ALASKA STATE LEGISLATURE
HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES STANDING COMMITTEE
November 2, 2007
3:14 p.m.

MEMBERS PRESENT

Representative Peggy Wilson, Chair
Representative Bob Roses, Vice Chair
Representative Anna Fairclough
Representative Wes Keller
Representative Sharon Cissna
Representative Berta Gardner

MEMBERS ABSENT

Representative Paul Seaton

OTHER LEGISLATORS PRESENT

Representative Andrea Doll

Senator Bettye Davis
Senator Fred Dyson
Senator Joe Thomas

COMMITTEE CALENDAR

SUBSTANCE ABUSE AND MENTAL HEALTH STRATEGIES

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

ANGELA SOLARNO, Advocacy Coordinator
Advisory Board on Alcoholism and Drug Abuse (ABADA)/Alaska Mental Health Board (AMHB)
Juneau, Alaska
POSITION STATEMENT: Presented a report of behalf of the Advisory Board on Alcoholism and Drug Abuse/Alaska Mental Health Board.

LONNIE WALTERS, Member

Advisory Board on Alcoholism and Drug Abuse (ABADA); Co-Executive Director, Communities Organized for Health Options (COHO)
Craig, Alaska
POSITION STATEMENT: Answered questions during the ABADA/AMHB report.

JEFF JESSEE, Chief Executive Officer
Alaska Mental Health Trust Authority (AMHTA)
Department of Revenue
Anchorage, Alaska
POSITION STATEMENT Participated in the roundtable discussion.

KARLEEN JACKSON, Commissioner
Department of Health and Social Services (DHSS)
Juneau, Alaska
POSITION STATEMENT: Provided information on the funding of behavioral health services.

DWAYNE PEEPLES, Deputy Commissioner
Office of the Commissioner
Department of Corrections (DOC)
Juneau, Alaska
POSITION STATEMENT: Participated in the roundtable discussion.

MELISSA STONE, Director
Division of Behavioral Health
Department of Health & Social Services (DHSS)
Anchorage, Alaska
POSITION STATEMENT: Participated in the roundtable discussion.

PATRICK HEFLEY, Director
Behavioral Health Service
SouthEast Alaska Regional Health Consortium (SEARHC)
Sitka, Alaska
POSITION STATEMENT: Participated in the roundtable discussion.

JERRY FULLER, Project Director
Office of Program Review
Office of the Commissioner
Department of Health & Social Services (DHSS)
Juneau, Alaska
POSITION STATEMENT: Participated in the roundtable discussion.

BILL HOGAN, Deputy Commissioner
Office of the Commissioner
Department of Health and Social Services (DHSS)

Juneau, Alaska
POSITION STATEMENT: Participated in the roundtable discussion.

COLLEEN PATRICK-RILEY, Mental Health Clinician
Department of Corrections (DOC)
Anchorage, Alaska
POSITION STATEMENT: Participated in the roundtable discussion.

SUSAN OHMER, Executive Director
Petersburg Mental Health Services, Inc.
Petersburg, Alaska
POSITION STATEMENT: Participated in the roundtable discussion.

ACTION NARRATIVE

CHAIR PEGGY WILSON called the House Health, Education and Social Services Standing Committee meeting to order at 3:14:00 PM. Representatives Fairclough, Keller, Cissna, Gardner, Roses, and Wilson were present at the call to order. Also present were Senators Davis, Dyson, and Thomas, and Representative Doll.

3:14:50 PM

Substance Abuse and Mental Health Strategies

3:16:10 PM

CHAIR WILSON announced that the first order of business would be a presentation by the Alaska Mental Health Board (AMHB) and the Governor's Advisory Board on Alcohol and Drug Abuse (ABADA).

3:19:29 PM

ANGELA SOLARNO, Advocacy Coordinator, Advisory Board on Alcoholism and Drug Abuse (ABADA)/Alaska Mental Health Board (AMHB), informed the committee that the joint boards of ABADA and AMHB share the goal of a full continuum of behavioral health services that will help reduce Alaska's future economic burden, improve the quality of life for Alaskans, and ensure the health and productivity of our citizens. Ms. Solarno explained that funding the public behavioral health system is a mix of Medicaid and grants; in fact, regulations direct that there are priority groups including: adults with a serious mental illness; children and youth who have serious emotional disturbances; and persons with a maladaptive pattern of substance abuse. Ms. Solarno stated that the present system provides good service to the priority population and clients show improvement and

satisfaction with the services they receive. She opined that, by and large, the system is only serving these priority groups as neither grants nor Medicaid serves the following: returning veterans; families, children, and youth who don't qualify; Alaskans with moderate illness; and those who cycle through the corrections system.

3:22:46 PM

CHAIR WILSON asked whether veterans are served by the U. S. Department of Veteran's Affairs (VA).

MS. SOLARNO answered that VA services are not helping returning veterans with mental problems, such as post-traumatic stress disorder.

3:23:56 PM

MS. SOLARNO spoke of the obstacles to the access of mental health services and said that even citizens that have private insurance are not guaranteed mental health services; there is insurance discrimination throughout the nation and a lack of parity. Furthermore, there may not be a provider nearby or there may be a restriction in coverage by a private insurer.

3:24:53 PM

CHAIR WILSON suggested that Ms. Solarno hold part of her presentation until the roundtable discussion.

3:25:33 PM

MS. SOLARNO asked the committee to review the handout titled, "Mandatory diversion of non-violent drug offenders: The California Experience" published by AMHB/ABADA.

3:25:41 PM

REPRESENTATIVE GARDNER asked for further information on the Alcohol Treatment and Prevention Fund.

MS. SOLARNO answered that, in 2002, Representative Murkowski's legislation, known as the "Dime a Drink" bill, created the Alcohol and Other Drug Treatment and Prevention Fund. She noted that the fund cannot be dedicated; however, the original intent was that half of all alcohol taxes were to go into this fund to be spent to enhance drug and alcohol treatment in the state.

The reality is that the money, which is about $17 million per year, is used to supplant general funds. Ms. Solarno asked the committee to consider how this fund could be re-directed to behavioral health services.

3:28:32 PM

CHAIR WILSON inquired as to how the ABADA and the AMHB are working together as a joint board.

3:29:03 PM

LONNIE WALTERS, Member, Advisory Board on Alcoholism and Drug Abuse (ABADA); Co-Executive Director, Communities Organized for Health Options (COHO), informed the committee that he retired after 22 years in the U. S. Navy and serves as a beneficiary member of the ABADA. He is one of four members of the board who are recovering alcoholics and he credits his recovery from alcoholism with saving his life and preserving his family. The military is motivated to support its members through recovery from addictions because of the expense invested in training its personnel; in addition, every Fortune 500 company has substance abuse treatment programs for employees because alcohol and drug abuse cost them money. Mr. Walters said that alcoholism is impossible to ignore in a small and rural town. Budget cuts have cost his small facility $72,000 and on an island with 4,000 residents that meant the loss of many services. He opined that alcohol and drug abuse is the number one problem in Alaska as indicated by its impact on the courts, law enforcement, emergency services, child abuse, spousal abuse, and school dysfunction. However, it is not the number one priority with state services. Mr. Walters said that he is unable to continue his work at the treatment center but will continue to be a member of the ABADA. The work is too hard considering the difficulty with recruiting and [in]adequate pay. Pay has declined, regulations are more complex, and the funding is cut. He emphasized that the state will not fund programs even though citizens are dying of alcoholism.

3:33:45 PM

CHAIR WILSON asked whether the center is able to provide the services that are necessary for his community.

MR. WALTERS said no.

3:34:06 PM

SENATOR DAVIS asked for further information on how AMHB and ABADA connect together and whether they have joint plans for the future.

3:34:35 PM

MS. SOLARNO acknowledged that the merger was a painful marriage, although members now meet together regularly as one board. There remain differences about the proper treatment for substance abuse and mental illness, but members are learning about the integration of treatments for co-occurring disorders. She opined that more time will go by before clinicians are trained in both disciplines; however, the two boards are now working together well. She explained that the two boards will not be combined into one due to the potential impact to the Alaska Mental Health Trust settlement.

3:36:04 PM

REPRESENTATIVE KELLER asked for the percentage of funds, for each board, that comes from the Alaska Mental Health Trust Authority (AMHTA).

MS. SOLARNO said that the exact percentages will be provided to the committee. She further explained that the boards were traditionally funded by the general fund (GF); since 2002, when budgets were slashed dramatically and the staff was merged, the boards request GF funds annually, but rely on the AMHTA for funding.

3:37:10 PM

REPRESENTATIVE CISSNA stated that, from her experience in behavioral health training, she has seen that alcohol and substance abuse is funded less and treated like a step-child by the system. She asked Mr. Walters to comment on the relationship and what pieces are missing.

3:38:23 PM

MR. WALTERS responded that many small and rural agencies have been combined because of a lack of space and available dollars. His facility on Prince of Wales Island is a combination of the mental health and substance abuse agencies; in fact, the agencies worked well together even before the mandate to merge. He opined that the combination has been at the expense of

substance abuse and substance abuse programs receive less and less. This may happen because most mental health field counselors have a higher degree of education and thus, wield more power.

The committee took an at-ease from 3:41 p.m. to 3:42 p.m.

3:42:39 PM

CHAIR WILSON announced that housing, recruiting, and retaining a workforce will be topics of the roundtable discussion.

3:43:45 PM

REPRESENTATIVE CISSNA asked whether the participants were ready to speak about the cost of each solution that they are proposing.

3:44:46 PM

CHAIR WILSON assured the committee that any missing information will be provided at a later date. She then asked Mr. Jessee to address the issue of creating the appropriate balance of Medicaid and grant funding.

3:45:26 PM

JEFF JESSEE, Chief Executive Officer, Alaska Mental Health Trust Authority (AMHTA), informed the committee that Medicaid has limitations regarding eligibility and covered services. The present system, which depends heavily on Medicaid, requires providers to wait for people to get seriously ill and destitute before they qualify for treatment; this is not a cost effective way to provide care. The AMHTA requests the legislature to give thought to the appropriate balance between grants that fund early intervention, and Medicaid, in order to prevent costs at the higher end of system. Notwithstanding the outcome for individuals, the state must consider the financial cost of not providing preventive services, and instead seeing the costs of treatment by the Department of Corrections (DOC) and hospital emergency rooms. He pointed out that this committee could, during this legislative session, adjust upward the rates of reimbursement as a first step toward solving workforce and capacity issues. Rates have not been adjusted, in some cases, for a decade and programs cannot continue to provide services. Mr. Jessee opined that DHSS is doing an excellent job reviewing the rates for review by the finance committee. The House

Health, Education and Social Services Standing Committee could pass legislation that would place rate reviews for community programs on the same footing and in the same timeframe as those for hospitals and nursing homes. In the long run, rates must be kept current to prevent degradation of the system and another crisis.

3:48:46 PM

REPRESENTATIVE KELLER asked for the percentage of AMHTA funds that are dedicated to prevention and early intervention.

MR. JESSEE estimated about 15 percent would go to areas of prevention.

3:49:18 PM

SENATOR THOMAS pointed out that the public is not educated about putting money upfront to forward fund services such as education and mental health. He asked how to answer those who see funding programs in advance as a demand for oil industry revenue to support "more big government." He opined that it is a problem to convince the general public that forward funding is an opportunity to save money in the long run.

MR. JESSEE suggested that the public be informed about how many people in prison have mental health and substance abuse issues, and the cost to serve them through the DOC, compared to serving citizens in the community and keeping them out of the prison system. Discussions of health care cost should include proof that a portion of emergency room costs are accrued because patients were not treated for mental health and substance abuse disorders in the community. He drew an analogy to the cost of the emergency measures taken by the oil industry when upfront dollars are not invested to maintain facilities and equipment. This can be explained as a business decision like any other.

3:52:45 PM

CHAIR WILSON announced that, due to time constraints, the committee will need to submit written questions to the roundtable participants for responses at a later date.

3:53:31 PM

MR. WALTERS expressed his belief that, over time, prevention measures are effective. For example, dental health and heart

health have improved tremendously over the last 30 to 40 years. He then spoke of the imbalance of Medicaid billing and pointed out that he was only able to serve two Medicaid patients last year, while his mental health counterpart saw much a higher percentage of patients because they qualified for Medicaid.

3:55:24 PM

KARLEEN JACKSON, Commissioner, Department of Health and Social Services (DHSS), reminded the committee of the other pieces of the health services funding system including: Indian Health Service (IHS), Medicare, the state retirement system, and the U. S. Department of Veterans Affairs (VA). She encouraged the committee to consider that the departments are funded in stand-alone chunks. It is important to consider not only where the costs are, but where funds can be leveraged together. Commissioner Jackson suggested that the committee see how to fund differently across functional areas and not just departments; for example, funding of the prevention and treatment of mental illness and substance abuse across the entire state system and not within individual departments. Similarly, how the legislature can plan, and fund, for more than one fiscal year at a time.

3:57:30 PM

DWAYNE PEEPLES, Deputy Commissioner, Office of the Commissioner, Department of Corrections (DOC), informed the committee that the DOC has a very limited role in direct community services to the mentally ill. There are about 5,500 individuals in institutions and another 5,500 in probation, parole, and community service. The DOC primarily provides case management and planning for the chronically mentally ill, but is very dependent on community services to provide substance abuse treatment to stabilize its outgoing population. He observed that, when there is a degradation of community services the prison census rises. In fact, at this time there is a sharp rise in population growth that is only explained by the increasing failure of former inmates to stabilize in the community. He stated that basic case management will strengthen the community and there needs to be a strong, stable, base for released mental health trust beneficiaries to prevent recidivism.

3:59:40 PM

MELISSA STONE, Director, Division of Behavioral Health, Department of Health & Social Services, told the committee that

they must first consider the issues of eligibility to determine who is served. Currently, the populations served are seriously emotionally disturbed children, seriously mentally ill adults and substance abusers. The populations that are missing, and that the state has to pay for, are at the other end of the continuum and are early intervention and prevention. She explained that for funding, there are services that can be selected relative to the populations chosen, such as outpatient substance abuse and inpatient residential services. Services not paid from Medicaid and general funds are: screening, grief counseling, early intervention, intensive case management, housing, and transportation. The determination of an appropriate balance between Medicaid and grant funding goes back to how much of the population will be served and how to pay for groups of individuals that are added to the populations served. The Pacific Health Consulting Group study suggested an expansion of substance abuse services in the state; in fact, the Division of Behavioral Health is developing a scope of work in order to determine how services can include those citizens, aged 22 to 64, who are not eligible for Medicaid.

4:03:21 PM

PATRICK HEFLEY, Director, Behavioral Health Service, SouthEast Alaska Regional Health Consortium (SEARHC), related his observation that the legislature speaks about money first; the focus for the SEARHC is on what needs to be done, and then how to pay for it. He informed the committee that tribal health organization facilities are frequently the only medical and behavioral health resource in rural areas. He further explained that the SEARHC organizations are a variation on the managed care concept; they have a budget that is defined for a scope of service and a mission to improve health care status. He opined that policy setters are regional consumers who need to redirect resources to address the issues specific to their region. His organization also provides rehabilitative services and early intervention. Mr. Hefley shared that there is a group working to deliver some recommendations for the tribes as how to work in partnership with the legislature.

4:06:16 PM

MR. HEFLEY continued to say that his group has determined three needs: treat people closer to where they live; treat people lower in acuity; and find a mechanism to have a continuity of care using various systems. In addition, the group has broken down three variables: the type of services; the type of

provider; and the location of the provider. He stated that recommendations from the working group are forthcoming. Mr. Hefley pointed out that over 90 percent of the money that SEARHC receives does not come through state as it costs too much to process state money. He suggested an all-inclusive rate to bundle the costs of services for behavioral health and simplify the billing system. He stated that the SEARHC is building its capacity but needs the states help. As SEARHC has 1,000 employees and must work together, he suggested that state agencies should work together as a policy. For example, SEARHC and Juneau Youth Services (JYS) spent almost two years working on the Bring the Kids Home Initiative, a successful partnership with the state to reduce costs and allow the state to divert its resources to other capacities.

4:10:35 PM

JERRY FULLER, Project Director, Office of Program Review, Office of the Commissioner, Department of Health & Social Services (DHSS) stated that the DHSS is quite aware of the current issues; further explanation and development of the new opportunities is needed. There is some amount of flexibility to change the system and the process to obtain a waiver from Medicaid, provide substance abuse services for all Alaskans, and to devise a best practices treatment delivery system, has just begun.

4:11:39 PM

BILL HOGAN, Deputy Commissioner, Office of the Commissioner, Department of Health and Social Services, emphasized the need to focus on positive outcomes for the people receiving services.

4:12:18 PM

COLLEEN PATRICK-RILEY, Mental Health Clinician, Department of Corrections (DOC), pointed out that the DOC is working on best practice initiatives with Social Security. Additionally, the DOC is partnering with the DHSS to increase applications for Medicaid eligibility; is participating in the state mental health court, and is participating in the Assess, Plan, Identify, Coordinate (APIC) best practices program. She opined that, while DOC is willing to expand its current services, it also strongly supports the need for improving the nature of services in the community that are funded through the DHSS. She reiterated her impression and belief in the real correlation

between the number of effective services available in the community and the numbers entering corrections.

4:14:01 PM

CHAIR WILSON inquired as to whether the DOC is informed about the mental health background of inmates at intake.

MS. PATRICK-RILEY answered that when an individual is booked there is a medical and mental health screening. However, the questions and observations are for very overt things and will not capture everyone with a mental health disability. In addition, not all facilities have an on-site clinician. She opined that Fetal Alcohol Spectrum Disorder (FASD) and traumatic brain injuries (TBI) are vastly under identified.

4:17:19 PM

CHAIR WILSON informed the roundtable participants that the next question involves Medicaid reimbursement and parity between mental health and substance abuse.

4:17:42 PM

MR. JESSEE pointed out that the Pacific Health Consulting Group report recommends obtaining a substance abuse waiver to get better Medicaid funding and the DHSS is working on a Request for Proposal (RFP) for this endeavor. He questioned allowing the private insurance industry to continue to cost-shift behavioral health services to the state. As long as private insurance does not cover behavioral health on parity with physical health, moderate and low income patients are forced to use the publicly funded system. Mr. Jessee encouraged the committee to write legislation that will solve this problem.

4:19:13 PM

MS. STONE informed the committee that the DHSS is developing a project to integrate the current Medicaid regulations. Currently, there are two different sets of Medicaid regulations for mental health and substance abuse; integration of these regulations will create parity and allow an integrated agency to serve, treat, and bill services for both substance abuse and mental health disorders.

4:20:35 PM

CHAIR WILSON asked for clarification on the regulations.

MS. STONE explained that state Medicaid regulations are being developed, by regulation writers, from concepts submitted by the Division of Behavioral Health.

4:21:06 PM

CHAIR WILSON informed the roundtable participants that the next question is about building Native behavioral health care capacity.

4:21:28 PM

MR. HEFLEY reported that his organization will submit recommendations on this topic within six months.

4:21:44 PM

CHAIR WILSON said that the next question is about increased capacity of residential substance abuse treatment (RSAT) within the DOC.

4:21:56 PM

MR. PEEPLES explained that the DOC currently operates three residential substance abuse treatment (RSAT) programs. The DOC is trying to strengthen current operations and is also pursuing intensive outpatient services for those in the general population. In addition, DOC is considering linking outpatient services to community services and expanding community outpatient follow-up.

4:23:37 PM

MR. WALTERS stated that many Prince of Wales Island residents have come out of prison; furthermore, 100 percent of his referrals from the probation officer are addicted or alcoholic. He explained that time in prison does not cure alcoholism. His experience is that parolees that have been through a RSAT program are emotionally ready to begin living outside; those that have not, are not. He said that he has not had an RSAT parolee violate parole.

4:26:59 PM

MS. PATRICK-RILEY pointed out that RSAT programs are for those who are sentenced to prison for over one year. Inmates also must volunteer for the program and there are very few spaces available. Additional facilities must be built in order to assist in this treatment effort.

4:28:38 PM

REPRESENTATIVE CISSNA commented that the RSAT programs, which sound like they are cost effective and successful, should be vigorously supported by the committee.

4:29:43 PM

CHAIR WILSON stated that the next question is about increased release and how the community can support released individuals through reintegration planning.

4:30:09 PM

MR. PEEPLES observed that the DOC is working with the AMHTA to expand its prerelease and discharge case management capacity. Additionally, the number of individuals eligible for Medicaid and social security can be increased; however, the DOC looks to community providers for services when individuals are returned to communities. He stressed that the DOC is charged with public safety and is only responsible to treat those incarcerated, on parole, or on probation.

4:32:07 PM

MS. PATRICK-RILEY recalled that there are about 200 individuals in the closely coordinated mental health release program; consistently there is a lower recidivism rate when community services are provided, even at a less than ideal level.

4:33:01 PM

SUSAN OHMER, Executive Director, Petersburg Mental Health Services, Inc., expressed her support of community behavioral health centers. She noted that, in Petersburg, there is support for accountability, but there is also concern for the changes the state is making that have seriously impacted the ability of a small and rural center to survive. She said that the increase in administrative requirements have cost her center a clinical position and have reduced the center's capacity by 100 patients per year. Furthermore, the addition of substance abuse services

to her center's caseload has tripled the number of cases while reducing its income by $30,000 per year.

4:35:42 PM

CHAIR WILSON said that the next question is about safe, stable, and affordable, housing.

4:36:14 PM

MR. JESSEE shared that the AMHTA has learned that without safe, secure, reliable, housing individuals become homeless and all the other services are for naught. A study of homelessness revealed that most of the federal low income housing funds are provided to those who have 70 percent and above of the median income. In fact, the homeless earn 30 to 40 percent and below of the median income. He explained that low income projects are subsidized but still must make some money. In addition, individuals with problems such as substance abuse, mental health, and domestic violence, are not as successful in low income housing unless they receive support services. AMHTA further discovered that the Housing First model, supported by a housing trust, is successful in over 30 states nationwide. A housing trust adds additional capital to reduce the cost of a project, thereby reducing the amount of the rent. It can also provide support service funding for case management, alcohol and mental health treatment, landlord support, and tenant education. Finally, it can provide a rental subsidy from the U. S. Department of Housing and Urban Development (HUD) Housing Choice Voucher Program, Section 8(housing) vouchers. For example, the Gates Foundation funded a $40 million homeless families initiative, that resulted in dramatic results in reducing homelessness, by supplying capital to projects, five to ten years of social support funding, and Section 8(housing) vouchers. Alaska's Council on the Homeless recommended the creation of a housing trust in Alaska and has the support of the governor. He suggested that excess revenue from the Alaska Housing Finance Corporation (AHFC) should be used to build a housing trust and address the problem of homelessness in the state.

4:43:04 PM

MR. WALTERS noted that rural areas do not report a lot of homelessness; however, individuals are returning to dysfunctional homes and still need a safer and a better place to live.

4:43:53 PM

COMMISSIONER JACKSON confirmed that safe, stable, and affordable housing is important in rural and urban areas. There must be efforts across all departments to address the core and underlying issues of this problem.

4:44:53 PM

MS. SOLARNO agreed that serving the entire family, and doing so early, are priorities as important as serving severely acute people.

4:45:24 PM

CHAIR WILSON announced that the discussion will now focus on recruiting and workforce development, competitive wages, grant funding, loan repayment, and housing stipend programs.

4:45:48 PM

MR. HEFLEY informed the committee that one in fourteen Alaskans works in the health care industry; of this pool, the third largest group is behavioral health workers. Of all occupational health areas, 29 percent of the vacancies are of behavioral health positions; this is a total of 1,033 vacant positions. The number one reason that positions are unfilled is that there were no qualified applicants. Moreover, there are the additional problems of inadequate pay and high turnover.

4:47:35 PM

CHAIR WILSON observed that Alaska no longer offers the enticement of higher pay when compared to the Lower 48.

4:48:28 PM

MR. WALTERS stated that he has resigned his position; there have been no qualified applicants to replace him in the last eight months. He opined that working conditions are important to retaining employees and the emotional load of putting up with the present system is too difficult. The working place needs to be less bureaucratic in order to keep workers on the job.

CHAIR WILSON re-stated that employee working conditions are a factor.

MR. WALTERS said that constant change keeps morale low.

4:51:35 PM

REPRESENTATIVE CISSNA opined that peer counselors are probably most effective, yet they do not receive the status that they deserve.

4:52:23 PM

MR. WALTERS agreed. He added that counselors are judged by their titles instead of by their competence.

4:53:19 PM

MS. SALERNO pointed out that there is a problem of reciprocity for professional licensing from state to state. She suggested that the committee study how Alaska's professional licensing statutes compare with other states.

4:54:28 PM

MR. HEFLEY recalled that psychiatrists and physicians recognize the work that counselors do. He pointed out that the last increase in state grants was in 1990; furthermore, the lower percentage of Medicare eligible patients requiring behavioral health services limits what SEARHC can pay staff. Residential programs must turn away business when shifts cannot be staffed at a safe level. Potential rate increases may help but the real help will come with a fair balance of eligibility.

4:58:22 PM

MS. STONE reemphasized the impact of vacancies, particularly in small agencies in rural areas, where the loss of one position may shut down a program. Furthermore, Medicaid has changed the nature of our provider agencies such that clinical agencies are forced to be business-oriented, thus have added administrative employees, human resources personnel, quality assurance personnel, and additional levels of practitioners at the detriment of services.

5:00:55 PM

MR. JESSEE stated that workforce is one of the five focus areas of AMHTA. Nevertheless, he encouraged the committee to first

study the rate review issue. As a matter of public policy, the legislature provides for regular rate reviews for hospitals and nursing homes. A conscience decision, he said, must be made whether to continue the state policy of not providing similar rate reviews for community programs simply because they have not been provided before.

5:02:47 PM

CHAIR WILSON stated that the roundtable will be continued at a later date.

5:03:26 PM

ADJOURNMENT

There being no further business before the committee, the House Health, Education and Social Services Standing Committee meeting was adjourned at 5:03:29 PM.