House Finance Health and Social Services
October 21st and 22nd
Post Meeting Questions
Division of Behavioral Health

1. **Please provide a comprehensive report as to what programs in the HSS budget were initially funded with MHTAAR funds and the funding history to date.**

   Please see the Pre-Meeting questions for the December meeting.

2. **Please reconstruct the numbers provided in your presentation to show the last five years.**

   Please see Attachment A. The last five years are tabbed.

3. **Please provide an example of what a Grantee quarterly reporting looks like.**

   Please see attachment B for quarterly reports required for Treatment and Recovery grants and those required for Prevention and Early Intervention grants.

4. **Please work with boards, providers, etc. to identify what would it take to provide enough services to alleviate wait lists?**

   The State of Alaska, Division of Behavioral Health funds two methadone treatment programs – one in Anchorage and one in Fairbanks. The Interior Aids Agency (Fairbanks) reported one person on their waitlist for methadone treatment and the Narcotic Drug Treatment Center (Anchorage) reported ten people on their waitlist. In order to alleviate the current and future waitlists, the Division will complete an assessment of:

   - how many referrals each agency receives annually,
   - what the typical length of stay is, and
   - how the agencies could revise their services to accommodate more people.**

   **Typically, as customers progress individually through a phased treatment like methadone treatment, they require less intensive counseling, which opens up clinic capacity and clinics to serve additional persons. In coordination with the provider community, the Division will devise a structure which provides adequate supports (groups and peer mentors) to make the client's transition successful and to help them avoid cycling back into intensive services or divert to using other substances like alcohol, marijuana, etc.

   Currently the Division of Behavioral Health bases grant agreement funding for opioid treatment on an anticipated client count. By redefining the grant purchasing specifications to address those covered by other payer sources or monitoring to ensure customers are receiving the phase of treatment that meets their current treatment needs may allow public funds to be used more effectively and to increase capacity with the same level of funding. The Division is reviewing its current funding practices and expects to have a recommendation to the Director by April 2014.

5. Please provide actual numbers of resources available and the possibility of pooling those together.

Community Service Planning Areas (that can be likened to the term "catchment areas") identify the communities that are served by each grantee organization. This allows the state to concentrate resources in a regional hub community to serve the outlying villages. This is primarily seen in the tribal grants that cover the beneficiaries of a particular native health corporation.

Please see attachment C1 for a list of agencies providing treatment and recovery services organized by community planning and services areas; see Attachment C2 for a list of agencies providing prevention and early intervention services in Alaska. The lists augment the maps provided during the House Finance Hearing in Fairbanks on October 21 and 22, 2013.

6. Please provide an analysis of what it would take to move from grants to contracts.

Although grants and professional services contracts are similar in many ways, in execution they are very different. While both may be awarded either competitively or non-competitively under specific conditions authorized by law, grants are more flexible than contracts and each are currently defined for different purposes.

Grants are used to provide funding for a defined process (service methodology) to achieve a desired outcome. Under 7 AAC 78, grantees act as agents of the State in the delivery of services. For the Department of Health and Social Services that is the delivery of services to clients to meet its mission *to promote and protect the health and well-being of Alaskans*. Compensation is dependent upon compliance with the approved methodology, and if the outcome is not achieved under the approved process, then the methodology evolves through a collaborative process. Consequences for non-compliance are usually limited to discontinuation of funding to the unsuccessful grantee. Under current regulations, for profits are not eligible to apply for grant funding. If the State switched to a contract model, nonprofits would be in competition with large for profits.

Contracts are used primarily to acquire property or services to carry out the business of State Government. Professional services contracts are usually secured to purchase a tangible deliverable or intellectual product. Therefore, a single provider is usually sought through the procurement process, which is then responsible to the department only for delivery of a defined end product within a given timeframe. Contractors determine their own budget and methods of completion. Contractors are expected to complete tasks within a given timeframe and on budget. Failure to perform and achieve the agreed upon deliverables could result in potential legal action and financial consequences. Professional services contracts may be secured with private for profit businesses as well as nonprofits but are restricted to those who meet the qualifications required to provide the deliverable.

Therefore, to switch from the State's current model of service delivery through grants to a contract model would require an in-depth analysis of the following:

- Review of all individual grant programs for potential impact to beneficiaries and communities;
- Review of all current statutes and regulations affecting grants, contracts, and procurement for revision and/or repeal;
- Review of federal requirements for pass through of grant funds to sub-grantees;

- Review for possible loss of other funding sources that are currently leveraged through grant funds.

7. Please explain why one organization would receive four or five audits at once and where the extrapolation issue comes from.

Medicaid providers are subject to various audits and reviews that are conducted by different agencies, authorities, and measures. Some audits result in identification of overpayments; other reviews measure quality of care; some reviews are related to licensing an agency to operate in the state (please see Attachment D). Because of the differing parameters it is possible that an agency is subjected to more than one review at the same time. However, to the degree possible, the department makes every attempt to minimize overlap of Medicaid claims reviews for the same time periods (that may result in overpayments).

Within their authorities the department conducts "investigations" to substantiate complaints against an agency or reports of harm. Investigations target the details included in the complaint, report of harm, or critical incident. Further reviews resulting from a substantiated complaint would be addressed under one of the authorities listed in Attachment D.

Regarding extrapolation, the department has authority under 7 AAC 160.120 to use statistical sampling methodologies to determine overpayments. Sampling and extrapolation are standard audit practices which reduce the cost of auditing in exchange for accepting a small amount of risk in the results.

When a sample is obtained randomly, it is possible to state, with a stipulated degree of confidence that the number of errors in the sample applies proportionately to the un-sampled universe as well. The alternative to sampling is to audit the entire universe. This increases the time and costs to conduct the audit and also causes additional time, disruption and resources from the provider to complete the audit.

The Department currently uses an extrapolation methodology consisting of the Greater of: Actual overpayments or the lower bound of a one-sided 90% confidence interval. In a one-sided 90% confidence interval, if the sampling process were to be repeated multiple times, we would expect that overpayment findings in each sample would be greater than or equal to the lower bound error 90% of the time.

8. Please provide a comparison of the costs of a stay at the Emergency Room versus a bed at API.

In FY2013 over three quarters (77.27%) of API admissions were referrals from emergency rooms in hospitals around the state. All patients pending admission to API must be medically cleared to assure patient safety. In this way, the cost coefficient for API is in addition to emergency room costs rather than as a comparison.

The average charge for behavioral health emergency room services in FY2013 was $1,842.00. (Source: Hospital Reports using DHSS Division of Public Health data.) In FY2013, API's Medicaid daily rate approved by the Office of Rate Review was $1,263.78. However, we are not completely comparing apples to apples.

Emergency room and API services are dissimilar in many ways starting with the goal of the care. The goal of emergency room care is to provide urgent and non-urgent treatment for effective care of a patient and deliver that patient to the next step in the continuum of care as quickly as possible. The goal of API services is to provide stabilization of acute psychiatric symptoms. API's longer-term mission is to work in partnership with individuals, their families, the community, natural networks, and providers to provide therapeutic services which assist individuals to achieve a personal level of satisfaction and success in their recovery. The average length of stay at an emergency room is measured in hours; whereas the average length of stay at API is measured in days.

9. Please provide the staffing levels required at API – including levels needed for lock down.

API is a secure, locked facility. In this way, the premises are in 'lock down' all the time. The staffing levels required to run API as an 80 bed, 4 unit hospital on a 24/7 basis are 254 total staff. This number includes 155 direct patient care staff, 85 support staff (e.g. administrative, environmental services, maintenance), and 14 medical staff.

The federal standards that address staffing ratios from both the Centers for Medicare and Medicaid Services (CMS) and the Joint Commission that API must comply with require that a psychiatric hospital have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures, and engage in discharge planning.

Direct patient care staff required are determined based on patient acuity as well as current and expected census numbers for a given shift on any specific unit. The Nursing Shift supervisor is charged with the responsibility to make sure there is adequate staffing on the units and has the authority to call in additional staff as necessary for the safety of patients and staff. An order for increased staffing or an order to reduce the staffing is based on patient's illness at the time and treatment team input, using the Close Observation Rating Scale (COSS). COSS of 1 to 1, 2 to 1, and 3 to 1 are the different ratios of staff to patients.

10. Is there an opportunity to have contracts statewide so there are regional partnerships that stipulate that if someone comes from API that they will be provide services to them?

A process is currently in place that assures services are provided by a local or regional community behavioral health center to any person discharged from Alaska Psychiatric Institute through the division's Comprehensive Behavioral Health Treatment & Recovery grant program.

Currently the Division funds 31 community behavioral health centers. These centers are statutorily defined as "local community entities" (AS 47.30.540) and are required to deliver services in all four of the core behavioral health service area which are:

1. Psychiatric Emergency Services (PES) to people in need of short-term crisis services (7 AAC 70.990(30);
2. Services to the Seriously Mentally Ill (SMI) adults (7 AAC 70.990(2));
3. Services to Severely Emotionally Disturbed Youth (SEDY) (7AAC 70.990(10)); and
4. Substance Use Disorder (SUD) services to adults or youth.

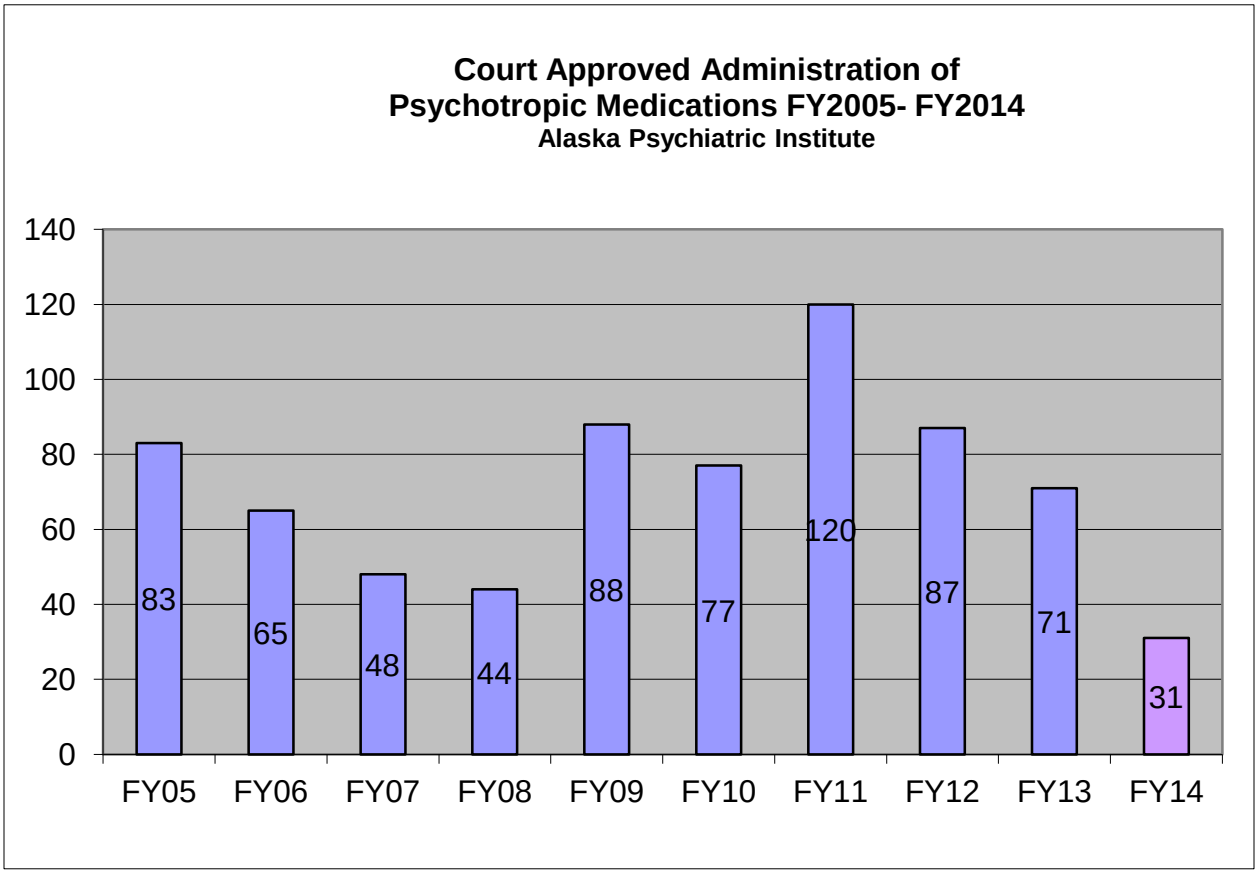
The key standards under the Psychiatric Emergency Services program type are articulated in an attachment to the Request for Proposals (RFP) that agencies apply for grant funds. Those standards require that the agency guarantee:

1. universal access to crisis services;
2. 24/7 availability of those services;
3. in-person interventions and evaluation;
4. a timely response to each crisis services request; and
5. post-hospitalization follow-up and documentation thereof.

The post-hospitalization follow-up standard provided in the Request for Proposal further states that the CBHC will ensure that such appointments are scheduled at its clinic within five (5) calendar days of the patient's date of discharge.

11. Please provide statistics on the number of people in API that are taking court ordered medications and what type of involvement there is with the Court system.

There were 1698 patients admitted to API in FY2013. In that same fiscal year, 71 patients (4%) were mandated for administration of psychotropic medications by the Court. (See Graph Below)



When a psychiatrist evaluating a patient's progress determines that the use of antipsychotic medication would likely result in substantial gains, and the patient declines voluntary medication administration, the psychiatrist has the option of petitioning the courts for approval of the administration of psychotropic medications.