapolis, Indiana 46204-2789
Tel: (317) 233-0696 Fax: (317) 232-2554

LSA Staff:

Susan Kennell, Attorney for the Commission
Chris Baker, Fiscal Analyst for the Commission

Authority: IC 12-21-6.5

MEETING MINUTES[1]

Meeting Date:	**August 9, 2011**
Meeting Time:	**1:00 P.M.**
Meeting Place:	**State House, 200 W. Washington St., Senate Chamber**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**1**

Members Present: **Sen. Connie Lawson, Chairperson; Rep. Cindy Noe; Rep. Charlie Brown; Kathleen O'Connell; Stacey Cornett; Margie Payne; Valerie N. Markley; Caroline Doebbling; Kurt Carlson; Chris Taelman; Jane Horn; Rhonda Boyd-Alstott; Dr. Danita Johnson Hughes; Dr. Brenna McDonald.**

Members Absent: **Sen. Vi Simpson; Ronda Ames; Bryan Lett.**

I. Call to Order and Introductions: Senator Connie Lawson, Chairperson, called the meeting to order at 1:05 P.M. and asked the members to introduce themselves. Senator Lawson thanked the members for their service.

II. Updates from the Family and Social Services Administration (FSSA)

Ms. Gina Eckart, Director, Division of Mental Health and Addiction (DMHA),

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[1] These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at http://www.in.gov/legislative Hard copies can be obtained in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for hard copies.

provided updates on the state hospital initiative, suicide prevention, clubhouse programs, Workforce Development Task Force, SEA 88, and federal level changes. (Exhibit 1) In answer to questions from Rep. Noe, Ms. Eckart stated that the Division of Disability and Rehabilitative Services (DDRS) is tracking individuals who are no longer being served at state-run institutions, and Ms. Eckart will ask DDRS for additional information for a future meeting. Ms. Eckart additionally reported that she will provide the Commission members with a list of the suicide commission members. Ms. Eckart reported that in other states, due to severe budget cuts, services are only being provided to individuals in crisis situations.

III. Update from the Indiana Council of Community Mental Health Centers

Mr. Matt Brooks, Executive Director and CEO, provided an update. (Exhibit 2) In answer to questions from Senator Lawson, Mr. Brooks stated that the Medicaid Rehabilitation Option (MRO) is responsible for sixty-seven percent (67%) of funding for centers. Approximately twenty percent (20%) of funding comes from commercial insurers. The five percent (5%) cut to MRO funding amounted to approximately one hundred nine million dollars in cuts to the centers. Representative Brown asked for information on what is happening to the individuals who are no longer receiving services due to MRO cuts. Mr. Brooks said that some are falling out of the system, some are incarcerated, and some are receiving services in hospitals.

IV. Update from Mental Health America

Mr. Steve McCaffrey, President and CEO, discussed the following issues:

(A) The General Assembly created the Council on Evansville State Hospitals to review services for children and adults in Evansville.

(B) The suicide coalition is developing models for planning. The basic plan is for locals to gear up and decide how to implement suicide prevention plans at the local level.

(C) Meetings have been and are being held with the Office of Medicaid Policy and Planning (OMPP), DMHA, and Clubhouse representatives to work out funding and program strategies.

(D) Discussions are under way concerning restructuring the DMHA Advisory Council and the Block Grant Committee.

(E) Policies for access to medications need to be revamped to insure that medications are geared for recoveries.

(F) The findings of the Pew Research Center study concerning reduction of sentencing are being considered by various groups in the state and could have impact an on the mental health delivery system. According to Mr. McCaffrey, much of that study is predicated on the release of nonviolent offenders. Many of those offenders have mental illness issues if they are released from correctional institutions, better mental health treatment will be needed, which will require additional funding for mental health services.

(G) There has been a tremendous response to licensure of addiction counselors. Mr. McCaffrey will be asking the Commission to consider an amendment to the licensure law for the 2012 Session of the General Assembly.

V. Future Meetings

In response to requests for more specific detail on the impact of changes in MRO, the Commission asked for more information on the impact of cuts to community mental health centers. Dr. Caroline Doebbling provided the following questions that the members of the COMHA would like to have answered by DMHA and the centers at the September meeting:

> (1) What is the trend for receipt of clinic option services in the population? A year over year analysis looking at specific services on a PMPM [per member per month] basis could be done. Caution must be given that all payment streams are not equivalent. Any analysis needs to separate out the three MCOs [managed care organizations] from each other, the Care Select CMOs [care management organizations] and the remainder of the FFS [fee for service] population. This is important because of provisions of a contract with Advantage Health Solutions that could result in withholding payments and providing bonuses based on staying below a trend. The effect could be to deny care for the Care Select population, all MRO for all Medicaid covered lives, and all other FFS [fee for service] members. MDwise also has the savings trend for Care Select only, but does not have any role in PA [prior authorization] for MRO. Any statement that inpatient costs are lower may only reflect a more tightly managed population.
>
> (2) What are the PA [prior authorization] denial or modification rates for members who received a service package and then requested additional units? This must include modifications because the PA [prior authorization] vendor has the right to approve a portion of what was asked for and not the total requested. For instance, if I asked for 40 hours of therapy and the PA [prior authorization] vendor allowed for only 25, this is a modification. Does the State ask Advantage to define modifications as approvals?
>
> (3) How many centers maintain full ACT [assertive community treatment] teams versus ACT-lite is the month over month trend of enrollment into ACT [assertive community treatment] programs?
>
> (4) What is the PMPM [per member per month] trend for inpatient behavioral health? What is the average length of stay for inpatient?
>
> (5) What does the waiting list look like for the SMI [serious mental illness] for SOF [state operated facility]? It may have changed for those DDRS/SMI SED [division of disability and rehabilitative services/ serious mental illness seriously emotionally disturbed] members, but what about for the non-duals? If a member is in an acute facility waiting for a SOF [state operated facility], there are costs associated with the acute day that also must be taken into account. What is the length of time for an individual on the waiting list?

VI Adjournment

The Commission will hold meetings on September 6, October 4, and October 25 (if needed). All meetings will be at 1:00 P.M. in the Senate Chamber

Senator Lawson adjourned the meeting at 3:15 P.M.

COMHA Meeting 1 August 9, 2011 Exhibit 1

DMHA Updates: Commission on Mental Health and Addiction

Gina Eckart
Division of Mental Health and Addiction
August 9, 2011

A Look Back at SFY 2010

- State Hospital Initiative
- Suicide Prevention
- Clubhouse
- Workforce Development Taskforce
- SEA88 Updates

State Hospital Initiative

- The transition plan announced last year has been completed.
- In partnership with BDDS, 108 patients have transitioned from state hospital beds to community living.
- Reduced SOF beds from 1205 at 85% capacity to 886 beds at 94% capacity.

State Hospital Initiative

- $20 million in savings to the State. From that savings, $5 million was set aside for community placements.
- LSH reduced over 300 staff positions, resulting in layoff of 108 employees.
- RSH achieved their staffing target without layoffs.

State Hospital Initiative

- Two providers are serving the residential addiction population formerly at Richmond – one north and one south rather than focused at one psychiatric hospital.

Suicide Prevention

- DMHA and ISDH have assembled and co-chair a Suicide Prevention Advisory Committee.
  - Representatives from ten organizations
    - Membership includes state agencies such as the Division of Aging and the Indiana Department of Education and...
    - Community organizations such as the Jayson Foundation, Minority Health Coalition, and the Northwest Indiana Suicide Coalition .

- The Committee is developing a new state suicide prevention plan to better meet the needs of Indiana residents and close existing service gaps.

Suicide Prevention

- The Suicide Prevention Advisory Committee has convened six times since inception.

- They have reviewed and analyzed several state suicide prevention plans as well as national strategies to discuss and select features that could be used in Indiana's Suicide Prevention Plan.

- Four subcommittees have been formed and are currently meeting and working on an outline for their assigned suicide risk group these groups are:
  - Universal Prevention Goals (aimed at general public)
  - Selective Prevention Goals (aimed at specific vulnerable groups)
  - Indicated Prevention Goals (aimed high risk groups)
  - Program Evaluation Surveillance Goals

Suicide Prevention

- Finalizing the State Suicide Prevention Plan
  - September 2011 reviewed by committee
  - October 2011 Review with stakeholders
  - December 2011 Final Plan

Suicide Prevention

- Other Suicide Prevention Initiatives
  - Expand Indiana Participation with the Lifeline Suicide Crisis Line
    - July 2011 webinar for agencies interested in becoming a part of the Lifeline Crisis Response Network.
  - DMHA and ISDH applied for a 3-year Garrett Lee Smith Youth Suicide Prevention and Early Intervention grant through SAMHSA, to provide training in suicide awareness and prevention with teachers, and staff working in Juvenile Corrections , and expand capacity of suicide coalitions across all part of the state.

Clubhouse Update

- Multiple Meetings and continued discussion of ways to support Clubhouse programs throughout the past year

- On site technical assistance (July 2011) provided to assist the Carriage House with accessing Medicaid reimbursement currently available.

Moving Forward

- Federal Level Changes
- Biennial Budget

Affordable Care Act

- Major Drivers
  - More people will have insurance coverage
  - Medicaid will play a bigger role in MH/SUD than ever before
  - Focus on primary care and coordination with specialty care
  - Major emphasis on home and community based services and less reliance on institutional care
  - Preventing diseases and promoting wellness is a huge theme

SAMHSA
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

8 Strategic Initiatives

1. Prevention of Substance Abuse and Mental Illness
2. Trauma and Justice
3. Military Families
4. Recovery Support
5. Health Reform
6. Health Information Technology
7. Data and Outcomes and Quality
8. Public Awareness and Support

Changes to Federal Block Grants

- SAMHSA encouraging states to submit a combined application for the MH and SAPT Block Grants.
- Emphasis on Non-Medicaid funded recovery supports.
- Emphasis on outcomes which will be tied to funding strategies.
- Accountability for every dollar down to the individual, service received, and benefit gained.

DMHA Advisory Council

- DMHA Advisory Council and Planning Council Merger
  - Proposed merger of the Advisory Council and Planning Councils
  - Held planning meeting with Technical Assistance from SAMHSA on June 13, 2011
  - Conducted meetings with existing councils to announce proposed merger
  - There is a need for statutory changes and new by-laws for the merged council

Advisory Council Con't

- Projected merger completion August 2011
- Kick-off Meeting Planned for the merged council tentatively titled the "Mental Health and Addiction Planning and Advisory Council"

Workforce Development Task Force – IC 12-21-4.1

- Established in February 2009
- 59 individuals from various organizations as required by House Bill 1210 participated
- Focus on four priority Areas:
  - Licensure, Certification, and Clinical Supervision
  - Culturally Competent and Culturally Diverse Workforce
  - Behavioral Health Workforce Undergraduate and Graduate Training in Core Disciplines
  - Recruitment and Retention

Workforce Development Task Force – IC 12-21-4.1

- Task Force Completed Charge with 28 recommendations submitted February 2010

- Recommendations completed that did not require new funding:
  - DMHA Recovery Focused Mission Statement
  - Cultural Competency Request for Proposal (RFP) in process

SEA 88 Updates

- Continuum of Care Workgroup
  - DMHA, advocates and providers meeting to define the continuum and discuss other policy changes to better meet the needs of consumers and families
  - Consensus on continuum definition, very similar to language in SB88, now working on developing the details.

Questions

CSMHA Meeting 1 August 9, 2011 Exhibit 2

Update on Status of the Community Mental Health Center System in Indiana

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Presentation to:
Indiana Commission on Mental Health and Addiction

MATTHEW G. BROOKS, M.A.
INDIANA COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS, INC.
INDIANAPOLIS, IN

AUGUST 9, 2011

Background on Community Mental Health

- The Indiana Council of Community Mental Health Centers (ICCMHC) represents the collective interests of all twenty-five (25) community mental health centers (CMHCs) currently certified and accredited to provide community based behavioral health in Indiana.
- The following information is a summary of historical data developed by the Indiana Council to document the current financial and operational status of CMHCs in Indiana.
- Medicaid Rehabilitation Option (MRO) services are the primary funding mechanism in Indiana to ensure adults, diagnosed with Serious Mental Illness (SMI), and children, diagnosed as Severely Emotionally Disturbed (SED), have access to critical behavioral health services.
- CMHCs in Indiana also provide important community based behavioral health services through the Medicaid Clinic Option, inpatient services, managed care programs, psycho-social rehabilitation programs, residential programs, abused and neglected child programs, addiction programs, and commercial insurance services. Many CMHCs have established foundations to further support community-based behavioral health services.
- CMHCs interact with numerous state agencies such as: the Family and Social Services Administration (FSSA), the Indiana Housing and Community Development Authority, the Department of Child Services, the Indiana Department of Workforce Development, the Indiana Department of Health, the Indiana Department of Corrections, the Indiana National Guard, and the Indiana Department of Education.
- The broad range of funding sources allows CMHCs to provide required safety net services included in the continuum of care to ensure individuals with SMI and SED have access to needed services.

Community Mental Health Center Funding

- The Indiana Council supports appropriate levels of state and county funding needed to ensure compliance with the continuum of care and the appropriate treatment of mental health consumers.
- These funding sources are critical to match the MRO program, as well as promote non-matched behavioral health services and off-set uncompensated care costs.
- In the FY 12-13 Biennial Budget, the Indiana General Assembly appropriated $109,377,959 for SMI and SED services; however, CMHCs were recently notified by DMHA that contracted state funding levels would be reduced by 5%. This amount is in addition to a 3% reduction in CMHC funding in FY09.
- In FY 11, CMHCs utilized $182,088,104 in DMHA administered Medicaid Rehabilitation Option (MRO) services.
- In FY11, CMHCs received $33,301,685 in county funds authorized under Indiana Code 12-29-2-2.
- CMHCs provided $85.5 million in uncompensated care in 2010.
- Newly developed child based services, established through an effective partnership with the Department of Child Services (DCS), has resulted in $7,211,904 in MRO services in FY11 benefitting children with emotional and behavioral health needs.

CMHC – MRO Services

- In July, 2010 the FSSA, Office of Medicaid Policy and Planning (OMPP) and the Division of Mental Health and Addiction (DMHA) instituted a number of changes in the MRO program aimed at improving the integrity of the existing program and to promote recovery for children and adults with mental illness.
- The changes were developed by OMPP/DMHA and submitted to the Centers for Medicare and Medicaid (CMS) as an Indiana State Plan Amendment (SPA). Additionally, state administrative rules were promulgated in the Indiana Administrative Code (IAC) in response to the established program changes.
- The Indiana Council supports public policies that ensure the continuation of programs and services authorized by CMS that promote evidence based practices with respect to community based behavioral healthcare in Indiana.
- The Community Mental Health Center system in Indiana experienced dramatic decreases in the utilization of DMHA administered MRO services following the implementation of the changes implemented FSSA on July 1, 2010.
- The reduction in MRO services has impacted the delivery of behavioral health services by reducing programs historically found to be recovery focused evidence based practices that serve as alternatives to restrictive and costly inpatient care within state hospitals and/or acute care psychiatric units such as Assertive Community Treatment (ACT), and psycho-social rehabilitation programs, such as clubhouse.
- Other program funding has been reduced in FY11 by FSSA, such as the SOF bed allocation reimbursement level and the dual diagnosis crisis management program.

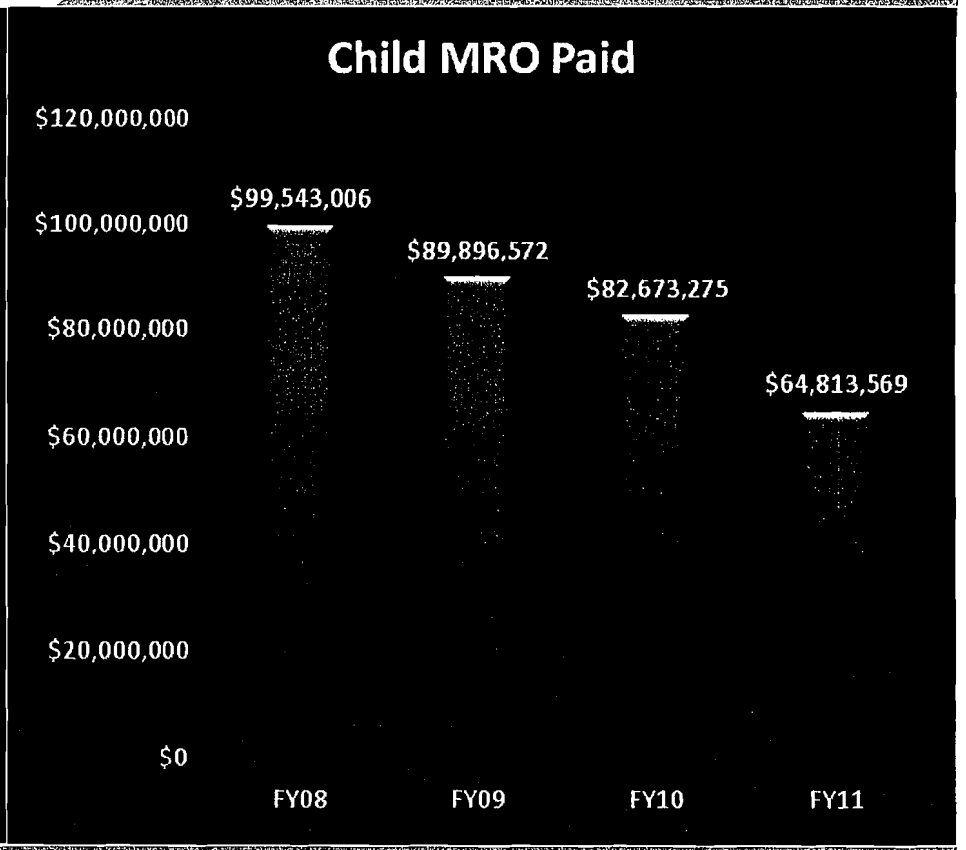
Background on Indiana Council Research

- In order to demonstrate the impact of the current MRO program on mental health consumers, available services and billing rates, the Indiana Council developed a series of research studies in FY 11 aimed at uncovering factual and statistically valid information with respect to MRO utilization and CMHC operational trends.
- Over the last year, the Indiana Council undertook a MRO service utilization study, a full time employee (FTE) impact analysis, a prior authorization analysis, a survey of CMHC clinicians on the impact of the MRO changes, an inpatient utilization research study, and a program change analysis.
- The various research studies were spearheaded by an Indiana Council metrics committee, which utilized statistically valid research techniques to uncover applicable data.
- The goal of the research was to analyze the changes on the CMHC system to ultimately determine how mental health consumers have been impacted by the changes developed by DMHA/OMPP.
- The information provided in today's presentation is based on a collective analysis of all CMHC providers to determine overall trends in the statewide system.
- Because local community and demographic needs related to behavioral health services vary across the state, it is important CMHCs have flexibility in their individually designed programs to ensure those needs are met.

MRO Utilization Data from FY2008 - FY2011

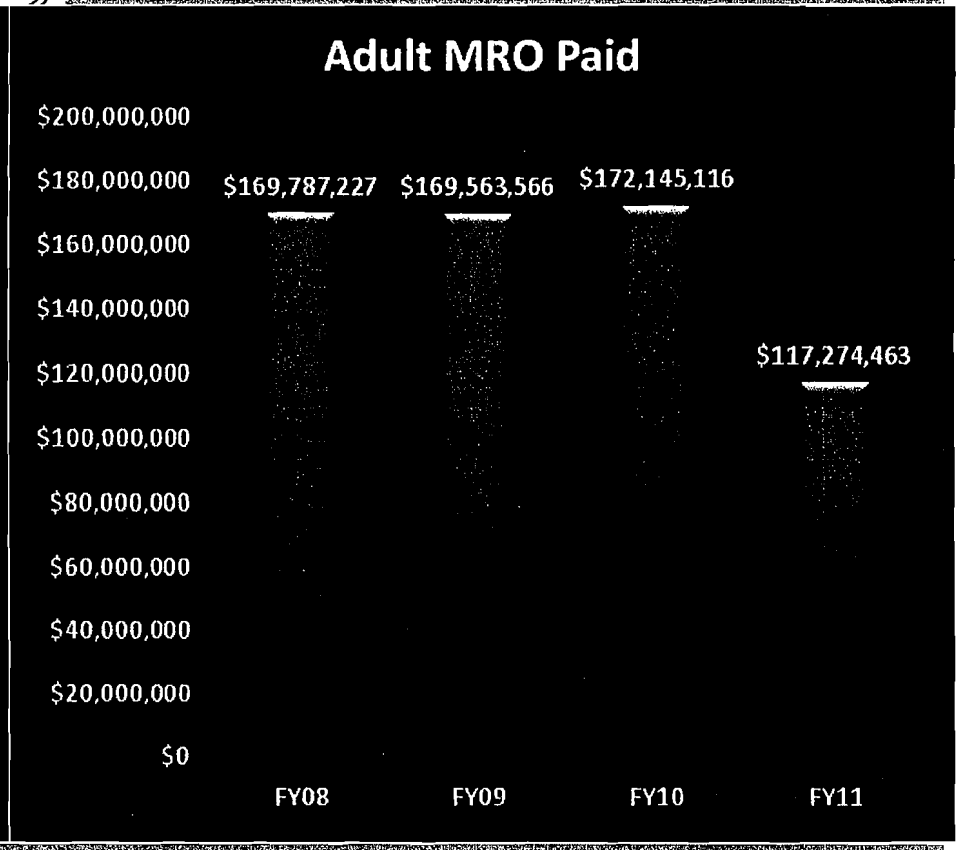
- The Indiana Council surveyed MRO data utilization by CMHCs with respect the number of consumers served and the utilization of approved service packets based on authorized billable services under the MRO program.
- Data used in the analysis was derived from published statewide MRO figures (consumers served & MRO paid) and from MRO service packet utilization data available from OMPP.
- The data provides supporting evidence on how various programs have been utilized by CMHCs with respect to allowable MRO services.
- The research data reflects that individuals with a high level of need (LON 4 or higher) are often exhausting initially approved service packet units resulting in extensive reliance in prior authorization requirements (which is administratively costly).
- The following summary slide demonstrates the trends in MRO consumers served and MRO paid between SFY 2008 and 2011.
- As you will see from the following slides, compared to FY08, in FY11 there were 17,873 fewer total consumers served or a reduction of (-23%), and $87,242,129 less MRO paid (-32%).

Child MRO: All services



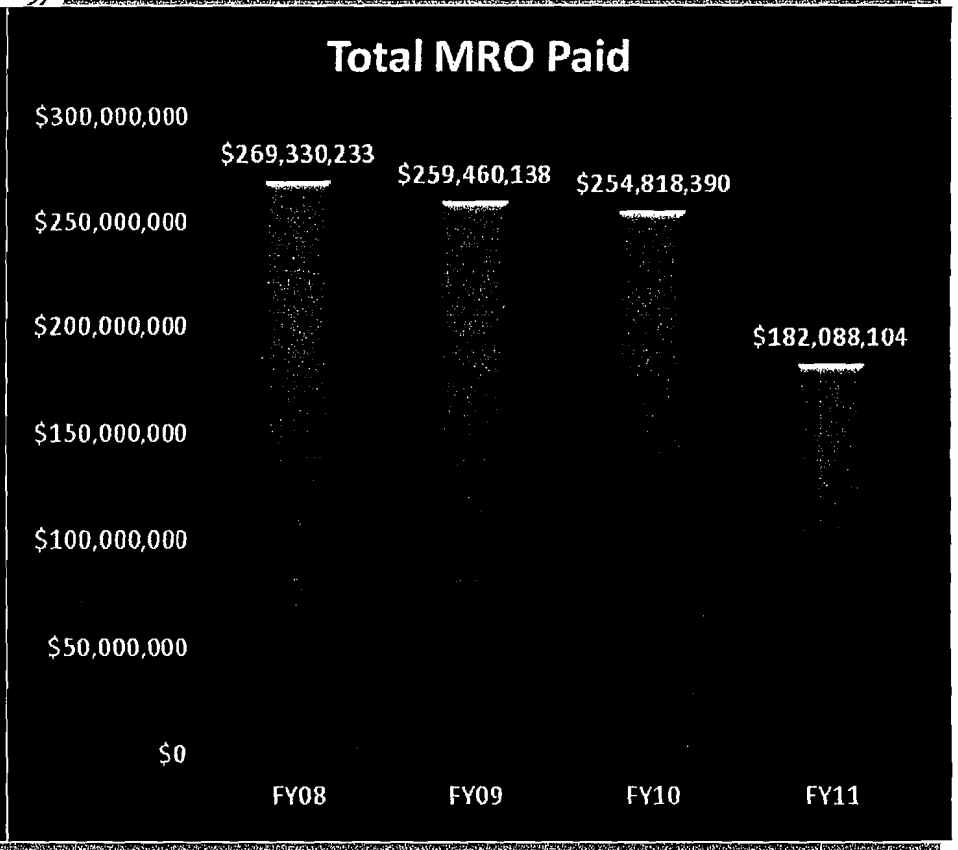
Compared to FY08, in FY11 there were 10,033 fewer child consumers (-26%), and $34,729,437 less MRO paid (-35%).

Adult MRO: All services



Compared to FY08, in FY11 there were 7,968 fewer adult consumers (-20%), and $52,512,764 less MRO paid (-31%).

Total MRO: All services

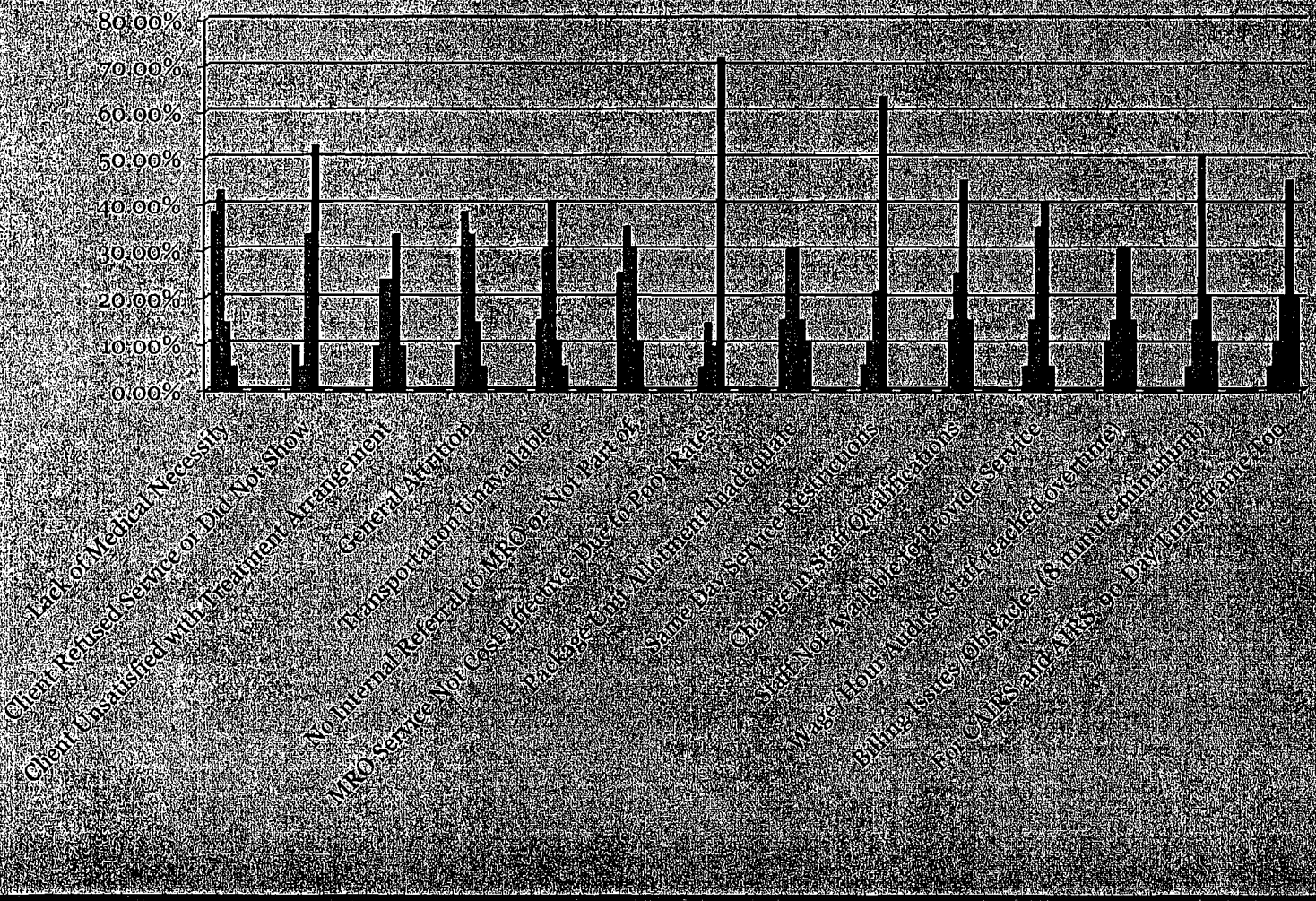


Compared to FY08, in FY11 there were 17,873 fewer total consumers (-23%), and $87,242,129 less MRO paid (-32%)

Survey of CMHC Clinicians Regarding Revised MRO Program

- The ICCMHC surveyed clinicians in a CMHC setting to inquire into their perceptions on the impact of the changed mental health system on the delivery of services to mental health consumers.
- Clinicians responded using a standard Likert rating to determine if they strongly agreed/disagreed with a host of CMHC treatment and service considerations.
- The study result reflects CMHC clinician concerns over MRO services not being cost effective, resulting in programs being eliminated or reduced.
- Other concerns are presented over limitations on same day service delivery and obstacles related to billing issues.
- The follows provides a summary of the survey findings:

Summary of Clinician Perceptions of Revised MRO Program



Indiana Council Recommendations to Improve the MRO Program

- In an effort to address the concerns identified by CMHC clinicians, the Indiana Council Board met with OMPP/DMHA to review the findings of the survey.
- In response to the findings, the Indiana Council developed a five point letter to OMPP/DMHA that recommended short-term solutions to the MRO program that would substantially improve the ability of CMHCs to provide services to mental health consumers.
- While OMPP/DMHA has indicated they are receptive to certain elements of the identified areas, they have indicated such changes would require SPA changes and Indiana Administrative Rule changes that may take at least one year to modify.
- The Indiana appreciates the willingness of OMPP/DMHA to consider these program improvements and want to continue to explore an expedited approach to the identified areas.
- A summary of the identified areas described in the letter are as follows:

Indiana Council Recommendations to Improve MRO program

1. **AIRS CAIRS SAME DAY SERVICE** - Eliminate the restriction on same day services up to 1.5 hours per day, for Skills Training as clients enrolled in these programs have a very high level of clinical need and require reinforcement of skills learned in order to maximize clinical benefit.
2. **CAIRS TOTAL NUMBER IN PACKAGE FOR SCHOOL BASED SERVICES** - Increase the number of hours for kids in a day to four to correspond with the DCS design of day treatment and an increase to a total of 95 days, to correspond with the school semester.
3. **AIRS TOTAL NUMBER OF DAYS** - Increase to 180 days before prior authorization (PA) in order to accommodate the serious extent of clinical problems and the amount of time to effect change. If there is concern regarding overuse of this service, handle it at the time of PA.
4. **MEDICATION EDUCATION AND TRAINING** – Since it is essential that CMHCs ensure that clients adhere to medication regimens and these services often are less than the 8 minute billing minimum, allow the first service delivered on a given day to be billed as one 15 minute unit and then additional services would be billed following the current "add up and round to the nearest unit" rules. This could be accomplished by simply removing the 8 minute minimum for a Medication Somatic billing on a given day.
5. **STAFF TO CLIENT RATIO** - Change the reimbursement for group delivered services for both counseling and ADL based upon a 1:4 staff to client ratio (from 1:6) in order to provide an adequate financial base for delivery of those services as presently the reimbursement for group has been a disincentive for use of that service modality.

In Patient Research Study

- At the end of FY 11, the Indiana Council undertook a study of inpatient trends following implementation of the change to the MRO program to determine the impact of the change on hospitalization for individuals with behavioral health needs.
- Based on a statistically valid sample size (n=13), CMHCs and those with hospital partnerships were surveyed.
- Across all levels of need, inpatient admissions did not change to a large degree.
- However, LONs (4,5) had more hospitalizations and more money was spent on inpatient services and less money spent on outpatient/MRO
- In patient utilization for Level of Need 5 is as follows:
  - FY10 total (N=326)
  - FY11 total (N=478)
- Cost savings associated with reduced MRO was largely erased by increased inpatient charges. Based on the research, the additional cost of inpatient services versus MRO services was $1,505,448 for LON 5 consumers.

Survey of CMHC Program Changes

- As a result of the service changes, the ICCMHC undertook a survey of CMHCs to determine the impact of the new mental health system on various programs.
- The survey asked CMHCs to indicated which programs in FY11 have been eliminated, reduced, or added in response to changes initiated on July 1, 2010.
- Based on the results, numerous programs were reduced or eliminated, such as:
  - Sub-acute and residential programs
  - Clubhouse programs
  - School based programs
  - Sex offender and monitoring programs
  - ACT programs
  - AIRS/CAIRS
  - Case management services
  - Transportation services
- While adding new programs has been challenging, some CMHCs in FY11 added primary health infrastructure in preparation for integrated care.

Where Do We Go From Here?

- The Indiana Council plans to use the information derived from various research and surveys to determine the impact these changes have had on mental health consumers.
- Because such a study requires appropriate time to determine the impact of the changes, it is recommended that following FY12, a detailed analysis be undertaken to determine if the changes to the MRO program have the promoted recovery of mental health consumers.
- The research study of consumers should include homeless populations, incarcerations trends, and individuals within the CMHC system.
- Future funding should ensure that non-match state funds, appropriated by the Indiana General Assembly for CMHC operations, are not restricted to allow sufficient flexibility with respect to individual community behavioral health needs.
- The state should pursue opportunities available in the Affordable Care Act (ACA) which encourage a strong partnership between behavioral and primary health providers by allowing medical billing in a CMHC for chronic primary healthcare services, such as diabetes, hypertension, and obesity.