SB

452

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

SB 452

Revision Date:
Title: An Act Providing Medicaid Coverage for rehabilitation & case management
Sponsor: Senate HESS
Requestor:

Dept. Affected: Health & Social Services
BRU: Alcohol & Drug Abuse Services
Component: Alcohol & Drug Abuse Grants

COMPONENT SERIAL NO. 1239

Expenditures/Revenues (Thousands of Dollars)

OPERATING	FY93	FY94	FY95	FY96	FY97	FY98
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	<118.5>	<260.7>	<286.8>	<315.4>	<346.9>	<381.7>
MISCELLANEOUS						
TOTAL OPERATING	<118.5>	<260.7>	<286.8>	<315.4>	<346.9>	<381.7>
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	<118.5>	<260.7>	<286.8>	<315.4>	<346.9>	<381.7>
FEDERAL FUNDS						
OTHER						
TOTAL	<118.5>	<260.7>	<286.8>	<315.4>	<346.9>	<381.7>

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary)

SEE ATTACHED ANALYSIS

Prepared by: Suzanne Perry
Division: Alcoholism & Drug Abuse
Phone: 465-2071
Date: March 20, 1992

Approved by Commissioner: Theodore A. Mala, MD, MPH
Agency: Department of Health and Social Services
Date: March 20, 1992

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
OMB
Impacted Agency(ies)

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. SB 452

Revision Date:
Dept. Affected: Health & Social Services
Title: An Act Providing Medicaid Coverage for rehabilitation & case management
BRU: Alcohol & Drug Abuse Services
Component: Administration
Sponsor: Senate HESS
Requestor:
COMPONENT SERIAL NO. 0302

Expenditures/Revenues (Thousands of Dollars)

OPERATING	FY93	FY94	FY95	FY96	FY97	FY98
PERSONAL SERVICES	54.8	56.8	59.7	62.6	65.8	69.0
TRAVEL	10.0	10.5	11.0	11.6	12.2	12.8
CONTRACTUAL	5.0	5.3	5.7	5.9	6.2	6.5
SUPPLIES	1.0	1.1	1.2	1.3	1.4	1.5
EQUIPMENT	7.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	**77.8**	**73.7**	**77.6**	**81.4**	**85.6**	**89.8**
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	38.9	36.9	38.8	40.7	42.8	44.9
FEDERAL FUNDS						
OTHER (interagency)	38.9	36.8	38.8	40.7	42.8	44.9
TOTAL	**77.8**	**73.7**	**77.6**	**81.4**	**85.6**	**89.8**

POSITIONS:

FULL-TIME	1.0	1.0	1.0	1.0	1.0	1.0
PART-TIME						
TEMPORARY						

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary)

SEE ATTACHED ANALYSIS

Prepared by: Suzanne Perry
Phone: 465-2071
Division: Alcoholism & Drug Abuse
Date: March 20, 1992

Approved by Commissioner: Theodore A. Mala MD, MPH
Date: March 20, 1992
Agency: Department of Health and Social Services

Distribution (by preparer):
Legislative Finance
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Impacted Agency(ies)

(Rev 12/91)

ANALYSIS (cont.):

Section 1 amends AS 47.07.030(b) to include rehabilitation services for substance abusers and chronically mentally ill adults, targeted case management services for substance abusers and chronically mentally ill adults as well as those severly emotionally disturbed persons under 21 years of age as optional services to be paid for by Medicaid.

Section 2 priortizes these additional services. Targeted case management services is the twelfth (12) service to be discontinued if a shortage of funds occurs, and rehabilitation services for substance abusers and chronically mentally ill adults is the thirteenth (13) service to be discontinued if a shortage of funds occurs.

There are 18 residential primary treatment facilities. Of these, there are two residential facilities which regularly treat pregnant women. There is one treatment center which is exclusively for pregnant women, and there is one post-treatment (half-way house) facility for substance abusing women.

The costs of treatment in these facilities varies from a high of $231/bed/day to a low of $96/bed/day.

The average cost is $150/bed/day for the primary treatment facilities.

As medicaid will not pay for room and board costs, we estimate treatment costs to be 70% of the total cost. Therefore, of a total cost of $150/bed/day, $105 would be medicaid reimbursable.

Outpatient costs average $50/hour. Outpatient charges include individual counseling and case management which is termed aftercare by the substance abuse field.

The assumptions which were used to develop the fiscal impact on grants include the following:

FY 93 -- six months of regulation development, and program training followed by six months of actual client activity.

Figures are based on 75 clients requiring 25 hours of outpatient care at $50/hr, with 50 hours of group counseling at $30./hr with 30 hours of aftercare (casemanagement) at $50/hr. Additionally, 25 clients would require 90 days of residential care at $105/day followed by 30 days of aftercare (casemanagement).

During the first six months of FY 92, for all programs there were 100 admissions which appear to be medicaid eligible clients. As intake information is gathered for client profile purposes and not for eligibility criteria, it is difficult to determine whether these clients are actually medicaid eligible. The formula which was used is:

75 clients X 25 OP hours X $50 = $ 93,750
75 clients X 50 GP hrs X $30 = $112,500
75 clients X 30 Aftercare hrs X $50 = $112,500
25 clients X 90 days resid. X $105 = $ 236,250
25 clients X 50 days Aftercare X $50 = $ 37,500
Total $592,500

During the first year, clients would be seen for a six month period due to initial start up activities. Therefore, medicaid eligible costs would be one half of $592,500 or $296,250. One half of these costs would be reimbursable by medicaid or $148,125.. Of this, 20% general fund would be retained and not be replaced. Therefore the total amount to be refinanced by medicaid in year one would be $148,125 X .80 = $118,500.

It is estimated that each year would see a 10% increase over the initial year.

For each subsequent year, a 10 % growth factor was taken on a full year. Therefore, for FY 94, the calculation was: $592,500 X 10% = $651,750 ; one half medicaid match = $325,875 X 80% = $260,700.

The vast majority of all clients seen are single persons with no children in the household with incomes under $10,000/year.

The Division of Alcoholism and Drug Abuse recently began collecting information on pregnancy status of women. It is not possible to determine from available information how many of these women were medicaid eligible. During the first six months of FY 92, there were 5 pregnant women in treatment. There were an additional 12 women seen at the pregnant women's treatment center.

It is also anticipated that the Division of Alcoholism and Drug Abuse would require a staff specialist in medicaid to assist programs with this effort. This position would be located in Juneau.

This position would be a Health Program Specialist at a range 17. This position would be able to provide written and on-site technical assistance to all programs regarding medicaid. The current COLA of 3.6% was used for salaries and 5% used for other costs after FY '93. Travel costs were based on the averge travel ($10.0) for a Health Facilities Surveyor with a full survey load. Travel throughout the entire state would be required to assist programs in obtaining capability to participate in medicaid. Contractual ($5.0) and supplies ($1.0) are a standard figures used by the division for these costs; and equipment ($7.0) is based on equipment and computer workstations that are required for a new position. No additional office space is anticipated.

It is anticipated that this position would be Medicaid funded. Therefore, one half of the costs of this position would be paid through an RSA from medicaid.

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. SB No. 452

Revision Date: _____ Department Affected: Health and Social Services

Title: An Act providing for Medicaid Coverage for ..... BRU: Medicaid

Component: Medicaid Non-Facility

Sponsor: Senate HESS

Requestor: _____ **COMPONENT SERIAL NO.** 0 2 2 9

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	161.9	112.4	121.9	132.1	143.4	155.6
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	1,736.3	2,235.9	2,459.5	2,705.5	2,976.1	3,273.7
MISCELLANEOUS						
TOTAL OPERATING	1,898.2	2,348.3	2,581.4	2,837.6	3,119.5	3,429.3
CAPITAL						
REVENUE FUND SOURCE:						

FUNDING (Thousands of Dollars)

GENERAL FUNDS	223.7	260.9	286.1	313.7	344.2	377.5
FEDERAL FUNDS	980.0	1,193.1	1,311.5	1,441.8	1,585.0	1,742.4
OTHER FUND SOURCE: IA	694.5	894.3	983.8	1,082.1	1,190.3	1,309.4
TOTAL	1,898.2	2,348.3	2,581.4	2,837.6	3,119.5	3,429.3

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY:	0	0	0	0	0	0

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary.)

See attached analysis

Prepared by: Kimberly B. Busch Kimberly B Busch Phone: 465-3355

Division: Medical Assistance Date: 3-24-92

Approved by Commissioner: Theodore A. Mala, MD, MPH

Agency: Department of Health and Social Services Date: 3/24/92

Distribution (by Preparer: Leg. Fin., Legislative Sponsor, Requestor,OMB/DBR,Gov.Legis. Ofc., & Impacted Agency(ies)

FISCAL NOTE ANALYSIS
SB NO. 452

1. Division of Alcoholism and Drug Abuse, Rehabilitation Services and Targeted Case Management Services. See related Fiscal Notes (2). (FY 93: Start Date of 7/1/92 for position, 1/1/93 for services.)

	FY 93	FY 94	
Benefit Cost	296.3	651.9	
Claims Cost	49.7	33.0	
RSA/Contractual	38.9	36.9	(for Position in DADA)
TOTAL COST	384.9	721.8	
Fed Match	224.4	387.7	
GF (RSA-DADA)	118.5	260.7	
GF (Medicaid)	42.0	73.4	
TOTAL REVENUE	384.9	721.8	

FY 93 contains one-time start-up contractual costs for the Medicaid Management Information system, consisting of 34.7 for new service modules, new edits, billing, billing system manuals and training, and new reports design. 15.0 is for processing new claims, at $6.23 per claim. FY 94 costs for claim processing are 33.0. Contractual costs also include an RSA with the Division of Alcoholism and Drug Abuse (DADA) for the Federal (50%) matching funds for a position in that Division.

FY 94 costs for benefits are the costs for FY 93, doubled, plus 10% growth in number of recipients enrolled. A similar 10% growth is assumed for FY 95 and following for claims processing costs.

2. Division of Mental Health and Developmental Disabilities, Rehabilitation Services and Targeted Case Management Services. See related Fiscal Note.
(Start date of 7/1/92 assumed)

	FY 93	FY 94
Benefit Cost	1,440.0	1,584.0
System Cost	73.3	42.5
TOTAL COST	1,513.3	1,626.5
RSA from DMHDD	576.0	633.6
Fed match	775.0	823.9
New Medicaid SGFM	162.3	169.0
TOTAL REVENUE	1,513.3	1,626.5

FY 93 contains one-time start-up contractual costs for the Medicaid Management Information System, consisting of 34.7 for new service modules, new edits, billing system manual and training, and new reports and existing reports redesign. Claims processing costs, at $6.23 per claim, (6,200) are estimated to be 38.6. FY 94 and following, a 10% annual increase in claims cost are estimated. System costs are 75% federal; benefits costs are 50% Fed, 50% SGFM.

Benefits cost for FY 94 and following are FY 93 costs increased by 10% annually for recipient and utilization increases.

In FY 94, the first full year of operation of this measure, the state will receive 1,211.6 in new federal funds. Grantees will be advantaged as follows:

Receive	2,235.9	New Medicaid Payments
Give up	894.3	State Grant Funds
	1,341.6	Advantage to Grantees

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. SB452

Revision Date:

Department Affected: Health & Social Services

Title: An Act Providing for Medicaid Coverage

BRU: Community Mental Health Grants

Component: Services to CMI, Services to SED Youth

Sponsor: Senate Hess

0800

Requestor:

COMPONENT SERIAL NO. 1 4 3 6

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	(576.0)	(633.6)	(697.0)	(766.7)	(843.4)	(927.7)
MISCELLANEOUS						
TOTAL OPERATING	(576.0)	(633.6)	(697.0)	(766.7)	(843.4)	(927.7)
CAPITAL						
REVENUE FUND SOURCE:						

FUNDING (Thousands of Dollars)

GENERAL FUNDS	(576.0)	(633.6)	(697.0)	(766.7)	(843.4)	(927.7)
FEDERAL FUNDS						
OTHER FUND SOURCE:						
TOTAL	(576.0)	(633.6)	(697.0)	(766.7)	(843.4)	(927.7)

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY:						

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary.)

Prepared by: Margaret Lowe, M.Ed., Ed.S. Mike Rogers for Margaret Lowe Phone: (907)465-3370

Division: Division of Mental Health & Developmental Disabilities Date: 3/19/92

Approved by Commissioner: Theodore A. Mala, MD, MPH

Agency: Health & Social Services Date: 3/19/92

Distribution (by Preparer: Leg. Fin., Legislative Sponsor, Requestor,OMB/DBR,Gov.Legis. Ofc., & Impacted Agency(ies)

Division of Mental Health and Developmental Disabilities
Fiscal Note Analysis
SB No. 452

Community Mental Health Clinics (CMHC) are currently billing Medicaid for clinic services. While the clinic option would remain in place and be used by private sector physician mental health clinics, we assume those clinic services currently billed by CMHCs would move to the rehabilitation services category. CMHC would also bill for some services allowed under the rehabilitation option but not under the clinic option, such as home-based therapy and therapies not delivered in the clinic. Targeted case management services now being provided but not billed will become billable.

For FY93, we anticipate total rehabilitation services billings of 2,706.2 (60,138 hours at $45.00/hour) and total case management billings of 3,589.4 (102,553 hours at $35.00/hour), for a total of 6,295.6. Until extensive discussions have been held with Federal Medicaid program authorities to precisely define each matchable rehabilitation and case management service and each CMHC can assess how best to reallocate staff to offer these matchable services, it is difficult to assess how much of this total will represent new Medicaid costs for services not now being billed under the clinic services option. Also, it is difficult to quantify the offsetting savings that will result from moving away from the clinic option, since home and community based services can be accomplished less expensively and are often more effective, so fewer service hours may be required to reach treatment goals.

However, we estimate that only 1,440.0 of these services will be new services for Medicaid purposes, 720.0 federal funds, 720.0 state general funds match. We propose to R.S.A. 80% of this amount, 576.0 from CMHC Grants to the Division of Medical Assistance, Medicaid Non-Facility, for matching purposes. The 20% to be retained by grantees will be used initially to staff for additional Medicaid billing effort, to transition from grant funding for fee-for-services funding, to accomplish staff changes and training; and for systems changes.

The interangency transfer to Medicaid is proposed to come from the following components: Services to Severely Emotionally Disturbed Youth - 192.0
Services to the Chronically Mentally Ill - 384.0
These FY93 transfer amounts are 1/3 and 2/3 of the FY93 total, respectively, FY94 and following, this same ratio applies.

FY94 and following, a 10% annual increase in this grant decrease/transfer is assumed, largely for caseload growth in the numbers of eligible persons receiving the services.

Alaska State Legislature

SENATOR ARLISS STURGULEWSKI, Chairman
SENATOR PAUL FISCHER, Vice Chairman
SENATOR SAM COTTEN
SENATOR LYMAN HOFFMAN
SENATOR CURT MENARD

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JUNEAU, ALASKA 99811
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Senate Committee on
Health, Education and Social Services

MEMORANDUM March 23, 1992

TO: All Members
Senate Health, Education & Social Services Committee

FROM: Senator Arliss Sturgulewski, Chairman
Senate Health, Education & Social Services Committee

RE: SB 451 "An Act relating to Medicaid coverage for pregnant women; reordering the priorities granted to optional services under the Medicaid program; and providing for an effective date."

SB 452 "An Act providing for Medicaid coverage for certain rehabilitation and case managements services; reordering the priorities given to optional services under the Medicaid program; and providing for an effective date."

In the course of discussions on Medicaid with the Department of Health and Social Services, they noted that SB 451 and SB 452 would be helpful to them in refinancing of Medicaid.

Senate Bill 451 is the same as CSHB 498(HES) and SB 452 is the same as CSSSHB 545(HES). Materials in the packets may refer to the respective house bill numbers.

ALASKA STATE LEGISLATURE

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REPRESENTATIVE BETTYE DAVIS

DISTRICT 14 SEAT B · EAST ANCHORAGE · MULDOON

S P O N S O R S T A T E M E N T

I appreciate the committee members hearing CCSSHB 545. CCSSHB 545 if adopted would provide Medicaid coverage for certain rehabilitation and case management services, an reorder the priorities given to optional services.

As you may know medicaid is a federal grant-in-aid program that is administered and partially funded by the State. Authorized by Title XIX of the Social Security Act, its purpose is to provide medical assistance to needy individuals.

Medicaid has become the largest funding source of public mental health services. Here in Alaska Medicaid dollars have been used to fund existing and traditional mental health services, rather than using the money to expand effective community services.

In January, the final Medicaid regulation for adult mental health services were approved. Some confusion remains regarding the broad scope of services that would be reimbursed by Medicaid. Alaska has, by statute, clinic option. This option has a number of serious limitations for services to severely mentally ill adults, particularly with regard to services provided in residential facilities. Under a clinic option, Medicaid cannot reimburse for services provided in a residential facility.

The new state regulations did not address this issue, as it was beyond the scope of the regulations. The regulations are intended to delineate options and procedures that are understood to be under clinic option.

The two key differences between rehabilitation and clinic services are as follows.

1. Clinic services must be offered in a clinic, but rehabilitation services can be provided anywhere they are appropriate or necessary; and

2. Clinics must be supervised by a physician who usually needs to be on-site, but rehabilitation services can be supervised by any qualified professional.

Since both the mentally ill and substance abuse treatment structures have been moving away from clinic-based services and toward residential facilities and in-patients homes and workplaces, it is time for Alaska to adopt the rehabilitation option.

This is a critical funding issue for the Mental Health Clinics. It is important that legislation pass this year, because clinics fear that services could be reduced or eliminated.

Thanks for your consideration.

POSITION PAPER
STATE OF ALASKA ★ DEPARTMENT OF HEALTH & SOCIAL SERVICES

POSITION PAPER
SENATE BILL NO. 452

"An Act providing for Medicaid coverage for certain rehabilitation and case management services; reordering the priorities given to individual services under the Medicaid program; and providing for an effective date."

Analysis

Section 1 of SB No. 452 would amend AS 47.07.030(b) to add rehabilitative services to the list of optional services Alaska's Medicaid program offers to eligible low-income persons, but it would restrict this service to those who are substance abusers or emotionally disturbed or chronically mentally ill adults. (Under federal mandates, the Department is adding rehabilitative services for individuals under 21 who are substance abusers or are severely emotionally disturbed.)

Section 1 also adds case management Medicaid services for three targeted groups: substance abusers of any age, chronically mentally ill adults, and severely emotionally disturbed children under 21.

Section 2 would place these new services twelfth and thirteenth in the AS 47.07.035 list of optional services to be deleted in the event of a Medicaid funding shortfall.

Section 3 amends AS 47.07.900 to restrict these service additions to grantees of the Division of Mental Health and Developmental Disabilities, in the Community Mental Health Centers system, and to the grantees of the Division of Alcoholism and Drug Abuse, to allow them to claim Medicaid's 50% Federal matching funds for the services they provide to Medicaid eligibles.

Discussion

The Department totally supports limiting these services to grantees. If we are to protect these essential services as Alaska's needy population grows and State revenues shrink, it can only be by maximizing other revenue sources such as Medicaid's federal match.

The current "clinic option" was added to AS 47.07.030 to add federal Medicaid funds to community mental health centers. This option, as it is defined federally, requires Medicaid-coverable diagnostic and treatment therapy services to be performed on the premises of a clinic and be supervised directly by a physician. This option's restrictions fit some of the services provided by community mental health centers, though the physician-supervision requirement is expensive and difficult for rural clinics. However, the primary treatment approach that is used to treat alcoholism and drug abuse does not fit either of the clinic option's two primary requirements.

Increasingly, each of these service systems find treatment best succeeds if it is delivered outside of a clinic setting, where the patient and his or her family actually lives, be it in the

patient's residence or in a group home or other residential treatment facility.

The "rehabilitation services" Medicaid option allows for services to be delivered in any appropriate setting, without any direct physician supervision. Adopting this option would allow DMH-DD grantees to bill Medicaid for more services than they currently do. (It will not fund all the services they find necessary to provide, for some services Medicaid federal rules will simply not let us cover, no matter what option is chosen). The rehabilitation option will also allow DADA grantees to enroll and begin billing Medicaid for services for the first time. Additionally, this rehabilitation option does allow Medicaid reimbursement for some skills re-training, to replace skills the patient has lost as a result of his or her illness. The clinic option does not cover these kinds of services to the same degree.

Both these treatment systems use case management as an integral part of their services, promoting the patient's access to necessary services. Adopting the case management option will allow these services to draw federal matching funds for the first time. Good case management services have the potential to restrain cost (by assuring the patient gets only necessary services) and to maximize federal matching funds (by making sure patients pursue and keep Medicaid eligibility). However, case management is not generally necessary and efficient unless it is restricted to the seriously ill; SB 545 restricts this service to those for whom it is most likely to be effective.

The Department believes that SB No. 452, as a refinancing initiative, lays the groundwork for very substantial fiscal advantages to Alaska. Not all of those advantages are summarized in this discussion or shown in our related fiscal notes; we plan to develop other refinancing strategies based on the rehabilitation option offered by this bill, and we will bring these to your attention as they are developed. However, we believe that the Legislature needs to keep in mind three key caveats:

(1) Developing the maximum funding advantages provided by this bill cannot be accomplished instantly, but requires extensive work by our staff and our grantees over a period of up to two years.

(2) Medicaid federal match will generally not replace State grant funds dollar-for-dollar, either initially or over the longer range. From other states' experience with the rehabilitation option and with their Medicaid refinancing projects, we believe that the percentage of state funds Medicaid can replace will vary widely depending on an array of factors. For the kinds of refinancing SB No. 452 calls for, we believe is appropriate to propose an 80% reduction: $200 of new Medicaid funding, including $100 of new Federal matching funds, can produce a corresponding $80 reduction in state grant funds. There are many unavoidable reasons for a 20%

retention: new staffing is needed by grantees to bill Medicaid, a number of clients often go into and out of Medicaid-eligible status, there is a need to adjust staff and programs to meet federal requirements, etc.

(3) The savings that would result from introducing or expanding Medicaid funding will vary widely from program to program, based on client characteristics and the types of services. For example, almost all chronically mentally ill persons are Medicaid-eligible, but very few substance abusers are. Thus Medicaid savings in DADA programs will be smaller than in DMH-DD programs. Also, Medicaid cannot pay for room and board costs in residential treatment facilities, which are more common in the DADA system.

Position

The Department believes SB No. 452 is an essential step toward refinancing programs supported by unmatched state general funds with 50% Federal Medicaid funds. We strongly support the passage of this bill.

Recommended by: Kimberly B Busch Date: 3-23-92

Kimberly B. Busch
Director
Division of Medical Assistance

Approved by: Theodore A Mala Date: 3/24/92

Theodore A. Mala, MD, MPH
Commissioner

POSITION PAPER
SPONSOR SUBSTITUTE FOR HOUSE BILL 545

PREPARED BY
COMMUNITY MENTAL HEALTH MEDICAID PROVIDERS

INTRODUCTION: This group consists of the community mental health center directors from Ketchikan, Juneau, Anchorage, Kenai, Fairbanks, and Matsu. The group endorses House Bill 545, adopting: 1) "Targeted Case Management" for severely emotionally disturbed persons under the age of 18 and for chronically mentally ill adults, and 2) "Rehabilitation Services" for chronically mentally ill adults, as part of the Alaska Medicaid Plan.

Possibilities for implementation of this plan include: 1) replacement of the clinic option with the rehabilitation option, or 2) retention of the clinic option with the new additions. The position of this group is that people currently eligible for services should not lose access through these changes. The recommendation is for program eligibility to be defined consistent with AS47.30.545.

Within the next few years, the proposed changes could allow effective leveraging of state monies through the Medicaid program and also allow continued development of community based services. The proposed changes best meet the needs of consumers by allowing services to be delivered in their communities and in their homes, rather than in institutions and hospitals.

SERVICE SYSTEM: Targeted case management and rehabilitation services are central to effective community services. Case management is a system under which a designated person or organization is responsible for locating, coordinating, and monitoring a group of services. It is used to access and manage multiple resources for eligible people. Rehabilitation is a set of services which focus development of independent living skills and vocational skills, as well as provision of supportive social programs.

Over the past six years, community mental health programs in Alaska have effectively served chronically mentally ill people in their communities. The census of the Alaska Psychiatric Institute has been reduced from a range of 160-180 to a range of 80-100 through these efforts. Current service availability will be restricted by new regulations developed to address the only existing Medicaid mental health option. The proposed options will allow continuation and development of necessary community services.

FUNDING: This group endorses the concept of maximizing federal participation in the cost of providing mental health services. The growing population in our areas is increasing the need for mental health services. We believe that the best way to meet the needs without increasing state funding is by pursuing opportunities to match state dollars with federal dollars. In the absence of regulations defining reimbursable services and rates, it is not possible to calculate the impact of Medicaid refinancing on the community mental health center. Therefore, the plan should be advanced in a way which "holds harmless" the mentally ill people who presently receive services from community mental health centers in Alaska.

The bill should have minimal initial costs due to costs shifted from the clinic option now in place to the rehabilitation option. In subsequent years existing costs, as well as necessary service expansion costs, can be met with funds transferred from grant components and leveraged with federal matching funds.

PROVIDER SYSTEM: Providers should be limited to agencies able to deliver a full range of services and full continuity of care. The community mental health system prioritizes area wide, least intensive, community based services. This model emphasizes a total system of care which is coordinated to insure continuity and availability of services. The system is consistent with managed health care models which seek to limit costs and to maximize services with available monies. In addition, nonprofit organizations are a clear choice for use of public monies in that all proceeds are returned to the service system.

The position of this group is that provider eligibility should be limited to comprehensive services providers. These providers are defined as legal entities approved by the Division of Mental Health and Developmental Disabilities as meeting the requirements under AS47.30.540 - 47.30.620.

TOTAL P.02

position papers

ALASKA CHAPTER
NATIONAL ASSOCIATION OF
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Executive Director
William Diebels, LCSW

March 7, 1992

The Honorable Bettye Davis
Alaska House of Representatives
P.O. Box V
Juneau, Alaska 99801

Regarding: SSHB 545

Dear Representative Davis,

The Alaska Chapter of the National Association of Social Workers (NASW) supports Medicaid coverage for rehabilitative services and targeted case management for substance abusers, chronically mentally ill adults and severely emotionally disturbed youth.

Medicaid's programs for mental health and chemical dependency care for low-income Alaskans could be significantly greater if Alaska expanded appropriate and effective community services. In adopting the rehabilitative and case management options, savings can be obtained from federal matching funds, and community outpatient care can be utilized in lieu of hospital care.

The Chapter does <u>not</u> *support reordering the priorities given to optional services under the Medicaid program, unless all the services are going to be re-prioritized to reflect their importance to Medicaid recipients.*

Any new service or provider should come in as priority 1 reflecting the most recent need for services. This is consistent with the Department of Health and Social Services' position relating to many Medicaid option bills. When acting upon 1990 CS HB 248, which added licensed psychologists and licensed clinical social workers as optional providers in the medicaid program, both the Senate and House Finance Committees relied upon the Department's advise on this, and agreed that every new service ought to come in at the bottom of the list.

Thank you for your time.

Respectfully,

Theresa Tanoury

Theresa Tanoury, LCSW
Social Action Committee Chair

Anchorage Daily News

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Halfway houses

Don't close the one we've got

When it comes to helping the homeless, soup kitchens and shelters — as crucial as they are — are the quick fix. Halfway houses are the means to get people off the streets and keep them off. They provide not just shelter but structure and support. They help homeless people make the transition to an independent life.

Halfway houses are especially important for the 40 percent of homeless people who suffer from a chronic, disabling mental illness. The structured environment of a halfway house can keep them on their medication, help them learn to cope with their illness.

We know all this. So why are we going backwards?

The Transitional Care Center, a halfway house for up to 18 severely mentally ill people, will close at the end of the month after losing its federal funding.

The center has received Medicaid funding since it opened 10 years ago. But the state took a second look at the federal regulations and decided the halfway house doesn't qualify and probably never should have, at least under the Medicaid plan the legislature chose years ago.

The legislature could close this loophole in the safety net by approving a different Medicaid option, one that covers a residential program. There is no justification for not funding the only help anyone has to offer the homeless mentally ill.

Nearly 30 years ago, Congress decreed that the mentally ill would be better served in communities, not in state mental hospitals. Now hospitals have only a fraction of their former patients, but communities weren't given the resources to care for the rest. People with disabling mental illness, who need help but can't get it, end up on the streets.

The Transitional Care Center gave some of them a place to go. We should be opening more halfway houses for the mentally ill. It's unconscionable that, instead, we're closing the one we've got.

Anchorage Daily News Editorial