From:	Erin Shine
To:	Doniece Gott
Subject:	FW: SB 78 SB 74 and CSSB 74\v
Date:	Thursday, February 25, 2016 3:14:30 PM
Importance:	High

From: Michele Federico [mailto:Michele_Federico@ghscorp.org]
Sent: Thursday, February 25, 2016 9:24 AM
To: Sen. Pete Kelly <Sen.Pete.Kelly@akleg.gov>; Sen. Anna MacKinnon <Sen.Anna.MacKinnon@akleg.gov>; Sen. Peter Micciche <Sen.Peter.Micciche@akleg.gov>; Sen. Click Bishop <Sen.Click.Bishop@akleg.gov>; Sen. Mike Dunleavy <Sen.Mike.Dunleavy@akleg.gov>; Sen. Lyman Hoffman <Sen.Lyman.Hoffman@akleg.gov>; Sen. Donny Olson <Sen.Donny.Olson@akleg.gov>
Cc: Tom Chard (tom.abha@gmail.com) <tom.abha@gmail.com>
Subject: SB 78 SB 74 and CSSB 74\v
Importance: High

Dear Senators,

Thank you for the work you are doing on Medicaid Reform.

One important aspect of the bill is a provision that would lift the grant requirement to be eligible to bill Medicaid for behavioral health services. (Sections 22 and 23). I believe this would be a mistake overall and create further problems for the delivery and quality assurance of behavioral health services.
I will outline my concerns:

1. As a Masters level licensed social worker, I would be eligible to set up an unaffiliated solo private practice in which I could selectively chose my service population, excluding those who are high utilizers, complex-trauma cases, moderately to highly functionally impaired, chronic (either in Mental health or substance abuse), and or criminally involved. These populations are not a lot of fun for clinicians to treat, they use up a lot of time and resources and tend to be high utilizers of emergency services, specifically, after hours contacts. These groups of consumers often require coordinated systems of care (bio pschyo social models of intervention—and care coordination). I could ethically provide those services I am eligible to bill for given the limits of my practice, skills and training, and hope that my NASW code of ethics, in which we always put clients best interest ahead of monetary gain would guide practice decisions. Many of the clients I see in agency work, are ill equipped to be able to file ethical complaints with licensing boards. We work with and are obligated to protect the vulnerable client we serve from exploitation, even by our own systems and from our own errors.

a. My concern is that if billing Medicaid is divorced from being a state grantee, **the highest degreed individuals with the highest skill level would chose to work with the low to moderate mental health and growth and development cases**, and leave our community agencies-- which already ***struggle to recruit Masters level staff to Alaska***, (especially those in small rural communities villages in Alaska); and would be forced ***to employee staff with lower degrees or certificates who are not equipped to deal with the complex-multi-problem, chronic and functionally impaired clients we see at JAMHI or Gastineau Human Service, Juneau Youth Services, or Rain forest Recovery.*** The clients of these agencies are not the

most appropriate clients for private practice, and if we remove the incentive for Master's level social workers or counselors in both mental health and substance abuse to remain connected to an agency, then our greatest talent will be encouraged to move into private practice (and deal with what we call quality of life problems or Cadillac problems) and away from agency based "trench" work.

b. Also, as **a substance use provider**, I can assure you that attracting Masters level staff to this **SPECIFIC** service population (almost 100% of those referred to treatment have correctional involvement) is very hard as it is. Very few Masters level staff want to deal with the reality of working with this population due to the stigma and profound difficulty. There is little social prestige associated with treating addicts and alcoholics and a lot of prestige in being in private practice or working in Mental health.

i. Please see: http://www.npr.org/sections/health-shots/2016/02/24/467143265/shortage-of-addiction-counselors-further-strained-by-opioid-epidemic

c. It also diminish quality of care: Clients could end up inappropriately matched to their providers and receive only minimums of care, or at worst , ineffective care.

d. If we remove the grantee requirement for clinicians to bill Medicaid, we diminish the ability for agencies who serve the most complex cases to provide living wages to their employees (masters level et al).

e. It also encourages a more splintered, fragmented system of care. It may not produce the "choice in provider" that people hope it will. It will appear that we have many providers, but based upon my experience of those in private practice, they do not like to take the hard cases, and maybe shouldn't. I don't think that we should encourage more Masters level social workers and counselors to leave agency work, which is based upon "access for all" and the ethic access to quality care.

Respectfully submitted,

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