

ALASKA LEGISLATURE COMMITTEE FILES

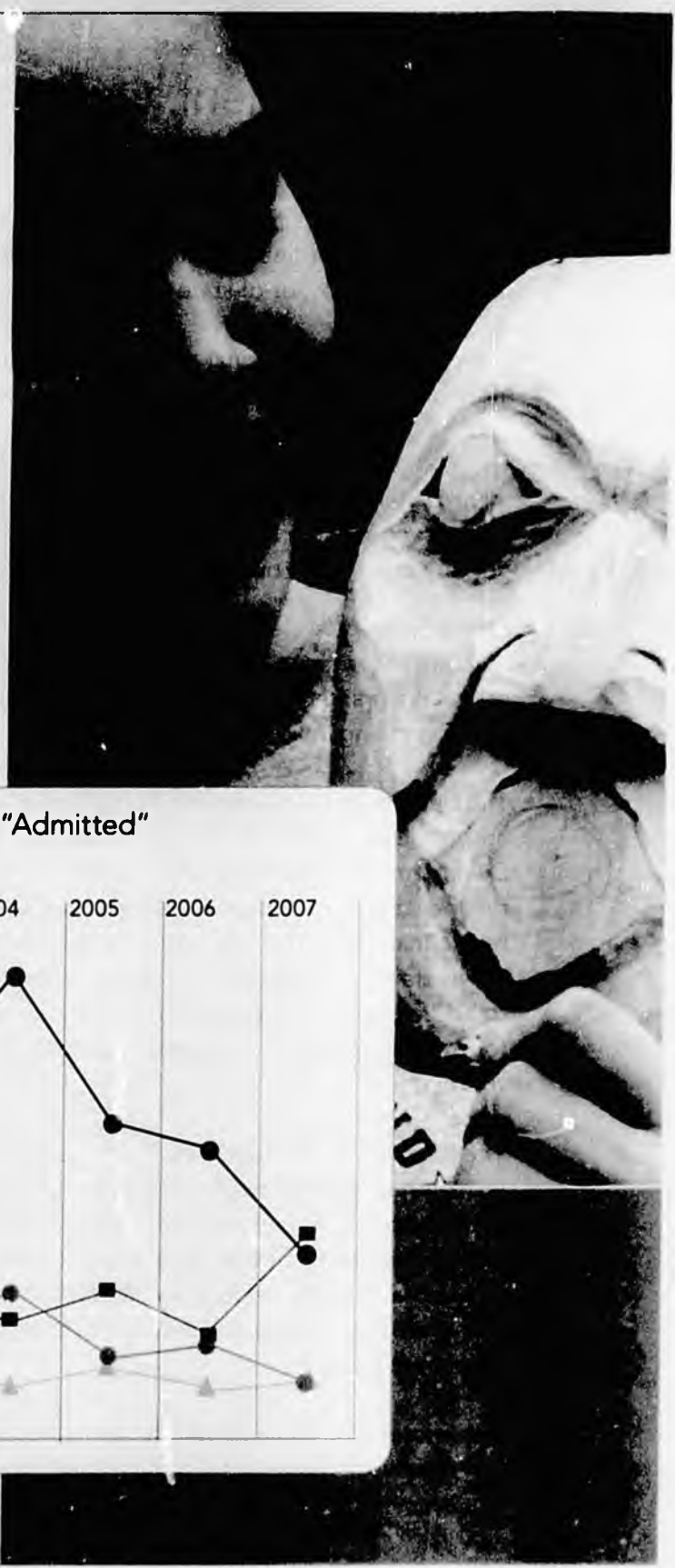
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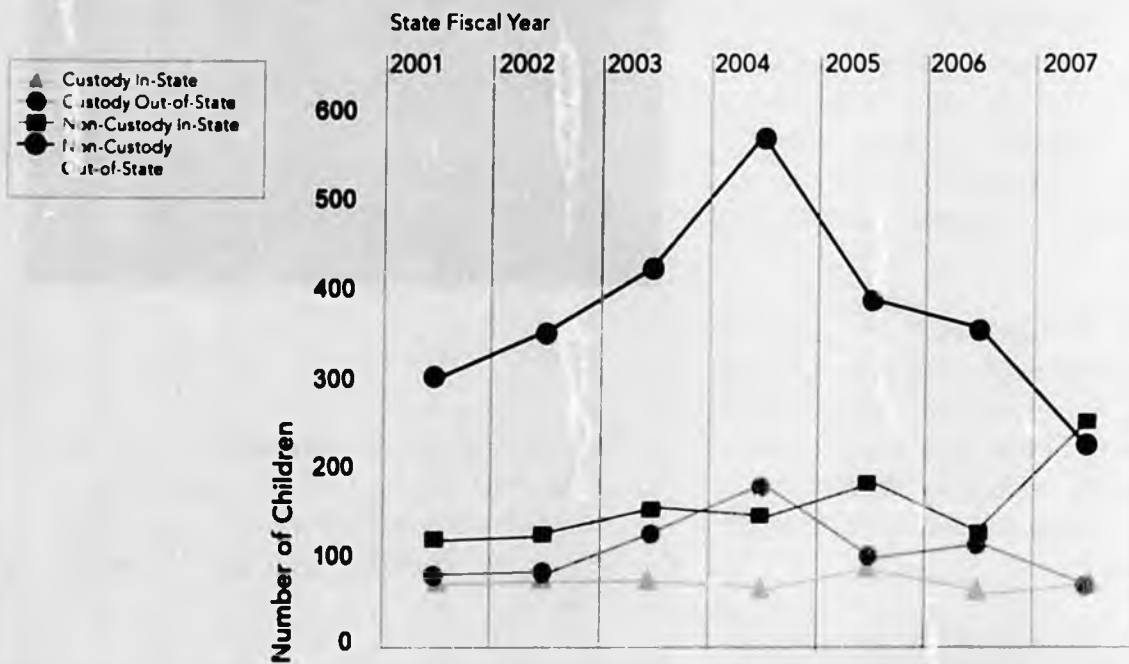
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## How do these activities affect outcomes?

For non-custody children, there is a decrease in the number out-of-state and an increase in those placed in-state. For children in state custody, systems were already in place for coordination and gatekeeping, so less impact is evident. (Table shows the distinct count of children admitted to Residential Psychiatric Treatment Centers during a fiscal year).



Residential Psychiatric Treatment Center Recipients "Admitted"



## System Management, Outcomes Tracking and Continuous Quality Improvement:

- The new care coordination team developed a database to track out-of-state referrals.
- The success of educational transitions will be monitored starting in fiscal year 2008.
- The Alaska Automated Information Management System (AK AIMS) is being developed to track and monitor behavioral health service delivery and system outcomes.
- An independent evaluator will monitor outcomes for new Bring the Kids Home operating grants starting in fiscal year 2008 and continuing in fiscal year 2009.
- The Department of Health and Social Services and the Department of Education and Early Development developed an agreement for the committees that review children for residential care. The departments are also jointly staffing an "Education Subcommittee" to address system gaps related to education for children with severe emotional disturbances.
- The Department of Health and Social Services is revising regulations to improve in-state capacity to serve children and families with behavioral health needs. One project gave Behavioral Health regulatory authority to authorize out-of-state Residential Psychiatric Treatment Centers.
- Behavioral Health developed a new contract for review of referrals to out-of-state care.



The contract expands care coordination, use of the level of care tool and regional team review of referrals. The contract was awarded and a new contractor will begin in January 2008.

For more information: [hss.state.ak.us/commissioner/btkh/reports.htm](http://hss.state.ak.us/commissioner/btkh/reports.htm)

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Between fiscal year 2006 and 2007, the exponential growth in out-of-state care was reversed: the number of children admitted to out-of-state residential psychiatric treatment centers dropped by 37 percent. This meant that 176 fewer Alaska children moved into out-of-state care.

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How do these activities affect outcomes?

As the numbers of youth in out-of-state care fall, expenditures have stabilized. Fiscal year 2007 expenditures for out-of-state care began to decline.



## Overall Bring the Kids Home Outcomes

Between fiscal year 1998 and fiscal year 2004 the total number of youth with severe emotional disturbances served<sup>2</sup> in out-of-state Residential Psychiatric Treatment Centers care per year steadily increased — 46.7 percent per year on average. However between fiscal year 2006 and fiscal year 2007 there was:

- a decrease of 19.8 percent in out-of-state Residential Psychiatric Treatment Centers recipients;
- an increase of 33.8 percent in in-state Residential Psychiatric Treatment Centers recipients; and
- a decrease of 4.8 percent in total Residential Psychiatric Treatment Centers recipients.

Between fiscal year 2006 and 2007, the exponential growth in out-of-state care was reversed: the number of children admitted to out-of-state residential psychiatric treatment centers dropped by 37 percent. This meant that 176 fewer Alaska children moved into out-of-state care.<sup>3</sup>

- a decrease of 36.3 percent in out-of-state non-custody Residential Psychiatric Treatment Centers admissions;
- a decrease of 37 percent in out-of-state Residential Psychiatric Treatment Centers admissions; and
- a decrease of 6.6 percent in total Residential Psychiatric Treatment Centers admissions.

There was also a change in the trend of out-of-state to in-state care:

- During fiscal year 2004, of the total children admitted to Residential Psychiatric Treatment Centers, 22 percent were in-state and 78 percent were out-of-state.

- During fiscal year 2007, of the total children admitted to Residential Psychiatric Treatment Centers, 52 percent were in-state and 48 percent were out-of-state.

Between fiscal year 1998 and fiscal year 2004, out-of-state Residential Psychiatric Treatment Centers Medicaid expenditures experienced an average annual increase of 59.2 percent and an overall increase of over 1,300 percent. Between fiscal years 2005 and 2006 :

- out-of-state Residential Psychiatric Treatment Centers Medicaid expenditures increased by only 4.4 percent;
- in-state Residential Psychiatric Treatment Centers Medicaid expenditures increased by 3.5 percent; and
- total Residential Psychiatric Treatment Centers Medicaid expenditures increased by only 4.7 percent — the smallest annual increase since 1998. (Despite an 18-percent increase in the fiscal year 2006 payment rate.)

Between fiscal years 2006 and 2007, Medicaid expenditures for out-of-state residential psychiatric treatment care decreased by 8.16 percent as fewer children accessed out-of-state care. This represents the first decline in out-of-state expenditures for residential psychiatric treatment since Bring the Kids Home efforts began. In-state residential psychiatric treatment centers Medicaid expenditures increased by 46.10 percent to reflect expanded in-state capacity, while total RPTC Medicaid expenditures increased by 6.13 percent. (See the *Bring the Kids Home fiscal year 2007 yearly report* for more details.)

<sup>2</sup>Unduplicated total youth served in Residential Psychiatric Treatment Centers during fiscal year, including those admitted a previous fiscal year.

<sup>3</sup>Unduplicated total youth admitted to Residential Psychiatric Treatment Centers during fiscal year, not including those admitted a previous fiscal year.

<sup>4</sup>FY07 Residential Psychiatric Treatment Centers expenditures were not available at publication, however, will be included in the FY07 Yearly Report. It is anticipated that between FY06 & FY07 expenditures for out-of-state Residential Psychiatric Treatment Centers will begin to decline.

## But will Bring the Kids Home Save Money?

The Bring the Kids Home initiative will shift expenditures from out-of-state to in-state care. Moving children from expensive out-of-state residential treatment to in-state residential treatment may decrease the length of stay and improve outcomes but increase costs per day. Even when children remain at home, it is expensive and intensive to serve children with severe emotional disturbances and their families. Thus, developing in-state capacity for children with **severe** disturbances is only a partial solution. The rest of the solution lies in providing services and supports **before** the child becomes severely disturbed. The state must invest in earlier interventions for children and families to keep problems from becoming severe.

### For more information:

[hss.state.ak.us/commissioner/btkh/reports.html](http://hss.state.ak.us/commissioner/btkh/reports.html)

1998-2004 Indicators

2007 Annual Report

2006 Annual Report

2005 Annual Report





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January 2008

This publication was released by the Department of Health & Social Services, Bring the Kids Home, produced at a cost of \$6.61 per copy in response to a request by the Legislature for a comprehensive report on Bring the Kids Home.

Printed in Anchorage, statewide distribution.

# Bringing (Keeping) the Kids Home



## 5 Year Plan

State of Alaska • Department of Health & Social Services • 5 Year Projected Plans, Fiscal Year 2009 – 2013

*More information can be found on our Web site: <http://www.hss.state.ak.us/commissioner/btkh/>.*

# Executive Summary



During the next five years, Bring the Kids Home (BTKH) efforts will build the in-state service continuum and vastly reduce use of out-of-state residential psychiatric treatment centers for children with severe emotional disturbances. These efforts are led by the Department of Health and Social Services in partnership with the Alaska Mental Health Trust Authority and with an extensive stakeholder group.

Funding strategies include using a mix of general fund dollars with Alaska Mental Health Trust Authority funds for startup, with a shift to long-term general funding by fiscal year 2013. These strategies will reduce dependence upon Medicaid funded out-of-state residential care; increase home and community based services and natural supports; invest in earlier intervention; and seek partnerships for system support and development. By the end of fiscal year 2013, *if infrastructure is funded and developed as outlined*, BTKH as an "initiative" is expected to end: the in-state behavioral health service continuum will be in place to serve children with severe emotional disturbances and/or to continue to develop that continuum.

By fiscal year 2013 the estimated funding required to sustain a system of care that treats children experiencing severe emotional disturbances and their families in-state is outlined below. Fiscal year 2013 base funding is shown in thousands of dollars. Detailed budget information can be found in attachment number one.

1. Capacity Infrastructure Development			
GF/MH	Federal	Other	<b>TOTAL</b>
\$17,480.0	\$1,250.0	\$135.0	<b>\$18,865.0</b>

2. Community Diversion, Care Coordination and Gate Keeping		
GF/MH	Federal	<b>TOTAL</b>
\$2,361.1	\$544.5	<b>\$2,905.6</b>

3. System Management, Outcomes Tracking and Continuous Quality Improvement		
GF/MH	Federal	<b>TOTAL</b>
\$2,203.4	\$105.0	<b>\$2,308.4</b>

4. Work Force Development	
GF/MH	<b>TOTAL</b>
\$975.0	<b>\$975.0</b>



## Six Primary Strategies

Bring the Kids Home strategies were developed by the stakeholder group using multiple in-state needs assessments. Over the next five years, six strategies will be the primary focus.

1. Building capacity for lower levels of non-residential care across the state. This will include residential care to stabilize children in their homes/communities or to provide safe therapeutic homes for children without an identified placement.
2. Expanding care coordination to ensure that children referred to residential treatment have access to lower levels of in-state care whenever appropriate.
3. Addressing systemic funding gaps and seeking federal funding support to leverage system development.
4. Improving reporting mechanisms to monitor system access, outcomes and service utilization.
5. Developing partnerships with communities and in-state providers to organize the resources and assistance needed to serve children experiencing severe disturbances and their families.
6. Implementing strategies to develop and maintain a skilled in-state behavioral health work force.

## System Change & Reinvestment

Bring the Kids Home efforts have resulted in system change and reinvestment. This is illustrated by the BTKH performance measures:

- 37 percent decrease in out-of-state Residential Psychiatric Treatment Center (RPTC) admissions and an increase of in-state admissions of 69 percent between fiscal years 2006 and 2007.
- 6.6 percent overall decrease in RPTC admissions during the same period.
- Change in placement patterns: 22 percent of children admitted to RPTC during fiscal year 2004 were served in Alaska; during fiscal year 2007 this increased to 52 percent.
- Drop in out-of-state expenditures for RPTC care between fiscal years 2006 and 2007 of 8.16 percent (the first drop in out-of-state expenditures since BTKH began).

## Performance Measures

Fiscal year 2013 BTKH Performance Measures for success include:

- decreasing out-of-state care to no more than 50 admissions per year;
- decreasing expenditures for out-of-state care to less than \$8 million per year;
- achieving client satisfaction with services of at least 75 percent;
- achieving client functional improvement of at least 75 percent; and
- an increasing percentage of the budget for children's behavioral health services invested for in-state expenditures (see figure 2 on page 14).





## 5 Year Projected Plan: Fiscal Year 2009-2013

During the next five years, Bring the Kids Home efforts will:

- vastly reduce the use of out-of-state residential psychiatric treatment centers for children with severe emotional disturbances;
- increase the continuum of in-home, community, school and transitional services available to children with severe emotional disturbances and their families;
- invest in services to prevent children and families from becoming severely impacted by behavioral health problems;
- increase the proportion of resources supporting in-home care and decrease the resources supporting residential care both in and out-of-state; and
- continue to build management systems, regulations and policies that support a family-driven system of care that builds on the strengths of families.

These efforts are led by the Department of Health and Social Services in partnership with the Alaska Mental Health Trust Authority and with an extensive stakeholder group. Stakeholders include the Alaska Planning Boards, parent and family organizations, tribal representatives, mental health and substance abuse providers, the Department of Education, the Special Education Service Agency and members of the public.

The primary funding strategy is to utilize a mix of general fund dollars with Alaska Mental Health Trust Authority funds for startup, with a shift to long-term general funding (if needed

for sustainability) by fiscal year 2013. A second strategy is to shift Medicaid funding from out-of-state residential care to in-state residential and community-based services. A third strategy is to pool resources, develop public-private partnerships and maximize use of natural supports. A fourth strategy is to develop tribal health care service delivery funded by 100 percent federal Medicaid. The final strategy is to gradually shift funding from intensive and costly services for a small number of children with severe disturbances towards less expensive and earlier interventions for a larger number of children and families not yet experiencing severe disturbances.

By the end of fiscal year 2013, *if core infrastructure is funded and developed as outlined*, the goal is to end BTKH as an "initiative." At that time, the basic in-state service continuum will be in place (or resources will be in place to develop it), and mechanisms will be established for system management and to monitor outcomes and ensure that youth experiencing severe emotional disturbances are treated in-state at the lowest level of care possible.

Bring the Kids Home strategies were developed by the stakeholder group to address system development comprehensively and over the long term. Resources included:

- literature reviews;
- 2002 Children & Youth Needs Assessment;
- the 2005 Alaska Rural Behavioral Health Needs Assessment;
- the 2007 BTKH Summits (Kodiak, Fairbanks, Kotzebue, Juneau, Bethel and Kenai);
- the 2007–2011 Shared Plan from the Alaska



Mental Health Board and the Advisory Board on Alcoholism and Drug Abuse,

- BTKH Yearly Reports for fiscal years 2005, 2006 and 2007;
- planning activities of the BTKH subgroups (Data, Care Coordination, Home and Community-based Services, Workforce);
- Denali Commission/DHSS Capital Business Planning Process;
- Certificate of Need process to control expansion of the most expensive Residential Psychiatric Treatment; and
- other planning and needs assessments.

# Bring the Kids Home Projects:

Bring the Kids Home projects are outlined below. Detailed budget information can be found in attachment number one, and project reports are at: <http://www.hss.state.ak.us/commissioner/btkh/>.

## I. Capacity (Infrastructure) Development

Over the next five years, there will be an emphasis on investing funding strategically to address significant gaps in the current system. The primary funding needs are for expanded grant services, individualized funding and implementing a foster care rate increase.

GF/MH \$17,480.0	Federal \$1,250.0	Other \$135.0	<b>TOTAL</b> <b>\$18,865.0</b>
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Fiscal year 2013 base funding in thousands of dollars

1. Build crisis respite stabilization beds to keep children safe during a crisis. Most children move out-of-state from expensive acute care settings. This happens quickly when no in-state placement is available: access to stabilization beds while an in-state service plan is developed will slow this down. The project will start in Anchorage, and then in hubs such as Bethel, Dillingham, Fairbanks, Homer (or Soldotna), Juneau, Ketchikan, Kodiak, Mat-Su, Nome (or Kotzebue), and Prince of Wales.
2. Establish sufficient grant funding to treat children in their homes or communities. Limited services and funding gaps contribute to the movement of children into residential care for treatment. Target projects to:
  - children with challenging presentations (example: self-harming);
  - a family system focus rather than just services for a specific child;
  - younger children and earlier interventions; and
  - needs identified through community/regional planning.
3. Establish grant funding through DHSS for school based behavioral health services to:
  - develop a tool kit to expand behavioral health services in school settings;
  - provide coordination between residential settings and school districts to increase the success of transitions for children moving out of residential care; and
  - provide startup grants to develop school-based behavioral health programs to serve children with emotional disturbances in their home school districts.
4. Increase the number of foster parents available for children experiencing severe emotional disturbances and retain quality foster parents by raising base rates and providing training. Base rates have not been raised for nine years.
5. Build an individualized services account to finance clinically necessary supports to keep a child out of residential care when there is no other funding source (Medicaid, grants, parental resources, community resources, etc).

For more information, [hss.state.ak.us/commissioner/btkh/reports.html](http://www.hss.state.ak.us/commissioner/btkh/reports.html).

## II. Community Diversion, Care Coordination and Gate Keeping

Over the next five years there will be an emphasis on linking families with supports and services while closely managing access to residential care resources in Alaska and out-of-state. Partnerships will be established with families, providers and communities to support children in their homes.

GF/MH \$2,361.1	Federal \$544.5	<b>TOTAL</b> <b>\$2,905.6</b>
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Fiscal year 2013 base funding in thousands of dollars

1. Expand assessment and coordination available to educate caregivers and assist them to access in-state resources and lower levels of care.
2. Expand scrutiny of residential psychiatric treatment referrals to ensure that out-of-state care is used only for children who cannot benefit from, or cannot get into, in-state services.
3. Continue Bring the Kids Home planning summits to identify gaps, develop community resources and identify additional resources needed for program planning and implementation.
4. Develop regional teams to assist in identifying community resources for children at risk of residential care and their families.
5. Evaluate criteria used for children to access acute care, establish a single point of entry into services and identify strategies to decrease use of acute care.
6. Continue to develop regulatory and policy strategies and standards for residential care as required to manage utilization and outcomes.
7. Implement regular review of residential psychiatric treatment centers both in-state and out-of-state, and actively manage providers to obtain desired outcomes.
8. Expand parent/peer navigation statewide to help families access natural supports and appropriate services, and to keep children in their homes.



For more information: [hss.state.ak.us/commissioner/btkh/reports.html](http://hss.state.ak.us/commissioner/btkh/reports.html)

### III. System Management, Outcomes Tracking and Continuous Quality Improvement:

Over the next five years there will be an emphasis on evaluating individual clinical outcomes, family outcomes, provider outcomes and system outcomes. An investment will be made in the tools and activities to improve these outcomes.

	GF/MH \$2,203.4	Federal \$105.0	<b>TOTAL</b> <b>\$2,308.4</b>
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Fiscal year 2013 base funding in thousands of dollars

1. Expand the capacity of the Bring the Kids Home coordinator to manage projects, communications and collaboration among Department of Health & Social Services, stakeholders, providers, planning boards, and The Trust by providing a project assistant.
2. Complete implementation of new regulations developed to: integrate behavioral health services; expand access to early childhood services; incentivize in-home services; and expand the services available to families of a child with a severe disturbance.
3. Incorporate the perspectives of consumers into Department of Health & Social Services planning, policy development and system oversight activities. There must be a partnership with consumers and their families in order for services to be effective.
4. Provide Behavioral Health with resources for hands-on assistance to children's services providers for infrastructure development. Funding will assist providers to meet performance-based funding goals and to improve delivery of integrated, family-driven and recovery-oriented services. Bring the Kids Home summits and community program planning will direct these activities. Assistance may be provided by state staff or contractors, on-site or by teleconference.
5. Support tribes to expand health service delivery, including for behavioral health, as recommended by Senate Bill 61 (Medicaid Reform report). Funding may support staff within Department of Health & Social Services Tribal Health Programs or within Behavioral Health or state contractors.
6. Expand monitoring of new Bring the Kids Home projects to include independent evaluation of outcomes by a contractor funded by The Trust.
7. Apply for federal funding to enhance resources available for system development from The Trust and the department. Gradually replace federal funding for proven components of care with general funds for Bring the Kids Home where required for sustainability.

For more information: [hss.state.ak.us/commissioner/btkh/reports.html](http://hss.state.ak.us/commissioner/btkh/reports.html)

## IV. Work Force Development

Over the next five years there will be an emphasis on institutionalizing mechanisms to develop a strong behavioral health work force. Strategies have also been put in place for advanced training and mentoring for the work force already in the field.

GF/MH \$975.0	TOTAL \$975.0
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Fiscal year 2013 base funding in thousands of dollars

1. Develop formal educational opportunities for behavioral health workers:
  - Support the University of Alaska Rural Human Services training academy
  - Expand scholarships for behavioral health care providers to obtain certification.
  - Expand cross-disciplinary classes for certification and degrees.
2. Develop training for the new DHSS demonstration waiver to keep children experiencing fetal alcohol spectrum disorders out of residential psychiatric treatment centers through:
  - initial training for new provider agencies at the University of Alaska;
  - ongoing mentoring for waiver providers; and
  - online classes for new staff.
3. Establish the capacity to train, monitor, and mentor providers in planning to wrap services around children and families and develop in-state trainers skilled in this wrap around planning model.
4. Develop the capacity to assess and treat young children with behavioral health disturbances and their families. Establish a project coordinator, learning collaborative and service grants.
5. Develop a training site at the new Eklutna residential psychiatric treatment center to provide paraprofessional training and clinical internships for university students seeking advanced degrees in behavioral health.
6. Expand tele-medicine capacity and billing mechanisms. Telemedicine is a component of BTKH work force and capacity expansion projects. Behavioral Health is expanding access through the Alaska Psychiatric Institute telepsychiatry project.



For more information: [hss.state.ak.us/commissioner/btkh/reports.html](http://hss.state.ak.us/commissioner/btkh/reports.html)



## V. Capital Funding Needs:

Over the next five years there will be an emphasis on supporting small residential options using models that are sustainable in hub areas and in developing sufficient crisis-respite stabilization capacity to keep children out of residential care.

Estimated capital needs between fiscal year 2009 and fiscal year 2013 are:

- \$7.1 million in general funds
  - \$6.3 million in federal authorization through the Denali Commission
1. Provide capital and startup funding to complete current residential care projects. For more information on current projects see the quarterly report on capital projects at: <http://www.hss.state.ak.us/commissioner/btkh/>.
  2. Develop three to five residential group homes in hub communities as needs are identified through community planning (and where sustainable).
  3. Establish a small pool of ongoing capital funding for renovations to develop foster care capacity for children with severe needs (unbreakable glass, etc).
  4. Assist two agencies to purchase homes for long-term therapeutic foster care as an alternative to residential placement.
  5. Where necessary, support development of crisis respite stabilization with capital funding.

For more information: [hss.state.ak.us/commissioner/btkh/reports.html](http://hss.state.ak.us/commissioner/btkh/reports.html)

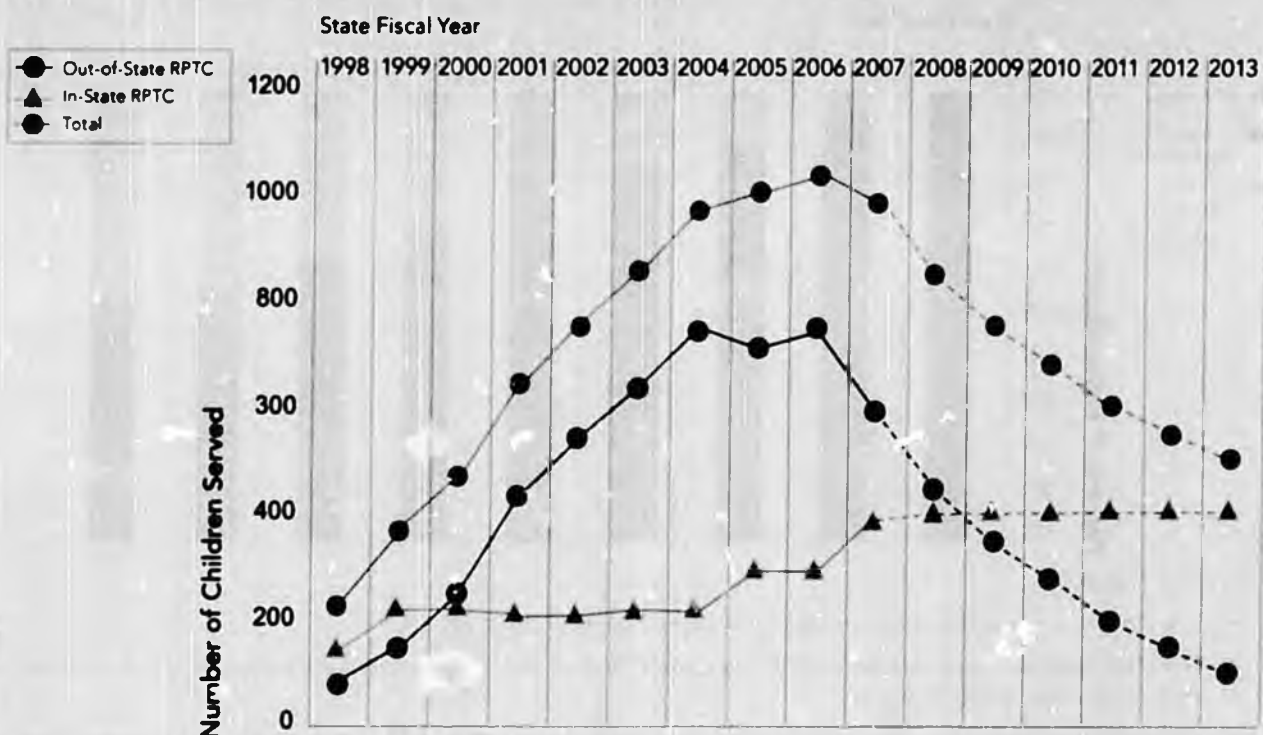
# Bring the Kids Home Performance Measures: System Change and Reinvestment

## Performance Measure 1: Client Shift (Bed Counts)

### Fiscal Year 2013 Goals

- The number of out-of-state residential psychiatric treatment center (RPTC) admissions per year will decrease from 297 admissions in fiscal year 2007 to less than 50 admissions to out-of-state RPTC during fiscal year 2013.<sup>1</sup>
- The distinct number of out-of-state RPTC recipients served per year will decrease from 596 served in fiscal year 2007 to less than 100 served in out-of-state care during fiscal year 2013.<sup>2</sup>
- The distinct number of recipients served per year at in-state RPTC will stabilize at no more than 400 by fiscal year 2013.

Figure 1 - Performance Measure 1  
Projected Change in Residential Psychiatric Treatment Utilization Over Time



### Notes on Figure 1.

- This chart shows a projection of change in children served in residential psychiatric treatment care over each fiscal year.
- Figures for fiscal years 2005–2007 are based on the actual number of children served in RPTC care.
- Figures for fiscal years 2008–2013 are based on BTKH goals for the number of children to be served in RPTC care.
- Data are from Behavioral Health, Policy and Planning section. Additional data are available in the BTKH annual reports at: <http://www.hss.state.ak.us/commissioner/btkh/>.

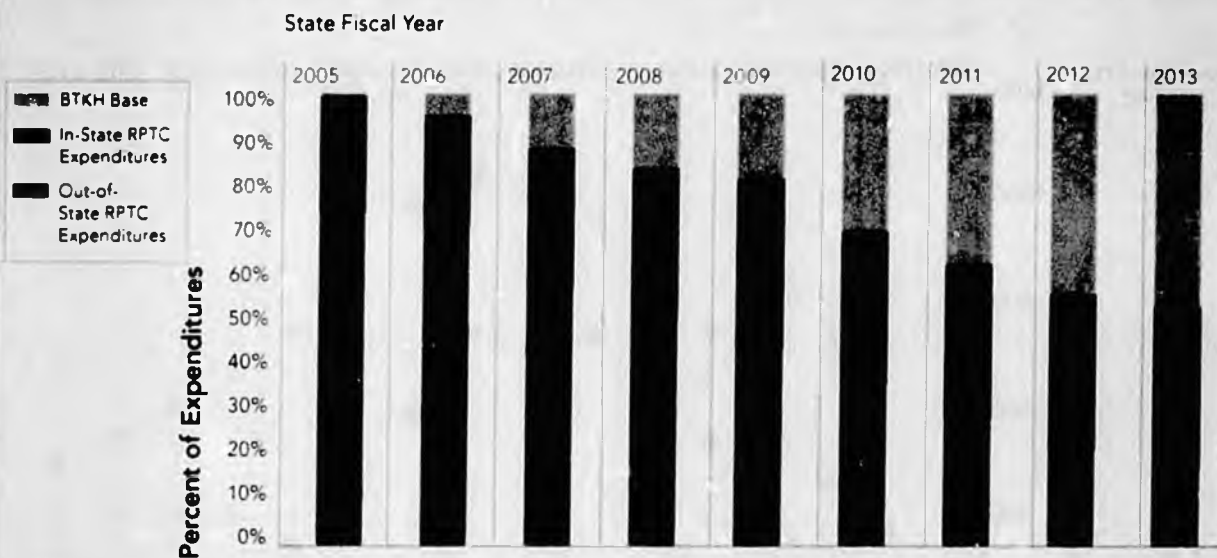
<sup>1</sup>Unduplicated total youth admitted to out-of-state RPTC during fiscal year, not including those admitted a previous fiscal year.

<sup>2</sup>Unduplicated total youth served in out-of-state RPTC during fiscal year, including those admitted a previous fiscal year

## Performance Measure 2: Funding Shift Fiscal Year 2013 Goals

- Medicaid expenditures for out-of-state residential psychiatric treatment center (RPTC) will decrease from \$40 million in fiscal year 2006 to less than \$8 million by fiscal year 2013
- In-state RPTC expenditures will stabilize at \$20 million or less by fiscal year 2013
- Department of Health & Social Services will strive to bring this number down as additional capacity to serve children in non-residential care is developed.

Figure 2: Performance Measures 2  
Projected Bring the Kids Home Reinvestment



### Notes on Figure 2

- This chart represents the reinvestment of resources into the in-state system.
- The chart captures expenditures for RPTC care and BTKH funding to develop in-state services and reduce the number of children moving into RPTC care.
- The first three years (fiscal years 2005–2007) are based on the actual BTKH base budget and the expenditures for residential psychiatric treatment center care.
- The remaining years are based on the projected BTKH base budget and expenditures for residential psychiatric treatment center care (based on Performance Measure 1).
- Expenditure data for fiscal years 2005 and 2006 are from Behavioral Health Policy and Planning based on paid claims for Medicaid data. Expenditure data for fiscal year 2007 are from calculations completed by DHSS Finance Management and include all claims incurred and paid in fiscal year 2007 as well claims incurred in fiscal year 2007 and paid in the first quarter of fiscal year 2008. Every attempt was made to replicate the parameters used between Behavioral Health and Finance Management Services. Parameters have now been standardized and future years will replicate the parameters used for fiscal year 2007.
- Additional data are available in the BTKH annual reports at: <http://www.hss.state.ak.us/commissioner/btkh/>.

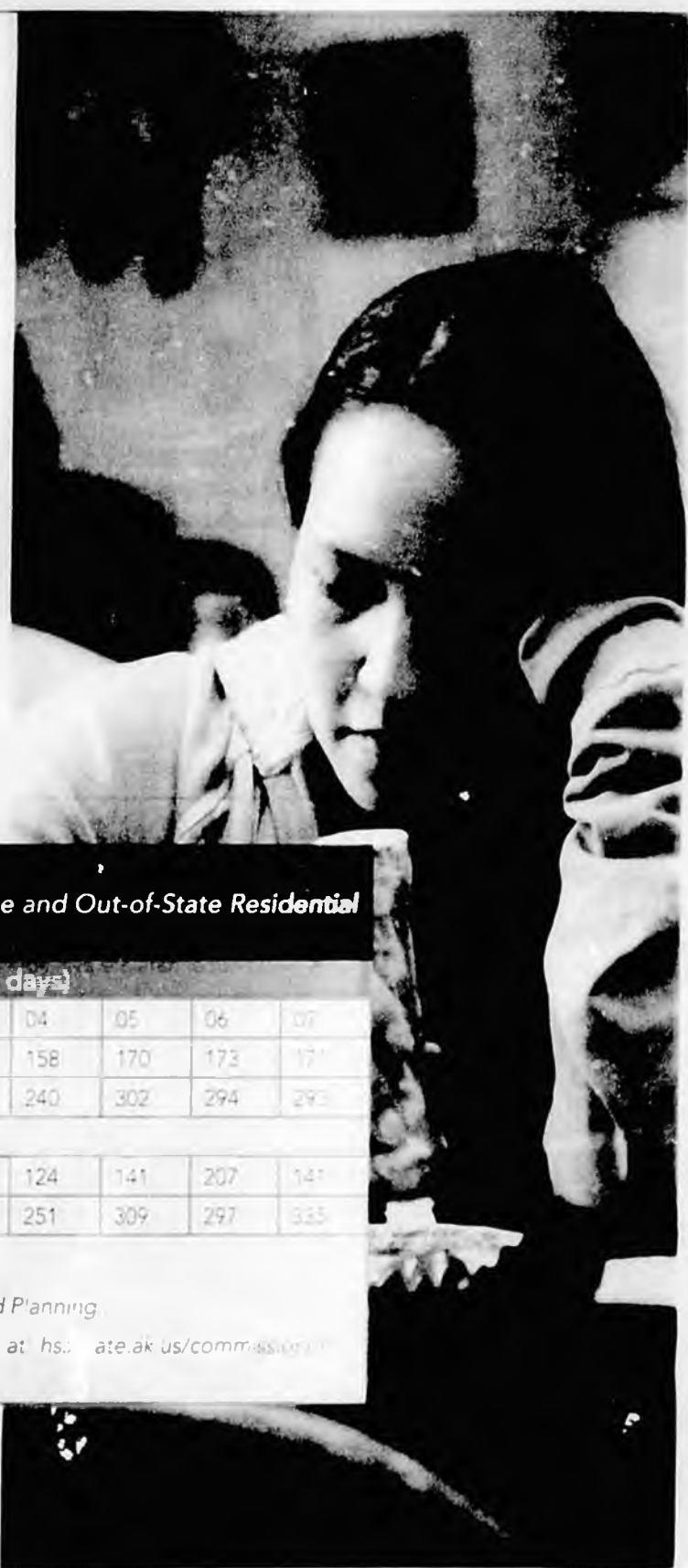
FY05 – FY07 based on actual BTKH budget and expenditures for residential psychiatric treatment center care

FY08 – FY13 based on projected BTKH budget and expenditures for residential psychiatric treatment center care

**Performance Measure 3: Length of Stay  
Fiscal Year 2013 Goals**

- The length of stay in out-of-state residential psychiatric treatment centers (RPTC) will average 260 days or less.
- The length of stay for in-state RPTC will average no more than 120 days

As significantly fewer children are served in RPTC, they will have more intensive needs and may require longer lengths of stay. Length of stay goals may require adjustment based on the clinical needs of the children served. For fiscal year 2007 the average length of stay is illustrated below.



**Figure 3 Performance Measure 3  
Average Length of Stay By Custody Status for In-State and Out-of-State Residential  
Psychiatric Treatment Centers.**

		Average Length of Stay (in days)							
Custody	IO	01	02	03	04	05	06	07	
Custody	In-State	129.5	154	146	158	170	173	171	
Custody	Out-Of-State	131.4	249	255	240	302	294	293	
Non-Custody	In-State	94.0	101	108	124	141	207	141	
Non-Custody	Out-Of-State	126.3	200	250	251	309	297	333	

**Notes on Figure 3.**

- These data were provided by Behavioral Health, Policy and Planning.
- Additional data are available in the BTKH annual reports at <http://hs.state.ak.us/commission/btkh/>.

### Performance Measure 4: Service Capacity (In-State Bed Counts)

#### Fiscal Year 2013 Goals

- In-state residential beds for children will increase 29.7 percent by fiscal year 2013.

Figure 4: Performance Measure 4  
Estimated Bed Capacity and Increase between Fiscal Year 2007 and Fiscal Year 2013

	FY07	FY13	Anticipated bed Count	Percent Increase
In-State Bed Capacity: below RPTC	638	821	183	28.7%
In-State RPTC Capacity	166	222	56	33.7%
TOTAL In-State Beds	804	1043	239	29.7%

#### Notes on Figure 4.

- These data were gathered from Health and Social Services staff based on current capacity and estimated capacity increases to behavioral health residential care operated using Medicaid or grant funding.
- Additional data are available in the BTKH annual reports at: [hss.state.ak.us/commissioner/btkh/](http://hss.state.ak.us/commissioner/btkh/).

### Performance Measure 5: Recidivism (In-State Bed Counts)

#### Fiscal Year 2013 Goals

- Overall average recidivism rates in residential psychiatric treatment centers (RPTC) will stabilize at 7.5 percent. Recidivism is defined as children/youth returning within one year to the same or higher level of residential care.

During fiscal year 2007, the overall recidivism rate was 7.5 percent for a readmission to an RPTC within 365 days of the date of discharge.

**Performance Measure 6: Client Satisfaction  
Fiscal Year 2013 Goals**

- Seventy-five percent of children and families will report satisfaction with services rendered on an annual basis.
- Client satisfaction reports will include both residential psychiatric treatment center care (in- and out-of-state) as well as community-based services.

Currently Behavioral Health reports on community-based services and is developing the capacity to expand this indicator to include residential psychiatric treatment centers. For fiscal year 2007, Behavioral Health youth satisfaction with services is illustrated below.



**Figure 5: Performance Measure 6  
Youth Behavioral Health Consumer Survey Respondents Satisfied with Services**

Access to Services	50%
Satisfaction with Services	64%
Participation with Treatment	62%
Cultural Sensitivity	78%
Positive Outcomes of Services	72%

Notes on Figure 5:

- These data were provided by Behavioral Health, Policy and Planning

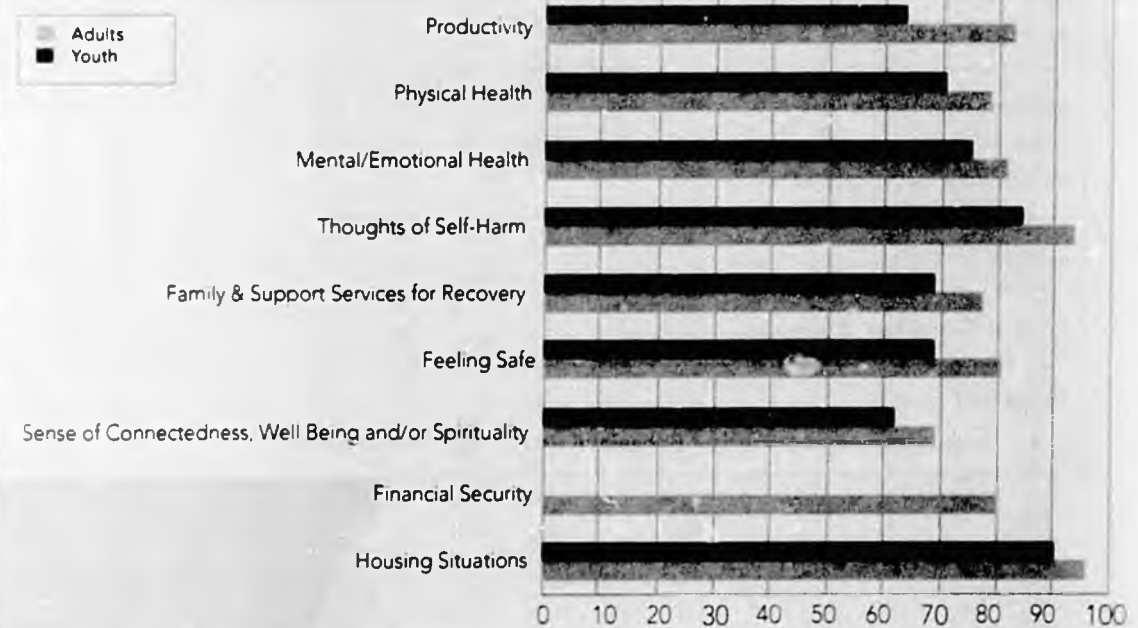
## Performance Measure 7: Functional Improvement

### Fiscal Year 2013 Goals

- Seventy-five percent of children and youth will show functional improvement in one or more life domain areas at discharge and one year after discharge
- Functional improvement will be tracked for residential psychiatric treatment center care (in and out-of-state) as well as community-based services

*Currently, Behavioral Health reports on community-based services and is developing the capacity to expand this indicator to include residential psychiatric treatment centers. Fiscal year 2007 Behavioral Health functional improvement measures are in the chart below.*

**Figure 6 — Performance Measure 7: 2007 Treatment Outcomes — Client Status Review: Youth & Adult**



## For more information:

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## Available on our Web site:

[hss.state.ak.us/commissioner/btkh/](http://hss.state.ak.us/commissioner/btkh/)

2007 Peer Navigation Report AYFN Qtr 1

2007 Family Voice Report

2006 BTKH Annual Report

2006 Capacity Grant Report

2005 BTKH Annual Report

BTKH Funding Focus Area Summary

1998 - 2004 BTKH Baseline Data





State of Alaska  
Department of Health & Social Services

***Bring the Kids Home***

Sarah Palin, Governor  
Karleen K. Jackson, Commissioner

Brita Bishop, LCSW  
Bring the Kids Home Coordinator

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January 2008

This publication was released by the Department of Health & Social Services, Bring the Kids Home, produced at a cost of \$8.49 per copy in response to a request by the Legislature for a comprehensive report on Bring the Kids Home.  
Printed in Juneau, statewide distribution.

*Attachment One*

Bringing (Keeping) the Kids Home: Actual and Projected Budget  
Information



**3 Year Update  
& 5 Year Plan**

State of Alaska  
Department of Health & Social Services  
Fiscal Year 2005 - 2013

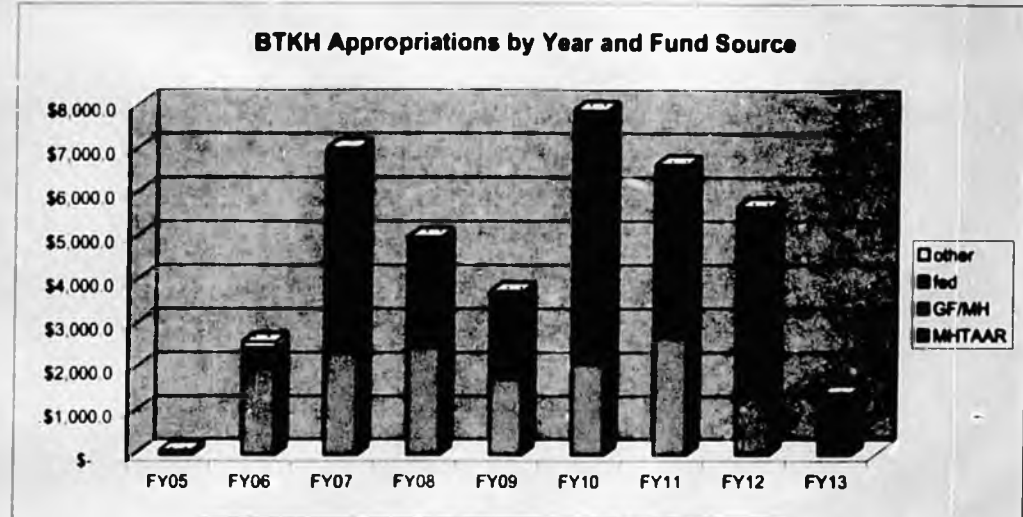
Additional information is available at  
<http://www.hss.state.ak.us/commissioner/btkh/>

## BRING THE KIDS HOME TOTAL BUDGET BY YEAR AND FUND SOURCE

*All funding shown in thousands of dollars*

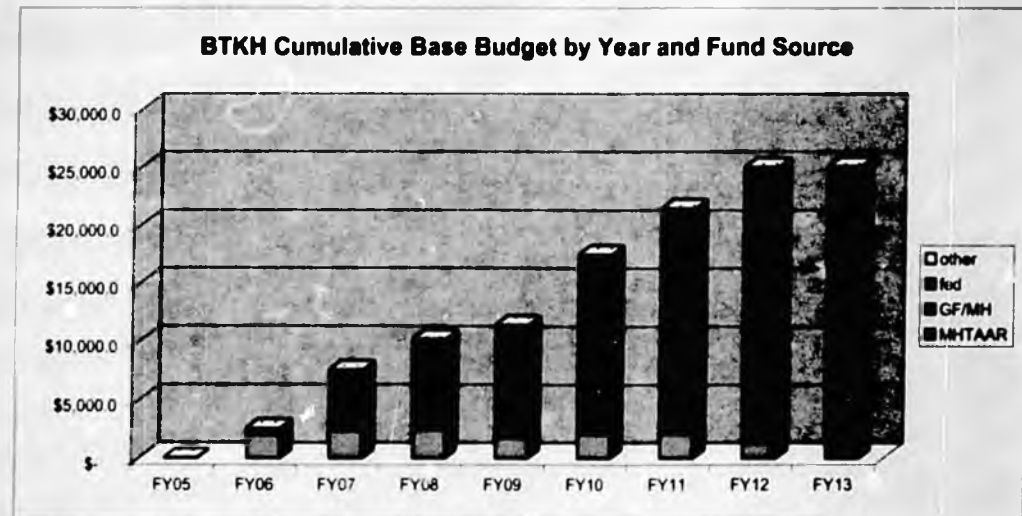
BTKH Appropriations by Year and Fund Source					
	MHTAAR	GF/MH	fed	other	TOTAL
FY05	\$ 100.0	\$ -	\$ -	\$ -	\$ 100.0
FY06	\$ 2,045.5	\$ 204.5	\$ 204.5	\$ 135.0	\$ 2,589.5
FY07	\$ 2,365.0	\$ 3,135.0	\$ 1,515.0	\$ -	\$ 7,015.0
FY08	\$ 2,500.0	\$ 2,489.0	\$ -	\$ -	\$ 4,989.0
FY09	\$ 1,775.0	\$ 1,975.0	\$ -	\$ -	\$ 3,750.0
FY10	\$ 2,100.0	\$ 5,588.2	\$ 180.0	\$ -	\$ 7,868.2
FY11	\$ 2,725.0	\$ 3,911.0	\$ -	\$ -	\$ 6,636.0
FY12	\$ 1,350.0	\$ 4,316.8	\$ -	\$ -	\$ 5,666.8
FY13	\$ -	\$ 1,400.0	\$ -	\$ -	\$ 1,400.0

*Fiscal year 2005 - 2008 = actual BTKH budget.  
Fiscal year 2009 - 2013 = projected BTKH budget.*



BTKH Cumulative Base Budget by Year and Fund Source					
	MHTAAR	GF/MH	fed	other	TOTAL
FY05	\$ 100.0	\$ -	\$ -	\$ -	\$ 100.0
FY06	\$ 2,045.5	\$ 204.5	\$ 204.5	\$ 135.0	\$ 2,589.5
FY07	\$ 2,365.0	\$ 3,339.5	\$ 1,719.5	\$ 135.0	\$ 7,559.0
FY08	\$ 2,500.0	\$ 5,828.5	\$ 1,719.5	\$ 135.0	\$ 10,183.0
FY09	\$ 1,775.0	\$ 7,803.5	\$ 1,719.5	\$ 135.0	\$ 11,433.0
FY10	\$ 2,100.0	\$ 13,391.7	\$ 1,899.5	\$ 135.0	\$ 17,526.2
FY11	\$ 2,125.0	\$ 17,302.7	\$ 1,899.5	\$ 135.0	\$ 21,462.2
FY12	\$ 1,350.0	\$ 21,619.5	\$ 1,899.5	\$ 135.0	\$ 25,004.0
FY13	\$ -	\$ 23,019.5	\$ 1,899.5	\$ 135.0	\$ 25,054.0

*Fiscal year 2005 - 2008 = actual BTKH budget.  
Fiscal year 2009 - 2013 = projected BTKH budget.*



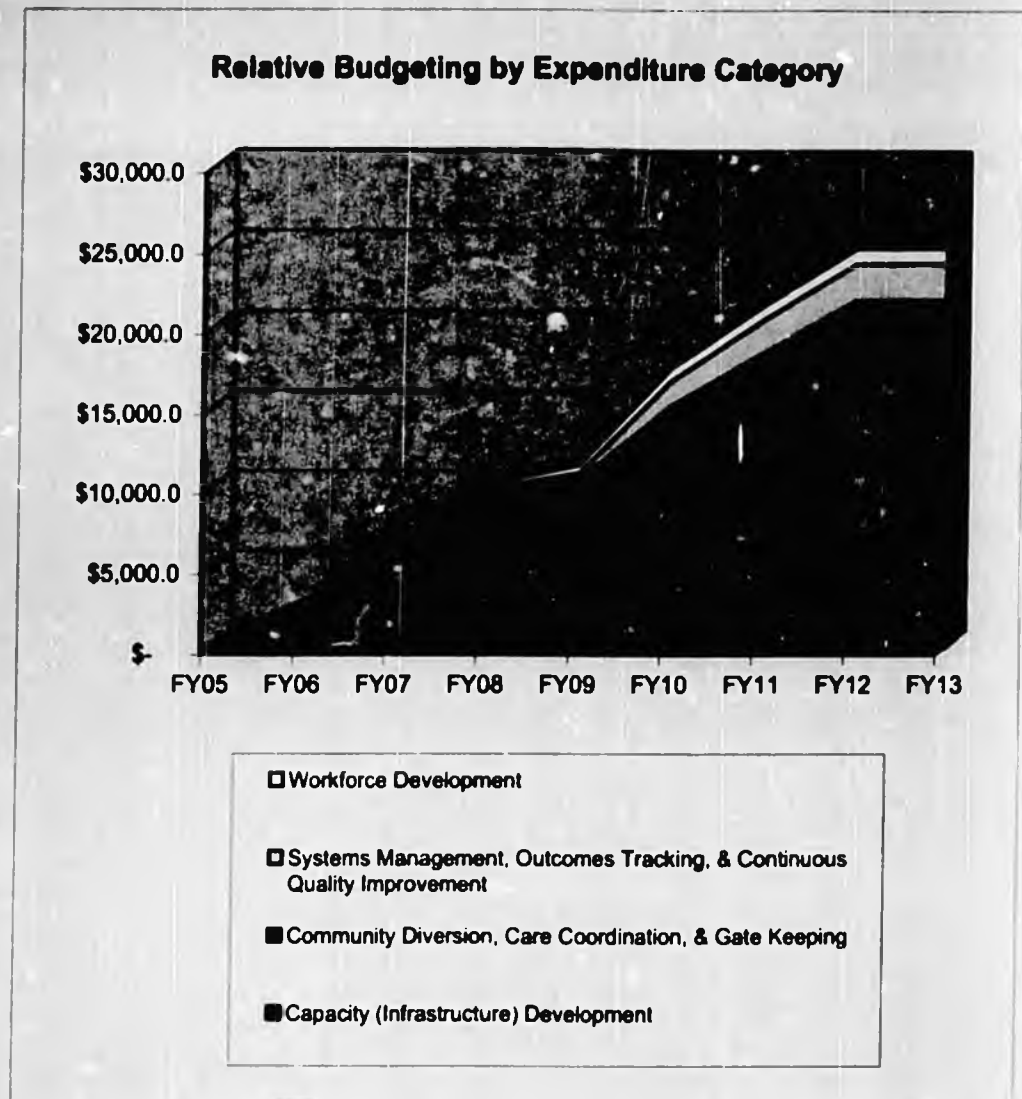
## BTKH RELATIVE BUDGETING BY EXPENDITURE CATEGORY WITHIN CUMULATIVE BASE BUDGET

*Funding shown in thousands of dollars.*

RELATIVE BUDGETING BY EXPENDITURE CATEGORY					
	Capacity (Infrastructure) Development	Community Diversion, Care Coordination, & Gate Keeping	Systems Management, Outcomes Tracking, & Continuous Quality Improvement	Workforce Development	TOTAL
<b>FY05</b>	\$ -	\$ 100.0	\$ -	\$ -	\$ 100.0
<b>FY06</b>	\$ 2,078.0	\$ 471.5	\$ 40.0	\$ -	\$ 2,589.5
<b>FY07</b>	\$ 5,305.0	\$ 1,719.0	\$ 535.0	\$ -	\$ 7,559.0
<b>FY08</b>	\$ 7,424.0	\$ 2,015.6	\$ 438.4	\$ 305.0	\$ 10,183.0
<b>FY09</b>	\$ 8,424.0	\$ 2,015.6	\$ 438.4	\$ 555.0	\$ 11,433.0
<b>FY10</b>	\$ 12,682.2	\$ 2,455.6	\$ 1,583.4	\$ 805.0	\$ 17,526.2
<b>FY11</b>	\$ 15,698.2	\$ 2,755.6	\$ 2,108.4	\$ 900.0	\$ 21,462.2
<b>FY12</b>	\$ 18,815.0	\$ 2,905.6	\$ 2,308.4	\$ 975.0	\$ 25,004.0
<b>FY13</b>	\$ 18,865.0	\$ 2,905.6	\$ 2,308.4	\$ 975.0	\$ 25,054.0

*Fiscal year 2005 - 2008 = actual BTKH budget.*

*Fiscal year 2009 - 2013 = projected BTKH budget.*

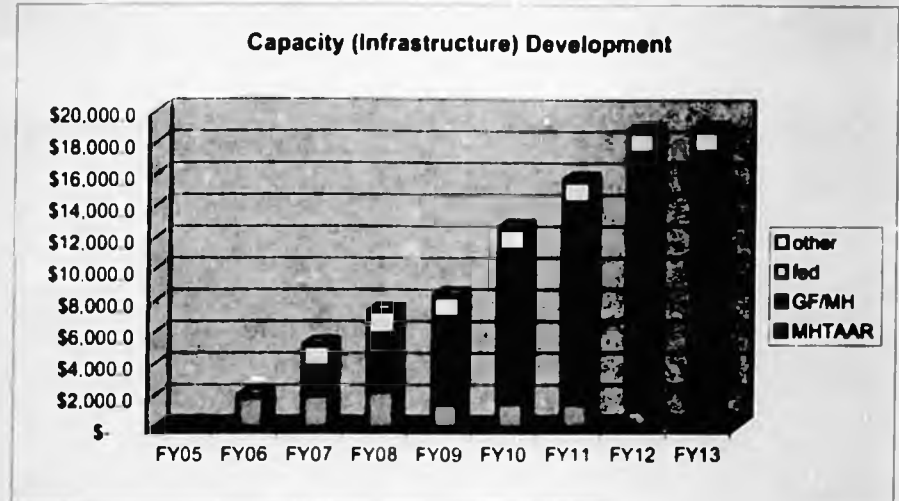


**FUND SOURCE DETAIL FOR  
BRING THE KIDS HOME RELATIVE BUDGETING BY EXPENDITURE CATEGORY  
WITHIN CUMULATIVE BASE BUDGET**

*All funding in thousands of dollars*

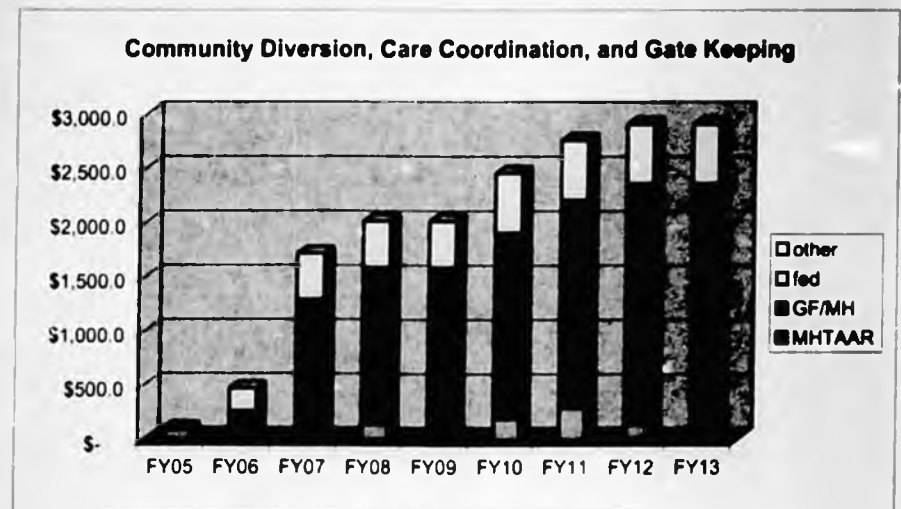
<b>Capacity (Infrastructure) Development</b>					
	<b>MHTAAR</b>	<b>GF/MH</b>	<b>fed</b>	<b>other</b>	<b>TOTAL</b>
<b>FY05</b>	\$ -	\$ -	\$ -	\$ -	\$ -
<b>FY06</b>	\$ 1,943.0	\$ -	\$ -	\$ 135.0	\$ 2,078.0
<b>FY07</b>	\$ 2,090.0	\$ 1,830.0	\$ 1,250.0	\$ 135.0	\$ 5,305.0
<b>FY08</b>	\$ 2,325.0	\$ 3,714.0	\$ 1,250.0	\$ 135.0	\$ 7,424.0
<b>FY09</b>	\$ 1,550.0	\$ 5,489.0	\$ 1,250.0	\$ 135.0	\$ 8,424.0
<b>FY10</b>	\$ 1,600.0	\$ 9,697.2	\$ 1,250.0	\$ 135.0	\$ 12,682.2
<b>FY11</b>	\$ 1,550.0	\$ 12,763.2	\$ 1,250.0	\$ 135.0	\$ 15,698.2
<b>FY12</b>	\$ 1,050.0	\$ 16,380.0	\$ 1,250.0	\$ 135.0	\$ 18,815.0
<b>FY13</b>	\$ -	\$ 17,480.0	\$ 1,250.0	\$ 135.0	\$ 18,865.0

*Fiscal year 2005 - 2008 = actual BTKH budget.  
Fiscal year 2009 - 2013 = projected BTKH budget.*



<b>Community Diversion, Care Coordination, and Gate Keeping</b>					
	<b>MHTAAR</b>	<b>GF/MH</b>	<b>fed</b>	<b>other</b>	<b>TOTAL</b>
<b>FY05</b>	\$ 100.0	\$ -	\$ -	\$ -	\$ 100.0
<b>FY06</b>	\$ 62.5	\$ 204.5	\$ 204.5	\$ -	\$ 471.5
<b>FY07</b>	\$ -	\$ 1,294.5	\$ 424.5	\$ -	\$ 1,719.0
<b>FY08</b>	\$ 150.0	\$ 1,441.1	\$ 424.5	\$ -	\$ 2,015.6
<b>FY09</b>	\$ 50.0	\$ 1,541.1	\$ 424.5	\$ -	\$ 2,015.6
<b>FY10</b>	\$ 200.0	\$ 1,711.1	\$ 544.5	\$ -	\$ 2,455.6
<b>FY11</b>	\$ 300.0	\$ 1,911.1	\$ 544.5	\$ -	\$ 2,755.6
<b>FY12</b>	\$ 150.0	\$ 2,211.1	\$ 544.5	\$ -	\$ 2,905.6
<b>FY13</b>	\$ -	\$ 2,361.1	\$ 544.5	\$ -	\$ 2,905.6

*Fiscal year 2005 - 2008 = actual BTKH budget.  
Fiscal year 2009 - 2013 = projected BTKH budget.*

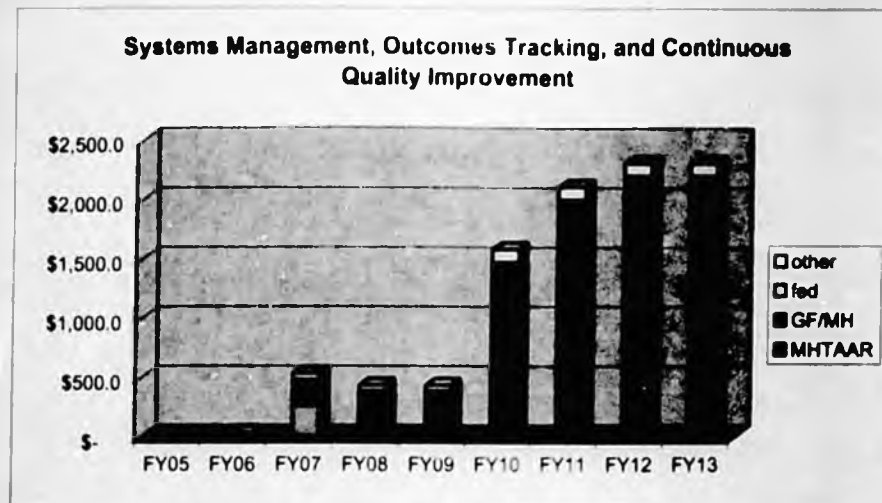


**FUND SOURCE DETAIL FOR  
BRING THE KIDS HOME RELATIVE BUDGETING BY EXPENDITURE CATEGORY  
WITHIN CUMULATIVE BASE BUDGET**

*All funding in thousands of dollars*

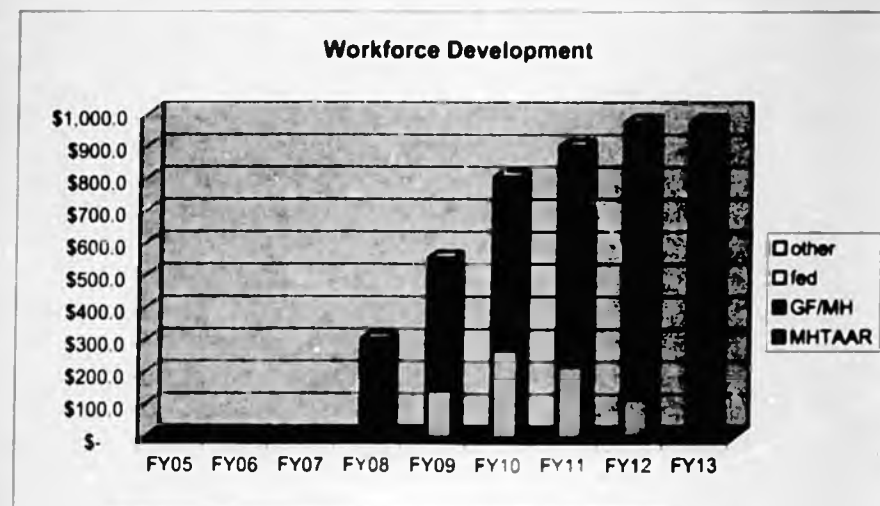
<b>Systems Management, Outcomes Tracking, &amp; Continuous Quality Improvement</b>					
	<b>MHTAAR</b>	<b>GF/MH</b>	<b>fed</b>	<b>other</b>	<b>TOTAL</b>
FY05	\$ -	\$ -	\$ -	\$ -	\$ -
FY06	\$ 40.0	\$ -	\$ -	\$ -	\$ 40.0
FY07	\$ 275.0	\$ 215.0	\$ 45.0	\$ -	\$ 535.0
FY08	\$ 25.0	\$ 368.4	\$ 45.0	\$ -	\$ 438.4
FY09	\$ 25.0	\$ 368.4	\$ 45.0	\$ -	\$ 438.4
FY10	\$ 25.0	\$ 1,453.4	\$ 105.0	\$ -	\$ 1,583.4
FY11	\$ 50.0	\$ 1,953.4	\$ 105.0	\$ -	\$ 2,108.4
FY12	\$ 25.0	\$ 2,178.4	\$ 105.0	\$ -	\$ 2,308.4
FY13	\$ -	\$ 2,203.4	\$ 105.0	\$ -	\$ 2,308.4

*Fiscal year 2005 - 2008 = actual BTKH budget.  
Fiscal year 2009 - 2013 = projected BTKH budget.*



<b>Workforce Development</b>					
	<b>MHTAAR</b>	<b>GF/MH</b>	<b>fed</b>	<b>other</b>	<b>TOTAL</b>
FY05	\$ -	\$ -	\$ -	\$ -	\$ -
FY06	\$ -	\$ -	\$ -	\$ -	\$ -
FY07	\$ -	\$ -	\$ -	\$ -	\$ -
FY08	\$ -	\$ 305.0	\$ -	\$ -	\$ 305.0
FY09	\$ 150.0	\$ 405.0	\$ -	\$ -	\$ 555.0
FY10	\$ 275.0	\$ 530.0	\$ -	\$ -	\$ 805.0
FY11	\$ 225.0	\$ 675.0	\$ -	\$ -	\$ 900.0
FY12	\$ 125.0	\$ 850.0	\$ -	\$ -	\$ 975.0
FY13	\$ -	\$ 975.0	\$ -	\$ -	\$ 975.0

*Fiscal year 2005 - 2008 = actual BTKH budget.  
Fiscal year 2009 - 2013 = projected BTKH budget.*



**3/5/08**

**PRESENT.:**

**MEDICAID**

**BEHAV-**

**IORAL**

**HEALTH**

**FEDERAL CHANGES  
CORPORATE COMPLIANCE**



# **MEDICAID BEHAVIORAL HEALTH**

**Presenter:**

Mary Thornton, BSRN, MBA  
National Expert and Trainer

**When:**

Tuesday, March 4, 2008  
8:30 a.m. to 4:30 p.m.

**Where:**

Centennial Hall in Juneau

**No Fee:**

However, you must be registered to attend. Please complete the registration form below and email to [Katiec@iys.org](mailto:Katiec@iys.org) or fax to Katie Crossley at 789-2106

Jointly sponsored by the Alaska Association of Homes for Children (AAHC) and the Alaska Behavioral Health Association (ABHA)

**Registration Form**

Medicaid Behavioral Health - Audits, Federal Changes, Corporate Compliance Training by Mary Thornton on March 4, 2008.

<b>NAME OF AGENCY:</b>		
<b>Persons Attending Training</b>	<b>Title</b>	<b>Email Address</b>

Email to [Katiec@iys.org](mailto:Katiec@iys.org) or fax to Katie Crossley at 789-2106

# Mary Thornton & Associates, Inc.

*Behavioral  
Health  
Collaborative  
Solutions*

**About BHCS  
Home Page  
BHCS, Inc.  
Parker Dowdman  
Slagden Consult**

## Are You 'Audit Proof'?

*Download these important and timely articles by Mary Thornton*

Protecting Yourself from an Adverse Federal Audit: Mary Thornton, 2005

OIG Work Plan for Fraud and Abuse Focuses on Behavioral Health: Mary Thornton, 2005

**Mary Thornton & Associates, Inc. (MTA)** is a healthcare consulting firm that specializes in operational solutions for behavioral health organizations nationwide. Recently MTA has focused on the revenue cycle within organizations that are undergoing significant change or need to reorganize and refocus management and staff attention on the development of diversified revenue sources. Using the organization's current revenue cycle as a baseline, MTA assists organizations to:

- ◆ Reduce the time from client referral to cash receipts;
- ◆ Redirect staff efforts towards billable activities with a focus on increasing quality of care
- ◆ Increase staff productivity
- ◆ Implement internal controls on revenue generation to ensure compliance with regulation and law
- ◆ Develop efficient and effective third party billing and reimbursement departments
- ◆ Implement practice management techniques that enhance service delivery and revenue generation focusing on the individual practices of different employee groups - medical staff, clinical staff, community-based workers
- ◆ Train staff on a variety of subjects that increase the power of the revenue cycle to positively impact the organization's bottom line including - marketing, corporate compliance, practice management; third party billing and reimbursement with a specialty in the federal health care programs, mental health rehabilitation services including delivery systems, documentation, service fidelity
- ◆ Increase the effectiveness of senior management in their work to develop flexible, strong, and financially viable organizations.

MTA believes that behavioral health can effectively use tools developed by the larger business community to implement a strong business-focused infrastructure. These infrastructures can better support the implementation of best practices, clinical models and the continuing innovation which are critical to behavioral health's future. MTA also believes that management needs to refocus their attention on payer requirements and regulations and to use those rules to support revenue maximization in a high quality environment.

Mary Thornton, BSRN, MBA, is the president of MTA and its founder. She is a talented and engaging consultant and trainer with significant expertise in mental health rehabilitation reimbursement systems, medical necessity and documentation, coding and reimbursement, and corporate compliance in behavioral healthcare. She combines a Bachelor's in Nursing with an MBA to assist behavioral healthcare service systems and providers in designing efficient, high quality services and programs. Ms. Thornton was a member of the consulting teams that assisted in the conversion to rehabilitation option for the states of Illinois, Georgia, Connecticut,

and the District of Columbia. She was also the lead consultant on compliance issues for the state of Ohio in its SOQC project designed to further operational efficiency through standardized documentation and training in medical necessity and rehabilitation option services. Ms. Thornton is the author of a number of publications on corporate compliance including *Ahead of the Game: Corporation Compliance for Behavioral Health* and on HIPAA including the *The HIPAA Handbook: What Community Behavioral Healthcare Organizations Need to Know about HIPAA*. These books and others were published by the National Council of Community Behavioral Healthcare. Ms. Thornton is also published in a number of behavioral healthcare journals where she contributes articles on compliance, coding and reimbursement, HIPAA, and other topics. She is also a nationally recognized trainer and a featured speaker for many state and national associations of provider agencies.

To contact *Mary Thornton & Associates, Inc* directly, please call or e-mail:

Phone: 617-730-5800

Email: Mary Thornton - [MThornton@marythornton.com](mailto:MThornton@marythornton.com)



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 Starfield Technologies, Inc.

# Behavioral Health Services

The New Medicaid Environment  
Presented by Mary Thornton

Sponsored by:

Alaska Behavioral Health Association &  
Alaska Association of Homes for Children



1

## Medicaid

- Shared cost federal and state
- Two opinions on quality and content of services
- Greater emphasis right now at federal level on cost savings
  - Narrower definitions
  - Medical mode! – health vs. wellness



2

## Among the Federal Frustrations with Medicaid

- Fraud efforts are uneven
  - Laws do not exist to prosecute as Feds would like
  - Investment in investigating arms is inadequate given the risk
  - Rules are different in each state making national coverage decisions and enforcement appear to be difficult
  - Providers implementation of compliance efforts appear to be inadequate given audit findings
  - “Medicaiding” services and other financing schemes



3

### I. New Auditors

- New landscape in federal oversight and provider requirements
- PERM: state focus
- DRA: state and provider focus
- RAC: bounty hunters
- Increase pressure on states to increase program integrity activities



4

**State Responsibilities**

**Federal Responsibilities**

**Medicaid Fraud/Program Integrity Units within program**

1. Often under funded.
2. No clear guidelines re: referrals – differ by states.
3. Referrals out to MCFU's differ greatly by state
4. Provider focus

**Medicaid Fraud Control Units**

1. Funding greatly different by state.
2. Usually significant return on investment.
3. Provider focus.
4. Usually state attorney general.

**County Audits & State Controller**

1. Vary by state
2. Some tail s-backs -usually no extrapolation.
3. Look at state and provider.

**RAC Auditors**

1. Going nationwide by 2010
2. Tax Relief and Health Care Act
3. "bounty hunters on contingency"

**Perm Audits**

1. Medicaid error rates
2. Medical necessity, eligible for Caidd, correct claim
3. Provider focused
4. Error rates >2.5% to Congress

**Medicaid Integrity Program**

1. Audit of providers – state must require payback – only appeal is by state
2. Audit and report card to state about program integrity

**OIG Audits**

1. OIG workplan
2. Lots more money for Caidd

**In about 10 states these functions being centralized under a Medicaid Inspector General**

State False Claims Acts

Federal Oversight/ Error Rates, Required Paybacks, Report Cards

DRA Whistleblower provisions

**Providers**

- Compliance program
- DRA Book – decisions
- Internal Education
- Watch for state activity
- Watch FCA and internal culture
- Pay back when you find errors
- Self-disclosure – if necessary
- Be clear who is asking for what
- Watch for new patterns of denials

focus only on Medicaid

## II. New Rules

- See the attached *NY Times* article
- Rehab Rule
- CM Rule
- Evidence-based Practices: CMS encyclical



## Expected Outcome: Rehab Rule

- 150mm in savings in 2008
- 2.2 billion in savings from 2008 to 2012
- Primary savings to come from Medicaid not paying for inappropriate services and services that are “intrinsic” to other services and already being paid for by another party



## Changes

- **Non-covered services:**
  - **Services that provided by non-medical program either as a benefit or as an administrative activity (e.g. case management), including services that are intrinsic elements of programs other than Medicaid.**
    - Therapeutic foster care
    - Packaged services furnished by foster care or child care institutions for a foster child
    - Adoption, family preservation, family reunification
    - Routine supervision and non-medical support by teacher's aides
  - **Habilitation services: individuals with mental retardation or related conditions**
  - **Recreational or social activities**
  - **Services provided to inmates**
  - **Services to residents of IMDs (Institutions for Mental Diseases)**
  - **Room and board**
  - **Services to those not Medicaid eligible**
  - **Services not to a specific individual**

## Proposed Savings: Case Management Services

- Current costs: 2006 - \$2.84 billion
- 1.28 billion over 4 years
- .37 billion in additional costs as programs in which case management is seen as an integral part take on their responsibilities
- Net 800,000,000 + in potential savings

## Case Management Defined

- Direct assistance in gaining access to services
- “In the context of this regulation, it is the individual’s access to care and services that is the subject of this management – not the individual.”
- Redefined in Deficit Reduction Act –it was effective as of January 1, 2006.



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## Case Management and Targeted Case Management (TCM)

- New definition:
  - Assessment
  - Treatment planning
  - Referral and referral related activities
  - Evaluation and monitoring of plan



11

## Case Management and TCM

- No monitoring and oversight of client activities
- No supplying services which are ordered in the underlying treatment plan



12

## Excerpt: \*CMS and The Evidence-Based Practices

### Family Psychoeducation:

- "consultation with other family members can be a necessary part of planning and providing care to patients in need of psychiatric services. Consultation can, however, devolve to a point where it becomes a means of treating others rather than, or in addition to, the primary recipient. Medicaid would not reimburse for services provided to ineligible family members for treatment of their problems not related to the treatment of the Medicaid patient. In addition, Medicaid would not reimburse for family psychoeducation classes unless tailored specifically toward the Medicaid beneficiary."
- Definition CM and Rehab confirm this as well

\*Center for Medicare & Medicaid Services



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## Excerpt: \*CMS and The Evidence-Based Practices

### Supported Employment:

- Medicaid is statutorily excluded from the provision of vocational services.
  - "Therefore, under the State Plan, Medicaid cannot pay for the employment of an individual. Similarly, payment may not be made for employment assessments or ongoing support to maintain employment (emphasis added) except under an HCBS waiver. However, Medicaid can pay for the medical services that enable an individual to function in the workplace."



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## III. Creating Silos

- Braiding not integrating
- Establishing separateness of systems – in new CM rule
  - Child Welfare
  - Probation/Parole
  - School: more limited



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## Case Management Silo

- **Integral components/duplicate services:**
  - **Foster Care:** includes case planning, case management activities
  - **Child Welfare/Protective services:** includes for some children under protective orders same as above – child welfare services are considered to be the “direct services” of the CW system and not Medicaid CM
    - This includes a prohibition on paying for contractors of the CW system who are providing CM services because they are fulfilling the obligations of the CW system.



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## Case Management Silo

- **Integral components/duplicate services:**
  - **Parole and Probation:** functions exist independent of the Medicaid program
    - No parole officers or contractors of the justice system for TCM
    - No services that are in effect part of the administration of the State's parole or probation system



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## Case Management Silo

- Integral components/duplicate services:
  - Public Guardianship
    - State or locally administered and independent of the Medicaid program
    - You can assist decision-makers but you are not the decision-maker
    - Cannot replace the function or fund the function
    - My opinion: this includes rep payee work



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## Case Management Silo

- Integral components/duplicate services:
  - Special Education
    - Exception made for CM and other services ordered under an IEP or IFSP – case manager must be Medicaid eligible provider.
    - IFSP requires a service coordinator from the beginning if the infant or toddler has a disability – these can be Medicaid CM/TCM services
    - Cannot cover administrative functions under the Individuals with Disabilities Education Act (IDEA), e.g. calling meetings, reports, writing plan



19

## IV. Reasserting Old Rules

- Exclusive Benefit: Family Treatment
- Specific and effective treatment: Parenting
- Medical necessity: Recovery Goals?
- IMD Issues



20

## IMD (Institutions of Mental Diseases) Defined

- Section 1905(i) of the Social Security Act (Act) and 42 Code of Federal Regulations (CFR)
- § 435.1009 define an IMD as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Psychiatric hospitals (including State-operated and private psychiatric hospitals) and inpatient psychiatric residential treatment facilities with more than 16 beds are IMDs.



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## Medicaid Funding

- Regulations found at 42 CFR §§ 435.1008 and 441.13 preclude paying FFP (federal financial participation) for any services to residents under the age of 65 who are in an IMD, except for inpatient psychiatric services provided to individuals under the age of 21 and in some instances those under the age of 22.



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## Medicaid Funding

- Medicaid will pay per diems for room and board only for those inpatient psych facilities that are PRTFs.
  - Certain staffing and facility requirements
  - Licensing
  - JCAHO accreditation
- Residential treatment rate setting concerns – how developed, is room and board sufficiently covered by other funds.



23

## Virginia/New York

- Medicaid exception for 21 and under is for inpatient psychiatric services only – not other medical or dental services
- NY Appellate Court seem to suggest leniency in application of this rule by suggesting auditors could have denied all non-psychiatric services provided in the hospital but instead chose to deny only those outside of hospital



24

## Georgia: Child Caring vs. RTC vs. IPRT

- Developed set of guidelines for children's providers
- Last edit in July 2007
- Based on their reading of distinct part hospital guidance, nursing facility guidance, the experience of Illinois
- Many and big disclaimers – no guarantee



25

## V. Financial/Payment Issues

- Unbundling



26

## Payment: Case Management

- "a state cannot employ a methodology or rate that results in payment for a bundle of services"
  - Per diem- no
  - Monthly -no
  - Weekly no
- Why: paying for anticipated not actual services; requires a great deal of federal oversight to make sure the bundled rate is reasonable.
- Yes to: 15 minute or less units of service – do understand that many case management activities are very brief.
  - Not clear if a rounding convention must be used or if minutes can be counted or if anything that is 15 minutes or less is ok.



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## What Needs to be Done

- Awareness at state level of potential impact
  - Proactive change
- Provider support:
  - Rewriting manuals
  - Technical assistance: Compliance, Service Delivery, Documentation
- Legislative advocacy



**February 24, 2008**

## **Governors of Both Parties Oppose Medicaid Rules**

**By ROBERT PEAR**

WASHINGTON — Governors of both parties strongly objected on Saturday to a half-dozen new federal **Medicaid** regulations that they said would shift billions of dollars in costs to the states, forcing them to consider cutbacks in services.

The rules, scheduled to take effect in the next few months, would reduce federal payments for public hospitals, teaching hospitals and services for the disabled, among others.

State officials voiced their concerns as they arrived here for the winter meeting of the **National Governors Association**.

Federal health officials said the new rules were needed to end creative financing techniques that states had used to obtain excessive amounts of federal Medicaid money.

But governors said the Bush administration was unilaterally reshaping Medicaid in ways that would harm some of their most vulnerable citizens. Moreover, they said, the rules are taking effect at a time when the national economic slowdown is cutting into state tax revenues.

"Governors strongly oppose the changes," said Gov. Jim Douglas of Vermont, a Republican who is chairman of the association's Health and Human Services Committee. "The timing could not be worse."

One of the rules would ban the use of federal Medicaid money to help pay for the training of doctors, a use that has been allowed since the inception of Medicaid more than 40 years ago. Another would set new limits on Medicaid payments to hospitals and nursing homes operated by states, cities, counties and other units of government.

A third rule would limit Medicaid coverage of rehabilitation services for people with disabilities, including serious mental illnesses.

Federal officials estimate that the rules will save the federal government \$15 billion over five years. But that figure may be low. California alone says it could lose \$12 billion over five years.

Congress delayed some of the rules last year, but they will soon take effect unless Congress intervenes again.

Gov. **Arnold Schwarzenegger** of California, a Republican, said the rule changes "would effectively end the federal government's participation in many crucial components of the Medicaid program."

Dr. Rhonda M. Medows, commissioner of the Georgia Department of Community Health, said: "We understand the need for financial safeguards, but these rules, taken together, would have a tremendous adverse impact. They would undermine the health care safety net for the entire state of Georgia, reducing federal Medicaid payments for hospitals, nursing homes and school clinics."

The National Conference of State Legislatures joined governors in criticizing what it described as "the regulatory activism" displayed in the new rules.

The federal government and the states share the cost of Medicaid, which provides health insurance to more than 60 million low-income people, including 30 million children.

Dennis G. Smith, director of the federal Center for Medicaid and State Operations, said the rules were needed to "protect the fiscal integrity of the Medicaid program." Since 2003, he said, federal officials have persuaded 30 states to end "questionable Medicaid financing arrangements." The purpose of such arrangements is to maximize the use of federal money while holding down the use of state and local revenue.

Although the most blatant problems have been corrected, the administration says, many states still use federal Medicaid money for purposes unrelated to Medicaid.

"We believe that paying for graduate medical education is outside the scope of Medicaid's role, which is to provide medical care to low-income people," Mr. Smith said. "There is no explicit authorization under the Medicaid statute to subsidize the training of physicians."

Robert M. Dickler, chief health care officer at the Association of American Medical Colleges, said, "It's a little surprising that the federal government would just now discover that there's no legal basis for the Medicaid payments it's been making for medical education since 1965."

Stan Rosenstein, the Medicaid director in California, said the payments were justified because "interns and residents provide a tremendous amount of care to Medicaid beneficiaries."

The federal government says this rule would save \$1.8 billion over five years. But New York, which trains 15 percent of the nation's doctors, says it would lose more than that alone. State officials are also concerned about a rule that would eliminate federal contributions for a whole category of public spending on health care for the poor — specifically, spending

by autonomous units of local government like the Denver Health and Hospital Authority.

"As a result of this rule, we will lose \$60 million a year," said Dr. Patricia A. Gabow, chief executive of the Denver agency, which operates a 477-bed public hospital, the city's public health department and its ambulance service. "We were part of the city government for more than 130 years. In 1997, we became an independent governmental entity, but we don't have taxing authority. So we don't qualify as a public provider, and we can't draw down critically important subsidies for services we provide to the entire community."

Larry S. Gage, president of the National Association of Public Hospitals, said the rule's importance went far beyond Medicaid because it would compromise the ability of public hospitals to provide vital services like trauma care and burn treatment.

New York City Health and Hospitals Corporation, the largest municipal health care system in the country, which gets 60 percent of its budget from Medicaid, said the rules would have "a potentially devastating impact" and could force cutbacks in services.

A group of 17 states, including Connecticut, Michigan and New Jersey, told the administration that the new restrictions were "simply awful public policy." Senators Jeff Bingaman, Democrat of New Mexico, and Elizabeth Dole, Republican of North Carolina, are fighting the rule on public hospitals.

The rule "would have a devastating effect on North Carolina's Medicaid system, costing our hospitals hundreds of millions of dollars annually," Mrs. Dole said.

The Medicaid rules were overshadowed last year by a battle over insurance for children.

"We can have a legitimate discussion about expanding the Children's Health Insurance Program," said Governor Douglas of Vermont. "But the Medicaid rules are different. They renege on commitments already made."

In Vermont, Mr. Douglas said, "we've come to rely on Medicaid to help pay for special education and other services to children with disabilities."

Medicaid is a crucial part of the foundation on which many states were planning to build coverage for the uninsured.

Deborah S. Bachrach, a deputy commissioner in the New York State Health Department, said, "The new Medicaid rules make it difficult to pay for current programs and nearly impossible to expand coverage to all."