

**ALASKA STATE LEGISLATURE**  
**SENATE HEALTH, EDUCATION AND SOCIAL SERVICES STANDING COMMITTEE**

March 5, 2008

1:34 p.m.

**MEMBERS PRESENT**

Senator Bettye Davis, Chair  
Senator Joe Thomas, Vice Chair  
Senator John Cowdery  
Senator Kim Elton

**MEMBERS ABSENT**

Senator Fred Dyson

**OTHER LEGISLATORS PRESENT**

Representative Sharon Cissna

**COMMITTEE CALENDAR**

Medicaid Behavior Health Presentation

**PREVIOUS COMMITTEE ACTION**

No previous committee action to be considered

**WITNESS REGISTER**

WALTER MAJORIS, President  
Alaska Behavioral Health Association  
Anchorage, AK

**POSITION STATEMENT:** Introduced Mary Thornton and commented on the new Medicaid rules.

MARY THORNTON, BSRN, MBA, President and founder  
Mary Thornton & Associates, Inc. (MTA)  
Boston, MA

**POSITION STATEMENT:** Gave a presentation on changes to the federal Medicaid program.

JERRY FULLER, Project Director  
Health Care Services, Medicaid Division  
Department of Health and Social Services (DHSS)  
Juneau, AK

**POSITION STATEMENT:** Explained how DHSS is preparing for the Medicaid rule changes.

MELISSA STONE, Director  
Division of Behavioral Health  
Department of Health and Social Services  
Anchorage, AK

**POSITION STATEMENT:** Commented on the impact of the new Medicaid rules.

#### **ACTION NARRATIVE**

**CHAIR BETTYE DAVIS** called the Senate Health, Education and Social Services Standing Committee meeting to order at [1:34:13 PM](#). Present at the call to order were Senators Elton, Cowdery, Thomas and Davis.

#### **Medicaid Behavior Health Presentation**

CHAIR DAVIS announced the Medicaid Behavior Health Presentation.

WALTER MAJORIS, President, Alaska Behavioral Health Association in combination with the Alaska Associations of Homes for Children, introduced Mary Thornton, a leading expert in terms of behavioral health as it relates to the federal Medicaid program.

Chair Davis recognized Representative Sharon Cissna.

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MARY THORNTON, BSRN, MBA, President and founder, Mary Thornton & Associates, Inc. (MTA), thanked Chair Davis and the committee for the opportunity to speak to them about what was happening at the federal level with Medicaid, and some of the changes that were anticipated. She reminded the members that Medicaid is a shared cost so there are two opinions, the state and the federal, on the quality and content of services. She said that the states' and the federal government's opinions on what are covered and high quality services for behavioral health had diverged recently. The federal government's focus was so much on cost savings that, for the first time, the total cost of Medicaid crossed Medicare. As a result, the center for Medicaid and Medicare Services and its enforcement and oversight arms were going in with much narrower definitions of services than in the past and, after spending quite a bit of time trying to steer behavioral health into the areas of wellness and recovery, were really emphasizing a medical model.

The federal frustrations "boiled over" after a number of government accounting office audits of Medicaid risks including fraud, abuse, and improper payments. They felt the fraud efforts were uneven at the state level and were frustrated that they couldn't have more oversight there. It seemed that the states were deciding how much emphasis to put on program integrity and in most cases, investment in the investigative arm at the state level was inadequate.

They were also frustrated about the fact that the rules were different on a state-by-state basis. They had a hard time trying to figure out whether or not differences in practice patterns and costs had real meaning in terms of quality or just reflected differences in how the states were managing program integrity. They felt that what was happening at the state level was the "Medicaiding" of services, that is, states were taking services that had formerly been paid for by state grants, changing the definition of services slightly, and then pushing them under the Medicaid umbrella. This resulted in a significant rise in the cost of behavioral health services.

MS. THORNTON presented five areas of change in the federal government's way of doing things that she believed would have an impact on behavioral health. The first was new auditors.

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New auditors: The Payment Error Rate Measurement (PERM) initiative, the Deficit Reduction Act (DRA), the Recovery Audit Contractors (RAC), and all of these sorts of federal audit functions are quite new. As a result of DRA, they have received hundreds of millions of dollars to produce savings in the federal Medicaid program through audits and other oversight activities. The whole landscape is really changing around audit functions.

Alaska will undergo its' PERM audit in the next year; the PERM audit is designed to develop an overall federal error rate for the Medicaid programs. Error rates greater than 2.5 percent in any one state will be sent to congress as a kind of "report card" on the state's ability to manage the integrity of the Medicaid program. PERM monitors will be in 17 states at a time; it will be a rolling audit, with a new cycle starting every 3 years.

They have also developed a Medicaid integrity program, which will have private contractors hired by the federal government looking at what is going on at the state level and going around

the state directly to providers. This is something new. Usually the audits coming out of Centers for Medicare & Medicaid Services (CMS) look at the state's management of providers; the auditors have not generally audited providers directly.

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On the state side, the federal government is pushing the states to adopt a False Claims Act similar to the federal Act, which has a lower level of intent and "whistle blower" provisions, including a provision that whistle blowers will collect a piece of whatever is recovered by the federal government. This will provide the Medicaid fraud control units with access to civil as well as criminal complaints.

The return on investment is expected to be quite high. The federal government stated that they generally get a 25 to 30 percent return on investment. Total investments as a result of the DRA have been in excess of \$200 million per year, focused just on Medicaid integrity.

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MS. THORNTON identified the second area of change as new rules.

New rules: The New York Times published an article about the Governor's Association meeting being "up in arms" about new rule changes proposed by CMS, which they believe will represent a significant cost shift away from the federal government and back to the states.

The federal government did pass a new rehabilitation rule that will shift hundreds of millions of dollars away from the federal government's Medicaid costs into state funded child welfare programs. The new rehab rules will reduce the kinds of services that can be provided to the seriously and persistently mentally ill, especially adults. The governors obtained a moratorium on the rule until the end of July 2008, but do not know what will happen after that time.

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Case management rule: The federal government pays a lot in matching funds for targeted case management and is concerned about the types of services being provided under case management. This would not just affect behavioral health; targeted case management groups include the developmentally disabled, pregnant women, the elderly and others will be affected.

Finally, in terms of new rules, SAMSA issued a number of evidence-based practices with the assumption that Medicaid would cover the cost of those services. Unfortunately, CMS came out with an encyclical on the evidence-based practices in mental health and really restricted the kinds of services within those practices that Medicaid will cover.

MS. THORNTON said these rule changes will have a huge impact on the way services can be provided in behavioral health. You can see the expected outcome from the rehab rule alone was supposed to be over \$2 billion from 2008-2012, and those savings are going to come primarily from children's services, with a cost shift into foster care and residential costs that are the responsibility of the state and away from the costs that Medicaid has paid to date. In particular, in terms of non-covered services, they are targeting therapeutic foster care; regular foster care services; child caring institutions and other kinds of rehabilitative activities.

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In some states that have been under pressure from CMS, they are seeing the "de-linking" of services from one another in rehab. The savings are expected to be about \$800 million a year on the case management side, although the governors have really disputed that figure. They say the federal government's savings will be a great deal higher, that they underestimated the additional costs the states will have to cover. Many of these savings will come from shutting down certain kinds of children's services. One of the things that the Case Management Rule emphasizes is that the case managers are there simply to link people to services, not to provide direct support. The new definition is quite restrictive; there are only about four different things people can do. In Massachusetts the state was told that it has to repay \$87 million of \$104 million it billed in Case Management Services because it did not meet the new definition; so to suggest that the savings are going to be only \$800 million when Massachusetts alone is going to come up with 1/8 of that really underestimates the impact on the states.

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The evidence-based practices, in terms of behavioral health, have really impacted the states' ability to target families as a treatment entity. Medicaid and Medicare both work from the position that the services are provided to an identified client and they must be exclusively directed to that identified client. So some of the intensive home-based services and other kinds of service delivery systems that have proven to be a best practice

are going to be impacted by the inability of a provider to target a family.

Another thing that is important in terms of the evidence-based practices, Ms. Thornton said, is that, for many in the adult systems, the targeted recovery outcome is to get the individual back to work. Medicaid is saying it will not fund any supported employment activities to help individuals get and keep jobs. This is often really problematic in behavioral health, especially with the seriously mentally ill, because the vocational rehabilitation dollars are very limited in scope and don't provide the long-term support that many individuals need to keep a job.

MS. THORNTON advised that the third area of change is the recreation of SILOs. [Creating Silos: Separating Medicaid from child welfare, juvenile justice and education systems with increased pressure on these other systems to pay for services that have been historically paid by Medicaid.]

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1) Payment Issues: Medicaid does not want to be part of an integrated system; it wants to be able to see its own services. She cited New Mexico as an example, where a wonderful children's integrated delivery system was developed whereby all of the buckets of money went into one place and were doled out as the child needed them. Medicaid pulled out of the integration at the last minute and required that it be a braided system so Medicaid could see exactly how its dollars were being spent. This is one area in which the federal government has created a SILO.

In the case management rule, for example, the federal government expects the Title IV-E [Child Welfare federal and state mandates] money that Alaska gets to pay for all of the case management services for children in protective custody. Historically, case workers have had very high caseloads, so a mental health worker from the mental health system would come in to provide case management and coordination services for the seriously emotionally disturbed or the seriously mentally ill. Under the new rule, that will no longer be possible, so the state's foster care and child welfare dollars will need to increase to cover the gap.

A second area is public parole and probation. They said that public parole and probation and the Criminal Justice System have their own dollars for health care and Medicaid cannot be used to supplement those. In Georgia, they literally took apart the

entire children's residential system because it was being partially paid for by the Juvenile Justice System and partially paid for by Medicaid. The federal government said that a resident, whether or not the child volunteered to go into residential services, was considered to be incarcerated and was not eligible for any Medicaid at all.

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A third area is public guardianship. In many cases, especially with the adult mentally ill, behavioral health providers are needed to help people make decisions about their health care. Medicaid is saying that they will not pay for those services any more. With special education, Medicaid did allow certain types of case management activities that were ordered as part of an Individualized Education Program (IEP) to remain in place, but they put strict limits on those. They can't include any kind of administrative work unless the IEP orders a service coordinator, or the individual family services plan orders a case coordinator.

The ties that Alaska built with Juvenile Justice in behavioral health really reduced costs and produced other benefits that will be lost if those links cannot remain.

4) Reasserting old rules: The federal government is really focusing on the issue of family treatment, saying that the family is not an entity as far as Medicaid is concerned and providers must treat individuals only. It has denied any training that teaches people how to be parents, saying that the cost of general parenting training is the responsibility of the public health or child welfare systems.

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On the medical necessity side of things, Medicaid is trying to implement new rules that will make it more difficult for providers to engage clients in services because there isn't enough time for the client and the provider to get to know one another enough to work together on treatment decisions. For example, in Texas they have a recovery goals system like the one Medicaid is now trying to sponsor. What happens is that the client meets someone for the first time, they do an assessment, and tell the client, based on that assessment, what the course of treatment should be. Clients have proven to be disinclined to follow the recommendation of a perfect stranger, so they are having a very difficult time getting people into services.

The final issue with regard to reasserting new rules relates to Institutions of Mental Diseases (IMD). The rules say that an IMD is any kind of institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of individuals with mental diseases, including substance abuse. They go on to say that if a facility is an IMD, Medicaid will not pay financial participation for any person between the ages of 21 and 65, and will pay for inpatient services only for those who are 21 and under. Children are not covered for medical, dental or any services other than inpatient psychiatric when they are in the IMD.

Medicaid has also said it will only pay per diems for services that are actually level five services, the highest level of psychiatric treatment. Because of that, states are trying to figure out what to do with the residential service programs. As soon as they bring treatment into the residence, Medicaid starts to question whether it is an IMD and the children are no longer covered for medical and dental services, resulting in a tug of war around payment.

What you have in many states including Alaska, is some fairly substantial campuses that were built when the providers were providing only child care services, so they were for the protection and safety of children. At some point in time, some states realized that these children had serious emotional issues or mental illness as a result of the abuse they had experienced so they brought treatment into the facilities. Now Medicaid is saying if there are more than 16 beds they will cover only a limited benefit and then only if there are certain medical and other staff on board, making the services much more expensive. The residential rate setting is becoming problematic in many states as they try and figure out how to provide residential services that are treatment oriented and meaningful but don't require a level five status in order to get Medicaid reimbursement.

There have been a number of audits in New York and Virginia. In one case a New York audit went to the appellate court, which upheld federal Medicaid's position on IMDs, that the psych under 21 benefit really was only for inpatient services.

Prior to this meeting, Ms. Thornton met with providers to go through a set of guidelines developed by the state of Georgia after it had its children's residential programs taken apart by CMS. They have provided advice to organizations about how to divide campuses into distinct parts, with distinct licenses and

treatment populations to prevent the government from lumping all of the beds together and making them IMDs.

Finally, there is the issue of "unbundling".

Medicaid is saying that it no longer wants to pay for per diems, monthly rates or any kind of case rates. It wants to see each and every service it is providing. In behavioral health in Alaska, you have a service called Behavioral Residential Service (BRS) This is a per diem that providers earn in residential facilities that allows them to bill multiple services throughout the day on one claim. Medicaid wants those services unbundled and documented individually. This increases the administrative costs significantly without having any impact on the quality of care.

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In the State of Alaska, in behavioral health as well as other areas where the bundling of services occurs, these will have to be unbundled in the future. The way that is worded in the Case Management Rule is "A state cannot employ a methodology or rate that results in payment for a bundle of services". Medicaid suggests that a 15 minute unit of service is appropriate, so they want even 7 day a week, 24 hour per day services laid out in 15 minute increments, which creates huge problems.

What needs to be done? The awareness at the state level of the potential impact is incredibly important. This is no time to wait for things to happen. The legislature, provider community, and consumers need to work together to look at these programs and services. There needs to be a lot of support for providers; new provider manuals that take the new information into account; technical assistance for providers as they work through the new rules and other changes. It will be terribly expensive for providers to work through this on their own; there needs to be a state-wide effort to make sure it works. There also needs to be continued legislative advocacy, advising congress that these rule changes will be devastating to the states.

CHAIR DAVIS asked Ms. Thornton whether there was anyone from the division [of health care services] present at her meetings yesterday.

MS. THORNTON replied that there were representatives from the division attending the meetings both yesterday and today.

CHAIR DAVIS asked when Alaska would have to start unbundling services.

MS. THORNTON advised that the interim Case Management Rule that requires unbundling went into effect March 4, 2008, but there was a lot of work going on at the federal level to create a moratorium on implementation of that rule until 2009. It is tied up in a law that President Bush already said he would veto, so no one really knows what the outcome will be.

CHAIR DAVIS ventured that Alaska was out of compliance if the moratorium did not go into effect.

MS. THORNTON agreed, but thought states would be given some time to change their state plans before any punitive measures would be taken.

MS. THORNTON added that, because this was introduced as an interim final rule, there was no time for public feedback; people didn't expect that the Case Management Rule would include so many extraneous measures, such as unbundling and de-linking. It was expected to deal only with the definition of services, because that seemed to be their focus.

MS. THORNTON said the PERM auditors would just be looking at the Medicaid error rate and would be in Alaska within the next year. In addition to that there would be the Office of the Inspector General auditors and the new Medicaid integrity auditors.

CHAIR DAVIS asked if the burden to pay those auditors would fall on the state or the federal government.

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MS. THORNTON advised that the federal government would be paying for the auditors, but they expect to get it back through the results of the audits.

CHAIR DAVIS speculated that these rules might be revamped with the change in administration.

MS. THORNTON clarified that the case management portion was already in law, but they could make the rules less onerous for the states. She was not sure how fast the rules could be changed once they have gone into effect.

SENATOR THOMAS said that, while he is sure many people here in the state would suggest things be done differently, it doesn't

appear that the goal was just to revamp and improve the system or make it more efficient. He wondered what the process was that resulted in these rules and whether they considered any input from people in the states.

MS. THORNTON said that based on how the rules turned out, she didn't think they were taking advice from anyone who actually operates in the behavioral health arena, because some of what they have suggested is almost operationally impossible. She added that the audits are often the only information states get from the federal government about what they like and dislike, so most providers are watching the audits to determine what is acceptable.

Rule changes are usually a response to unexpectedly high error rates. What probably happened is that the costs of rehab services in mental health were higher than expected around the country, so they sent in auditors who came back with some bad findings, which resulted in the rule changes.

CHAIR DAVIS asked Ms. Thornton whether the providers she met with yesterday talked to her about their state audits.

MS. THORNTON confirmed that they did discuss that and the providers wondered whether they could rely on these audit findings in the face of a federal audit; was the state audit rigorous enough that they could feel comfortable that if they met the requirements of the state, they would come out alright on a federal audit. She said that she couldn't respond to that because she had not seen any of the audits that had been done, but noted that Alaska is on the cutting edge in that it does extrapolated audits. Meaning that Alaska does random samples and extrapolates the results across the entire population, which seems to be the direction many states are moving toward.

CHAIR DAVIS asked Mr. Majoris what prompted him to bring experts in to train his workers.

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WALTER MAJORIS, President, Alaska Behavioral Health Association, explained that he was most worried about the audits because there are so many and because he thinks the goal is big paybacks, without regard for the quality of service. He was also very concerned about the reinterpretation of old rules. He gave an example based on his own organization, Juneau Youth Services. Under IMD, if a facility offers mental health or substance abuse services in a residential or institutional setting with more

than 16 beds, it is not reimbursable for federal Medicaid. Partly because of that rule, all of JYS facilities are less than 16 beds but, as an agency they have 54 beds. CMS has been in contact with Alaska about this already. On any day, they could deny all federal participation based on the fact that we have, in total, more than 16 beds. That would represent millions of dollars just from his agency.

SENATOR ELTON admitted that her testimony was extremely disturbing. He asked who they could look to for a good program or model to review how to deal with the coming tsunami.

MS. THORNTON did not believe there were any models at that time. She acceded that all of the states were trying to figure out what to do in the face of this, but suggested they could talk to Jim Sheehan, Medicaid Inspector General for the state of New York and a well known health prosecutor. Mr. Sheehan moved from a federal position to a state job and might be able to help providers begin to find their way through this. She pointed out however, that what would also help was just what they did in their meetings earlier in the day; create a list of priority items and address them one at a time.

SENATOR ELTON said he anticipated, with all of these new audits, especially the bounty hunters...

MS. THORNTON interjected that what the federal government had done with the RAC auditors was quite disturbing! These contractors come out of the Tax Relief and Welfare Act and have access to software that can filter huge amounts of data. They take the publicly available data on the Medicaid program and look for aberrant practice patterns. For example, they might find that in West Virginia it only costs \$500 per year for services but in Alaska it costs \$10,000, then start looking for an explanation for the discrepancy. She called them "bounty hunters" because they can request that the provider make pay backs. The provider can appeal, but even if he appeals and wins the RAC auditors get to keep the percentage they earned, so they have no incentive to ensure that they have a good case. She pointed out that they work with Medicare only at this point, not Medicaid.

SENATOR ELTON continued that he assumed, with the RAC Auditors and all the others, the administrative costs for the association would skyrocket as they go through audit after audit.

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MR. MAJORIS was also concerned about that and about the difference between the state audits and federal audits. His agency submitted 11,000 pieces of paper associated with the two Meyers & Stoffer state audits they went through, and scored 100 percent. In talking to Ms. Thornton however, he learned that if the federal government finds differently, it will make no difference whether they complied with all of the state's regulations and requirements.

MS. THORNTON confirmed that administrative costs are going up for organizations as a result of these changes.

CHAIR DAVIS proposed that the committee meet with the Medicaid division after session to find out where they are on all of this. She thought they had hired a contractor to help them with some of these problems.

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JERRY FULLER Project Director, Health Care Services, Medicaid Division, Department of Health and Social Services (DHSS), said this has been on their radar for a couple of years. They have submitted state plan amendments around rehabilitative services in the past, only to hit a brick wall with CMS; we pulled back the state plans rather than reconfigure our system based on state plan amendments rather than regulations. In addition to the targeted case management and rehabilitation services, there are another five regulations that will also have negative impacts. The Department's focus has been working with Alaska's delegation to put the kibosh on these regulations. The National Governors' Association sent a letter to Secretary Levitt and to Congress advising them that this is too much. When moratorium language for the Targeted Case Management was added to the Indian Healthcare Reauthorization bill, the Senate voted for it unanimously; so there is some momentum back East to stop this.

MR. FULLER said that the [United States] House Subcommittee on Government Reform and Oversight recently published a survey of all of the Medicaid programs in the country. CMS in their testimony to Congress said that these seven regulations were expected to save the federal government approximately \$15 billion, so the committee surveyed all of the states to get an estimates from the state Medicaid directors. Once it was added up, the total was closer to \$50 billion from the states' perspective. Whatever the figure, it is all a cost shift to the state General Fund, at a time when Congress is talking about an economic slow-down and economic stimulus packages to help the states out.

He continued that Congress would have to pass a bill before June 30<sup>th</sup> [2008] to deal with Medicare and the fact that Medicare reimbursement would drop 10 percent if they did not act. Congress could use that as a vehicle to add language for a moratorium on the Medicaid rules, so the Department was focusing on that.

MS. THORNTON added that she wanted to be very clear about the fact that the rule changes were only one of five big things going on at the Medicaid level. The fact that there was a moratorium on the Case Management and Rehabilitation Rule probably would not diminish the risk to providers by much. She conceded that the Alaska Department was really "on top of" the situation compared to other states.

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SENATOR ELTON asked Mr. Fuller whether, given what's at risk just on the component they'd been discussing, he had a team working with other states to coordinate a message, or attorneys reviewing the interpretations of old and new rules. If not, he asked if he needed to assemble a team of people and how much that would cost. He was concerned that, if they waited, they might not have time to deal with it.

MR. FULLER reassured him that he had two or three people in the department focused on this issue and that they were in contact with many other states to get feedback regarding their audits. He said he was personally working with the National Association of State Medicaid Directors and American Public Health Services Association and NGA [NGA Center for Best Practices] to get it on the agenda for the upcoming meeting so they can develop a cohesive approach to approach the next administration. In addition, he said a lawsuit was filed on Monday [March 3, 2008] by four states seeking an injunction against implementation of the targeted case management regulations by the federal Centers for Medicaid and Medicare Services. That suit was organized by a Washington DC law firm, Covington & Burling.

SENATOR ELTON asked for copy of the lawsuit and some indication of the arguments they were using. He commented that a number of the legislators on the committee belonged to the National Conference of State Legislatures (NCSL) and that there might be avenues for them to supplement the department's efforts.

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MR. FULLER said he would provide them with whatever information they would like.

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MELISSA STONE, Director, Division of Behavioral Health, Department of Health and Social Services, said she appreciated the providers coming together and bringing Ms. Thornton to the state. She believed it was important to continue to support the existing system while looking to the future, but was certainly concerned about the magnitude of the problem facing them. In the short-term, she felt the challenge was garnering the resources to protect their systems and to prepare for these changes. She admonished them not to lose sight of the people they serve and the quality of those services in their efforts to deal with funding.

CHAIR DAVIS asked Ms. Stone if there were any money in the current budget to help them.

MS. STONE replied that there was no money in the 2009 budget for admin services, but there was money allocated for Medicaid rates, which would help providers.

SENATOR ELTON thanked Ms. Stone for reminding them of the clients who would be affected. He thought it might be helpful to bring someone in to do an assessment of how many clients would fall out of the system and what the cost of that to the state would be in the future.

There being no further business to come before the committee, Chair Davis adjourned the meeting at [2:41:13 PM](#).