ALASKA STATE LEGISLATURE
HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES STANDING COMMITTEE
February 16, 2006
3:09 p.m.

MEMBERS PRESENT

Representative Paul Seaton, Vice Chair
Representative Vic Kohring
Representative Sharon Cissna
Representative Berta Gardner

MEMBERS ABSENT

Representative Peggy Wilson, Chair
Representative Tom Anderson
Representative Carl Gatto

COMMITTEE CALENDAR

OVERVIEW(S):

DR. TOM HAMILTON - "COST-EFFECTIVE ALTERNATIVE TO CRIMINALIZING THOSE WITH A MENTAL ILLNESS;"

- HEARD

LEWIN GROUP - "LONG-TERM FORECAST OF MEDICAID ENROLLMENT AND SPENDING IN ALASKA;"

- HEARD

STATE CITIZEN REVIEW PANEL

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

ALEXANDER VONHAFFTEN, M.D., President
Alaska Psychiatric Association
Anchorage, Alaska

POSITION STATEMENT: Testified that although the community mental health system in Alaska is fragmented and broken, there are opportunities to make it better.

TOM HAMILTON, PhD
Medora Investments, LLC
Houston, Texas
POSITION STATEMENT: Presented a cost-effective alternative to criminalizing those with a mental illness.

JOHN SHIELDS
Lewin Group
Virginia
POSITION STATEMENT: During the long-term forecast of Medicaid enrollment and spending in Alaska presentation, answered questions.

TED HELVOIGHT, Economist
ECONorthwest
Eugene, Oregon
POSITION STATEMENT: Presented the long-term forecast of Medicaid enrollment and spending in Alaska.

FRED VAN WALLINGA, Chair
Citizens' Review Panel
Willow, Alaska
POSITION STATEMENT: Presented an overview of the Citizens' Review Panel.

SUSAN HEUER, Member
Citizens' Review Panel
Anchorage, Alaska
POSITION STATEMENT: Presented an overview of the Citizens' Review Panel.

ACTION NARRATIVE

VICE CHAIR PAUL SEATON called the House Health, Education and Social Services Standing Committee meeting to order at 3:09:32 PM. Representatives Gardner, Cissna, and Seaton were present at the call to order. He noted that Representatives Wilson and Gatto were excused.

OVERVIEW (S):
"Cost Effective Alternative To Criminalizing Those With A Mental Illness"

VICE CHAIR SEATON announced that the first order of business would be an overview of the cost effective alternative to criminalizing those with a mental illness.

3:10:16 PM

ALEXANDER VONHAFFTEN, M.D., President, Alaska Psychiatric Association (APA), informed the committee that he began doing clinical work in Alaska in 1990 as a Washington, Alaska, Montana, Idaho Medical Education Program (WAMI) resident. He further informed the committee that he has worked throughout the state in a variety of clinical settings, including community mental health, the Alaska Psychiatric Institute, the Department of Corrections, the Alaska Native Medical Center, et cetera. Dr. vonHafften then said that the bad news is that the community mental health system in Alaska is fragmented and broken. He pointed out that the Alaska Department of Health and Social Services 2001 In-Step Report highlights some of the challenges faced in Alaska.

DR. VONHAFFTEN opined that the community mental health system is largely designed for failure in that the least-desired outcomes too often become the most likely outcomes. For instance, the [community mental health system] increases the likelihood of disability and pernicity and increases the likelihood of arrest and incarceration. The system, he pointed out, is crisis driven. However, he opined that the good news it that the system can be made better and there are opportunities to do so. Dr. vonHafften then introduced Dr. Tom Hamilton, who has a doctorate in engineering and has had a distinguished career in the oil and gas industry. Dr. Hamilton, he related, is present to speak today because he has a son with schizophrenia, and thus since 1992 he and his wife have learned about psychiatric illness and the mental health system. The aforementioned has resulted in Dr. Hamilton's involvement in several Texas Department of Mental Health and Mental Retardation task forces regarding resource allocation. Currently, Dr. Hamilton is a member of the board of trustees for the Harris County Mental Health and Mental Retardation Authority, which has one of the largest catchment areas in the country.

TOM HAMILTON, PhD, turned the committee's attention to a document entitled, "Redirecting Resources: Cost-Effective Alternatives to Criminalizing Those With A Mental Illness." He began his presentation with a history of mental illness, which is as old as the human race and its cause has been attributed to

everything from physical to demonic, to biological reasons. Furthermore, the stigma associated with mental illness is centuries old as is the tendency to characterize individuals with a mental illness as inmates. However, the truth is that mental illnesses are treatable illnesses with efficacy rates higher than most other illnesses. The problem is that the policies in place are riddled with unintended consequences due to lack of understanding. Dr. Hamilton pointed out that one of the results of those unintended consequences is that individuals with mental illnesses are three to fives times overrepresented in the criminal justice system.

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DR. HAMILTON turned to the term transinstitutionalization, which was coined by J. L. Penrose in 1939 [after observing] that when the number of beds in mental hospitals in Europe increased there was an increase in the number of beds in the criminal justice system. The term refers to moving individuals from one institution to another. He related information gathered in 1880 and in 1955, which were the height of institutionalization. Today one finds that there has been a 10-fold decrease in the number of individuals in state hospitals, of which one-third have been remanded by the court. However, one finds today that 0.3 percent of the U.S. population in the criminal justice system is thought to have a mental illness [which is the same proportion of the U.S. population that was institutionalized in 1955]. He then drew attention to the graph entitled, "Transinstitutionalization", which illustrates the height of institutionalization in 1955 to its 10-fold decline and corresponding increase in incarceration in 2000. He reminded the committee of the following key events during the aforementioned timeframe: 1973 Community Mental Health Center Act signed; the drug culture in the 1960s and 1970s; philosophy change from rehabilitation to punishment in the 1980s. He highlighted that in the mid 1990s state spending on the criminal justice system was dominant and has continued as such ever since.

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DR. HAMILTON explained that the result of the aforementioned is that prisons have become the state's largest psychiatric institutions. He related that in 2000 the American Psychiatric Association estimated that 20 percent of the prison population has a serious mental illness. He related various other statistics regarding the percentage of prisoners that have

mental illnesses. Juvenile offenders with serious emotional disturbances are estimated in the range of 40-75 percent. Dr. Hamilton related his belief that the one thing upon which everyone can agree is that prisons are not set up to nor do they provide a therapeutic environment for addressing mental illnesses. The net result of the aforementioned is treatment-resistant individuals who recidivate. He then related data from a 2004 sampling of a Texas prison and informed the committee that 25-50 percent of inmates have a diagnosable mental disorder. Although some might suggest that there are so many inmates with mental disorders because mental illness causes people to behave in a criminal manner, much data refutes such a notion. Data specifies that those who are treated appropriately aren't more likely to commit a crime or be violent than the general public. However, lack of treatment of those same group of individuals increases the likelihood of arrest, which is usually for a minor offense at the outset. Unfortunately, there is a large population with a co-occurring substance abuse disorder and the lack of treatment for this group dramatically increases the likelihood of arrest and violence. He pointed out that consumers of mental health services are at two-thirds greater risk for being arrested per encounter than nonconsumers. Some officers are trained to recognize those who might have a mental disorder and to deal with such individuals. With crisis intervention trained officers and community alternatives, the arrest rate drops to 1-2 percent, which is about the same as the general population. "There's a wealth of information out there, which tells us that these individuals are not more criminally inclined. We just normally lack alternatives to deal with them in the community," he said.

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DR. HAMILTON addressed what is known about this population, offenders with a mental impairment (OMI), from general data across the country. In answer, he related that half are non-violent, misdemeanor offenders; three of four have a co-occurring substance abuse disorder; and they usually receive little or no treatment in prison. With regard to the lack of treatment received in prison, Dr. Hamilton noted that prisoners are guaranteed by the U.S. Constitution to treatment. He continued by relating that typically prisons lack rehabilitation and pre-release planning, which results in a lack of a connection to treatment and places a safety risk in the public. In the general public, these individuals are victimized more often than the general public. Therefore, when such individuals are placed in an environment like a prison, they spend a

disproportionate amount of time in administrative segregation or solitary confinement. The aforementioned adds complexity to the running of the prison, which in turn adds cost. Therefore, it's more expensive to keep these individuals in prison and these individuals serve longer sentences for comparable crimes under comparable circumstances. In fact, the Pennsylvania Department of Corrections estimates that an inmate with a serious mental disorder costs 75 percent more to maintain than a non-mentally ill inmate. He then pointed out that in addition to those costs, there are significant additional law enforcement and judicial system costs that haven't been captured.

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DR. HAMILTON then provided the committee with jail data from Harris County Texas, which includes the Houston area and has a population of about 5 million. In 2004 information from the [Texas] public mental health system and the Harris County Criminal Justice System was merged and compared. He noted that there are fairly high barriers to enter the public mental health system in Texas, and therefore one must be very ill to enter it. He also noted that this data doesn't include those who have a mental disorder but have never entered the system. Therefore, "the message here is the numbers are going to be higher than one in four," he said. Based on intake records, there are 16 entry points into the public mental health system in Harris County, with the jail being the largest as it provided 38 percent of the first-time entrants. Once those who have a mental illness are incarcerated, they serve twice the number of jail episodes per defender. Through the process of incarceration and not treating the mental illness and having subsequent incarcerations, these individuals are criminalized and technically become felons. He related further statistics regarding how inmates with mental illnesses have more average jail days per episode and are more likely to recidivate and have more post-release jail days.

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REPRESENTATIVE GARDNER inquired as to what are post-release jail days.

DR. HAMILTON clarified that post-release jail days refers to the number of jail days an inmate spends in jail after he/she recidivates.

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REPRESENTATIVE CISSNA inquired as to the morale of the employees of the prisons and the inmates without mental illness because she opined that [the lack of treatment for inmates with a mental illness] would have a confounding effect that would drive many other aspects of this equation.

DR. HAMILTON agreed, adding that some of the most frustrated are the county sheriffs, deputies, and jailers, who readily relate that they weren't set up to address [inmates with mental illness]. The situation is demoralizing and unhealthy for everyone, he opined.

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REPRESENTATIVE GARDNER inquired as to the proportion of the mentally ill in the general population who never have any contact with the criminal justice system.

DR. HAMILTON indicated that to be about 50 percent.

3:37:16 PM

REPRESENTATIVE CISSNA related her belief that if issues such as mental illness and fetal alcohol spectrum disorder were addressed early on, the prison population would be diminished.

DR. HAMILTON agreed, and emphasized that this cycle will never be broken unless a more proactive course that diverts people from jail and treats juveniles and those with [mental] illnesses. "These are either pay me now or pay me later illnesses; we're either going to pay for it on the front end or we're going to pay a lot more for it on the back end, with enormous human suffering on the part of the individuals, their families, their communities, and everyone else," he opined.

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VICE CHAIR SEATON then asked the committee to hold any general discussion questions until the conclusion of Dr. Hamilton's presentation.

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DR. HAMILTON then turned to the cost and resource allocation issues associated with this. He related that an average stay in the Harris County jail costs more than intensive community care, annually it amounts to approximately $38 million. If the

incarceration rate matched the epidemiological rate and jail days matched regular offenders, it would cost approximately $5 million, and therefore he suggested that the $30 million in savings could be put toward treatment of the mentally ill population. By diverting individuals with a mental illness from jail or connecting them with community treatment, there is a potential savings in Harris County of 40 percent per consumer.

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DR. HAMILTON addressed community treatment and related that in Harris County there is a model program entitled, "New Start." The program, which has been in existence for 12 years, was originally designed to pick up people at the gate of the prison and connect them with appropriate services. In 2004 this program served 600 serious offenders, including those who committed murder. In 2004 the recidivism rate of this program was 5 percent, much of which he attributed to technical violations such as not making a meeting with the parole officer or the community treatment team. However, the recidivism rate over the 12 years of the program is about 1 percent, which is in stark contrast to the 60-70 percent recidivism rate when folks with mental illnesses aren't connected to services. Furthermore, long-term studies show that "the graduates" of this program don't re-offend at rates any higher [than the general population]. This program, he opined, protects the general public from a safety point of view, which is a strong argument for treatment. Dr. Hamilton informed the committee that the average cost per individual in the New Start Program was $14,400, which is about $10,000 less than keeping the individual in jail. In fact, if everyone above the epidemiological rate had been diverted, it would amount to a $9 million savings. However, he stressed that it would take much time to establish a program to take care of that many individuals. The program is being expanded at this point to accept those who have been diverted from the criminal justice system. In response to Representative Gardner, Dr. Hamilton confirmed that the program only takes people who are in the criminal justice system, either entering or exiting.

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DR. HAMILTON then turned to the matter of determining the cost data for incarceration versus treatment, which is difficult. However, there have been studies by Substance Abuse and Mental Health Services Administrator (SAMHSA) a federal organization that reviewed the nine diversion programs in the nation. Four

of those studies attempted to answer whether it's cost effective to divert as opposed to incarcerate. From those studies, it was learned that diversion does reduce jail time without increasing the public safety risk. The studies also concluded that connection to services decreases recidivism. However, with regard to the next cost, two studies determined that diversion costs more and two studies determined that it cost less. The question one has to ask is to what is the individual being diverted because the quality of community programs is highly variable. Furthermore, unless the community programs are set up to receive these individuals, they will be costly programs. The reason, he opined, two of the programs cost more to divert rather than incarcerate is because the only community program was emergency services. Moreover, these studies lasted one year or less and the most costly year of diversion is the first year due to the individual's need for much intensive treatment to stabilize him/her, which typically requires about 18 months. He opined that most communities aren't ready for large scale diversion.

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DR. HAMILTON then made the following hypothetical assumptions: the cost of the criminal justice system would cost $20,000 per year and that it would cost $20,000 per year to divert people to mental health services. Following the model results that specify that after 18 months there is a decline in the services required to keep these individuals stable in the community, the cost per year would decline to $12,000 per year. Therefore, after 18 months diversion should produce economical benefits. In response to Representative Gardner, Dr. Hamilton clarified that the treatment programs in the hypothetical would be residential such as the New Start program. He further clarified that the first year of a diversion program would be the intensive treatment, but as individuals are stabilized they become out-patients.

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REPRESENTATIVE GARDNER asked if these individuals, once stable and with decreased mental health services, are utilizing public assistance.

DR. HAMILTON answered that such individuals are likely to be utilizing public assistance. However, he indicated that it depends upon whether vocational rehabilitation services and psychosocial services can be provided. Still, he maintained

that it's very unlikely that a large percentage of this population will return to [the workforce]. In further response to Representative Gardner, Dr. Hamilton agreed that the benefit is in the recidivism rate because far more could be spent up-front than the figures show. He did point out that the same could be said of prison costs. Dr. Hamilton then continued his presentation and informed the committee that if evidence-based practices are used, those individuals receiving such services qualify for Medicaid. The aforementioned results in cost shifting/saving such that the state's burden dramatically decreases.

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REPRESENTATIVE CISSNA related her belief that the opportunity cost is not included nor is the part-time job that an individual who has received treatment can do. Furthermore, the costs associated with the extended family in regard to travel isn't included. There are, she opined, large costs associated with being institutionalized. She mentioned that some of these individuals with mental illnesses may even be parents. She questioned whether any data has been gathered on the aforementioned.

DR. HAMILTON responded that he has seen some attempts to capture those issues, although he said that he hasn't seen any data that has been able to encapsulate all the issues. He noted his agreement with Representative Cissna that there are huge burdens that aren't included in related data. In fact, he highlighted the burden placed on society in regard to the homeless population.

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DR. HAMILTON then continued his presentation by discussing how the system was changed in Texas. He related that in 2001 he was involved with examining the cost of warehousing persons with mental illnesses and created a macro economic model. During fiscal year 2002-2003, the Texas Legislature didn't build a new prison but rather redirected $35 million from punishment to treatment. During the 2004-2005 legislative session in Texas, the Texas Legislature renewed the $35 million to treatment and legislated a dramatic change in the delivery of mental health care in the state such that the state went to a disease management jail diversion model, which is a recovery-based model. The aforementioned model, which combines substance abuse money into the behavioral health model, was introduced in

September 2004. Furthermore, this model required every community center to have a jail diversion plan.

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DR. HAMILTON reviewed the 1997 one-day snapshot from the Alaska Department of Corrections (DOC), which relates that 29 percent of the DOC population exhibits mental illness. That percentage and the fact that most suffer a co-occurring substance abuse disorder is consistent with national data. While the [percentage of the DOC population exhibiting mental illness] was increasing, the number being treated was much lower. In fiscal year 2000, DOC served 2,556 individuals who were suffering from various conditions at the time of arrest. He said that the data is a subtle way to indicate that Alaska has the same problems as elsewhere. Dr. Hamilton related that the basic elements to address this problem, although they may be inadequate or insufficient, exist in Alaska the same as elsewhere. He acknowledged that in Alaska correction officers are receiving some training and that there is a functioning mental health court, a jail alternative services program, and an institutional discharge program. However, he opined that many of the aforementioned programs are based on federal funds.

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DR. HAMILTON concluded by reminding the committee that mental illnesses are real illnesses that are treatable. Without treatment those suffering from mental illness are much more prone to violence and arrest than the general public, but with treatment these individuals are no more prone to such than the general public. Dr. Hamilton opined that at worst, it's cost neutral to treat those with mental illnesses rather than incarcerate them. Furthermore, treatment of these individuals is more likely to result in a cost saving over the long term.

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DR. HAMILTON, in response to Representative Cissna, related that in the Texas criminal justice system there is an agency that addresses offenders with mental impairments and helps to ensure they receive treatment. However, since not everyone with a mental illness is identified, Texas was originally only addressing 14 percent or so.

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The committee took an at-ease from 4:02 p.m. to 4:06 p.m.

Lewin Group and ECONorthwest "Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2005-2025"

VICE CHAIR SEATON announced that the next order of business would be a presentation by the Lewin Group regarding the long-term forecast of Medicaid enrollment and spending in Alaska.

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JOHN SHIELDS, Lewin Group, began by informing the committee that the Lewin Group consists of specialists in developing health care models. The model presented today is based on designs that have been successfully used in other states. He noted that the Lewin Group is committed to nonpartisan research.

TED HELVOIGHT, Economist, ECONorthwest, began by reminding the committee that in March 2005, the Department of Health and Social Services (DHSS) contracted with the Lewin Group and ECONorthwest to develop a model that would allow the department to project future Medicaid spending and update its long-term spending projections. Mr. Helvoight noted that the model is entirely data driven and thus is based on historical claims-based data in Medicaid from Alaska. The model also has the capability of reviewing scenarios that may occur, even if no historical data exists for those scenarios. Additionally, the companies, upon request, created a report describing a baseline forecast for Alaska while documenting the methodology followed and the data used in the model. Therefore, this presentation highlights some of the points of the report.

MR. HELVOIGHT reviewed the steps utilized to build the model, with the first being Alaska's population because Medicaid spending in the future relates to the population. The population projections are based on the Alaska Department of Labor & Workforce Development (DLWD) projections that are at the state level and review population growth by gender and age. For this analysis, the population growth was reviewed per region and Native and non-Native status. The Native and non-Native status is important due to the Federal Matching Assistance Program (FMAP). All of the aforementioned resulted in 220 subpopulations that were reviewed for the forecasting. Once the population forecast is established, the next step is determining Medicaid enrollment, which differs quite a bit by age and gender. The next step is to review the utilization of services. To continue, one must next review the total spending on claims,

the amount of state funds spent; and other payments and offsets. Mr. Helvoight emphasized that the committee should keep in mind that the legislature/state is in control of the following: eligibility requirements, reimbursement rates, and services provided. However, there are factors, such as population growth, demographic changes, and changes in medical technology.

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MR. HELVOIGHT then highlighted that the baseline analysis is based on the assumption that the status quo as of fiscal year 2004 will remain for the next 20 years because the data supports that. Therefore, the baseline analysis doesn't anticipate policy changes such as the following made in 2005-06: cost containment; Bring the Kids Home initiative; personal care attendant regulation changes; or Medicare Part D drug benefit. However, it's clear that all four of the aforementioned will have an impact on spending over time, which DHSS will be able to review for each initiative.

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MR. HELVOIGHT moved on to the population, which will be the largest driver throughout this analysis. He informed the committee that the 65 and older population, currently totaling 43,000, is projected to triple to 124,000 between 2005 and 2025. Furthermore, between 2005 and 2010 the state's population is estimated to slow from about 1 percent per year to .6 percent in 2025. Most of the growth will occur in the Anchorage/Mat-Su region while Southeast Alaska will experience a slight population decrease over the next 20 years. Furthermore, Mr. Helvoight projected that the Native population will grow significantly faster than the non-Native population. He then turned attention to the Alaska Population growth graph on slide 14, which breaks out the population growth by age. This graph indicates that there will be significant growth primarily in the elderly population.

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MR. HELVOIGHT continued with Medicaid enrollment, which the analysis projects will grow faster than the state's population as a whole such that Medicaid enrollment in Alaska will grow from 132,000 in 2005 to 175,000 by 2025. Medicaid enrollment will grow much faster for the elderly than for the entire state population. The elderly enrollment will grow from approximately 10,000 in 2005 to 33,000 by 2025. Similarly, the graph on slide

18 indicates that there will also be growth in Medicaid enrollment for the children and working age groups.

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MR. HELVOIGHT addressed the utilization of services, which will determine how many services each of the 220 sub-populations enrolled in Medicaid will use. He clarified that for this analysis Medicaid utilization is the annual unduplicated count of Medicaid enrollees who used a particular Medicaid service during a particular year. The department aggregated Medicaid services into 20 service categories and the growth projected in utilization will differ greatly among the service categories. He reminded the committee that the personal care service category doesn't include any changes made to that category, and therefore the hope is that the 9.7 percent projected will actually be less. Still, it will be a category that will grow fast.

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REPRESENTATIVE CISSNA recalled from the House Finance Health, Education, and Social Services subcommittee that the personal care attendant service is much less expensive than growth in the residential nursing home. Therefore, she questioned whether a decrease in the personal care service would actually be less costly because it could mean that a more expensive alternative is being utilized.

MR. HELVOIGHT agreed that it's not a good thing if it's a case in which personal care regulation changes push people to nursing homes. However, if it's a case in which some might consider the inappropriate use of personal care, then it's probably appropriate. He specified that if the things aren't related to nursing home care, then it's a good change.

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MR. HELVOIGHT continued with regard to utilization of services and directed attention to slide 21, which specifies 6 of the 20 service categories. Each category is projected to grow at a different rate, which is based largely on historic growth rates. For all Medicaid utilization as a whole, the Centers for Medicare and Medicaid Services' (CMS) national forecast of growth is utilized to guide the overall growth of such in Alaska. He related that CMS projects future growth of about 2.2 percent in utilization growth. The aforementioned, he noted,

was a required assumption when doing such analysis. He then mentioned that slower relative growth in nursing home services is partially offsetting the very high projected growth in personal care and Medicaid home- and community-based (HCB) waiver categories. He further mentioned that in addition to the 220 subpopulations projected through time, the analysis projects 20 different service categories through time. Therefore, there is a certain complexity with regard to the utilization of services and the spending on services.

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MR. HELVOIGHT turned to total spending and highlighted that of primary importance are the findings related to the direction and approximate magnitude of changes in spending on Medicaid. In 2005 calendar year total spending by the state and federal governments on Medicaid claims in Alaska was approximately $1 billion. By calendar year 2025, total spending by the state and federal governments on Medicaid claims in Alaska is expected to increase to about $4.8 billion in actual dollars or to about $2.2 billion in inflation adjusted dollars. The difference between the two growth rates is medical specific. Mr. Helvoight related that in 2005 inpatient hospital services is the largest Medicaid service category and is responsible for 15 percent of total spending on Medicaid plans while the HCB waivers and personal care constitute approximately 11 percent and 10 percent of spending, respectively. However, the projection for 2025 is that inpatient hospital services will only account for 5 percent of the total Medicaid service spending while HCB waivers and personal care will grow to about 22 percent and 27 percent, respectively. Therefore, half of all spending in 2025 would be in the aforementioned two categories, which he attributed to the demographics. Mr. Helvoight then drew the committee's attention to two graphs on slides 29 and 30, both of which illustrate the proportion of spending by each of the three age cohorts. In 2005, about 44 percent of all Medicaid spending is for children with about 22 percent for the elderly. However, by 2015 the spending for the elderly will surpass spending on working age adults and by 2018 it will surpass spending on children. Therefore, the program will be very different than it is today.

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REPRESENTATIVE CISSNA recalled being told by AARP that in other states when it comes time for nursing home care, those residents without a family base in the area return to the state in which there is a family base. However, she surmised that in Alaska

the growth is too recent to determine what will happen, which could substantially change the projections.

MR. SHIELDS agreed that such could change the projections. The influx of individuals in and out of Alaska is a serious issue in terms of its impact on the estimates. To the extent the aged are leaving Alaska today, the assumption is that it will continue at the same rate in the future. However, there will be so many more aged people that it will seem to mushroom and could have a dramatic impact. Mr. Shields noted that Mr. Helvoight will present a slide that addresses what will happen if the demographics are very different than projected today. Although the number is very different, it remains larger than the spending for children and adults. The aforementioned is what Mr. Shields referred to as a "robust result" that is very likely to occur.

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MR. HELVOIGHT explained that the models built for DHSS will allow it to conduct long-term forecasts of different scenarios. For example, the department could forecast the effect on total spending if the elderly population grows slower than is forecasted by the DLWD and the department could also determine the effect on spending if utilization grows slower than is projected in the models. He presented graphs illustrating the aforementioned possible effects on slides 33 and 35. Mr. Helvoight related that CMS projects that nationally Medicaid spending will grow by 7.5 percent per year through 2014. This analysis projects that over the same period, total Medicaid spending in Alaska will increase by 7.7 percent. However, state spending will be different. In calendar year 2005 state matching fund spending on Medicaid services was approximately $380 million, but by calendar year 2025 it's actual spending will grow to approximately $2.1 billion. The aforementioned is an 8.9 percent growth rate over the next 20 years, which illustrates that the growth in spending will clearly be greater for the state than the federal government. In fact, over the next five years is when much of this change will occur. He projected that between 2005-2010, the state will increase its spending by 10.5 percent per year while the federal government will only increase its spending by 6.3 percent, which he attributed to the federal matching rate that is projected to be at the minimum by 2008. Mr. Helvoight then informed the committee that on a per capita basis every man, woman, and child of Alaska is paying about $500 for Medicaid services. By 2025 that will increase in actual terms to just over $2,500, which is

a must faster growth than will occur with real per capita income over that same time period.

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MR. HELVOIGHT concluded by addressing the topic of "Going Forward." He related the following quote from Janet Clarke, Assistant Commissioner, DHSS, "The Alaska Medicaid program will fundamentally change over the next 20 years from a program that centers on children to one that is dominated by seniors." Therefore, in the future Medicaid will look more like Medicare. He then emphasized the importance of recognizing that in 2025 almost half of the spending will be for the elderly, although the elderly will only account for 33,000 out of 175,000 Medicaid enrollees. The legislature, to some extent, has control over the following: eligibility requirements; reimbursement rates; and services provided.

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VICE CHAIR SEATON asked if the shift from Medicaid prescription phase to Medicare prescription phase was included.

MR. HELVOIGHT replied no, but stated that it should have an impact. He confirmed that this could be included in the model.

MR. SHIELDS explained that the claw back provision in which what is saved in the state Medicaid program will be paid back into the program to some degree. Therefore, the savings won't be a windfall but rather will be used to help pay for the program. "It's complicated, but it's not clear whether you break even or spend more or spend less," he said.

Citizens' Review Panel

4:49:54 PM

VICE CHAIR SEATON announced that the final order of business would be the overview by the Citizens' Review Panel (CRP).

4:50:43 PM

FRED VAN WALLINGA, Chair, Citizens' Review Panel, introduced the members of the panel present. He informed the committee that this panel was established by the federal government and works with the Office of Children's Services (OCS) to improve services to the citizens of Alaska.

SUSAN HEUER, Member, Citizens' Review Panel, related that this group has been working together for two years. The CRP is federally mandated to review the policies and procedures of OCS. Over the past two years, CRP has conducted four town meetings in Anchorage, Wasilla, Juneau, and Bethel. She noted that CRP has had training with regard to performing an audit of OCS records. Based on the public testimony, the most concerns arose from the town meeting in Wasilla, which prompted a site review in the Matanuska-Susitna area.

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MS. HEUER explained that two weeks ago, four CRP members went to the Matanuska-Susitna area to interview eight collateral agencies that deal with OCS as well as OCS itself. The interviews reviewed how the agencies worked together and how they view child protection in the community. For those meetings, a list of positives and negatives will be shared with the community, the legislature, and the federal government. Furthermore, some short-term recommendations have been provided to OCS to be implemented by the end of this fiscal year. The short-term goal for CRP is to help implement changes in the Matanuska-Susitna office such that the public's concerns are addressed and more children are being protected. The long-term goals of CRP are to continue community meetings around the state. The goal, she opined, is for there to be an increased adherence to policies and procedures by OCS and stronger collaboration among agencies working with OCS. The goal is also to increase the level of protection of children in Alaska such that incidences of child abuse and neglect will decrease.

4:55:53 PM

MS. HEUER expressed concern that as CRP is becoming more public, more individuals are contacting CRP with concerns. The panel is a volunteer group that has no means to meet that level of time and concern. Therefore, CRP would like to refer people to the grievance procedures already established by OCS and the Ombudsman's Office. However, at some point CRP will address how to track those grievances and review the outcome after the grievance process. Ms. Heuer related that more members are needed throughout Alaska in order to have as balanced a board as possible. However, travel expenses make [a board with representation throughout the state] cost prohibitive. "We have touched the tip of the iceberg, functionally, with this," she

opined. She further opined that CRP hopes to establish a positive relationship with OCS.

4:57:59 PM

VICE CHAIR SEATON commented that as legislators can relate to colleagues that questions can be properly directed to OCS and the Ombudsman's Office. Recalled presentations from other departments and agencies, and recalled frustration with regard to the time it takes for data input into reports as it reduces the amount of service the agencies can provide to clients. Therefore, he suggested checking with those in the field to determine whether there are reporting provisions that aren't working and inhibiting service.

5:00:11 PM

REPRESENTATIVE CISSNA expressed concern that there may be individuals who want to relate concerns to CRP because there could be a conflict of interest when OCS is the responder to questions of OCS's service. Furthermore, the Ombudsman's Office is very understaffed. Therefore, she asked whether anything has been worked out with the Ombudsman's Office.

MR. VAN WALLINGA explained that most often the calls come after going through the process with OCS. The first thing that he said he relates is that CRP can't handle individual cases and they are directed to the Ombudsman's Office. However, going to the Ombudsman's Office is like going to OCS to those making the complaint. In most of the cases CRP receives, it seems to be a lack of communication at some point.

5:03:20 PM

VICE CHAIR SEATON related his understanding that the directive of CRP is to determine where the system is not working.

MR. VAN WALLINGA agreed that is what CRP will be doing, although he clarified that CRP won't do much with the Ombudsman's Office because it isn't in CRP's area. He mentioned that he understood the difficulties with the new system, Online Resources for the Children of Alaska (ORCA).

5:05:22 PM

REPRESENTATIVE CISSNA related her understanding that since the legislature [this committee] has oversight over OCS, it's

reasonable to speak with the Ombudsman's Office regarding ways to help with this.

VICE CHAIR SEATON noted that the Ombudsman's Office is under the purview of the legislature as well.

5:05:44 PM

ADJOURNMENT

There being no further business before the committee, the House Health, Education and Social Services Standing Committee meeting was adjourned at 5:05:52 PM.