HOUSE FINANCE COMMITTEE
FIRST SPECIAL SESSION
May 21, 2019
1:29 p.m.

1:29:39 PM

CALL TO ORDER

Co-Chair Wilson called the House Finance Committee meeting to order at 1:29 p.m.

MEMBERS PRESENT

Representative Neal Foster, Co-Chair
Representative Tammie Wilson, Co-Chair
Representative Jennifer Johnston, Vice-Chair
Representative Dan Ortiz, Vice-Chair
Representative Ben Carpenter
Representative Andy Josephson
Representative Gary Knopp
Representative Bart LeBon
Representative Kelly Merrick
Representative Colleen Sullivan-Leonard
Representative Cathy Tilton

MEMBERS ABSENT

None

ALSO PRESENT

Representative Chuck Kopp; Nancy Burke, Housing Services Coordinator, Municipality of Anchorage; Sean Case, Captain, Anchorage Police Department; Representative Ivy Spohnholz, Chair, Health and Social Services Committee; April Kyle, Vice President, Division of Behavioral Services, Southcentral Foundation; Elizabeth Ripley, chief Executive Officer, Mat-Su Health Foundation; Dr. Melissa Kemberling, Vice President of Programs, Mat-Su Health Foundation; Representative Geran Tarr; Representative Sharon Jackson.

PRESENT VIA TELECONFERENCE

Natasha Pineda, Director, Anchorage Health Department; Lance Johnson, Behavioral Health Services Director, Norton

sound Health Corporation; Philip Licht, Executive Director, Set Free Alaska.

SUMMARY

CSSSSB 19 (FIN)
APPROP: CAPITAL BUDGET; SUPPLEMENTAL

CSSSSB 19 (FIN) was HEARD and HELD in committee for further consideration.

HB1001 APPROP: 2020 EDUCATION FUNDING/REPEAL

HB 1001 was HEARD and HELD in committee for further consideration.

PRESENTATION: SUBSTANCE USE and MENTAL HEALTH RESPONSE IN ANCHORAGE

PRESENTATION: SOUTHCENTRAL FOUNDATION

PRESENTATION: MAT-SU HEALTH FOUNDATION

Co-Chair Wilson reviewed the agenda for the meeting.

#hb1001
HOUSE BILL NO. 1001

"An Act making appropriations for public education and transportation of students; repealing appropriations; and providing for an effective date."

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Co-Chair Wilson asked about the will of the committee.

Vice-Chair Johnston MOVED to report HB 1001 out of Committee with individual recommendations.

Co-Chair Wilson OBJUECTED.

Representative Knopp opposed the legislation. He wanted to see the issue addressed in the judicial system.

A roll call vote was taken on the motion.

IN FAVOR: LeBon, Merrick, Sullivan-Leonard, Tilton,

OPPOSED: Knopp, Ortiz, Josephson, Johnston, Wilson, Foster

Representative Carpenter was absent from the vote.

The MOTION FAILED (4/6).

#sb19
CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 19(FIN)

> "An Act making appropriations, including capital appropriations, supplemental appropriations, reappropriations, and other appropriations; amending appropriations; making appropriations to capitalize funds; and providing for an effective date."

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REPRESENTATIVE CHUCK KOPP had been asked to provide some opening comments. He noted that the legislature had adopted public safety legislation to toughen the laws on crime. He spoke to drug treatment. He addressed the underlying reasons for crime and noted that substance abuse and mental health issues were the drivers of over 80 percent of the state's incarcerated population. He stressed the importance of addressing the issues that were tearing apart families and communities. He related that the governor's drug advisor, Andy Jones, had recently testified to the House Heath and Social Service Committee. He recounted that in the prior 4 years the legislature began to seriously address the issue via funding in recognition of the crisis. Recently, the legislature supplemented Medicaid grants by a ratio of 1 to 3. He indicated that in 2015 the state had $62.5 million in grants and $38.4 in leveraged funding amounting to $101 million that served approximately 20 thousand Alaskans. In 2018, Alaska had $54 million in grants and $150 million in Medicaid billing totaling $205 million that served approximately 38 thousand Alaskans. The state was currently serving twice as many people but still had a huge demand for services. He provided statistics for a Department of Health and Social Services (DHSS) in-treatment waitlist. He reported that the waitlist in Fairbanks was 60 days, in Juneau the waitlist amounted to 30 days, on the Kenai the wait time was 2 weeks, in Dillingham the wait period was 1 month, and in Wasilla the waitlist was up to 2 months. He delineated that DHSS was currently completing a gap analysis of services necessary

for addiction treatment. The 1115 Medicaid Waiver application to the Center for Medicaid Services (CMS) stated that the state needed another 200 treatment beds in addition to the 325 already established representing a 62 percent increase. The same document stated that Alaska needed 23 withdrawal management programs and 28 out-patient treatment programs. He believed that the programs served in the interest of public safety and offender rehabilitation and that early intervention could prevent incarceration. He announced that the following presentation would reveal that addiction was fueling crime and the state lacked treatment options. The state had shovel ready projects with matching grants to incentivize communities to invest in treatment centers. He maintained that accessible treatment was necessary in order to "get though on crime."

Co-Chair Wilson explained that she intended to include treatment funding in the capital budget and the reason the issue was presently under discussion.

^PRESENTATION: SUBSTANCE USE and MENTAL HEALTH RESPONSE IN ANCHORAGE

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NANCY BURKE, HOUSING SERVICES COORDINATOR, MUNICIPALITY OF ANCHORAGE, introduced herself. She shared that she was a clinically trained social worker and previously helped with the development of the Alaska Mental Health Trust Authority (AMHTA) predevelopment program that examined the infrastructure needs of treatment services across the state.

NATASHA PINEDA, DIRECTOR, ANCHORAGE HEALTH DEPARTMENT (via teleconference), provided her background information in public health prevention. She had worked on health policy with the Department of Administration (DOA), served as a program officer for AMHTA for substance abuse, and worked for the Department of Health and Social Services (DHSS), Division of Behavioral Health as a grant manager and Chair of the Alaska Committee to prevent underage drinking.

SEAN CASE, CAPTAIN, ANCHORAGE POLICE DEPARTMENT, introduced the PowerPoint presentation: "Substance Use and Mental Health Response in Anchorage."

Captain Case began with slide 2: Drug Impact on Police Services." He reported that the Anchorage Police Department (APD) made 1700 arrests with drug seizures annually and 650 drug only arrests. He noted that roughly 6.5 arrests per day were associated with drugs. The department responded to over 30 overdose deaths, which did not represent the total number of overdoses in Anchorage.

Vice-Chair Johnston asked whether Narcan was helpful. Captain Case reported that APD did not use Narcan because they could quickly respond along with the Alaska Fire Department (AFD) and employ other readily available and effective methods.

Vice-Chair Johnston asked whether the fire department used Narcan. Captain Case responded in the affirmative. Vice-Chair Johnston deduced that the concerted efforts of the police and fire department saved lives but HIPPA [Health Insurance Portability and Accountability Act] prevented the statistical data collection regarding the number of lives saved. Captain Case replied that he was unable to answer the HIPPA question but concurred that the combined effort saved more lives. Vice-Chair Johnston suggested that if the Anchorage Fire Department did not use NARCAN the number of overdose deaths could be higher. Captain Case answered in the affirmative.

Representative Merrick asked Captain Case how many total arrests the APD had in one year. Captain Case did not know the answer to her question but could provide it.

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Captain Case pointed to the graph on the far right of slide 2. He indicated that the graph showed clearly what the police department was up against daily. The graph included three types of drug categories: Amphetamines and Methamphetamines, Heroin, and Prescription Drugs. He delineated that prescription drugs that were illegally obtained or possessed were the most commonly seized drugs and the numbers were on the rise over the last 5 years except for 2018. Methamphetamines was the second largest seizure and rose steadily over the last 5 years. He added that other jurisdictions reported that Methamphetamines had played a substantial role in bush communities more so than heroine. He noted that heroine seizure was on the rise over the last 5 years. He related that the APD had started a

criminal diversion process. However, due to drug addiction problems and the lack of availability of drug treatment the diversion process proved challenging.

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Representative Sullivan-Leonard asked about the statistic regarding the various arrests. She was aware that SB 91 "created an open-door policy." She hoped that with the passage of HB 49 - Crimes; Sentencing; Drugs; Theft; Reports [2019] it would provide additional tools for the law enforcement community. Captain Case responded in the affirmative. He believed that tougher sentencing forced treatment, which had been effective.

Co-Chair Wilson remarked that imposing stiffer sentences without treatment availability created the open door. She noted that some offenders were unable to get the treatment they sought. Captain Case confirmed that stricter sentencing without treatment created a criminal justice cycle. He concurred that not only did the law enforcement system need the additional tools of HB 49, treatment was necessary for a holistic approach. Co-Chair Wilson asked whether there were other states that had examples of treating the offender on the "front side" early on in their sentence versus the "back side," which took place before release but after a length of incarceration. She wondered if data was available regarding which option was more successful. Captain Case relayed that the answer was not in his area of expertise but acknowledged that the point in the criminal justice process when treatment was more efficacious was prior to incarceration. Co-Chair Wilson surmised that treatment could be part of a plea deal.

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Representative Carpenter wanted to better understand the use of the term, "forced treatment." Captain Case explained that he was referring to treatment that was part of a plea deal for a reduced sentence or treatment that occurred during custody.

Captain Case moved to slide 3: "Mobile Response (March 2019)." He explained that the table applied to the number of mental health clients the APD had been involved with. He noted that out of 821 total police reports related to mental health issues the department had provided 173

transports to hospitals. He reported that out of the 173 people, approximately 40 needed emergency mental health care. He ascertained that transporting roughly 143 individuals with mental health issue and no other support or options was problematic for the APD and emergency rooms (ER). He thought that delivering people to the ER did not provide "an affordable early response" and offered that approximately 60 to 65 of the individuals would respond to "street level intervention."

Co-Chair Wilson asked what reasons the 173 individuals were picked up by the APD under Title 47. Captain Case explained that the 173 individuals were not under arrest but were being transported from a Department of Corrections DOC facility. The problem in the policing world where a loved one or friend threatened suicide, required the APD to place the suicidal person in a safe environment such as a hospital.

Representative Carpenter asked for an explanation of the "No Action" line on the table that numbered 84. Captain Case replied that 84 mental health related calls lead to no arrest or action of any kind by the APD.

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Ms. Pineda continued with slide 4: "Substance Misuse Summary of Findings."

- Alcohol is the substance of highest use and misuse in Anchorage
- Compared to all other substances, alcohol contributes to the most deaths, EMS ambulance transports, hospitalizations, OCS intakes

Ms. Pineda relayed that over the past year the Anchorage Health Department (AHD) conducted a substance misuse assessment. She highlighted the findings. She reported that initially, the AHD assessed opioid and prescription drug misuse but discovered that a much broader assessment was necessary. She elaborated that alcohol was the most common form of substance use and abuse and contributed to many AFD emergency transports and hospitalizations. Alaska's rate of consumption and binge drinking was in line with the national average. However, the age adjusted mortality rate was twice as high as the rest of the country. The AHD saw a serge in polly substance use, which involved the use of two

or more substances concurrently. She noted that polly substance use was particularly dangerous because of the possibility of drug interaction leading to overdose. Sometimes substance users were unaware that one of the drugs was mixed with another drug that users might not be aware of i.e. fentanyl. She reported that in response to Rep. Johnston's query, Anchorage had 51 opioid overdose deaths in 2017 that dropped to 25 in 2018. The number of Narcan kits distributed in Anchorage in 2017 was 1,510 and in 2018 the number was 3,511.

Representative Sullivan-Leonard wanted to know how AHD had compiled her data. She asserted that the statistic on the table on the right side of slide 4 showed heroin use at 0.5 percent of Alaskans 18 plus years old who used or misused in the past year or month. She thought it was confusing when the opioid epidemic was widely reported. She asked how the data was compiled. Ms. Pineda responded that the data was derived from the National Survey on Drug Use and Health 2016-2017 and was self-reported. She admitted that the data could be an underreporting error and was not AHD data.

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Representative Sullivan-Leonard asked whether Anchorage had undertaken its own polling. Ms. Pineda answered that the national survey had included a variety of different data sources that included state and local data that provided more complete data on how substance abuse was impacting Anchorage; however, she was unable to include additional information in the slide.

Ms. Pineda advanced to slide 5: "Substance Misuse Summary of Findings."

- Methamphetamine use is increasing
- 2013-2018: methamphetamine-related overdose mortality rate increased 233%. All other drug mortality rates declined in this period.

Ms. Pineda revealed that methadone use was increasing in Anchorage and it was expected to be the next epidemic. The number of AFD Emergency Services (EMS) Methamphetamine Transports steadily increased from 2016 to 2018. She discerned that some of the increase in meth use may be due to polly substance use or the use of opioids can lead to use of methamphetamine. She reported that 3.5 percent of

Anchorage high school students reported ever using meth versus 2.5 percent nationwide. The reported use is higher in female students than male students and from 2015 to 2017 she noted a 153 percent increase in the percent of lifetime use in female students compared to a 24 percent increase among male students. She reported that the second graph on the slide depicted the number of "AFD EMS: Total Calls by Primary Impression." The graph highlighted that Behavioral Health Disorder was the most common primary impression followed by alcohol. The category that included "Poisoning/Drug Ingestion and Substance/Drug Abuse" was less predictable and increased or decreased over 4 years. She pointed that that the categories were not mutually exclusive and could co-occur. She elaborated that the graph illuminated that alcohol misuse was a consistent problem and behavioral health disorders were present with greater frequency at acute emergency levels. She surmised that the increase could represent a lack of "more comprehensive systems of care." The AFD thought that the alcohol numbers could be higher if the data included EMS response to alcohol related injuries and the number would likely be staggering. She added that Alaska had one of the highest rates of traumatic brain injuries in the country. She recommended solutions that helped the vulnerable population through treatment and recovery and through a focus on prevention.

Ms. Burke advanced to slide 6: "Filling Treatment Gaps in Alaska."

Projected capacity to serve up to 250 people annually

Residential (In-patient) Treatment Program:
Program capacity: 18 individuals with 9 double double occupancy bedrooms

Length of stay: 90 days
Population served: adult males

- Ambulatory Withdrawal Management Capacity: 8
Length of Stay: 15 days

- Transitional Housing: Capacity: 44 individuals
Length of Stay: Average 6 months

- Out-patient Treatment Program:

Program capacity: Variable based on staffing capacity
Length of program: 60 days
Days per week operated: 4

Ms. Burke indicated that Anchorage had a treatment facility located near the Anchorage airport that fell into disrepair and needed replacement. The building housed a successful treatment program for individuals with co-occurring mental illness and substance use. She discussed that Anchorage was a place where people had higher needs, and many were reflected in the homeless population. She offered that 70 percent of the homeless population experienced mental illness or substance abuse issues and 53 percent of the 70 percent had traumatic brain injuries. She suggested that to fill the gap, Anchorage was proposing a new treatment facility with a mix of services that mirrored new treatment options available under the 1115 Medicaid Waiver that allowed step up and step down services and ensured people were stable before they left the treatment facility. In addition to offering specific treatment for individuals with cognitive disorders along with mental illness and substance abuse issues. The city was hoping to begin construction by the spring of 2020.

Representative Merrick asked how the municipality determined that the current treatment center was successful. Ms. Burke answered that the facility was run by a non-profit via a service contract with the state of Alaska and was located on municipal land. The transition out of the program was reportedly successful but she did not have the data and would provide it later.

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Representative Knopp had heard her mention the 1115 waiver and asked for more information about the waiver. Ms. Burke explained that the 1115 waiver was a mechanism to utilize Medicaid that allowed more flexibility to provide for different levels of need for those with substance abuse issues. The waiver was a tool used by many communities across the country to stabilize people in residential services and provide further services upon release. Representative Knopp asked if the waiver was part of Medicaid expansion. Ms. Burke responded in the affirmative.

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REPRESENTATIVE IVY SPOHNHOLZ, CHAIR, HEALTH AND SOCIAL SERVICES COMMITTEE, explained the 1115 waiver. She reported that the 1115 was a "state innovation waiver" that the state applied for with the federal government. She detailed that the state had strict guidelines for the kinds of services that was covered under Medicaid. The state found that the allowable services were not meeting the needs in Alaska. The waiver allowed the state to experiment and offer more lower cost more effective strategies for delivering care in Alaska. The strategies were employed in other areas of healthcare but were restricted in the substance abuse arena.

Representative Josephson asked whether the current facility was due to close in the following month. Ms. Burke answered the facility was damaged by the earthquake and the city was indefinitely extending its lease to allow the program to remain in the building. Representative Josephson asked if the state were to invest in the new treatment facility what the cities' portion of the investment was. Ms. Burke responded that municipal funds were included in the anticipated bond package for the following year. The Municipality of Anchorage recognized the need for the more costly services. Representative Josephson wondered whether the people of Anchorage were willing to make the investment at a cost of $4.5 million.

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Ms. Burke moved to slide 7: "Construction and Infrastructure Costs" in order to answer the question.

Design Costs and Timeline

Design cost estimate - ~$1.2 million

- Current timeline:
- August – September 2019 – RFP released and Contract awarded
- September – January 2020 – Design completed
- Design includes:
- Residential (in-patient) treatment
- Out-patient treatment
- Transitional Supportive Housing
- Administrative office space

Construction Costs and Timeline

Infrastructure improvement cost - ~$2.85 million
- Improvements will be made to the road, water, sewer, and gas utilities.
- Funding will come from 2020 MOA bond proposition.
- Timeline:
- Improvements will coincide with construction of treatment center.
- Total Treatment Center construction estimate – ~$17.9 million
- Proposed timeline:
- March 2020 – Construction permit issued
- May 2020 – Construction begins
- Outstanding amount to complete construction – $14.5 million

Representative Josephson asked Captain Case whether an individual was compelled to treatment due to an active criminal case, or if individuals just wanted to "get off the street." Captain Case observed that he had seen both scenarios.

Vice-Chair Ortiz asked if alcohol abuse treatment was offered in the treatment facility. Ms. Burke answered in the affirmative and confirmed that alcohol was the largest substance abused. Vice-Chair Ortiz asked whether treatment for alcohol abuse was sought voluntarily. Captain Case responded that the criminal cases could require alcohol treatment such as domestic violence.

Representative Sullivan-Leonard asked about the inception of the project. She noted that it appeared much planning had been done. Ms. Burke responded that the current phase of the project began in 2015. Representative Sullivan-Leonard asked if the people of Anchorage would support the bond package in 2020. She assumed the bond would cover much of the construction costs and design work. Ms. Burke replied that $1.2 million depicted on the slide was grant funding currently in the city's possession and would move forward with design work. She reported that the $2.85 million of bond funds would be used for the necessary infrastructure upgrades. The $14.5 million was the outstanding balance needed to complete construction. Representative Sullivan-Leonard asked where the municipality was expecting to obtain the remaining funds.

Ms. Burke responded that all avenues of funding would be considered to meet the construction expense.

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Representative Sullivan-Leonard was aware that other entities would be involved in the funding process. She requested a list of potential investors. She pointed to the state's fiscal crisis and advised that garnering state support would be challenging. She encouraged the municipality to take on the brunt of the costs.

Co-Chair Wilson pointed out that the cost of incarceration was $178. per day per prisoner without treatment. She asked for a breakdown of the costs associated with individuals receiving treatment depending on the level of treatment. Ms. Pineda was unable to answer the question. She indicated that the Salvation Army operated the current facility and they could provide the costs. She was waiting for final numbers related to rates under the 1115 waiver and would provide exact amounts for the services associated with slide 5. Co-Chair Wilson asked about the success rate of treatment and whether "further intense treatment" was necessary. Ms. Pineda deferred the question to a behavioral health expert. She acknowledged that some people need treatment multiple times, but most ultimately achieved recovery.

Co-Chair Wilson asked about the possibility for the facility to provide treatment beds to individuals under the custody of DOC. Ms. Burke thought that it was a beneficial option worth exploring. She expounded that the facility was designed to fill in the gaps existing in treatment and stop the cycle of incarceration or homelessness.

Ms. Burke transitioned into slide 8: "Aftercare and Community Supports."

- Many people will stabilize in housing with supportive services appropriate for their needs
- Community integration through housing (Pay for Success) = Reductions in emergency and first responder resources

Ms. Burke spoke of the importance of "syncing up the systems" that offered resources and had proven success with recovery and assisting the transitions back into the

community. She addressed the facilities step up or step down approach of either intensifying or reducing service according to need.

Co-Chair Wilson reminded the committee that 80 percent of incarcerated individuals had mental health issues. She did not know how the state could not afford treatment and expect change.

Representative Merrick asked whether the facility would be a municipal or a statewide project. Ms. Burke replied that the project was statewide. Representative Merrick asked how residential space would be prioritized. Ms. Burke replied that space was determined through a "funding configuration." She exemplified that a contract with DOC would provide prioritization. She suggested that partnering with other communities that could not offer the facility's level of care was the best approach for Anchorage.

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Representative Josephson reiterated that he had been told that there was an "ample supply" of transitional treatment but residential treatment was still lacking. He wondered how the scenario impacted treatment systems. Ms. Burke deferred the answer to other professionals.

Representative Carpenter asked whether the facility would include sex offenders. Ms. Burke replied in the affirmative.

^PRESENTATION: SOUTHCENTRAL FOUNDATION

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APRIL KYLE, VICE PRESIDENT, DIVISION OF BEHAVIORAL SERVICES, SOUTHCENTRAL FOUNDATION, introduced herself and discussed the Southcentral Foundation services. The foundation was a regional native healthcare organization serving 65 thousand Alaska native and American Indian people in the region. The system of care employed was called the "NUKA System of Care," which was a relationship based primary care focused system that included an extensive array of behavioral health services. She elaborated that the foundation operated the detox program, which they were expanding to 22 beds through support by the state. The program served roughly 600 admissions per year

and they expected to exceed 800 upon expansion. She asked the committee to consider how the service would provide treatment after detox. She noted that the program served the entire state and strove to find treatment post detox. The gold standard in a detox program was to offer a "bed to bed transfer" from detox to treatment. Most individuals leaving detox needed a clinical level of treatment appropriate for residential treatment. The program operated one program in Anchorage, which was a 16 bed women's detox program that allowed children to accompany their mothers. She spoke to the lengthy waitlist of up to 2 months to participate in the program. She furthered that residential placement for elders with medical needs was difficult, as well as access to medically assisted treatment for substance use disorder.

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She addressed the 1115 waiver that originally had three portions: substance abuse disorder, adult, and children. The CMS approved the substance abuse disorder portion of the waiver first and the state created an implementation plan. The state planned for 110 new treatment beds; 90 adult beds and 24 youth beds. In addition, the state planned 24 new beds specifically for traumatic brain injury and cognitive impairment with a statewide focus and 66 high-intensity adult beds or medium-intensity youth beds. She communicated that the state received an exemption to allow residential treatment beyond 16 beds, which made treatment more economical. The exemption allowed existing or new programs to grow. Treatment centers would still require start-up funds and facility costs. In addition to one-time money needed to launch a program, it took multiple years to reach full capacity, and subsidies were needed in the ramp up years. The exemption provided opportunity, but upfront money was still necessary to launch a program.

Ms. Kyle continued that in 2017, $6 million of capital funding was awarded to three providers: The Sober Center in Fairbanks operated by Tanana Chiefs, the detox program at Central Peninsula Hospital, and Set Free women's residential treatment center in the Mat-Su. She emphasized that treatment and recovery changed people into functioning adults. She observed the reverse for people on waitlists. She reported having a difficult time sleeping knowing there were people out there waiting for treatment. She reported

that it was costlier for the state not to expend funds for treatment than the cost of treatment itself.

Co-Chair Wilson requested the range of costs per individual including Medicaid funding. Ms. Kyle agreed to provide the information.

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Representative Knopp asked why CMS had a 16-bed limit. He asked whether the exemption had a cap or if the number was unlimited. Ms. Kyle answered that the 16-bed limit was established at a time when mental health services were institutionalized and served a great number of patients. The idea behind the limits was to eliminate the need for large institutions. She noted that the state was working to move beyond the limit and was unaware of a new cap.

Representative Carpenter asked how many beds across the state were designated for alcohol treatment. Ms. Kyle was uncertain of the answer and relayed that typically most treatment programs employed a multiple substance approach.

Representative Spohnholz interjected that the state currently had 325 in-patient beds. The 1115 waiver process estimated that Alaska needed approximately 200 more beds at a more intense level of treatment than currently offered in the state. Representative Carpenter was looking at previous slides that showed the number of people discharged for alcohol related treatment was over 9,000 in 2017. He thought that 9,000 occurrences with a total of 525 treatment beds in the state would not solve the problem.

Co-Chair Wilson thought it was important to know what the beds were for.

Representative Spohnholz noted a document "Number of New Services by Region According to Appendix 1 of 1115 SUD Waiver Implementation Plan" (copy on file) that described the range of services the Division of Behavioral Heath determined were needed. She agreed that an additional 200 beds were not enough. However, additional non-residential treatment programs were included in the plan. She expounded that not everyone needed residential treatment. The division estimated that an additional 23 withdrawal management programs were necessary throughout the state along with 28 additional intensive out-patient treatment

centers. She surmised that the state needed to increase access to treatment.

Co-Chair Wilson asked Ms. Kyle to explain her relationship with the state. Ms. Kyle answered the foundation had a variety of programs and one program; the Family Wellness Warriors Initiative provided services within the Department of Corrections.

2:42:40 PM

LANCE JOHNSON, BEHAVIORAL HEALTH SERVICES DIRECTOR, NORTON SOUND HEALTH CORPORATION (via teleconference), was the administrative director of the corporation and served in the capacity since 2012. He expounded that Norton Sound served approximately 9,800 people. He had appreciated the previous comments. He wanted to emphasize the need for beds and treatment facilities in rural areas. He was aware of the large population in Alaska that was addicted to substances. He acknowledged that the most abused substance remained alcohol. He had observed the effects of limited treatment resources for people wanting treatment. The effects were further complicated by care that was only available out of the region; i.e., residential treatment centers and psychiatric hospitals. He requested that the committee reflect upon how to build rural treatment infrastructure.

Mr. Johnson provided information about what the Norton Sound Health Corporation (NSHC) provided. He reported that the corporation provided out-patient substance misuse and mental health treatment services. The corporation also provided intensive out-patient substance misuse services of up to 9 hours a week per individual. The corporation had an onsite psychiatry program available 7 days a week. In addition, the corporation provided telehealth and itinerant clinicians for the 15 surrounding villages. He elaborated that each community had a village based highly experienced counselor and by October 2019 all would become a certified behavioral health aide. Norton Sound decided to act on their own out of the need to change the narrative that rural areas were "stuck", and people had to leave the area to get better. He believed that more could be done in partnership with the state to provide higher levels of care that was culturally reflective to keep people in the region. He emphasized that local treatment was cost effective and relieved "the burden of a stressed system."

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Vice-Chair Johnston asked whether NSHC worked with the Nome Youth Facility and other correctional facilities in the region. Mr. Johnson answered in the affirmative but explained that the Nome facility recently hired its own clinician and NSHC currently participated in an ancillary role. The corporation had a contract with DOC for the Anvil Mountain Correctional Center and the Seaside Residential Community [half-way house] in Nome that provided a full time clinician that offered individual and group services for mental health and substance misuse. He reported that the Correctional Center had a waitlist for services.

Vice-Chair Johnston understood that inmates did not qualify for Medicaid. She wondered whether DOC and HSHC could build a continuum of care to eliminate the prison waitlist for services. She asked whether Mr. Johnson thought that the in-house clinician was providing and adequate level of care at the youth facility. Mr. Johnson voiced that NSHC was already providing a continuum of care at Anvil Mountain and Seaside facilities but indicated that the need was greater than the number of providers available. He acknowledged that inmates had to wait to apply for Medicaid once they were released and he noted that services would be available to instruct newly released prisoners in how to apply for Medicaid and other life skills. He relayed that the NSHC opened a day center in Nome for homeless, substance users from 8:30 AM until 7:30 PM and hired recovery coaches that were peer support coaches to help people recover. In addition, behavioral health providers worked in the center for 4 hour per day to engage in relationships and build trust. He communicated that the day center was really a way to gain access to treatment other than entering the criminal justice system. He stressed that rural treatment infrastructure would mitigate the demands for treatment beds in other parts of the state.

Mr. Johnson continued to address Vice-Chair Johnston's question regarding the Nome treatment facility. He informed the committee that by adding treatment beds, the facility served the youth well. He was aware that the Nome Youth Facility was slated for closure in the future. He viewed it as an opportunity for transitional housing for inmates released from jail. He used his prior scenario as "an interesting example on a way to build treatment infrastructure."

Co-Chair Wilson asked why the youth facility hired its own clinician. He reported that the goal of the facility was to develop treatment beds and provide services they wanted. Co-Chair Wilson wondered whether the Seaside residents qualified for Medicaid. She noted that the center was a Community Residential Center (CRC). Mr. Johnson understood that the residents' Medicaid was still suspended in a CRC because the residents were still in DOC custody. The corporation provided services to the residents through a contract due to the lack of Medicaid. Co-Chair Wilson asked whether the residents could leave for treatment or work. Mr. Johnson responded that Seaside housed roughly 50 residents, and some received furlough status to work or participate in treatment. Co-Chair Wilson informed the committee that if the residents had freedom of movement, they were Medicaid eligible and DOC was supposed to help the residents fill out the Medicaid application. She remarked that the facility currently housed 23 individuals and was disappointed that the state did not utilize all 50 beds.

Representative Carpenter asked how many communities in the Norton Sound area were dry. He wondered whether Mr. Johnson observed alcohol addiction in the dry communities. Mr. Johnson responded that 14 out of the 15 outlying communities were dry. He reported that there were alcohol abuse issues in the communities. He noted that there was a "significant issue with boot-legging."

Co-Chair Wilson asked what would be accomplished by offering treatment versus longer jailtime. Mr. Johnson did not believe that longer sentencing was the answer and that a certain level of substance abuse treatment should be provided in prisons. He related that 90 percent of the inmates at Anvil Mountain were in jail due to substance misuse. He wanted to mitigate the numbers by attempting to offer a full continuum of care for treatment services in Nome. He revealed that NSHC was working on such a project, the Wellness Center in Nome, in partnership with the Alaska Mental Health Trust Authority (AMHTA) offered a full continuum of care including intensive out-patient, out-patient, day treatment, and a sober center in the facility. He furthered that the facility had sober housing attached as well. He noted that the project was shovel ready. The corporation contributed $8 million and was seeking $5 million more in funding. Construction would commence in the summer of 2019. He reminded the committee that relapse was

part of treatment for some before recovery holds and offering a regional full continuum of care offered the wrap around services, cultural relevancy, family support and unification, and levels of services necessary for the individual. He commented that treatment in prison was still necessary, but the numbers of incarcerated individuals would drop over time.

Vice-Chair Johnston asked how many beds the Wellness Center would provide. Mr. Johnson characterized the facility as "pseudo-residential," which offered a residential level of care, but the patients would live in the sober housing. He shared that 52 slots were available in total. Vice-Chair Johnston asked about the number of beds in the sober housing. Mr. Johnson responded that a total of 48 beds would be available.

Co-Chair Wilson thanked Mr. Johnson for his presentation.

^PRESENTATION: MAT-SU HEALTH FOUNDATION

3:07:28 PM

ELIZABETH RIPLEY, CHIEF EXECUTIVE OFFICER, MAT-SU HEALTH FOUNDATION, introduced herself and the PowerPoint presentation: "Mat-Su Health Foundation.". She reminded committee members that the Mat-Su Foundation was originally the Valley Hospital Association that operated the preceding Valley Hospital in Palmer. The association wanted to build a new hospital to accommodate the growing valley population and entered into a partnership with a "for-profit proprietary company" to build the Mat-Su Regional Medical Center. She reviewed untitled slide 2 titled:

> The Mat-Su Health Foundation shares ownership in Mat-Su Regional Medical Center and invests its profits from that partnership back into the community to improve the health and wellness of Alaskans living in the Mat-Su.

Ms. Ripley turned to slide 3:

> Theory of Change
>
> - Community-driven
> - Data-driven and strategic
> - Capacity-builder

Ms. Ripley emphasized that the foundations priorities were community driven. She related that the community's priorities were focused on mental health substance use and child maltreatment and were asking for more treatment and recovery supports.

Ms. Ripley advanced to slide 4:

Good News!

New Mat-Su BH Services Fill Gaps in the Continuum of Care:

- Set Free residential SUD Treatment for women*
- Peer Treatment Services
- Outpatient SUD treatment
- SUD treatment in a local high school

Ms. Ripley indicated that all the services on the slide were started with a state appropriation in 2018.

Ms. Ripley continued to slide 5:

Our Role As A Funder

- Support data and research efforts
- Convene and advocate to make systems' improvements and build a complete continuum of care
- Provide local match funding for start-up and scholarships to develop workforce

Ms. Ripley related that the foundation worked closely with DHSS to continually improve its operating systems. They used data to find problems and provide match funding for identified "gaps in the continuum of care." She explained that the photo on the slide housed the Set Free Alaska program that received a grant from the state and the foundation to add residential treatment beds for women and pregnant women. The funding was sustained by billing Medicaid or other insurers. She thanked the state for the initial funding and hoped the state would offer $20 million in additional funding support.

Ms. Ripley advance to slide 6:

More Good News! BH Systems Improvements in Mat-Su

- Crisis Intervention/Mental Health First Aid Training for first responders
- High Utilizer Mat-Su (HUMS) Program
- Peer support services in the emergency department
- Planned psychiatric emergency department and behavioral health beds

Ms. Ripley wanted to ensure the committee that any state funding was used "prudently with maximum administrative efficiency" and obtained desired health outcomes. The projects on slide 6 were invested in to maximize the returns to the state and improved behavioral health services in the Mat-Su. She highlighted the second bullet item: High Utilizer Mat-Su (HUMS). She shared that the foundation invested half of $1 million into the program and reduced emergency room (ER) use by 61.7 percent within the first year of the pilot project, which saved the state over $1.1 million. The programs success was due to the ability to fill gaps in the continuum of care.

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Ms. Ripley turned to slide 7: "The Mat-Su Health Foundation Uses a Systems Approach." She indicated that the graphic depicted the Substance Abuse and Mental Health Services Administration (SAMHSA) model for a "good and modern addiction mental health service system." The foundation had been working on creating the model continuum of care for about 5 years and was still in progress. The foundation worked at a systems level to provide its continuum of care. She reported that the 1115 waiver drove the system and would pay for services in the long run. The slide provided a wholistic picture of how services should work in the state.

Ms. Ripley moved to slide 8:

"Prevention is Key."

WELLNESS
EARLY SIGNS &
SYMPTOMS
DISORDER
CRISIS

3:14:40 PM

Ms. Ripley turned to slide 9:

Mat-Su Regional Medical Center Emergency Department.

- 2013: 2,391 patients w/BH diagnoses = $23M [increase] in charges
- 2016: 3,443 patients w/BH diagnosis = $43.8M [increase] in charges
- Additional costs borne by law enforcement, or Mat-Su Borough EMS for dispatch and ambulance services

Ms. Ripley indicated the slide showed "where and how" the foundation was investing the state's dollars downstream. She noted that the increase in ER costs was largely due to the opioid crisis and lack of out-patient treatment access. She stressed that if treatment was available prior to the point of crisis the citizens and the state would benefit. Additional funding was needed in other areas of the continuum of care. She asserted that when they first compiled the data on the slide it proved that the ER was the most utilized service for those in a behavioral health crisis and represented a downstream investment that did not offer a return.

Representative Merrick asked about the $20 million appropriation Ms. Ripley had referred to earlier. Ms. Ripley indicated that Representative Spohnholz was hoping for a $20 million appropriation in the capital budget for treatment services. Representative Merrick asked how much of the amount Ms. Ripley expected to receive. Ms. Ripley replied that the Division of Behavioral Health (DHSS) would issue an RFP (request for proposal) as part of a competitive process. She expounded that the foundation would assist a local provider produce a competitive application and would not receive any funding directly. Funding was not guaranteed with a competitive bidding process and needs all over the state.

Co-Chair Wilson asked whether the foundation was looking at capital funding or funding for existing programs. Ms. Ripley deferred the answer to a later slide.

Ms. Ripley turned to that the list on untitled slide 10:

- Alcohol-related disorders: 438 visits costing on average $4,246/visit
- Substance Use disorders: 218 visits costing on average $5,274/visit
- Anxiety-related disorders: 195 visits costing on average $3,895/visit
- Suicide and self-harm disorders: 315 visits costing on average $3,161/visit
- Mood Disorders: 172 visits costing on average $3,846/visit

Ms. Ripley reported that the slide data reflected the number one visits and average cost per visit in 2016. The information came from a 2016 McDowell Group study of Mat-Su Regional ER charges. She reminded the committee that the ER was not providing mental health or substance abuse treatment and believed that treatment offered a more cost effective way to address the crisis.

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Ms. Ripley detailed slide 11:

"Statewide, substance use disorders are costly."

- 39,000 Alaskans - alcohol dependent or abuse in the past year
- 13,000 Alaskans were dependent on illicit drugs (2017)
- Cost of alcohol abuse was $1.84 billion (2015)- 42.9% paid by government
- Cost of drug abuse was $1.22 billion (2015)

Ms. Ripley voiced that the slide data was extracted from two reports (Economic Cost of Alcohol Abuse published in 2017 and the Economic Cost of Drug Abuse in Alaska published in 2016) funded by the AMHTA prepared by the McDowell Group. She offered to provide a breakdown of costs.

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Ms. Ripley moved to slide 12:

> Two areas supported by the Medicaid waiver where we can save money by having the right services:

- Substance Use Disorder Treatment
- Crisis prevention and care

Ms. Ripley detailed that the foundation would direct any additional state funding to the areas reflected on the slide.

DR. MELISSA KEMBERLING, VICE PRESIDENT OF PROGRAMS, MAT-SU HEALTH FOUNDATION, offered that she had a master's degree in public health and a PhD in Sociology and previously worked for the Alaska Native Tribal Health Epidemiology Center.

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Dr. Kemberling skipped to slide 14:

Crisis Prevention and Treatment Gaps

- Crisis Call center
- Mobile Crisis Unit*
- Crisis Stabilization and Respite*
- Supportive housing

* Medicaid 1115 Waiver application includes these services.

Dr. Kemberling offered that Ms. Riplely illustrated the huge cost associated with the lack of crisis prevention and treatment resulting in individuals turning to the ER for care. She explained that a model called "Crisis Now" was identified on the slide. The model prevented or shortened the crisis. The call center coordinated the type of care data and adhered to the Suicide Prevention Lifeline model to help channel the caller to the appropriate care. The Mobil Crisis Unit offered a "rapid response to assess an individual and resolve a crisis" for both children and adults. The focus of the team was to link people with services and coupled with the Crisis Stabilization and Respite Center, reduce the acute symptoms and stabilize the individual within 24 hours to avoid hospitalization.

Dr. Kemberling advanced to slide 15:

"The right continuum of crisis services in Phoenix, Arizona"

- 37 FTE Police Officers engaged in public safety instead of mental health transport/security
- Drastic reduction in psychiatric boarding in emergency departments ($37 million in cost savings)
- Reduced potential state acute care inpatient expense by $260 million (net savings of $100 million)

Dr. Kemberling reported that the AMHTA was examining the approach for Alaska. The Medicaid waiver could provide the operating dollars.

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Dr. Kemberling reported the list of capital needs that were reflected on slide 16:

"Moving Towards a Complete Behavioral Health Continuum of Care in Mat-Su."

Capital Needs

- Detox: ambulatory and residential
- Residential Treatment for Individuals with Substance Use Disorder
- Crisis Call Center
- Mobile Crisis Program
- Sub-acute Stabilization (crisis prevention and step-down)
- Supportive Housing

Dr. Kemberling pointed out the list reflected the needs of the borough and the foundation's approach. She concluded with untitled slide 17:

Investment in capital funding with a "systems approach" to start these services is crucial for saving lives, saving dollars and improving the health of Mat-Su and Alaska.

Co-Chair Wilson asked whether the foundation had a contract to provide services for behavioral health with the Mat-Su Pretrial Facility. Dr. Kemberling responded that the foundation did not directly provide behavioral health services but provided grants to non-profits and community agencies and had not provided a grant to the pretrial facility. Co-Chair Wilson asked if she was aware of other organizations providing behavioral health to the Mat-Su

Pretrial Facility. Dr. Kemberling acknowledged that the Prisoner Reentry Coalition and Mat-Su Pretrial was involved in community coalitions and the foundation's Crisis Intervention Team Coalition as well.

Co-Chair Wilson commented that the facility was different from a long-term facility and she wondered whether any reentry services were available.

Representative Sullivan-Leonard was sorry she was unaware of the capital grant by the Mat-Su Foundation. She asked for an update on the foundation's attempt to increase behavioral health beds and how the capital grant may help if the hospital was unable to move forward. Ms. Ripley responded that the hospital was in a holding pattern waiting for the legislature to pass a budget and the available funding from Medicaid. The foundation created a business plan. The construction had proceeded, and a director had been hired. The goal was to have available beds by the fall of 2019.

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Co-Chair Wilson informed everyone that there were no grants in the capital budget. She furthered that the idea was to look at how additional capital budget funds could be used for treatment and to fill in the gaps. She reiterated that currently the $20 million was not available in the budget.

Representative Sullivan-Leonard thanked the chair and noted that it was "apparent" organizations were informed of the possible additional funding and she wanted to learn how the funds would be utilized.

Ms. Ripley was trying to demonstrate that, although they had worked with the state to fill the gaps in the care continuum still many remained. She indicated that if capital funding was available the foundation would be able to assist a non-profit as a local partner.

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AT EASE

3:35:05 PM
RECONVENED

PHILIP LICHT, EXECUTIVE DIRECTOR, SET FREE ALASKA (via teleconference), introduced himself. He recounted that several years ago a client showed up at Set Free Alaska after his fourth DUI while his children were in the car. The offender faced an additional charge of endangering the welfare of a child. The thought of losing custody of two children sparked the motivation to change. No one had considered the individual's horrific backstory of physical and sexual abuse as a child that set the path of shame and addiction. He declared that at Set Free Alaska everyone was valued as a unique individual. The individual was initially very guarded, but overtime completed treatment, regained custody of the children, and gained employment. After a few years of sobriety, the person applied and was hired by the program. He believed the person's life had changed forever and he no longer cost the state money under incarceration. He informed the committee members that treatment did work. The goal was to help people stop offending and stop charging people and start changing them. He noted the many success stories under the program's partnership with the criminal justice system. He cited the lack of treatment beds and access to treatment. He relayed that most criminal justice cases and social ills were connected to addiction. Often, court ordered treatment helped people break the cycle of addiction and incarceration, but lack of treatment kept offenders in the cycle. He was pleased that the legislature was considering capital funding for addiction treatment. The cost of launching new treatment centers was a major barrier to providing enough treatment. He remarked that the Valley Oaks program was one of the only residential treatment facilities that was opened in the last ten years. He revealed that Set Free Alaska was in the process of opening another residential treatment center in Homer for men where children could accompany the men to treatment. The new programs would not have been possible without substantial capital and operational funding support during the initial phase of the projects. The programs were sustained long-term through earned revenue. The proposed funding could help start other similar projects around the state. He indicated that increased funding meant increased capacity which helped more people. He emphasized that criminal justice reform must go "hand in hand with treatment and rehabilitation." He opined that people must be treated as persons rather than just locking them up. He relayed a personal story about his brother's journey with addiction and incarceration.

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Mr. Licht spoke of the accomplishments by his younger brother after his treatment, education, and job training while in prison in Arizona and support upon release. His brother was a success story with over three years sobriety. He concluded that treatment does work, and people do get better. He thought the collaborative efforts between the criminal justice system and treatment providers was powerfully effective.

Representative Sullivan-Leonard thanked Mr. Licht. She was happy to hear about the program's expansion in other areas of the state. She asked if the current Alaska congressional delegation in Washington had offered to assist in any way. Mr. Licht reported that he had asked Senator Dan Sullivan about funding for addiction treatment. He confirmed that funding for opioid and other treatment would continue but he did not mention specific funding for the state.

Co-Chair Wilson asked whether Set Free Alaska had a relationship with DOC. Mr. Licht reported that the entity was on the list of DHSS approved providers for criminal justice system that included OCS and DOC. The organization had a contract with DOC through the Wellness Courts in Mat-Su to provide treatment services for Wellness Court and Family Infant/Toddler Court. In addition, the organization worked closely with the probation officers for felons and Mat-Su ASAP treatment services for misdemeanants.

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Co-Chair Wilson asked if it was accurate to say that without treatment crime would continue. Mr. Licht answered in the affirmative.

Co-Chair Wilson thanked the committee. She believed that providing more treatment was an urgent need.

#hb1001
HOUSE BILL NO. 1001

> "An Act making appropriations for public education and transportation of students; repealing appropriations; and providing for an effective date."

3:48:12 PM

Representative LeBon RECINDED his action on HB 1001. There being NO OBJECTION, it was so ordered.

A roll call vote was taken on the motion to REPORT HB 1001 out of committee.

IN FAVOR: Merrick, Sullivan-Leonard, Tilton, Carpenter
OPPOSED: LeBon, Ortiz, Josephson, Johnston, Knopp, Foster, Wilson

The MOTION FAILED (4/7). HB 1001 did NOT report out of committee.

#
ADJOURNMENT

3:49:18 PM

The meeting was adjourned at 3:49 p.m.