SB
135

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 135
( ) Publish Date:

Revision Date/Time (Note if correction):
Title: Mental Health Information & Records
Sponsor: RLS by Request of Leg Budget & Audit
Requester: S(HES)

Dept. Affected: Health & Social Services
BRU: Institutions & Administration
Component: Mental Health/DD Admin
Component Number: 310

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2001) cost: 0.0

Check this box (X) if funding for this bill is included in the Governor's FY 2002 budget proposal: [ ]

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

Section 2 of this bill requires Community Mental Health Centers receiving State mental health grant funds to report confidential information to the Division about State-funded consumers' demographics, service and cost of service, and to notify the Division in the case of a missing, injured or deceased State-funded consumer. These data reporting requirements are being included in the FY02 Request for Mental Health Grant Proposals.

This statutory change bears no direct cost implication for the Division.

Prepared by: Sarah Brinkley, Administrative Manager
Division: DMHDD
Phone: 465-3167
Date/Time: 3/17/01 3:21 PM
Approved by: Elmer A. Lindstrom, Special Assistant
Agency: Department of Health & Social Services
Date: 3/17/01 3:21 PM

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 3/12/01

FURTHER: Judiciary

Date of 5-Day Notice: 03/29/01
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 04/12/01

Health, Education and Social Services Committee considered SENATE BILL NO. 135

"An Act relating to mental health information and records; and providing for an effective date."

and recommends:

[x] be **replaced** with _____ CS SB 135 (HES)

[ ] adopt **previous** _____ CS __________ (______)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by ______________ Committee

[ ] further referral to ______________ Committee

Senate Bill:
[X] same title
[ ] new title

House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#
Health & Social Services	3/17/01		X	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
Loren D. Leman	✓			
Gary Wilken	✓			
Lyda Ward	✓			
Bettye Davis	✓			
CHAIR: Lyda Green	✓			

22-LS0683\C
Lauterbach
4/11/01

CS FOR SENATE BILL NO. 135(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATE RULES COMMITTEE BY REQUEST OF THE LEGISLATIVE BUDGET AND AUDIT COMMITTEE

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to mental health information and records; and providing for an**
2 **effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * **Section 1.** AS 08.02 is amended by adding a new section to read:
5 **Sec. 08.02.040. Access to certain mental health information and records**
6 **by the state.** (a) Notwithstanding AS 08.29.200, AS 08.63.200, AS 08.86.200,
7 AS 08.95.900, another provision of this title, or a regulation adopted under this title, a
8 licensee or an entity employing or contracting with a licensee may disclose
9 confidential patient mental health information, communications, and records to the
10 Department of Health and Social Services when disclosure is authorized under
11 AS 47.30.540, 47.30.590, 47.30.845, or AS 47.31.032. Information, communications,
12 and records received by the Department of Health and Social Services under this
13 section are confidential medical records of patients and are not open to public
14 inspection and copying under AS 40.25.110 - 40.25.120.

1 (b) In this section, "licensee" has the meaning given in AS 08.01.110.
2 * **Sec. 2.** AS 47.30.540(b) is amended to read:
3 (b) An entity designated by the department to receive money under
4 AS 47.30.520 - 47.30.620 shall ensure a broad base of community support as
5 evidenced by a governing board reasonably representative of the professional, civic,
6 and citizen groups in the community and including persons with mental disorders or
7 family members of persons with mental disorders. No more than two members, or 40
8 percent of the membership, whichever is greater, may be providers of services under
9 the program. In order to receive **money** [FUNDS] under AS 47.30.520 - 47.30.620, a
10 local community entity shall agree [TO]
11 (1) **to** give priority to mental health programs and services consistent
12 with the priorities set out in AS 47.30.056 and that provide the maximum services for
13 the least expenditure of money from the mental health trust settlement income
14 account;
15 (2) **to** furnish services through a qualified staff meeting reasonable
16 standards of experience and training;
17 (3) **to** conform to a state cost accounting system showing the true cost
18 of services rendered, collect fees for services according to a schedule based on an
19 analysis of reasonable ability to pay, and provide that a person may not be refused
20 services because of inability to pay for those services;
21 (4) **to** maintain adequate clinical and administrative records and
22 furnish periodic reports to the department;
23 (5) **to** furnish the authority and the department an annual report of the
24 preceding fiscal year, including an evaluation of the effectiveness of the previous
25 year's programs and their costs; [AND]
26 (6) **to** furnish the authority and the department satisfactory needs
27 assessments for the population and area it serves and an annual update of a long-range
28 planning and budget statement that describes program goals for the coming year, the
29 steps and resources necessary to implement the goals, the projected means by which
30 these resources will be secured, and the procedures necessary to evaluate the program**;**
31 **(7) to furnish the department with confidential and other**

1 information about recipients of services paid for, in whole or part, under
2 AS 47.30.520 - 47.30.620 and comply with regulations of the department
3 regarding the submission of this information; and
4 (8) to notify the department immediately of emergency situations
5 involving recipients of services paid for, in whole or in part, under AS 47.30.520 -
6 47.30.620 and comply with regulations of the department regarding this
7 notification; for purposes of this paragraph, "emergency situations" include the
8 disappearance, injury, or death of a recipient.
9 * **Sec. 3.** AS 47.30.590 is amended by adding a new subsection to read:
10 (b) Notwithstanding (a) of this section, the department is authorized to review,
11 obtain, and copy confidential and other records and information about the clients of
12 services requested or furnished under AS 47.30.520 - 47.30.620 to evaluate
13 compliance with those statutes. The department may obtain the records and
14 information regarding clients from the client or directly from an entity designated by
15 the department under AS 47.30.520 - 47.30.620 that furnished those services. Records
16 obtained by the department under this subsection are medical records, shall be handled
17 confidentially, and are exempt from public inspection and copying under
18 AS 40.25.110 - 40.25.120.
19 * **Sec. 4.** AS 47.30.845 is amended to read:
20 **Sec. 47.30.845. Confidential records.** Information and records obtained in
21 the course of a screening investigation, evaluation, examination, or treatment are
22 confidential and are not public records, except as the requirements of a hearing under
23 AS 47.30.660 - 47.30.915 may necessitate a different procedure. Information and
24 records may be copied and disclosed under regulations established by the department
25 only to
26 (1) a physician or a provider of health, mental health, or social and
27 welfare services involved in caring for, treating, or rehabilitating the patient;
28 (2) the patient or an individual to whom the patient has given written
29 consent to have information disclosed;
30 (3) a person authorized by a court order;
31 (4) a person doing research or maintaining health statistics [,] if the

1 anonymity of the patient is assured [,] and the facility recognizes the project as a bona
2 fide research or statistical undertaking;
3 (5) the Department of Corrections in a case in which a prisoner
4 confined to the state prison is a patient in the state hospital on authorized transfer
5 either by voluntary admission or by court order;
6 (6) a governmental or law enforcement agency when necessary to
7 secure the return of a patient who is on unauthorized absence from a facility where the
8 patient was undergoing evaluation or treatment;
9 (7) a law enforcement agency when there is substantiated concern over
10 imminent danger to the community by a presumed mentally ill person**;**
11 **(8) the department in a case in which services provided under**
12 **AS 47.30.660 - 47.30.915 are paid for, in whole or in part, by the department or in**
13 **which a person has applied for or has received assistance from the department**
14 **for those services**.
15 * **Sec. 5.** AS 47.31 is amended by adding a new section to read:
16 **Sec. 47.31.032. Access to records and information by the department.** The
17 department is authorized to review, obtain, and copy confidential and other records
18 and information about the patients who were eligible for or were provided financial
19 assistance under this chapter to evaluate compliance with this chapter. The
20 department may obtain the records and information from the patient or directly from
21 the evaluation facility or the designated treatment facility. Records obtained by the
22 department under this section are medical records, shall be handled confidentially, and
23 are exempt from public inspection and copying under AS 40.25.110 - 40.25.120.
24 * **Sec. 6.** Section 6, ch. 87, SLA 1999, is amended to read:
25 Sec. 6. AS 47.31.005, 47.31.010, 47.31.015, 47.31.020, 47.31.025, 47.31.030,
26 **47.31.032,** 47.31.035, 47.31.900, and 47.31.990 are repealed.
27 * **Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section to
28 read:
29 DATA FROM PRIOR YEARS. (a) As a condition of receiving state money for state
30 fiscal year 2002 under AS 47.30.520 - 47.30.620, 47.30.660 - 47.30.915, or AS 47.31, the
31 entity eligible for the state money shall agree to furnish the Department of Health and Social

1 Services with confidential and other information about recipients of services paid for, in
2 whole or part, with state money during state fiscal years 2000 and 2001 under AS 47.30.520 -
3 47.30.620, 47.30.660 - 47.30.915, or AS 47.31. The entities governed by this subsection shall
4 comply with regulations of the department regarding the submission of the information
5 required under this subsection.
6 (b) The department may review, obtain, and copy the information submitted under (a)
7 of this section. The department may also obtain information of the type described in (a) of
8 this section from the patient who received the services described in (a) of this section and
9 review or copy that information.
10 (c) Records and information obtained by the department under this section are
11 medical records, shall be handled confidentially, and are exempt from public inspection and
12 copying under AS 40.25.110 - 40.25.120. The records and information may be copied and
13 disclosed under regulations established by the department only under the same circumstances
14 as provided for confidential records under AS 47.30.845, as amended by sec. 4 of this Act.
15 (d) The department may review the information obtained under this section to
16 evaluate compliance with the applicable statutes and grant contracts. However, the
17 department may not use the information furnished under this section to impose civil or
18 administrative penalties for failure to comply with applicable statutes and contracts. The
19 department may use the information to establish a database on which to base future
20 management practices and to impose restrictions and conditions on use of state money in
21 fiscal year 2002 and later.
22 (e) In this section, "department" means the Department of Health and Social Services.
23 * **Sec. 8.** This Act takes effect immediately under AS 01.10.070(c).

Reporting of Confidential Client Data
SB 135

The Division of Mental Health and Developmental Disabilities has had difficulty in its efforts to gather confidential information about clients. Some providers are resistant to reporting data, and to notifying the division of emergent situations when clients are missing, seriously injured or deceased. Some providers claim that they fear potential litigation if they supply confidential information, that reporting would violate client rights to privacy and professional ethics. Some providers are experiencing technical difficulties or may have back-burnered the submission of data. While most providers are cooperative, in-order for the state to insure the health, safety and well being of consumers, it is necessary to strengthen and clarify laws to specify the Departments legal positions on these matters.

The gathering of this data is essential to the division's ability to monitor, make management decisions, meet service needs of Alaskans with mental illness, and to comply with legislative expectations for providing accurate performance measure information. The requirement that providers notify the division of missing, seriously injured, and deceased consumers involves emergent situations, and is consistent with the intent of HIPPA and HCFA.

This bill:

- Gives the Department of Health and Social Services the statutory authority to require that mental health centers that receive state funds report certain confidential client data to the Division of Mental Health and Developmental Disabilities (DMHDD), and comply with regulations regarding such data submission.

- Protects licensed mental health clinicians who report required confidential client data.

- Clarifies that confidential client data are considered to be "confidential medical records" and are not open to the public for inspection or copying.

- Requires that mental health providers notify DHSS of emergency situations involving mental health clients—most other states have these requirements.

- Provides access to confidential information regarding consumers utilizing the Mental Health Treatment Assistance Program and requires confidential handling of that information.

- Protects consumers rights to privacy by insuring that confidential information is used and handled appropriately

- Promotes the health and safety of Alaska's mental health consumers.

RECEIVED

MAR 2 6 2001

ACMHSA

Alaska Community Mental Health Services Association
3050 Fifth Avenue
Ketchikan, Alaska 99901

March 26, 2001

Senator Lyda Green
Capitol Room 125
Juneau, Alaska 99811

Re: SB 135

Dear Senator Green,

The Alaska Community Mental Health Services Association (ACMHSA) supports SB 135 regarding mental health information and records.

ACMHSA is a statewide association representing all of the non-profit mental health providers in the state. We urge you to move this legislation through the Senate HESS Committee you chair.

Sincerely,

Ron Adler
President

Ron Adler, Chair
Brenda Knapp, Treasurer
Pete Braveman, Vice Chair
At-Large: Bill Hogan, Doug Veit
Diana Strzok, Secretary

Phone: (907) 225-4135
FAX: (907) 247-4135
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LETTER OF SUPPORT

Audit Report

DEPARTMENT OF HEALTH AND SOCIAL SERVICES, DIVISIONS OF MEDICAL ASSISTANCE AND MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, COMMUNITY MENTAL HEALTH CENTER PROGRAM, FOLLOW-UP

December 1, 2000

Audit Control Number:

06-4599-01

Division of Legislative Audit

P.O. Box 113300, Juneau, Alaska 99811-3300

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DIVISION OF LEGISLATIVE AUDIT

The Legislative Budget and Audit Committee is a permanent interim committee of the Alaska Legislature. The committee is made up of five senators and five representatives, with one alternate from each legislative chamber. The chairmanship of the committee alternates between the two chambers every legislature.

The committee is responsible for providing the legislature with audits of state government agencies. The programs and activities of state government now cost more than $6 billion a year. As legislators and administrators try increasingly to allocate state revenues effectively and make government work more efficiently, they need information to evaluate the work of governmental agencies. The audit work performed by the Division of Legislative Audit helps provide that information.

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ALASKA STATE LEGISLATURE

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December 1, 2000

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 of the Alaska Statutes, the attached report is submitted for your review.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES,
DIVISIONS OF MEDICAL ASSISTANCE
AND MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES
COMMUNITY MENTAL HEALTH CENTER PROGRAM, FOLLOW-UP,
December 1, 2000

Audit Control Number

06-4599-01

This report addresses a special request by the Legislative Budget and Audit Committee, we reviewed records and interviewed employees and stakeholders within the mental health system to determine the current status of recommendations made in a previous audit: *Department of Health and Social Services, Divisions of Medical Assistance and Mental Health and Developmental Disabilities Community Mental Health Center Program Selected Issues* Audit No. 06-4544-97.

The audit was conducted in accordance with generally accepted government auditing standards. Fieldwork procedures utilized in the course of developing the findings and discussion presented in this report are discussed in the Objectives, Scope, and Methodology section of this report.

Pat Davidson, CPA
Legislative Auditor

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Department of Health and Social Services 57

OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with a Legislative Budget and Audit Committee special request and the provisions of Title 24 of the Alaska Statutes, we conducted a follow-up review of the State's community mental health center program, which is organizationally located in the Department of Health and Social Services (DHSS).

Objectives

The overall objective of this report was to determine the current status of recommendations made in a prior Legislative Audit report, released September 1, 1997 (Audit No. 06-4544-97, *Department of Health and Social Services, Divisions of Medical Assistance and Mental Health and Developmental Disabilities Community Mental Health Center Program Selected Issues).* Specifically, these objectives included the following:

1. Identify and assess agency efforts to contain overall community mental health center costs.
2. Determine the status of managed care implementation.
3. Evaluate changes made to Medicaid mental health regulations and assess the Medicaid rate setting methodology.
4. Assess the effectiveness of the client data collection system.
5. Determine whether service outcome measures have been developed and implemented.
6. Review the Integrated quality assurance program to determine whether it includes non-Medicaid file reviews, consumer satisfaction information, and medial necessity determinations.
7. Determine the status of current and prior potential Medicaid overpayments to providers.

Scope

Due to the follow-up nature of this report, we concentrated primarily on data from the previous three fiscal years FY 98-00. In reviewing programs and interviewing personnel, we attempted to focus on changes that may or may not have occurred since the previous report. Data presented from the timeframe preceding these last three years is the result of the previous audit and is presented here for comparative purposes only.

Methodology

To address the above listed audit objectives, we reviewed the following documents:

- Attorney general opinions and memoranda applic ıble to mental health.

- Alaska statutes and regulations pertaining to Community Mental Health Center (CMHC) Medicaid and grant funding, Division of Mental Health and Developmental Disabilities (DMHDD's) annual community mental health grant budget documents submitted to the governor of FY 97 through FY 00.

- Information related to CMHC grants from the state accounting system.

- Various reports either contracted for or produced by the Alaska Mental Health Board (AMHB) including:

  - *A Shared Vision II.*

  - *Deciding Key Issues Regarding Carve Out v. Carve in: Strategies for Achieving Higher Value and Lower Cost* (Phil Smith and Associates).

  - *Beyond Managed Care (*Phil Smith and Associates).

  - Reports to the Alaska Mental Health Trust Authority Request for Recommendations FYs 99-01.

  - Review of *DMHDD Integrated Quality ance Process* (AMHB Program Evaluation and Review Committee).

  - AMHB Annual Reports FY 98-99.

- Alaska Mental Health Trust Authority (AMHTA) 1999 Annual Report.

- AMHTA Newsletters.

- *The Comprehensive Integrated Mental Health Plan* (DHSS, June 1999).

- *Mental Health: A Report of the Surgeon General*.

- *Comparison of Outpatient Mental Health Reimbursement Systems* (Myers and Stauffer).

- DHSS quality assurance reports and clinical record reviews for selected providers.

- Audited financ tatements for selected providers.

- FY 99 grant documents for selected providers.
- Providing and Documenting Professional Mental Health Services in Alaska's Public Mental Health System, (a training offered by DMHDD's quality assurance unit).

- 1993 Alaska Youth Mental Health Needs Assessment: *A Pilot Study of the Prevalence of Seriously Emotionally Disturbed Youth in Alaska*, (Norman Dinges, Ph.D. University of Alaska Fairbanks).

- *Ahead of the Game: Compliance Strategies for the Behavioral Healthcare Industry* (Mary Thornton).

- Chapter 8, Recommended Stages of Billable Hours Standards from *Service Capacity Enhancement* by David Lloyd.

- Various internal documents, memos, and reports from the divisions of Mental Health and Developmental Disabilities and Medical Assistance.

- Various audit reports from other states related to their divisions of mental health.

- In addition, we attended meetings of both the AMHB and the AMHTA and conducted interviews with the following:

- DHSS management and staff.

- AMHTA and AMHB personnel.

- Personnel of selected CMHCs.

- Several AMHB board members.

- United States Department of Health and Human Services, Health Care Financing staff.

(Intentionally left blank)

ORGANIZATION AND FUNCTION

The mental health services delivery system in Alaska is complex due, in part, to the number of entities that influence the system. These entities include state divisions of various departments, the Alaska Mental Health Board (AMHB), the Alaska Mental Health Trust Authority (AMHTA), the Mental Health Provider's Association And various consumer advocacy groups. The brief descriptions of the following entities are designed to provide the reader with an overview of the functions of each entity. This list is by no means exhaustive and includes only those entities that have the most direct relationships with the state Department of Health and Social Services.

Division of Mental Health and Developmental Disabilities

The Division of Mental Health and Developmental Disabilities (DMHDD) under the Department of Health and Social Services (DHSS) provides services to individuals who experience mental illness and/or developmental disabilities.

DMHDD operates community mental health programs to promote mental health and improve the quality of life of those with a mental illness. These services are provided primarily through grants to community mental health centers and other non-profit and government agencies for a wide range of services.

DMHDD also operates the Alaska Psychiatric Institute, located in Anchorage, to provide psychiatric inpatient care to those individuals whose service needs are beyond the capacity of local community mental health providers.

Division of Medical Assistance

The Division of Medical Assistance (DMA) exists within DHSS to ensure eligible low-income Alaskans have access to needed health care. DMA accomplishes this by operating the state-funded Medicaid program. Medicaid funds mental health services to clients if such services are considered medically necessary.

Division of Family and Youth Services

The Division of Family and Youth Services (DFYS) is mandated to protect children at risk of abuse and neglect. DFYS, DMHDD, and the Department of Education and Early Development work together to administer the Alaska Youth Initiative (AYI) program. AYI provides individualized services to severely emotionally disturbed youth at risk of being placed in highly restrictive, out-of-state treatment facilities.

Alaska Mental Health Board

The Alaska Mental Health Board is the state agency charged with planning and coordinating mental health services funded by the State of Alaska. The AMHB consists of 12 to 16 members appointed by the governor. The AMHB is an advocate for Alaskans with mental illnesses.

Alaska Mental Health Trust Authority

The Alaska Mental Health Trust Authority manages the mental health trust established through the Alaska Mental Health Enabling Act of 1956. AMHTA is responsible for protecting and enhancing the Trust corpus and ensuring the development of a Comprehensive Integrated Mental Health Program in Alaska.

A legal settlement in 1994 reestablished the trust with 1 million acres and a $200 million cash endowment. Income earned from trust land and investments is used to pay for services in the comprehensive integrated mental health program and the cost of managing the trust.

State advisory boards, including the AMHB, exist to represent each of four beneficiary groups. These groups, with their representative boards, are shown in the chart below.

Condition	**Representative Board/Council/Commission**
Mental Illness	Alaska Metal Health Board
Mental retardation or similar disabilities	Governor's Council on Disabilities and Special Education
Chronic alcoholism with psychosis	Advisory Board on Alcoholism and Drug Abuse
Alzheimer's disease or related dementia	Alaska Commission on Aging

These boards plan services for their respective populations and make funding recommendations to AMHTA. From these recommendations, the AMHTA makes funding recommendations to the governor and the legislature for mental health service in Alaska.

BACKGROUND INFORMATION

As described in the Objectives, Scope and Methodology section of this report, this review is designed to follow-up on a previous audit: *Department of Health and Social Services, Divisions of Medical Assistance and Mental Health and Disabilities Community Mental Health Center Program Selected Issues* (Audit No. 06-6544-97), released in December, 1997.

That audit criticized the Department of Health and Social Services (DHSS) over various issues related to the implementation of Medicaid refinancing of mental health costs and the administration of mental health state grants. Areas of specific criticism included Medicaid rates that appeared to be unsupported, the inability of Division of Mental Health and Disabilities (DMHDD's) management information system to capture and report non-Medicaid client information, and a quality assurance process that reviewed only Medicaid cases. As shown in the Findings and Recommendations section of this report, the previous audit also recommended the development of both a managed care system and service delivery performance outcome measures.

Medicaid refinancing to shift costs from state to federal funding increases costs, clients

During FY 93, The Department of Health and Social Services began to shift mental health services that had been primarily funded through general fund grants to federal funding. The Division of Medical Assistance defines this effort, referred to as Medicaid refinancing:

> *Medicaid refinancing means identifying program activities supported solely with State general funds and shifting part of the program's cost to the federal Medicaid program. These cost shifts increase the Medicaid budget but allow the state to collect matching federal funds for these services that were previously funded using only general funds. Every division in the department of Health and Social Services as well as some in other departments benefits fiscally from Medicaid refinancing efforts.*

DMHDD makes grant funding cuts, Medicaid refinancing to make up difference

Medicaid refinancing was initiated through passage of Chapter 38, SLA 1992. Effective July 1, 1992, this legislation expanded optional Medicaid services to include rehabilitation services for chronically mentally ill adults and severely emotionally disturbed children under 21. The bill also restricted eligible providers of these services to DMHDD grantees. From July 1992 through FY 97, when the previous audit was completed, Medicaid costs, as expected, increased significantly. There were, however, some unexpected results of Medicaid refinancing. All areas of the State have not benefited equally from these changes. DHSS has, over the last several years, recognized that Medicaid refinancing has not produced the most effective mental health programs for some rural communities (see Exhibit 1 next page).

Exhibit 1

Effects of Medicaid Refinancing Mixed for Rural Providers

During FY 93, the Department of Health and Social Services began an effort, referred to as Medicaid refinancing, to shift some mental health costs previously funded by general fund grant dollars to federally funded Medicaid programs. In recognition of this additional funding source, the Division of Mental Health and Developmental Disabilities (DMHDD) reduced state grant funding for most providers. The division envisioned that the reductions, which were phased in over the years, would be recaptured through Medicaid reimbursements.

Some rural providers have been able to bill Medicaid as envisioned, resulting in an increase of more than $1million in the overall amount of mental health funding in rural Alaska. Of the CMHCs receiving the largest Medicaid reimbursements, Bethel, Seward, and Sitka have added programs to address needs for children's services, while Wrangell has expanded its existing services through the addition of a clinical staff.

For other rural providers, however, the initial vision has not materialized. Of the 18 rural areas, 15 have absorbed grant-funding cuts over the years between FY 92 and FY 00. Of these, seven have not recaptured the amounts in Medicaid reimbursements. These seven areas, representing catchment areas of more than 18,000 people, have been unable to develop either the community interest in or the technical abilities to bill Medicaid extensively. Some reasons for this are outlined below.

Privacy issues, service delivery model limit Medicaid consumer base in rural areas

Many rural providers have been unable to convince the consumers in their catchment areas to apply for Medicaid funding for mental health services. According to both rural providers and consumers, the reasons for this range from the general stigma attached to both mental illness and Medicaid to the more technical aspects of actually filing Medicaid claims.

The AMHB's guiding document for community mental health service delivery, *A Shared Vision II* comments on these providers' ability to bill Medicaid.

> *In many cases, the pool of Medicaid and third party clients is small in rural communities, which creates a disincentive for pursuing these reimbursement options. In addition, rural programs often lack the personnel resources and administrative infrastructure to capture Medicaid reimbursement, and are reluctant to divert scant existing resources away from direct client services. It is also difficult to receive Medicaid and third party reimbursement for prevention and early intervention efforts, which are perceived as essential in rural communities.*

Rural providers struggle with isolation, burnout, and low levels of support staff

In addition to the consumer base differences noted above, rural programs tend to differ from urban CMHCs in basic living conditions, size of the community, and available resources. The combination of these elements requires rural mental health providers to operate in a manner very different from their city counterparts.

Many rural providers are isolated from colleagues, training opportunities, and other resources available to their urban counterparts. The isolation and the expense of travel limits the opportunities for rural providers to network with other providers or AMHB and DHSS staff. Rural providers often seem less likely to request and receive training from the division's quality assurance section, but more likely to have high non-compliance rates with standards. Rural providers' limited interaction with the division, specifically the quality assurance team, throughout the year may contribute to a reticence on the part of these providers to request such technical assistance. The absence of fellow providers in these areas also reduces the likelihood that rural providers will be able to rely on peers for professional support.

Providers frequently express frustration and concern over the level of burnout among rural clinicians. Because the communities are small and the clinicians are well known, they are essentially always on call. For one-clinician centers, there is little or no relief from consumers. While providers in larger communities generally employ more than one clinician and have available other community resources, clinicians often provide services outside of their official duties because there is no place to refer consumers.

The division has proposed in its FY 02 governor's budget, an increment of $820,900 to ensure that small clinics receive at least $225,000 in grant funds. The proposal, designed to equalize the rural areas at a basic functional level, is based on the estimated costs for each clinic to employ two clinicians along with an effective infrastructure, appropriate clerical staff, and requisite travel funding. The budget request has been submitted to and approved by both the AMHB and the trust for inclusion in the governor's budget.

Grant funding to many providers was reduced in the expectation that those providers would recapture the funding through Medicaid billings but Medicaid refinancing allowed an overall increase in funding for mental health services. Instead of shifting costs from state grant funds into Medicaid funding, many providers saw Medicaid refinancing as an opportunity to expand services. As a result, both the costs and numbers of clients associated with community mental health services increased dramatically from FY 92 to FY 97.

Increases in Alaska's clients and services reflect national trends

Of the mental health services for Medicaid clients, children's services have grown the most. Community mental health services for children in Alaska, as in many states, have historically been very limited. When Medicaid refinancing allowed some providers to expand services, many chose to increase accessibility to children's services. This growth is most apparent in the Medicaid service category activity therapy (see Appendix A), which increased substantially in both cost ands clients from FY 94 to FY 99 before beginning to level off.

According to the surgeon general's report on mental health, approximately one in five children and adolescents experience the signs and symptoms of a DSM-IV[1] disorder during the course of a year. The report also comments that states have only recently realized that children have mental health needs distinct from those of adults. As in Alaska, this realization has led to a recent growth in these types of services in many states.

Separate recording methods for grant and Medicaid funding complicate accountability

The dramatic increases in overall mental health costs amplified the need for accountability for them. Accounting for total costs, however, is complicated by differences between grant funding and Medicaid funding. While federally required Medicaid client and funding information is captured in the Medicaid Management Information System (MMIS), state grant funding information is accumulated in the Alaska Recipient Outcome Research Application (ARORA), a state system separate from MMIS. Though ARORA is apparently capable of storing and summarizing client and expenditure data, the division has been unable to collect such data (see Recommendation No. 4).

In addition to segregated data capture systems, the funding process is also complicated by differences in how the funding is allocated. Grant funding is based on grant awards, generally to pre-existing providers, for certain broad service categories (see Exhibit 2).

In general, providers receive quarterly installments on their annually allocated grant funds. While providers are required to submit quarterly financial statements, these statements do not account for expenditures by clients, instead amounts spent are listed by category only. In contrast, Medicaid reimbursements are on a fee-for-service basis, which requires a specific client and a specific service to be reimbursed.

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[1] The DSM-IV is the Diagnostic and Statistical Manual, Version 4. The manual provides a listing of diagnostic codes for mental illnesses and is used as a standard guide by mental health professionals in the United States.

Exhibit 2

Community Mental Health Grant Services

Services to the Chronically Mentally Ill – a comprehensive network of outpatient and residential services that provide treatment, rehabilitation, support, and residential services for adults with severe mental illness.

Services to Emotionally Disturbed Youth – funding for case management, children's day treatment, outreach, and home-based therapy, residential services, individual and family therapy, and other support services for youth with a severe emotional disturbance as well as those who are at risk of becoming severely emotionally disturbed.

General Community Mental Health Grants – assessment and treatment of persons experiencing depression, suicidal ideation or behavior, or other serious, but generally not persistent or disabling, individual family or psychiatric dysfunction.

Designated Evaluation and Treatment – provides funding for psychiatric evaluation and treatment services at local community hospitals.

Psychiatric Emergency Services – provides funding to aid person in psychiatric crisis. Services include crisis intervention, respite and brief therapeutic intervention to help stabilize the client. Also funds crisis/respite services.

However, as the previous auditors noted, the cost increases between FY 92 and FY 97 climbed by about 348%, far outpacing the number of clients, who had grown by only about 37%. The unexpected magnitude of these cost increases caused DHSS to take several steps to contain costs related to community mental health centers. These steps included contracting for studies on managed care, the implementation of a prior authorization program for mental health services, and a revised quality assurance process.

Managed care studies, steering committee make cost containment recommendations

Managed care is a system of financing and organizing service delivery to influence utilization and costs of services. The goal of managed care is to maximize access and quality while containing costs. Managed care processes for mental health services have been implemented in many lower 48 states. These efforts have met with varying degrees of success, with many states unhappy with the effects on access and quality of care. Alaska's DHSS has also considered managed care options.

In September 1997, the AMHB issued a report titled *Deciding Key Issues Regarding Carve Out Versus Carve In: Strategies for Achieving Higher Value and Lower Cost.* In a traditional managed care environment, a managed care organization functions as a contractual intermediary between the payer and provider. The report, which concluded fee-for-service reimbursement is not effective in achieving the goals of increasing access, quality, and cost management, recommended that Medicaid funded mental health care be included in a managed care contract agreement. The report also recommended DHSS contract directly with providers rather than through an intermediary.

A second report released in April 1998, *Beyond Managed Care* studied the issue further and made recommendations outside of the conventional managed care realm. The *Beyond Managed Care* report, like its predecessor, also recommended against using an intermediary:

In a public mental health system that has been in existence less than 40 years and that does not have the resources to address all unmet and undermet need, the costs for using intermediaries are insupportable in two ways. First, funding for intermediaries reduce funding for vital services. Second, human resources for operating intermediaries are diverted from the already limited workforce available to provide mental health care.

The report instead supported a "capacity building" approach. Under this approach, the intermediary is eliminated and direct risk-sharing relationships between the payer and providers are established.

The *Beyond Managed Care* report also listed several infrastructure requirements of an effective managed care or beyond managed care program. At the time of the report, not all of these elements were in place. Key among the requirements were the following:

1. *The use of quality assurance to track high profile diagnoses and to develop programs for improving the quality of care. This recommendation also included a comment that QA reviews should be made available to consumers and providers.*
2. *A program for consumer satisfaction established by the State and passed down through the providers.*
3. *Further analysis of the DMHDD MIS system, once operational, to determine the actual performance of the system.*

Exhibit 3

***Beyond Managed Care* Framework for Recommendations:**

Each recommendation in the *Beyond Managed Care* report was developed within the context of the following acknowledgements of Alaska's unique circumstances:

1. Acknowledge the significant range of experience that CMHC's and other DMHDD grantees have in managing financial risks.
2. Acknowledge the range of skills and attitudes that mental health workers have about managing clinical and financial risks.
3. Recognize that some areas of the state have very little experience in generating Medicaid revenues.
4. Affirm the cultural characteristics and diversity within each region, and the value that different cultures bring to the mental health system.
5. Recognize that the per capita fiscal and human resources for public mental health care varies significantly across regions of the State, and bringing all regions up to the level of the most adequately funded regions will require an annual increase of several million dollars.

In addition to the above infrastructure requirements, the report also noted that the task to improve care and control costs in a state as "*unique, large, and diverse as Alaska*" is an ambitious one.

A Managed Care Steering Committee was created in September 1997 to examine managed care principles and potential tools to alleviate quality of care and cost concerns within Alaska's mental health delivery system. The committee included consumers, providers, advocates, and various state agency representatives. Initially, the steering committee was charged with overseeing DHSS' prior authorization attempt and the two managed care studies described above.

After the reports were complete, the steering committee advocated a beyond managed care framework and endorsed most of the initiatives suggested in that report. A November 1998 report to the trust from the steering committee accomplished three objectives. The report:

1. Defined the elements of a unified mental health care system.

2. Provided guiding principles for the development of such a system.

3. Outlined specific actions to help develop a cost-effective, unified mental health care system in Alaska.

<u>DHSS implements, rejects prior authorization</u>
In an effort to manage utilization of Medicaid services, the Division of Medical Assistance (DMA) contracted with First Mental Health of Tennessee to implement prior authorization. Services subject to prior authorization included outpatient services that exceeded regulatory limits and inpatient services, which were already covered in a previous contract. To obtain prior authorization, providers were required to submit client data with a request for services. The contractor reviewed the materials and approved or denied requests based upon the determined need for services.

Due to complaints from providers and consumers and DMHDD's concern that harmful delays in service were occurring, the reviews of outpatient services were cancelled in January 1998, less than three months after the contract was initiated. Currently, independent reviews for inpatient services continue to exist, but reviews of intensive rehabilitation and children's services that exceed regulatory limits are determined wholly by an interdisciplinary team. The team consists of caregivers and mental health professionals.

<u>DMHDD replaces MIS but continues to struggle with data management</u>
DMHDD discontinued using a previous management information system in exchange for the Alaska Recipient Outcome Research Application (ARORA) beginning in FY 98. Though ARORA is apparently capable of storing and summarizing data, efforts to obtain comprehensive client data have been unsuccessful. Some of the problems with data are related to the system implementation, while others (discussed in the Report Conclusions section) are associated with more recent developments.

During the planning phase of ARORA, DMHDD opted to allow grantees to choose their own software to report to ARORA. For providers intending to report electronically, this

meant finding an MIS vendor to develop either ARORA compatible software or modify their existing systems. Though at least 39 providers committed in writing to implementing an automated information system before FY 98[2], many of these endeavors have been unsuccessful. Many providers still do not have a system capable of reporting under ARORA. Some providers have essentially abandoned efforts of trying to persuade their MIS vendor to fully resolve various technical problems that preclude regular and accurate data submission. Many of these providers assert they do not have the personnel resources to complete the volumes of forms required by alternative paper submission.

Various mental health entities collaborate for *A Shared Vision II*

In the previous audit report, the auditors commented that the *"planning and decision making of the State's community mental health program is often fragmented and lacking guidance."* Considering the complexity of the mental health delivery system in the State, this is not a surprising observation. Key players in this system include the Alaska Mental Health Board, the Alaska Mental Health Trust Authority (the trust), DMHDD, and the Division of Medical Assistance (DMA). In addition to these state entities, many advocacy groups and the mental health provider's association participate in the decision-making process.

Since the previous audit, the mental health delivery system appears to have become both more focused and more cohesive. The shared perspectives of each of the participating entities is set out in a document published by the AMHB in early 1999: *A Shared Vision II, The Alaska Mental Health Strategic Plan 1999-2003.*

In 1991, the AMHB began a strategic planning process focusing on improving the statewide mental health system with an emphasis on strengthening community based services. This planning resulted in the 1991 document *A Shared Vision: The Alaska Mental Health Strategic Plan for the 90s.* In January 1999, the AMHB published an updated version of the strategic plan: *A Shared Vision II, The Alaska Mental Health Strategic Plan 1999-2003.*

Representatives from DMHDD, DMA, AMHB, the Trust, as well as from other state and private entities participated in drafting the new four-year plan. In addition to discussing each of type of service, its current status and objectives for the next four years, the document also listed ten guiding principles (see exhibit 4, next page). These principles were designed to support the mission of *A Shared Vision II*, which was *"To establish a service and advocacy plan which maximizes the ability of mental health consumers to lead positive and productive lives within our society."*

[2] In exchange for this commitment, DMHDD provided $700,000 in additional funds to these providers to procure hardware and software.

The guiding principles have helped stakeholders to identify shared principles and to develop a more unified approach to addressing mental health issues. While DMHDD, AMHB, and the trust continue to operate as separate entities, these three key players have, by all reports, significantly improved cooperation and communication over the last few years.

Exhibit 4

Guiding Principles for the Mental Health System under *A Shared Vision II*

1. Consumer Centered Services: Mental health consumers have a primary role in defining their individualized needs and have choices among services which address those needs.

2. Consumer Rights: Respect for consumer dignity and rights, including confidentiality and the unique cultural framework for each consumer, underlies all services.

3. Consumer Directed Policy Development: Consumers are actively involved in shaping policies and laws affecting persons experiencing mental illnesses.

4. Comprehensive System: Services which address fundamental life needs--such as housing, employment, education, health care, and transportation--are included in addition to comprehensive mental health services.

5. Integrative/Collaborative System: Consumers, family members, advocates, providers and government agencies work in partnership to integrate diverse services and minimize service barriers.

6. Strengths Perspective: Services incorporate and build upon the strengths of consumers, family members, friends and natural community supports.

7. Home and Community Focus: Services are provided as close to the consumer's home and community as possible, and local communities stake active ownership in providing needed and least restrictive services.

8. Preventive Services: An emphasis on prevention and early intervention helps reduce the need for more intensive, crisis oriented services.

9. Outcome Based System: Consumer satisfaction and other measurable outcomes help define "success" and promote accountability for service providers.

10. Cost Effectiveness: Services are effectively managed to maximize resources, promote efficiency and minimize duplication.

System becomes more consumer-centered, DMHDD adds consumer affairs position

The previous audit report commented on the apparent lack of consumer involvement in the division, and AMHB policy decisions. Both the auditors and the division viewed this as a weakness in the mental health delivery system. Since that audit, the AMHB and the division have placed more emphasis on consumer input and feedback. An AMHB representative comments that the mental health delivery system has become much more consumer-centered than provider-centered. One of the indications of a new concentration on consumers is the trust's funding for a consumer affairs position within DMHDD.

During FY 99, the division, with funding from the trust, began efforts to establish a consumer affairs position as a senior DMHDD staff member. The position description, outlines the goals of the position as follows:

> *...to increase the inclusion of consumers' perspective into the State's decision making process regarding mental health issues and to maintain a balance between access to internal policy making and external*

accountability. As a senior DMHDD staff member the position ensures ongoing access to the State's policy making process; facilitates interaction with statewide consumer organizations; ensures greater leadership by consumers in planning and implementing system changes; and provides expertise as a consumer consultant to senior management in all aspects of planning, development, coordination, monitoring and evaluation of mental health programs and services for all populations.

Due to a hiring freeze and various other complications, the position was not actually filled until November 1999. Since that time, the staff member has participated in quality assurance on-site visits, the development of standards for CMHCs, administration of funding for trust mini-grants, hiring mental health regional coordinators, and attends meetings of the trust and the AMHB. In addition, she is in constant contact with consumers, consumers' families, and advocacy groups. She has become an integral part of the organization and views her role as the one charged with reminding the various committees, boards, and administrators to consider the consumer in all policy decisions.

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REPORT CONCLUSIONS

Over the last three years, the Department of Health and Social Services (DHSS) has made several specific efforts toward controlling costs for community mental health programs, clarifying programmatic ambiguities, and educating mental health care providers. The results of some of these efforts are measurable in an overall reduction of cost per client in Medicaid funding. Though DHSS has realized successes in cost containment efforts, the full impact of revised policies and increased technical assistance on costs or programs can not be calculated due to continuing problems with data collection for state grant funding. Efforts made by DHSS to address previous recommendations are discussed below and in the Findings and Recommendations section.

Medicaid costs per client decrease, state grant costs per client remain unavailable

The previous audit noted steep increases in Medicaid costs over fiscal years 93 through 97. Since that time, these costs have leveled out and, in some cases, decreased. As illustrated in Exhibit 5 and 6 below, Medicaid mental health costs per client have decreased slightly in each fiscal year since FY 97, resulting in an overall 15% reduction when compared to costs per client in FY 97. Since that time, the number of clients has increased by 21% with only a 3% increase in total costs.

Medicaid receipts have comprised about 57% of the funding for community mental health centers (CMHCs) over the last three years. The reduction in Medicaid costs on a per client basis appears to be the result of several cost containment efforts since the prior audit. One of the most effective cost containment efforts was the establishment of the integrated quality assurance review process and related technical assistance. This process is discussed in more detail below and in Recommendation No. 6.

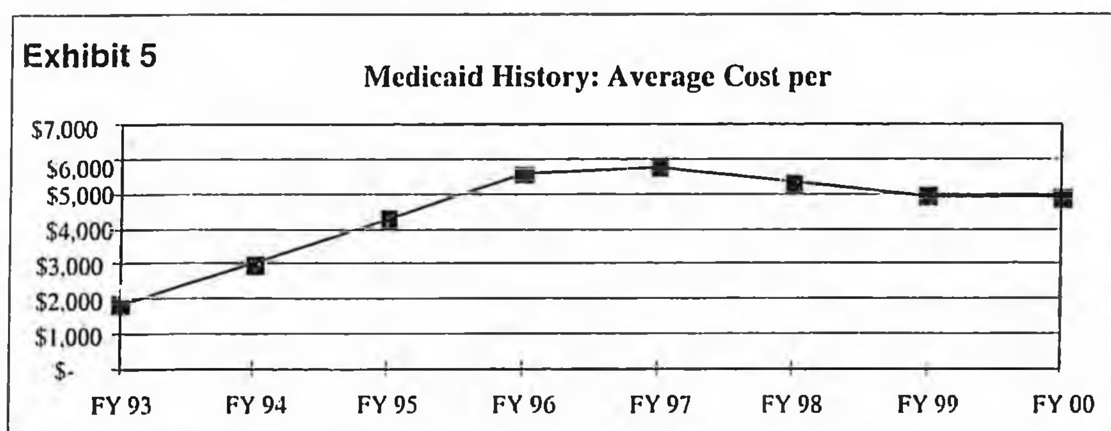


Exhibit 6

Fiscal Year	Medicaid Payments	Number of Clients	Cost Per Client
93	$ 6,883,879	3,721	1,850
94	13,176,224	4,406	2,991
95	20,422,901	4,756	4,294
96	27,363,382	4,905	5,579
97	33,635,127	5,822	5,777
98	33,589,581	6,307	5,326
99	33,657,958	6,798	4,951
00	34,636,087	7,058	4,907

The remaining 43% of CMHC funding is allocated by the Division of Mental Health and Developmental Disabilities (DMHDD) through a state grant process. Since FY 97, the total amount of the state grant has remained essentially level, with only small increases or decreases in each year.

Due to data capture difficulties, no expenditure amount per non-Medicaid client calculation is available. While federally required Medicaid client and funding information is captured in the Medicaid Management Information System (MMIS), state grant funding information is accumulated in the Alaska Recipient Outcome Research Application (ARORA), a state system separate from MMIS. Though ARORA is apparently capable of storing and summarizing client and expenditure data, the division has been unable to collect such data (see Recommendation No. 4).

The prior audit noted that, without adequate client information from both the Medicaid and the state grant systems, it would be possible to bill services for one client to both systems. Due to the data difficulties outlined below, a possibility remains that some services may be reimbursed by both the state grant and by Medicaid. However, the implementation of comprehensive quality control reviews and some provider's accounting structures have limited this opportunity.

<u>Data collection efforts hindered by providers and technical difficulties</u>
As discussed in the Background Information section, many small providers claim to have neither the technology nor the staff to submit timely comprehensive reports. Many CMHCs are small, with only a few staff and high turnover rates. For these clinics, data submission is low on the list of priorities and if done at all, is often not timely or complete. Though DMHDD added a requirement to all community mental health center grants issued after FY 97 for CMHS to submit individual client data, some still do not comply with the requirement.

The DMHDD information services section is in frequent contact with providers regarding data submissions or lack thereof. Non-compliant providers also receive periodic letters from the division director reminding them of the state grant reporting requirements. Some providers receiving these letters have attempted to comply, while

others openly admit that it is a low priority for them. The latter group emphasizes their belief that actual direct service provision is more important than the associated paperwork. The division has been reluctant to force compliance through financial sanctions due to concerns about impacts on client services.

Quality of ARORA data submitted, lack of edit checks, makes reliability questionable

In addition to grantees that fail to report, the quality of data that is submitted is sometimes substandard. For data submitted to and accepted for ARORA inclusion as of September 11, 2000, 15% of total discharge records did not have the required admission record association; 14.4% of consumer contact or status records could not be associated with a required episode of care. ARORA data submissions must pass only a minimum of edit checks. Many of these errors are not detected until they accumulate to a level that is noticeable. When information services does detect an accumulation of a certain type of errors, the errors sometimes involve reports that are several months old. Grantees report that DMHDD has occasionally required providers to correct more than a year of data submissions at one time.

Even providers that do submit data complain that it is a labor-intensive process for which they see little result. Some who regularly report to the ARORA system note that DMHDD does not provide meaningful feedback concerning the data they report, and comment that the number of clients or encounters for given periods of time would be useful managerial information. The absence of data feedback for use in decision making has been characterized as a disincentive for investing the staff time to maintain compliance.

Lawsuit further complicates data issues

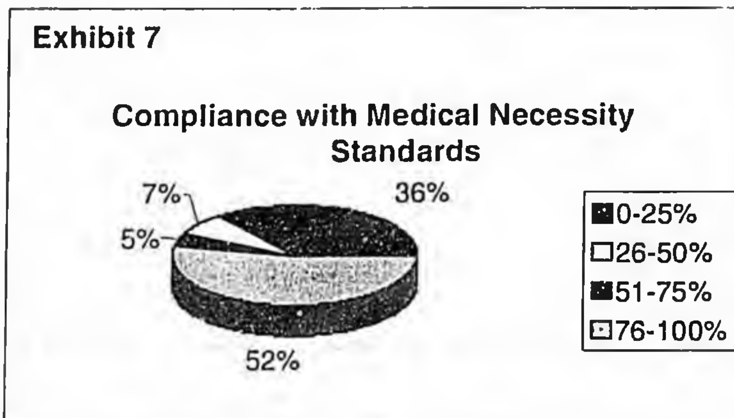
As a further complication to the data issue, one large provider filed a lawsuit to prevent the division from collecting client information in an ostensible effort to protect client confidentiality rights. Fairbanks Community Mental Health Center (FCMHC) filed suit against the state, alleging DMHDD does not have the authority to collect data under the ARORA system. One complaint revolves around the potential identification of clients using ARORA consumer algorithms. The lawsuit remains a challenge to the authority of the state to collect comprehensive client information. Currently, FCMHC submits data to the ARORA system, but double encrypts their consumer algorithms. DMHDD accepts the data although double encryption prevents the division from having accurate data pertaining to clients receiving services from multiple grantees.

Funding decisions limited by lack of complete client data

Because the division has been unable to collect comprehensive client information, annual funding decisions have not typically been based on actual client data. Instead, funding decisions are made based on a combination of anecdotal information and national prevalence data. Sources for data include public testimony at Alaska Mental Health Board and trust meetings, advocacy agencies, regional coordinators, and consumer satisfaction surveys. In addition to anecdotal information, funding decisions are based on a combination of national mental health prevalence data with periodic adjustments to maintain CMHCs at minimum acceptable service levels. While these

sources of information provide a context in which to review client data, the information is not an adequate substitute for comprehensive client information (See Recommendation No. 4).

As discussed in the Background Information section, DMHDD substantially revised the quality assurance review process in FY 99. The reviews were expanded to integrate a consumer satisfaction element as well as the clinical records review. Beginning with the new integrated review, a new emphasis in the event audit[3] was placed on both the medical necessity[4] of services provided and on active treatment. The quality assurance team has, over the last two fiscal years, reviewed nearly every community mental health services provider funded by the State. The quality assurance unit has now summarized the results of these reviews and is able to identify specific standards and certain regions of the State in which compliance is low.



Discussions between reviewers and providers during the course of quality assurance reviews have afforded providers the opportunity for feedback and assistance in interpreting medical necessity documentation requirements. However, the quality assurance review has not yet been used to its full potential. Due to staffing levels and the time commitment involved in performing reviews, the quality assurance unit has been unable to follow-up with all providers needing additional assistance. Given these finite resources, the quality assurance section has focused its main technical assistance efforts on providers with the larger Medicaid reimbursements.

Overall standards compliance rates by provider range from 16% to 100%. This wide range suggests very different levels of understanding or acceptance of the medical necessity standards across the State. As shown in Exhibit 7 above, though compliance rates and resultant training requirements vary across the state, compliance rates are concentrated at the higher levels, which results in an overall statewide compliance rate of 73.3%.

[3] An event audit consists of comparing Medicaid billing data with the clinical record to determine if the services billed to Medicaid were rendered.

[4] Medical necessity is a federal requirement for payment of mental health services. Medical necessity is determined through reviews of client assessments, treatment plans, progress notes and treatment plan reviews. Files for both Medicaid and state grant clients are reviewed for medical necessity.

In general, providers located in or near Anchorage, where the quality assurance offices are located, have the highest compliance scores. This suggests that the availability of technical assistance has helped these providers to comply with regulations. While providers in and near Anchorage seem to have benefited from the proximity of technical assistance, providers in more rural areas have had more difficulties with the regulations pertaining to medical necessity.

Many rural providers appear to be less likely than their urban counterparts to request and receive training from the division's quality assurance section. Rural providers' limited interaction with the division, specifically the quality assurance team, throughout the year may contribute to a reticence on the part of these providers to request such technical assistance. Rural providers, who typically have smaller staffs than urban facilities, also have larger staff turnover rates and smaller applicant pools than other facilities. This combination of personnel concerns and distance from the quality assurance office puts rural providers at higher risk of non-compliance with medical necessity standards.

For Medicaid cases, noncompliance with the regulations has resulted in the quality assurance unit referring questioned costs to the Division of Medical Assistance (DMA) for further investigation (see Recommendations No. 7 and 8). Though, in general, providers with the lowest compliance rates bill Medicaid the least, continued noncompliance with federal requirements for Medicaid reimbursement could result in a liability for the State.

Quality Assurance refers potential overpayment cases to DMA, review is delayed

Quality assurance site reviews conducted during FY 99-00 included event audits that compared Medicaid billing data with the clinical record to determine if the services reimbursed were provided. From these event audits, quality assurance has identified $181,547 in claims that require additional review to determine whether they are actually reimbursable. The costs questioned by quality assurance are referred to DMA for further investigation and determination regarding actual overpayment amounts. DMA has delayed reviewing these questioned costs until questioned cost issues identified in previous reviews have been settled. This situation is discussed further in Recommendation No. 8.

DMHDD measures outcomes as directed by statute, develops broader indicators

The legislature, in conjunction with DHSS, has developed three specific outcome measures related to the mental health section of the division. These measures and their outcomes are shown on the following page. When the legislative committee met with the division staff to develop these performance measures, DMHDD was working in conjunction with the AMHB, providers, and consumers to develop a more comprehensive set of performance measures. The legislative committee informally agreed that when these measures were completed, they would replace the legislative measures to provide a broader look at mental health outcomes.

The legislative measures and the related results for FY 00, according to DMHDD, are as follows:

1. **Increase the percentage of mental health consumers who show improved functioning as a result of the services.** Based on the results of Global Assessment of Functioning (GAF)[5] scores from admission to discharge or most current reassessment in FY 00, 20% of consumers had improved, 69% were stable, and 11% actually scored lower on the GAF.

   According to the 1999 AMHB Annual Report, about 3,900 of the estimated 22,000 (approximately 18%) CMHC consumers in 1998 were chronically mentally ill. For these consumers, significant improvements in functioning are not anticipated. Instead, they are on maintenance programs and treatment is considered successful if these consumers are relatively stable over extended periods of time.

   The quantity and quality of data currently available through the ARORA system limit the reliability of the results for this measure.

2. **Increase percentage of mental health and developmental disabilities provider programs reviewed for consumer satisfaction to at least 50%.** During FY 99, 49% mental health providers were reviewed. During FY 00, 56% of the mental health providers were reviewed.

3. **Decrease the average number of publicly funded psychiatric hospital days used per hospitalized person.** During FY 99, the average stay at API was 12.83 days. In FY 00, average stay was 10.25 days.

DMHDD has worked extensively with providers, consumers, and the AMHB to develop an array of outcome measures far more comprehensive than those currently required by statute. These proposed measures include the areas of access to care, appropriateness and quality of care, consumer outcomes, and management structure. These measures will soon be piloted with several community mental health centers in an effort to identify systemic barriers to data collection and any required modifications to the assessment tool. As information for the pilot project will be collected through a manual process rather than through the troubled ARORA system, systemic barriers are not expected to include the ability of providers to submit data.

Medicaid regulation revision project eliminates some service categories, changes rates

The previous audit raised several concerns related to Medicaid re ulations. The auditors were particularly critical of the rates and the rate setting metho logy. They also noted that service descriptions were difficult to decipher. Since the previous audit, DHSS has taken steps to address these concerns. The combination of a Medicaid rate study, the

[5] The Global Assessment of Functioning (GAF) is a series of questions asked of a consumer to quantify the consumer's level of functioning at a given point in time. Consumer reassessments using the GAF are done approximately every three to six months. Most mental health services offered under Medicaid require a GAF score of 50 or lower.

documentation of the department's rate setting methodology, and expanded training efforts have all contributed to improvements in Medicaid billings documentation.

In recognition that some sections of the original Medicaid mental health regulations should be amended, DHSS began a comprehensive revision project in late 1997. This process, due to the inclusion of public testimony and extensive rewrites based on that testimony was more lengthy than originally planned. DHSS has now, after two public comment periods, readopted the regulations and filed them with the Lieutenant Governor. In a readoption notice on DMA's web site, the division discusses how the new regulations will be handled:

> *Although the regulations become effective on November 1, 2000, the department intends to provide several months for enrolled providers to transition client treatment plans from the "old" services to the "new." The Division of Mental Health and Developmental Disabilities will be providing technical assistance to enrolled providers during the transition.*

The new regulations include clarification of terminology, the elimination and addition of certain service categories, and new rates. The once elusive "medical necessity" requirement, historically a source of complaint from many providers, is now defined in several areas. The regulations now also emphasize the necessity of active treatment, clarify documentation requirements, and ensure that rates reflect the costs of providing services. An extensive discussion of the elements to be considered in quality assurance reviews of clinical records is also included. In an effort to more closely tie service descriptions to actual services, several service descriptions have been changed. The effort to tie service descriptions to actual services resulted in a transition to more active treatment descriptions and services.

DHSS studies Medicaid rates and documents rate setting methodology

DHSS has substantially revised the Medicaid regulations, including some of the rates, in an effort to more clearly define allowable services and more closely align rates with the costs of services provided. In addition to revising the Medicaid rates, DHSS has also documented the rate setting methodology. This methodology, based on the average costs of providing mental health services across the state, is supported by an abbreviated cost study of several providers.

Among the amended service categories is the former activity therapy, now termed group skill development services. As the new name implies, the treatment expectations have been elevated to include specific skills development through active treatment in group settings. In addition to changing the name of these services, the regulations have clarified documentation requirements, defined a client to clinician ratio, and reduced the payment rate from $45 per hour to $30 per hour.

Aside from activity therapy, the new regulations provide for small increases in a few of the rates. These increases, generally no more than $5 per hour of service, were based primarily on increases in salaries since the original rates were designed. One notable exception was a $125 increase in the rate for a psychiatric assessment, originally $105, now set at $230. According to DHSS personnel, this rate was originally far less than the cost of service and is now more in line with current costs.

Overall improvements don't mitigate the need for comprehensive client data

While we recognize that DHSS has improved significantly in most of the areas of concern noted in the previous audit, client data collection remains an unresolved issue. As noted in the Findings and Recommendations section of this report, we believe this data is essential for effective funding and programmatic decision-making related to community mental health centers. The department reportedly now has a data system capable of producing comprehensive client information, yet for various reasons discussed above, has been unable to collect data from providers.

DHSS has, over the last three years, attempted to work cooperatively with the providers that will not or cannot supply the data required to meet their grant conditions. The department has been reluctant to impose financial sanctions or take any action that may be viewed as punitive. Though a cooperative relationship is optimal, this method has enjoyed little success over the last three years. With the restructuring of DMHDD's information systems section, the division has an opportunity to focus more attention on this lingering problem. Accordingly, we strongly encourage DMHDD to take prompt action to resolve outstanding data issues.

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Original Recommendation	Degree of Implementation			
	None	Limited Progress	Significant Progress	Full
1. The commissioner of the Department of Health and Social Services (DHSS) should gain immediate cost and program control of state community mental health center funding.	Recommendation No. 1 from the previous audit was an umbrella recommendation encompassing overall accountability concerns developed in more detail in other recommendations.			
2. We recommend the directors of DMA and DMHDD continue to pursue development of managed care to achieve long-term cost containment while maintaining accessible and effective mental health services.		X[6]		
3. (A)The Directors of DMHDD and DMA should revise the State's Medicaid mental health regulations to clearly define eligible services.				X
(B) The Directors of DMHDD and DMA should ensure Medicaid mental health rates are reasonable.				X
4. DMHDD should obtain client service data to enable effective management of the State's community mental health programs.		X		
5. DMHDD should develop meaningful outcome measures.			X	
(B) DMHDD should collect meaningful outcome data to determine effectiveness of services provided by public community mental health funding.		X		
6. The commissioner of DHSS should improve the reviews of community mental health center clinical records and billings.				X
7. DHSS should consult the Department of Law regarding appropriate recoupment of payments to mental health providers.				X

[6] DHSS, in conjunction with the Alaska Mental Health Board and the Trust decided not to pursue managed care options. This decision was made based on the recommendations of the managed care steering committee and the report *Beyond Managed Care*

FINDINGS AND RECOMMENDATIONS

This section describes the current status of each of the seven recommendations from the previous audit report. In addition to those seven recommendations, a new recommendation, No. 8, is presented as a part of this review.

Three of the seven recommendations (Recommendation Nos. 1,4, and 5) from the previous audit report are linked to Division of Mental Health and Developmental Disabilities (DMHDD's) inability to collect comprehensive client specific data. Though providers have been required since their FY 97 grants to collect and submit such data, most providers are not in complete compliance with the grant requirements. Full implementation of Prior Recommendation No. 4 will significantly improve the division's progress toward satisfying all of the previous recommendations.

Recommendation No. 1 from the previous audit was an umbrella recommendation encompassing overall accountability concerns developed in more detail in other recommendations. The primary elements of this recommendation are reiterated in Recommendation Nos. 3 through 5. Accordingly, Legislative Audit's current position on Prior Recommendation No. 1 is described in the follow-up on those recommendations.

Prior Recommendation No. 2

We recommend the directors of Division of Medical Assistance (DMA) and DMHDD continue to pursue development of managed care to achieve long-term cost containment while maintaining accessible and effective mental health services.

Due to the rise in mental health expenditures identified between FY 92 and FY 97, we believe DMA and DMHDD should strongly consider a complete overhaul of Alaska's public community mental health program through implementation of a managed care delivery environment.

Current Status of Prior Recommendation

The Department of Health and Social Services (DHSS), in conjunction with the Alaska Mental Health Board (AMHB) and the Alaska Mental Health Trust Authority (the trust), has decided not to pursue many of the traditional managed care mechanisms. A managed care steering committee was created to examine managed care principles and potential tools to alleviate quality of care and cost concerns within Alaska's mental health delivery system. Based on the many negative experiences of other states and Alaska's own experience with prior authorization, the committee decided against some traditional managed care principles. The committee then contracted with Phil Smith and Associates Goodrick and Goodrick to study Alaska's community mental health delivery system to identify how to improve care and control costs. The report, *Beyond Managed Care*, was issued in April 1998. Based on that report, the steering committee advocated several initiatives that are currently underway.

Some of the initiatives considered necessary in either a managed care or "beyond managed care" environment include establishing consumer satisfaction mechanisms, defining measurable outcomes and enhancing information system capabilities. Information system difficulties notwithstanding (see Recommendation No. 4), the division has made significant progress in addressing these initiatives. The division has also implemented a strong quality assurance review and changed Medicaid regulations to more clearly define services and align costs of services with Medicaid rates. Progress on consumer satisfaction within the quality assurance section and outcome measurements is discussed in Recommendation Nos. 5 and 6 respectively.

Legislative Audit's Current Position

Based on the results of the *Beyond Managed Care* study and the current trends of Medicaid costs per client, we believe the agency has appropriately adopted necessary cost containment measures. We encourage DHSS to continue efforts to support these measures with a fully functioning management information system.

Prior Recommendation No. 3

The directors of DMHDD and DMA should revise the State's Medicaid mental health regulations to clearly define eligible services. In addition, they should ensure Medicaid mental health rates are reasonable.

We believe the nature of Medicaid mental health regulations has made a significant contribution to the rapid escalation of mental health costs. Service allowability requirements are not clear and rates appear to exceed cost reimbursement for many services. In addition to the inherent unenforceable nature of weak regulations, this ambiguity has caused inefficiencies across the community mental health system including excessive billings, provider billing abuse, and frustration across the provider community.

We found the Medicaid mental health regulations to be confusing at best. The Medicaid Fraud Unit within the Department of Law also finds the regulations vague, weak, and ineffective. A letter written by DMHDD personnel in 1996 attempting to clarify issues surrounding certain Medicaid services indicates that there is not a consensus within DHSS regarding how certain Medicaid services should be delivered.

Most providers we interviewed also believe the regulations are very difficult to interpret and further believe that DMHDD has not provided adequate technical support to aid their understanding. Specifically, they state their frustration stems from not knowing what services are allowable and what documentation requirements are necessary to validate Medicaid billings. Some personnel note that their frustration has been exacerbated by untimely quality assurance and subsequent clinical record reviews which have resulted in payback requests from DHSS. Some of the questioned costs relate to documentation problems which certain providers feel have never been made clear.

Current Status of Prior Recommendation

The rate setting methodology, now fully documented, bases the various rates on the costs of the personnel providing specific mental health services. Though the calculated rates were based on estimates, an abbreviated cost study[7] has shown that the estimates are materially supported by actual expenditure data.

The previous audit also identified the combination of vague service descriptions in the regulations and limited technical assistance from the divisions as problematic. As discussed above, the expansion of the quality assurance program to include technical assistance has helped to alleviate some of the confusion in Medicaid service descriptions and clarify file documentation requirements.

Activity therapy was one of the more ambiguous service categories that, by FY 97, had shown steep cost increases. Accordingly, this category was of particular concern to both the auditors and the division. After the previous audit, the division made an effort to emphasize active treatment and required thorough documentation for activity therapy. The costs per client for this service have decreased by more than 19% since FY 97.

Legislative Audit's Current Position

As a result of the above actions, we believe the agency has fully implemented prior Recommendation No. 3. We encourage DHSS to continue with plans to fully train providers on the new regulations and to periodically review the regulations and the associated rates to ensure that they remain reasonable.

Prior Recommendation No. 4

DMHDD should obtain client service data to enable effective management of the State's community mental health programs.

Currently, the lack of client service data renders DMHDD unable to determine if community mental health funding is appropriate. No reliable data currently exists which accurately reflects the total number of clients annually receiving publicly funded community mental health services. While the Medicaid payment system does collect the number of clients served through Medicaid, major deficiencies exist in DMHDD's data collection concerning clients served by state grant funds.

DMHDD has collected selective mental health client data from providers for many years using a management information system (MIS). However, the type of information collected is not adequate to measure the number of clients served by the state grant system. Inherent system inadequacies such as no mandatory provider participation requirements, no data verification process, and a varying definition between providers of who qualifies as a "client" makes the reliability of the data suspect. Some providers we

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[7] The cost study consisted of actual personal services and overhead expenditure data from each of 6 providers. The providers sampled were selected in an effort to produce a representative cross section of providers with regard to size, region, and funding amounts.

interviewed expressed frustration that while they spend the time to submit data reports to DMHDD, they receive little for their efforts.

Furthermore, current data collection methods do not allow unduplication between the number of clients served as reported by DMHDD's MIS and the number of clients served as reported by the Medicaid MIS. Without this ability, DHSS cannot identify the total population of mental health clients served nor detect if Medicaid payments are being made for clients also funded through state grants.

While the number of clients served does not reflect the amount of service delivered, we believe that a significant element of grant funding decisions should be based on the historical number of clients served in an area. Currently, it appears DMHDD bases its grant funding allocations primarily on how much a provider was granted in prior years.

Current Status of Prior Recommendation

Since the previous report, DMHDD has installed a new data system, ARORA. This system is capable of capturing the individual client data, but DMHDD has found it difficult to actually collect and use the data for grant management decisions. Problems surrounding the collection of data from providers have included technical difficulties, providers' inability to submit data in a timely fashion, and a lawsuit ostensibly filed to protect the confidentiality of client data.

DMHDD has been ineffective in its efforts to collect comprehensive client information. The information services section is in frequent contact with providers regarding data submissions or lack thereof. Non-compliant providers also receive periodic reminders of their reporting obligations from the division director, but the division has been reluctant to become more assertive with these providers. While financial sanctions for providers that will not submit the required data would likely be the most effective method to gain compliance, the division is concerned with the effect these sanctions might have on consumers.

Legislative Audit's Current Position

The division's inability to collect comprehensive client data continues to limit its ability to use the management information system for grant funding decisions, ensure that services are not dual billed, or offer providers feedback about services and the associated costs. While we recognize that other sources of information, as discussed in the Reports Conclusions section, provide a context in which to review client data, that information is not an adequate substitute for comprehensive client data.

Many of the data problems are the result of provider noncompliance with specific grant requirements. To remedy this noncompliance, DMHDD may be forced to institute financial sanctions by withholding grant funds from grantees determined to be out of compliance with data submission requirements.

DMHDD is currently restructuring its data processing section, exploring possibilities to facilitate data submission, and discussing potential sanctions for providers that do not comply with data submission requirements. Though we view these efforts as steps in the

right direction, the actual implementation status of the recommendation remains limited. In addition to current efforts to obtain client data, we encourage DHSS to consider its long-term data needs and assess whether a system that collects only mental health data is cost effective when many clients receive services from multiple divisions.

Prior Recommendation No. 5

DMHDD should develop meaningful outcome measures and collect meaningful outcome data to determine effectiveness of services provided by public community mental health funding.

DMHDD does not collect sufficient data to measure the effectiveness of Alaska's community mental health services. We believe such information is necessary for proper management of the State's community mental health programs. Without these tools, program managers are without the necessary information to evaluate the success of services provided to Alaskan's with mental illness.

The FY 98 community mental health grant budget documents identify that:

> *There is no effective way to assure that grant funds are used in the most therapeutic way; there are funding duplications due to grantees having multiple funding sources; services are agency-driven, not consumer-driven; and services are not always clearly tied to an identified treatment need.*

Current Status of Prior Recommendation

Though DMHDD has been unable to collect and measure individual client data, the division receives frequent anecdotal feedback from consumers, advocacy groups, the AMHB, and the trust. Additionally, the division has developed several numerical indicators of consumer satisfaction and the effectiveness of services. These indicators include data gathered through the consumer satisfaction section of the integrated quality assurance reviews as well as measures developed by the legislature.

As discussed in Recommendation No. 6, DHSS has added a consumer satisfaction survey to its quality assurance program. The results of the consumer satisfaction section of the quality assurance reviews over the last two fiscal years suggest that consumers are generally satisfied with the services they have received from community mental health centers. Consumers from 46 community mental health centers responded to questions designed to determine how satisfied they were with the services provided through the CMHCs. Of the consumers surveyed, 71% said they were fully satisfied, while 14% were partially satisfied. Nine percent were not satisfied and 6% did not know or felt the questions did not apply to their circumstances.

The division and the AMHB have initiated a performance measurement project designed to define performance measures, develop tools for gathering data to measures and implement the data collection and measurement process. A steering committee

consisting of DMHDD staff, providers, consumers, and the AMHB was formed. Three subcommittees were established and charged with making recommendations to address each of the following:

1. Issues and required changes related to the data system.
2. Core questions for consumer assessment necessary to support the selected indicators.
3. Consumer survey instrument, administration and analysis.

The assessment subcommittee has developed an array of outcome measures far more comprehensive than those currently required by statute. These proposed measures include the areas of access to care, appropriateness and quality of care, consumer outcomes, and management structure.

A new subcommittee has now been formed to pilot the measures developed by the Assessment and Consumer Satisfaction Committees. This phase will be conducted with providers selected to give a range of provider type (rural and urban). The pilot project phase, targeted to begin before the end of December 2000, will not be complete for several months. This period of time reflects the estimated time required to assess, treat, and reassess a consumer. Reassessment will take place at discharge or after a period of treatment deemed sufficient to impact some change. After several months, the subcommittee will review the data, reevaluate the instruments, make adjustments and begin the statewide implementation. Full implementation is expected during FY 02.

Legislative Audit's Current Position

DMHDD has significantly implemented the prior recommendation to develop and collect meaningful outcome data. The recommendation will be considered fully implemented after systemic reporting and analysis of this data is operational.

When full implementation of the performance outcome measurements is imminent, the division should consider the method by which the required data will be submitted. While manual processing may appear slower and more cumbersome, problems associated with the ARORA system, as discussed in Recommendation No. 4, will need to be addressed before the reliability of the system becomes adequate to support this project.

Prior Recommendation No. 6

The commissioner of DHSS should improve the reviews of community mental health center clinical records and billings

DHSS initiated its current quality assurance process early in 1996. DMHDD has performed reviews of a substantial number of community mental health grantees.

Since the possibility for manufactured clinical records exists, we believe billing reviews should also consider contacting clients in an attempt to determine whether services billed were received. Additionally, because clients may be Medicaid ineligible and therefore receive community mental health services exclusively through state grants, the quality assurance reviews should also include evaluation of grant funded client services for effectiveness and appropriateness. Currently, only Medicaid client records are examined.

Providers we interviewed had a clear perception that Medicaid refinancing would involve a partnership between themselves and DHSS. For most providers, Medicaid introduced new concepts for service delivery and clinical record requirements. Their expectation was that these quality assurance reviews would be a learning experience and some evidenced concern that requests for payment involved issues they felt had never been made clear. Several providers note that their most recent quality assurance reviews were very beneficial.

The commissioner should continue reviews of clinical and billing records to increase the efficient use of state and federal dollars in the provision of community mental health services. These reviews should be conducted utilizing statistically sound sampling procedures and should include determination of the medical necessity and clinical appropriateness of services. Any recoupment should be based upon actual overpaid dollars throughout the period of review and valid extrapolations.

Current Status of Prior Recommendation

The new Integrated Quality Assurance process has addressed the elements recommended in the previous audit. As discussed in the Report Conclusions section, the Quality Assurance program was revised in FY 99 to include an additional section on consumer satisfaction. The division also changed the method by which files were identified for review and added a requirement to test non-Medicaid files. Quality assurance reviewers, while reviewing for the medical necessity and clinical suitability of specific treatments, are able to identify areas in which provider technical assistance may be needed. The quality assurance unit has offered technical assistance in many areas, but inadequate training remains a common theme among provider complaints about the system.

The quality assurance reviews that have been completed over the last two fiscal years have, in themselves, provided useful technical assistance related to the medical necessity documentation required to support Medicaid billings. As noted in the previous audit,

when the quality assurance reviews began, Medicaid introduced new concepts for service delivery and clinical record requirements. The discussions generated through the review process and resultant trainings offered by the division have generally helped providers to become more knowledgeable about the intricacies of Medicaid billing.

Though the quality assurance team has fully implemented the prior recommendation, the process has not yet reached optimal effectiveness. As discussed in the Reports Conclusions section, a recent quality assurance report on the reviews performed throughout FYs 99 and 00 found large differences in compliance rates with medial necessity standards. By individual provider, the compliance rates range from 16% to 100%. The Anchorage region, where DMHDD's quality assurance office is located, has the highest average compliance rate with more than 77%, and the Northern Region, with providers the farthest away from the quality assurance office have the lowest average compliance score with 68.4%.

It is likely that the division has focused training efforts on larger agencies to positively affect the quality of services for the largest number of consumers. The geographical proximity of technical assistance has probably also been helpful to the providers in the Anchorage area. Given the relative success of these training efforts, expansion to include more of the rural providers could help to reduce the high error rates encountered in those facilities. Though the quality assurance unit responds to all requests for technical assistance, rural providers may be more reticent about making such requests (for further discussion, see Rural Provider's section on page 8).

For providers with particularly low compliance scores, quality assurance reviews should be performed more often than every two years. Community mental health clinics in rural areas often experience high personnel turnover. Given this high turnover and the limited availability of training, it is especially important to focus quality assurance and technical assistance efforts on providers at higher risk of non-compliance with regulatory requirements.

Legislative Audit's Current Position

The quality assurance team has completed an exhaustive 2-year cycle of on-site reviews for nearly every Alaskan provider of community mental health services. The information gathered from this process provides the division with an invaluable tool for directing further training efforts, focusing additional quality assurance reviews, and ensuring that the community mental health system meets consumer's needs. We recommend that the division use that information more proactively in tackling non-compliance issues identified through the quality assurance reviews.

Prior Recommendation No. 7

DHSS should consult the Department of Law regarding appropriate recoupment of payments to mental health providers.

In 1995, DHSS did not seek complete reimbursement of overpayments made to community mental health providers. These overpayments were made because edit checks in MMIS which processes Medicaid billings, were either not in place or in place and not working. As a result, payments were processed to mental health providers in excess of service limitations contained within the Medicaid regulations. Consequently, mental health providers were paid more than allowable under Alaska's regulations. DHSS estimated $1.9 million as over the service limits.

Medicaid payments to community mental health providers are generally funded 50% by federal dollars, DHSS worked with the federal government to calculate an amount due them regarding this issue. With federal concurrence, DHSS used a new methodology to determine the amount overpaid. Under that methodology, the amount determined as overpaid was approximately $800,000. As a result, DMA directed DHSS Division of Administrative Services personnel to process adjustments to its federal reports for a net reduction of approximately $400,000 ($800,000 multiplied by the federal financial participation rate of 50%). This resolved the amount due to the federal government. However, the amount due the federal government by DHSS for the above was approximately $200,000 greater than the amount sought by the department from the community mental health providers. Additionally, the department's recovery effort does not recognize the $400,000 general fund portion of that overpayment.

According to DMA personnel, it was a policy decision to seek less than $200,000 reimbursement from the mental health providers rather than the amended $800,000 identified as over the service limits. This decision was reached apparently because of problems with initiation of the program edits, problems with training given to providers, and problems with provider case management systems not being capable of editing overlimit services. We recommend that DHSS consult the Department of Law regarding appropriate recoupment of these overpayments to mental health providers.

Current Status of Prior Recommendation

In 1996, DHSS consulted with the Department of Law regarding recoupment of overpayments to mental health providers. When the Department of Law advised that recovery of extrapolated amounts was extremely unlikely. DHSS requested repayment of funds specifically identified in case records that had been reviewed. In response, the providers from whom refunds were requested all immediately filed appeals. Of those 12 cases, 9 have now been resolved. The three largest cases have all appealed for a formal hearing. Though DMA has requested and received some repayments, the potential

outstanding overpayment amount is still more than $1million. [8] There have been various delays related to obtaining information, changes in attorneys and attempts at resolution without a formal hearing. DMA would like to have each of these three remaining cases settled before the end of FY 01.

Legislative Audit's Current Position

DHSS has fully implemented the prior recommendation through discussions with the Department of Law and continuing efforts to collect previous overpayments. Further, DHSS has revised its regulations to explicitly authorize file reviews and extrapolation of overpaid amounts through the use of statistical sampling. However, the quality assurance section, through continued reviews of provider's records, has identified additional questioned costs that must now be addressed (see Recommendation No. 8).

Recommendation No. 8

DHSS should ensure that questioned billings identified by quality assurance are promptly investigated and all amounts determined to be actual overpayments should be recovered from providers.

Through the FY 99-00 round of event audits,[9] quality assurance has identified $181,547 of CMHC Medicaid billings that have been questioned and forwarded to DMA for further investigation. These potential questioned costs are the result of a review of $722,433 in Medicaid claims filed by 41 providers over the course of the last two fiscal years.

As discussed in Recommendation No. 7, DMA is currently involved in attempts to settle previous potential provider overpayments. Though DHSS paid the federal portion due on those claims, it has yet to recapture those amounts from the providers due to an extended formal hearing process. As a result of this previous lengthy process and the uncertainty of the outcome, the division is hesitant to set in motion another round of investigations, repayment requests, and appeals. DMA expects the current cases to be settled before the end of fiscal year 01, and may begin investigation of the FY 99-00 potential overpayments at that time.

Delaying the investigation of these potential overpayments effects both providers and the State. Though DMA staff have commented that the actual overpayment amount determined after closer inspection is likely to be considerably less than the original $181,547, each of the 41 providers may be responsible for repaying up to the full amount of the potential overpayment. The questioned amounts range from $37.50 to $25,140 and average about $4,400 across all providers. While a repayment of $37.50 is

[8] When the decision was made to appeal these cases, the full amount initially identified for reimbursement was restored.
[9] An event audit consists of comparing Medicaid billing data with the clinical record to determine if the services billed to Medicaid were rendered.

unlikely to endanger the financial viability of any of the providers, potential repayments in the larger ranges may create budgeting problems for some providers.

In addition to potential problems for providers, the State faces a possible liability to the federal government. Because these billings represent amounts for which CMHCs have received reimbursement from the Medicaid program, as much as $108,565 (Medicaid funds are generally matched with 59.8% state funds) may be owed to the federal government.

DMA should promptly determine which of the questioned billings represent actual overpayments to providers and take action to recover those amounts. Additionally, the division should ensure that future questioned billings are investigated in a timely manner and recovery efforts begin as soon as possible.

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APPENDICES

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Appendices A through C

The following appendices are presented to provide additional detail for items discussed in the report conclusions and recommendations and findings sections. Appendix A describes the most used Medicaid service types and shows the changes in expenditures and clients from FY 93 through FY 00. Appendix B contains funding information on each community mental health center. This appendix compares grant and Medicaid funding from FY 97 to grant and Medicaid funding from FY 00. Appendix C lists the quality assurance reviews conducted throughout FY 99-00.

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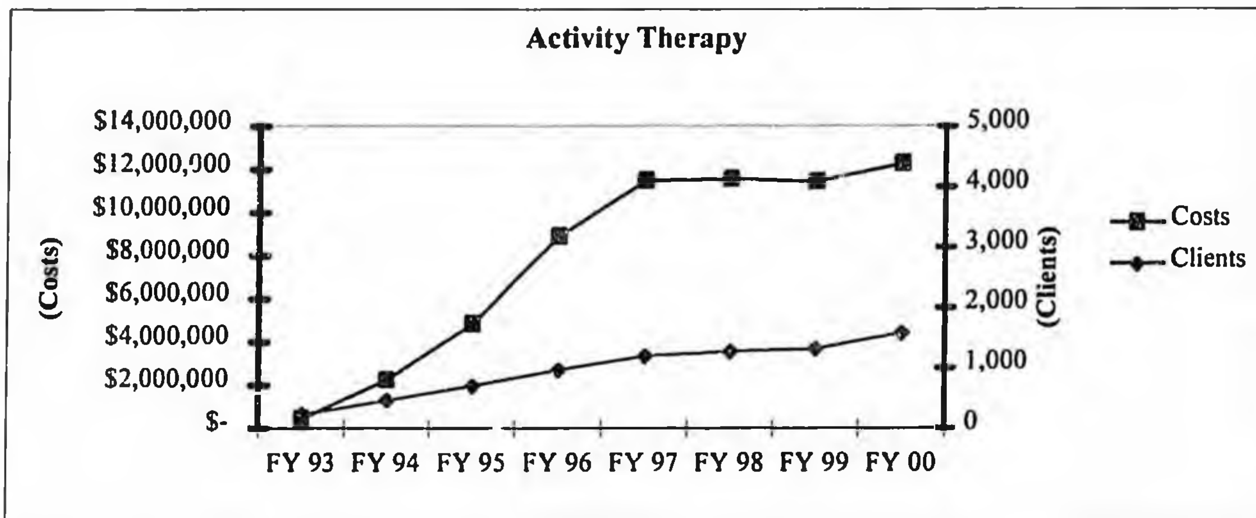
Appendix A

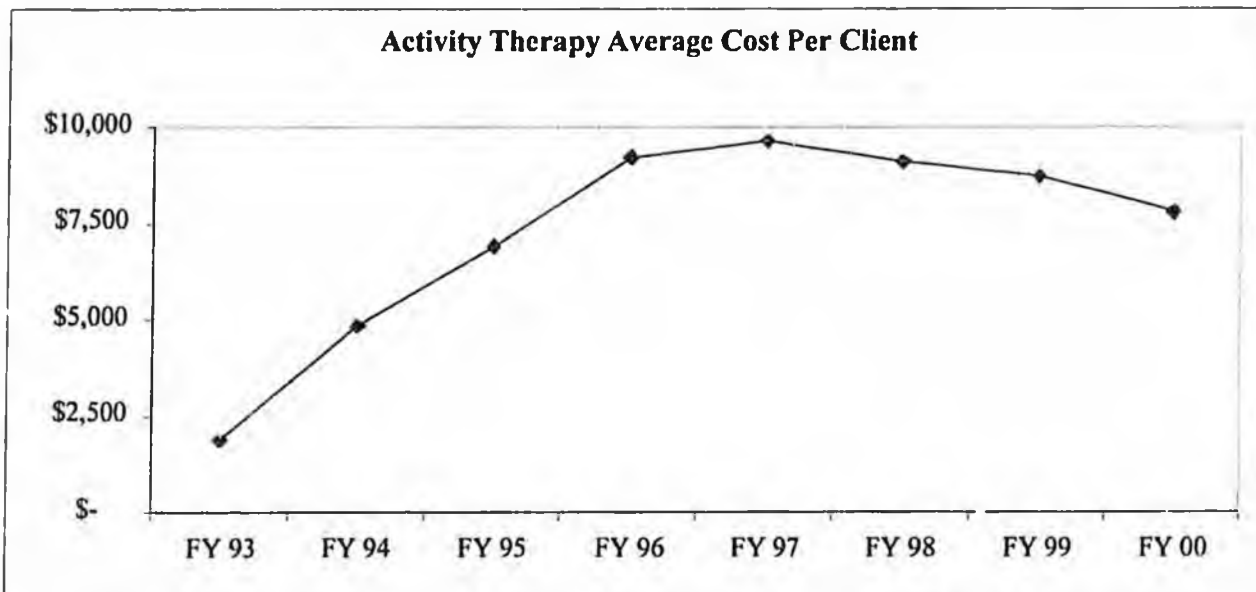
Medicaid Cost and Client Trends by Service Category

Activity Therapy

Activity Therapy is a service delivered to a recipient under age 21 to assist the recipient in adapting to home, school, and community. This therapy includes teaching living skills, social and communication skills, and other needed life skills.



% increase in Medicaid costs FY 97 – FY 00: 7%.
% increase in Medicaid clients served from FY 97 – FY 00: 32%.



% decrease in cost per client from FY 97 – FY 00: 19%.

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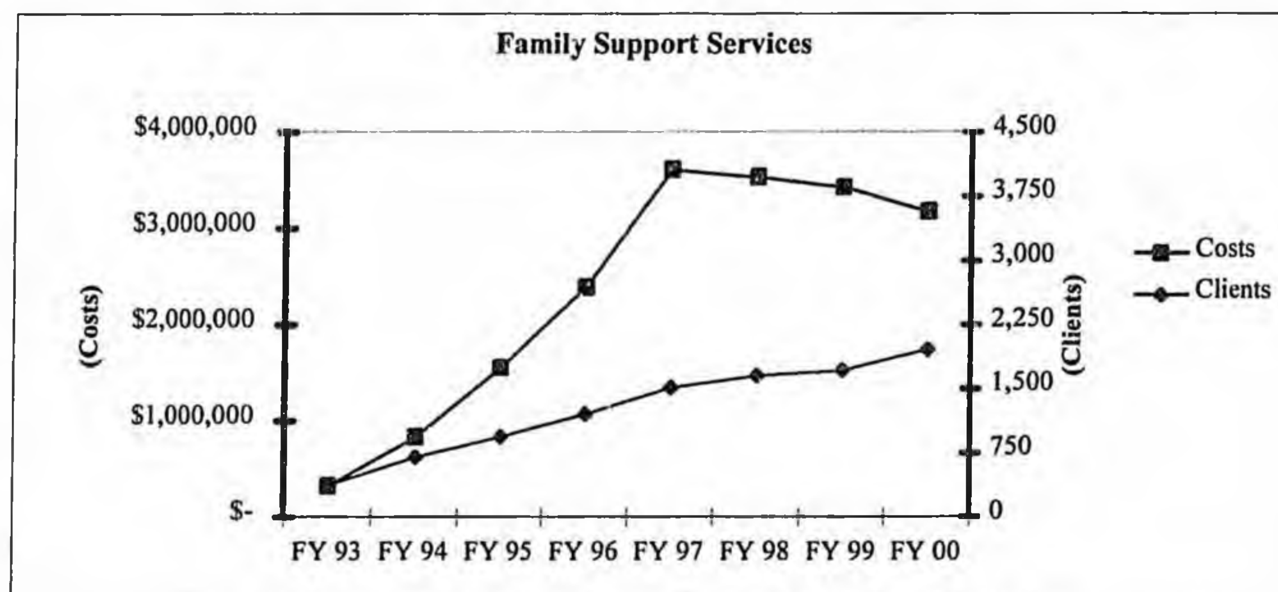
<u>Appendix A</u>

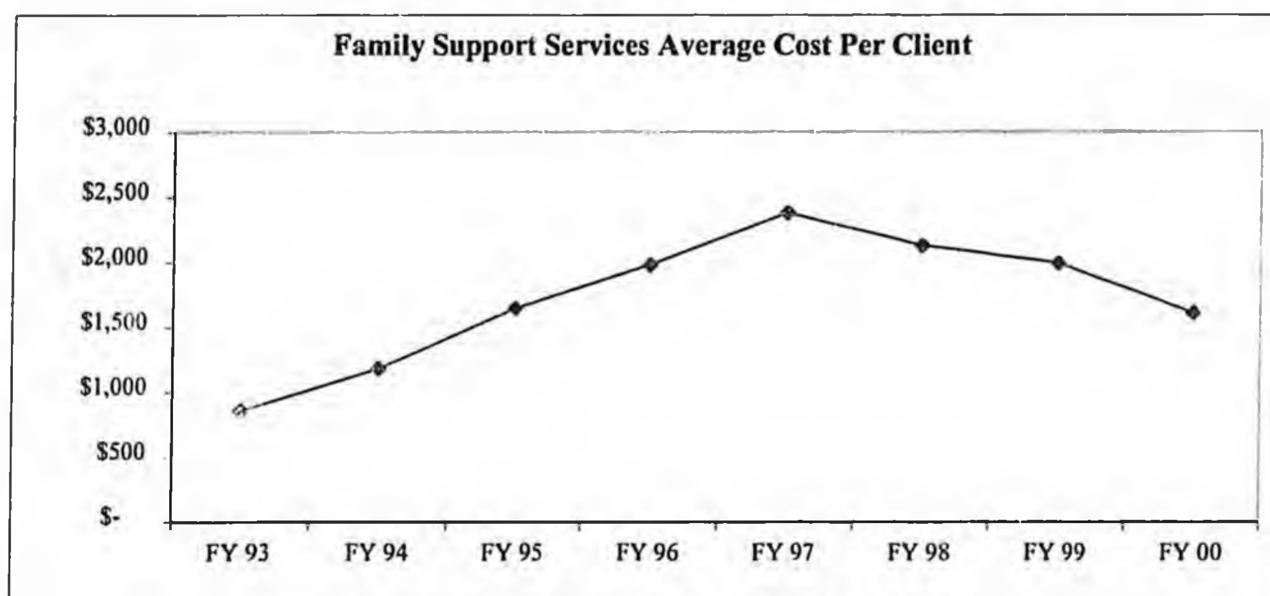
Medicaid Cost and Client Trends by Service Category

Family Support Services

Family support services are intended to maintain the recipients physical survival, promote personal growth, promote family, school, and community participation. Additionally these services promote recovery from severe emotional disturbance by coordinating assessment and treatment services, facilitating access to appropriate services, providing treatment and crisis assistance planning.



% decrease in Medicaid costs from FY 97 – FY 00: 12%.
% increase in Medicaid clients served from FY 97 – FY 00: 30%.



% decrease in cost per client FY 97 – FY 00: 32%.

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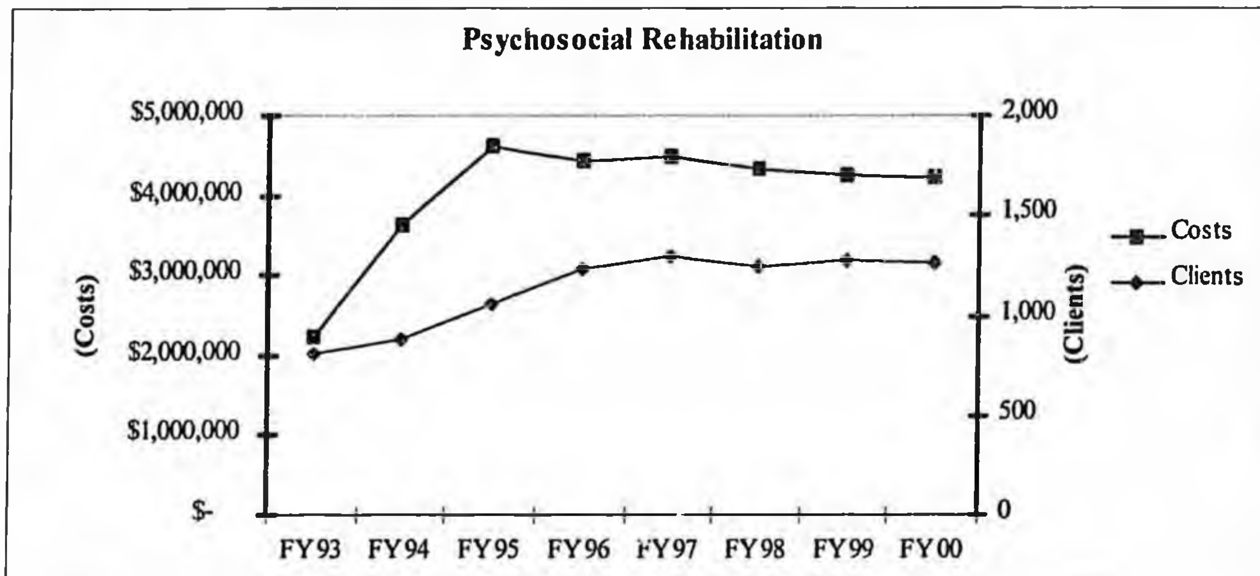
Appendix A

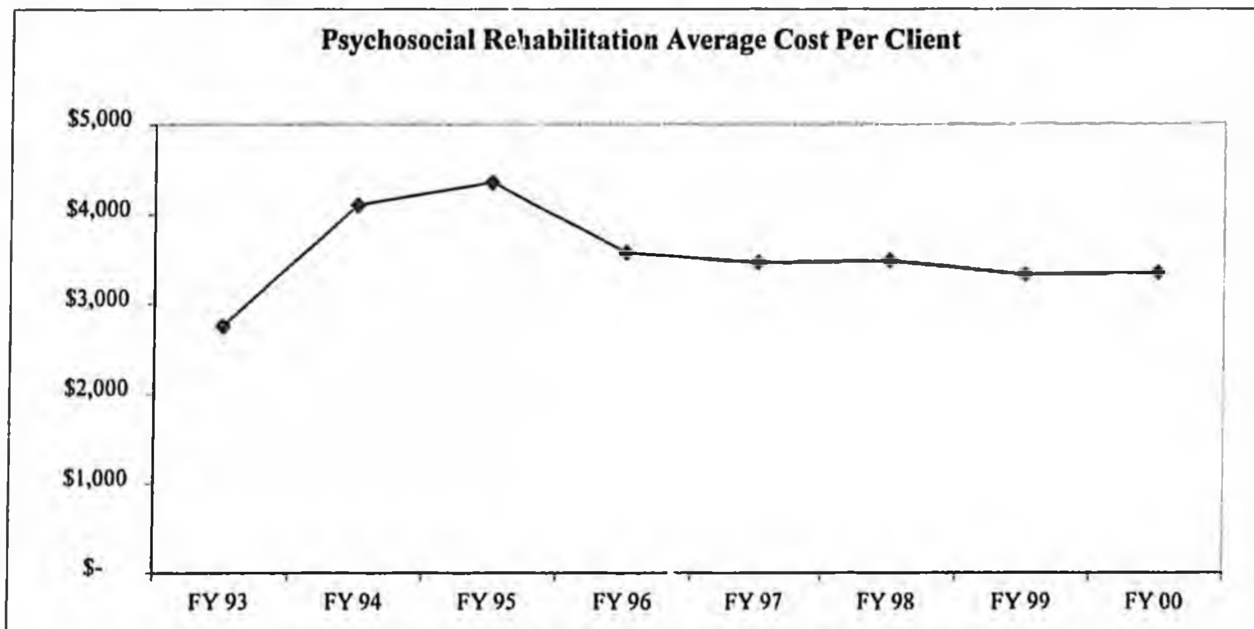
Medicaid Cost and Client Trends by Service Category

Psychosocial Rehabilitation

Psychosocial rehabilitation services are delivered in an individual or group setting to adult recipients with severe disabling mental disorders. The objective is to improve the functioning level of the recipient through supporting or strengthening behavioral, emotional, or intellectual skills necessary for the recipient to function in the recipient's own environment at the highest possible level of independence.



% decrease in Medicaid costs from FY 97 – FY 00: 5%.
% decrease in Medicaid clients served from FY 97 – FY 00: 2%.



% decrease in cost per client from FY 97 – FY 00: 3%.

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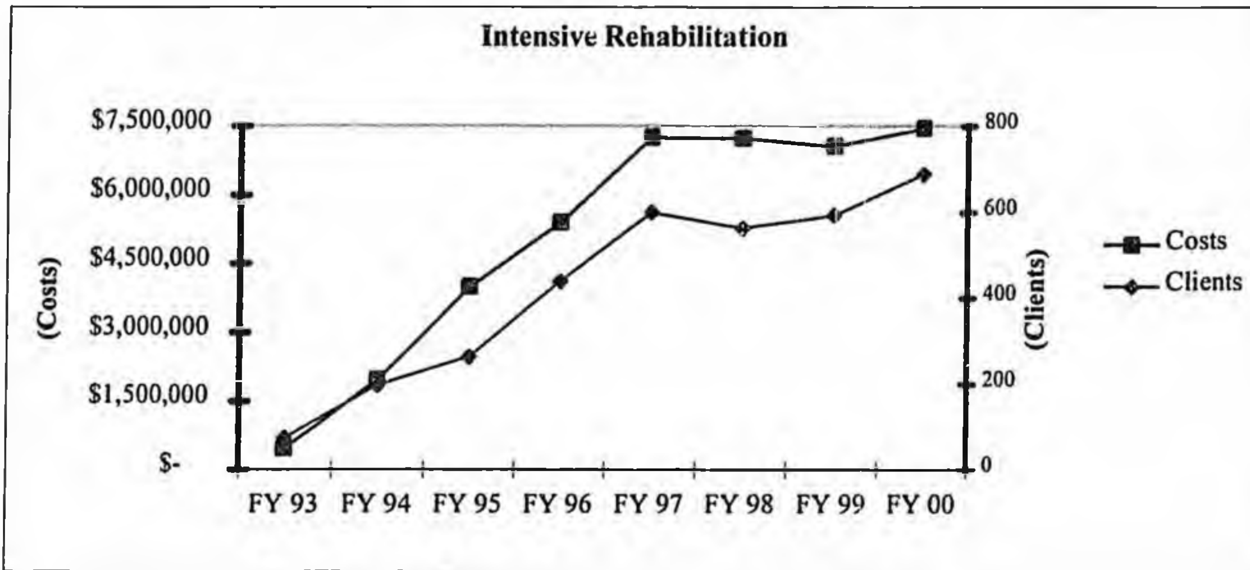
Appendix A

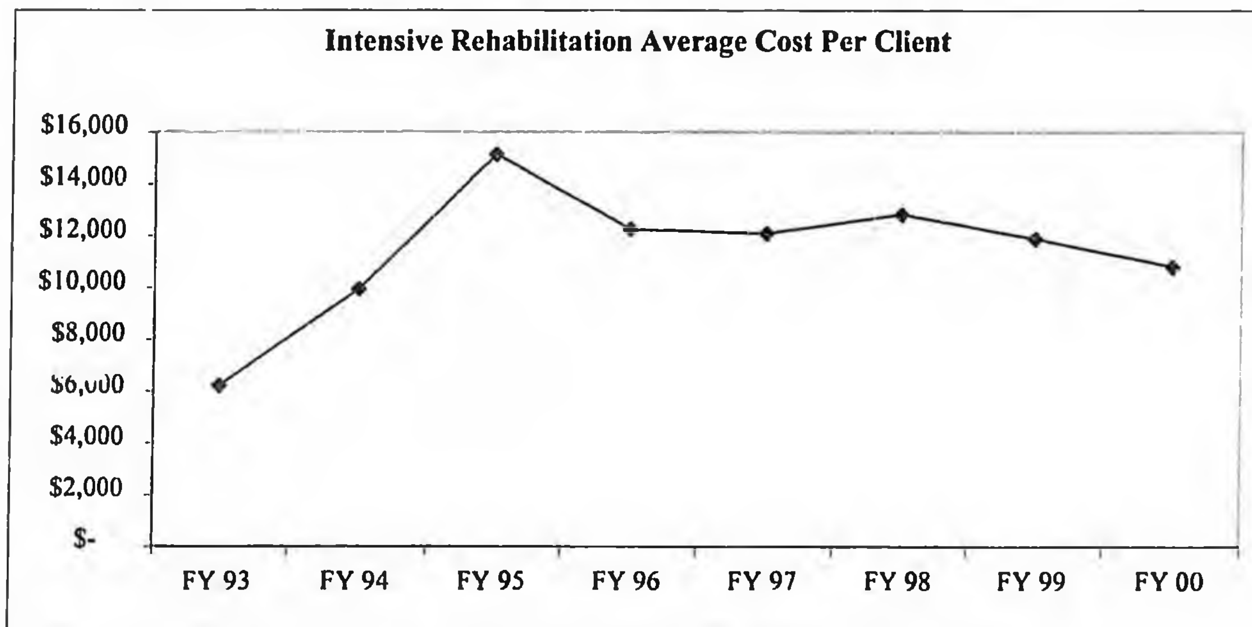
Medicaid Cost and Client Trends by Service Category

Intensive Rehabilitation

Intensive rehabilitation services are provided to a chronically mentally ill adult or a severely emotionally disturbed child whose disability is so severe that ordinary treatment, support, and rehabilitation programs are not sufficient to meet that recipient's treatment needs. These services include monitoring of self-care and providing intensive daily structure and support.



% increase in Medicaid costs from FY 97 – FY 00: 3%.
% increase in Medicaid clients served from FY 97 – FY 00: 15%.



% decrease in cost per client from FY 97 – FY 00: 11%.

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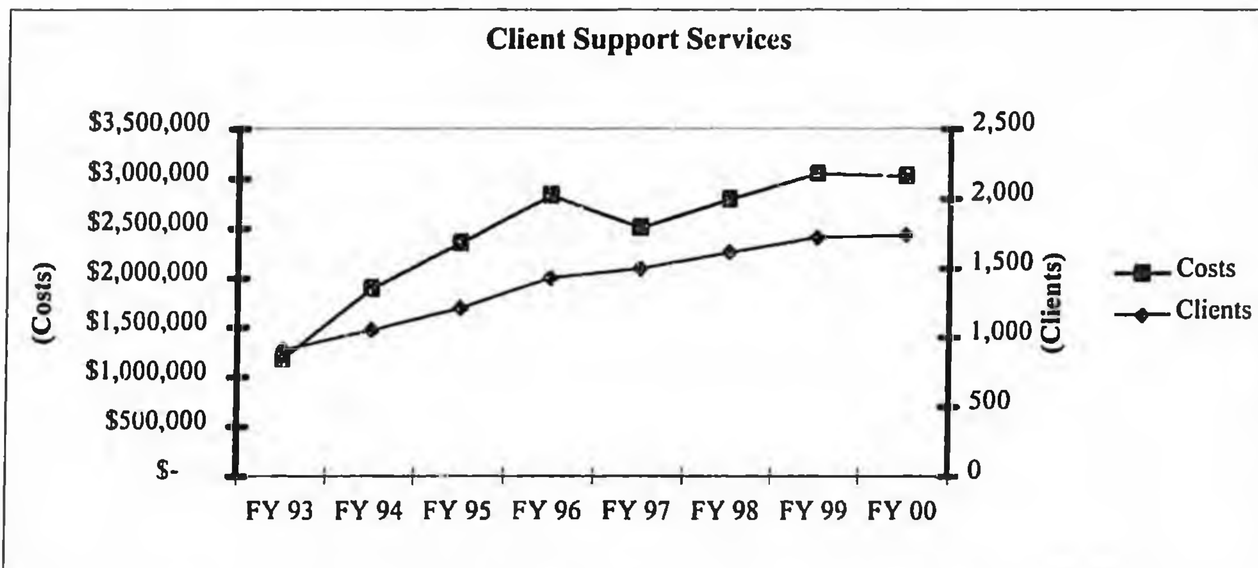
<u>Appendix A</u>

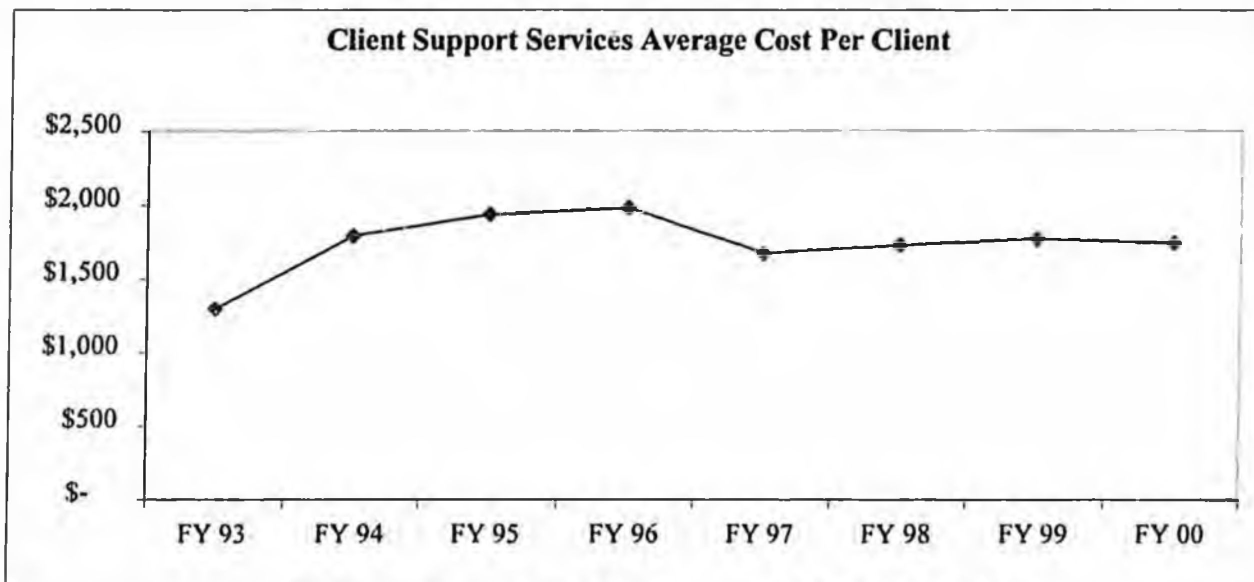
Medicaid Cost and Client Trends by Service Category

Client Support Services

Client support services are those that promote overall maintenance of a person's physical survival, personal growth, community participation, and recovery from or adaptation to severe psychiatric disorders. These services include coordinating assessment and treatment services, facilitating access to appropriate services, assessing client skill level, and providing treatments and crisis assistance. Additional services in this category include providing linkages between the recipient's needs and services, coordinating the training of the recipient in the use of basic community resources, and monitoring the overall delivery of services.



% increase in Medicaid costs FY 97 – FY 00: 21%.
% increase in Medicaid clients served from FY 97 – FY 00: 16%.



% increase in cost per client from FY 97 – FY 00: 4%.

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Appendix B

Provider	Location	FY 97 Funding Medicaid	FY 97 Funding Grant	FY 97 Funding Total	FY 00 Funding Medicaid	FY 00 Funding Grant	FY 00 Funding Total	FY 97-00 Difference	% Total Change
ASSETS (AK SPECIALIZED ED)	Anchorage	1,534,054	453,064	1,987,118	1,556,307	927,681	2,483,988	496,870	25%
ANCHORAGE CTR FOR FAMILIES	Anchorage	214,020	296,000	510,020	245,369	293,700	539,069	29,049	6%
ANCHORAGE COMM MH	Anchorage	3,395,309	6,055,537	9,450,846	4,638,165	6,203,457	10,841,622	1,390,776	15%
SCF COMM MH CTR	Anchorage	349,051	209,601	558,652	1,076,830	212,663	1,289,493	730,840	131%
THE ARC OF ANCHORAGE	Anchorage	1,362,826	525,268	1,888,094	1,103,460	597,247	1,700,707	(187,387)	(10%)
ALTERNATIVES COMM MH	Anchorage	4,032,838	159,913	4,192,751	3,705,163	2,598	3,707,761	(484,991)	(12%)
HOPE COTTAGES INC	Anchorage	1,296,091	65,667	1,361,758	435,812	10,623	446,435	(915,323)	(67%)
KNA COMMUNITY COUNSELING CTR	Aniak	5,861	106,275	112,136	-	106,275	106,275	(5,861)	(5%)
BETHEL COMMUNITY SVCS	Bethel	464,308	210,853	675,161	349,791	128,333	478,124	(197,037)	(29%)
COPPER RIVER COMM MH	Copper Ctr	10,644	192,900	203,544	-	191,185	191,185	(12,359)	(6%)
CORDOVA COMM HOSPITAL	Cordova	8,129	132,600	140,729	16,255	152,600	168,855	28,126	20%
COMM ORGANIZED FOR HEALTH OPTIONS	Craig	9,974	158,750	168,724	4,924	146,100	151,024	(17,700)	(10%)
BRISTOL BAY AREA HLTH CORP	Dillingham	62,931	338,900	401,831	75,203	249,891	325,094	(76,738)	(19%)
FAIRBANKS COMM MH	Fairbanks	1,843,495	2,680,140	4,523,635	1,586,305	3,383,651	4,969,956	446,320	10%
FAMILY CENTERED SVCS	Fairbanks	3,342,829	414,277	3,757,106	2,165,356	622,053	2,787,409	(969,696)	(26%)
LYNN CANAL MH	Haines	4,000	153,511	157,511	3,385	151,229	154,614	(2,897)	(2%)
SOUTH PENNINSULA MH ASSN	Homer	1,479,060	430,077	1,909,137	1,879,379	379,089	2,258,468	349,331	18%
JUNEAU COMM MH	Juneau	645,411	749,887	1,395,298	541,433	183,277	724,710	(670,588)	(48%)
JUNEAU YOUTH SERVICES	Juneau	2,289,676	319,966	2,609,642	2,498,875	357,199	2,856,074	246,431	9%
JUNEAU ALLIANCE MENTALLY	Juneau	1,167,384	780,410	1,947,794	1,106,556	994,303	2,100,859	153,065	8%
CENTRAL PENINSULA MH	Kenai	2,857,462	715,266	3,572,728	3,607,604	605,288	4,212,892	640,165	18%
KENAITZE INDIAN TRIBE IRA	Kenai	7,805	5,000	12,805	44,358	4,767	49,125	36,320	284%
KENAI PEN COMM CARE CTR	Kenai	165,322	17,020	182,342	292,726	18,310	311,036	128,693	71%
COMMUNITY CONNECTIONS	Ketchikan	379,475	59,384	438,859	310,000	47,649	357,649	(81,210)	(19%)
GATEWAY COMM MH CTR	Ketchikan	284,783	824,118	1,108,901	463,048	805,828	1,268,876	159,975	14%
KODIAK ISLAND M H	Kodiak	226,265	486,777	713,043	191,394	505,838	697,232	(15,811)	(2%)
4 RIVERS CNSEL SVC	McGrath	263	130,800	131,063	-	174,977	174,977	43,915	34%
RAILBELT MENTAL HEALTH	Nenana	2,319	138,871	141,189	9,259	139,782	149,041	7,851	6%
NORTON SOUND HEALTH	Nome	12,738	354,600	367,338	384,169	148,357	532,526	165,188	45%
PETERSBURG MH	Petersburg	39,011	154,303	193,314	82,948	148,947	231,895	38,580	20%
EASTERN ALEUTIAN TRIBES	Sand Point	375	299,383	299,758	-	349,299	349,299	49,541	17%
SEWARD LIFE ACTION CNCL	Seward	304,344	281,312	585,656	271,638	267,842	539,480	(46,176)	(8%)
SITKA MH CLINIC	Sitka	295,965	366,091	662,056	408,553	302,162	710,715	48,659	7%
MH CONSUMERS OF AK	Statewide	8,460	123,442	131,902	9,388	173,300	182,688	50,785	39%
TOK AREA MH CTR	Tok	6,154	165,732	171,886	8,910	235,096	244,006	72,120	42%
VALDEZ COUNSELING CTR	Valdez			-	21,438	145,815	167,253	167,253	100%
CITY OF VALDEZ	Valdez	12,301	108,825	121,126				121,126	100%
MAT-SU COMMUNITY MH	Wasilla	4,546,944	1,969,415	6,516,359	2,740,766	1,634,706	4,375,472	(2,140,887)	(33%)
MAT-SU SVCS	Wasilla	375,350	107,901	483,251	169,895	50,674	220,569	(262,682)	(54%)
WRANGELL MH SVCS	Wrangell	110,854	182,282	293,136	93,166	162,951	256,117	(37,019)	(13%)

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Appendix C

Integrated Quality Assurance Reviews Performed FY 99-00

Name of Community Mental Health Center	Location	Date Last Reviewed
4Rivers Counseling Services	McGrath	April 2000.
Alaska Children's Services	Anchorage	January 2000
Alaska Youth and Parents	Anchorage	February 2000
Adult Learning Programs of Alaska	Fairbanks	September 1999
Alternatives Community Mental Health Center	Anchorage	February 2000
Anchorage Center for Families	Anchorage	February 2000
ARC of Anchorage	Anchorage	January 2000
Assets	Anchorage	April 2000
Bethel Community Services	Bethel	September 1999
Catholic Social Services	Juneau	February 2000
COHO	Craig	May 2000
Community Connections	Ketchikan	May 2000
Connecting Ties	Valdez	November 1999
Copper River Mental Health Center	Copper Center	June 1999
Crossroads Counseling and Training	Fairbanks	October 1999
Deaf Community Services	Fairbanks	October 1999
Fairbanks Community Mental Health Agency	Fairbanks	September 1999
Fairbanks Resource Agency	Fairbanks	October 1999
Family Centered Services	Fairbanks	November 1999
Gateway Center for Human Services	Ketchikan	June 2000
Horizons Unlimited	Valdez	November 1999
Hope Community Resources	Kodiak/Aleutian/Pribilof	May 2000
Hope Community Resources	SouthEast	April 1999
Hope Community Resources	Anchorage/Mat-Su/	March 2000
Juneau Alliance for the Mentally Ill	Juneau	April 1999
Juneau Youth Services	Juneau	April 1999
Kuskokwim Native Assoc. Com. Counseling	Aniak	September 2000
LifeQuest	Wasilla	May 1999
Lynn Canal Counseling Services	Haines	June 2000
Maniilaq Association	Kotzebue	April 2000
Mat-Su Services for Children and Adults	Wasilla	May 1999
North Slope Borough Com Counseling Ctr	Barrow	April 1999
Norton Sound Health Corporation	Nome	March 2000
Petersburg Mental Health Services	Petersburg	May 2000
Providence Kodiak Island Mental Health Ctr	Kodiak	May 1999
Railbelt Mental Health and Addictions	Nenana	May 1999
Reach	Juneau	April 1999
Seward Life Action Council	Seward	March 1999
SouthCentral Counseling	Anchorage	January 2000
Southcentral Foundation	Anchorage	December 1999
South Peninsula Mental Health Assoc.	Homer	February 1999
South Peninsula	Homer	September 1999
Tanana Chiefs	Fairbanks, Interior & Doyon	September 1999
Tok Area Mental Health Center	Tok	June 1999
Valdez Counseling Center	Valdez	November 1999
Wrangell Community Services	Wrangell	January 1999
YKHC (Yukon Kuskokwim Health Corporation)	Yukon	September 1999
Yukon-Koyukuk Mental Health Program	Yukon	June 1999

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STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

TONY KNOWLES, GOVERNOR

P.O. BOX 110601
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FAX: (907) 465-3068

December 26, 2000

Pat Davidson
Legislative Auditor
Division of Legislative Audit
P.O. Box 113300
Juneau, Alaska 99811-3300

VED
... 28 2000
LEGISLATIVE AUDIT

Dear Ms. Davidson:

Thank you for the opportunity to review and respond to findings from the follow-up review to the 1997 audit of selected mental health and medical assistance program issues.

The report on these issues reflects a high level of cooperation and communication between auditors and Department staff throughout the review process. Because of that I believe that it accurately represents the status of the issues reviewed.

Your findings and conclusions clearly reflect the positive results of significant management actions taken to improve the cost effectiveness of Alaska's publicly funded mental health system.

- The issue of managed care was fully explored and, based on advice of stakeholders a thoughtful decision was made to implement alternative, equally effective means of achieving cost effectiveness.
- New Medicaid regulations have been adopted and implemented which resolve definition and rate issues previously identified.
- An extraordinary effort has been undertaken to expand quality assurance efforts, including reviews of clinical and billing records and an ambitious schedule is underway to provide training on the new Medicaid regulations.
- A joint project has been undertaken with the Alaska Mental Health Board to develop appropriate outcome measures with results more comprehensive than envisioned by the Legislature's statutory initiative.

As your report demonstrates the intent of your original recommendations has essentially been accomplished with a single exception - collecting complete data on services provided and persons served by mental health programs supported with grant funds.

6-F38LH

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The progress illustrated in your report is significant for several reasons not the least of which is the effort necessary to achieve that progress. Designing and implementing significant system changes such as those we have accomplished since your first audit obviously requires close coordination between divisions within the Department. It also requires substantial work to collaborate externally with stakeholders affected by those changes including the Alaska Mental Health Trust, the Mental Health Board, providers and consumers. I believe the auditors involved in the most recent review have developed a more thorough understanding of both the complexity and value of this external collaboration than was true in the past and that their understanding is reflected in your report.

The importance of this collaboration, both in terms of its added complexity and its impact in achieving effective and constructive change, cannot be emphasized too greatly. Assuring that projects and program changes have the support and involvement of stakeholders contributes immeasurably to the success of the undertakings. Doing so, however, comes at a cost of time, resources, and efficiency. The positive result, however, justifies the cost.

With regard to the single outstanding issue remaining from the initial review, I agree entirely that complete, accurate data is essential to support effective management decisions and overall development of the mental health program. Your current review identifies some of the important impediments to our ability to obtain complete data reporting, including: 1) a direct legal challenge of our authority to do so; and 2) technical limitations of systems operated by grantees which are the source of data.

Although progress has been made toward the acquisition of complete data it has been slower than desired and much remains to be done. Future efforts to resolve this issue will necessarily focus on clarifying the legal framework supporting data collection and overcoming technical impediments to reporting.

I disagree slightly with your suggestion that the most appropriate logical step to achieve compliance with reporting requirements is imposition of financial sanctions. I agree that greater efforts to encourage or enforce compliance *may* be necessary where lack of compliance is not based on a legitimate impediment. For that reason we will address this issue directly and fully in the solicitation, evaluation, award and administration of FY01grants for community mental health services. However, I believe we should maintain a constructive approach that allows grantee agencies to explain legitimate barriers to compliance, demonstrate a plan and schedule for achieving compliance, and receive support in carrying out the plan.

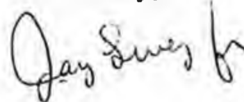
In response to the new recommendation identified in this report (#8), I concur that questioned billings should be investigated and if actual overpayments are determined recovery should be initiated. However, these efforts must be cost-effective. In some instances the value of the recovery may potentially be less than the cost of the recovery. We believe the most cost-effective method is to educate and train providers to avoid errors that might lead to a need for

cost recovery. With limited resources staff efforts should be primarily allocated to avoiding mistakes rather than recovery after the errors and mistakes have occurred.

However, instances of erroneous billing representing substantial value or prevalent practice errors should be pursued for recovery where doing so is cost-effective. The quality assurance reviews provide a means of identifying questioned costs. The estimated questioned costs are a starting point of a very labor intensive effort to determine if a given medical claim was an actual over billing and applying criteria (such items as dollar value, frequency or prevalence of practice, total annual billings or service volumes) to determine the cost effectiveness of pursuing recovery. If the results of the review fall below established thresholds, the matter may be closed without further action.

Finally, staff members within the department and stakeholders of the mental health system have commented that this legislative audit follow-up has been a positive experience. Your staff's thorough examination of the mental health system has contributed to a constructive process and identified the significant improvements that have been achieved. We have appreciated the professionalism your staff has shown in pursuing the broad scale programmatic issues as well as detailed fiscal and program operations of the mental health system.

Sincerely,



Karen Perdue
Commissioner

Alaska State Legislature

SENATOR
GENE THERRIAULT
Chair

SESSION ADDRESS
State Capitol
Juneau, Alaska 99801-1182
(907) 465-4797
Fax: (907) 465-3884

Legislative Budget and Audit Committee

Request for Hearing

To: **Senator Lyda Green, Chair**
Senate Health, Education, and Social Services Committee

Subject: **SB Bill 135**

Sponsor: **Rules by Request of the Legislative Budget and Audit Committee**

Date: **March 20, 2001**

On behalf of the Department of Health and Social Services the Legislative Budget and Audit Committee respectfully requests a hearing on Senate Bill 135 "An Act relating to mental health information and records; and providing for an effective date."

Senate Bill 135 specifically addresses Recommendation No. 4 of the Audit Report titled: *"Department of Health and Social Services, Divisions of Medical Assistance and Mental Health and Developmental Disabilities, Community Mental Health Center Program Follow-Up"* dated December 1, 2000 (excerpt attached). An analysis of the bill's provisions and zero fiscal note were provided by the Department and are attached.

INTERIM ADDRESS
119 N. Cushman Suite 101, Fairbanks, Alaska 99701 • (907) 488-0857 • Fax: (907) 488-4271

SENATE HEALTH & SOCIAL SERVICES COMMITTEE

DATE: 4/9/01

SUBJECT OF MEETING:

SB 135-MENTAL HEALTH INFORMATION AND RECORDS

PLEASE SIGN IN

PLEASE PRINT:

NAME	ADDRESS (MAILING & ZIP)	REPRESENTING	DO YOU WANT TO TESTIFY?
Elmer Lindstrom	Special Assistent DHSS		Yes
Pat Davidson	Leg Auditor	Leg Audit	yes
[illegible]			

DEPARTMENT OF HEALTH AND SOCIAL SERVICES, DIVISIONS OF MEDICAL ASSISTANCE AND MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES, COMMUNITY MENTAL HEALTH CENTER PROGRAM, FOLLOW-UP

December 1, 2000

Audit Control Number:

06-4599-01

Division of Legislative Audit

P.O. Box 113300, Juneau, Alaska 99811-3300

Aside from activity therapy, the new regulations provide for small increases in a few of the rates. These increases, generally no more than $5 per hour of service, were based primarily on increases in salaries since the original rates were designed. One notable exception was a $125 increase in the rate for a psychiatric assessment, originally $105, now set at $230. According to DHSS personnel, this rate was originally far less than the cost of service and is now more in line with current costs.

Overall improvements don't mitigate the need for comprehensive client data

While we recognize that DHSS has improved significantly in most of the areas of concern noted in the previous audit, client data collection remains an unresolved issue. As noted in the Findings and Recommendations section of this report, we believe this data is essential for effective funding and programmatic decision-making related to community mental health centers. The department reportedly now has a data system capable of producing comprehensive client information, yet for various reasons discussed above, has been unable to collect data from providers.

DHSS has, over the last three years, attempted to work cooperatively with the providers that will not or cannot supply the data required to meet their grant conditions. The department has been reluctant to impose financial sanctions or take any action that may be viewed as punitive. Though a cooperative relationship is optimal, this method has enjoyed little success over the last three years. With the restructuring of DMHDD's information systems section, the division has an opportunity to focus more attention on this lingering problem. Accordingly, we strongly encourage DMHDD to take prompt action to resolve outstanding data issues.

Current Status of Prior Recommendation

The rate setting methodology, now fully documented, bases the various rates on the costs of the personnel providing specific mental health services. Though the calculated rates were based on estimates, an abbreviated cost study[7] has shown that the estimates are materially supported by actual expenditure data.

The previous audit also identified the combination of vague service descriptions in the regulations and limited technical assistance from the divisions as problematic. As discussed above, the expansion of the quality assurance program to include technical assistance has helped to alleviate some of the confusion in Medicaid service descriptions and clarify file documentation requirements.

Activity therapy was one of the more ambiguous service categories that, by FY 97, had shown steep cost increases. Accordingly, this category was of particular concern to both the auditors and the division. After the previous audit, the division made an effort to emphasize active treatment and required thorough documentation for activity therapy. The costs per client for this service have decreased by more than 19% since FY 97.

Legislative Audit's Current Position

As a result of the above actions, we believe the agency has fully implemented prior Recommendation No. 3. We encourage DHSS to continue with plans to fully train providers on the new regulations and to periodically review the regulations and the associated rates to ensure that they remain reasonable.

Prior Recommendation No. 4

DMHDD should obtain client service data to enable effective management of the State's community mental health programs.

Currently, the lack of client service data renders DMHDD unable to determine if community mental health funding is appropriate. No reliable data currently exists which accurately reflects the total number of clients annually receiving publicly funded community mental health services. While the Medicaid payment system does collect the number of clients served through Medicaid, major deficiencies exist in DMHDD's data collection concerning clients served by state grant funds.

DMHDD has collected selective mental health client data from providers for many years using a management information system (MIS). However, the type of information collected is not adequate to measure the number of clients served by the state grant system. Inherent system inadequacies such as no mandatory provider participation requirements, no data verification process, and a varying definition between providers of who qualifies as a "client" makes the reliability of the data suspect. Some providers we

[7] The cost study consisted of actual personal services and overhead expenditure data from each of 6 providers. The providers sampled were selected in an effort to produce a representative cross section of providers with regard to size, region, and funding amounts.

interviewed expressed frustration that while they spend the time to submit data reports to DMHDD, they receive little for their efforts.
Furthermore, current data collection methods do not allow unduplication between the number of clients served as reported by DMHDD's MIS and the number of clients served as reported by the Medicaid MIS. Without this ability, DHSS cannot identify the total population of mental health clients served nor detect if Medicaid payments are being made for clients also funded through state grants.

While the number of clients served does not reflect the amount of service delivered, we believe that a significant element of grant funding decisions should be based on the historical number of clients served in an area. Currently, it appears DMHDD bases its grant funding allocations primarily on how much a provider was granted in prior years.

Current Status of Prior Recommendation

Since the previous report, DMHDD has installed a new data system, ARORA. This system is capable of capturing the individual client data, but DMHDD has found it difficult to actually collect and use the data for grant management decisions. Problems surrounding the collection of data from providers have included technical difficulties, providers' inability to submit data in a timely fashion, and a lawsuit ostensibly filed to protect the confidentiality of client data.

DMHDD has been ineffective in its efforts to collect comprehensive client information. The information services section is in frequent contact with providers regarding data submissions or lack thereof. Non-compliant providers also receive periodic reminders of their reporting obligations from the division director, but the division has been reluctant to become more assertive with these providers. While financial sanctions for providers that will not submit the required data would likely be the most effective method to gain compliance, the division is concerned with the effect these sanctions might have on consumers.

Legislative Audit's Current Position

The division's inability to collect comprehensive client data continues to limit its ability to use the management information system for grant funding decisions, ensure that services are not dual billed, or offer providers feedback about services and the associated costs. While we recognize that other sources of information, as discussed in the Reports Conclusions section, provide a context in which to review client data, that information is not an adequate substitute for comprehensive client data.

Many of the data problems are the result of provider noncompliance with specific grant requirements. To remedy this noncompliance, DMHDD may be forced to institute financial sanctions by withholding grant funds from grantees determined to be out of compliance with data submission requirements.

DMHDD is currently restructuring its data processing section, exploring possibilities to facilitate data submission, and discussing potential sanctions for providers that do not comply with data submission requirements. Though we view these efforts as steps in the

right direction, the actual implementation status of the recommendation remains limited. In addition to current efforts to obtain client data, we encourage DHSS to consider its long term data needs and assess whether a system that collects only mental health data is cost effective when many clients receive services from multiple divisions.

Prior Recommendation No. 5

DMHDD should develop meaningful outcome measures and collect meaningful outcome data to determine effectiveness of services provided by public community mental health funding.

DMHDD does not collect sufficient data to measure the effectiveness of Alaska's community mental health services. We believe such information is necessary for proper management of the State's community mental health programs. Without these tools, program managers are without the necessary information to evaluate the success of services provided to Alaskan's with mental illness.

The FY 98 community mental health grant budget documents identify that:

> *There is no effective way to assure that grant funds are used in the most therapeutic way; there are funding duplications due to grantees having multiple funding sources; services are agency-driven, not consumer-driven; and services are not always clearly tied to an identified treatment need.*

Current Status of Prior Recommendation

Though DMHDD has been unable to collect and measure individual client data, the division receives frequent anecdotal feedback from consumers, advocacy groups, the AMHB, and the trust. Additionally, the division has developed several numerical indicators of consumer satisfaction and the effectiveness of services. These indicators include data gathered through the consumer satisfaction section of the integrated quality assurance reviews as well as measures developed by the legislature.

As discussed in Recommendation No. 6, DHSS has added a consumer satisfaction survey to its quality assurance program. The results of the consumer satisfaction section of the quality assurance reviews over the last two fiscal years suggest that consumers are generally satisfied with the services they have received from community mental health centers. Consumers from 46 community mental health centers responded to questions designed to determine how satisfied they were with the services provided through the CMHCs. Of the consumers surveyed, 71% said they were fully satisfied, while 14% were partially satisfied. Nine percent were not satisfied and 6% did not know or felt the questions did not apply to their circumstances.

The division and the AMHB have initiated a performance measurement project designed to define performance measures, develop tools for gathering data to measures and implement the data collection and measurement process. A steering committee

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

TONY KNOWLES, GOVERNOR

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December 26, 2000

Pat Davidson
Legislative Auditor
Division of Legislative Audit
P.O. Box 113300
Juneau, Alaska 99811-3300

VED
28 2000
LEGISLATIVE AUDIT

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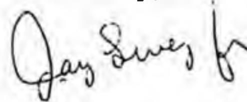

Karen Perdue
Commissioner

// LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
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State Capitol
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Deliveries to: 129 6th St., Rm. 329

MEMORANDUM April 11, 2001

SUBJECT: Mental Health Records (CSSB 135(HES), Version "C")

TO: Senator Lyda Green
Attn: Aurora Hauke

FROM: Terri Lauterbach
Legislative Counsel

Enclosed is a draft CS for SB 135.

The only new language is in sec. 7 of the draft. It deals with the ability of the DHSS to get information related to prior grant years. Although, with your staff's permission, I have consulted with Legislative Audit in order to gain an understanding of the general issue about prior years' data, the language in sec. 7 does not necessarily reflect the legislative auditor's views about specific aspects of the issue, and the language has not been reviewed by either the legislative auditor or by DHSS.

If you want me to discuss this language with either the auditor or DHSS or if I may be of other assistance, please let me know.

TML:jhb
01-026.jhb

Enclosure