Moving Maine Towards a Managed Behavioral Health Care System

Stakeholder Input Summary Report of Findings

March 6, 2006 – April 14, 2006

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The Stakeholder Input Process

The Maine legislature has mandated that Managed Care will be implemented with regard to Behavioral and Mental Health Services. See Appendix A – Legislative Mandate.

In order to ensure that stakeholders have input and are involved in the design process, the Department of Health and Human Services established a Managed Care Stakeholder Group and four Sub-Groups.

The purpose of the Managed Care Stakeholder Group is to provide input and recommendations to the Department of Health and Human Services on how to best implement Managed Care. The sub-groups are meant to provide a forum for input regarding specific populations.

The sub-groups and the Managed Care Stakeholder Group are advisory to the Department of Health and Human Services who is responsible for making final decisions.

The stakeholder input process has been professionally facilitated on behalf of DHHS by Good Group Decisions in collaboration with the Institute for Public Sector Innovation of the Muskie School for Public Service.

The Managed Care Stakeholder Group

The Managed Care Stakeholder Group met for the first time on March 6, 2006 at the Department of Health and Human Services in Augusta. For a list of group members, see Appendix B.

The meeting had three main topics of discussion and information. The first was to provide an overview of the Managed Care Initiative. The second was to provide Stakeholders with general information and the status of work on the Managed Care Initiative. The third purpose was to do organizational work. That is, the Stakeholders formed sub-groups and developed schedules for meetings. The Meeting Report from the March 6, 2006 meeting appears as Appendix C of this Report.

12 Sub-Group Meetings

Four Sub-Groups met from 2-4 times each between March 17, 2006 and April 12, 2006. The groups were defined as follows:

- Adults with Serious and Persistent Mental Illness

- Children, including Child Welfare, and Children with Serious Emotional Disturbance

- Elder and Adults – General Population

- Substance Abuse

In addition, a special additional meeting was convened to discuss housing issues.

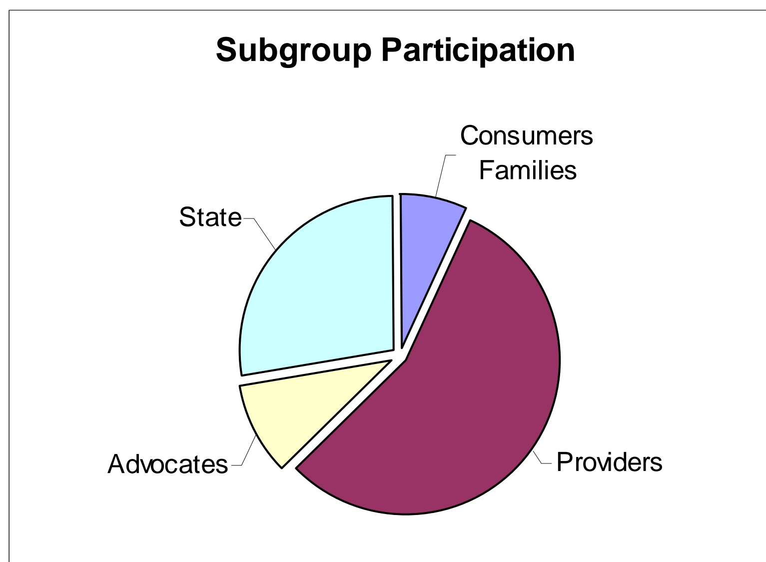
The Sub-Groups were asked to provide input regarding specific populations in the following areas:

- Identify ideas/processes to hold onto
- Identify areas of concern
- Identify questions
- Identify must haves
- Prioritize issues

All sub-group meetings were announced in advance and open to the public. Ground rules used by the sub-groups can be found in Appendix C: March 6, 2006 Meeting Report.

This report is organized by topic rather than by sub-group, but to see the specific topics discussed by each sub-group, see Appendix D: Summary of Sub-Group Discussion Topics. For the Sub-Group meeting schedule, see Appendix E: Schedule of Sub-Group Meetings.

A total of 101 people attended at least one sub-group meeting. Below is a pie chart illustrating the types of people who attended. There were a total of 7 consumer/family members, 10 Advocates, 28 State representatives and 56 Providers who participated in meetings. For a list of participants, see Appendix F: Sub-Group Meeting Participants.



The Website, Written Comments, and Listserv

A Stakeholder Input Website was developed for the convenience of gathering and sharing information. At the website, one could find the schedule of all sub-group meetings, a list of members of the Stakeholder Group, Rough Notes from Sub-Group meetings, agendas, resources about managed care, and the most recent updates from DHHS. All of this information is available at: http://www.GoodGroupDecisions.com/ManagedCare

Rough Notes

After each sub-group meeting, Rough Notes were posted to the website, which was found to be extremely useful to participants. The notes were intended as a rough approximation of what was discussed at the meeting and were presented "as recorded." The Rough Notes served as a tool to the members of the sub-groups. With the Notes, participants could become more familiar with the process, keep up to date with other sub-groups, or stay informed if a meeting was missed.

Resources

Throughout the Stakeholder process, resources were posted to the website in response to requests made from participants and as new information became available. Stakeholders have access to a plethora of information through the resources section of the website.

Written Public Comments

Sub-Group members and Stakeholders were invited to make public comments and recommendations via email or in hardcopy. Yellow comment forms were provided to every participant at every meeting. A total of 11 comments were submitted electronically and 6 were submitted in hardcopy. For a list of those who provided comments, see Appendix G: List of Public Comments.

Managed Care Stakeholders Listserv

Upon request from a participant at a sub-group meeting, a listserv was developed at YahooGroups for the purpose of sharing information and further discussing Managed Care. The listserv is voluntary and not an official State function. It does not represent the policy of the Department of State of Maine and is not monitored or overseen by DHHS or Good Group Decisions. To join the listserv, visit:
http://groups.yahoo.com/group/ManagedCareStakeholders/

Findings

Many participants in the sub-groups shared that managed care can be an excellent method for managing behavioral health services, if developed correctly. The challenge, however, will be to develop a system that preserves the good aspects of the present system and incorporates the best of managed care so that clients are well served.

Cross-Cutting Findings

Working well now

Each of the Sub-Groups were asked to discuss what is working well in the current system in order to identify positive aspects of the system that should be carried over in the design and implementation of a new system. The following is a list of over-arching themes from those discussions:

In the current system, we like the….

- Flexibility
- Choice of providers
- Commitment of the workforce
- Community support for consumers
- Ability to be creative in developing services
- Recovery-based process

Key concerns

Top Concerns

- **Stakeholders need to be involved in the design process**
  - We need to transition slowly enough for stakeholders to be involved
  - We need good information to give good advice
  - To the extent that service reviews result in decisions, stakeholders should be able to give advance input

- **Where's the money going to come from?**
  - For FY 2006/2007, the legislature has mandated $10.4m in cuts – where will those cuts come from?
    - This is an even greater concern if the $10.4m comes out of the Medicaid seed account which will effectively result in cuts of an additional $20m.
  - How will savings be achieved year after year?

- Administering the managed care contract will cost money (the Bangor Daily News recently said 8-10% of $400m). Where will this 8-10% come from?
- There is skepticism that savings can be achieved at all if there are carve outs. The MCO might be inclined to "shift" clients out of the managed care system into the carve outs.

- **Access to care may suffer**
  - There is skepticism that access can be improved in an environment of cost cutting
  - There is also concern that some small providers, particularly in rural areas, may not stay viable in a managed care system, thus reducing access

- **Quality of care may suffer**
  - Lack of flexibility to provide services appropriate to consumer needs
  - Increased burden on providers may result in less attention to quality service delivery
  - The uncertainty associated with a new system may result in lack of quality
  - There is skepticism that quality can be improved in an environment of cost cutting

- **The transition**
  - Readiness is an issue. There is concern that providers, consumer, and state agencies may not be ready in time for the new system to be implemented
  - Significant consumer education will be necessary to empower consumers to use the new system effectively

Other Concerns

Below are other concerns expressed in various sub-groups throughout the input process:

- I don't trust this process of implementing managed care
- There is no choice of vendors for managed care in Maine
- Services could be limited by the evidence base the ASO uses to make evaluations
- The ASO needs to have a good track record
- The ASO should be someone who could be the managed care organization also
- That managed care is about saying "no" and saving money
- An ASO is not accountable for people
- All the decisions have already been made
- Stakeholders are not able to make/ be involved in making decisions
- States can over-rely on the managed care organization's Quality Improvement measures and not do enough to develop their own standards and track quality

- Someone needs to be responsible for things not captured in the contract, like migration
- There is a potential for complications with private practitioners doing intakes
- It is difficult for MaineCare recipients to find a primary care physician
- There is some hesitation in paying for management rather than putting money towards services
- In other states who have implemented a managed care system, the substance abuse profession has disappeared, resulting in untrained and unlicensed people providing treatment
- Managed care needs to be applied to all providers evenly and fairly with the rules being the same for all; that is, programs run in-house by the state and contracted programs should be reviewed and reimbursed equally
- Right now, there are enormous complications with the intersection of Medicare and Medicaid and different reimbursement rates

Outstanding Questions

As the input process progressed, many questions from Stakeholders and a need for more information arose. The Department of Health and Human Services was generally very responsive to providing requested information and answers to questions. There is still some key data needed in order to design the managed care system and for Stakeholders to give input in a meaningful way. Each sub-group did not identify each item below; rather, the following list is a compilation of outstanding questions identified among the sub-groups:

- Information
  - The Actuarial data coming from Mercer
  - Draft performance measures forthcoming from DHHS
- Questions
  - What is the overall underlying strategy or approach to improve results in maintaining people in the community? What are the State's ideas?
  - How will the workforce be trained to deliver services in regard to a change in eligibility criteria?
  - What will happen to clients who are unable to get hospital services?
  - Is there a template for the contract?
  - How will consumers be able to get more services when their services are nearing an end?
  - Is Beacon meeting the established NCQA standards?
  - Who will monitor the external evaluation process regarding consumer migration?
  - How will we monitor provider satisfaction with the managed care company?
  - Will provider licensing requirements remain the same?
  - To what extent will the provider's opinion influence treatment options and services available for consumers?

- Why are we not building our own system rather than paying an entity to do managed care for us?
- How will the Department make saving money secondary to quality and access?
- There has been talk of cost savings via reducing administrative burdens. How will administrative burdens on providers be reduced?

Clarifications from DHHS

During the course of the sub-group meetings, the following was clarified by Chris Zukas-Lessard and other DHHS officials:

- The difference between a risk-based (MCO) model and non risk-based (ASO) model
  - With an ASO (non-risk based) model, the vendor merely receives a fixed amount to manage the services.
  - With an MCO (risk-based model), the vendor both manages the services and assumes financial risk and reward for the delivery of services.
- An RFP legally has to accept applications from both for-profit and non-profit organizations
- Provider rates will not change as of July 1, 2006
- Stakeholder input will continue as the managed care process moves forward
- There will be no savings for reinvestment the first year of the MCO unless the savings target is reached
- Cutting services is not the intent of a managed care system, the intent is the utilization of appropriate services
- The Department is looking at expanding its contract with Beacon to include Service Reviews
  - This would occur for 6-8 months
- Beacon currently has two contracts with the Department
  - Children's Services and Adult Services
    - Service authorizations for specific mental health services in clinics
    - Some service reviews
- Contracts between providers and the Department will remain the same as of July 1, 2006
- There will be no change in provider reimbursement rates for at least 6 months
- With a full managed care model, the vendor decides which providers to contract with, as they would be responsible for the development of a provider network
  - Decisions are based on credentials, need in area, etc
- The ASO will need to contract with providers in order to do prior authorization
- As an interim model in moving to managed care, utilization reviews without consequences will help us to determine the baseline for setting standards

- At this time there is no particular line item(s) that the Department has identified for a deappropriation based on any assumptions about where we might expect to see savings
- Pharmacy is managed separately from the behavioral health system

Findings by Sub-Group

Adults with Serious and Persistent Mental Illness

The Adults with Serious and Persistent Mental Illness Sub-Group met three times during the sub-group input process at the Disability Rights Center in Augusta. The following are the key ideas from their discussions by topic.

Characteristics of a Great Managed Care System

The group found it useful to brainstorm and consider what a great managed care system would look like during their process of developing recommendations for managed care in Maine. The group considered access, standards, quality and system design. The following are key ideas on those topics:

Access

A great managed care system would have….

- Increased access to rehabilitative services and decreased use of institutional care
- Increased access for currently underserved populations
- Access for everyone everywhere
- Full access to primary care services coinciding with mental health services
- Choice
    - A big network with many providers
- Services for everyone regardless of coverage
- Services available at the needed level of care
- Coordination of services for dually eligible

Standards

A great managed care system would have….

- Standardization of reasons for hospitalization

- Clear public, published standards to use as a guideline in developing treatment plans
- A non-political dispute resolution and appeal process for consumers and for providers
- Service limitations based on evidence, with exceptions allowed

Quality

A great managed care system would have….

- The consumer considered as a whole
- Responsibility for finding solutions for the client
- Excellent coordination with institutions when they're needed
- Seamless integration of all services directed by the consumer
- A sustainable process in linking with people's lives
- Everyone involved and not be adversarial
    - Consumers, providers and managers
- Incentives to provide care rather than not provide care (cut costs, etc)
- An ongoing feedback and evaluation process from the consumer and families

System Design

A great managed care system would have….

- Ease of access and use for the consumer
- Make saving money secondary to quality and access
- A reinvestment requirement: saved money goes back into mental health services
- Decreased administrative burdens
- Attractive employment opportunities for staff
- The ability to change if needed, flexibility
- An external assessment
- Assessed reasons for emergencies and emergency hospitalization and developed preventative treatments
    - Processes to reduce crisis

ASO as an Interim Step

In response to the idea of an ASO model as an interim step in moving to a managed care system, the group discussed the implications, concerns and desired characteristics of an ASO model. The following are key ideas from their discussions:

Desired Characteristics

We would like to see….

- The "Characteristics of a Great Managed Care System" from above applied to an ASO as well
- More access to move people through the psychiatric world
- A system that looks at other pockets of the system for people to get services
  - If a service is denied, an alternative service is found for the consumer
- All components managed so people aren't excluded
- A clear and explicit conflict resolution process, starting with the consumer
  - The process would specifically address abandonment of care and other issues
- Education and public relations directed toward the consumer so they can access the system through whatever door they walk through
- Seamlessness for the consumer, they would be easily processed for their needs
  - The consumer would not be required to do things they don't want to do in order to get services they want and need
  - The consumer would have their choice of recovery-based services
- That any restriction on services has to be evidence-based
  - This should be in the regulations as well as the contract

Concerns

We are concerned….

- That we do not have an overall, underlying approach to improve results and maintain people in the community.
- That the ASO may arrive with a strategy we weren't a part of creating or figure it out as they go along
- About changes in eligibility criteria for services and how people will be trained to deliver those services
- About maintaining efficiency, timeliness, and a good PA process.
- About the timeframe for getting services
- That, as we tighten on productivity expectations, there needs to be a mechanism to analyze if we're creating more cost and less quality of life for people
  - The people who are the most ill are those whose community services cost the most.
- That we have no capacity to determine the outcomes with utilization review
  - We need outcomes on individuals
- That an ASO is not accountable for people

Other Discussion

- In-patient hospitals, including Acadia and Spring Harbor, are costing 10% of our Medicaid dollars, about $55 million
- An ASO may be a way to take a step into managed care in response to things moving so quickly
  - A transitional plan could work out to our benefit
  - With an ASO, the State maintains the risk and control
- Good design and planning are essential for an effective and good ASO or MCO system
  - A good planning process would involve stakeholders publicly and make questions visible
- Stakeholders need as much information as possible in order to provide input. Have we considered what other States are doing?
- A managed care system has to have a focus on hard-data measures
  - Using ER services as a measure can be dangerous
- The ASO needs to have a good track record
- The ASO should be an organization who could be the managed care organization as well
- We need to develop a guiding philosophy or guiding principles to ensure the creation of a system which will work better

Performance Standards

The following are key ideas discussed about the development of Performance Standards for the managed care contract and system:

- **Areas to be Addressed with Performance Standards**
  - Grievances
    - Needs to include: client satisfaction around the process and accessibility of the grievance process
  - Indicators specific to private practitioners
  - Access to psychologists in hospitals
  - Trauma-specific services
  - Crisis lines and warm lines
  - ACT teams required to meet fidelities
    - Fidelity guidelines
      - 30 standards with 1-5 rating
        - Ex. Staff to client ratio
      - Assessed over a range of criteria
  - ACT Team managers need to be involved in treatment and discharge planning
  - Mental health emergency hospitalizations

        - How the emergency department sees psychiatric patients
    - Reduction of Emergency Department Services use
        - There needs to be a timeliness measure in this regard
        - We should measure length of stay in Emergency Departments, not just incidence
    - Involuntary and voluntary hospital admissions
        - Sometimes people are admitted involuntarily because there are no beds for voluntary admittance
    - Consumers making a successful transitions from clinical supports to natural supports
    - Graduation from services and meeting all goals for community inclusion and integration
        - Career development for consumers is part of successful integration
    - Migration and the number of consumers who do not become involved with the criminal justice system
        - In examining this piece, we should consider an increase in other services with regard to limiting drugs
    - The range of quality peer-support programs available
    - Use of Advance Directives as well as Crisis Plans
    - Appointments with outpatient medication prescribers within 3-10 days of discharge from an inpatient psychiatric setting
    - We want to increase flexible and appropriate services

- **Evidence-based treatment**
    - Evidence-based treatment can become a way of limiting services rather than getting quality services
    - We should consider the idea of "evidence informs services"
    - Peer support services are not evidence-based at this point
    - Evidence-based may be a promising approach
    - The Department is working on an evidence-based definition with various levels
    - When referring to use of evidence-based practices, we should be specific about what they are and where the definition comes from

- **Comments on the process of developing standards**
    - We need a baseline for each indicator
    - There should be a definition of "consumer" and an inclusion of family in the process
    - We need to use language to involve consumers and not convey a "do something to consumers" attitude
    - Anything indicating measurements needs to state how the measure is made, where the data comes from, the cost, the paperwork, etc
    - We need to focus on eliminating the bad and introducing the good with less money in the current system
    - We need different indicators for different populations
        - Public guardianship, kids, etc

    - Prior-approval for anyone not SPMI
    - No prior-approval for adults with SPMI

Children, including Child Welfare and Children with Serious Emotional Disturbances

The Children, including Child Welfare and Children with Serious Emotional Disturbances Sub-Group met four times during the sub-group input process at various locations in Augusta. The following are the key ideas from their discussions by topic.

Processes and Services

The following lists are processes of the current system and services of the continuum of care the group discussed while working to develop recommendations to the State. The group suggested an examination of how each of the listed processes would work for each of the listed services in a managed care system:

Processes

- Eligibility
- Gatekeeping
- Enrollment
- Assessment
- Prior authorization
- Utilization review
- Quality management
- Provider credentialing
- Contracting oversight
- Claims processing
- Appeals
- Timeframe
- Submission of data
- Data analysis
- Needs assessments

Services

- Respite
- Treatment Foster Care
- Homeless Residential PNMI

- Outpatient Services
- Case Management
- Inpatient Psychiatric Facilities
- In-Home Services
- Substance Abuse
- Crisis
- Medication Management
- Residential Group Care
- Home-Based Services
- Family Visitation Services
- ACT Teams
- Assessment/PCP and Treatment
- Day Treatment
- Infant Mental Health

Performance Standards

The following list of Performance Standards was developed with the idea that "these standards should be considered for application to the ASO, the State, and the Providers with which the State and/or ASO contracts."

- Collaboration among State agencies and schools
    - Family and child at the center
- Timely responses regarding care
    - The central issue is what is in the child's best interest at the moment
- Confidentiality/Due process
    - We need to make sure that in collaboration with schools, there is a collective understanding of the different confidentiality requirements of organizations
- Decisions based on information from several sources
    - Not too burdensome reporting for small providers
- Standards specific to specific populations
    - We need a mechanism to take circumstances into account, specifically for homeless youth
- Consistency in payment and licensing
    - Currently we have two sets of standards in MaineCare and we need consistency
        - Licensure
        - MaineCare billing requirements
- Simple access for families
    - We need services proximate to the child's home
- Everyone is referred to appropriate services
- NCQA standards

- We could apply NCQA standards developed in areas such as:
  - Access, delivery, complaints, billing, information, credentialing, etc
- Beacon has attained accreditation through NCQA
  - Are they meeting these standards though?

- Timely payments to providers
- Amount of $ in profit needs to be capped
  - We want to ensure that a certain amount of money is spent on care
    - We want to see how much money is spent and on what
    - The MCO should not have too much profit
- Permanency
  - In aggregate (not a case by case basis)
- Readiness assessment
  - We need to do a readiness assessment for providers, and the vendor and the providers should work together on this
- Children's improvement
  - We need a functional measure of improvement in regard to outcomes assessments

Defining Medical Necessity

The following are key ideas the group discussed regarding Medical Necessity:

- We should tend toward a broad definition of medical necessity
- The Vermont definition could be useful to us
  - Add "appropriateness" from Minnesota
  - Add:
    - Ensure access
    - Best interests of the member
    - Based on medical, social and educational factors
    - Least restrictive level of care that is safe and effective
- We should have different definitions for different user groups
  - Broader for children
  - There could be different definitions for different populations of children
- We need to know the parameters of the ASO before providing more details
  - Identify the steps and where the medical necessity definition fits
- We need assurance regarding services left out
- The insurer must determine medical necessity on the basis of health information provided by:
  - Individual
  - Family
  - PCP
  - Multi-disciplinary team in regard to educational and other organizations who have evaluated

    - A variety of evaluative sources to make decisions
- A medical necessity definition allows determination of how clients fit criteria for levels of care
    - The diagnosis would be "bounced off" the definition
    - It helps determine eligibility
    - It helps determine what services and level of care are best match for child
- We should develop an overarching statement of medical necessity, and then develop definitions for each area of care
    - Residential Treatment, Outpatient Care, Treatment Foster Care
    - Each type is different enough to have its own definition
    - We need to be especially mindful to address the needs of homeless youth. The definition of medical necessity should be particularly broad for them.
- Medical necessity can be used to restrict services, but it can also require that people are receiving a certain level of care

How to Continue to Involve Stakeholders

Stakeholder Involvement was discussed by the group in each meeting. The following is a list of key ideas developed to facilitate continued Stakeholder involvement:

- Keep us informed
    - Decisions made
    - Finances
    - Best practices
    - Visions for each service
- We should participate in decisions
- Input by Service Area
    - Eligibility assessments
    - Performance standards
    - Utilization review
    - Prior authorization
- Regular Meetings
    - On a monthly basis
- Input on special topics
    - Comp. Benefits
    - Licensing
- Start with assessments
    - Readiness assessments to providers
        - Detailed questionnaire about IT, clients, etc
    - Provider assessments
        - Who do we have and what services are being provided
- Educate and involve consumers and families
    - Before the new system is in place

In addition, some have urged that if the Department makes any decisions based on the service reviews that are about to be conducted, that stakeholders first have a chance to give direct input to the Acting Commissioner or at least ask questions.

How to Educate Families

The Group discussed methods of educating families about the upcoming changes in the behavioral health system as well as how their services may be affected. The following are key ideas from their discussion:

- There are plans to hold public forum around the State with Beacon for families
    - A letter of intent would be sent beforehand inviting participation
    - The forum would outline the proposed structure of the managed care system
    - The forum would allow a chance to ask questions and share information
- There has been some training provided to parents by the Department
    - A Listserv and a forum have been used
- Regional meetings around the State (teleconferencing available), with advance mailings (electronic and hardcopy), offering opportunities to comment in various forms
- We have to assume that most parents have not heard about this and are probably not informed
- We need to give an educational overview before asking for input
- We should consider how families have been involved in other States
- Other ways to involve families are….
    - Mass mailings – letters pointing to information
    - Provide phone numbers to call for information and to make comments
    - Communicate in multiple ways to reach as many people as possible
    - Media
        - Radio, TV, newspapers, etc
    - Develop and send small documents with bulleted information to parent organizations
    - Send information through providers
    - Send information through schools

Substance Abuse

The Substance Abuse Sub-Group met twice during the sub-group input process at the Cross Building in Augusta. The following are the key ideas from their discussions by topic.

Performance Standards

- Define access indicators as follows:
  - How quickly clients are seen from the initial call
  - How quickly clients get services from the time of assessment until they are admitted to the appropriate level of care
- We should have indicators to track the occurrence of integrated screening and assessment
- We should make data reporting for providers as easy as possible
- Co-occurring disorders should be addressed
  - There is an existing list of outcomes around co-occurring disorders that could be added to and applied to co-occurring cases
- Consumer satisfaction should be a quality measurement
- Some assessment should be done by a third party
  - According to Federal Waiver

Covered Services

- **Substance Abuse Services versus Mental Health Services**
  - Problems co-occur, an integrated treatment is preferable
    - Treatment that meets the needs of the individual
    - All issues need to be addressed for the person to be successful
  - Substance abuse is a disorder with its own nuances, and needs special considerations
  - Clinicians fill the role of case managers in substance abuse
  - There are some differences in treatment between substance abuse and mental health
    - There are less services available in substance abuse
  - Mental health doesn't have enough active treatment, case management becomes the treatment
  - The problems within mental health and within substance abuse are very different problems
  - If we don't keep the systems separate, we may lose substance abuse services
  - Some clients served in substance abuse may not have a diagnosable mental health illness

- **Services to Provide or Improve**
    - The outpatient services sector should be exempt
    - There should be a flexibility in the number of sessions
    - We currently have a limit on out-patient counseling
        - 30 weeks, up to 3 sessions a week
        - Intensive outpatient limited to 16 weeks
    - No limits on long-term medication-based treatments
    - Expanded services for family systems
    - Detox services should not be managed, they are considered to be medical
    - There are many paths to recovery, often outside the treatment system
        - The system is not supporting access to outside help
    - Transportation for self-help should be provided

- **Other**
    - We want to see people get the right services for their needs
    - Substance abuse services are already managed and limited by program design
    - We need a larger review of needs in the State

<u>Covered Members</u>

- Outpatient services will most likely change, is it will be necessary for organizations to schedule more clients than they currently do
- We will need to implement practices to retain clients – new practice
- We will have to look at more quickly transitioning clients out of out-patient services
- There will not be as many individual out-patient based services
- We should not try to manage individuals with a large number of challenges and needs, at least until we have specific services needed available
- We should change systems for treating complex situations last
    - Management could bring additional resources to these clients
- We need a system to account for the complexity of the case

<u>Access</u>

- **System**
    - There should be improvement on a continuous basis with a baseline of where we are now
    - We should assess where we are now and inform Beacon about the improvements we want to see
    - The contract should improve access system-wide for the clients relative to access currently
    - We don't have enough substance abuse services to be managed

        - If more funds will not be shifted to substance abuse, it should be carved out of managed care

- **Access timeframes**
    - Outpatient and Intensive Out Patient services should be available within one hour of request
    - Detox services should be available within one hour of request
    - Residential Services should be available within 30 days from request
    - We should have a one-day response for services defined in the contract

- **Assessment**
    - All providers should use the same assessment tools
    - ASAM criteria should be applied when doing assessments
        - The criteria define what symptoms and conditions warrant certain levels of care
        - Consumers should not have to have failed a lower level of service in order to get services they are eligible for from the assessment
    - After the ASAM assessment, the managed care entity and the provider would discuss the best treatment options
        - Prior approval is not needed to start the process
        - Consumers are not assessed for specific services, but generally assessed for need

- **Service Options**
    - We should have more availability of providers and more choice of providers
    - All options should be available to every person
    - Options should be discussed and made clear to the client
    - The client gets what they need/want when they need/want it
    - The State should require certain levels of care be available in all regions
        - If it doesn't exist, the managed care organization should create it
    - MaineCare recipients should be able to get out-patient services from any provider
        - No prior approval, use American Society for Addiction Medicine (ASAM) criteria
    - People currently cannot always get the higher levels of service because they don't exist
        - People are misplaced
    - The distance consumers travel to services should be measured and considered

Additionally, some have expressed skepticism that improving access can be done commensurate with cutting costs.

Utilization Review and Pre-Certification

- We shouldn't have pre-certification
  - An outside company might just put up another barrier for services
- Emergency services cannot be pre-authorized
  - The hospital could forward patients to the appropriate services as alternatives to hospitalization
- We need to allow many sessions
- We should look at the research to see where progress occurs in treatment sessions
- Use the appropriate research to look at what is appropriate for most people within specific populations

Data Management

- Information should be collected and available on:
  - Treatment levels
  - Demographics on services provided, denied, and appealed
  - Payments
  - Initial contacts, etc
- Prevalence data on all disorders should be collected, included prevalence of co-occurring conditions
- The managed care system should link or integrate with the State's data system to avoid duplication

Provider Credentialing

- To start, there should be open enrollment, and any willing licensed provider should be in the network
- Providers should consider co-occurring disorders
- Concern that provider profiling would be done by the managed care entity
- We're concerned about both access and quality

- **Individual Provider Licensing and Billing of MaineCare**
  - "Provider" is currently defined as an agency or organization
  - Licensing individual providers could be helpful for areas of the State where services are sparse and needs are unmet
  - Opening MaineCare to individual providers is concerning because:
    - MaineCare usage would expand dramatically
    - Oversight of agencies is more stringent than that of private practitioners and would therefore have to change
  - There is a concern with quality of care with individual provider licensing
  - Maybe organizations should be encouraged to hire individual providers as an employee of a remote site

        - A waiver process could be developed for specific areas to promote access if this cannot be arranged

- **About revoking provider contracts**
    - Reasons a Provider Contract could be revoked and the Process
        - Not reporting data
        - Contracting with specialists
        - Incorrectly billing
    - The process of revoking a contract
        - The process should require OSA involvement
        - Access should be considered before excluding a provider from the network

Grievances and Appeals

- There should be a different process for someone currently receiving services than for someone who is newly entering the system
    - If the person is already in the system, services should continue during the grievance process
    - For someone new to the system, a decision should be made within 24 hours on an appeal for denied services
- There should be an appeals process for both providers and consumers
- An appeal can be initiated by either the client themselves or the provider on their behalf
- We need to include language in the contract about the levels of the appeal process (1, 2, 3) and the criteria for each
    - The first step of the appeal would take place within the managed care organization
    - The second step of the appeal would involve the State
    - Should be the Office of Substance Abuse
    - The third level of the appeal would involve the judicial system
- We don't currently have a formal appeal process for substance abuse, and we need one

Rate Setting

- Rates should be set in collaboration with the Office of Substance Abuse and in alignment with their current model
- We would like to see equitable rates between mental health and substance abuse providers
- There should be enhanced rates for co-occurring enhanced programs
- There should be standard rates for standard services
    - There should be a standard rate for specific services provided by an equally credentialed provider, regardless of where they are

        - Example, all LCSWs paid the same
    - An agency should not get a higher rate for having a more costly infrastructure and overhead
    - There could be a possible cost of living adjustment for various areas where it is warranted
- We should have some flexibility in rate policies to improve access
    - Example: A geographical waiver for remote, less accessible areas
- We need to move away from negotiated rates
    - There may be some flexibility to ensure access when appropriate
- Information on rates should be accessible
- The purpose of rate-setting is to ensure access, access is the highest priority
- We should not go to a full risk system right away, but work to it gradually
    - Do not move risk to the provider level
    - Inappropriate since all healthcare in Maine is not being managed

Elders and Adults – General Population

The Elders and Adults – General Population Sub-Group met three times during the input process at the Bureau of Elder Services in Augusta. The following are the key points from their discussions by topic.

Data Management

- Providers should be provided with an easy-to-use, low-cost, web-based program to track data
- Providers should only have to report data to one entity
- The State owns the data collected by providers
- We want the data managed well and with care
- We want the data from the vendor in a consistent format
- We want data that will really be able to show us what is happening within each age group

Access

- We want to encourage the co-location of mental health and medical health services
    - Example: Allowing an LCSW to provide services in line with a PCP and co-locating a LCSW at a primary health practice
- We need to protect the most vulnerable populations and ensure they have access
- We need to at least maintain the current levels of service

- We should give providers incentives to participate in order to ensure broad access
- We need to improve access for Elders with both Medicare and Medicaid
- There are currently many barriers to service in the system that need to be addressed, such as:
    - Non-uniform standards, assessments, demands, principles
- Elders without a serious and persistent mental illness are currently underserved, we need to improve access for this population
- Access is a top priority to be addressed in the design of the new system

Covered Members

- In developing the new system, we need to consider special populations with disorders such as:
    - Brain injury, autism, developmental disabilities, etc
- Categorically vulnerable people who need liberal access to services, make sure they can get what they needed
    - We need timely access for these populations
    - We need a broader definition of "vulnerable"

Covered Services

- Behavioral Health for Elders should be included in primary care, as the two are intimately connected
- We shouldn't promote non-specific services without evidence
- There should be a focus on more preventative types of wellness activities
- Mental Health needs to be integrated with and screened in Primary Care

Policy and System Design

- In designing the system, we must build in the ability to make adjustments to programs
- Before we can design a new system, we need information on what works and doesn't work for the people in Maine
    - Must include information gathering on outcomes
- It is critical and important to focus on how services are designed and delivered
- We can build our own system instead of hiring a company to do it for us
- What can a managed care company do for Maine that we cannot do for ourselves?
- We need to a better job of defining critical areas and establishing priorities

Education and Outreach

- The public and providers need to informed about the changes that will result from the move to a managed care system
- We haven't done a good job so far conveying to the public what we are trying to do
    - We want to promote access and quality
- We need to inform and encourage the development of the workforce

Grievances and Appeals

- We need an appeals system no less protective than what we have now
- We should develop additional processes regarding appeals, addressing:
    - Where do appeals happen within the managed care entity?
    - When does the appeal go back to the Department?
- Grievances and appeals is a top priority to be designed well in the new system

Housing

A special sub-committee to address housing and how it would be influenced with a managed care system met on April 10, 2006. Sheldon Wheeler, the Director of Housing for the Department of Health and Human Services attended the meeting to hear concerns as well as provide clarifications when possible. The following are key ideas from their discussion:

- Housing should be a large part of the managed care system
- The system is currently administered so that housing is available to persons who qualify for adult mental health services under Section 17 of the MaineCare Benefits Manual
    - There could be a similar qualification for BRAP in managed care
    - There could be an Annual Review component within managed care
- People would not lose their housing for getting better
- The Department is currently working with local housing authorities as well as Maine State Housing Authority to modify administrative plans
    - BRAP recipients will be made a priority population
    - We're encouraging housing authorities to apply for Mainstream Vouchers
        - Vouchers administered almost identically to Section 8 (Housing Choice) targeted to persons with disabilities
- The State is working to address rising rent costs and to bring rising rents down so that they are more in line with fair market rents.
- Adult Mental Health PNMIs are expected to be part of managed care, with regard to substance abuse

- BRAP and Shelter Plus Care would continue to be administered in partnership, but exist outside of the MCO model.
- Having housing and services hooked together with PNMIs is difficult
- There are some difficulties with licensing issues which require a certain amount of services be provided with housing
- The needs of homeless youth are unique. They need the benefit of temporary residential placement if and when no other more permanent housing is immediately available.
    - If managed care means losing homeless safety net inventory, we better re-think how homeless services get corralled/swept up into the proposed managed care system.

Recommendations

General

The following list of recommendations was developed by Good Group Decisions staff based on all that we heard during the sub-group stakeholder input process. Although these recommendations were not formally approved by the stakeholders, it is our sense that there is general consensus among participants on the following (in no particular order of priority).

In the design of a new managed care system in Maine, stakeholders want to see…..

- **Access for everyone everywhere**
  - Anyone in Maine with a behavioral health need, regardless of location, income, or other factors, should be able to access the system
  - Access to services should be no less than it is now

- **Consumer centered services**
  - Services should be provided with the needs of the consumer foremost
  - There should be flexibility in the type and amount of services available, depending on the needs of the consumer
  - In the case of service limitations, there needs to be a way to make exceptions
  - There should be a broad and inclusive definition of Medical Necessity so that consumers can get the services they need
  - There should be co-location of primary care and behavioral health services
  - The appeals and grievance process should be no less protective than now

- **Continued stakeholder involvement**
  - Stakeholders should be involved in decision-making, not just invited to give input
  - Stakeholders should be involved in the design of the managed care system and in review of system implementation

- **System standardization with clear guidelines**
  - All in-house and contracted providers should be held to the same standards and regulations, and should be reimbursed at similar rates for similar services.
  - It needs to be quick and easy for providers to determine what services would be covered so treatment decisions "in the field" can be made quickly

- **Simplification for providers and consumers**
    - A decrease in administrative burdens
    - A simple system that reduces uncertainty for providers and consumers

- **Adequate readiness before system implementation**
    - Significant advance education for providers and consumers about how the new system will work
    - Readiness assessments among providers, consumers, and state officials

- **The largest number of services possible included in managed care**
    - The fewer carve-outs the better the system will be and the more chance it has of saving money while preserving access and quality

- **Savings resulting from managed care should be reinvested into the system**

Specific

The following list of recommendations is a compilation from all the sub-groups. Each of the sub-groups did not deliberate on each recommendation. Some of the recommendations fall into multiple categories and appear twice in the list. Consensus was reached within at least one sub-group on each of the items listed below.

- **Access**
    - Access should be defined as follows:
        - How quickly clients are seen from the initial call
        - How quickly clients get services from the time of assessment until they are admitted to appropriate level of care
    - The contract should improve access system-wide for the client relative to access currently
    - Access would be considered before excluding a provider from the network
    - We should move away from negotiated rates, but allow some flexibility to ensure access when appropriate
    - Access and appeals are the two top performance standards to focus on
    - No person who's referred or shows up at a gatekeeper goes away without being referred to services

- **Appeals**
    - There should be an appeals process for both providers and consumers
    - Access and appeals are the two top performance standards to focus on

- **Data**
    - Prevalence data on all disorders should be collected, included prevalence of co-occurring conditions

- The managed care system should link or integrate with the State's data system a to avoid duplication

- **Providers and Rates**
  - To start, there should be open enrollment, and any willing licensed provider is in the network
  - We should move away from negotiated rates, but allow some flexibility to ensure access when appropriate

- **Input**
  - A readiness assessment needs to be done as a first step in beginning to design a managed care system. Those who should be assessed are:
    - Providers
    - Consumers
    - State
    - ASO
  - An assessment should be conducted to determine if the behavioral health system can absorb the $30 million in addition to the managed care contract amount
  - Stakeholders groups should continue to meet
  - Consumers should have ample opportunity to comment on their experiences with providers
  - Continuing discussions should focus on specific service areas

- **Other**
  - We should not go to a full risk system right away, but work to it gradually
  - We don't have enough substance abuse services to be managed, if more funds will not be shifted to substance abuse, it should be carved out of managed care

Appendices

Appendix A: Legislative mandate

The following is the legislative mandate for moving to managed care in the behavioral health system. The language was developed by members of the AFS and HHS Committees and representatives of the Maine Association of Mental Health Services and agreed to by the Department.

PART ZZZ

Sec. ZZZ-1. Managed behavioral health care system. The following provisions apply to the managed behavioral health care services initiative to be undertaken by the Department of Health and Human Services pursuant to Public Law 2005, Chapter 457, Part PP through an administrative services organization or managed care organization:

1. Prior to implementation of administration or management of services, savings projected to be achieved by the managed behavioral health care services system may not be achieved through reductions in provider rates below their levels on January 1, 2006 or through eliminations of categories of services provided by community providers or consumer groups; and

2. With regard to any contracts with administrative services organizations or managed care organizations entered into by the department in the implementation of managed behavioral health care:

A. Except for the treatment provided at the Riverview Psychiatric Center and Dorothea Dix Psychiatric Center, any contract for administrative or managed behavioral health care services must included all adults and children's mental health services funded under the MaineCare program and no services may be excluded, delayed, carved out or administered under separate contract;

B. Any contractual agreement for administrative or managed behavioral health care services must include utilizations review functions for all categories of services;

C. The administrative services organization or managed care organization may perform rate-setting functions without regard to current levels of reimbursement for providers of services; and

D. During the first year of any contract, the administrative services organization or managed care organization shall contract with all providers of mental health services that meet the departmental requirements and received MaineCare funding as of June 30, 2006.

Appendix B: Members of the Managed Care Stakeholder Group

Organization	Representative
Adoptive and Foster Families of Maine	Bette Hoxie
Advocacy Initiative Network	Elizabeth Carignan
American Academy of Pediatrics	Donald Burgess, MD
American Association of Retired Persons	Shawn Lewin
Child Welfare Ombudsman	Dean Crocker
Consumer Advisory Council	Kaitlyn Bragdon Roe
Disability Rights Center	Helen Bailey
Foster Family-Based Treatment Association	Meg Calloway
GEAR - Guiding Empowerment Allows Results	Carol Tiernan
Home Care Alliance of Maine	Joseph Pickering
Legal Services for the Elderly	Leo Delicata
MAAR	Deb Dettor
Maine Administrators of Services for Children with Disabilities MADSEC--Special Ed. Directors	Barbara Gunn
Maine Association of Area Agencies on Aging	Graham Newson
Maine Association of Group Care Providers	Jack Mazzotti
Maine Association of Mental Health Services	Kitty Purrington
Maine Association of Peer Support and Recovery Centers	Kelly Staples
Maine Association of Psychiatric Physicians	Patrick Maidman, MD
Maine Association of Substance Abuse Providers	Lynn Duby
Maine Council of Child and Adolescent Psychiatry	Joseph Lebenzon, MD
Maine Equal Justice Project	Jack Comart
Maine Hospital Association	David Winslow
Maine Medical Association	Gordon Smith
Maine Nurse Practitioners Association	Pam Cahill
Maine Osteopathic Association	Kellie Miller
Maine Psychological Association	Dr. Richard Staples
Maine State Employees Association	Ginette Rivard
Maine Youth Leadership Advisory Team	Shannon Heath
NAMI Maine	Carol Carothers
National Association of Social Workers-- Maine Chapter	Catherine Stakeman
Office of Minority Health	Lisa Sockabasin
Statewide Quality Improvement Council	Margaret Degon
Substance Abuse Commission	Patricia Hickey
Department of Corrections	Lars Olsen
Department of Education	David Stockford
Statewide Homeless Council	Don Gean
Court Master	Daniel Wathen
DHHS Representatives:	Jim Beougher
	Sabra Burdick
	Andy Cook
	Elsie Freeman

Marie Hodgdon
Jereal Holley
Kim Johnson
David Proffitt
Diana Scully
Joan Smyrski
Sharon Sprague
Jay Yoe
Chris Zukas-Lessard

Appendix C: March 6, 2006 Meeting Report

Managed Care Stakeholder Group

Meeting Report
of
Monday, March 6, 2006

Department of Health and Human Services,
Augusta, Maine

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Opening

The group was welcomed by Acting Commissioner Harvey. She explained that the purpose of meeting was to discuss the latest information about where DHHS is in the work of moving to Managed Care. In addition, the group would learn how DHHS arrived at the current situation, what is Managed Care, and form sub-groups in order to get the program implemented in the next six months. The focus of the sub-groups will be how to move towards Managed Care and to outline outstanding issues and priorities within the system. Acting Commissioner Harvey asked participants to introduce themselves.

Attendance

Patricia Hickey	Substance Abuse Services Commission
Jay Yoe	Quality Improvement, DHHS
Margaret Degon	Quality Improvement Council
Ginette Rivard	Maine State Employees' Association
Kim Johnson	Office of Substance Abuse
Ginger Roberts	Office of MaineCare Services
Joe Pickering	Home Care Alliance
Helen Bailey	Disability Rights Center
Andy Cook	Office of Child and Family Services, DHHS
Bette Hoxie	Adoptive and Foster Families of Maine
David Stockford	Maine Department of Education
Kaitlyn Bragdon Roe	Consumer Advisory Council
Carol Tiernan	Guiding Empowerment Allows Results
Leo Delicata	Legal Services for the Elderly
Carol Carothers	NAMI Maine
Jack Comart	Maine Equal Justice
Jack Mazzotti	Maine Association of Group Care Providers
Meg Calloway	Foster Family Based Treatment Association
Richard Staples	Maine Psychological Association
Shannon Heath	Muskie – IPSI – YLAT
G. Dean Crocked	Maine Children's Alliance
Graham Newson	Maine Association of Area Agencies on Aging
Lisa Sockabasin	Office of Minority Health, DHHS
Debbie Dettor	Maine Alliance for Addiction Recovery
David Winslow	Maine Hospital Association
David Proffitt	Riverview
Rob Creamer	for Dan Wathen, Court Master, Pierce Atwood
Nadine Edris	Muskie School of Public Service
Kelly Staples	Maine Association of Peer Support and Recovery Centers
Patrick Maidman	Maine Association of Psychiatric Physicians
Kitty Purington	Maine Association of Mental Health Services
Lynn Duby	Maine Association of Substance Abuse Providers

Diana Scully	Office of Elder Services
Brenda Harvey	Acting Commissioner, DHHS
Chris Zukas-Lessard	DHHS
Craig Freshley	Good Group Decisions
Jessica Dafni	Good Group Decisions

Agenda

The following Agenda was distributed to the group at the onset of the meeting:

9:00 – 9:30	Welcome and Introductions – Acting Commissioner Harvey and Group Members
9:30 – 10:00	Overview of Managed Care Initiative – Acting Commissioner Harvey
10:00 – 10:30	General Managed Care Information and Status of Work – Chris Zukas-Lessard Questions from Group Members
10:30 – 10:50	Organizational Work – Craig Freshley and Group Members
10:50 – 11:00	Schedule of Meetings – Chris Zukas-Lessard and Group Members

Overview of Managed Care Initiative

Acting Commissioner Harvey provided an overview of the Manage Care Initiative. The following are key points presented:

- Serious mental illnesses has been a focus in both Children and Adult Mental Health Services
- Many Maine citizens have needs for mental health services
- Funding for services have been based on Federal dollars and then MaineCare
  - Each with different rules and processes
- By others' views, Maine has a well-developed array of services for people in comparison with the rest of the country
- We are celebrating an overall "B" grade, one of five states in the country

- Recent NAMI report card gives Maine a D in infrastructure
- The system is fragmented
- Maine is looking for a different approach from other states
- What we want to achieve with Managed Care
  - Increased access
  - Maintaining quality
  - Continuity of care for evidence based services
- We want to move fully to the Managed Care model with MaineCare dollars
  - Accepted as an initiative in the last budget
- Moving to Managed Care is not about devastating what's in place, but about using our resources better
- We pay nearly $600 million for behavioral health services in Maine
  - Most of that amount goes to 24/7 care
- DHHS is excited about moving forward in this direction. It allows us to address many issues that have been before us:
  - Mental health for ALL who need it
  - Firm up an array of services for special populations
  - Infrastructure support through the MCO where we got a D rating
- Maine is thin in infrastructure compared to most states
  - We need to clarify personnel roles
- Many have said moving to a MCO for July 1 is too fast
  - We're talking with Maine Health Strategies (Beacon) about taking more time to implement fully
- Right now, we're focusing on how to stay within budget with the $10.4 million cut
  - This is a 5% cut, which is an amount that is recommended not to exceed.
- The earliest we will have rate information is in April
- We are focused on behavioral health services rather than all MaineCare services at this point because behavioral health is so split
  - Will likely see a lot more managed care in the MaineCare program over time
- Are phasing of the services going to be changed? From ASO to an MCO model?
  - DHHS would continue to be contractors, they do authorization and review
  - Phasing in other resources is fairly long-term
- Sabra Burdick will chair the Managed Care Stakeholder Group

General Managed Care Information and Status of Work

Chris Zukas-Lessard presented a handout, titled **Managed Care for Behavioral Health Overview** (see Appendix A). A **Concept Paper** and **Update to Concept Paper** were also referenced and handed out (see Appendices B and C). After Ms. Zukas-Lessard's presentation, group discussion ensued as follows and the following key points were made:

- We are managing care for a defined population
- Behavioral health is being carved out
- Rates are negotiated with a vendor and the vendor negotiates rates with providers
- We want the contract to ensure that we're moving in the direction we want to go
- There would still be sections of policy that apply during the transition
- We will have increased accountability – one organization to turn to regarding services
- We are looking forward to having the right services at the right time in the right amount
- The State is asking Federal Government to waive certain Medicaid requirements
    - The biggest one is requiring enrollment in a single managed care organization
- MaineCare rules governing the program, including financial solvency for the MCO, will need to be reinstated
    - Other rules will need to be defined in the manual
    - The contractor will probably not be a licensed HMO, therefore, they would not fall under the rules of the Bureau of Insurance
- Some policy requirements may be rethought with Managed Care
    - We need to get clarification on this from CMS
    - Will have to do some new rule-making for services provided under the ASO model
- The $600 million budget figure does not include substance abuse, which is $24 million and a $5 million grant, but does include everyone else
- There has already been some refinement of budget information since talking with the Legislature
- The State recommends continuing to administer some mental health services in the first phases of managed care:
    - Intensive case management
    - State psychiatric
    - Pharmaceuticals
- The State hospitals have been placed into Phase 2. They currently function as a safety net for those consumers who are not able to get care within their community
    - The role of the State Hospitals needs further examination and clarification before changes can occur
    - Until clarity and consensus of their role is reached, they are the bottom line safety net
    - Once we have black and white guidelines, we can include State Hospitals in the Managed Care effort
- Overall issues of the State Hospitals should be a focus for a sub-groups
- We are taking the most significant clearly behavioral health services in the first year and then adding to that as appropriate and necessary
- More research needs to be done to determine whether the Forensic Hospital will be part of the Managed Care System
- Integration of mental and physical health will be coordinated with the PCP

    - More details are needed on this
    - It is an advantage for the PCP to know what kinds of services consumers are receiving
        - Haven't been investing in monitoring the coordination
        - PCPs want to give direct services
- Group Care, Residential Care, and Therapeutic Foster Care all fall into Phase One

Organizational Work

Craig Freshley of Good Group Decisions was introduced by Acting Commissioner Harvey. Mr. Freshley pointed out that he has been engaged to manage the stakeholder input process in collaboration with the Muskie School.

Craig explained the intention to break into six sub-groups and he pointed out the six signs for proposed sub-groups around the room. Craig explained that each group should schedule 2-3 meetings (2 hours each) between now and April 14, 2006.

Purpose of the Sub Groups

Craig explained that the purpose of the sub-groups is to give advice to the Department on how to implement Managed Care.

Acting Commissioner Harvey added the following points regarding the purpose of the sub-groups:

- Identify ideas/processes we need to hold onto
- Identify areas of concern
- Identify questions
- Identify must haves
- Prioritize issues

Sub-groups are encouraged to round out their groups as needed and can decide who the membership of the group is. However, it will be most helpful if people are committed to the process and attend all meetings of a particular sub-group.

Ground Rules for Sub-Groups

Craig reviewed proposed Ground Rules for sub-groups to use throughout their meetings as follows:

1. Consensus not necessary, but noted
2. Disagreements okay, and noted
3. All meeting public, although discussion is limited primarily to members
4. All views heard
5. All members equal
6. All input recorded
7. Facilitators serve the group as a whole and manage the process

After some discussion, and additional ground rule was added:

8. At least one week notice for all meetings

Organization of Sub-Groups

After some discussion of the proposed six sub-groups, it was decided that there would be just four sub-groups, as follows:

1. Adults with Serious and Persistent Mental Illness
2. Elders General Population and General Population Adults
3. Children, including Child Welfare and Children with Serious Emotional Disturbance
4. Substance Abuse

Discussion

- Children including Welfare and Children with Emotional Disturbances
    - Issues can be very different
    - Desire to integrate the two systems
    - We're looking at children with behavioral health problems
    - Will collapse them and make a note of the differences
- Elders and General population – merged sub-groups
    - People try to apply serious mental health services to everyone, there is a spectrum of issues, example common ailments
    - Vast majority of elders have the same kinds of requirements as the general population
    - Need access to different kinds of services, particularly with medical care
    - Access issues are very different
    - Residential issues
- Substance abuse and mental health co-occurring disorders missing
    - Subset of discussions around co-occurring in this group

Logistics and Scheduling

- A master list of contacts and meeting times, dates and places will be shared with the entire group
- Members can participate in more than one group
- We have a very short time frame to complete this entire process, which is why we have just six weeks for the work of the sub-groups
    - Each group should meet 2-3 times if possible
- The Stakeholder Group will meet again once the sub-groups complete their work
- Letters and comments on the Managed Care concept paper submitted prior to this meeting will be shared with the appropriate sub-groups
- An Agenda for each subgroup will be drafted and sent in advance
- Adequate advance notice (at least one week) for all meetings
- No meetings scheduled through next Monday
- No meetings to be scheduled immediately in order to accommodate a week's notice
- Published report will be out well in advance before the larger group meets again

Appendix D: Schedule of Sub-Group Meetings

Adults with Serious and Persistent Mental Illness

Monday, March 20, 2006	9:00-11:00am	Disability Rights Center 24 Stone Street
Monday, March 27, 2006	9:00-11:00am	Disability Rights Center 24 Stone Street
Monday, April 10, 2006	2:00-4:00pm	Disability Rights Center 24 Stone Street

Children, including Child Welfare, and Children with Serious Emotional Disturbance

Tuesday, March 21, 2006	1:00-3:00 pm	AMHI - Marquardt Building Conference Room 1A
Thursday, March 30, 2006	3:00-5:00pm	Department of Transportation Conference Room 216
Monday, April 3, 2006	2:00-4:00pm	Pine Tree State Arboretum Elsie Viles Conference Room
Tuesday, April 11, 2006	3:00-5:00pm	Department of Transportation Conference Room 216

Elder and Adults – General Population

Friday, March 17, 2006	2:00–3:30pm	Bureau of Elder and Adult Services Conference Room 1A
Wednesday, March 29, 2006	8:30-10:00am	Bureau of Elder and Adult Services Conference Room 1A
Friday, April 7, 2006	9:30-11:00am	Bureau of Elder and Adult Services Conference Room 4

Substance Abuse

Friday, April 7, 2006	1:00-3:00 pm	Cross Office Building Room 600
Wednesday, April 12, 2006	2:30-4:30pm	Cross Office Building Room 400

Special Meeting to Discuss Housing Issues

Monday, April 10, 2006	12:45-1:45pm	Disability Rights Center 24 Stone Street

Appendix E: Sub-Group Meeting Participants

The following people attended one or more stakeholder input meetings:

Name	Organization
Alice Danworth	Youth Alternatives
Andy Cook	OCFS
Anne Archibald	FFTA/Youth Alternatives
Barbara Piotti	Kennebec Valley Mental Health Center
Bart Beattie	Providence
Bette Hoxie	Adoptive and Foster Families of Maine
Betty Foley	Medical Care Development
Bob Long	KVMHC
Bob Rowe	New Beginnings
Carol Carothers	NAMI Maine
Carol Tiernan	G.E.A.R. Parent Network
Catherine Stakeman	NASW – Maine Chapter
Cheryl Davis	Kennebec Valley Mental Health Center
Chris Zukas-Lessard	DHHS
Cindy Fagan	Sweetser
Claudia Bepko	Co-Occurring Collaborative of Southern Maine
Craig Freshley	Good Group Decisions
Dale Hamilton	CHCS
David Faulkner	Day One
David McCluskey	Community Care
David Moltz	Maine Association of Psychiatric Physicians
David Winslow	Maine Hospital Association
Dean Bailey	Maine State Employee Association
Dean Crocker	UCA
Deb Dettor	MAAR
Debra Hannigan	DOE
Diana Scully	Office of Elder Services
Don Harden	Catholic Charities Maine
Ed Morton	Community Care and Providence Service
Elsie Freeman	DHHS
Emilie van Eeghen	Maine General
Frances Ryan	DHHS – OCFS
Gayla Dwyer	AMHC
Ginette Rivard	Maine State Employees Association
Ginger Roberts	OMS Policy/DHHS
Graham Newson	Maine Association of Area Agencies on Aging
Helen Bailey	Disability Rights Center
Howard Hymes	CHCS
Jack Comart	Maine Equal Justice
Jack Mazzotti	Maine Association of Group Care Providers
Jane Flett	Catholic Charities of Maine

Janis Petzel, M.D.	Maine Association of Psychiatric Physicians
Jean Nielsen	Common Ties Mental Health
Jessica Crocker	Acadia
Jessica Dafni	Good Group Decisions
Jill Adams	MADSEC
Jim Beougher	DHHS
Joan Churchill	Community Concepts
Joan Smyrski	CBHS/DHHS
Joanie Klayman	Youth Alternatives
John Carroll	Richardson Hollow Mental Health
Kait Bragdon-Roe	Consumer Advisory Counsel
Kane Loukas	Youth Alternatives
Karen Mosher, PhD	KVMHC
Kate Young	USM, Clinical Rehab Department
Katherine Carter	Community Health and Counseling
Kathryn Vezina	Counseling Services Inc
Kelly Staples	Maine Association of Peer Support and
Kerry Sack	Shaw House
Kevin M. Strickland	Family
Kim Johnson	DHHS
Kitty Purington	MAMHS
Leo Delicata	Legal Services for the Elderly
Leslie Melhearn	Mid-Coast Mental Health Services
Leslie Rozeff	Muskie School
Leticia Huttman	DHHS, Adult Mental Health Services
Lisa Libby	Community Health and Counseling Services
Lisa Sockabasin	Maine CDC Office of Minority Health
Lynn Duby	Youth & Family Services
Margaret Degon	Maine Parent Federation
Mark Rush	Richardson Hollow Mental Health Services
Mary Bradgon-White	AMHC
Mary Faust	DHHS
Mary Louise McEwen	Dorothea Dix Psychiatric Center
Meg Callaway	Community Care, representing FFTA – ME Mental Health Services
Myriah Crouse	Acadia
Nadine Edris	Muskie
Nancy Connolly	DOE
Pat Hickey	Substance Abuse Commission
Peter Driscoll	Amistad
Richard Staples	Maine Psychological Association
Rick Tardiff	Shaw House
Ruth Blauer	MASAP
Rita De Fio	Sweetser
Robert Moore Jr.	Consumer, Mental Health
Ron Scott	Opportunity Farm

Ruth Belchetz	Consumer/AIN Ombudsman
Sally Tadiff	Shaw House
Scott Farnum	Acadia Hospital
Shannon Heath	Muskie School Youth Leadership Advisory
Sharon Sprague	DHHS
Shawn Lewin	AARP Maine
Sheldon Wheeler	DHHS
Sheryl Peavey	HHS
Steve Tuck	Becket House Programs
Stirling Kendall	Muskie
Susan Burns Chong	Muskie IPSI/YLAT
Susan Hancock	Catholic Charities of Maine St. Michael's
Tamara Campbell	Aroostook County Mental Health
Thomas A. Coulombe	Department of Education
Velma Evans	Catholic Charities Maine

Appendix F: List of Public Comments

By Email

- Kevin Strickland — March 24, 2006
- Cindy Fagan — March 29, 2006
- Joan Churchill — March 29, 2006
- Tamara Campbell — March 31, 2006
- Ruth Belchetz — March 31, 2006
- Dean Crocker — April 3, 2006
- Cindy Fagan — April 5, 2006
- Kay Carter — April 6, 2006
- Bob Rowe — April 7, 2006
- Dean Crocker — April 9, 2006
- COSIG State Advisory Group
- Maine Alliance for Addiction Recovery – April 13, 2006

In Hard-Copy

- Carol Tiernan — March 21, 2006
- Janis B. Petzel, MD — March 29, 2006
- Joan Churchill — March 30, 2006
- Anonymous Children's Participant — April 3, 2006
- Anonymous Children's Participant — April 3, 2006