

Members

Rep. Charlie Brown, Chairperson
Rep. Cindy Noe
Sen. Connie Lawson
Sen. Timothy Skinner
Kathleen O'Connell
Stacey Cornett
Margie Payne
Ronda Ames
Valerie N. Markley
Bryan Lett
Caroline Doebbling
Kurt Carlson
Chris Taelman
Jane Horn
Rhonda Boyd-Alstott
Dr. Danita Johnson Hughes



COMMISSION ON MENTAL HEALTH

Legislative Services Agency
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Authority: IC 12-21-6.5

MEETING MINUTES¹

Meeting Date: September 7, 2010
Meeting Time: 10:00 A.M.
Meeting Place: State House, 200 W. Washington St., House Chamber
Meeting City: Indianapolis, Indiana
Meeting Number: 2

Members Present: Rep. Charlie Brown, Chairperson; Rep. Cindy Noe; Sen. Connie Lawson; Stacey Cornett; Margie Payne; Ronda Ames; Valerie N. Markley; Bryan Lett; Caroline Doebbling; Kurt Carlson; Chris Taelman; Rhonda Boyd-Alstott; Dr. Danita Johnson Hughes.

Members Absent: Sen. Timothy Skinner; Jane Horn; Kathleen O'Connell.

I. Call to Order

Representative Charlie Brown, Chairperson, called the meeting to order at 10:05 A.M. Representative Brown introduced Rhonda Boyd-Alstott, a new member on the Commission on Mental Health (COMH) and welcomed her to the COMH.

II. Update on the Residential Care Assistance Program (RCAP) Funding Cuts

(A) Mr. Nick Petrone, Deputy Director, Aging Administration, Family and Social Services Administration (FSSA), told the members that little has changed concerning funding for RCAP since the last meeting. The State's economic condition has

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.

forced the Division of Aging to make difficult choices. The Division is trying to serve the neediest of the needy and is redirecting money to those most in need. Representative Brown expressed concern that the money for RCAP had been appropriated in a specific line item of the budget, and the administration appeared to redirect the money to other areas. Representative Brown also expressed concern that the decision to cut RCAP funding would have a ripple effect on jails and other institutions. Mr. Petrone reported that the Aging Administration was in discussions with township trustees and other local entities concerning steps to be taken because of the RCAP budget cuts. Representative Brown asked the members of the COMH to check with their local communities to determine what fallout there has been due to the budget cuts.

(B) Mr. Randall Fearnow, Krieg Devault, representing Miller Beach Terrace, provided the COMH with information on the impact of cutting funds for RCAP. (Exhibit 1)

(C) Mr. Robert Krumweid, Regional Mental Health Center in Lake County, told the COMH that his Center provides room and board assistance (RBA) services in Lake Station. (RBA and Assistance to Residents of County Homes (ARCH) were combined into the RCAP program.) The room and board facility in Lake Station has suffered losses similar to those of Miller Beach as discussed by Mr. Fearnow and is facing closure. Most services at the room and board facility in Lake Station are provided to individuals who come in off the streets.

Representative Brown asked Mr. Matt Brooks, Executive Director and CEO of the Indiana Council of Community Mental Health Centers, to provide the COMH with information at the next meeting on the impact of the RCAP funding reductions on the community mental health centers.

III. Follow Up from the Youth Law T.E.A.M. on Implementation of Indiana Statewide Juvenile Mental Health Screening Assessment and Treatment Pilot Project

Ms. JauNae Hanger and Ms. Amy Karozos reported that the screening program is funded by a grant from the Criminal Justice Institute. Costs to the detention centers are minimal and related mostly to computer programming. Allen and St. Joseph counties are not included in the pilot, but both counties are using an assessment tool. The success of the screening program does not rest on the screening process alone. It is important to have services at the local level to meet the needs of the youth identified as needing services through use of the screening tool. There will be a report at the end of this year when the pilot project ends that will include recommendations on how to work with detention centers in the future.

IV. Update on the Flow of Medical Information between Local Sheriffs and the Department of Correction (DOC)

(A) Mr. Steve Luce, Indiana Sheriff's Association, provided members with copies of the form for the transfer of medical information used when inmates are transferred from the local sheriffs to the DOC. (Exhibit 2) Mr. Luce reported that there has been improvement in the transfer of medical information when individuals are transferred from local jails to the DOC. Seventy-eight of the ninety-two jails in the State contract for medical services. Each fall the Association of Indiana Counties sponsors a conference on medical issues for jails. A few jails are beginning to transfer medical records to DOC electronically, which helps in providing accurate and timely information to DOC.

In answer to questions from Representative Brown, Mr. Luce said if medical records are

not transferred electronically, the records are transferred physically when the inmate is transferred. In answer to questions from Senator Lawson and Representative Noe, Mr. Luce said that the form used for the transfers is filled out by medical personnel at the jail or by jail staff. It is not filled out by the inmates. Mr. Luce further indicated that during the intake process at the jails, the jail personnel do not contact the inmate's personal physician. Inmates are given medical examinations within 14 days of entering the jails. Also, the form includes screening results for TB but not HIV.

(B) Mr. Kenneth Whitker, Executive Liaison for Adult Jails, DOC, reiterated Mr. Luce's comments concerning the improved flow of medical information between jails and DOC. Mr. Whitker said that there also needs to be a flow of information when inmates leave DOC and return to local jails or community correction facilities.

V. Update on Drug Formulary Used by DOC

(A) Mr. Steve McCaffrey, President and CEO, Mental Health America of Indiana, reminded the members of the COMH that the COMH has considered the issue of the DOC formulary for mental health drugs for many years. The 2009 Session of the General Assembly enacted HEA 1210, as recommended by the COMH, to create the Mental Health/Corrections Quality Advisory Committee modeled on the committee that currently advises the Office of Medicaid Policy and Planning (OMPP) on drugs. The purpose of the Committee is to advise and make recommendations concerning the DOC formulary for mental health and addiction medications and to report to the COMH with advice and recommendations. Mr. McCaffrey indicated that he is pleased that the DOC is calling for appointment of members to the committee to guide the DOC in formulary policy.

(B) Mr. John Dallas, Regional Vice President of Correctional Medical Services (CMS), Mr. Michael Mitcheff, DO, Regional Medical Director of CMS, Mr. Jamie Wiles, PsyD, Regional Mental Director of CMS, Dr. Vickie Burdine, psychiatrist with CMS, and Dr. Willis Triplett, pharmacist with CMS, discussed the formulary. Mr. Mitcheff said that there is some misunderstanding about the formulary. When individuals leave the DOC and return to the community, they likely use the same drugs as are on the DOC formulary if they are not on Medicaid. Just because a drug is on the Medicaid formulary does not mean it will be used in the private sector. There is concern with using a drug at the DOC that is on the Medicaid formulary when the individual could not afford the drug upon release. Mr. Mitcheff also indicated that ninety percent of requests for non-formulary drugs are approved. Mr. Mitcheff stated that the formulary used does not compromise quality of care for cost. In his testimony, Mr. Dallas estimated that the cost of changing to the Medicaid drug formulary would be \$4 million annually. In answer to questions, Mr. Dallas indicated that requests to use drugs not on the formulary are responded to within 48 hours. Dr. Burdine stated that the formulary used by the DOC is like the formulary used in most hospitals. Ms. Harriette Rosen, National Alliance on Mental Illness (NAMI), expressed concern that much of the discussion on the formulary centered around individuals with depression and not serious mental illness. Dr. Burdine responded that there is not that much difference between the old anti-psychotic and new anti-psychotic drugs in treating individuals with severe mental illness.

VI. Update on the Medicaid Rehabilitation Option (MRO)

(A) Ms. Gina Eckart, Director, Division of Mental Health and Addiction (DMHA), and Ms. Sarah Jagger, OMPP, provided the COMH with an update on the MRO. (Exhibit 3) In answer to questions from Representative Brown, Ms. Jagger indicated that requests for prior authorization come from community mental health centers and are approved by

Advantage. There is an appeal process if a request for prior authorization is denied. The lack of medical necessity is the main reason for denial of prior authorization.

The COMH recessed for lunch at 11:40 A.M. and resumed at 1:05 P.M.

(B) Mr. Matt Brooks, Executive Director and CEO, Indiana Council of Community Mental Health Centers, updated the COMH on the experience the community mental health centers have had with the changes in MRO. (Exhibit 4) The roll out of the new procedures has gone smoothly for the most part.

(C) Mr. Steve McCaffrey, President and CEO, Mental Health America of Indiana and Chairperson of the Lawson Select Group on Mental Health, updated the COMH on the meetings of the Lawson Select Group on Mental Health. (Exhibit 5) In answer to questions from Representative Noe, Mr. McCaffrey indicated that issues surrounding turf protection and silos of service have not completely been resolved but progress has been made, and the State is moving toward a more integrated system of service. Mr. McCaffrey also reported that there has been progress made in funding of clubhouse programs. The State is working on a new billing code to allow for funding of clubhouse services.

VII. Discussion of Plans for State Operated Facilities

(A) Ms. Gina Eckart, Director, DMHA, and Mr. Kevin Moore, Assistant Director, DMHA, discussed plans for changes to the State hospitals. (Exhibits 6 and 7) No hospitals will be closed, and no hospitals will be privatized. However, there are major changes at Logansport and Richmond State Hospitals. They will be downsized. Individuals with developmental disabilities who are in the hospitals are going to be placed back in their communities. In answer to questions from Representative Brown, DMHA indicated that the money saved by downsizing the hospitals is meant to follow the patients. **Dr. Eric Wright, Director, IU Center of Health Policy**, discussed a comprehensive study of patients who left Central State Hospital when it was closed. (Exhibit 8)

(B) Comments

Ms. Harriette Rosen, NAMI, had questions about how the money would follow individuals. Ms. Eckart indicated that the DMHA is still in the process of formulating its budget for the next legislative session.

VIII. Select Meeting Date for Final Meeting

Representative Brown announced that the next meeting will be October 27 at 12:30 P.M. in the House Chamber. He asked individuals who want legislation considered at that meeting to have their request to him by October 7. Representative Brown adjourned the meeting at 3:00 P.M.

Written testimony concerning Medicaid reimbursement and addiction counselors was presented to the COMH by Mr. David Bell, CEO, Valle Vista Hospital (Exhibit 9)

COMH
Meeting 2
September 7, 2010
Exhibit 1

September 1, 2010

Randall R. Fearnow
Direct Dial: (312) 423-9304
E-mail: rfearnow@kdlegal.com

Honorable Charlie Brown
Chairman
Indiana Mental Health Commission
200 West Washington Street
Indianapolis, IN 46204-2786

Re: RCAP Funding for Miller Beach Terrace

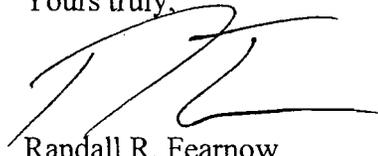
Dear Chairman Brown:

Thank you again for the opportunity to address the Commission last month and for placing the RCAP issue on the agenda for the September 7th meeting. There has been no change in the administration's position toward RCAP since the last meeting.

Enclosed with this correspondence please find some additional information which may be helpful to you and the Commission in understanding the impact of the RCAP moratorium on the delivery of mental health services in Lake County. I have enclosed a copy of my testimony from last month's meeting along with additional materials compiled by Iris Kuhn and other professionals at Miller Beach Terrace. In these material we present some compelling profiles of five representative residents at Miller Beach. We believe the plight of these residents, whose identities we have of course concealed, is indicative of the pressures placed on the mental health delivery system as a direct result of the RCAP moratorium.

Thank you again for your interest and that of the Commission in this important matter. I plan to be available on September 7th to answer any further questions you or Commission members may have.

Yours truly,



Randall R. Fearnow

RRF:vlg
Enclosures

KD_2964483_1.DOCX

**Testimony before the Indiana Commission on Mental Health
August 19, 2010, Indianapolis, IN**

Good Afternoon. My name is Randall Fearnow. I am an attorney with Krieg DeVault LLP and represent Miller Beach Terrace, a residential facility serving the needs of disabled individuals in Gary, Indiana. The vast majority of the residents of Miller Beach Terrace are receiving treatment for mental illness. The facility has served this population successfully for many years. The current owners and operators of the facility have been in the same location for twenty years.

The facility employs approximately 50 people in an area of Lake County which has been hit especially hard by the recession. Miller Beach Terrace is licensed by the Indiana State Department of Health for 168 residential beds and until very recently the facility enjoyed an average census of about 160 residents.

The reason I am here today is to draw your attention to a policy of the Division of Aging which has reduced Miller Beach's occupancy to 125 residents and has placed the facility in jeopardy of closing. The 35 residents who have left the facility are presumably either on the streets of Gary or are receiving services funded by the state and federal governments at a cost far greater than the state incurs at Miller Beach Terrace.

100% of Miller Beach Terrace's residents are participants in the residential care assistance program. Miller Beach is paid the princely sum of \$49 a day for the care of each of its residents. Miller Beach is surveyed by the Indiana State Department of Health. The facility enjoys a good survey history with the state and is in substantial compliance with ISDH regulations governing residential facilities.

The Indiana General Assembly allocates certain funds each year to the Family and Social Services Administration (“FSSA”) for the purpose of funding the Residential Care Assistance Program (“RCAP”). The Legislature’s allocation of those funds is not a general allocation. The funds are specifically designated to the RCAP program, not the general FSSA budget. I think the controlling statute indicates those funds allocated to the FSSA must be used for this designated purpose and cannot be reallocated. There is an indication that these funds are not being spent on the RCAP program in Lake County.

Historically, the FSSA has managed the RCAP budget by limiting the number of facilities in each county enrolled as RCAP providers. The number of beds licensed for RCAP participation in any given county is equal to the number of beds the FSSA is budgeted to fund. Therefore, as long as each licensed facility is admitting no more RCAP participants than they have licensed beds, the program will not go over budget.

In the past, as residents left the facility, Miller Beach Terrace accepted new residents for those vacant RCAP beds with the understanding that RCAP funding would be available to eligible applicants. However, in December 2009, Miller Beach Terrace was notified that the RCAP program would not be making any new approvals. Since that time, the census at Miller Beach Terrace has decreased to 125 RCAP participants. The participants that are leaving Miller Beach Terrace are not moving to other RCAP facilities. In fact, other RCAP facilities in Lake County are experiencing a similar decrease in census. Therefore, the total number of RCAP participants in the county is decreasing. Miller Beach receives calls every day from consumers seeking admission. All are rejected. None have anyplace else to go.

Miller Beach Terrace employs fifty individuals in various capacities, all of whom are at risk of lay off if the facility is not able to maintain a normal census. While it is hard to determine

exactly when Miller Beach Terrace will be forced to close its doors, it is safe to say that, without a reinstatement of RCAP funding to the facility, the facility's closure is imminent. In an effort to keep all of its employees, Miller Beach has reduced schedules in response to the decline in census and now has most employees on a four day week.

In addition to the loss of jobs associated with the withholding by the Division of Aging of RCAP funding, the loss of services to the residents still residing at Miller Beach Terrace is frightening. Considering that all facilities in the county are in a similar situation with regard to RCAP funding, it is likely that other facilities will close as well. Therefore, the 125 residents currently living at Miller Beach Terrace will be forced into competition with other displaced residents for an ever-decreasing number of RCAP beds in the county.

Very recently it was learned that the State of Indiana is seeking alternative placements for residents who are being moved from state institutions but who continue to require a residential setting. These residents are currently being cared for at a cost of several hundred dollars per day more than Miller Beach receives under RCAP. Miller Beach is ideally situated geographically and in other respects to accept some of these potential new residents and provide a low cost alternative to state institutionalization. Ideally situated, of course, but for the fact the state is currently preventing Miller Beach Terrace from admitting eligible residents.

It would clearly be in the state's best interest to relax the moratorium as to Miller Beach Terrace immediately to allow for the admission of new residents and to approve RCAP eligibility for new and current residents.

Many years ago, in October of 1996 to be exact, I represented residential provider Chicagoland Christian Village when the State of Indiana did exactly the same thing it is doing

today, that being to impose an illegal moratorium on admission to what was then called the room and board assistance program.

The moratorium in 1996 was determined to be illegal because it was imposed without legislative approval and without the agency even attempting to promulgate a regulation. The Indiana Court of Appeals, on October 9, 1996, in a case titled Chicagoland Christian Village v. Indiana Family & Social Services Administration, determined that the 1996 RBA moratorium had the force and effect of law and since it was not duly promulgated was invalid and unenforceable. The court of appeals ordered FSSA to process Chicagoland's application for RBA provider status at that time. I have no idea how the state can justify legally the current moratorium in the face of judicial precedent. It is apparently attempting to do so in a case pending here in the Marion Superior Court brought by a facility from Southern Indiana known as Lee Allen Bryant. Miller Beach Terrace is not a party to that litigation. We were told though, when we attempted to discuss Miller Beach's particular situation in relation to the residents I represent, that the state would not talk to us because of the pending litigation, litigation in which we are not participating.

Consequently, we come to you to make you aware of our situation. We greatly appreciate Chairman Brown giving us time today to discuss this matter with you.

I have with me today Iris Kuhn, a long serving administrator at Miller Beach 19 years. With Iris is the Director of Nursing Peggy Kreisch at the facility. I will attempt to answer any questions any members of the Commission may have. It is likely though you would prefer to hear from the people who are actually at the facility day after day attempting to deal with this crisis. That would be Iris and Peggy. Thank you again for your time and attention.

Miller Beach Terrace is a residential care facility that has offered services to the mentally ill population for 20 years in the city of Gary. The facility is surveyed by the Indiana Department of Public Health and licensed by the State of Indiana. Mentally ill are often described as the faceless population and Miller Beach Terrace has become their face and voice.

Some of the services provided are 24 hour nursing, 24 hour security, dietician approved meals, housekeeping, laundry and activities. All medications are distributed and monitored by a professional nursing staff. A medical doctor and a psychiatrist visit weekly to provide services. An MSW, therapist, provides group and individual therapy daily.

For the past 20 years Miller Beach Terrace has had a contract with FSSA as a provider in the RCAP program. We can only bill as an RCAP provider, at \$49.35 per/day as set by the state, we are not eligible to bill Medicaid or Medicare.

Effective December 01, 2009 the withholding of new applicants to the RCAP funding by the division of aging has reduced occupancy from 160 to 125 residents and has placed the facility in jeopardy of closing. We receive admission inquiries daily from hospitals, nursing homes and state agencies which we cannot accept due to lack of funding. Closing the facility would result in the elimination of over 50 jobs in Gary.

The 35 residents who have left the facility are presumably either on the streets of Gary or are receiving services funded by state and federal governments at a cost far greater than the state incurs at Miller Beach Terrace.

An internal audit completed of 2009 discharges indicated:

25% of discharged residents failed at community placement and were readmitted to facility,

20% went to nursing homes for a cost of approximately \$190.00 per/day,

15% were incarcerated at approximately \$100.00 per/day,

30% are homeless on the streets of Gary,

10% unknown.

Of clients interviewed who returned to Miller Beach Terrace stated that they had on average 3 (three) emergency room visits while in the community, at a cost between \$1,000.00-\$1,500.00 per visit which was probably billed to Medicaid.

Miller Beach Terrace can no longer admit or re-admit any clients that have been discharged due to the closed RCAP Program. Considering all the facilities in the county are in a similar situation with regards to RCAP funding, it is likely that other facilities will close as well. Therefore, the 125 residents currently living at Miller Beach Terrace will be forced into competition with other displaced residents for an ever-decreasing number of RCAP beds. Due to the clients poor judgment they are unable to manage their own affairs. Therefore, the clients who are failing in the community have no place to go and are not capable of communicating their need for help. This also means that they are off of their medications and can become a danger to themselves and others. The cost in human suffering is incalculable.

Enclosed are 5 profiles and histories, as an example, of residents living at Miller Beach Terrace. People presenting these profiles today would no longer be eligible for admission. All of these people now have benefits which were obtained through the efforts of Miller Beach Terrace. Upon discharge, due to their inability to manage their own affairs and poor judgment, they will be imminent danger or losing these benefits. These benefits include, but are not limited to Medicaid, Social Security, Disability, pensions (if eligible).

Resident #1 was homeless at the time of admission. He was received from the emergency room. Resident had no Medicaid or income. He had been diagnosed with paranoid schizophrenia at the age of 30. Had been receiving social security benefits but had been unable to manage benefits due to his difficulty concentrating and poor judgment and impulse. Social Security had been suspended. Resident on admission was very hostile with delusional conversation. Stated he was hearing voices. Resident stated he was having seizures daily. Personal hygiene was poor, clothes had to be thrown away, did not have any personal items.

Today he is alert and orientated. Concentration is still poor, delusional conversation is present but he is able to communicate his needs. Hygiene is improved. No longer has seizure activity. Seizures controlled by medication.

*On reverse side is medication and diagnosis.

If Miller Beach Terrace is forced to close their doors, due to the closed RCAP Program, this client has the potential to become homeless on the streets of Gary, un-medicated, unsupervised, suffering and uncared for.

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DAVERCI

Physicians Orders By Date Range

From 8/1/2010 To 8/31/2010

Print Date : 8/20/2010
Print Time : 11:51:28AM

Page 1 of 2

Start Date DC Date	Physicians Orders By Date Range
Primary Orders	
07/15/2008	ACTIVITY AS TOLERATED
07/15/2008	FREE OF COMMUNICABLE DISEASE INCLUDING TB IN AN INFECTIOUS STATE: <input type="checkbox"/> YES <input type="checkbox"/> NO
07/15/2008	MAY CRUSH APPROPRIATE MEDS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
07/15/2008	MAY DO THERAPEUTIC CHORES
07/15/2008	MAY SEE: <input type="checkbox"/> DENTIST, <input type="checkbox"/> EYE DR, <input type="checkbox"/> PODIATRIST, <input checked="" type="checkbox"/> MENTAL HEALTH CLINICIAN, AUDIOLOGIST, PRN
03/09/2009	DEPAKOTE LEVEL MONTHLY DILANTIN LEVEL MONTHLY
Dietary	
07/09/2008	REGULAR 2PM 8PM SANDWICH W DRINK
Med	
07/10/2008	Combivent 103-18MCG/ACT AEROSOL Use 2 Puff(s) BY INHALATION QID: Four Times Daily AT 8:00 AM; AT 12:00 PM; AT 4:00 PM; AT 8:00 PM; Start Date: 07/10/2008 8:00AM Entered By: Kresich, Peggy
07/10/2008	Dilantin 100MG CAPSULE Take 2 Capsule(s) BY MOUTH BID: Twice Daily AT 8:00 AM; AT 4:00 PM; Start Date: 07/10/2008 8:00AM Entered By: Kresich, Peggy
07/10/2008	Oyst-Cal-D 500 500-200MG-IU TABLET Take 1 Tablet(s) BY MOUTH BID: Twice Daily AT 8:00 AM; AT 4:00 PM; Start Date: 07/10/2008 8:00AM Entered By: Kresich, Peggy
07/10/2008	SIMVASTATIN 40MG TABLET Take 1 Tablet(s) BY MOUTH QHS: At Bedtime AT 8:00 PM; Start Date: 07/10/2008 8:00PM Entered By: Kresich, Peggy
07/10/2008	Omeprazole 20MG CAPSULE DELAYED RELEASE Take 1 Capsule(s) BY MOUTH QD: Daily AT 8:00 AM; Start Date: 07/10/2008 8:00AM Entered By: Kresich, Peggy
08/23/2008	Amitriptyline HCl 100MG TABLET Take 1 Tablet(s) BY MOUTH QHS: At Bedtime AT 8:00 PM; Start Date: 08/23/2008 8:00PM Entered By: Kresich, Peggy
03/10/2009	ARTANE 2MG TABLET Take 1 Tablet(s) BY MOUTH BID: Twice Daily AT 8:00 AM; AT 4:00 PM; Start Date: 03/10/2009 8:00AM Entered By: Kresich, Peggy
05/08/2009	Lorazepam 1MG TABLET Take 1 Tablet(s) BY MOUTH BID: Twice Daily AT 8:00 AM; AT 4:00 PM; Start Date: 05/08/2009 8:00AM Entered By: Kresich, Peggy
05/09/2009	Depakote ER 500MG TABLET SR 24 HR* Take 3 Tablet(s) BY MOUTH QHS: At Bedtime AT 8:00 PM; Start Date: 05/09/2009 8:00PM Entered By: Kresich, Peggy
07/14/2009	Detrol 2MG TABLET Take 1 Tablet(s) BY MOUTH QD: Daily AT 8:00 AM; Start Date: 07/14/2009 8:00AM Entered By: Kresich, Peggy DX: Hypertonicity of Bladder
10/21/2009	One-Tablet-Daily TABLET Take 1 Tablet(s) BY MOUTH QD: Daily AT 8:00 AM; Start Date: 10/21/2009 8:00AM Entered By: Kresich, Peggy
03/22/2010	Alavert Allergy/Sinus 5-120MG TABLET SR 12 HR* Take 1 Tablet(s) BY MOUTH BID: Twice Daily AT 8:00 AM; AT 4:00 PM; Start Date: 03/22/2010 8:00AM Entered By: Kresich, Peggy
06/05/2010	Abilify 5MG TABLET Take 1 Tablet(s) BY MOUTH Daily AT 8:00 AM; Start Date: 06/05/2010 8:00AM Entered By: Nutt, Dawna J.

Resident Name	DOB	Age	Gender	Admit Date	Physician Name	
		51	M	07/09/2008		
Resident ID	LOC/CM	Nursing Alerts			Phone	Embr Phone
					(XXX)-XXX-XXXX	
Station	Room/Bed	Primary Dx			Primary Physician Signature	
Building Miller Bea	Room A-L --	PARANOID SCHIZOPHRENIA COPD SEIZURE DISORDER HYPERLIPIDEMIA ARTHRITIS GERD				
Reviewed By	Date	Date Signed				
Allergies						
NKA						

Resident #2 was admitted as homeless. Resident had no Medicaid or income. Was not receiving treatment for schizophrenia, and had been diagnosed for 20 years previously. Conversation was delusional and had hallucinations. Today conversation is within normal range. Still exhibits poor judgment and poor impulse control. She denies hallucinations.

*On reverse side is medication and diagnosis.

If Miller Beach Terrace is forced to close their doors, due to the closed RCAP Program, this client has the potential to become homeless on the streets of Gary, un-medicated, unsupervised, suffering and uncared for.



DAVERCI

Miller Beach Terrace

Physicians Orders By Date Range

From 8/1/2010 To 8/31/2010

Print Date : 8/26/2010
Print Time : 1:17:14PM

Page 1 of 1

Start Date DC Date	Physicians Orders By Date Range
08/01/2007	BASED UPON THE INFORMATION AVAILABLE AT THE TIME OF THE REVIEW & ASSUMING THE ACCURACY & COMPLETENESS OF SUCH INFORMATION, IT IS MY PROFESSIONAL JUDGMENT THAT AT SUCH TIME, THE RESIDENT'S MEDICATION REGIMEN CONTAINED NO NEW IRREGULARITIES (AS DEFINED IN SOM APPENDIX PP 483.60 (c))
08/01/2007	SEE REPORT FOR ANY NOTED IRREGULARITIES
08/01/2007	ACTIVITY AS TOLERATED AD. LIB
08/01/2007	MAY ALTER DIET FOR SPECIAL OCCASION MEALS: <input type="checkbox"/> YES <input type="checkbox"/> NO
08/01/2007	MAY CRUSH APPROPRIATE MEDS <input type="checkbox"/> YES <input type="checkbox"/> NO
08/01/2007	MAY DO THERAPEUTIC CHORES
08/01/2007	MAY SEE: <input type="checkbox"/> DENTIST, <input type="checkbox"/> EYE DR, <input type="checkbox"/> PODIATRIST, <input type="checkbox"/> MENTAL HEALTH CLINICIAN, <input type="checkbox"/> AUDIOLOGIST, PRN
08/01/2007	MEDICATIONS REVIEWED BY CONSULT RPH: _____
02/05/2007	REGULAR
09/01/2007	Haldol Decanoate 50MG/ML SOLUTION Inject 1 ml(s) INTRAMUSCULARLY EVERY 1 MONTH(S) AT 2:00 PM; Start Date: 09/01/2007 2:00PM Entered By: Nutt, Dawna J. DX: Psychosis
11/13/2008	Cogentin 1MG TABLET Take 1 Tablet(s) BY MOUTH QD: Daily AT 8:00 AM; Start Date: 11/13/2008 8:00AM Entered By: Kresich, Peggy
02/06/2007	Risperdal 1MG TABLET Take 1 Tablet(s) BY MOUTH BID: Twice Daily AT 8:00 AM; AT 4:00 PM; Start Date: 02/06/2007 4:00PM Entered By: Daverci Service
02/06/2007	Haloperidol 10MG TABLET Take 1 Tablet(s) BY MOUTH QD: Daily AT 8:00 AM; BRAND: HALDOL Start Date: 02/07/2007 8:00AM Entered By: Daverci Service
02/06/2007	DIDANOSINE 400 MG CAPSULE DELAYED RELEASE Take 1 Capsule(s) BY MOUTH QD: Daily AT 8:00 AM; BRAND: VIDEX EC Start Date: 02/06/2007 8:00AM Entered By: Daverci Service
10/01/2007	MAY HAVE ANNUAL FLU VACCINE, FLUVIRIN .5CC IM ONE TIME DOSE ONLY FOR OCTOBER FOR INFO ONLY Start Date: 10/01/2007 12:00AM Entered By: Nutt, Dawna J.
08/22/2007	Sandwich with drink at 230pm and 7pm FOR INFO ONLY Start Date: 08/22/2007 12:00AM Entered By: Nutt, Dawna J.

Resident Name	DOB	Age	Gender	Admit Date	Physician Name
		50	F	02/05/2007	
Resident ID	Room/Unit	Nursing Alerts		Phone	Enter Phone
				(219)-884-3210	
Building	Room/Unit	Primary Dx		Patient/Physician Signature	
Building Miller Bea	Room M-Z/ --	SCHIZOPHRENIA,			
Reviewed By	Date			Date Signed	

NO KNOWN ALLERGIES

Resident #3 was admitted from hospital. He had been living homeless. Resident had no Medicaid or income. Debilitated and was not treating depression, that had psychotic features i.e. hostility, threatening behavior. No treatment for HIV except for beginning medication at hospital. Client's depression has improved. No longer has psychotic features. HIV labs have not showed any progression of the illness.

*On reverse side is medication and diagnosis.

If Miller Beach Terrace is forced to close their doors, due to the closed RCAP Program, this client has the potential to become homeless on the streets of Gary, un-medicated, unsupervised, suffering and uncared for.



DAVERCI

Miller Beach Terrace Physicians Orders By Date Range

From 8/1/2010 To 8/31/2010

Print Date : 8/26/2010
Print Time : 1:31:11PM

Page 1 of 2

Start Date DC Date	Physicians Orders By Date Range
08/01/2007	___ BASED UPON THE INFORMATION AVAILABLE AT THE TIME OF THE REVIEW & ASSUMING THE ACCURACY & COMPLETENESS OF SUCH INFORMATION, IT IS MY PROFESSIONAL JUDGMENT THAT AT SUCH TIME, THE RESIDENT'S MEDICATION REGIMEN CONTAINED NO NEW IRREGULARITIES (AS DEFINED IN SOM APPENDIX PP 483.60 (c))
08/01/2007	___ SEE REPORT FOR ANY NOTED IRREGULARITIES
08/01/2007	ACTIVITY AS TOLERATED
08/01/2007	FREE OF COMMUNICABLE DISEASE INCLUDING TB IN AN INFECTIOUS STATE: ___ YES ___ NO
08/01/2007	MAY ALTER DIET ON SPECIAL OCCASIONS: ___ YES ___ NO
08/01/2007	MAY CRUSH APPROPRIATE MEDS ___ YES ___ NO
08/01/2007	MAY DO THERAPEUTIC CHORES
08/01/2007	MAY PARTICIPATE IN ACTIVITIES PER PLAN AD LIB AS TOLERATED
08/01/2007	MAY SEE: ___ DENTIST, ___ EYE DR, ___ PODIATRIST, ___ MENTAL HEALTH CLINICIAN, AUDIOLOGIST, PRN
08/01/2007	MEDICATIONS REVIEWED BY CONSULT RPH:
08/01/2007	MY SIGNATURE BELOW INDICATES THE RESIDENT CONTINUES TO NEED CARE TO A RESIDENTIAL LEVEL

REGULAR

05/01/2009	Aspir-Low 81MG TABLET ENTERIC COATED Take 1 Tablet(s) BY MOUTH QD: Daily AT 8:00 AM; Start Date: 05/01/2009 8:00AM Entered By: Kresich, Peggy
10/18/2009	ATRIPLA NO STRENGTH LISTED TABLET Take 1 Tablet(s) BY MOUTH QHS: At Bedtime AT 8:00 PM; Start Date: 10/18/2009 8:00PM Entered By: Kresich, Peggy
04/12/2007	ONE-TABLET-DAILY NO STRENGTH LISTED TABLET Take 1 Tablet(s) BY MOUTH QD: Daily AT 8:00 AM; (MULTIVITAMIN) Start Date: 04/12/2007 8:00AM Entered By: Daverci Service
02/04/2010	Zocor 40MG TABLET Take 1 Tablet(s) BY MOUTH At Bedtime AT 8:00 PM; Start Date: 02/04/2010 8:00PM Entered By: Kresich, Peggy
02/04/2010	Zetia 10MG TABLET Take 1 Tablet(s) BY MOUTH At Bedtime AT 8:00 PM; Start Date: 02/04/2010 8:00PM Entered By: Kresich, Peggy
02/05/2010	Tricor 145MG TABLET Take 1 Tablet(s) BY MOUTH QHS: At Bedtime AT 8:00 PM; Start Date: 02/05/2010 8:00PM Entered By: Kresich, Peggy
03/27/2010	Niaspan 1000MG TABLET CONTROLLED-RELEASE* Take 1.5 Tablet(s) BY MOUTH At Bedtime AT 8:00 PM; Start Date: 03/27/2010 8:00PM Entered By: Kresich, Peggy
09/17/2008	Dixipam HCl 100MG CAPSULE Take 1 Capsule(s) BY MOUTH QHS: At Bedtime AT 8:00 PM; Start Date: 09/17/2008 8:00PM Entered By: Kresich, Peggy DC'D: 06/06/2010 11:00PM DC'D By: Kresich, Peggy

Resident Name	DOB	Age	Gender	Admit Date	Physician Name	
		40	M	04/12/2007		
Resident ID	LOC/OM	Nursing Alerts			Phone	Pager Phone
					(219)-884-3210	
Setting	Room No.	Primary Dx			Primary Physician Signature	
Building Miller Bea	Room A-L/ --	MAJOR DEPRESSION, HX OF PANCREATIC CANCER HIV				
Reviewed By	Date	Date Signed				

NO KNOWN ALLERGIES

Resident #4 was admitted from hospital. 35% total burned area. Resident is a veteran that had no Medicaid or income. Medicaid had been applied for. He would have been homeless if not admitted. Resident continued to need skilled care that was managed through out-patient treatment. He was not nursing home eligible due to no benefits. Resident recovered with physical deformities.

*On reverse side is medication and diagnosis.

If Miller Beach Terrace is forced to close their doors, due to the closed RCAP Program, this client has the potential to become homeless on the streets of Gary, un-medicated, unsupervised, suffering and uncared for.



DAVERCI

Physicians Orders By Date Range

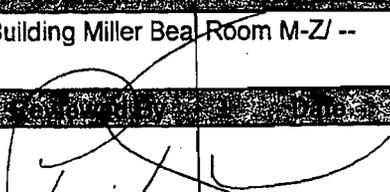
From 8/1/2010 To 8/31/2010

Print Date : 8/30/2010
Print Time : 11:58:55AM

Page 1 of 2

Start Date DC Date	Physicians Orders By Date Range
08/01/2007	BASED UPON THE INFORMATION AVAILABLE AT THE TIME OF THE REVIEW & ASSUMING THE ACCURACY & COMPLETENESS OF SUCH INFORMATION, IT IS MY PROFESSIONAL JUDGMENT THAT AT SUCH TIME, THE RESIDENT'S MEDICATION REGIMEN CONTAINED NO NEW IRREGULARITIES (AS DEFINED IN SOM APPENDIX PP 483.60 (c))
08/01/2007	SEE REPORT FOR ANY NOTED IRREGULARITIES
08/01/2007	MAY ALTER DIET FOR SPECIAL OCCASION MEALS: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
08/01/2007	MAY CRUSH APPROPRIATE MEDS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
08/01/2007	MAY PARTICIPATE IN ACTIVITIES PER PLAN: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
08/01/2007	MAY SEE: <input type="checkbox"/> DENTIST, <input type="checkbox"/> EYE DR, <input type="checkbox"/> PODIATRIST, <input checked="" type="checkbox"/> MENTAL HEALTH CLINICIAN, <input type="checkbox"/> AUDIOLOGIST, PRN
08/01/2007	MEDICATIONS REVIEWED BY CONSULT RPH:
08/01/2007	UP AD LIB

01/11/2007	REGULAR WITH 230 PM AND 7PM SANDWICH AND DRINK
06/11/2009	Remeron 30MG TABLET Take 1 Tablet(s) BY MOUTH QHS: At Bedtime AT 8:00 PM; Start Date: 06/11/2009 8:00PM Entered By: Kresich, Peggy
01/12/2007	Famotidine 20MG TABLET Take 1 Tablet(s) BY MOUTH QD: Daily AT 8:00 AM; BRAND: PEPCID Start Date: 01/13/2007 8:00AM Entered By: Daverci Service
01/12/2007	Therapeutic TABLET Take 1 Tablet(s) BY MOUTH QD: Daily AT 8:00 AM; BRAND: THERAPEUTIC MULTIVIT Start Date: 01/13/2007 8:00AM Entered By: Daverci Service
01/12/2007	Docusate Sodium 100MG CAPSULE Take 1 Capsule(s) BY MOUTH QD: Daily AT 8:00 AM; Start Date: 01/13/2007 8:00AM Entered By: Daverci Service
01/12/2007	Folic Acid 1MG TABLET Take 1 Tablet(s) BY MOUTH QD: Daily AT 8:00 AM; Start Date: 01/13/2007 8:00AM Entered By: Daverci Service
02/05/2010	Artificial Tears 1.4% SOLUTION Apply 2 Drop(s) IN THE EYE BID: Twice Daily AT 8:00 AM; AT 4:00 PM; Apply In Both Eyes MKAB Start Date: 02/05/2010 8:00AM Entered By: Kresich, Peggy
09/03/2007	Analpram-HC 1-1% CREAM Insert 1 Dab(s) RECTALLY As Needed MKAB Start Date: 09/03/2007 12:00AM Entered By: Nutt, Dawna J.
08/23/2007	As Needed Analpram 2.5 as directed prn mkab Start Date: 08/23/2007 8:00AM Entered By: Kresich, Peggy
02/05/2010	Afrin Nasal Spray 0.05% SOLUTION Use 2 Spray(s) NASALLY As Needed EVERY 12 HOUR(S); NO MORE THAN 1 Spray(s) EVERY 12 HOUR(S) Apply In Both Nostrils MKAB Start Date: 02/05/2010 7:00AM Entered By: Kresich, Peggy
07/20/2010	Ambien 10MG TABLET Take 1 Tablet(s) BY MOUTH QHS: At Bedtime PRN As Needed AT 8:00 PM; Start Date: 07/20/2010 8:00PM Entered By: Kresich, Peggy

Resident Name	DOB	Age	Gender	Admit Date	Physician Name
		52	M	01/11/2007	
					Phone
					(219)-884-3210
					Emergency Phone
					Primary Dx
Building Miller Bea	Room M-Z/ --	2006 35% TBSA WITH 4 FINGER CONTRACTIONS			Physician Signature
					

NO KNOWN ALLERGIES

Start Date DC Date	Physicians Orders By Date Range
09/26/2007	Continue OT for 4 more weeks FOR INFO ONLY Start Date: 09/26/2007 12:00AM Entered By: Nutt, Dawna J.
10/01/2007	MAY HAVE ANNUAL FLU VACCINE, FLUVIRIN .5CC IM ONE TIME DOSE ONLY FOR OCTOBER FOR INFO ONLY Start Date: 10/01/2007 12:00AM Entered By: Nutt, Dawna J.

Resident Name	DOB	Age	Gender	Admit Date	Physician Name
		52	M	01/11/2007	
Resident ID	LOS	Nursing Alerts		Phone	Emer. Phone
				(219)-884-3210	
Building	Room	Primary Dx			Primary Physician Signature
Building Miller Bea	Room M-Z/ --	2006 35% TBSA WITH 4 FINGER CONTRACTIONS			
Reviewed By	Date				Date Signed
NO KNOWN ALLERGIES					

Resident #5 was admitted from homeless shelter. Resident had no Medicaid or income. Resident was verbally hostile. History of cerebral palsy and has motor function dysfunctions including rigidity. She has slow deformed gait with limp. Right foot is completely perpendicular to other foot as she ambulates. Appears thin and frail. Poor personal hygiene. Delusional conversation. Has no belongings. Today resident shows some improvement. Delusional conversation improved. Able to communicate her needs. Hygiene is improved.

*On reverse side is medication and diagnosis.

If Miller Beach Terrace is forced to close their doors, due to the closed RCAP Program, this client has the potential to become homeless on the streets of Gary, un-medicated, unsupervised, suffering and uncared for.



DAVERCI

Physicians Orders By Date Range

Miller Beach Terrace
From 8/1/2010 To 8/31/2010

Print Date: 8/26/2010
Print Time: 1:27:23PM

Start Date DC Date	Physicians Orders By Date Range
08/01/2007	___ BASED UPON THE INFORMATION AVAILABLE AT THE TIME OF THE REVIEW & ASSUMING THE ACCURACY & COMPLETENESS OF SUCH INFORMATION, IT IS MY PROFESSIONAL JUDGMENT THAT AT SUCH TIME, THE RESIDENT'S MEDICATION REGIMEN CONTAINED NO NEW IRREGULARITIES (AS DEFINED IN SOM APPENDIX PP 483.60 (c))
08/01/2007	___ SEE REPORT FOR ANY NOTED IRREGULARITIES
08/01/2007	FREE OF COMMUNICABLE DISEASE INCLUDING TB IN AN INFECTIOUS STATE
08/01/2007	MAY ALTER DIET ON SPECIAL OCCASIONS
08/01/2007	MAY CRUSH APPROPRIATE MEDS
08/01/2007	MAY DO THERAPEUTIC CHORES
08/01/2007	MAY PARTICIPATE IN ACTIVITIES AS TOLERATED AD LIB
08/01/2007	MAY SEE: ___ DENTIST, ___ EYE DR, ___ PODIATRIST, ___ MENTAL HEALTH CLINICIAN, AUDIOLOGIST, PRN
08/01/2007	MEDICATIONS REVIEWED BY CONSULT RPH:
08/01/2007	MY SIGNATURE BELOW INDICATES THE RESIDENT CONTINUES TO NEED CARE TO A RESIDENTIAL LEVEL

09/12/2006 REGULAR W/ 2PM SNACK & 7PM SANDWICH W/ JUICE

09/19/2007	Lorazepam 1MG TABLET Take 1 Tablet(s) BY MOUTH QD: Daily AT 8:00 AM; Start Date: 09/19/2007 8:00AM Entered By: Nutt, Dawna J. DX: anxiety
09/22/2007	LYRICA 75MG CAPSULE Take 1 Capsule(s) BY MOUTH QD: Daily AT 8:00 AM; Start Date: 09/22/2007 8:00AM Entered By: Nutt, Dawna J. DX: pain
02/27/2008	Multi-B Complex No Strength Listed CAPSULE Take 1 Capsule(s) BY MOUTH QD: Daily AT 8:00 AM; Start Date: 02/27/2008 8:00AM Entered By: Kresich, Peggy
11/26/2008	Motrin 800MG TABLET Take 1 Tablet(s) BY MOUTH BID: Twice Daily AT 8:00 AM; AT 8:00 PM; Start Date: 11/26/2008 8:00AM Entered By: Kresich, Peggy DX: Mild to Moderate Pain
09/09/2009	Ultram 50MG TABLET Take 1 Tablet(s) BY MOUTH BID: Twice Daily AT 4:00 PM; AT 8:00 PM; Start Date: 09/09/2009 4:00PM Entered By: Kresich, Peggy
05/05/2007	SIMVASTATIN 20 MG TABLET Take 1 Tablet(s) BY MOUTH QHS: At Bedtime AT 8:00 PM; Start Date: 05/05/2007 8:00PM Entered By: Daverci Service
04/27/2007	CYMBALTA 30 MG CAPSULE Take 1 Capsule(s) BY MOUTH QD: Daily AT 8:00 AM; Start Date: 04/27/2007 8:00AM Entered By: Daverci Service
09/13/2006	ONE-TAB-DAILY W/ IRON NO STRENGTH LISTED TABLET Take 1 Tablet(s) BY MOUTH QD: Daily AT 8:00 AM; Start Date: 09/13/2006 8:00AM Entered By: Daverci Service
04/09/2010	Mobic 15MG TABLET Take 1 Tablet(s) BY MOUTH QD: Daily AT 8:00 AM; Start Date: 04/09/2010 8:00AM Entered By: Kresich, Peggy

Resident Name	DOB	Age	Gender	Admit Date	Physician Name
		51	F	09/12/2006	
Resident ID	Room/CM	Nursing Alerts		Phone	Email/Phone
				(219)-884-3210	
Station	Room/Bed	Primary Dx		Primary Physician Signature	
Building Miller Bea	Room A-L/ --	CEREBRAL PALSY, MAJOR DEPRESSION WITH PSYCHOTIC FEATURES, NEUROPATHY			
Reviewed By	Date			Date/Signature	

NO KNOWN ALLERGIES



SUMMARY OF COUNTY JAIL MEDICAL RECORDS

Indiana Department of Correction
Division of Health Care Services

COMH Meeting 2 September 7, 2010

Exhibit 2

This form to be completed in its entirety by Jail staff and submitted to the Indiana Department of Correction receiving facility in Adobe Acrobat/.pdf format. Attach additional pages as necessary.

GENERAL INFORMATION

OFFENDER NAME (Last, First, Middle):	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	DOC # (if known)
ALIAS(ES):	COUNTY OF COMMITMENT	CAUSE NUMBER	

MEDICAL/MENTAL HEALTH HISTORY

Blank space for Medical/Mental Health History.

ALLERGIES: NONE UNKNOWN KNOWN (LIST KNOWN ALLERGIES):

SURGICAL HISTORY

Blank space for Surgical History.

CURRENT MEDICATIONS

Blank space for Current Medications.

CURRENT DIAGNOSES

Blank space for Current Diagnoses.

CURRENT ONGOING TREATMENTS

Blank space for Current Ongoing Treatments.

TB HISTORY

Known TB Exposure? No Yes Known Positive PPD? No Yes

Date/Location Treatment Received (if applicable):

Medications Received (if applicable):

Prepared By:

Signature of Staff Completing this Form	Title
Printed Name of Staff Completing this Form	Date

Distribution: Offender Records, Receiving facility, Sending County Jail



COMH
Meeting 2
September 7, 2010
Exhibit 3

Medicaid Rehabilitation Option (MRO) Implementation Update

Gina Eckart, Director

Division of Mental Health and Addiction

Sarah Jagger, Policy Director

Office of Medicaid Policy and Planning





MRO Changes Update

- Implementation on July 1, 2010.
- Mental Health System Transformation framework based on recovery oriented care model.
- Person centered treatment planning and individualized care.



DMHA Activities in Preparation for MRO Changes

- January and February shared process flow for service package assignments and information about required data elements with all CMHCs.
- Provided information to CMHCs regarding issues with Medicaid RID numbers (March - June).
- Invited CMHCs to send staff to DMHA to work on cleaning their data – 8 CMHCs did so.
- All CMHCs received monthly communications and specific data files that indicated potential issues with diagnoses and assessments (April-July).



DMHA/OMPP Activities in Preparation for MRO Changes

- Tested the HP system process for service package assignment with four selected CMHCs (May-June).
- Amended MRO Rule after extensive collaboration with stakeholders to ensure changes were clinically and operationally sound.
- Developed public website which housed all master documents, presentations, training materials, and FAQs
- FAQs – 500+ questions collected and answered through transformation@fssa.in.gov.
- Completed 4 “Initial Loads” during July with HP – ensuring as many consumers as possible received packages based on assessments from January 2010 through June 2010.
- Developed and published new MRO Manual.



DMHA/OMPP Activities in Preparation for MRO Changes - Provider Training and Technical Assistance (TTI Grant)

Activity	Dates
MRO Train-the-Trainer (4 regional trainings) Presenters: Sarah Jagger (OMPP) Debbie Herrmann (DMHA)	March 31 – April 1, 2010 April 5 – 6, 2010 April 12 – 13, 2010 April 26 – 27, 2010
Recovery-Based Care Presenter: Dr. Janis Tondora	July 26, 2010 July 27, 2010 July 28, 2010 July 29, 2010 9 am - 4 pm local time
Assessing and Treating Individuals with Co-occurring Disorders Presenter: Vicki Ley, MA, LMHC, MAC, ICAC II, CADACII	<u>Webinar</u> June 10, 2010 10:00 – 12:00 (Eastern) Repeated from 1:00 – 3:00 (Eastern)
Recovery Outcomes Presenter: Maria O'Connell, Ph.D. Assistant Professor, Yale University, Department of Psychiatry Yale Program for Recovery and Community Health (PRCH)	<u>Webinar</u> September 15, 2010 10:00am — 12:00pm (EST) or 2:00pm — 4:00pm (EST)



DMHA/OMPP Activities in Preparation for MRO Changes

MRO Service Package and PA Process

Presenters: HP and Advantage

Webinar

May 18, 2010

10:00am – 3:00pm (Eastern)

Community, Consumer and Family focused Town Hall Meetings

Facilitated by MHA

Presenter: Gina Eckart

May 18, 2010

May 24, 2010

May 27, 2010

June 2, 2010

June 14, 2010

June 17, 2010

July 14, 2010

Technical Assistance

Multiple Presenters

Webinar

June 8, 2010

July 13, 2010

August 10, 2010

September 14, 2010

October 12, 2010

November 9, 2010

December 7, 2010

January 11, 2011

February 8, 2011

March 8, 2011



MRO Service Package Assignments

Preliminary System Wide Results

Total Consumers with an Open Episode in DARMHA*	104,873
Total Medicaid RID Numbers in DARMHA with necessary data*	57,246 (55%)
Total Service Packages Assigned as of 8/27/10**	44,994
Percentage of Medicaid Consumers with a Service Package**	79%

*Data from DARMHA as of 7/31/2010.

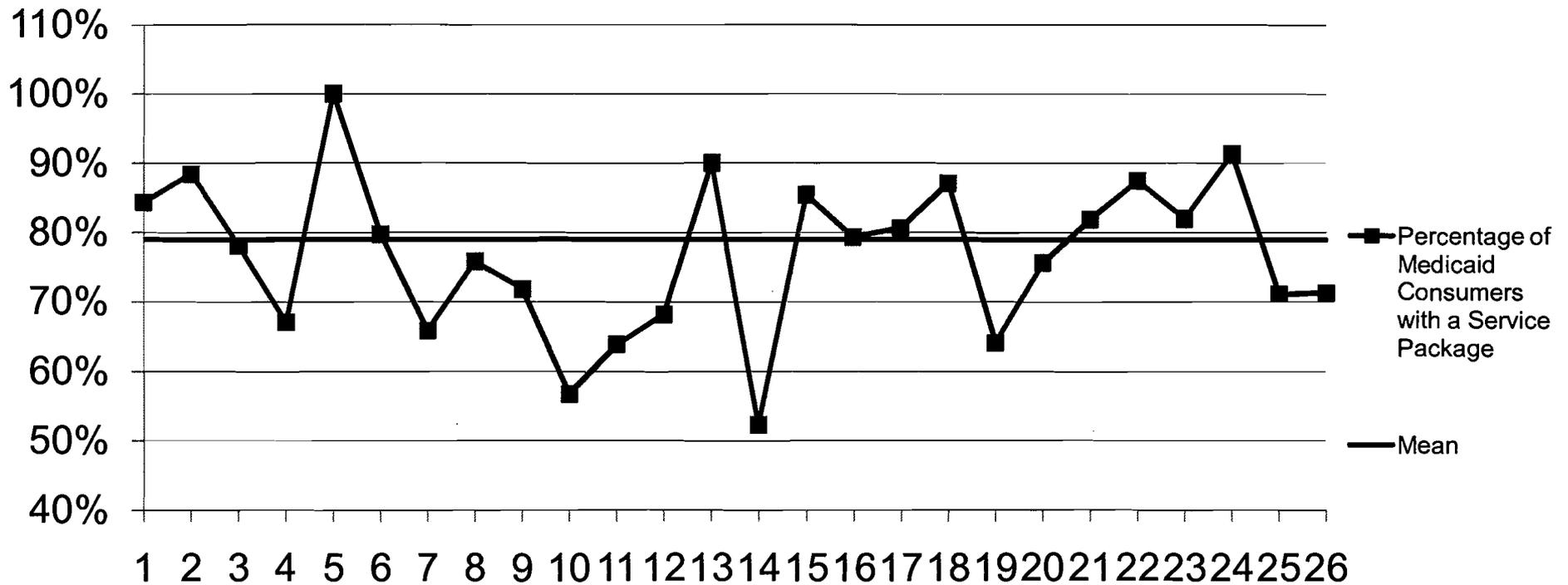
**This data does not include those consumers who have been prior authorized for MRO services.

- **Provider data is approximate due to:**
 - Inclusion of consumers that may be inactive.
 - Issues with the Medicaid RID number or eligibility, missing diagnoses or missing assessments.



Percentage of Consumers with Medicaid Receiving a Service Package, by Provider

Mean = 79%; Highest = 100%; Lowest = 52%



Updated with July 31, 2010 counts of eligible



MRO Service Package Assignments by Level of Need

Total Children	Total Adults	TOTAL
20,379	24,615	44,994

Service Package	3	4	5	5A
# Adults	8,929	10,798	3,942	946

Service Package	2	3	4	5
# Children	3,974	9,439	4,838	2,128



Historical Unduplicated Number of Individuals Served with MRO

July 1, 2009 – December 31, 2009

- 46,096 Medicaid members received at least one MRO service



Prior Authorization (PA) Scenarios

- **Scenario 1:** A member depletes service units within his or her MRO service package and requires additional units of a medically necessary MRO service.
- **Scenario 2:** A member requires a medically necessary MRO service not authorized in his or her MRO service package.
- **Scenario 3:** A member does not have one or more qualifying MRO diagnoses and/or LON for the assignment of an MRO service package, and has a significant behavioral health need that requires a medically necessary MRO service.
- **Scenario 4:** A member is newly eligible to the Medicaid program, or had a lapse in his or her Medicaid eligibility, and was determined Medicaid eligible for a retroactive period. In this case, a retroactive request for prior authorization is appropriate for MRO services provided during the retroactive period.



Prior Authorization (PA) Data

	July	August	Total
# of PAs requested	425	1,758	2,210
Average # of (business) days to process	8.49	7.7	8.26

Contract requires an average turnaround time of less than 10 days.

Number of MRO PA Requests, by Provider

	Number of MRO PAs	% of Total MRO PAs
1	15	0.68%
2		0.00%
3	21	0.95%
4	69	3.12%
5	127	5.74%
6	83	3.75%
7	54	2.44%
8	82	3.71%
9	26	1.18%
10		0.41%
11		0.18%
12	54	2.44%
13	51	2.31%
14	141	6.38%
15	100	4.52%
16	27	1.22%
17		0.41%
18	58	2.62%
19		0.41%
20	24	1.09%
21		0.05%
22		10.13%
23	105	4.75%
24	145	6.56%
25	42	2.22%
26		33.02%
Grand Total	2210	100.00%



Number of PA Lines, by Status

As of 8/20/2010

	Evaluation	Approved	Denied	Modified	Suspended	Total
July	0	283	646	24	351	1,306
August	1,102	139	115	19	288	1,661
Total	1,102	422	761	43	639	2,967



Prior Authorization Status Definitions

- **Evaluation:** This is a prior authorization that has been received, but no decision has been rendered yet.
- **Approved:** Prior authorization request was approved as submitted.
- **Modified:** Prior authorization request was approved, but required an adjustment to the dates or units requested from the originally submitted request.
- **Suspended:** The prior authorization received did not contain enough information to render a decision, and we need additional information from the provider. Providers will be notified via prior authorization decision letter of specific information needed in order to process request.
 - Additional information must be received within 30 days of suspension or request will automatically be denied.
- **Denied:** This prior authorization request has been denied and cannot be remedied.
 - Specific reason for denial is provided to the member and provider on the prior authorization decision letter.



Breakdown of Denial Reasons

Denial Reason	# Lines Denied
No assessment on file	297
Duplicate request	276
Auto denial	106
H0031 additional units not allowed	72
Other	10
Total	761

No PA lines have been denied due to lack of medical necessity.



Advantage PA Assistance

- Conducted an onsite orientation session for the following CMHCs:

Bowen Center	Warsaw, IN	May 10, 2010
Four County	Logansport, IN	June 17, 2010
Grant Blackford	Marion, IN	July 12, 2010
Gallahue	Indianapolis, IN	August 5, 2010

- In addition, Advantage has conducted outreach to assist the following CMHCs:

Aspire	Cummins
Adult and Child	Centerstone
Park Center	Oaklawn
Southern Hills	Porter Starke
Regional	Howard Regional
Hamilton Center	Madison Center



Next Steps

- Quality Management
 - Service Package Utilization
 - Service Package Assignments
 - Prior Authorization
- Provider and Stakeholder Education and Support

COMH
Meeting 2
September 7, 2010
Exhibit 4

ICCMHC

Indiana Community Mental Health Centers - Mental Health Commission Talking Points

MRO Services

The changes to the MRO program implemented on July 1, 2010 have gone relatively smoothly from an administrative standpoint. DMHA should be commended for a smooth rollout of the new program.

Some administrative issues related to computer system data transfer have been reported.

Some administrative issues related to the prior authorization process have been reported, including the need to accept electronic signatures.

The ICCMHC has formed a MRO transformation metrics outcome committee in order to develop an objective analysis regarding the impact on consumer recovery as it relates to MRO.

The committee is currently working on the development of benchmark data, including the current utilization of service packets, the prevalence of prior authorization processes, and the impact on FTEs within the CMHC network.

The committee is also reviewing the opportunity of developing an objective study which will track behavioral health consumers in their recovery using a process similar to what was used with the closure of Central State Hospital.

The initial reports from CMHCs related to the impact on billing for the month of July has been dramatic in comparison with the June billing information. Centers are reporting significant reductions in MRO billings. Some of the reductions can be attributed to the start up issues involved in having the staff fully understand the complexity of the new process. More analysis is needed to determine if these reductions will continue.

The ICCMHC is very much interested in ensuring that FSSA actively pursues the 1915(i) option as a way to ensure services are available for those individuals needing continuous services.

The ICCMHC will continue to monitor the changes to the MRO program and work towards determining if the two established goals of moving individuals into recovery and improving the integrity of the Medicaid system have been accomplished.

COMH
Meeting 2
September 7, 2010
Exhibit 5

State of Indiana

Senate

Senator Connie Lawson
Majority Floor Leader
State House, Senate Chamber
200 West Washington Street
Indianapolis, Indiana 46204-2785

Committees:
Local Government, Chair
Joint Rules, Chair
Elections, R.M.
Appointment & Claims
Tax & Fiscal Policy
Rules & Legislative Procedure

March 12, 2010

Stephen C. McCaffrey, JD
President and Chief Executive Officer
Mental Health America of Indiana
1431 North Delaware Street
Indianapolis, IN 46202

Dear Steve:

As you know, the Mental Health Commission has received testimony over the last couple of years on the issue of changes to reimbursement for mental health services. As a result of that testimony, and as Chair of the Commission, I authored SCR 3 and SCR 6. The first asked the Indiana General Assembly to make the topic of MRO changes a priority for the Commission this summer and the second sought support for the Clubhouse Model. This discussion has continued into the 2010 session of the Indiana General Assembly in a way that has created conflict among many of the stakeholders regarding the provision of mental health services.

It would seem that the resolution of this issue cannot occur in this session of the General Assembly, but at the same time, cannot wait until the Mental Health Commission meets again this summer. It is clear to me that a final resolution cannot be reached without the collaboration of the stakeholders involved. You have, in the past, assisted the Commission by bringing together stakeholders in conflict to develop a collaborative approach for resolution. I am asking you, as the CEO of Mental Health America of Indiana and as Chair of the DMHA Advisory Committee, to take on this role once again. I am calling on FSSA, DMHA, OMPP, and the Community Mental Health Centers to participate in this endeavor in good faith.

If you will accept my request, I would charge you with the responsibility of convening a select group of CMHC CEOs and appropriate FSSA staff, including DMHA and OMPP, to develop resolution to the issues raised this session. These should include MRO, 1915i, Clubhouse and other issues raised by the select group. I would ask you to keep me up-to-date and current on your progress, and to provide a report of your progress--with recommendations, if any--to the Mental Health Commission.

I know that I do not have to say this to you, but I want to make sure that the focus of the select group is on the consumer and the services that they require.

Thank you for your effort and I appreciate your willingness to take this on.

Sincerely,

A handwritten signature in black ink that reads "Connie Lawson". The signature is written in a cursive, flowing style.

Senator Connie Lawson
Majority Floor Leader

cc: All Indiana Legislators
Anne Murphy, Cabinet Secretary, FSSA
Gina Eckart, Director, DMHA
Matt Brooks, Indiana Council of Community Mental Health Centers



Lawson Select Group on Mental Health Report

August 30, 2010

On March 12, 2010 Senator Connie Lawson, then Chair of the Mental Health Commission, asked Mental Health America of Indiana to convene a group of mental health and addiction stakeholders to develop a collaborative approach to resolve issues of service reimbursement that had created concern and controversy among some providers. The Group was composed of CMHC CEOs, FSSA staff (OMPP and DMHA leadership), Advocates and Consumers.

The Select Group was charged with resolving these issues, specifically addressing MRO, 1915i, Clubhouse, and other issues raised by the stakeholders. Although many of the issues raised came from providers concerning reimbursement, the Select Group was to address the issues from a consumer perspective. The findings and recommendations, if any, were to be reported to the Mental Health Commission.

The member stakeholders of the Select Group include:

Ronda Ames, Key Consumer
John Browning, Southwestern Indiana CMHC
Pat Casanova, OMPP
Suzanne Clifford
Tom Cox, Amethyst House
Rick Crawley, Wabash Valley Hospital
Caroline Doebbling, OMPP
Gina Eckart, DMHA
Galen Goode, Hamilton Center
Debbie Herrmann, DMHA
Sarah Jagger, OMPP
Danita Johnson-Hughes, Edgewater Systems
Denny Jones, FSSA
Robert Krumwied, Regional Mental Health Center

Stephen C. McCaffrey, JD, Mental Health America of Indiana
 Pam McConey, NAMI
 Margie Payne, Midtown Mental Health Center
 Robert Williams, Centerstone
 Paul Wilson, Park Center
 Andy Wilson, Carriage House

The Lawson Select Group on Mental Health met on six occasions: April 16, April 30, May 10, June 7, July 19, and August 30. The following is the final report.

Findings and Recommendations

Communication Strategies

Town Halls:

The Division of Mental Health and Addiction received a grant that enabled them to partner with Mental Health America of Indiana to host 7 Town Hall meetings around the state, including the following counties: Marion, Tippecanoe, Vigo, Vanderburg, Lake, Allen, and Jackson. These meetings included consumers, advocates, families, providers and policy makers. In each instance, a presentation was made by Gina Eckart, DMHA Director, regarding the Recovery Model. MHAI also coordinated a media campaign of PSAs and paid advertisements on Recovery.

Trainings:

DMHA/OMPP provided training statewide on MRO , PA, and recovery oriented care. These trainings were facilitated by ASPIN and directed toward behavioral health providers, community stakeholders, and key advocates.

Activity	Dates
MRO Train-the-Trainer OMPP and DMHA presented 4 regional trainings Sarah Jagger and Debbie Herrmann	March 31 – April 1, 2010 April 5 – 6, 2010 April 12 – 13, 2010 April 26 – 27, 2010
Recovery-Based Care Dr. Janis Tondora Presenter	July 26, 2010 July 27, 2010 July 28, 2010 July 29, 2010 9 am - 4 pm local time
Assessing and Treating Individuals with Co-occurring Disorders Vicki Ley, MA, LMHC, MAC, ICAC II, CADACII Presenter	<u>Webinar</u> June 10, 2010 10:00 – 12:00 (EST) Repeated from 1:00 – 3:00 (EST)

<p>Recovery Outcomes Maria O'Connell, Ph.D. Assistant Professor, Yale University, Department of Psychiatry Yale Program for Recovery and Community Health (PRCH)</p>	<p><u>Webinar</u> September 15, 2010 10:00am — 12:00pm (EST) Repeated from 2:00pm — 4:00pm (EST)</p>
<p>MRO Service Package and PA Process HP and Advantage Presenters</p>	<p><u>Webinar</u> May 18, 2010 10:00 – 3:00 (EST)</p>
<p>Town Hall Meetings Facilitated by MHA Community, Consumer and Family focused Gina Eckart Presenter</p>	<p>May 18, 2010 Indianapolis May 24, 2010 Lafayette May 27, 2010 Terre Haute June 2, 2010 Evansville June 14, 2010 Merrillville June 17, 2010 Fort Wayne July 14, 2010 Seymour</p>
<p>Technical Assistance - Multiple Presenters on Transformation Topics – Schedule the second Tuesday of each month from 1:00-3:00 pm (EST)</p>	<p><u>Webinar</u> June 8, 2010 July 13, 2010 August 10, 2010 September 14, 2010 October 12, 2010 November 9, 2010 December 7, 2010 January 11, 2011 February 8, 2011 March 8, 2011</p>

Implementation Issues

Act Rule Update:

OMPP communicated orally and in writing the changes Proposed in the ACT Certification Rule. The Rule added definitions for purposes of the rule that included: *Authorized Health Care Professional, CMHC, Direct Service, Individual, Other Behavioral Health Professional, Qualified Health Professional, Qualified Behavioral Health Professional, Full Time Equivalent, Licensed Professional, Person Centered*

Planning, and Remote Participation. OMPP provided a full explanation of the Operational Standards and Requirements. Changes under the new rule would make providing the service more practical, requiring that the psychiatrist to evaluate each individual every 6 months and review 20% of caseload. Further, a psychiatrist would attend 70% of treatment planning meetings.

Clubhouse:

A PSR Code for Clubhouse was requested by Clubhouse advocates irrespective of the rate amount. It was determined that there are additional ways to make up some of the costs, like fundraising and private donations, but that there needs to be a Medicaid service and rate that offsets some of the costs of Clubhouse. It was made clear that Medicaid, as it currently exists, can only reimburse for appropriate and allowable services. It was further requested by the Clubhouse advocates that only certified clubhouses be permitted to utilize the PSR code. It was agreed that (OMPP) and (DMHA) would participate on an implementation committee to finalize a service definition and rate for the Medicaid state plan amendment and rule changes that will be required. Park Center committed to providing resources to support the committee's efforts. A draft proposal has been submitted to FSSA for consideration.

Info Systems:

There was concern expressed pertaining to the new information systems. DMHA tested the system in advance to make sure that it would work properly. DMHA provided a flow chart of the Indiana MRO Process starting effective July 1, 2010 as well as a written step-by-step MRO data flow chart. This information was disseminated to all CMHC CEOs prior to implementation. Post implementation, a report was provided to the group outlining the initial roll out process and number of service packages assigned during the roll out period in July. Provisions were made by OMPP to make retro-active PA available during July and August to allow time for all involved to ramp up and to ensure continuity of care and payment for individuals in need of MRO services.

1915i:

The implementation of 1915i has been slowed at the federal level with the passage of Health Care Reform. OMPP has been in communication with CMS regarding what will and will not be acceptable, how it can be structured, and how it can be manageable. OMPP has participated in conference calls with CMS as part of the National Association of State Medicaid Directors. OMPP has submitted questions to CMS and is awaiting a formal response. The two biggest concerns involve the inability to appropriately limit the program and how the independent assessment process will be structured. CMS has responded that while the state cannot cap the program for anyone meeting set criteria, the state can be specific in their target population. In preparation for implementation, DMHA is doing a Medicaid 1915(i) match set aside across all CMHC's in the amount of five million dollars. DMHA/OMPP did provide CMHCs direction for providing MRO services during the interim period, while awaiting the development and implementation of 1915i. During this time, it will be critical to document the progress of recovery with focused and measurable goals; assess those who meet institutional LOC to pursue

appropriate waiver options; monitor consumer needs and utilization of MRO services; and be proactive in requesting prior authorization of services.

MRO:

There was considerable concern and discussion about the proposed MRO changes and DMHA responded with proposed rule changes that were presented and discussed with the providers and stakeholders. This effort led to an MRO rule amendment promulgated with an effective date of July 1, 2010.

The MRO changes did in fact become effective July 1, 2010. Prior to the effective date calls were made to a number of providers to ensure that there were no issues with data systems or eligibility for consumers. It is estimated that approximately 78% of consumers received Service Packages. This does not include services received as a result of prior authorization. PA requests that were denied were done so primarily for administrative reasons. There was concern that some clients that have a proper diagnosis would not receive service packages, because they are Developmentally Disabled or have other disabilities (such as head injury as part of a diagnosis) and not able to receive prior authorization. This needs to be a continued focus and will be addressed further by the newly formed Dual Diagnosis Task Force. Other concerns included:

- An increase in the administrative “burden”, although it was anticipated that such would be reduced after the initial start up.
- Client concern over no longer receiving services that they have historically received, even though they may have been over served or not appropriately served.
- Some clients had not been properly educated or informed about the transition that has taken place and this created anxiety as a result. It was suggested that providers could refer clients to support groups for those days when clients are not receiving services. It was important that everyone agree that services that the client needs should be driving the resources, not what service packages are available. Further, there are many places in the community where clients can go for additional support and resources when they are not in a day treatment setting, for example.
- There is provider concern regarding the reduction in revenue for the initial month of July. This will be watched in the succeeding months.

Employment:

It is recommended that OMPP and DMHA get together and review their policies to see what would inadvertently discourage consumers from employment. It was reported that the most common reason for consumers not going to work is the belief that they will lose Medicaid. There is a lack of understanding of the resources available – by consumers and Medicaid employees at the local offices. It was recommended that Vocational Rehabilitation be a part of the conversation in addressing these issues.

Hospital:

The state hospital transition plan was reviewed.

1. The *civil beds* at Logansport State Hospital (LSH) will close. This impacts a total of 254 beds of capacity at LSH. In addition, utilize 50 beds on Larson units for forensic/ high acuity patients making LSH a 134-bed psychiatric hospital.
2. Close the *substance abuse services* at Richmond State Hospital (RSH). This will close 101 substance abuse beds. An RFP has been submitted to provide this service regionally throughout the State via contracted providers.
3. Close the *youth services* at Richmond State Hospital. This will close 20 beds. This population will be consolidated at Larue Carter Hospital.
4. Close 30 bed *noncertified* MRDD unit at Richmond State Hospital.
5. Close 30 bed *certified* MRDD unit at Evansville State Hospital.
6. Close two 15 bed *certified* MRDD units (30 beds) at Madison State Hospital.

While the above actions would, as stated, remove 465 beds from capacity, several additional actions are required to optimize use of physical plants and best meet patient needs. As such, some of the above beds would be utilized for other patient populations. They are as follows:

1. Utilize the 30 bed unit at RSH for SMI patients
2. Utilize the 20 bed unit at RSH for SMI patients
3. Utilize 30 bed unit at ESH for SMI patients
4. Utilize two 15-bed units (30 total) at MSH for SMI patients.

The above, combined will result in a net closure of 355 beds, or approximately 30% of capacity. It is anticipated that these changes will be finalized by February 1, 2011.

- Annually, the state discharges more patients than it admits, so hospitals are regularly releasing clients into the community with great success. At 180 days, recidivism is less than 5%, which is well below the national average, and is a testament to the hospitals and community service providers. The changes being made are not the result of economics, but rather because of the transformation of the system based on recovery-oriented care. There will however be a financial savings to the state as a result of being more efficient with the remaining resources.
- Clients will not be released unless they are clinically ready to be released and have access to necessary treatment and appropriate housing. The discharge

process has not changed. Despite the job loss at hospitals, the shifting of services and intermittent care model has prevented an entire hospital closure (DMHA is at 85-89% capacity at all hospitals) and although there could have been a complete closure, DMHA was committed to considering the needs of clients and the affected communities.

- It was clarified that Forensic beds will be operated by DMHA, not DOC.
- The Evansville Psychiatric Children's Center (EPCC) issue was considered, as Sen Becker and DMHA have agreed to the creation of a commission to look at services currently being provided, as well as how those services could be provided. The state does not have to be the sole provider of those services, and many could be provided in the community or within PRTFs.
- DDARS Director Julia Holloway is already interviewing providers to assist those consumers that will be transitioning out of the state hospital. It is understood that this will be further discussed by the Mental Health Commission.

Care Select

The changes in the Care Select program were reviewed. Individuals with an SMI or SED diagnosis will remain eligible for the program.

Clearly, the work of the Lawson Select Group on Mental Health met its objective to enhance communication and collaboration among providers, the administration, consumers and advocates as Indiana implements the Recovery model throughout its service delivery and reimbursement system. It was suggested that the Committee might need to be called together again at some future time should issues present themselves such that this would be helpful. The Committee members remain available if such is needed.

State Psychiatric Hospitals: History and Trends

Gina Eckart

Division of Mental Health and Addiction

Commission on Mental Health Presentation

September 7, 2010

COMH
Meeting 2
September 7, 2010
Exhibit 6

Lutterman, T., Berhane, A., Phelan, B., Shaw, R., & Rana, V. (2009). *Funding and characteristics of state mental health agencies, 2007*. HHS Pub. No. (SMA) 09-4424. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.



Psychiatric Hospitals: State of the States

- In every state, there are state-owned-and-operated psychiatric inpatient beds that are used for persons in need of the most intensive level of mental health services.
- In most states (44), the operation of state psychiatric hospitals is part of the SMHA's responsibilities. In six states (Colorado, New Hampshire, New Mexico, Rhode Island, South Dakota, and Wyoming), a separate state government agency has this responsibility.



Psychiatric Hospitals: State of the States

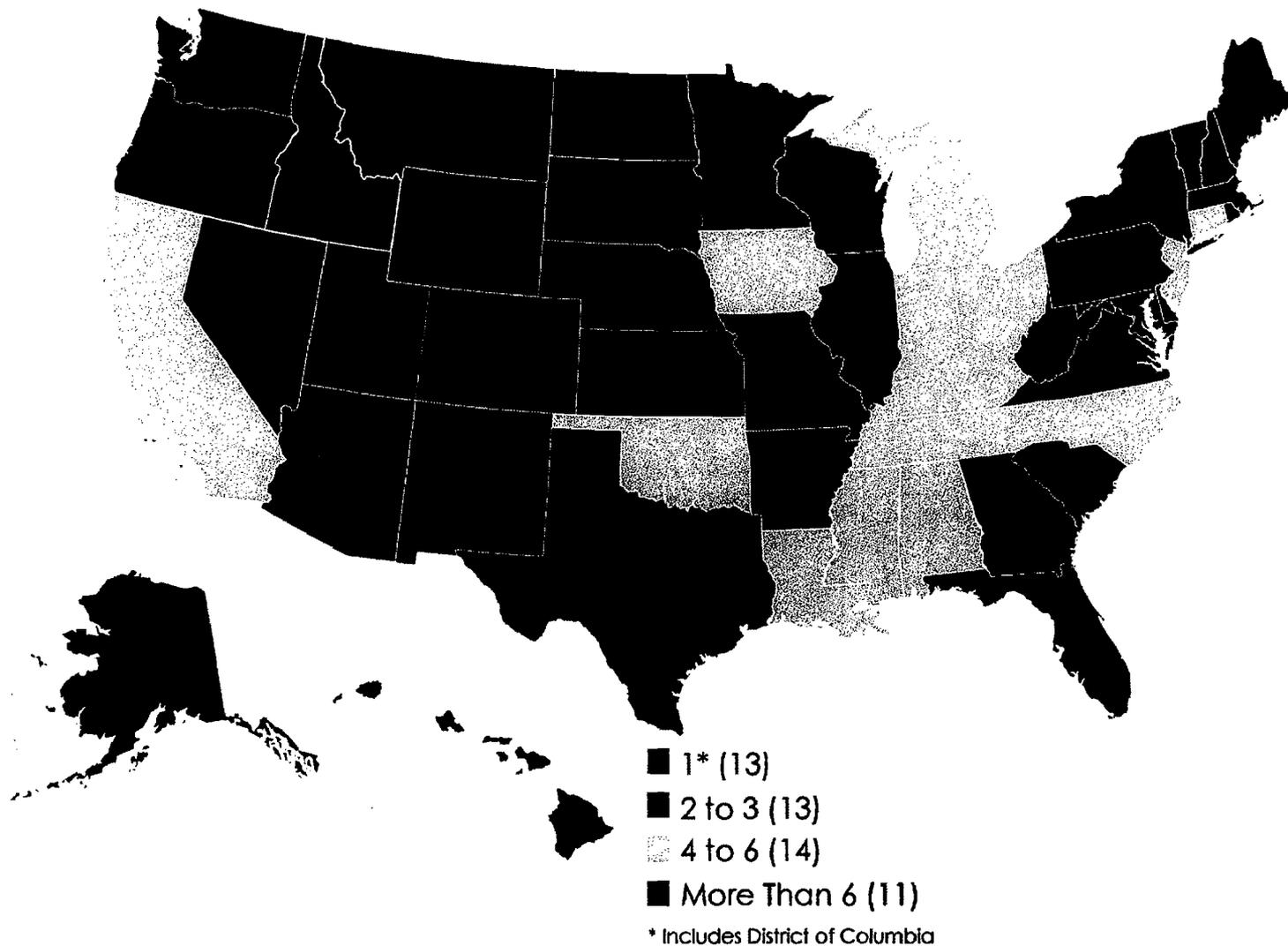
- Forty-nine states and the District of Columbia operate a total of 232 state psychiatric hospitals—hospitals that are operated and staffed by the SMHA that provides specialized inpatient psychiatric care.
- Rhode Island is the only state that does not have a stand-alone state psychiatric hospital



Psychiatric Hospitals: State of the States

- In over half the states (26), there are 3 or fewer state psychiatric hospitals.
- the 13 states that have only 1 state psychiatric hospital tend to be in the mountain-frontier west and New England.
- The 11 states that have 6 or more state psychiatric hospitals are all larger-population states and are mostly in the east and southern regions of the country

Number of State Psychiatric Hospitals (2007)



Lutterman, T., Berhane, A., Phelan, B., Shaw, R., & Rana, V. (2009). *Funding and characteristics of state mental health agencies, 2007*. HHS Pub. No. (SMA) 09-4424. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Psychiatric Hospitals: State of the States

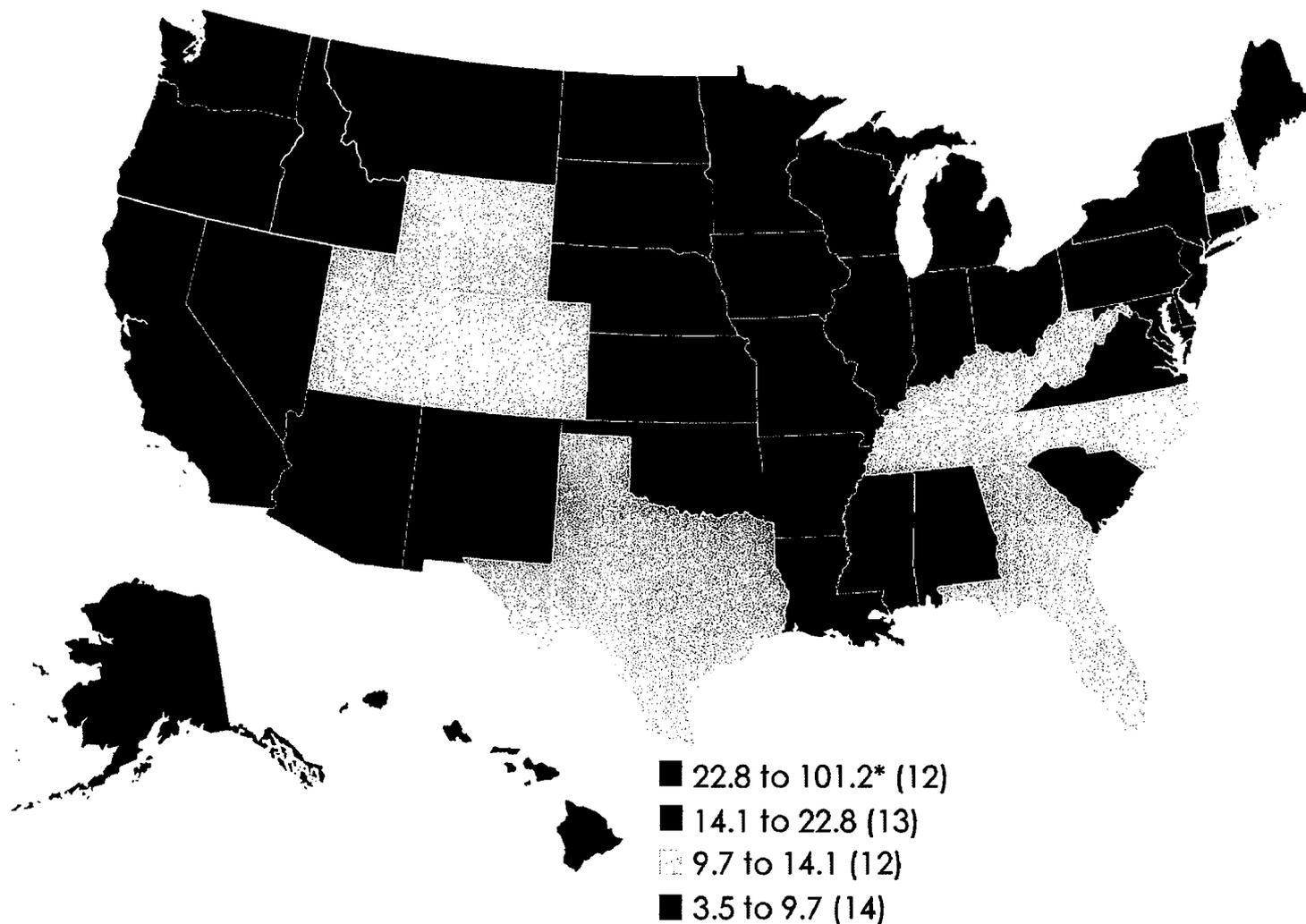
State	Number of State Hospitals (2007)	Population Estimate as of July 1, 2007	Acute, Intermediate, Long Term
Arizona ¹	1	6,338,755	A, I, LT
California	5	36,553,215	I, LT (+ Acute Forensic)
Florida	7	18,251,243	LT (adults only)
Indiana	6	6,345,289	LT*
Massachusetts	10	6,449,755	A, I LT-Adults only
Tennessee	5	6,156,719	A, I (adults only), LT (adults only)
Wisconsin	3	5,601,640	A, I, LT

Source: 2007 SMHA Profiles, unless noted : (1) 2006 NRI State Profiles

Acute (fewer than 30 days)

Intermediate (30-90 days) * Indiana has intermediate stays for research beds at Larue Carter Hospital Only

State Psychiatric Hospital Residents per 100,000 Population (2007)



* Includes District of Columbia

Psychiatric Hospitals: State of the States

- At the end of 2006, there were **43,601** patients residing in state psychiatric hospitals.
- States varied widely in the number of inpatients they had, ranging from **66** in Alaska to **6,327** in California.
- The median number of state psychiatric hospital residents was **655**. Indiana: 1,000-1,050
- On average, states had **14.5** state psychiatric residents per 100,000 population (the median was 13.7). The range was from a low of 3.5 in New Mexico to a high of 41.0 in North Dakota (see Figure 15).



“Even prior to the 1963 Community Mental Health Centers Act, which established a goal of having a nationwide network of community mental health centers, states were under pressure to reduce the size of state psychiatric hospitals. One of the goals of the Federal Community Mental Health Services Block Grant is to help states minimize their use of state psychiatric inpatient beds. As a result of these policies, there were many fewer state hospitals in 2007 than before, and many fewer patients in them.”

Lutterman, T., Berhane, A., Phelan, B., Shaw, R., & Rana, V. (2009). *Funding and characteristics of state mental health agencies, 2007*. HHS Pub. No. (SMA) 09-4424. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.



State Hospital Trends

- According to CMHS, in **1950**, there were **512,501** patients in state and county psychiatric hospitals. **By 2005**, that number had **declined by 90 percent** to only **49,947** patients
- The number of state psychiatric hospitals has also declined by 37 percent



State Hospital Trends

- The state psychiatric hospitals of the 1950s and 1960s were much more focused on long-term care, with many patients remaining in the hospital for years.
- At the current time, most state psychiatric hospitals are much smaller but also have much shorter lengths of stay.

Number of Hospitals and Resident Patients in State and County Psychiatric Hospitals: 1950-2005

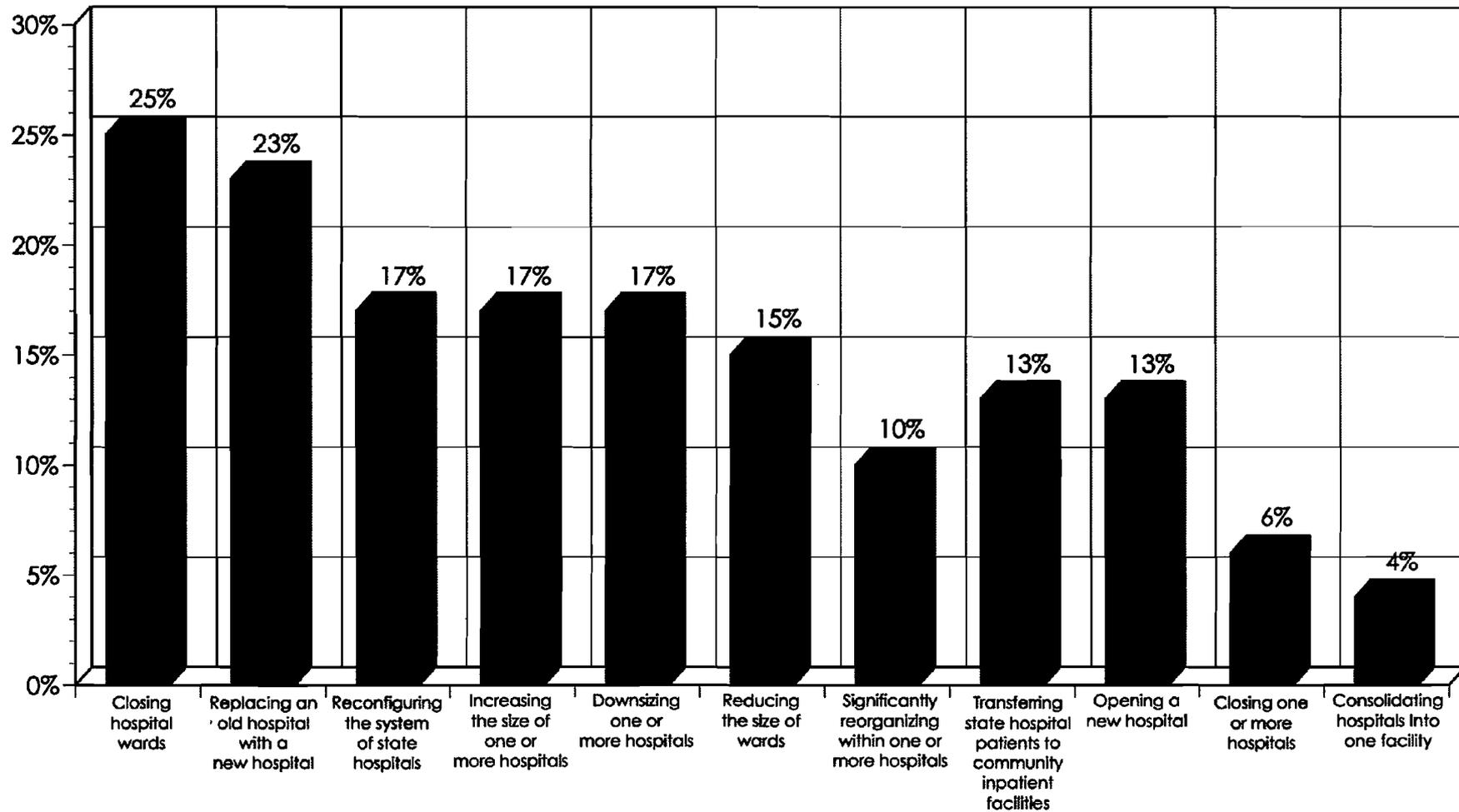
Year	Number of Hospitals	Residents at End of Year
1950	322	512,501
1955	275	558,922
1960	280	535,540
1965	290	475,202
1970	315	337,619
1975	313	193,436
1980	276	132,164
1985	279	116,136
1990	281	92,059
1995	258	69,177
2000	230	54,836
2005	204	49,947



State Hospital Trends

- As a result of the major decrease in the number and size of state psychiatric hospitals, many states are reorganizing their state psychiatric hospital systems.
- In 2007, just over half of the states (54 percent) reported they were involved in some aspect of reorganization of their state psychiatric hospital system.

State Psychiatric Hospital Reorganization Activities, 2007



48 States Responding

Lutterman, T., Berhane, A., Phelan, B., Shaw, R., & Rana, V. (2009). *Funding and characteristics of state mental health agencies, 2007*. HHS Pub. No. (SMA) 09-4424. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.



Closing State Psychiatric Hospitals

- Over the last 55 years, there has been a reported net decrease of 118 state psychiatric hospitals.
- In 2007, five states reported they had closed a total of seven state hospitals over the last 2 years, and three states reported they were currently planning to close a state psychiatric hospital.
- Five states reported they were working on plans to close an additional six state psychiatric hospitals in the next 2 years.
- The data show that although many of the state hospital beds were closed during the 1950s to 1970s, the majority of state psychiatric hospitals have been closed since 1990.

State Hospital Trends

How States Use Their Psychiatric Hospitals

- Acute vs. Long Term Care
 - Acute=less than 30 days
 - Intermediate=60-90 days
 - Long Term=greater than 90 days (Indiana)
- Populations Served
 - Adults (Indiana)
 - Youth (Indiana)
 - Forensic (Indiana)

Number of States Using State Psychiatric Hospitals by Age and Service, 2007

Population	Age 0-17 (Less than 30 days)		Age 18-64 (30-90 days)		Age 65+ (More than 90 days)	
	Number of States	Percent	Number of States	Percent	Number of States	Percent
Children	23	47%	20	41%	15	31%
Adolescents	29	59%	26	53%	20	41%
Adults	41	84%	43	88%	43	88%
Elderly	37	76%	40	82%	40	82%
Forensic	36	73%	41	84%	43	88%



Population Served and Length of Stay

- All States have inpatient psychiatric beds for treating adult mental health consumers
- In three states, state psychiatric hospitals are focused on providing acute or intermediate-length inpatient services (30-90 days) to adults, i.e. no long term beds.
- Over half of all patients discharged from state hospitals had a length of stay of 30 days or less.
- In a few states (Arkansas, Georgia, and Tennessee), over 90 percent of discharged patients had a length of stay of 30 days or less.
- Indiana had under 10 percent of clients discharged in 30 days or less.



Populations Served (cont.)

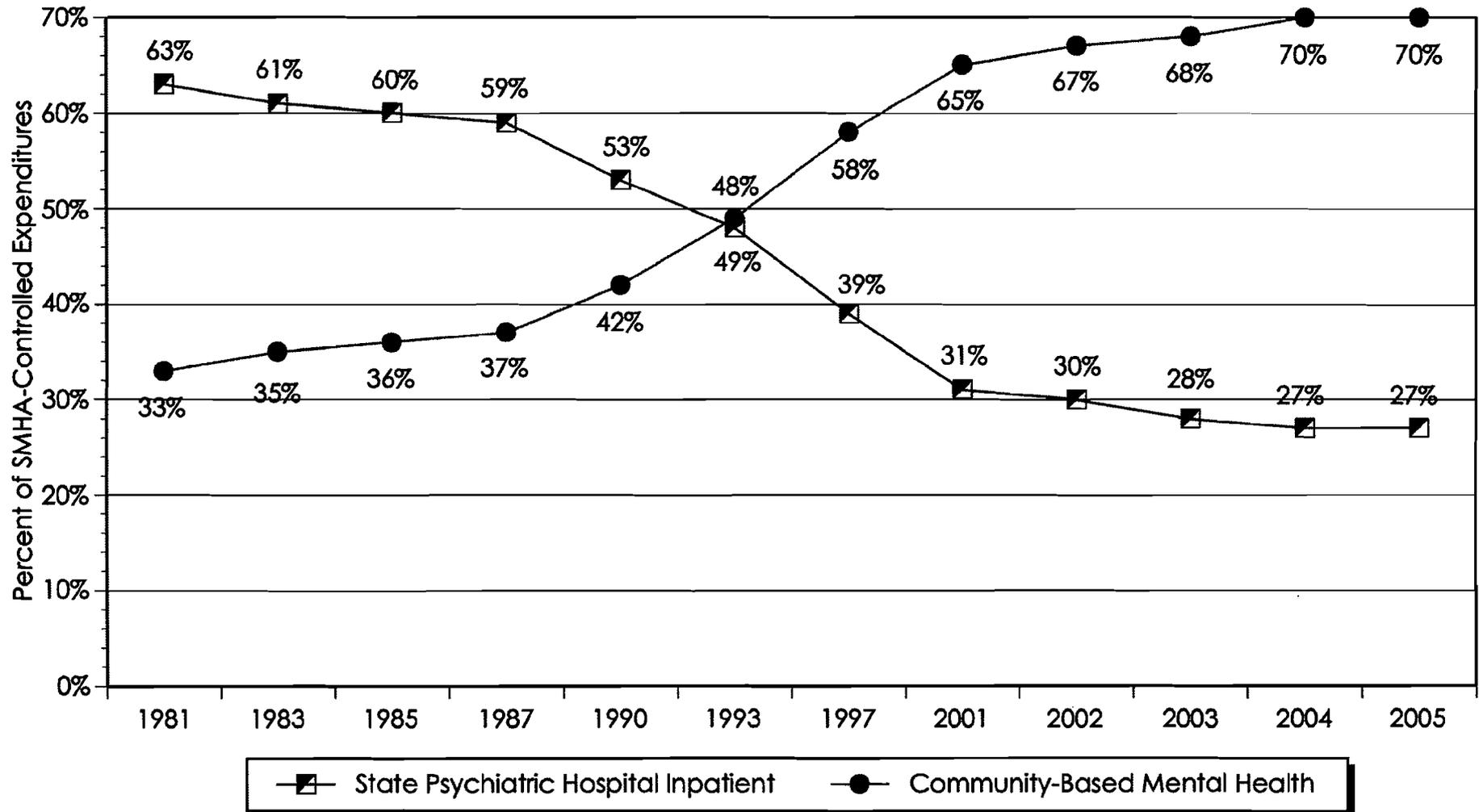
- Some states dedicate their state psychiatric inpatient beds for adults and forensic clients and do not have inpatient beds for children.
- There were 32 states that reported that they serve children and adolescents in state psychiatric hospitals, and for 12 of these states the focus is on acute/ intermediate length of stays for children. (Indiana: long term)



State Hospital and Community-Based Care

- Over the last 25 years, states have shifted their treatment paradigm to focus on providing comprehensive mental health services in the community.
- In FY 2005, community mental health expenditures accounted for 70 percent of total SMHA-controlled expenditures, and state psychiatric hospital-inpatient expenditures were 27 percent.
- This is an historic shift from FY1981, when community-mental health expenditures accounted for 33 percent of SMHA expenditures and state psychiatric hospitals were 63 percent of expenditures.
- SMHAs also varied widely in the distribution of their mental health expenditures between community-based services and state psychiatric hospitals. The national average was 70 percent on community based programs as opposed to 27% on institutional care.

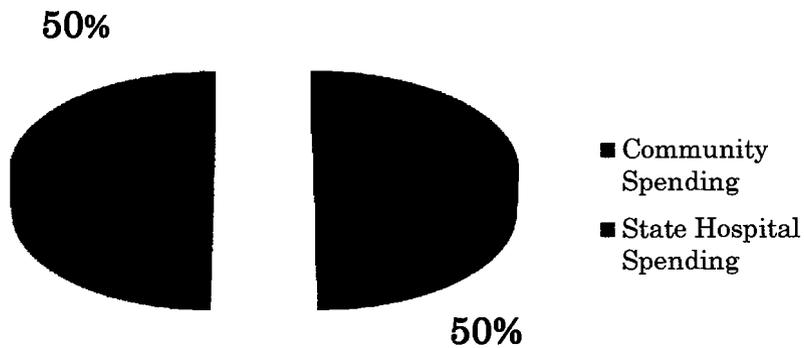
SMHA Expenditures for State Psychiatric Hospital Inpatient and Community-Based Services as a Percent of Total Expenditures: FY 1981 to FY 2005



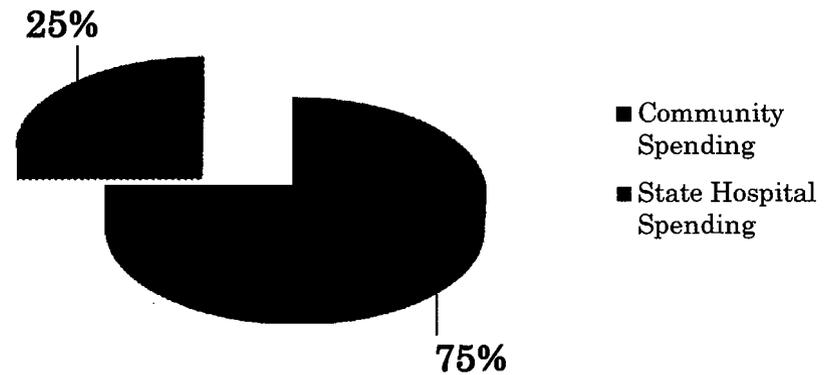
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Institution vs. Community Focus

Current DMHA Spend



National SMHA Trend





Why the Shift?

- Improvements in the treatment of behavioral health disorders
 - Effective medications with improvements related to efficacy and side effects.
 - Community/evidenced-based practices identified and implemented.
 - Medicaid Rehabilitation Option
 - Assertive Community Treatment
 - Community Alternatives to Psychiatric Residential Treatment Facilities



Why the Shift?

- Recovery Movement
 - A future in which everyone with a mental illness at any stage of life has access to effective treatment and supports—essentials for living, working, learning, and participating fully **in the community**.
 - Care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience, not just managing symptoms.



Why the Shift?

Olmstead

- On June 22, 1999, the United States Supreme Court held in *Olmstead vs. L.C.* that it is a violation of the civil rights of Americans with disabilities to require a person to be institutionalized in order to receive necessary disability supports and services, if these services are more appropriately provided in the community .

Why the Shift?

Efforts Re-energized Around Olmstead

- Multiple “State Director” letters from HHS, SAMHSA, and CMS
 - Increased availability of Home and Community Based Services leads to....
 - Funding focus on HCBS.
 - IMD Exclusion-remove funding as a deterrent to SOF utilization
- Increased enforcement by the Department of Justice
 - Providers and State Agencies will be held accountable- and we should be!



Indiana Successes: The Central State Hospital Discharge Study

Indiana Consortium for Mental Health Services Research. 2005. "Central State Hospital Discharge Study. Tenth Anniversary Public Report Series." Bloomington, IN: ICMHSR, Indiana University.

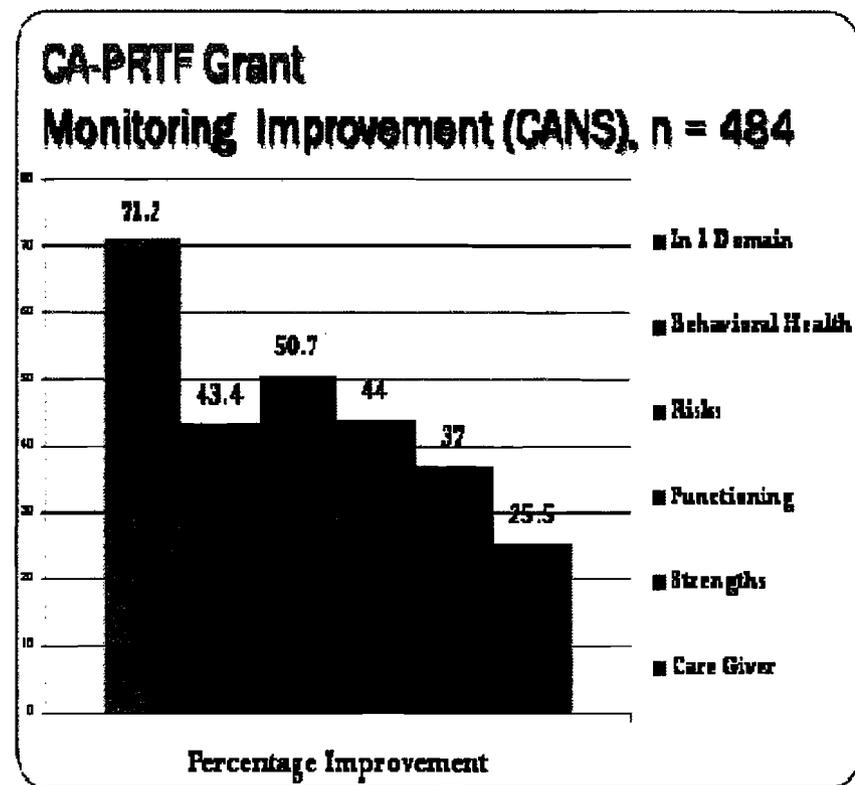
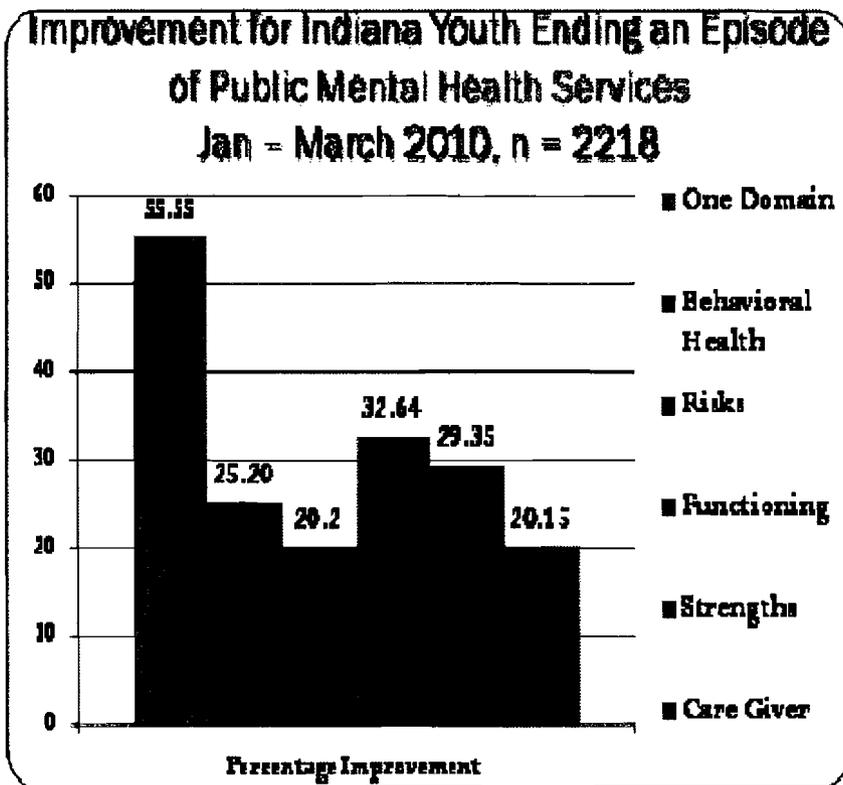
- John McGrew, PhD, Bernice Pescosolido PhD, and Eric R. Wright, PhD
- April 1993-June 2005

Indiana Successes-Youth

Community Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF)

- Demonstration grant to prevent PRTF placement or promote discharge from PRTF
- To date in SFY11 over 600 children served with family and within the community as opposed to out of home placement in PRTF
- Improvement in functioning has been 32.64% for those in usual public services, and 44% for those on the grant. The improvement in any one domain is 55.55% for those in usual public services, and 71.2% for kids on the grant

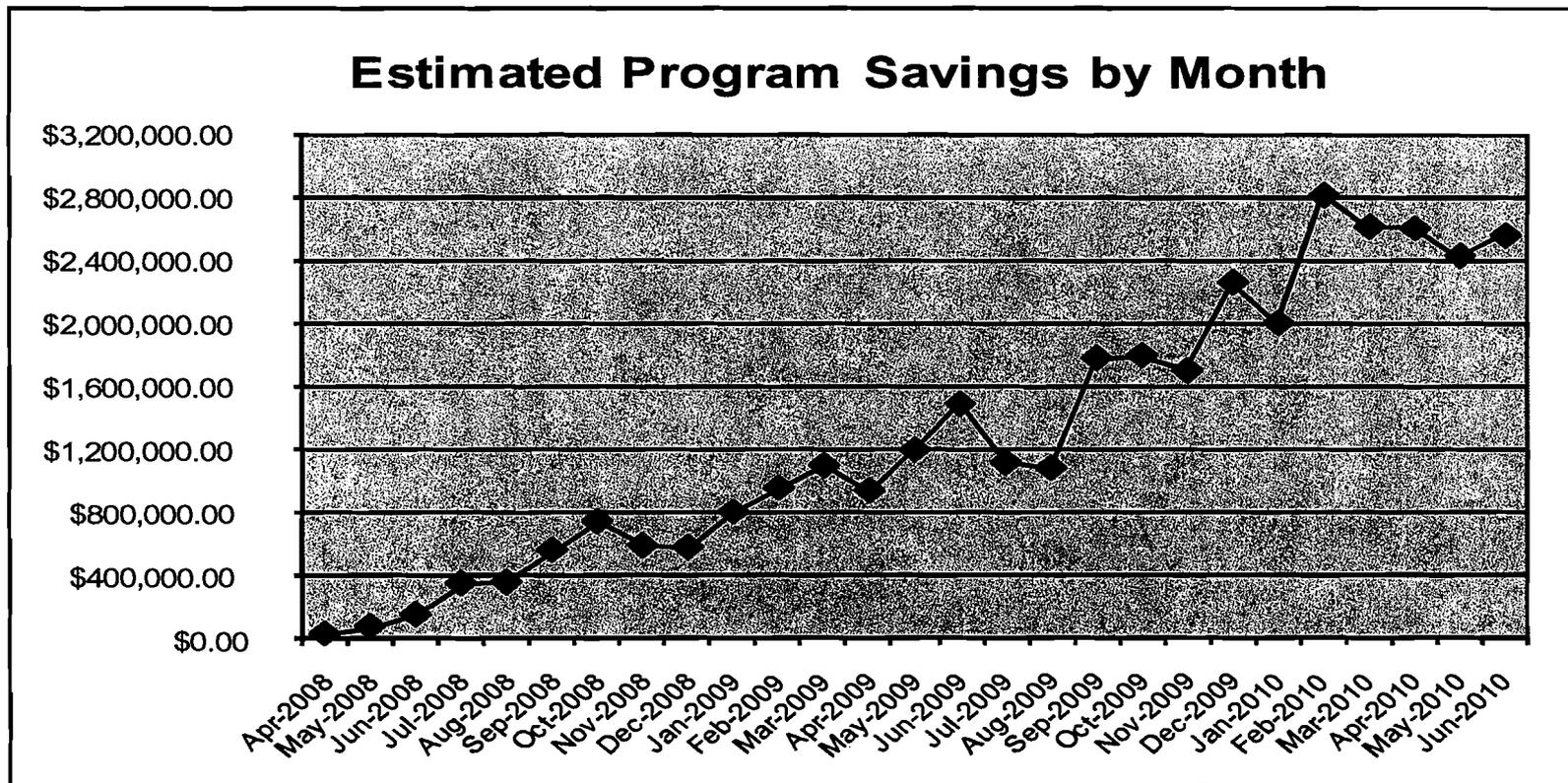
Improvement in Functioning: CA-PRTF vs. Regular Care



SOF/PRTF Cost Comparison

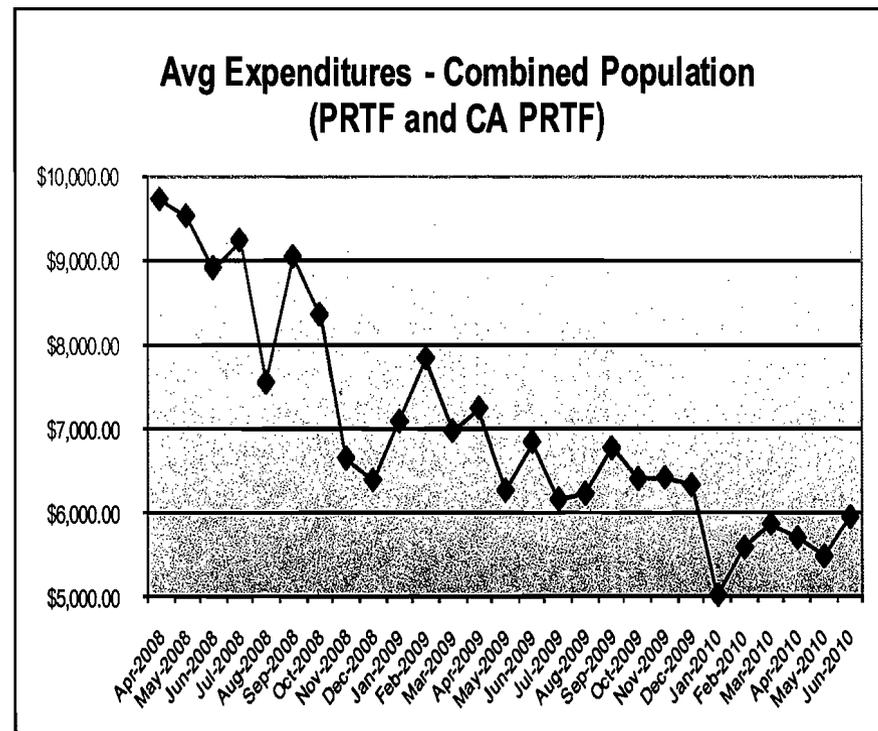
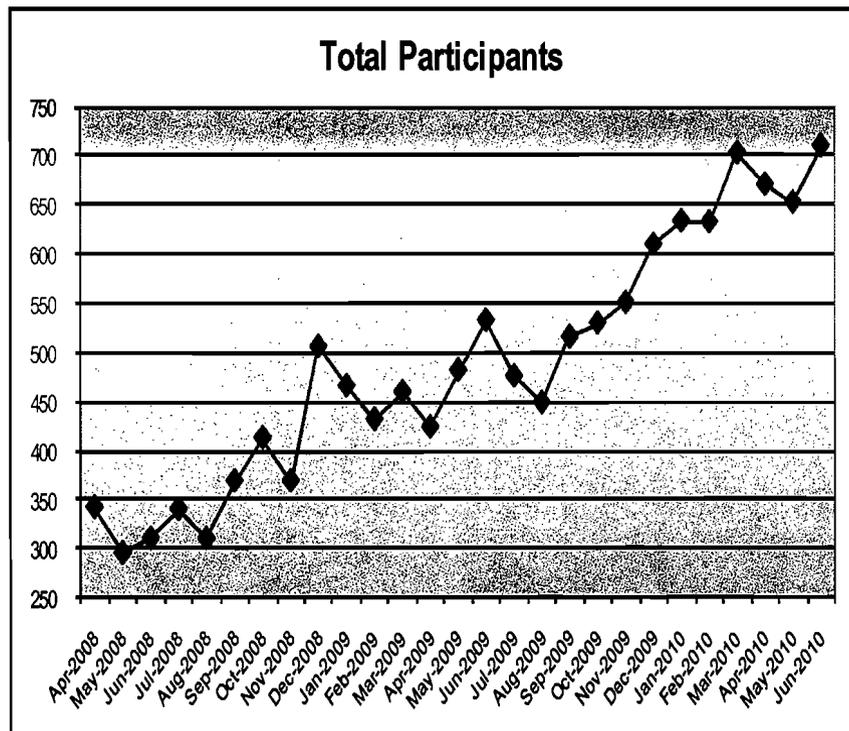
	Cost Per Patient Day	Match Rate	Annual Cost Per Patient	State Portion	Projected Per Patient Annual Savings	Overall Projected Annual Savings
EPCC	\$992	Current SMAP (34.07%)	\$362,080	\$123,360		
PRTF Facility	\$343	Current SMAP (34.07%)	\$125,195	\$42,654	\$80,706	\$968,472
CA-PRTF	\$93	Current SMAP (34.07%)	\$33,945	\$11,565	\$111,795	\$1,341,540

Indiana Successes-Youth



A basic calculation taking the average cost per client per month difference between PRTF residents and CA PRTF Grant participants, and multiplying by the number of Grant participants per month, illustrates cost effectiveness to the State. This calculation alone estimates a total Program savings of \$34.5 million over the past 27 months. (Provided by HP: PRTF/CA PRTF Activity Analysis-June 2010)

CA-PRTF & PRTF: Expenditures and Numbers Served



Indiana Successes-Substance Abuse

Impact of Indiana Access To Recovery (ATR) on Department Of Correction (DOC)

- DOC rate of recidivism = **37.5%**
- DOC offenders who have been connected to
ATR II rate of recidivism = **27.6%**
- ATR had a cost savings to the Department of
Correction of **\$13,211,209.20**

This is based on taking the per diem (\$54.28) multiplied by our average length of stay (1.4 years) multiplied by the number of offenders who did not return during the period (475 offenders).

State Operated Facilities Transition Plan

Recovery and Reinvestment
Commission on Mental Health
September 7, 2010

COMH
Meeting 2
September 7, 2010
Exhibit 7

What is Happening?

- Public announcement on 7/8/10 of the implementation of the transition plan for patients and staff
- Sequence of events that allow all state hospitals to remain open
- Specific patient populations have been identified to move from hospitalization to community services
- Result is the **net closure of 355 beds** system-wide which represents an approximately **30% decrease** of current capacity.
 - Current capacity: 1205
 - Revised capacity: 850
- Re-deploy 110 beds for persons with SMI
- SOFs will transition to intermediate care facilities and shift from long term residential housing to the greatest extent possible

Current Picture (84% occupancy as of 8/30/10)

- ESH (95%)
 - Capacity 168
 - Population 160
- Madison (84%)
 - Capacity 150
 - Population 126
- Logansport (77%)
 - Capacity 388
 - Population 299
- Richmond (85%)
 - Capacity 312
 - Population 264
- Carter (97%)
 - Capacity 159
 - Population 154
- EPCC (54%)
 - Capacity 28
 - Population 15

Transition versus Closing

- Prevents closure of a state hospital
- Maintains statewide service
- Services in the least restrictive setting by moving individuals to community
- No completely vacant assets for State to dispose of or maintain. All bonded structures remain in operation
- Diversity of mental health population & ability of each facility to provide appropriate services
- Minimization of disruption in services and community concerns
- Greater efficiencies than closing a single hospital
- Maintain statutory compliance specific to ESH and Carter

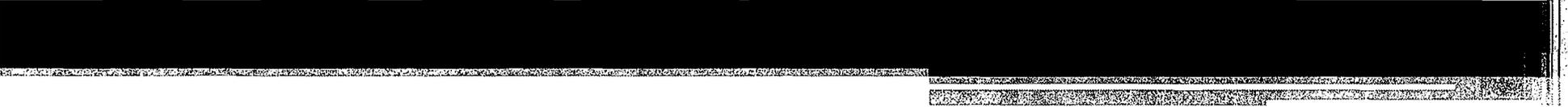
Logansport

- Remain a high acuity forensic psychiatric hospital with limited civil beds
- Persons with MR/DD will be assessed for transition to the community
- 110 persons with SMI will transfer to other SOFs
- Capacity: 134
- Maintain approximately 500 employees
- **Why such a large impact at LSH?**
 - Large population with MR/DD
 - Expertise with forensic and high acuity patients
 - Significant investment of state funds

Richmond

- Transition adolescent unit to services for persons with SMI
- Shift CA program to community providers resulting in closure of the addiction services building. RFP has been released for community –based services
- Transition persons with MR/DD to community services and convert unit for persons with SMI
- Capacity: 211
- Maintain approximately 495 employees

- Significant impact at RSH is due to the transition of the addiction services program



Madison

- Transition 30 persons with MR/DD to community services
- Receive 30 persons with SMI
- Capacity: 150

Evansville

- Transition 30 persons with MR/DD to community services
- Receive 30 persons with SMI
- Capacity: 168

Larue Carter

- Transition youth from Richmond unit
- Capacity: 159

Patient Future

- Carefully screened for community assignment
- Coordination with BDDS providers for best fit
- Involvement of patients and families
- Patient needs and community safety are paramount concerns

Building Usage

- Other state agencies
- County/city opportunities
- School options

Proposal Details

Logansport:

- Close most civil beds (254 beds)

Larue Carter:

Youth from Richmond moved to LC (utilization of 20 Existing Beds)

Evansville:

- Close 30 bed MRDD unit & transition to community
- Utilize 30 bed unit for persons with SMI



Richmond:

- Close substance abuse unit (101 beds)
- Close youth services unit (20 beds)
- Close MRDD unit (30 beds)
- Use 50 beds for persons with SMI

Madison:

- Close two MRDD units (30 beds)
- Utilize 30 beds for persons with SMI

Lay-off Process

- Affected classifications and number of employees needed after the transition have been identified
- Order of layoff in each affected classification is determined by State Personnel Department through the merit employee retention scoring process
- Layoffs will occur over a period of several months and will be concluded by 3/1/2011. Each State employee impacted by this transition will be notified of a specific layoff date as those dates are established in accordance with the transitions of patients to new living arrangements



Next Steps

- Need to provide continuing quality care for patients throughout and following the transition
- Transition planning with patients and families
- SPD coordinating employee informational sessions with benefits section, PERF and DWD

COMH
Meeting 2
September 7, 2010
Exhibit 8

Findings from the Central State Hospital Tracking Project: A Ten Year Retrospective

Eric R. Wright, Ph.D.

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Associate Director, Indiana Consortium for Mental Health Services Research

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The Tracking Project Team

- John H. McGrew, Ph.D.
- Bernice A. Pescosolido, Ph.D.
- Eric R. Wright, Ph.D.
- Terry White, MBA
- Susan Jaeger, MPH
- Anthony Lawson, BS
- Harold Kooreman, MA



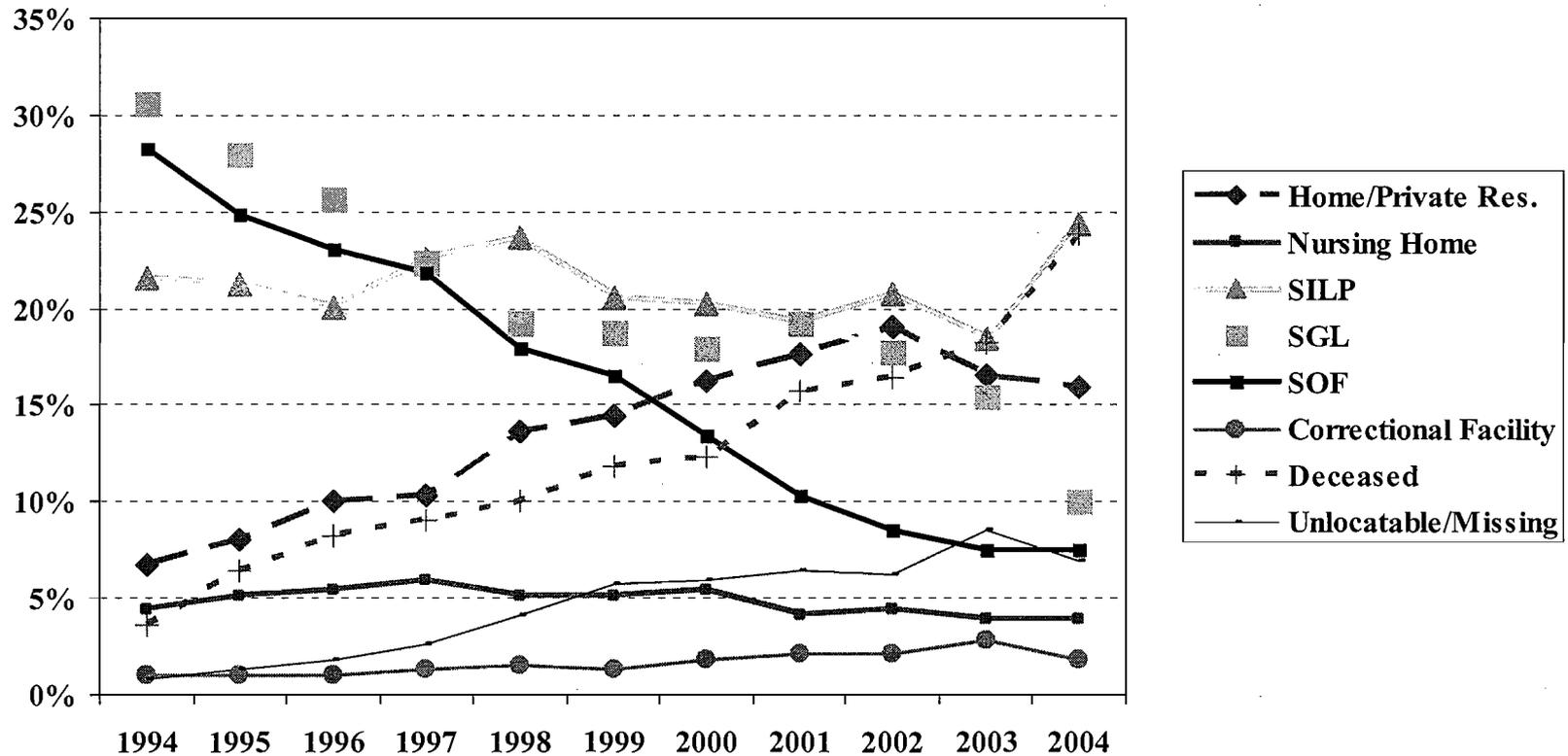


The Tracking Form

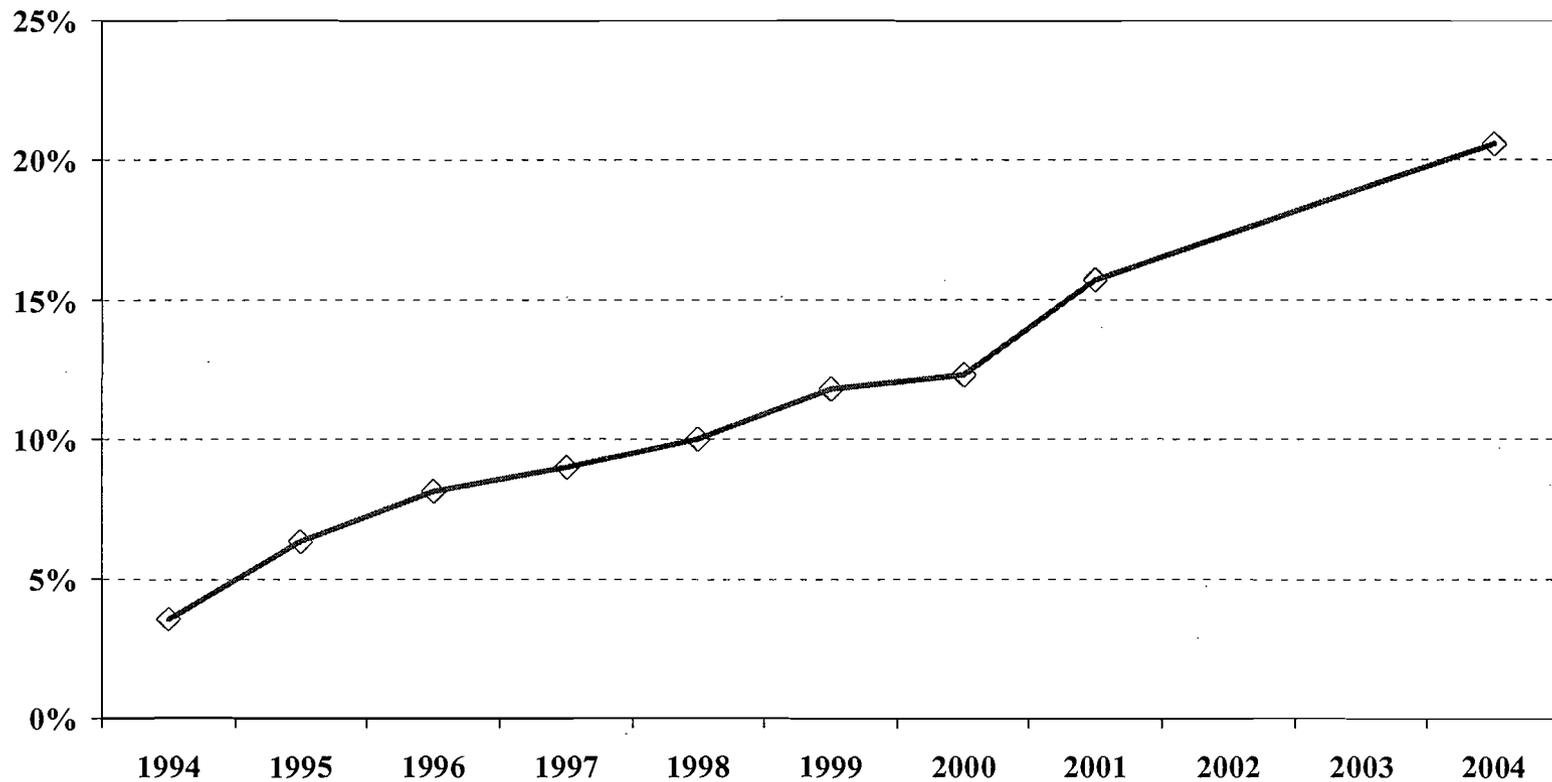
- DMHA Required Data
 - Location (Facility and City State)
 - Service Status
- ICMHSR Suggested Supplemental Data
 - Clinical Functioning
 - Acute Care Hospitalizations
 - Health Status (i.e., physical health problems)
 - Contacts with Law Enforcement
- Three Major Substantive Revisions of the Tracking Form



Former CSH Clients' Main Residential Placements, July, 1994 to July, 2004



Mortality Trend in the Former CSH Client Cohort (July 1994 to December, 2004)



Indiana Consortium for Mental Health Services Research



Major Causes of Death of Former CSH Clients Through December 2002 (N=80)

	N	%	N	%
ACCIDENTS			3	3.8%
AIDS RELATED COMPLICATIONS			1	1.3%
ASPIRATION			2	2.5%
CANCER			9	11.3%
DIABETES RELATED COMPLICATIONS			1	1.3%
EXPOSURE (homeless)			1	1.3%
EXSANGUINATION (ruptured blood vessel)			1	1.3%
HEART CONDITIONS			11	13.8%
LUNG CONDITIONS			6	7.5%
“NATURAL CAUSES”			8	9.7%
ORGAN FAILURE			2	2.5%
RUPTURED ESOPHAGUS			1	1.3%
SEIZURE DISORDER			4	5.0%
SPONTANEOUS INTRA-CRANIAL HEMORRHAGE			1	1.3%
SUDDEN DEATH SYNDROME			1	1.3%
UNKNOWN			28	35.0%
TOTAL			80	100.0%



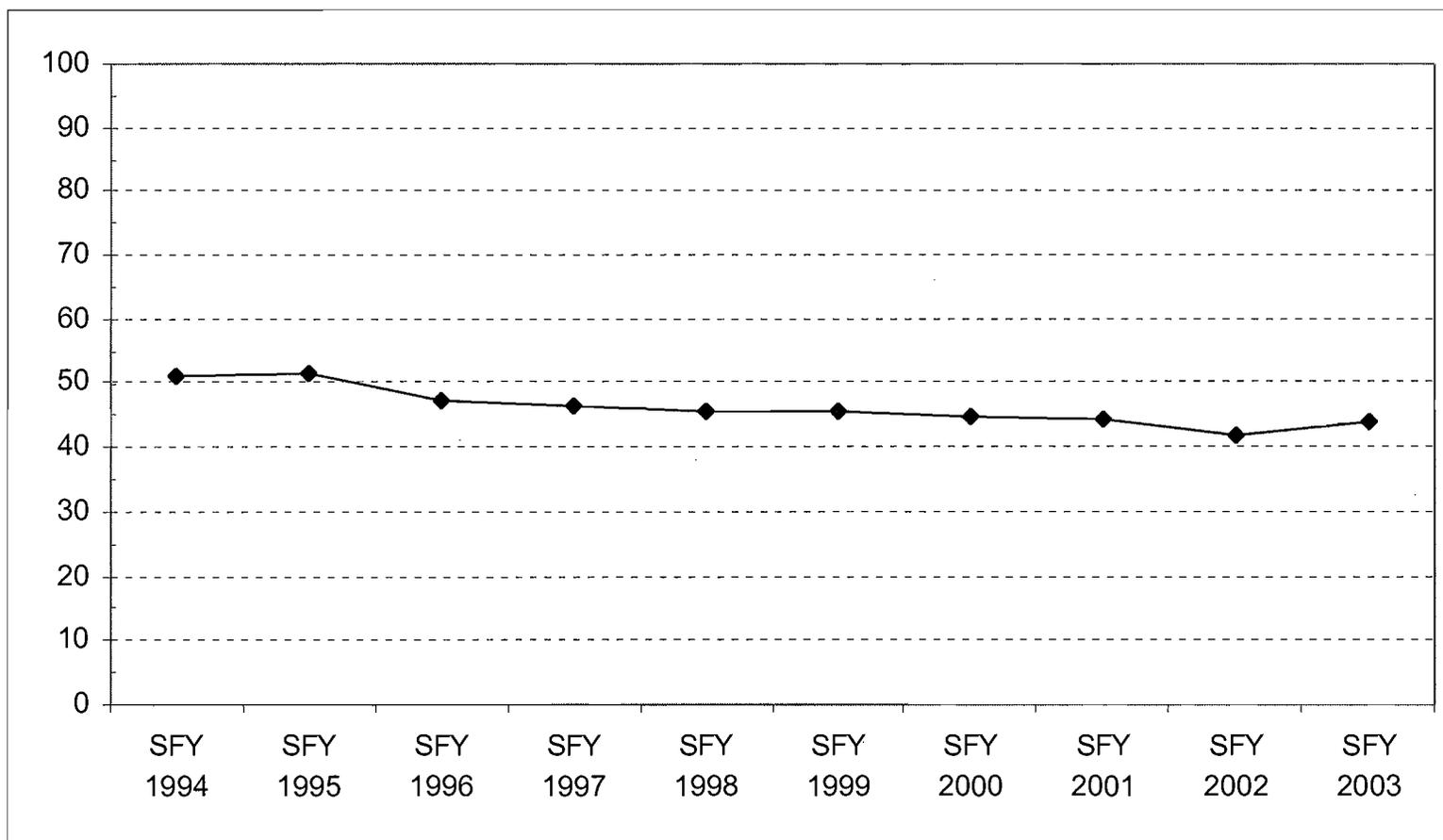
Leading Causes of Death By Sex, Indiana and CSH Cohort (through 2002)

	General Population		CSH Cohort	
	N = 55,123	Overall Rate	N = 80	Overall Rate
1. Heart Disease	M = 7,353 F = 7,826	13.3% 14.2%	M = 9 F = 2	11.3% 2.5%
2. Cancer	M = 6,531 F = 6,240	11.9% 11.3%	M = 5 F = 4	6.3% 5.0%
3. Stroke	M = 1,336 F = 2,338	2.4% 4.2%	M = 0 F = 0	0.0% 0.0%
4. Chronic Lower Respiratory Disease	M = 1,569 F = 1,558	2.8% 2.9%	M = 3 F = 3	3.8% 3.8%
5. Accidents	M = 1,270 F = 816	2.3% 1.5%	M = 3 F = 0	3.8% 0.0%

M = Male, F = Female



Mean GAF Score of Former CSH Clients From July 1, 1994 through June 30, 2004

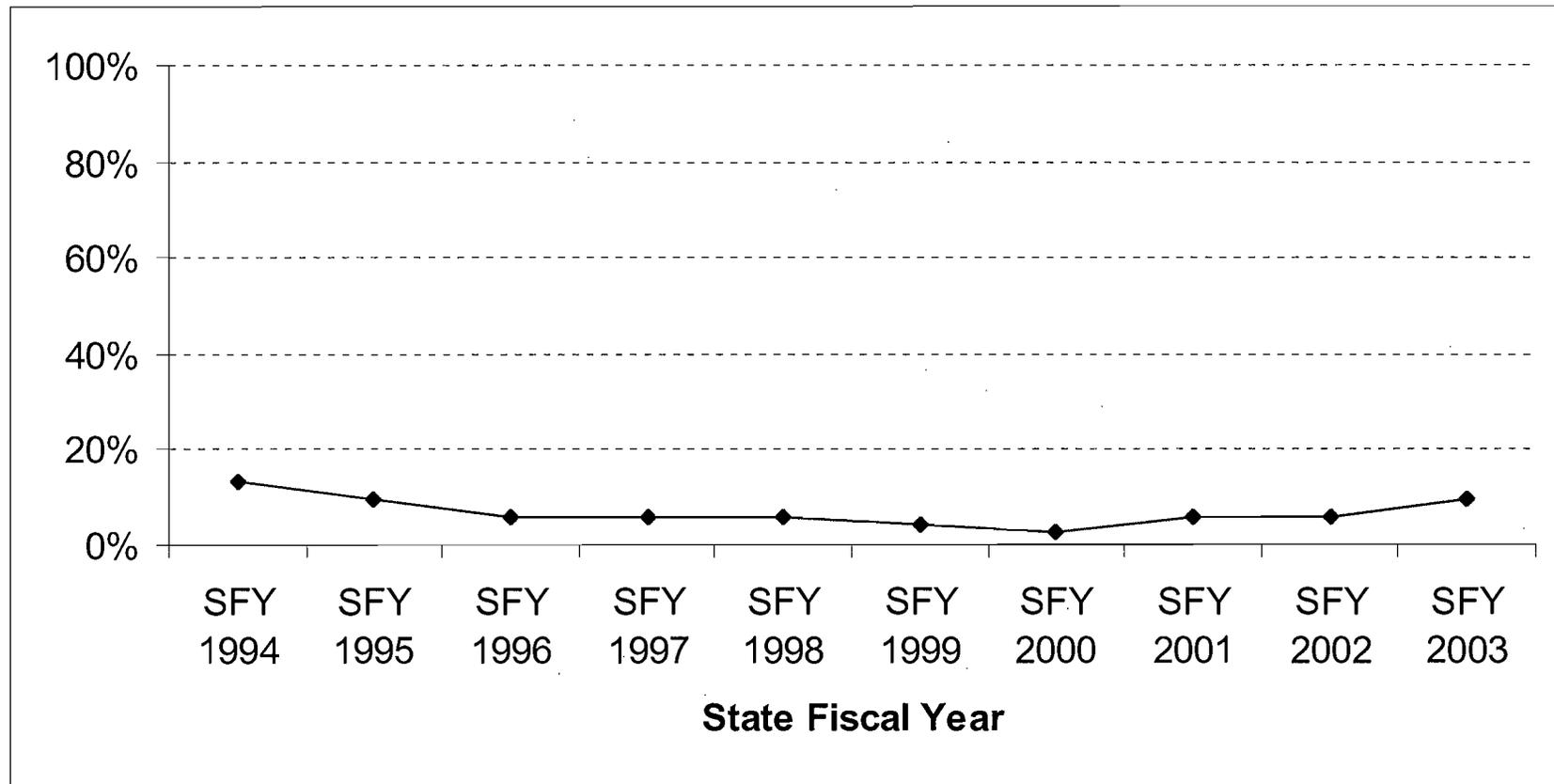


Overall Mean: 46.47 (SD=13.89)

Indiana Consortium for Mental Health Services Research



Percent of Living Cohort Admitted to Acute Care From July 1, 1994 through June 30, 2004

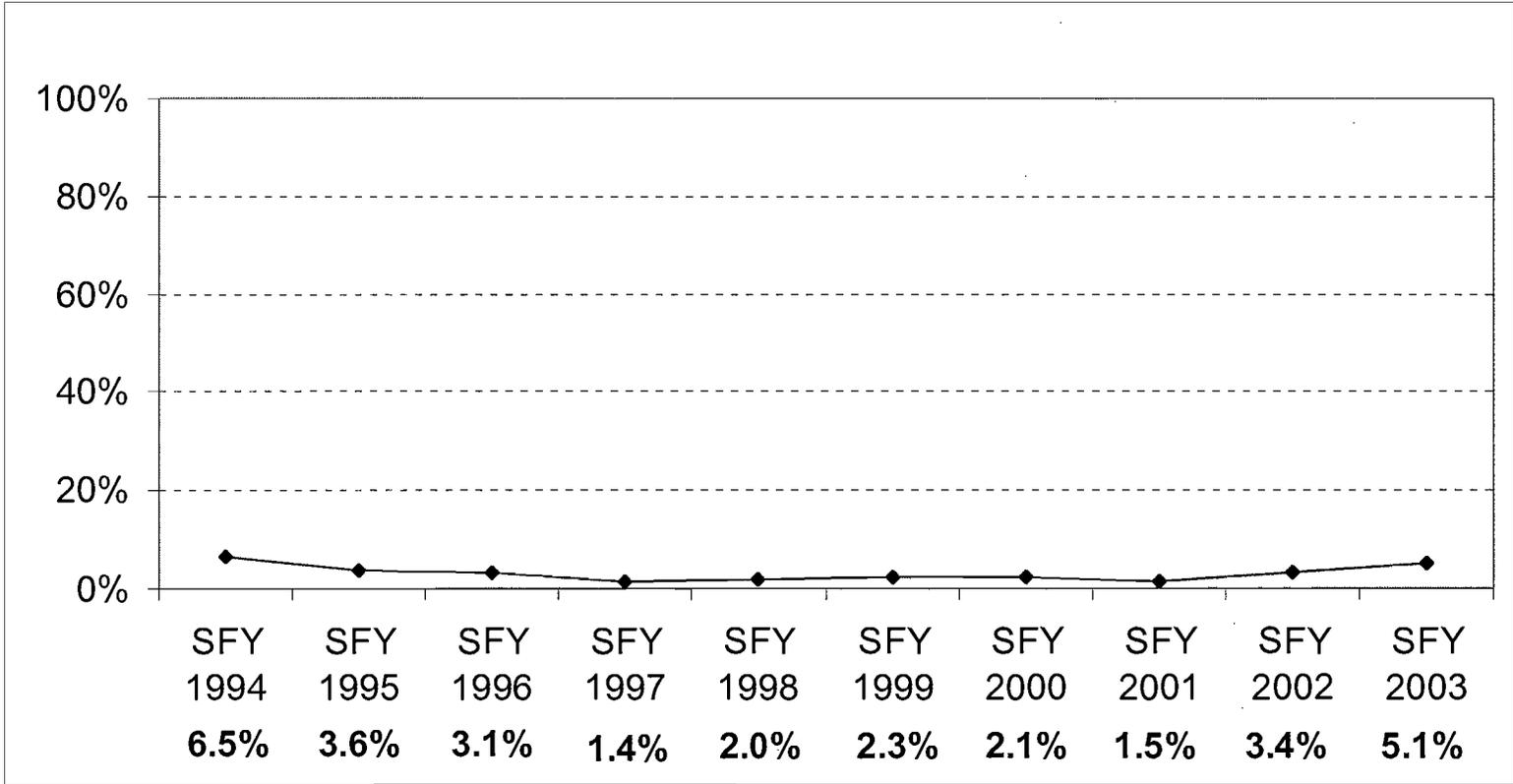


Acute Care Hospitalization Admissions From July 1, 1994 through June 30, 2004

Year	Total Acute Care Admissions	Number of Clients Admitted	Average Stay per Admission		
SFY 1994	96	49	13.62		
SFY 1995	57	34	10.12		
SFY 1996	39	21	11.47		
SFY 1997	36	20	15.95		
SFY 1998	35	20	6.55		
SFY 1999	30	15	9.45		
SFY 2000	30	9	13.92		
SFY 2001	37	19	11.18		
SFY 2002	39	19	6.03		
SFY 2003	50	29	10.72		
M=44.9 SD=19.8		M=23.5 SD=11.7		M=11.31 SD=10.93	



Former CSH Clients' Police Contact Trends From July 1, 1994 through June 30, 2004



Police Contacts of the Former CSH Clients July 1, 1994 through June 30, 2004

NON-VIOLENT CONTACTS	N	%
Missing	24	12.4
Public Intoxication	23	11.9
Probation Violation	19	9.8
Missing Persons Report	17	8.8
Other	12	6.2
Detained	11	5.7
Hospital Escort	9	4.7
Police called to respond	8	4.1
Apprehension and Return	6	3.1
Emergency Detention	6	3.1
Immediate Detention	6	3.1
Trespassing	6	3.1
Possible Illegal Substance	5	2.6
Theft	5	2.6
Domestic Disturbance	5	2.6
Indecent behavior/public indecency	5	2.6
Unknown	4	2.1
Harassment, not specified	3	1.6
Per Judges Orders	3	1.6
Vandalism	3	1.6
Traffic violation	3	1.6
Loitering	2	1.0
Fight with Mother, not specified	1	.5
Found in Chicago/incoherent	1	.5
Possible Theft	1	.5
Possession of Paraphernalia	1	.5
Restraining Order Violation	1	.5
Walking down street with open alcohol	1	.5
False reporting	1	.5
Soliciting a minor	1	.5





**Police Contacts of Former CSH Clients
July 1, 1994 through June 30, 2004 (cont.)**

Violent Contacts	N	%
Assault	23	69.7
Sexual assault	4	12.1
Battery	3	9.1
Arson	2	6.1
Weapons charge	1	3.0

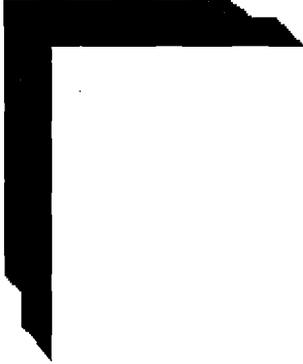


Law Enforcement Contact Type From July 1, 1994 through June 30, 2004

POLICE DESCRIPTIVES FROM JULY 1, 1994 TO

Year	% Non-violent	% Violent
SFY 1994	70.6%	29.4%
SFY 1995	88.2%	11.8%
SFY 1996	90.5%	9.5%
SFY 1997	57.1%	42.9%
SFY 1998	100.0%	0.0%
SFY 1999	78.9%	21.1%
SFY 2000	75.0%	25.0%
SFY 2001	83.3%	16.7%
SFY 2002	63.6%	36.4%





Reasons for the “Successful” Deinstitutionalization

- Funding for services followed the client into the community.
- There was effective, coordinated communication and discharge planning between the former CSH personnel and the staff at the receiving facilities.
- The Tracking Project served as “quality management tool” that imposed accountability on the receiving facilities over the ten year follow-up period.



COMH

Meeting 2

September 7, 2010

Exh.b.t 9

The Honorable Charlie Brown, Chairman
Indiana Mental Health Commission
Indiana State House
200 W. Washington St., House Chamber
Indianapolis, Indiana 46204

Re: Public Testimony Regarding Medicaid Reimbursement and Addiction Counselors

Dear Chairman Brown:

We offer this testimony on behalf of Psychiatric Solutions, Inc.'s Indiana freestanding facilities: Meadows Hospital (Bloomington), Valle Vista Hospital (Greenwood), Michiana Behavioral Health Center (Plymouth), Wellstone Regional Hospital (Jeffersonville), and Columbus Behavioral Health Center for Children and Adolescents (Columbus). With this testimony we are setting forth the reasons why licensed clinical addiction counselors should be added to the list of those professionals eligible for Medicaid reimbursement for both the outpatient clinic option and partial hospitalization services ("Outpatient Mental Health Services"). Licensed clinical addiction counselors are permitted by the recently revised rule¹ to provide billable Medicaid Rehabilitation Option ("MRO") services delivered by community mental health centers, but they have been omitted as a billable provider under both the outpatient clinic option and the partial hospitalization provisions of the rule.

In the final rule published in the Indiana Register by the Family and Social Services Administration ("FSSA") on May 24, 2010, licensed clinical addiction counselors are not listed among those professionals who are eligible for Medicaid reimbursement for Outpatient Mental Health Services.² The list of eligible professionals includes only:

- licensed psychologists;
- licensed independent practice school psychologists;
- licensed clinical social workers;
- licensed marital and family therapists;
- licensed mental health counselors;
- persons holding a master's degree in social work, marital and family therapy, or mental health counseling (except that partial hospitalization services provided by such persons shall not be reimbursed by Medicaid); and

¹ See "Attachment A" for LSA Document # 10-45.

² IC § 5-20-8 lists those professional who are eligible for Medicaid reimbursement for outpatient mental health services for group, family, and individual outpatient psychotherapy services.

September 7, 2010

Page 2

- advanced practice nurses who are licensed, registered nurses with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.

In other words, licensed clinical addiction counselors are the only type of licensed clinical mental health providers not included in this list.

We as providers who are familiar with the needs of mentally ill individuals, feel strongly that they should be eligible for Medicaid reimbursement for providing care to our patients. As you know, many of our patients with mental illness also have considerable substance abuse and addiction issues. Furthermore, we believe licensed clinical addiction counselors were omitted from the list of those professionals eligible for Medicaid reimbursement for Outpatient Mental Health Services simply because their recognition and certification occurred later than the other providers listed in the rule. This omission is inconsistent with effective treatment and better outcomes for Indiana's Medicaid-eligible patients.

First, it is important to emphasize the immense value and skill that licensed clinical addiction counselors bring to the Outpatient Mental Health Services treatment of individuals suffering from behavioral health and substance abuse and addiction. In order to be licensed in Indiana as a licensed clinical addiction counselor, a professional must meet incredibly stringent requirements. For example, licensed clinical addiction counselors are required to have completed a master's or doctor's degree in addiction counseling, addiction therapy, or a related area with twenty-seven (27) semester hours or forty-one (41) quarter hours of graduate course work that must include graduate level course credits with material in at least the following content areas:

- (A) Addiction counseling theories and techniques.
- (B) Clinical problems.
- (C) Psychopharmacology.
- (D) Psychopathology.
- (E) Clinical appraisal and assessment.
- (F) Theory and practice of group addiction counseling.
- (G) Counseling addicted family systems.
- (H) Multicultural counseling.
- (I) Research methods in addictions.

Additionally, licensed clinical addiction counselors are required to have completed a supervised practicum, internship, or field experience in an addiction counseling setting, providing at least seven hundred (700) hours of clinical addiction counseling services. Finally, licensed clinical addiction counselors are required to have completed two (2) years of related addiction counseling experience. As is evident from the State-imposed licensure requirements, licensed

September 7, 2010

Page 3

clinical addiction counselors are extremely educated and experienced in their field, and trained specifically for treating individuals with the conditions so often treated by our facilities.

A significant proportion of those who are mentally ill also suffer from the co-occurring condition of a substance abuse disorder or addiction. Specifically, it is estimated that 37% of alcohol abusers and 53% of drug abusers also have at least one serious mental illness.³ We believe that this duality is even higher in the Medicaid population. The prevalence of substance abuse disorders among the population of the Medicaid enrollees we treat for mental illness clearly demonstrates the critical need for the highly-educated and experience-driven treatment provided by licensed clinical addiction counselors as part of the continuum of care.

In addition to the fact that licensed clinical addiction counselors are necessary for effective treatment of our patients, we believe that licensed clinical addiction counselors should be added the list of those professionals eligible for Medicaid reimbursement for Outpatient Mental Health Services because we believe there is no reason for their omission from the Outpatient Mental Health Services portion of the recently revised rule. Instead, when we commented at the public hearing on LSA #10-45 (Outpatient Mental Health Services and MRO Services final rule) we stated that licensed clinical addiction counselors should be added to the list of professionals who can bill Medicaid. We were told by FSSA representatives that FSSA would not revise the rule to add licensed clinical addiction counselors because they were not included in the original list of those eligible for Medicaid reimbursement. After further examination of FSSA's response, we discovered that licensed clinical addiction counselors could not have been originally included in the list of those professionals eligible for Medicaid reimbursement for Outpatient Mental Health Services because the category of providers did not exist at the time the original Outpatient Mental Health Services rule was written. While the Outpatient Mental Health Services rule has been in existence for many years, the Senate Bill creating the category of licensed clinical addiction counselors was only recently passed in 2009.⁴ If FSSA's concern is additional Medicaid spending, we firmly believe that to omit licensed clinical addiction counselors from the list of those providers eligible to bill for Outpatient Mental Health Services will only result in considerably more Medicaid expenditures due to the exorbitant cost of untreated substance abuse and addiction.

We strongly believe that the Medicaid population should have access to licensed clinical addiction counselors just as other populations who suffer from co-occurring conditions. Additionally, we feel that it would be inappropriate to disadvantage the Medicaid population by continuing to omit licensed clinical addiction counselors from the list of those professionals

³ *Fact Sheet: Dual Diagnosis*, Mental Health America website, available at <http://www.nmha.org/index.cfm?objectid=C7DF9405-1372-4D20-C89D7BD2CD1CA1B9>.

⁴ Senate Enrolled Act 96, First Regular Session 116th General Assembly (2009), available at <http://www.in.gov/apps/lsa/session/billwatch/billinfo?year=2009&session=1&request=getBill&docno=96> (Attached here as "Attachment B").

September 7, 2010
Page 4

eligible for Medicaid reimbursement for Outpatient Mental Health Services merely due to the fact that such category of providers was created at a time later than the categories of included providers already reimbursable.

For the reasons stated herein, we respectfully request the support and assistance of the Mental Health Commission in promulgating legislation that would require licensed clinical addiction counselors be added to the list of those professionals eligible for Outpatient Mental Health Services reimbursement. As our Medicaid program continues to emphasize care in the least-restrictive environment as is medically appropriate, the addition of these professionals is crucial for effective mental health care.

Sincerely,



David Bell
CEO, Valle Vista Hospital

cc: John Hollinsworth, Division President, Psychiatric Solutions, Inc.
Bryan Lett, CEO, Michiana Behavioral Health Center
Jean Scallon, CEO Bloomington Meadows Hospital
Thomas Stormanns, CEO, Wellstone Regional Hospital
Kelly Ulreich, CEO, Columbus Behavioral Health Center for Children and Adolescents