

HB

312

HFIN

FILE

HOUSE COMMITTEE REPORT

(11)

Date Referred to Committee: January 16, 2008

FURTHER REFERRALS:

Date of Committee Action: 2/28/08

The FINANCE Committee considered:

HB 312

HOUSE BILL NO. 312

APPROP: MENTAL HEALTH BUDGET

"An Act making appropriations for the operating and capital expenses of the state's integrated comprehensive mental health program; and providing for an effective date."

Recommends it be replaced with HCS or HCS for HB 312 (Fin)
 For Senate Bills with new title: Technical Title New Title: HCR _____ Same Title New Title

- attach amendments
- add new referral to _____ Committee
- Letter of Intent _____ Committee

List of Abbrev for Depts.:
 ADM
 CED
 COR
 CRT
 EED
 DEC
 DFG
 GOV
 HSS
 LWF
 LAW
 LEG
 MVA
 DNR
 DPS
 REV
 DOT
 UA

<u>NEW</u> FISCAL NOTES				
*Assigned by Chief Clerk's Office				
List by Dept(s):	*FN#	Fiscal	Indet.	Zero

<u>PREVIOUS</u> FISCAL NOTES				
List by Dept(s):	FN#	Fiscal	Indet.	Zero

<u>Signing with recommendations</u>	Printed Last Name	DP	DN?	NR	AM
<i>Michael C. Hawk</i>	Hawker	*			
<i>Harvey Goodfriend Jr</i>	CRAWFORD			✓	
<i>John Kelly</i>	KELLY			X	
<i>John Thomas</i>	Thomas			X	
<i>Bill Stoltz</i>	STOLTZ				
<i>Eric Gava</i>	Gava				✓
Chair: <i>K. Meyer</i>	Meyer	X			
Chair: <i>M. Chénault</i>	Chénault	X			

2/21/08

adopted M/O

25-GH2008\C
Bailey
2/20/08

CS FOR HOUSE BILL NO. 312(FIN)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY THE HOUSE FINANCE COMMITTEE

**Offered:
Referred:**

Sponsor(s): HOUSE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

1 "An Act making appropriations for the operating and capital expenses of the state's
2 integrated comprehensive mental health program; and providing for an effective date."

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

4 (SECTION 1 OF THIS ACT BEGINS ON PAGE 2)

1 * Section 1. The following appropriation items are for operating expenditures from the
 2 general fund or other funds as set out in section 2 of this Act to the agencies named for the
 3 purposes expressed for the fiscal year beginning July 1, 2008 and ending June 30, 2009,
 4 unless otherwise indicated. A department-wide, agency-wide, or branch-wide unallocated
 5 reduction set out in this section may be allocated among the appropriations made in this
 6 section to that department, agency, or branch.

	Appropriation	General	Other	
	Allocations	Funds	Funds	
	*****	*****		
	***** Department of Administration *****			
	*****	*****		
12	Legal and Advocacy Services	1,875,100	1,736,300	138,800
13	Office of Public Advocacy	1,581,700		
14	Public Defender Agency	293,400		
15		*****	*****	
16		***** Department of Corrections *****		
17		*****	*****	
18	Population Management	611,500	611,500	
19	Offender Habilitation	611,500		
20	Programs			
21	Inmate Health Care	6,140,400	5,930,400	210,000
22	Inmate Health Care	6,140,400		
23		*****	*****	
24		***** Department of Education and Early Development *****		
25		*****	*****	
26	Teaching and Learning Support	339,800	39,800	300,000
27	Student and School	339,800		
28	Achievement			
29	Alaska Postsecondary	200,000		200,000
30	Education Commission			
31	Program Administration &	200,000		

1		Appropriation	General	Other
2		Allocations	Items	Funds
3	Operations			

4	*****	*****		
5	*****	Department of Health and Social Services	*****	
6	*****		*****	

7 No money appropriated in this appropriation may be expended for an abortion that is not a
8 mandatory service required under AS 47.07.030(a). The money appropriated for Health and
9 Social Services may be expended only for mandatory services required under Title XIX of the
10 Social Security Act and for optional services offered by the state under the state plan for
11 medical assistance that has been approved by the United States Department of Health and
12 Human Services. This statement is a statement of the purpose of the appropriation and is
13 neither merely descriptive language nor a statement of legislative intent.

14 It is the intent of the legislature that the Department continues to aggressively pursue
15 Medicaid cost containment initiatives. Efforts should continue where the Department
16 believes additional cost containment is possible including further efforts to contain travel
17 expenses. The Department must continue efforts imposing regulations controlling and
18 materially reducing the cost of Personal Care Attendant (PCA) services. Efforts must be
19 continued utilizing existing resources to impose regulations screening applicants for
20 Residential Psychiatric Treatment Center (RPTC) services, especially for out-of-state
21 services. The department must address the entire matrix of optional Medicaid services,
22 reimbursement rates and eligibility requirements that are the basis of the Medicaid growth
23 algorithm. This work is to utilize the results of the Medicaid Assessment and Planning
24 analysis. The legislature requests that by January 2009 the Department be prepared to present
25 projections of future Medicaid funding requirements under our existing statute and regulations
26 and be prepared to present and evaluate the consequences of viable policy alternatives that
27 could be implemented to lower growth rates and reducing projections of future costs.

28 It is the intent of the legislature that the department continues to evaluate [and, where
29 possible, proceed to incorporate] an asset test in Denali KidCare and other Child Care
30 Benefits programs' eligibility criteria that includes the value of assets leased and not owned by
31 the applicant. The department should report to the legislature, no later than January 20, 2009,
32 possible asset test structures, their projected consequences on program participants and any
33 necessary changes to statute, regulation or Alaska's Medicaid State Plan. The report should

1	Appropriation		General	Other
2	Allocations	Items	Funds	Funds
3	identify any federal restrictions on asset tests and any potential consequence of an asset test			
4	on the availability of federal funding.			
5	Alaska Pioneer Homes	13,353,200	13,353,200	
6	It is the intent of the legislature that the Department maintain regulations requiring all			
7	residents of the Pioneer Homes to apply for all appropriate benefit programs prior to a state			
8	subsidy being provided for their care from the State Payment Assistance program.			
9	It is the intent of the legislature that all pioneers' homes and veterans' homes applicants shall			
10	complete any forms to determine eligibility for supplemental program funding, such as			
11	Medicaid, Medicare, SSI, and other benefits as part of the application process. If an applicant			
12	is not able to complete the forms him/herself, or if relatives or guardians of the applicant are			
13	not able to complete the forms, Department of Health and Social Services staff may complete			
14	the forms for him/her, obtain the individuals' or designee's signature and submit for eligibility			
15	per AS 47.25.120.			
16	Alaska Pioneer Homes	64,300		
17	Management			
18	Pioneer Homes	13,288,900		
19	Behavioral Health	107,444,500	84,601,000	22,843,500
20	Alcohol Safety Action	335,500		
21	Program (ASAP)			
22	Behavioral Health Medicaid	44,066,900		
23	Services			
24	Behavioral Health Grants	19,822,100		
25	It is the intent of the legislature that the department continue developing policies and			
26	procedures surrounding the awarding of recurring grants to assure that applicants are regularly			
27	evaluated on their performance in achieving outcomes consistent with the expectations and			
28	missions of the Department related to their specific grant. The recipient's specific			
29	performance should be measured and incorporated into the decision whether to continue			
30	awarding grants. Performance measurement should be standardized, accurate, objective and			
31	fair, recognizing and compensating for differences among grant recipients including acuity of			
32	services provided, client base, geographic location and other factors necessary and appropriate			
33	to reconcile and compare grant recipient performances across the array of providers and			

		Appropriation	General	Other
		Allocations	Funds	Funds
		Items		
1				
2				
3	services involved.			
4	Behavioral Health	2,620,400		
5	Administration			
6	Community Action Prevention	958,100		
7	& Intervention Grants			
8	Rural Services and Suicide	2,115,200		
9	Prevention			
10	Psychiatric Emergency	7,893,000		
11	Services			
12	Services to the Seriously	12,474,200		
13	Mentally Ill			
14	Designated Evaluation and	1,761,900		
15	Treatment			
16	Services for Severely	9,952,200		
17	Emotionally Disturbed Youth			
18	Alaska Psychiatric Institute	5,299,400		
19	Suicide Prevention Council	125,600		
20	Children's Services		12,209,200	11,979,200
21	Children's Medicaid Services	4,185,600		230,000
22	Children's Services	64,100		
23	Management			
24	Front Line Social Workers	148,600		
25	Family Preservation	150,000		
26	Foster Care Augmented Rate	500,000		
27	Foster Care Special Need	747,900		
28	Residential Child Care	1,956,300		
29	Infant Learning Program	4,456,700		
30	Grants			
31	Adult Preventative Dental		1,400,000	1,400,000
32	Medicaid Services			

33 It is the intent of the legislature that the Adult Preventative Dental Medicaid Services not over

	Appropriation	General	Other
	Allocations	Funds	Funds
1			
2			
3	spend authority granted by authorizing statute and adjust benefits available to individual		
4	participants as necessary to maintain and conduct the program throughout the entire fiscal		
5	year.		
6	Adult Preventative Dental	1,400,000	
7	Medicaid Services		
8	Juvenile Justice	945,500	745,800
9	McLaughlin Youth Center	654,500	
10	Fairbanks Youth Facility	101,000	
11	Bethel Youth Facility	56,700	
12	Probation Services	133,300	
13	Public Health	798,300	593,300
14	Women, Children and Family	500,000	
15	Health		
16	Certification and Licensing	120,000	
17	Community Health Grants	98,300	
18	Health Planning and	80,000	
19	Infrastructure		
20	Senior and Disabilities	14,474,600	13,721,900
21	Services		752,700
22	It is the intent of the legislature that regulations related to the General Relief / Temporary		
23	Assisted Living program be reviewed and revised as needed to minimize the length of time		
24	that the state provides housing alternatives and assure the services are provided only to		
25	intended beneficiaries who are actually experiencing harm, abuse or neglect. The department		
26	should educate care coordinators and direct service providers about who should be referred		
27	and when they are correctly referred to the program in order that referring agents correctly		
28	match consumer needs with the program services intended by the department.		
29	General Relief/Temporary	740,300	
30	Assisted Living		
31	Senior and Disabilities	2,390,100	
32	Services Administration		
33	Senior Community Based	3,419,400	

		Appropriation	General	Other
	Allocations	Items	Funds	Funds
1				
2				
3	Grants			
4	Community Developmental	7,924,800		
5	Disabilities Grants			
6	Departmental Support Services	1,758,400	1,758,400	
7	Commissioner's Office	105,000		
8	It is the intent of the legislature that the Department of Health and Social Services complete			
9	the following tasks related to fiscal audits required in CHAPTER 66, SLA 2003 of all			
10	Medicaid providers:			
11	1. Develop regulations addressing the use of extrapolation methodology following an audit of			
12	Medicaid providers that clearly defines the difference between actual overpayment of funds to			
13	a provider and ministerial omission or clerical billing error that does not result in			
14	overpayment to the provider. The extrapolation methodology will also define percentage of			
15	"safe harbor" overpayment rates for which extrapolation methodology will be applied.			
16	2. Develop training standards and definitions regarding ministerial and billing errors versus			
17	overpayments. Include the use of those standards and definitions in the State's audit contracts.			
18	All audits initiated after the effective date of this intent and resulting in findings of			
19	overpayment will be calculated under the Department's new regulations governing			
20	overpayment standards and extrapolation methodology.			
21	It is the intent of the legislature that the department continues working on implementing a			
22	provider rate rebasing process.			
23	It is the intent of the legislature that the department develops a ten year funding source and			
24	use of funds projection for the entire department.			
25	Administrative Support	476,100		
26	Services			
27	Information Technology	827,300		
28	Services			
29	HSS State Facilities Rent	350,000		
30	Boards and Commissions	1,787,300	465,400	1,321,900
31	AK Mental Health & Alcohol	849,000		
32	& Drug Abuse Boards			
33	Commission on Aging	193,600		

	Appropriation		General	Other
	Allocations	Items	Funds	Funds
1				
2				
3	Governor's Council on	744,700		
4	Disabilities and Special			
5	Education			
6		*****		
7		***** Department of Law *****		
8		*****		
9	Civil Division	76,800	76,800	
10	Human Services and Child	76,800		
11	Protection			
12		*****		
13		***** Department of Natural Resources *****		
14		*****		
15	Resource Development	1,686,400		1,686,400
16	It is the intent of the legislature that the department provide an annual expenditure report for			
17	the funds appropriated to the Oil & Gas development allocation relating to the one-time Oil &			
18	Gas funding, AGIA, and the new petroleum tax initiative.			
19	Mental Health Trust Lands	1,686,400		
20	Administration			
21		*****		
22		***** Department of Revenue *****		
23		*****		
24	Alaska Mental Health Trust	2,467,000		2,467,000
25	Authority			
26	Mental Health Trust	2,467,000		
27	Operations			
28		*****		
29		***** University of Alaska *****		
30		*****		
31	Statewide Programs and	390,000		390,000
32	Services			
33	Statewide Programs &	390,000		

1		Appropriation	General	Other
2		Allocations	Funds	Funds
3	Services			
4	University of Alaska Campuses	1,528,300	295,800	1,232,500
5	Anchorage Campus	1,488,300		
6	Fairbanks Campus	40,000		
7		*****	*****	
8		***** Alaska Court System *****		
9		*****	*****	
10	Alaska Court System	1,577,700	589,900	987,800
11	Trial Courts	1,577,700		
12		(SECTION 2 OF THIS ACT BEGINS ON PAGE 10)		

1 * Sec. 2. The following sets out the funding by agency for the appropriations made in sec. 1 of
2 this Act.

3	Funding Source	Amount
4	Department of Administration	
5	1037 General Fund / Mental Health	1,736,300
6	1092 Mental Health Trust Authority Authorized	138,800
7	Receipts	
8	*** Total Agency Funding ***	\$1,875,100
9	Department of Corrections	
10	1037 General Fund / Mental Health	6,541,900
11	1092 Mental Health Trust Authority Authorized	210,000
12	Receipts	
13	*** Total Agency Funding ***	\$6,751,900
14	Department of Education and Early Development	
15	1037 General Fund / Mental Health	39,800
16	1092 Mental Health Trust Authority Authorized	500,000
17	Receipts	
18	*** Total Agency Funding ***	\$539,800
19	Department of Health and Social Services	
20	1037 General Fund / Mental Health	127,218,200
21	1092 Mental Health Trust Authority Authorized	8,040,500
22	Receipts	
23	1180 Alcohol and Other Drug Abuse Treatment &	18,912,300
24	Prevention Fund	
25	*** Total Agency Funding ***	\$154,171,000
26	Department of Law	
27	1037 General Fund / Mental Health	76,800
28	*** Total Agency Funding ***	\$76,800
29	Department of Natural Resources	
30	1092 Mental Health Trust Authority Authorized	1,686,400
31	Receipts	

1	*** Total Agency Funding ***	\$1,686,400
2	Department of Revenue	
3	1094 Mental Health Trust Administration	2,467,000
4	*** Total Agency Funding ***	\$2,467,000
5	University of Alaska	
6	1037 General Fund / Mental Health	295,800
7	1092 Mental Health Trust Authority Authorized	1,622,500
8	Receipts	
9	*** Total Agency Funding ***	\$1,918,300
10	Alaska Court System	
11	1037 General Fund / Mental Health	589,900
12	1092 Mental Health Trust Authority Authorized	987,800
13	Receipts	
14	*** Total Agency Funding ***	\$1,577,700
15	***** Total Budget *****	\$171,064,000
16	(SECTION 3 OF THIS ACT BEGINS ON PAGE 12)	

1 * Sec. 3. The following sets out the statewide funding for the appropriations made in sec. 1 of
2 this Act.

3	Funding Source	Amount
4	General Funds	
5	1037 General Fund / Mental Health	136,498,700
6	***Total General Funds***	\$136,498,700
7	Federal Funds	
8	***Total Federal Funds***	\$0
9	Other Non-Duplicated Funds	
10	1092 Mental Health Trust Authority Authorized	13,186,000
11	Receipts	
12	1094 Mental Health Trust Administration	2,467,000
13	1180 Alcohol and Other Drug Abuse Treatment &	18,912,300
14	Prevention Fund	
15	***Total Other Non-Duplicated Funds***	\$34,565,300
16	Duplicated Funds	
17	***Total Duplicated Funds***	\$0

18 (SECTION 4 OF THIS ACT BEGINS ON PAGE 13)

1 * Sec. 4. The following appropriation items are for capital projects and grants from the
 2 general fund or other funds as set out in section 5 of this Act by funding source to the
 3 agencies named for the purposes expressed and lapse under AS 37.25.020, unless otherwise
 4 noted.

	Appropriation	General	Other
	Allocations	Funds	Funds
	Items		
	*****	*****	
	***** Department of Health and Social Services *****		
	*****	*****	
10	MH Home Modification and	500,000	250,000
11	Upgrades to Retain Housing		250,000
12	(HD 1-40)		
13	MH Treatment and Recovery	750,000	250,000
14	Based Special Needs Housing		500,000
15	(HD 1-40)		
16	*****	*****	
17	***** Department of Natural Resources *****		
18	*****	*****	
19	Mental Health Trust	350,000	350,000
20	Facilities Maintenance (HD		
21	1-40)		
22	Mental Health Trust Land	650,000	650,000
23	Development (HD 1-40)		
24	*****	*****	
25	***** Department of Revenue *****		
26	*****	*****	
27	AHFC Beneficiary and	1,750,000	1,750,000
28	Special Needs Housing (HD		
29	1-40)		
30	AHFC Emergency Assistance	200,000	200,000
31	Grants for Mental Health		

	Appropriation	General	Other
	Allocations	Funds	Funds
1			
2			
3	Trust Beneficiaries (HD		
4	1-40)		
5	AHFC Homeless Assistance	2,000,000	500,000
6	Program (HD 1-40)		1,500,000
7	AHFC Housing Trust (HD 1-40)	10,000,000	2,500,000
8	*****	*****	
9	***** Department of Transportation/Public Facilities *****		
10	*****	*****	
11	Coordinated Transportation	1,100,000	800,000
12	and Vehicles (HD 1-40)		300,000
13	(SECTION 5 OF THIS ACT BEGINS ON PAGE 15)		

1 * Sec. 5. The following sets out the funding by agency for the appropriations made in sec. 4 of
2 this Act.

3	Funding Source	Amount
4	Department of Health and Social Services	
5	1037 General Fund / Mental Health	500,000
6	1092 Mental Health Trust Authority Authorized Receipts	500,000
7	1139 Alaska Housing Finance Corporation Dividend	250,000
8	*** Total Agency Funding ***	\$1,250,000
9	Department of Natural Resources	
10	1092 Mental Health Trust Authority Authorized Receipts	1,000,000
11	*** Total Agency Funding ***	\$1,000,000
12	Department of Revenue	
13	1037 General Fund / Mental Health	3,000,000
14	1092 Mental Health Trust Authority Authorized Receipts	3,200,000
15	1108 Statutory Designated Program Receipts	2,500,000
16	1139 Alaska Housing Finance Corporation Dividend	5,250,000
17	*** Total Agency Funding ***	\$13,950,000
18	Department of Transportation/Public Facilities	
19	1037 General Fund / Mental Health	800,000
20	1092 Mental Health Trust Authority Authorized Receipts	300,000
21	*** Total Agency Funding ***	\$1,100,000
22	***** Total Budget *****	\$17,300,000

23 (SECTION 6 OF THIS ACT BEGINS ON PAGE 16)

1 * Sec. 6. The following sets out the statewide funding for the appropriations made in sec. 4 of
2 this Act.

3	Funding Source	Amount
4	General Funds	
5	1037 General Fund / Mental Health	4,300,000
6	***Total General Funds***	\$4,300,000
7	Federal Funds	
8	***Total Federal Funds***	\$0
9	Other Non-Duplicated Funds	
10	1092 Mental Health Trust Authority Authorized	5,000,000
11	Receipts	
12	1108 Statutory Designated Program Receipts	2,500,000
13	1139 Alaska Housing Finance Corporation Dividend	5,500,000
14	***Total Other Non-Duplicated Funds***	\$13,000,000
15	Duplicated Funds	
16	***Total Duplicated Funds***	\$0

17 (SECTION 7 OF THIS ACT BEGINS ON PAGE 17)

1 * Sec. 7. PURPOSE. In accordance with AS 37.14.003 and 37.14.005, the appropriations
2 made by this Act are for the state's integrated comprehensive mental health program.

3 * Sec. 8. NONGENERAL FUND RECEIPTS. (a) Alaska Mental Health Trust Authority
4 authorized receipts (AS 37.14.036) or administration receipts (AS 37.14.036) that exceed the
5 amounts appropriated by this Act are appropriated conditioned upon compliance with the
6 program review provisions of AS 37.07.080(h).

7 (b) If Alaska Mental Health Trust Authority authorized receipts (AS 37.14.036) or
8 administration receipts (AS 37.14.036) fall short of the estimates appropriated in this Act, the
9 affected appropriation is reduced by the amount of the shortfall in receipts.

10 * Sec. 9. SALARY AND BENEFIT ADJUSTMENTS. (a) The appropriations made in sec.
11 1 of this Act include amounts for salary and benefit adjustments for public officials, officers,
12 and employees of the executive branch, Alaska Court System employees, employees of the
13 legislature, and legislators and to implement the terms for the fiscal year ending June 30,
14 2009, of the following collective bargaining agreements:

- 15 (1) Alaska Public Employees Association, for the confidential unit;
- 16 (2) Alaska State Employees Association, for the general government unit;
- 17 (3) Public Employees Local 71, for the labor, trades and crafts unit;
- 18 (4) Alaska Correctional Officers Association, representing correctional
19 officers;
- 20 (5) Teachers' Education Association of Mt. Edgecumbe.

21 (b) The operating budget appropriations made to the University of Alaska in sec. 1 of
22 this Act include amounts for salary and benefit adjustments for the fiscal year ending June 30,
23 2009, for university employees who are not members of a collective bargaining unit and for
24 implementing the monetary terms of the collective bargaining agreements including the terms
25 of the agreement providing for the health benefit plan for university employees represented by
26 the following entities:

- 27 (1) Alaska Higher Education Crafts and Trades Employees;
- 28 (2) Alaska Community Colleges' Federation of Teachers;
- 29 (3) United Academics;
- 30 (4) United Academics-Adjuncts.

31 (c) If a collective bargaining agreement listed in (a) or (b) of this section is not ratified

1 by the membership of the respective collective bargaining unit, the appropriations made by
2 this Act that are applicable to that collective bargaining unit's agreement are reduced
3 proportionately by the amount for that collective bargaining agreement, and the corresponding
4 funding source amounts are reduced accordingly.

5 (d) Appropriations made in sec. 1 of this Act for salary and benefit adjustments as
6 described in (a) and (b) of this section are for the benefit of the state's integrated
7 comprehensive mental health program only and do not necessarily affect every group of
8 noncovered employees or every collective bargaining unit listed in (a) and (b) of this section.

9 * Sec. 10. This Act takes effect July 1, 2008.

2/5/09

House Finance
FY 09
Mental Health
Budget Bill



Alaska Mental Health Trust Authority

The TRUST
The Alaska Mental Health
Trust Authority

UM FILE

HB 836312

Key Terms of Settlement

- **Trust resources to act as a catalyst for change**
- **Separate appropriation bill**
- **Comprehensive planning for mental health program**
- **Trust Lands released for development**

Trust beneficiaries

- **People with mental illness**
- **People with developmental disabilities**
- **People with alcoholism**
- **People with Alzheimer's disease and other dementia**
- **People with brain injury**

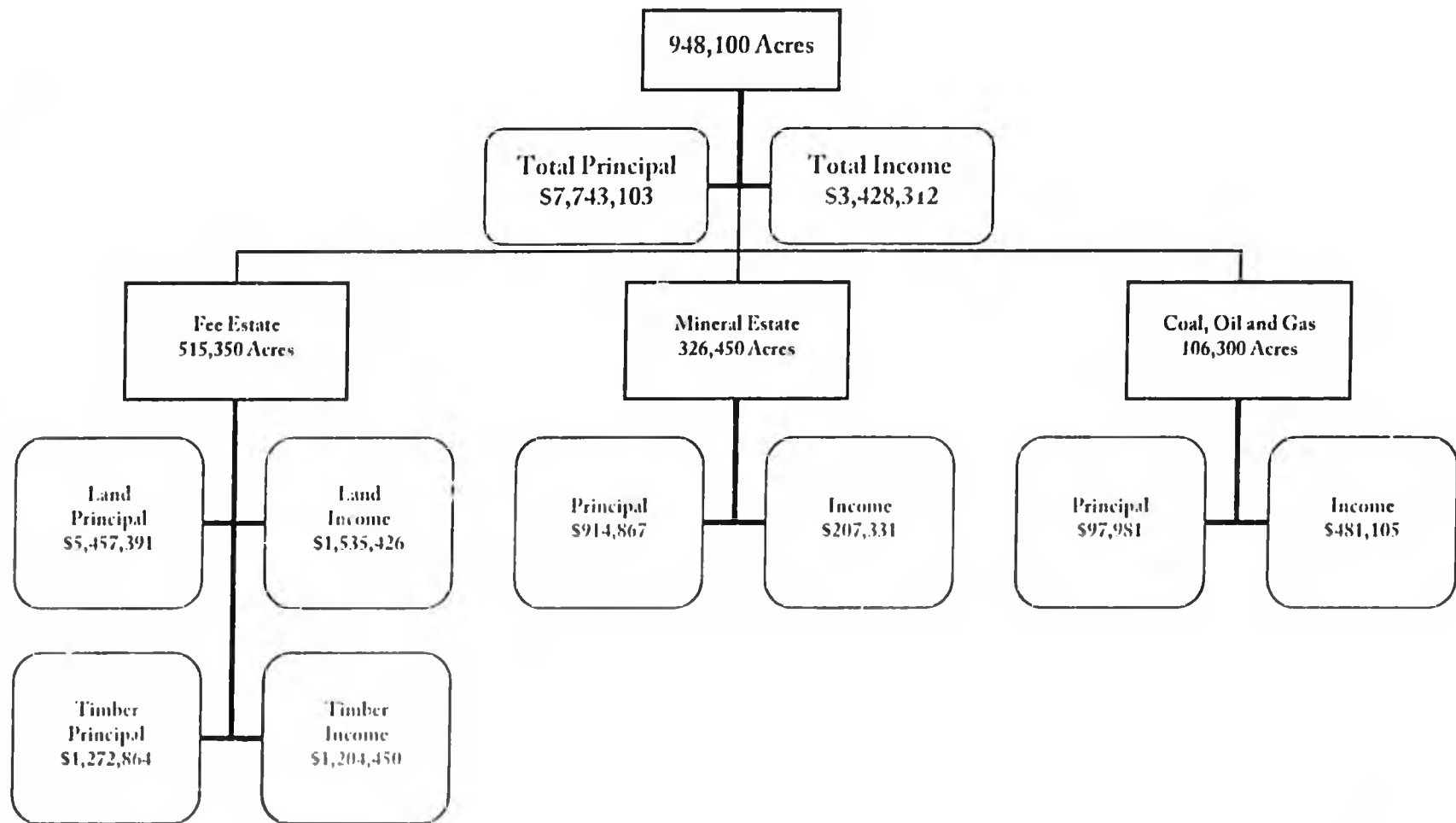
TRUST ADVISORS

- **Alaska Mental Health Board**
- **Advisory Board on Alcoholism & Drug Abuse**
- **Governor's Council on Disabilities & Special Education**
- **Alaska Commission on Aging**
- **Commissioners of Health and Social Services, Natural Resources, Revenue, and Corrections**
- **Alaska Brain Injury Network**
- **Statewide Suicide Prevention Council**

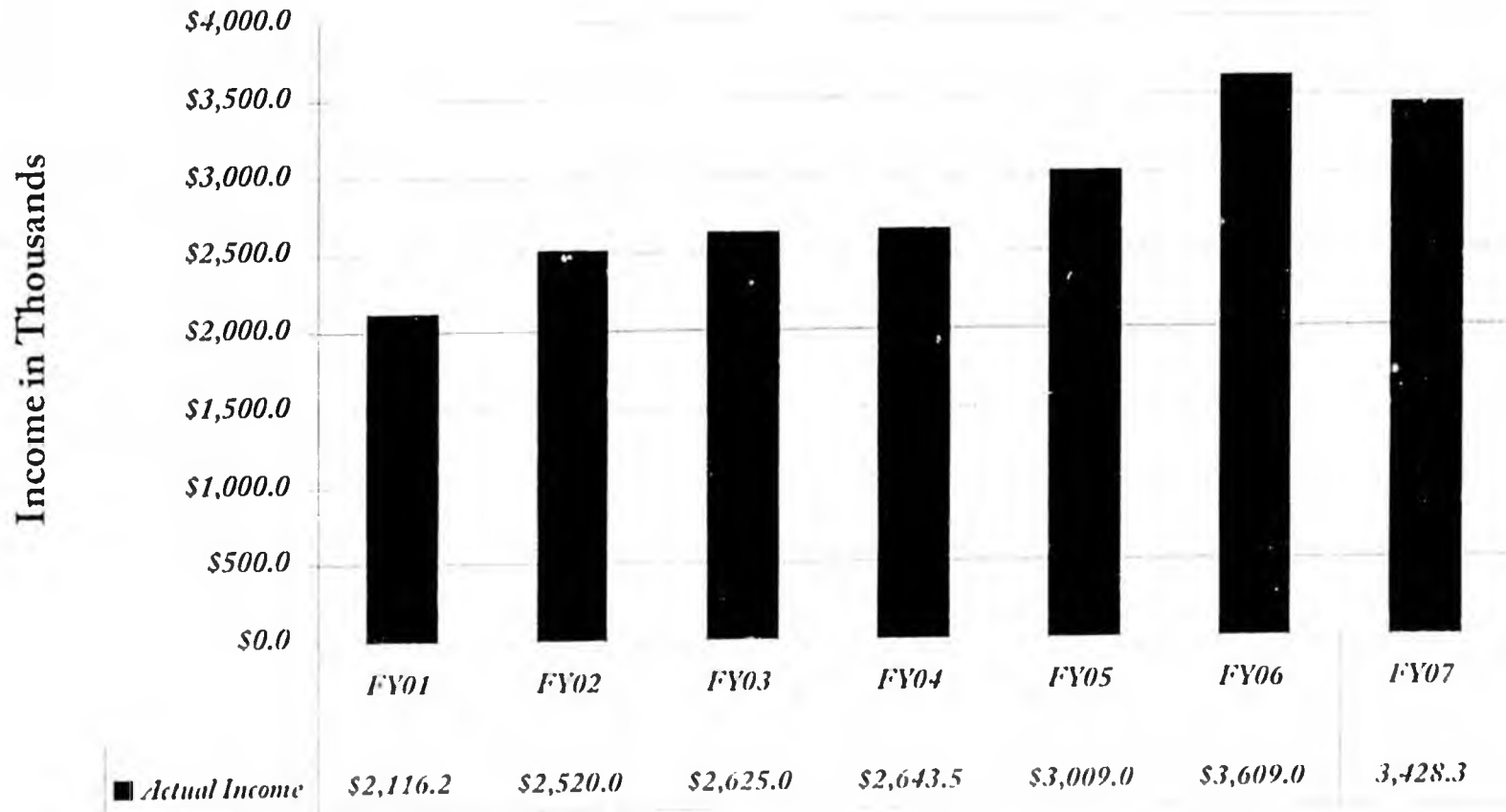
Trust Funding FY09

<u>Trust Distributable Income</u>	
Land Office Income	\$ 1,600,000
<i>Trust Fund Payout 4.25%</i>	\$21,346,719
Prior Year Lapse	\$ 4,356,596
Interest	<u>\$ 1,650,000</u>
Total Trust Projected	\$28,953,315

FY07 Revenue from Trust Land



Spendable Income from Trust Land



Treatment and Services Work

- Fund behavioral health grant increments
- Support brain injury training increment
- Invest in community health centers
- Continue adult dental services
- Support underage drinking prevention program and new prevention increments
- Partner on autism services



Formula for Success

- Identify a problem or community need
- Collaborate with governmental agencies, advisory groups, non profits, service providers, philanthropic organizations and private sector
- Develop strategic, sharply focused solutions
- Make lasting system improvements for Trust beneficiaries

committed partners + strategic thinking = results for Trust beneficiaries

Five Focus Areas

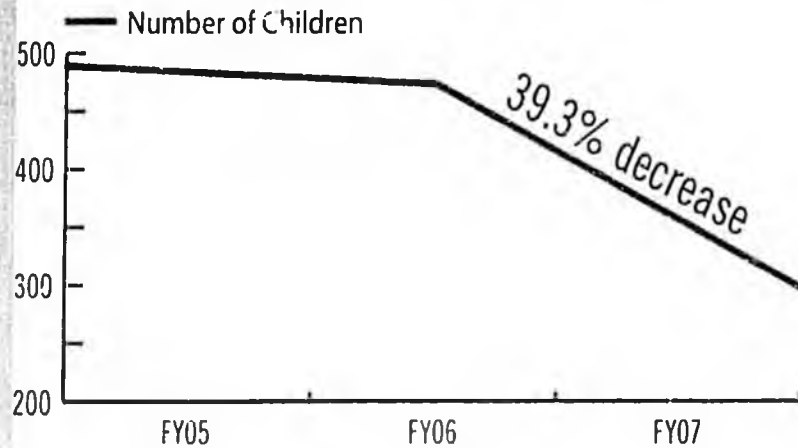
- **Bring the Kids Home**
- **Affordable, Appropriate Housing**
- **Disability Justice**
- **Trust Beneficiary Projects Initiative**
- **Workforce Development**

Bring the Kids Home

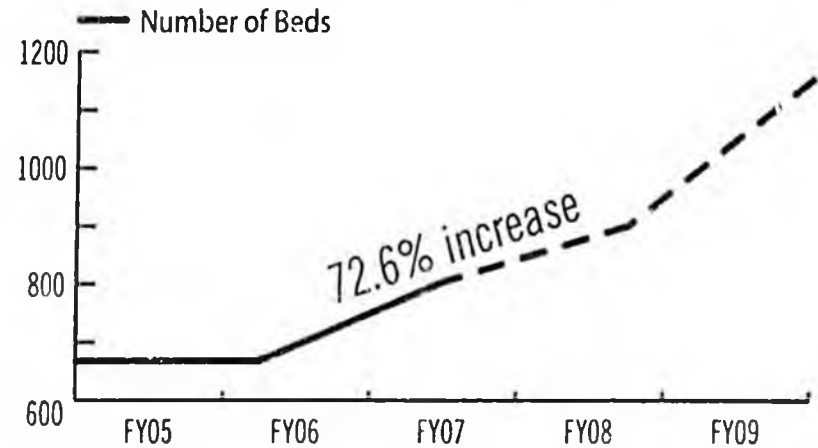
- **Problem or community need**
 - 700 Alaskan children with severe emotional disturbances separated from families, communities
 - placed in out-of-state residential psychiatric treatment centers
 - \$40 million for out-of-state care
- **Committed partners**
 - DHSS, Denali Commission, partner boards, Alaska Native health providers, other service providers, parents, advocacy groups, AHFC
- **Strategic thinking**
 - Each child treated at appropriate level of care as close to home as possible
 - Build appropriate treatment facilities in Alaska
 - Increase capacity/core competencies of in-state providers
 - Provide family supports
 - Involve parents and youth in the solutions

Results for Beneficiaries

CHILDREN IN OUT-OF-STATE
RESIDENTIAL TREATMENT FACILITIES

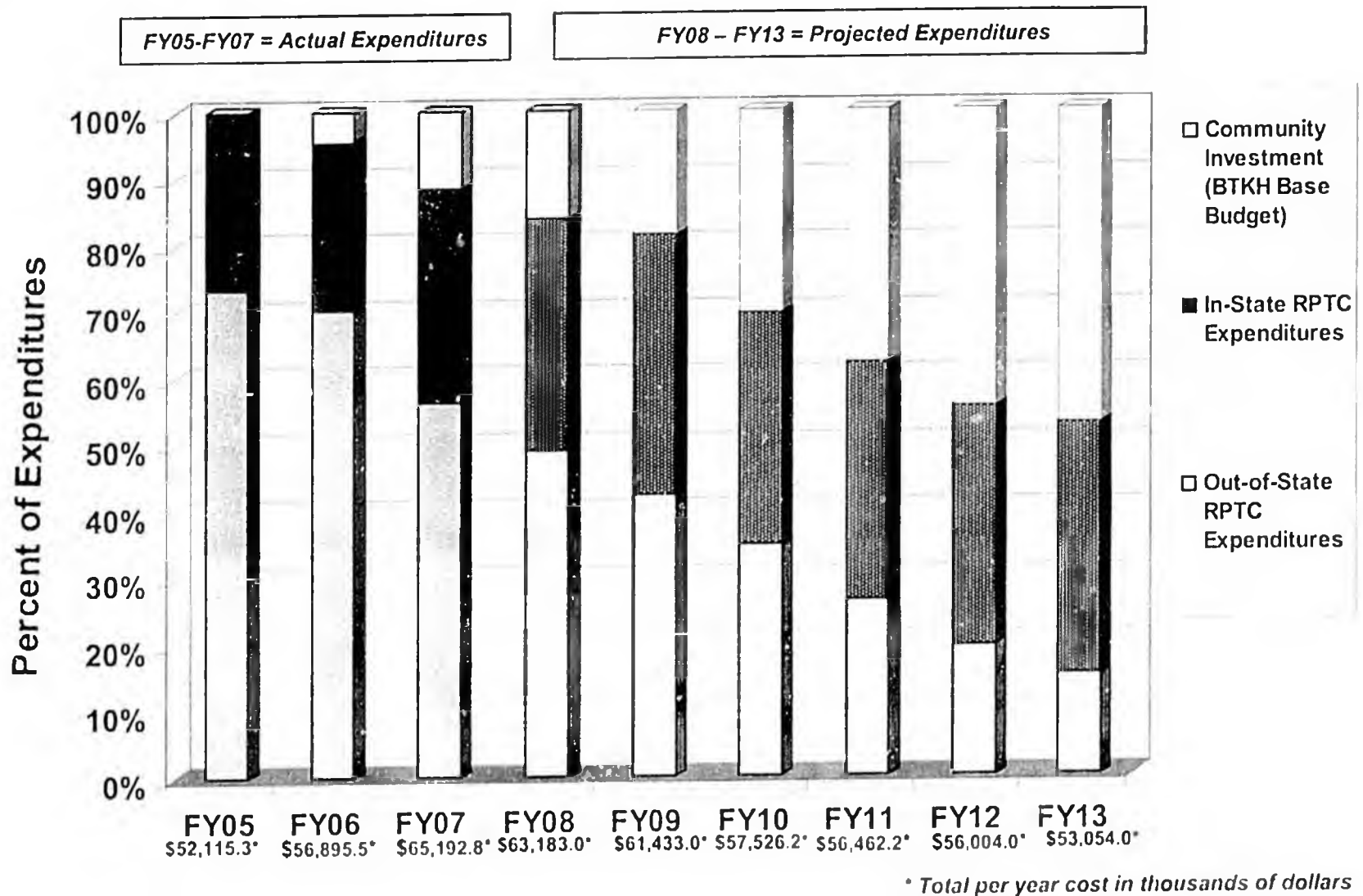


RESIDENTIAL TREATMENT CAPACITY IN ALASKA



- Number of youth admitted to out-of-state residential psychiatric treatment facilities dropped 39.3%, from 489 in FY05 to 297 in FY07
- Service capacity in state increased from 668 beds in FY05 to 804 beds in FY07
- Another 349 beds will be added in FY09, bringing total in-state capacity to 1,153 beds for a 72.6% increase over FY05

Projected BTKH Reinvestment



Data for FY05-06 are from Behavioral Health based on paid claims for Medicaid data. Expenditure data for FY07 are from Finance Management Services and includes all claims incurred and paid in FY07 and claims incurred in FY07 and paid in the first quarter of FY08.

Ahead in '09

Transition into BTKH Base Budget:

	MIITAAAR	GF/MH	Total
• Peer navigation services	\$ 0	\$ 0	\$ 0
<i>Requested Amendments:</i>	\$ 50.0	\$ 100.0	\$ 150.0
• Individualized services	\$ 250.0	\$ 250.0	\$ 500.0
• BTKH strong family voice	\$ 25.0		\$ 25.0

Build capacity within BTKH Base Funding:

• Community BH capacity development	\$ 500.0		\$ 500.0
<i>Requested Amendments:</i>	\$ 250.0	\$1,250.0	\$1,500.0
• Crisis stabilization services (Anchorage)	\$ 100.0	\$ 200.0	\$ 300.0
• Early childhood mental health	\$ 225.0	\$ 150.0	\$ 375.0
• School based services	\$ 300.0		\$ 300.0
• Foster parent/parent services	\$ 75.0	\$ 75.0	\$ 150.0
• RPTC training site	\$ 50.0	\$ 50.0	\$ 100.0

BTKH Capital Funding:

- Continue planning for projects in development for FY10. No FY09 budget request.

Funding in thousands of dollars

BTKH 5-Year Plan

Capacity Infrastructure Development

<i>GF/MH</i>	<i>federal</i>	<i>other</i>	<i>total</i>
\$17,480.0	\$1,250.0	\$135.0	\$18,865.0

- Expanding grant services
- Implementing system for access to individualized funding
- Developing crisis stabilization services statewide
- Obtaining a foster care rate increase

Community Diversion, Care Coordination and Gate Keeping

<i>GF/MH</i>	<i>federal</i>	<i>total</i>
\$2,361.1	\$544.5	\$2,905.6

- Linking families with supports
- Managing access to residential care resources
- Developing partnerships to support children and families in lower levels of care
- Developing peer to peer supports

System Management, Outcomes Tracking & Continuous Quality Improvement

<i>GF/MH</i>	<i>federal</i>	<i>total</i>
\$2,203.1	\$105.0	\$2,308.1

- Evaluating individual clinical, family, provider and system outcomes
- Developing and implementing regulations and policy changes
- Supporting provider & tribal health infrastructure development

Funding in thousands of dollars

Affordable, Appropriate Housing

- **Problem or community need**
 - 3,500 Alaskans homeless on any given night
 - 1,600 are in families with children
 - disproportionately affects Trust beneficiaries
 - can end up clients of public safety, courts, corrections
 - safe, affordable, appropriate housing key to healthy lifestyle
 - housing alone is not enough – need supportive services
- **Committed partners**
 - governor's office, AHFC, DHSS, regional tribal housing authorities, HUD, USDA-Rural Development, Wells Fargo Bank, Rasmuson Foundation, social service providers, homebuilders
- **Strategic thinking**
 - create a housing trust
 - invest in permanently affordable housing
 - include supportive services (case management, treatment, crisis intervention, tenant education, financial literacy, job counseling, life skills training)
 - administer through AHFC

Alaska Housing Trust

- **A proven model**
 - 600 housing trust funds operating nationwide in more than 30 states
 - generate more than \$1.6 billion a year
 - each \$1 spent leverages \$7 in other funds
 - combines housing with supportive services

Alaska Housing Trust

- **Why a housing trust in Alaska?**
 - 4,000 Alaskan households on waiting list for public housing
 - most are families with children
 - families with children fastest growing segment of homeless population
 - 20,000 low income Alaskan households spend more than 50% of income on housing costs placing them at risk of homelessness
 - 57% of Alaskans cannot afford a median priced home
 - 46% of Alaskans cannot afford average rent
 - high personal cost to individuals and families
 - greater family stress
 - lower student achievement
 - vulnerable to crime victimization
 - insufficient supportive housing driving individuals to services only reimbursable by Medicaid
 - contributes to increased State costs for emergency services, medical/behavioral health services, public safety, courts, jails

Alaska Housing Trust

- **A housing trust allows projects such as:**
 - Construction of new housing
 - Purchase and rehabilitation of existing housing
 - Purchase of land and support for land trusts
 - Case management, counseling supports and housing operations funding
 - Crisis intervention services and financial counseling

Results for Alaska

- **Creates permanently affordable housing**
- **Promotes strong families and community stability**
- **Children more successful in school**
- **Seniors and persons with disabilities can live independently with dignity**
- **Grows State services without expanding government's size**
- **Reduces public funding for other services (public safety, courts, jails)**
- **Helps keep Alaska's housing construction industry strong**
- **Encourages partnerships between Alaska's social service and business sectors**

Results for Beneficiaries

- **Homelessness among Trust beneficiaries linked to**
 - challenges associated with disabling conditions
 - lack of opportunities for economic advancement
 - need for supportive living situations
 - accommodations required to meet special needs
- **Supportive housing can provide**
 - case management
 - treatment
 - crisis intervention
 - tenant education
 - financial literacy
 - job counseling
 - life skills training
- **Less likely to end up in revolving door of State supported services**
 - emergency hospital and psychiatric services, shelters, courts, jails

Ahead in '09

- **Governor's Council on the Homeless**
 - expanded to include additional commissioners and rural housing authority representatives
 - charged with creating and overseeing housing trust
- **\$10 million in Governor's capital budget**
 - \$2.5 million GF
 - \$2.5 million AHFC
 - \$2.5 million The Trust
 - \$2.5 million public/private donors
- **Enabling legislation – HB324 & SB231**
 - AHFC will administer housing trust fund
- **Pilot project in progress**
 - \$1 million from The Trust
 - \$1 million matching from Rasmuson Foundation
 - AHFC, Municipality of Anchorage and The Trust combined application processes for AHFC's FY08 capital projects

Disability Justice

- **Problem or community need**
 - 42% of those incarcerated in DOC on a given day were Trust beneficiaries
 - hundreds of beneficiaries incarcerated for their “safety” because services not available
 - thousands of beneficiaries arrested for “status offenses” resulting from behaviors associated with symptoms of their disorders
 - beneficiaries who do not receive mental health services after release have higher recidivism rates
- **Committed partners**
 - Alaska Court System, DOC, DHSS, Law, Public Defender Agency, Public Safety, University of Alaska, local governments, law enforcement, behavioral health treatment providers

Effects of Public Policy Options on Criminal Justice Systems in Washington State

- **Programs in adult offender system**
 - Adult mentally ill program (-20%)
 - Intensive supervision: treatment-oriented programs (-16.7%)
 - Vocational education in prison (-9.0%)
 - Adult drug courts (-8.0%)
 - Cognitive-behavioral therapy in prison or community (-7.0%)
 - Drug treatment in in prison (therapeutic communities or outpatient) (-5.7%)
- **Programs in juvenile offender system**
 - Multidimensional treatment foster care (-22.0%)
 - Adolescent diversion project for lower risk offenders (-19.9%)
 - Counseling/psychotherapy for juvenile offenders (-18.9%)
 - Functional family therapy on probation (-15.9%)
 - Family integrated transitions (-13.0%)
 - Other family-based therapy programs (-12.2%)
 - Multi-systemic therapy (-10.5%)
 - Juvenile behavior modification (-8.2%)
 - Juvenile drug courts (-3.5%)
 - Juvenile cognitive-behavioral treatment (-2.5%)

From Washington State Institute for Public Policy presentation to the Alaska Senate 2008 Crime Summit

Strategic Thinking

- **Recommendations from study of Trust beneficiaries in DOC**
 - continue support for existing diversion programs
 - therapeutic mental health and addiction courts, specialized release programs
 - improve screening and assessment to capture higher, more accurate count of Trust beneficiaries
 - develop more community-based mental health, substance abuse treatment and support services for beneficiaries exiting DOC
 - expand culturally sensitive programs for Alaska Natives, who have highest recidivism among Trust beneficiaries receiving treatment after release



Ahead in '09

	<u>MITTAAR</u>	<u>GF/MIH</u>	<u>Other</u>	<u>Total</u>
<u>Sustain & Expand Therapeutic Models & Practices</u>				
• Fairbanks Juvenile Mental Health Court	\$263.3			\$263.0
• Juneau Mental Health Court	\$204.4			\$204.4
• Anchorage Mental Health Court – Increased Capacity	\$ 99.4			\$ 99.4
<u>Transitional Planning for Beneficiaries Involved with Criminal Justice System</u>				
• APIC Discharge Planning Model	\$210.0	\$ 50.0		\$260.0
• Increased Mental Health Clinician Capacity			\$446.0	\$446.0
• Residential Substance Abuse Treatment			\$331.8	\$331.8
• Institutional Outpatient Substance Abuse Treatment			\$801.0	\$801.0
• Increased Mental Health Clinician Capacity	\$189.2	\$ 264.2		\$453.4
• Develop Alternatives to Incarcerations for Title 47 Substance Abuse Protective Custody Holds	\$480.0			\$480.0

Funding in thousands of dollars

Workforce Development

- **Problem or community need:**
 - shortage of health care workers in Alaska at near-crisis level
 - health services industry fastest growing sector of Alaska's economy, more than 7% of workforce
 - burgeoning demand for increased health services for the state's steadily growing and aging population, some are Trust's beneficiaries
 - need to increase pool of qualified employees in Alaska who serve Trust beneficiaries and keep adequately trained
- **Committed partnerships:**
 - More than 20 partners
 - service providers, DHSS, Dept. Labor and Workforce Development, non-profit and faith-based organizations, University of Alaska system
- **Strategic thinking:**
 - Key focus areas
 - recruitment,
 - retention
 - training

Ahead in '09

- Support student loan repayment strategies for health professionals
- Support increments for University of Alaska health programs
 - Increases training for careers in beneficiary-related services
 - Interdisciplinary education in children's mental health

Trust Beneficiary Projects Initiative

- **Problem or community need:**
 - involve consumers in defining their recovery
 - may prevent need for more intensive traditional service
 - beneficiaries and families interested in developing consumer-driven services but lack expertise or training
- **Committed partners:**
 - beneficiary grantees, 25 since program began in 2006
 - Trust advisory boards, SAMHSA, Division of Behavioral Health, First Alaskans Institute, Rasmuson Foundation, and national and state technical assistance providers
- **Strategic thinking:**
 - provide grantees with seed money and technical assistance
 - administered through a contract with The Foraker Group
 - fund grassroots projects that focus on peer-to-peer support
 - Mini grants for equipment and services to directly improve beneficiaries' quality of life and independent functioning
 - Small Projects grants for one-time, small beneficiary-directed projects
 - \$250,000 annually

Results for Beneficiaries

- **Wide range of beneficiary-run programs**
 - peer-support services
 - clubhouses
 - drop-in centers
 - community outreach
 - illness self-management
- **In communities from Nenana to Ketchikan**
- **Provides sense of empowerment**
- **Promotes recovery among both the beneficiary providers and recipients**
- **FY07 more than 1,600 Trust beneficiaries received direct or indirect services nearly all provided by fellow beneficiaries and/or family members**

Medicaid

- **Medicaid funding critical to Trust beneficiaries**
 - **Support rate adjustments to ensure services are available**
 - **Fund increments to replace Pro Share**

Alaska Mental Health Trust Authority

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www.mhtrust.org

Bring the Kids Home



3 Year Update

State of Alaska • Department of Health & Social Services • Fiscal Years 2005 - 07

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



Bring the Kids Home is an initiative to return children with severe emotional disturbances from out-of-state residential facilities to treatment in Alaska and to keep new children from moving into out-of-state care.

Three primary goals guide the initiative:

- Significantly reduce the numbers of children and youth in out-of-state care and ensure that the future use of out-of-state facilities is kept to a minimum.
- Build the capacity within Alaska to serve children with all intensities of need.
- Develop an integrated, seamless system that will serve children in the most culturally competent, least restrictive setting, and as close to home as possible.

History:

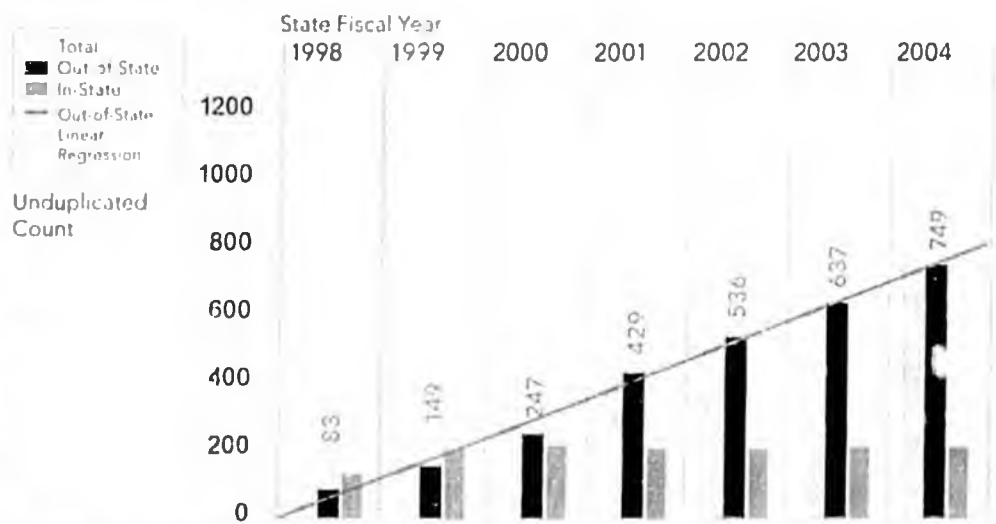
From 1998 to 2004, Alaska's behavioral health system became increasingly reliant on Residential Psychiatric Treatment Centers (RPTC) for treatment of youth with severe emotional disturbance. Out-of-state placements grew by nearly 800 percent. Alaska Native children were over-represented. 49 percent of children in state custody and 22 percent of non-custody children in out of state placements were Alaska Native while only 16 percent of the general population is Alaska Native.



Out-of-State Residential Psychiatric Treatment Centers

Between fiscal year 1998 and fiscal year 2004, out-of-state Residential Psychiatric Treatment Centers (RPTC) Medicaid expenditures experienced an overall increase of over 1,300 percent. By fiscal year 2006, Medicaid expenditures were over \$40 million for a relatively small number of children with severe emotional disturbances in out-of-state Residential Psychiatric Treatment Centers.¹

Distinct Count of Medicaid Residential Psychiatric Treatment Centers (RPTC) Recipients

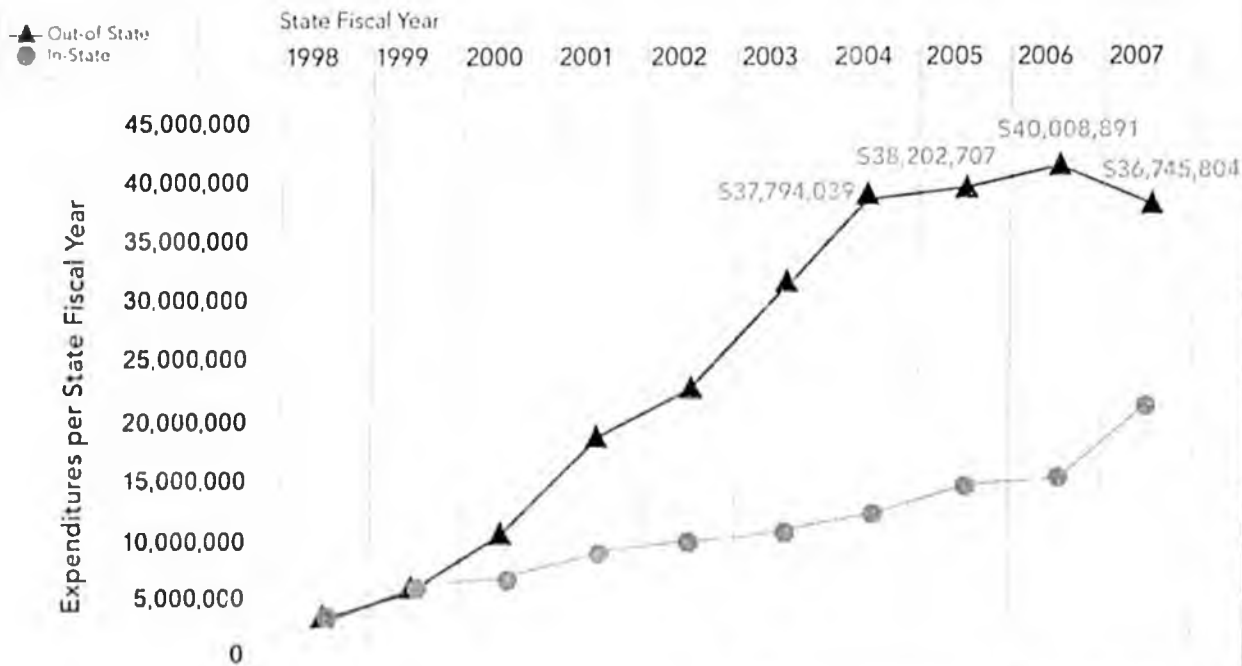


¹ Data found in this update are from Behavioral Health's report "Understanding the Needs of Alaska's Children with Severe Emotional Disturbances" and are being included here to provide a historical context for the data. For more information, visit <http://www.alaska.gov/behavioralhealth/updates/2007>.

By fiscal year 2006, Medicaid expenditures were over \$40 million for a relatively small number of children with severe emotional disturbances in out-of-state Residential Psychiatric Treatment Centers.



Residential Psychiatric Treatment Centers: Decrease in Out-of-State Expenditures and Shift to In-State Care



State Fiscal Year (SFY) calculations completed by the Department of Health & Social Services (DHSS) in conjunction with the Alaska Department of Health & Social Services (ADHSS) are based on the data reported and paid in SFY, as well as those reported in SFY and paid in the 12 months prior to SFY. SFY calculations were based on the Alaska Department of Health & Social Services (ADHSS) data for the period between SFY and SFY. Parameters for the SFY and SFY calculations were based on the SFY and SFY data reported in SFY.



System impact of these trends:

The foregoing cited trends limit the development of in-state mental health care because Alaska Medicaid resources are already invested in the out-of-state services. These trends create difficulty coordinating a child's return home, resulting in problems with medication management, school records and involving families in clinical supports in the community. Families and children are separated and cultural differences can be significant. If children need residential care, it is better delivered close to home.

As noted, these trends represent a financial investment in residential services. However, waiting until children move into residential care increases the problems experienced by the child, the family and the community. Alaska needs proactive, community-based services to keep children from becoming severely disturbed and needing residential treatment, as well as in-state residential services for children with severe emotional disturbances.

Human impact of these trends:

When a child needs intensive mental health services in Alaska, the family often faces a serious dilemma: what is the best thing for their child and what can they afford?

A story (names and situation are composites to preserve privacy):

When Jill was 13, she became withdrawn and suicidal. Her mother (Lisa) tried counseling, consequences and bribes. Nothing helped. Jill attempted suicide when she was 14. By

then, their insurance benefits were used up. The family went to a Community Mental Health Center (CMHC), but services were limited by funding, workforce, training and geography. Both Lisa and the CMHC were afraid that Jill would hurt herself again. Lisa took increasing time off from work and her boss began to complain. The younger children started to act out. Local residential treatment facilities did not want to admit a child who had attempted suicide when there were other children with less severe problems being referred.

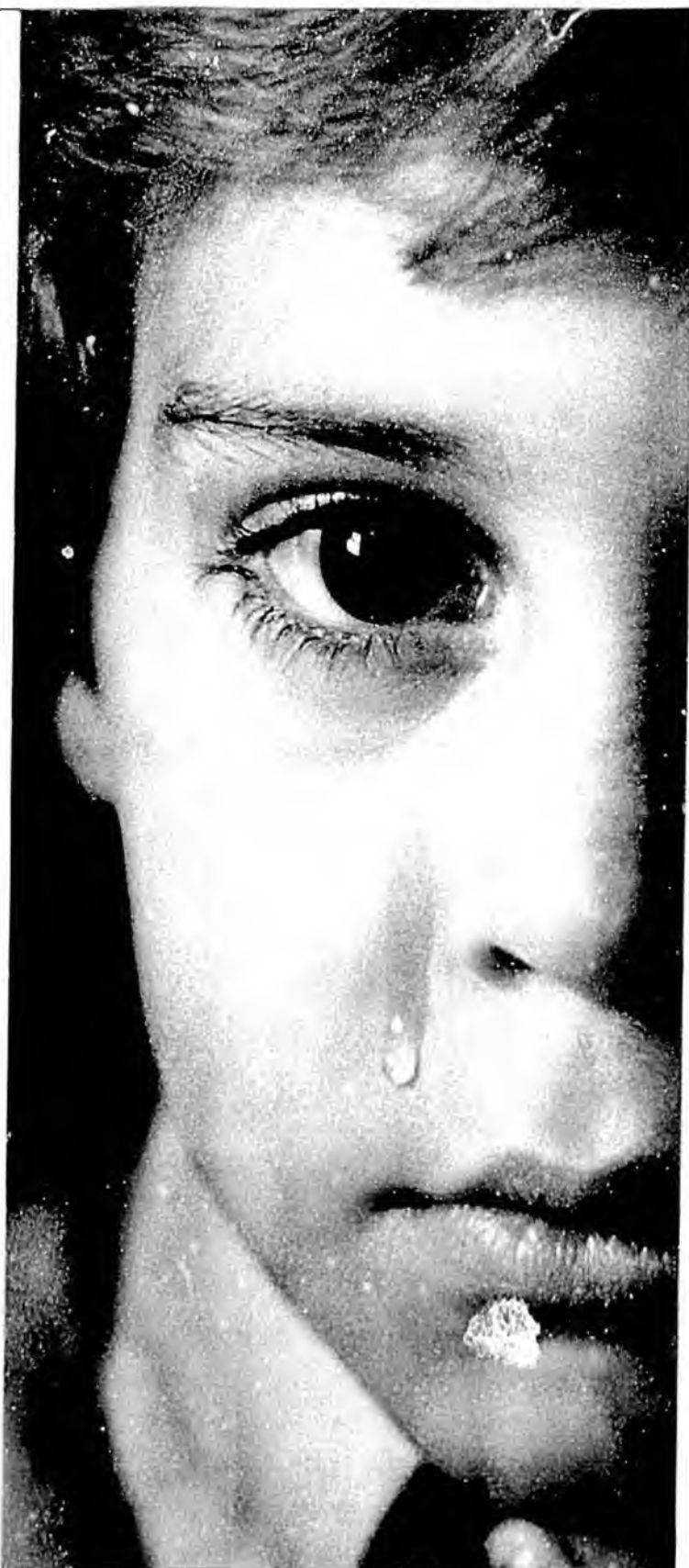
A friend told Lisa about an out-of-state facility that boasted a strong school program and welcomed suicidal and depressed children. The state would pay for Jill's treatment after 30 days. Out-of-state residential care seemed the only option.

How can families manage in these very difficult circumstances?

Problems exist with a system that cannot provide care before a child becomes severely disturbed. Problems can include:

- The family's insurance, financial and emotional resources are exhausted.
- Family relationships are disrupted and the other children begin to have difficulties.
- The child becomes more disturbed.
- School performance suffers and school resources are stretched thin.
- The juvenile justice or children's protective services systems become involved.

A frequent result is that a child enters acute care and is referred for long-term residential placement. After 30 days, the state begins to pay for most residential care through Medicaid.



Bring the Kids Home Accomplishments:

The following is a summary of Bring the Kids Home accomplishments. Detailed reports and budget information are available on the Bring the Kids Home Web site at: hss.state.ak.us/commissioner/btkh/.

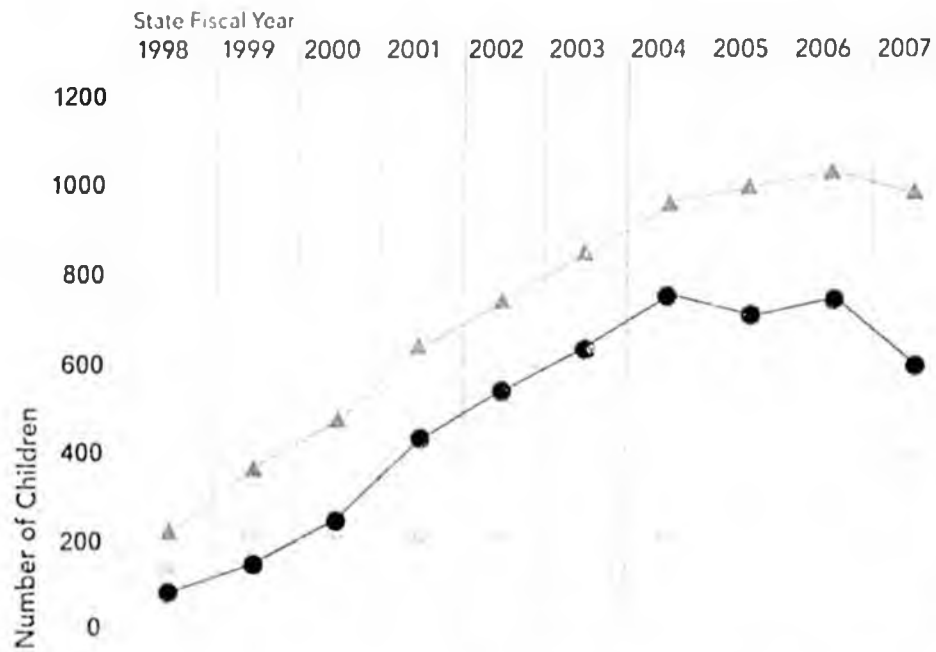
Capacity Development

- 28 new Bring the Kids Home operating grants are developing services in 12 communities. During fiscal year 2006 and 2007, 56 new in-state beds were developed, 236 children were stepped down from more restrictive in-state or out-of-state care and approximately 500 children were served.
- Individualized Service Agreements (ISA) were created to fund services to prevent children from moving into residential care. During the first full year, ISA supported 61 children in community-based settings.
- A Department of Health & Social Services rate review mandated an 18 percent increase for behavioral rehabilitation services and new regulations expanded access to 54 in-state beds for non-custody children. During fiscal year 2007, the length of stay for non-custody children in in-state Residential Psychiatric Treatment Centers was 141 days, whereas the out-of-state average was 335 days.
- Funding was identified to develop a facility in Anchorage to stabilize children in acute crisis and help return them to community settings. This will proceed in fiscal year 2008.
- Regulations were developed for school Medicaid mental health service delivery as part of a child's individualized education plan. During fiscal year 2008, a "tool kit" will be created to assist with expanding school mental health capacity. Two schools enrolled in fiscal year 2007.
- New capital funding is developing residential treatment/group homes in Anchorage, Fairbank, Juneau, Ketchikan, Kenai, Kotzebue, Dillingham and Eklutna.
- New funding is supporting expanded tribal mental health services that are culturally competent, closer to home, and that access the 100 percent federal reimbursement rate. One new tribal facility estimates full year savings of state general funds of \$500,000.
- Workforce issues are being addressed with new grants: through training and mentoring, and through the Bring the Kids Home workforce subcommittee. During fiscal year 2007 the "Residential Services Certificate Program" enrolled 58 students; the Fetal Alcohol Spectrum Disorder demonstration waiver trained its first cohort of over 25 participants, and a statewide early childhood mental health learning collaborative trained providers and began follow-up mentoring.

How do outcomes reflect this capacity development?

Out-of-state care is declining and in-state care is increasing. (Table shows the distinct count of children served in Residential Psychiatric Treatment Centers during a fiscal year.)

Change in In-State and Out-of-State Residential Psychiatric Treatment Centers Placements Over Time



Community Diversion, Care Coordination and Gate Keeping:

- A new care coordination team within the Department of Health and Social Services is monitoring referrals to out-of-state Residential Psychiatric Treatment Centers (RPTC) care, ensuring use of in-state resources prior to out-of-state RPTC care and engaging in system development. The team's activities will expand during fiscal year 2008. A pilot project by this team diverted 37 children in acute care from out-of-state Residential Psychiatric Treatment Centers care during fiscal year 2007.
- Parent/Peer Navigation grants are diverting youth from residential care by helping parents and youth navigate the system and access in-state resources. Between March and September 2007, 55 youth referred for Residential Psychiatric Treatment Centers care were served. Of these, 45 percent (25) were able to remain in community settings. Another 34 percent moved into in-state residential settings. In total, 79 percent were maintained in-state.
- Behavioral Health held Bring the Kids Home summits in 2007 in Bethel, Fairbanks, Juneau, Kenai and Kodiak to identify service gaps and to build collaboration. Additional summits will be held in fiscal year 2008, starting with Kotzebue. Information is used for planning, system development and ongoing coordination of services for children and families.
- In 2007, the Department of Health and Social Services began a pilot project to return/divert children from the Mat-Su region from out-of-state care. The contractor will coordinate comprehensive service plans for the children and their families. If effective, this model may be expanded.
- A new fiscal year 2008 project will coordinate educational transitions, establish protocols and monitor success for children returning from care in Residential Psychiatric Treatment Centers.
- A Level of Care Assessment was implemented at three acute care sites to standardize decision-making. During 2008, it will become part of out-of-state placement reviews.

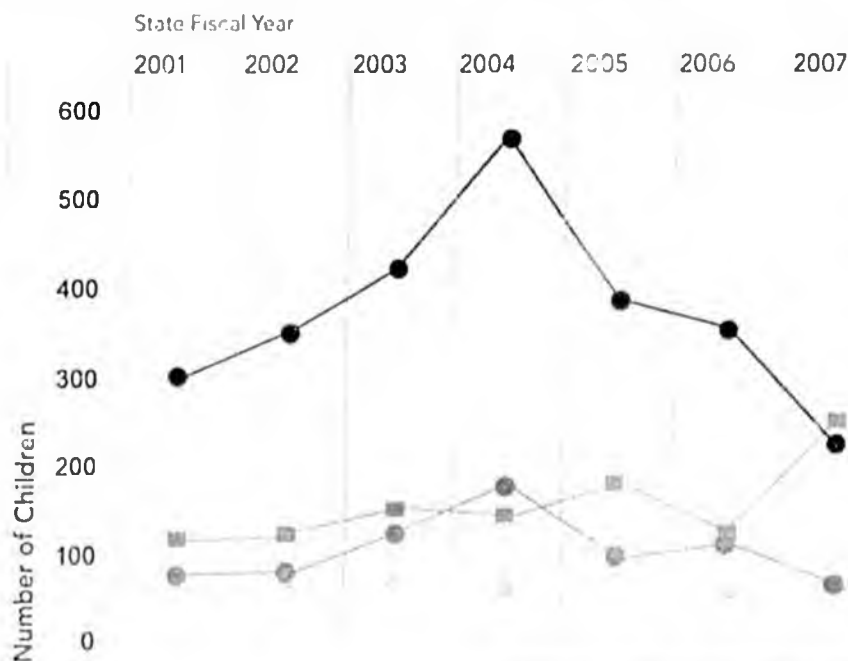
Downloaded from <http://ajph.org/> on November 10, 2014

How do these activities affect outcomes?

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



Residential Psychiatric Treatment Center Recipients "Admitted"



System Management, Outcomes Tracking and Continuous Quality Improvement:

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



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

For more information, visit www.dhss.state.ak.us or call 907-451-2000.

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

How do these activities affect outcomes?

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



But will Bring the Kids Home Save Money?

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

For more information:

<http://www.state.ak.us/commissioner/btkh/reports.html>

1998-2004 Indicators

2007 Annual Report

2006 Annual Report

2005 Annual Report





State of Alaska
Department of Health & Social Services
Bring the Kids Home

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Bringing (Keeping) the Kids Home



5 Year Plan

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

More information can be found on our Web site: <http://www.1-800-272-2262>

Executive Summary



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

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

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

1. Capacity Infrastructure Development			
General Fund	Federal	Other	TOTAL
\$17,800.0	\$1,800.0	\$136.0	\$18,865.0

2. Community Diversion, Care Coordination and Gate Keeping		
General Fund	Federal	TOTAL
\$2,905.6	\$0.0	\$2,905.6

3. System Management, Outcomes Tracking and Continuous Quality Improvement		
General Fund	Federal	TOTAL
\$2,308.4	\$0.0	\$2,308.4

4. Work Force Development	
General Fund	TOTAL
\$975.0	\$975.0



Six Primary Strategies

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

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

System Change & Reinvestment

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

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

Performance Measures

Fiscal year 2013 BTKH Performance Measures for success include:

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





5 Year Projected Plan: Fiscal Year 2009-2013

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

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

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

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

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

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

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

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



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

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

Bring the Kids Home Projects:

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

I. Capacity (Infrastructure) Development

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

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

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

For more information, visit <http://www.ak.us/commissioner/btkh/projects.html>

II. Community Diversion, Care Coordination and Gate Keeping

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

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

1. Expand assessment and coordination available to educate caregivers and assist them to access in-state resources and lower levels of care.

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



For more information, call 907.465.6600 or visit <http://www.alaska.gov/healthservices/bringthekidshome/>

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

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

GF/MH \$2,202.4	Federal \$106.0	TOTAL \$2,308.4
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Fiscal year 2013 base funding in thousands of dollars

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

For more information, visit <http://dhs.alaska.gov/bringthekidshome>

IV. Work Force Development

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

GF/MH	TOTAL
\$975.0	\$975.0

Fiscal year 2013 base funding in thousands of dollars

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



For more information, visit www.alaska.gov/commerce/eh/behavioralhealth



V. Capital Funding Needs:

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

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

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

For more information see state.ak.us/commissioner/btkh/quarterly.html

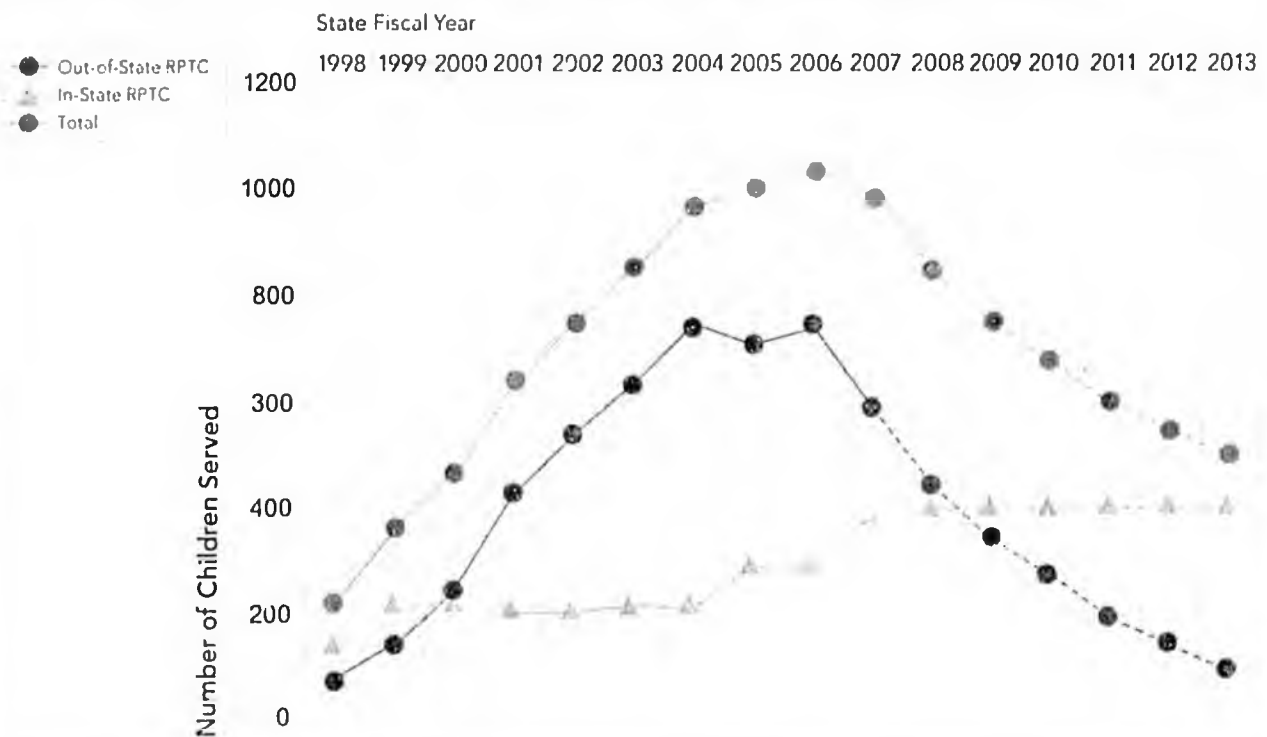
Bring the Kids Home Performance Measures: System Change and Reinvestment

Performance Measure 1: Client Shift (Bed Counts)

Fiscal Year 2013 Goals

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

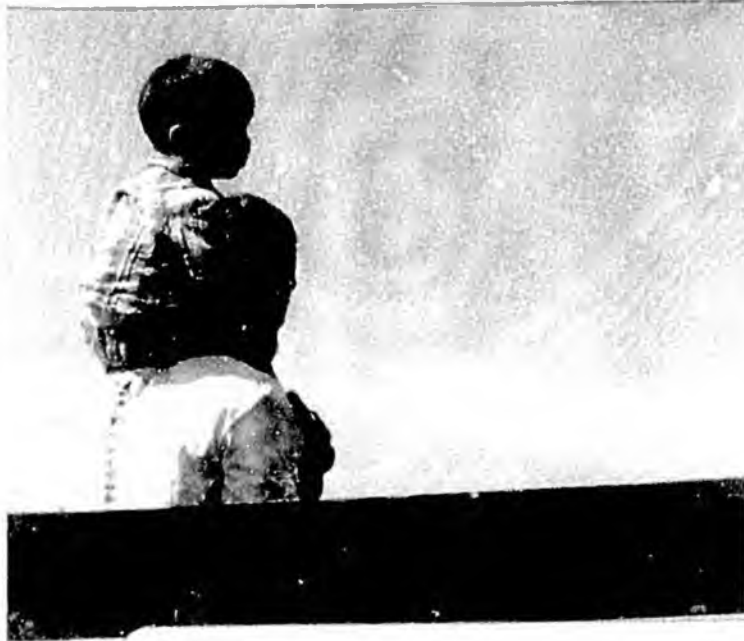
Figure 1 - Performance Measure 1
Projected Change in Residential Psychiatric Treatment Utilization Over Time



Notes on Figure 1.

- This chart shows a projection of change in children served in residential psychiatric treatment centers over each fiscal year.
- Figures for fiscal years 2000-2007 are based on the actual number of children served in RPTC care.
- Figures for fiscal years 2008-2013 are based on ETKI goals for the number of children to be served in RPTC care.
- Data are from ETKI annual Health, Disability and Planning section. Additional data are available in the ETKI annual reports at: <http://www.hhs.state.ak.us/comm/comm/etki/>

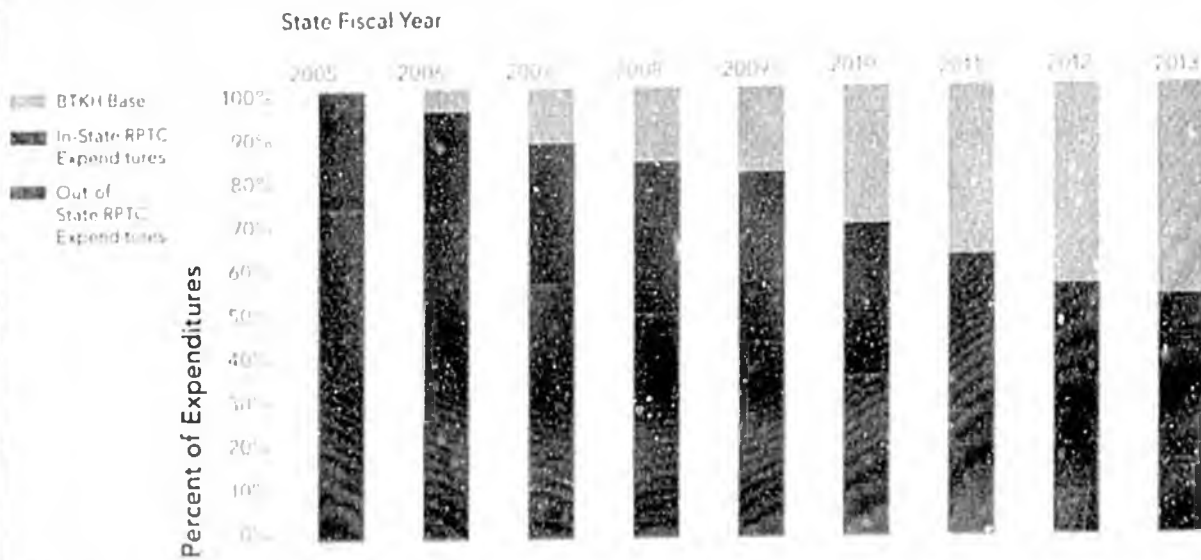
Information that is readily available to the public (RPTC annual fiscal year reports and the ETKI annual reports) is provided for informational purposes only. It is not intended to be used for legal purposes. Information is provided for informational purposes only.



Performance Measure 2: Funding Shift Fiscal Year 2013 Goals

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

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



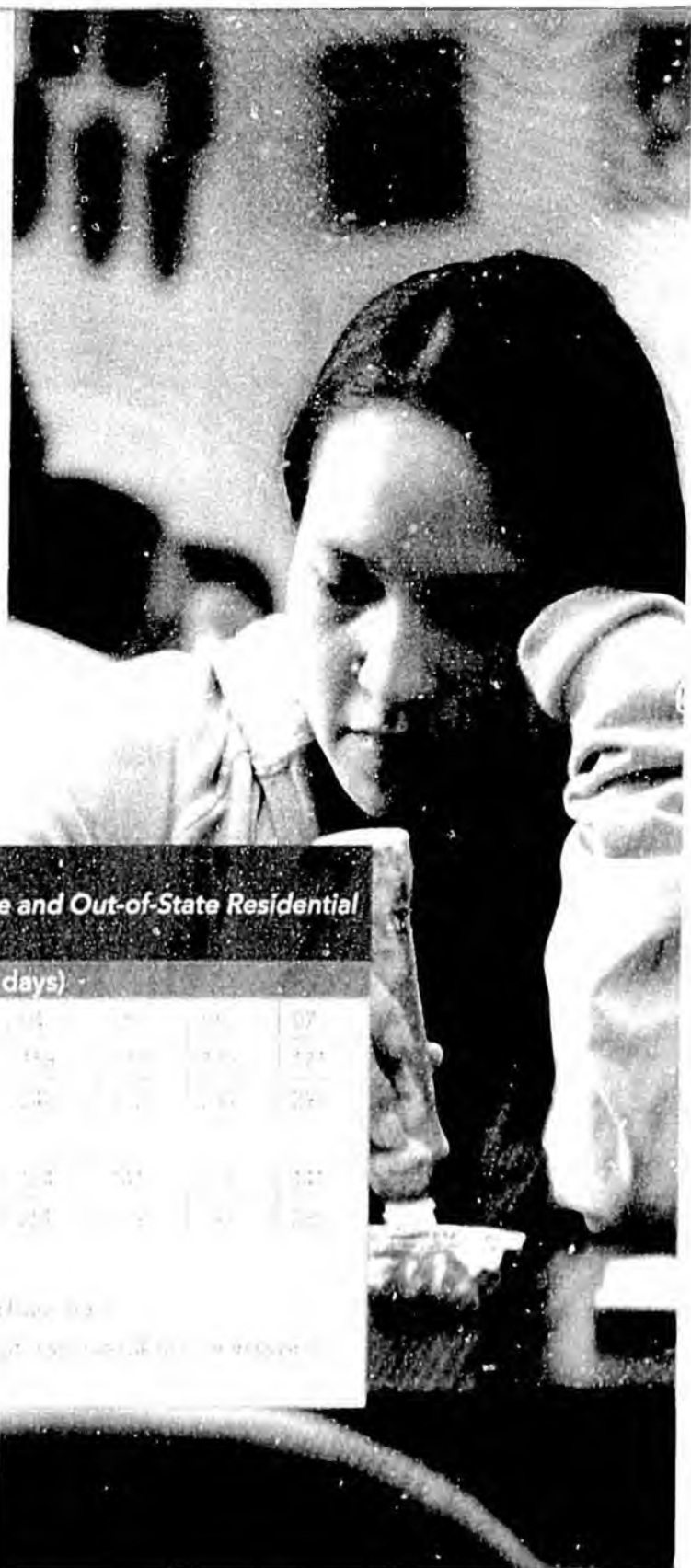
- In FY08, the Department of Health & Social Services (DHSS) will allocate \$15.5 million to the BTKH Base.
- The BTKH Base will be used to fund the majority of the BTKH Base. The BTKH Base will be used to fund the majority of the BTKH Base.
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FY05 - FY07 based on actual BTKH budget and expenditures for residential psychiatric treatment center care, FY08 - FY13 based on projected BTKH budget and expenditures for residential psychiatric treatment center care.

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

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

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



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

		Average Length of Stay (in days)							
		2007	2008	2009	2010	2011	2012	2013	Goal
In-State	Male	105	102	105	105	105	105	105	120
	Female	105	102	105	105	105	105	105	120
Out-of-State	Male	260	260	260	260	260	260	260	260
	Female	260	260	260	260	260	260	260	260

Notes on Figure 3:

- Data is not available for 2007 for Out-of-State Residential Psychiatric Treatment Centers.
- Data is not available for 2007 for In-State Residential Psychiatric Treatment Centers.

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

Fiscal Year 2013 Goals

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

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

	FY07	FY13	Anticipated bed Count	Percent Increase
In-State Bed Capacity below RPTV	135	207	185	26.7%
In-State RPTV Capacity	166	215	215	29.5%
TOTAL In-State Beds	301	422	400	29.7%

Notes on Figure 4

- These data were derived from the HSPH and the State Staff Training Program. The estimated capacity increase is based on the anticipated capacity increase of the RPTV and the current funding.
- Additional capacity will be provided by the RPTV and the State Staff Training Program.

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

Fiscal Year 2013 Goals

- Overall, the rate of recidivism in residential residential treatment centers (RPTV) will decrease 75 percent, recidivism defined as a child re-offending within one year of the time of completion of residential care.

During fiscal year 2007, the overall recidivism rate was 75 percent for a maximum of one RPTV within one year of the date of discharge.

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

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

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



Figure 5. Youth Behavioral Health Consumer Survey Respondents Satisfied with Services





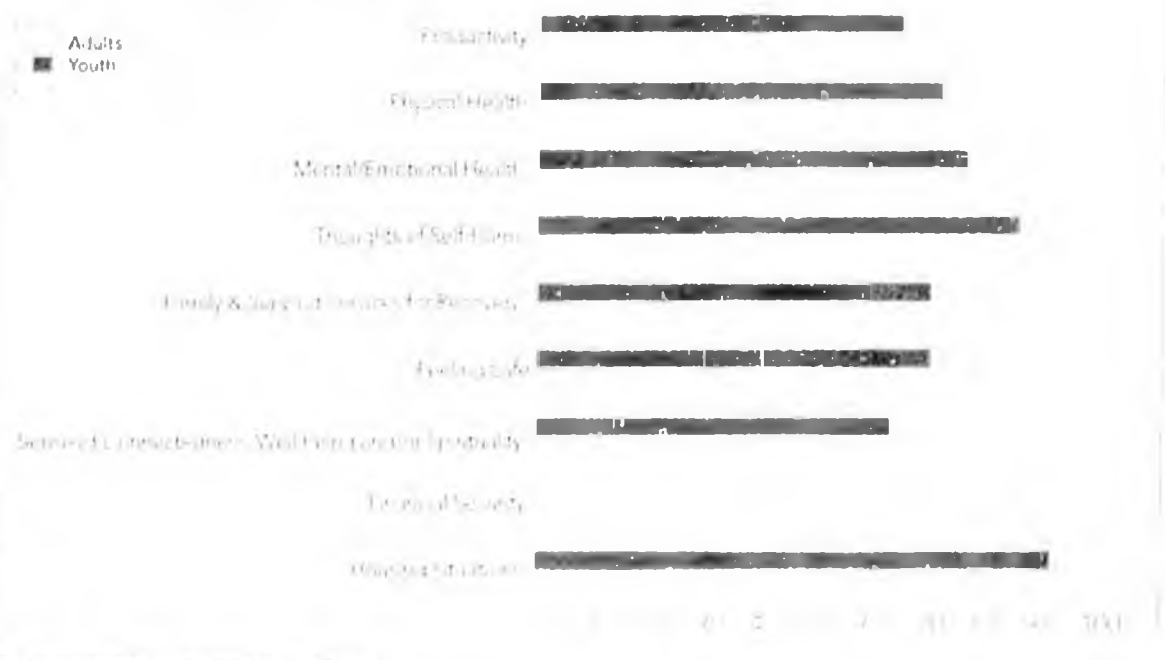
Performance Measure 7: Functional Improvement

Fiscal Year 2013 Goals

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

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

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



For more information:

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Phone: (907) 465-4994

Fax: (907) 465-3068

Web: hss.state.ak.us/commissioner/btkh/

Available on our Web site:

hss.state.ak.us/commissioner/btkh/

2007 Local Navigation Report (PDF) (2/07)

2007 Child Welfare Report

2007 PERI Annual Report

2006 Community Care Report

2006 HHS Annual Report

2006 HHS Annual Report Summary

Press: 2007 HHS Annual Report





State of Alaska
Department of Health and Social Services
Bring the Kids Home

Child Abuse and Neglect
Reporting and Investigation Unit
1400 E. 14th Ave., 2nd Floor
Juneau, Alaska 99801-3000

1-907-586-2200
Juneau, Alaska 99801-3000
Telephone: (907) 586-2200
TDD: (907) 586-2200

State of Alaska, Department of Health and Social Services, Child Abuse and Neglect Reporting and Investigation Unit, 1400 E. 14th Ave., 2nd Floor, Juneau, Alaska 99801-3000. Telephone: (907) 586-2200. TDD: (907) 586-2200.

Attachment One

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



3 Year Update
& 5 Year Plan

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

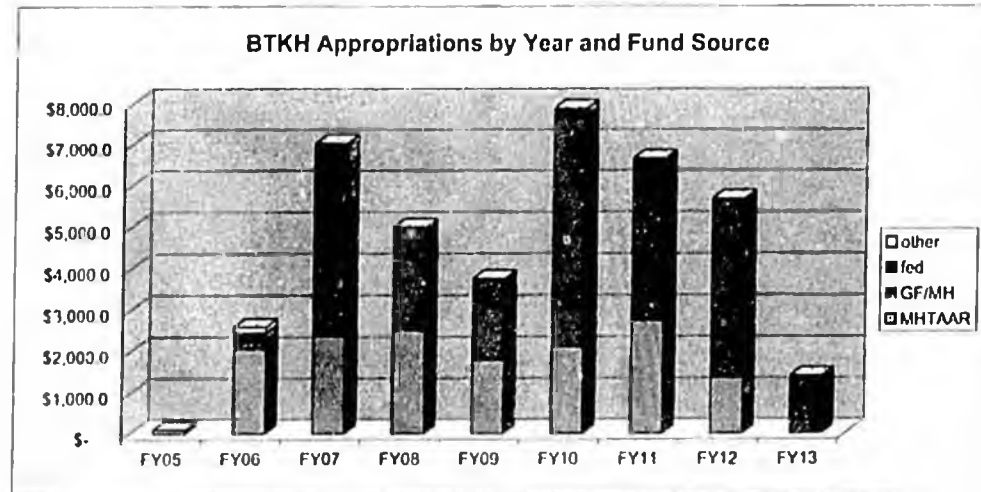
Additional information is available at
<http://www.hss.state.ak.us/communities/tkbh>

BRING THE KIDS HOME TOTAL BUDGET BY YEAR AND FUND SOURCE

All funding shown in thousands of dollars

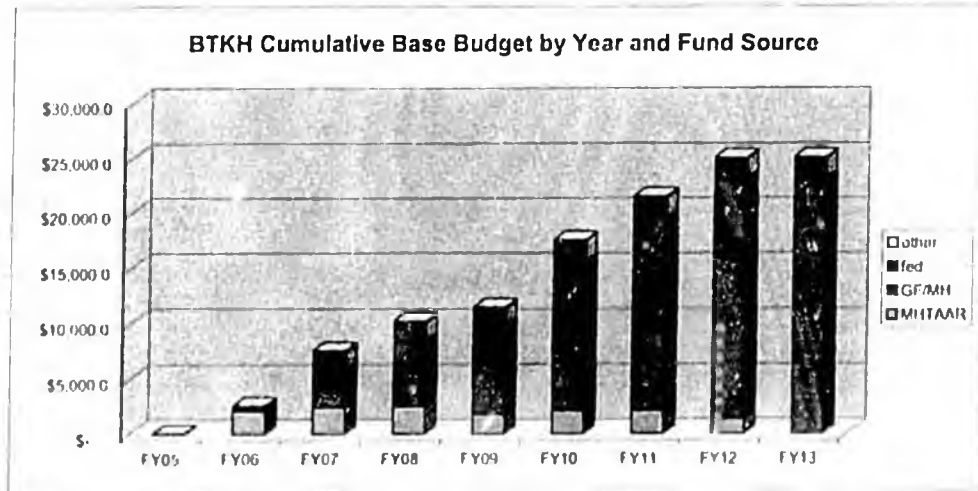
	MHTAAR	GF/MH	fed	other	TOTAL
FY05	\$ 100.0	\$ -	\$ -	\$ -	\$ 100.0
FY06	\$ 2,045.5	\$ 204.5	\$ 204.5	\$ 135.0	\$ 2,589.5
FY07	\$ 2,365.0	\$ 3,135.0	\$ 1,515.0	\$ -	\$ 7,015.0
FY08	\$ 2,500.0	\$ 2,489.0	\$ -	\$ -	\$ 4,989.0
FY09	\$ 1,775.0	\$ 1,975.0	\$ -	\$ -	\$ 3,750.0
FY10	\$ 2,100.0	\$ 5,588.2	\$ 180.0	\$ -	\$ 7,868.2
FY11	\$ 2,725.0	\$ 3,911.0	\$ -	\$ -	\$ 6,636.0
FY12	\$ 1,350.0	\$ 4,318.8	\$ -	\$ -	\$ 5,668.8
FY13	\$ -	\$ 1,400.0	\$ -	\$ -	\$ 1,400.0

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



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

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

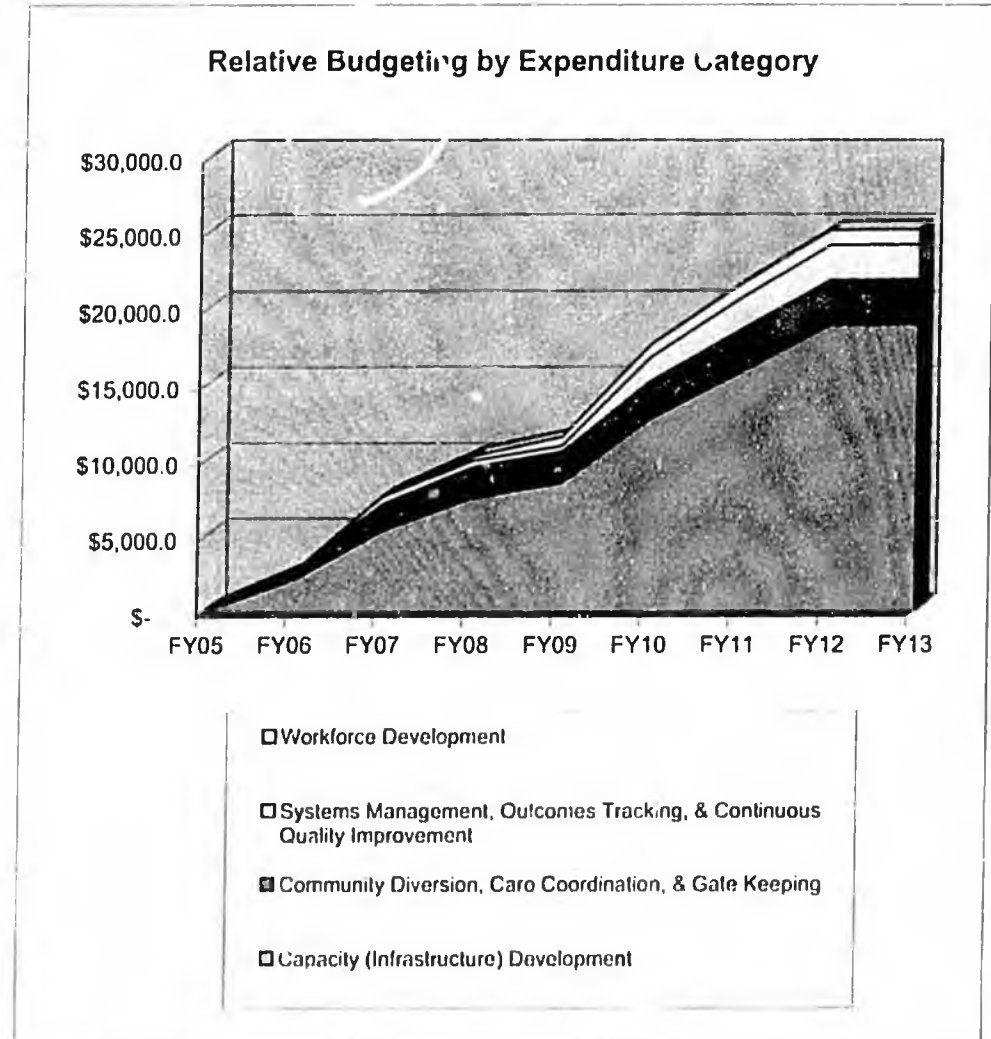


BTKH RELATIVE BUDGETING BY EXPENDITURE CATEGORY WITHIN CUMULATIVE BASE BUDGET

Funding shown in thousands of dollars.

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

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

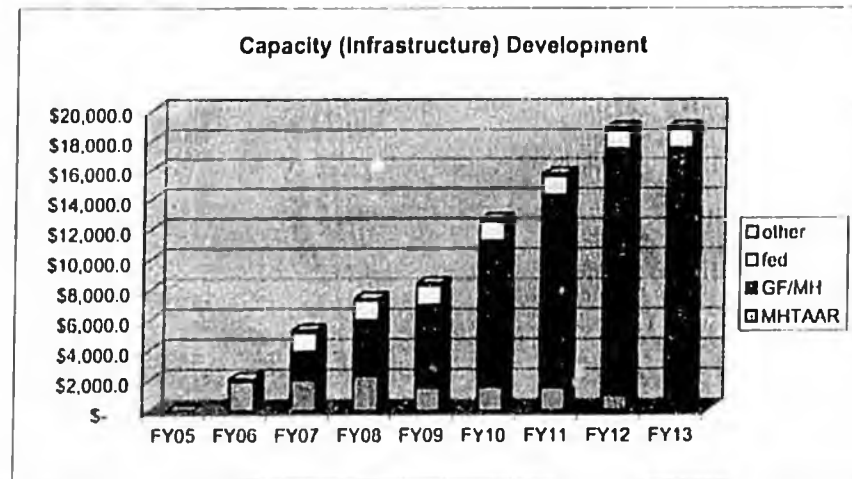


**FUND SOURCE DETAIL FOR
BRING THE KIDS HOME RELATIVE BUDGETING BY EXPENDITURE CATEGORY
WITHIN CUMULATIVE BASE BUDGET**

All funding in thousands of dollars

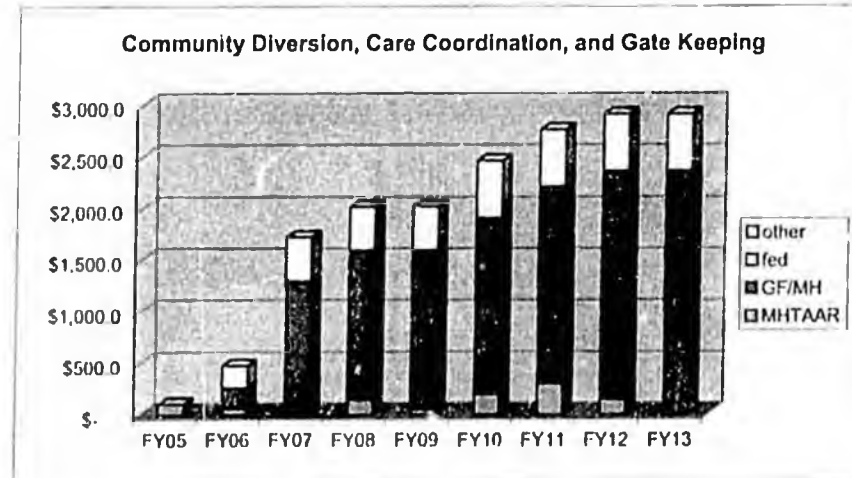
Capacity (Infrastructure) Development					
	MHTAAR	GF/MH	fed	other	TOTAL
FY05	\$ -	\$ -	\$ -	\$ -	\$ -
FY08	\$ 1,943.0	\$ -	\$ -	\$ 135.0	\$ 2,078.0
FY07	\$ 2,090.0	\$ 1,830.0	\$ 1,250.0	\$ 135.0	\$ 5,305.0
FY08	\$ 2,325.0	\$ 3,714.0	\$ 1,250.0	\$ 135.0	\$ 7,424.0
FY09	\$ 1,550.0	\$ 5,489.0	\$ 1,250.0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

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



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

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



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

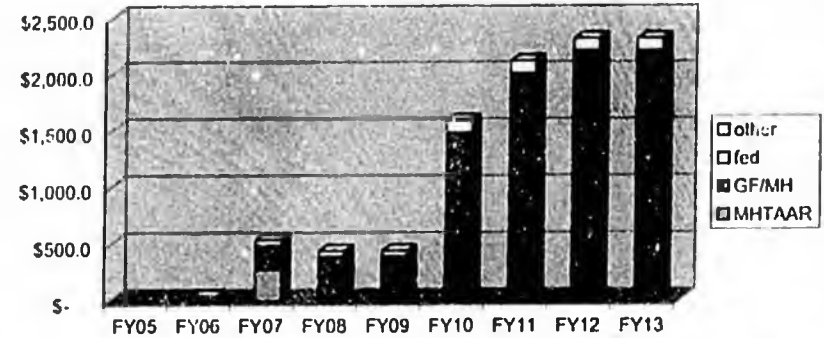
All funding in thousands of dollars

Systems Management, Outcomes Tracking, & Continuous Quality Improvement

	MHTAAR	GF/MH	fed	other	TOTAL
FY05	\$ -	\$ -	\$ -	\$ -	\$ -
FY06	\$ 40.0	\$ -	\$ -	\$ -	\$ 40.0
FY07	\$ 275.0	\$ 215.0	\$ 45.0	\$ -	\$ 535.0
FY08	\$ 25.0	\$ 368.4	\$ 45.0	\$ -	\$ 438.4
FY09	\$ 25.0	\$ 368.4	\$ 45.0	\$ -	\$ 438.4
FY10	\$ 25.0	\$ 1,453.4	\$ 105.0	\$ -	\$ 1,583.4
FY11	\$ 50.0	\$ 1,953.4	\$ 105.0	\$ -	\$ 2,108.4
FY12	\$ 25.0	\$ 2,176.4	\$ 105.0	\$ -	\$ 2,308.4
FY13	\$ -	\$ 2,203.4	\$ 105.0	\$ -	\$ 2,308.4

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

Systems Management, Outcomes Tracking, and Continuous Quality Improvement

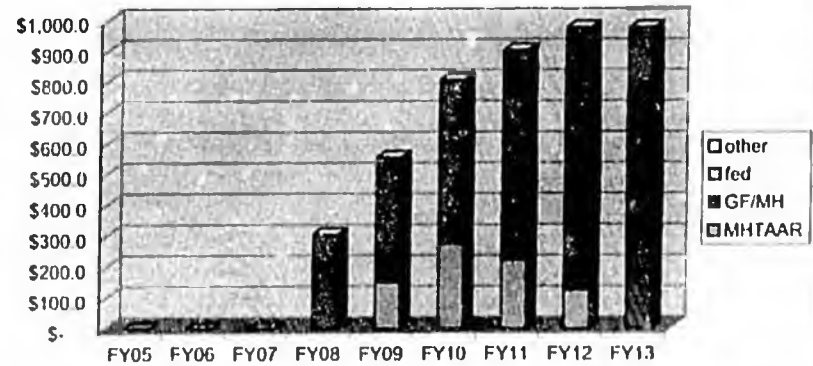


Workforce Development

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

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

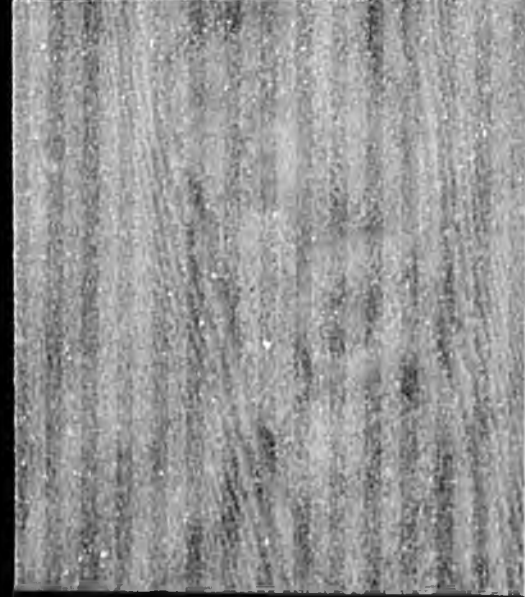
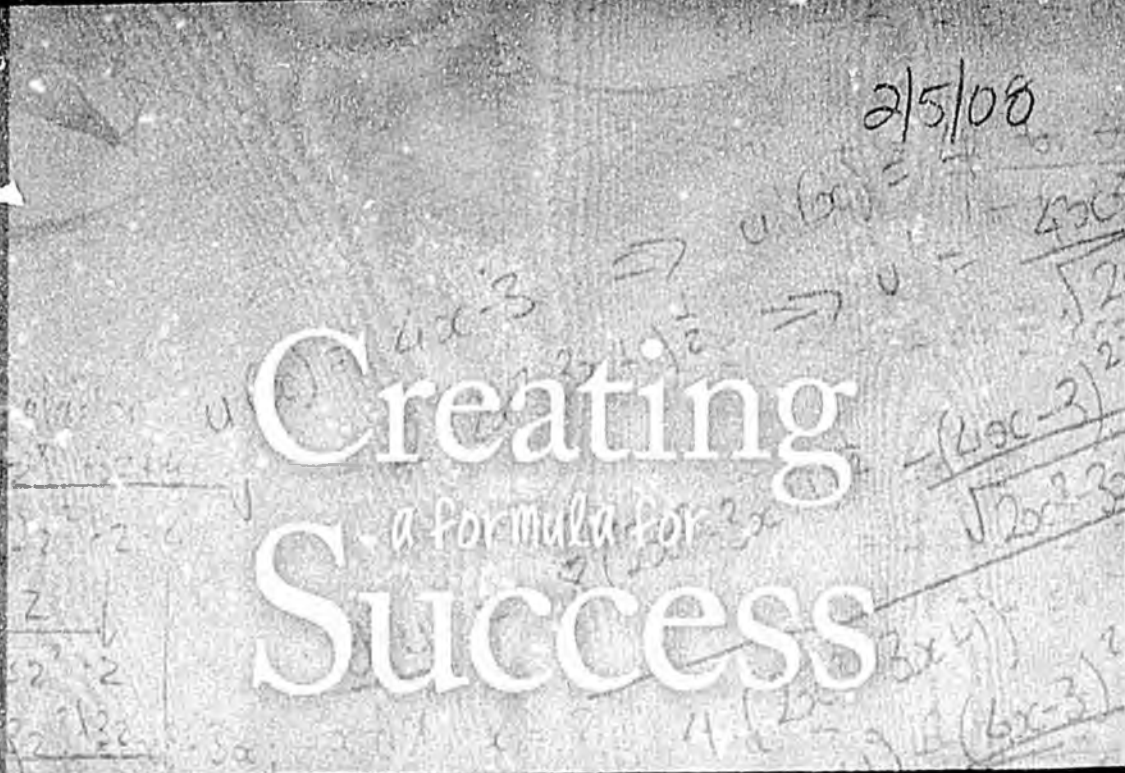
Workforce Development



2/5/08

2007
Annual
Report

Creating a formula for Success



TRUST
The Allstate Group
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ON FILE

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FY07 Year in Review

As we assess the many things we accomplished at the Alaska Mental Health Trust (The Trust) during fiscal year 2007, there is clear evidence that we have continued to improve and refine our efforts because we are reaping more targeted results for Trust beneficiaries than ever. We attribute this success to the many collaborative relationships we are engaged in and the strategic thinking that evolves from these relationships. We have found this formula to be very successful and it will continue to guide us through the coming year. Thus, the theme for this annual report is "*committed partners + strategic thinking = results for Trust beneficiaries.*"

At the center of our success are our relationships with hundreds of committed partners, including local, state and federal agencies, our advisory groups, non-profits, service providers, philanthropic organizations and private sector leaders. Working with these partners has reinforced the old adage that "two heads are smarter than one," because together we have developed strategic, well-thought-out programs that are helping make a difference in the lives of Trust beneficiaries.

Like any organization, we work to learn from the past so that we are continuously improving and innovating. Over the years we have discovered that we are most successful when we focus our efforts like a laser beam on a few critical issues rather than scattering our funding across diverse program areas. From this knowledge evolved the concept of "focus areas," in which we concentrate funding and other resources on a few specific issues in an effort to substantially improve services and delivery systems across the state, and ultimately improve the lives of Trust beneficiaries. Currently The Trust is working on five focus areas that address issues with significant impact on Trust beneficiaries:

1. Bring the Kids Home – bringing home to Alaska children who are being treated in out-of-state psychiatric institutions and increasing treatment services statewide;
2. Affordable Appropriate Housing – increasing the availability of a continuum of housing options for Trust beneficiaries;
3. Justice for Persons with Disabilities – reducing the involvement and recidivism of Trust beneficiaries in the criminal justice system;
4. Trust Beneficiary Projects Initiative – supporting grassroots, consumer-driven programs and small, one-time projects that improve the lives of beneficiaries; and
5. Workforce Development – creating an available and competent workforce for Trust beneficiary service providers.


In each focus area we have partnered with agencies and organizations that can bring the most influence to the table or that are essential in helping us navigate through the current landscape of services and support available for beneficiaries. In many instances we have directly engaged beneficiaries or

their family members – after all, who can better speak about these issues – to get guidance and feedback. From all these discussions we have fashioned specific performance measures that help us gauge how we are doing and whether we are turning the curve when it comes to improving the lives of beneficiaries. This annual report will address each of these focus areas and describe how we are making a difference.

All of this effort takes funding, of course, and fortunately The Trust had a highly successful financial year in FY07. Investments with the Alaska Permanent Fund increased approximately 14 percent over the previous year. As a result approximately \$26 million was available to support programs of direct benefit to Trust beneficiaries in FY07. We expect to fund at a similar level in FY08 and in FY09. The full details of our financial performance are included later in this report.

The Trustees take their fiduciary responsibilities at The Trust very seriously. Trustees are also conscious of the need to develop Trust policies and programs that adequately and appropriately reflect the needs of beneficiaries, especially as state and federal funding tightens and philanthropic support is spread more thinly. We are committed to a prudent investment plan that will result in sustained growth over time and stability for the work of The Trust. At the beginning of FY08, The Trustees hired Harry Noah as the new executive director for the Trust Land Office and he has been tasked with seeking new ways to take advantage of the investment opportunities created by our land and non-cash assets.

We urge you to read through this annual report to see the progress we made in FY07 using our formula for success, and what lies ahead for FY08 as we continue to collaborate with our partners for the betterment of our beneficiaries.


William Doolittle, M.D.
Chair




Jeffrey L. Jessee
Chief Executive Officer



Bring the Kids Home Focus Area

The **Bring the Kids Home Focus Area** is a model example of how committed partners, strategic thinking and measurable outcomes provide results for Trust beneficiaries.

THE PROBLEM OR COMMUNITY NEED:

The events that led to formation of the Bring the Kids Home Focus Area began building in the late 1990s when the number of Alaska children being sent at state expense for treatment in out-of-state psychiatric institutions began rising dramatically. The situation was devastating to the children and their families, and it was expensive for the state.

By 2005, the state was paying almost \$40 million for out-of-state care for more than 700 Alaskan children with severe emotional disturbances. That same year the Department of Health and Social Services and The Trust partnered to bring home the kids who were being treated in out-of-state psychiatric institutions. We also began building a continuum of services from in-home supports to foster and group homes, which are needed in order to curtail the practice in the future. By improving the treatment delivery system, we hope to improve the lives of these youth and their families, and control the state's cost for children's mental health care.

COMMITTED PARTNERSHIPS:

The Bring the Kids Home Focus Area is one of the most complicated efforts The Trust has undertaken because it involves so many players, including representatives from the Department of Health and Social Services, the Denali Commission, behavioral health providers, Trust partner boards, a parent advocacy group, individual parents, Alaska Housing Finance Corporation and The Trust. Plus, this initiative requires service system redesign, capital infrastructure development and workforce development, each of which can involve complex and protracted solutions.

STRATEGIC THINKING:

The initial planning and funding efforts focused on the following:

- ensuring that each child is treated at the appropriate level of care as close to home as possible,
- building appropriate treatment facilities in state,
- increasing the capacity and core competencies of in-state providers so they can provide services that meet the needs of kids with severe emotional disturbances,
- ensuring youth and their parents are supported as they navigate the system of care, and
- involving parents and youth in the entire process so they are part of the solution.

From the outset, the partners in the initiative agreed that this process would be data-driven and success would be gauged by significant changes in areas directly impacting the children, namely treatment location, length of stay, recidivism, functional improvements, and service satisfaction. In addition, we began tracking increases in service capacity and shifts in funding from out of state to more in state. Our goal is to achieve significant improvements in all these areas by fiscal year 2012.

RESULTS FOR BENEFICIARIES:

After two years of intense work, our data-driven effort is showing signs of impacting the problem and changing service delivery for this group of children. Some key indicators are:

- The number of youth admitted to out-of-state residential treatment facilities has dropped 39.3 percent, from 489 when this focus area launched in FY05 to 297 at the close of FY07.
- With the infusion of capital funding from the State and The Trust's partners, service capacity – the number of beds available in state – has increased from 668 in FY05 when the initiative launched to 804 in FY07. Another 349 beds are expected to be added by the close of FY09, bringing total capacity to 1,153 for a 72.6 percent increase over FY05.



Construction site for the new Denali Commission building, which will house the Bring the Kids Home Focus Area.



Construction site for the new Denali Commission building, which will house the Bring the Kids Home Focus Area.

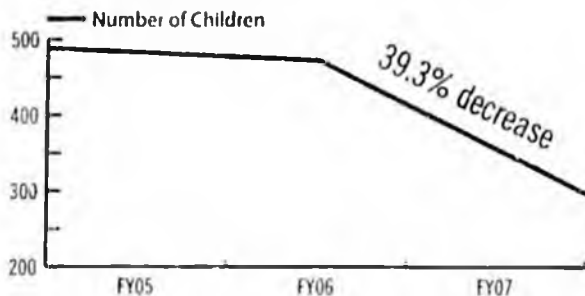


The Denali Commission building, which will house the Bring the Kids Home Focus Area.

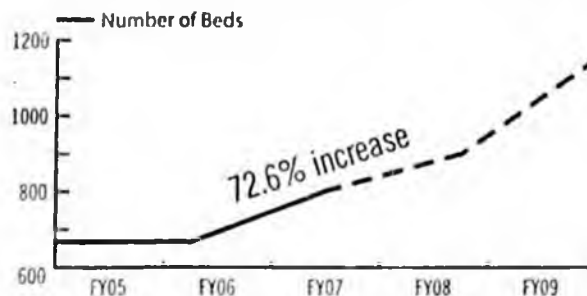


Construction site for the new Denali Commission building, which will house the Bring the Kids Home Focus Area.

CHILDREN IN OUT-OF-STATE RESIDENTIAL TREATMENT FACILITIES



RESIDENTIAL TREATMENT CAPACITY IN ALASKA



AHEAD FOR '08:

Our initial efforts in FY06 and FY07 focused heavily on increasing in-state residential treatment capacity in order to bring home the kids who were being treated in out-of-state psychiatric facilities. In FY07 we began to shift our focus to early intervention programs. These are primarily home and community-based programs involving families, schools and day care centers. This effort will receive greater attention in FY08 and FY09 in an attempt to help children experiencing severe emotional disturbances get assistance early in their lives. Our goal is to prevent these kids from advancing to residential treatment.

Capacity building remains an issue, however, and several capital projects are on the horizon in FY08 that will help increase capacity and improve the state's service delivery system. For example, in early FY08 bids were being accepted to build a 44-bed facility in Eklutna, which is expected to be complete sometime in FY09. Plus, construction began in late FY07, expanding the ARCH residential treatment facility in Eagle River from 16 to 24 beds. This project is expected to be complete by late FY08.

While great strides were made in FY07 and are ahead for FY08, creating a sensible and sustainable program that keeps Alaska's children home and controls out-of-state spending will take years of continuous effort.

Affordable Appropriate Housing Focus Area

The goal of The Trust's Affordable Appropriate Housing Focus Area is to increase the availability of a continuum of housing options that are best suited to Trust beneficiary needs, and that will improve or sustain their quality of life.

THE PROBLEM OR COMMUNITY NEED:

Statistics from around the state are conclusive: many Alaskans of all ages do not have a place to truly call home. What is most

disturbing to The Trust is that the statewide housing shortage disproportionately affects Trust beneficiaries. Having safe, decent, affordable, accessible and appropriate housing is often the key for beneficiaries in maintaining a healthy lifestyle.

The high incidence of homelessness among Trust beneficiaries can be linked to challenges associated with disabling conditions, lack of opportunities for economic advancement, the need for supportive living situations, or accommodations required to meet special needs. Increasingly, the cost of providing these supportive services, such as treatment, crisis intervention, job counseling or life-skills training, is too expensive for mainstream landlords and challenging even for skilled social service providers.



Rural CAP celebrated 10 years of offering supportive housing to Alaskans.



Housing advocates across the state support the Alaska Housing Trust.



Rural Peninsula Housing Initiative completed construction, supported housing in Soldotna.



Valley Residential Services operates several supported housing units in Mat-Su.

COMMITTED PARTNERS:

A steering committee was formed in 2006 to examine possible ways to increase the number of affordable housing units in Alaska and how to maintain them securely over time. Among the models examined was creation of a housing trust. The committee included representatives from the governor's office, The Trust, Alaska Housing Finance Corporation, Alaska Department of Health and Social Services, several regional tribal housing authorities, U.S. Department of Housing and Urban Development, U.S. Department of Agriculture Rural Development, Wells Fargo Bank, Rasmuson Foundation, social service providers, and homebuilders.

STRATEGIC THINKING:

Based on the success of housing trusts in more than 30 states, The Trust and its partners agreed to create the Alaska Housing Trust. A housing trust is a pot of non-federal funds devoted to housing activities for individuals and families with greater housing needs. It allows flexibility in spending and the opportunity to be innovative and entrepreneurial in solving housing problems.

By creating a housing trust, Alaska can increase the number of affordable units available for rent and help maintain them securely over time. Funding from a housing trust can serve as the glue to meld federal resources and social service funding, and can subsidize areas of supported housing projects that are not covered by traditional funding streams. With assistance from a housing trust, these units are more affordable and secure for tenants because additional support services and subsidies are built into the overall project costs. These service-enriched units are also attractive to developers and landlords because they create mechanisms for tenants to afford their rents, become reliable, long-term residents, and receive assistance with skills training and crisis management.

RESULTS FOR TRUST BENEFICIARIES:

In tandem with our efforts to create a housing trust, this focus area also funded several programs in FY07 that provide or promote stable housing for Trust beneficiaries. For instance, The Trust, the Denali Commission, the Rasmuson Foundation and The Foraker Group partnered to create a predevelopment program that offers technical assistance to housing and social service agencies interested in expanding or retaining their

existing portfolio of special needs housing units. The Trust also collaborated with the Division of Behavioral Health's Supported Housing Office in developing a supported housing business plan for small housing developers that takes into account the cost of providing support to Trust beneficiaries. Additionally, in FY07, The Trust helped fund rental subsidies at Bridge Home, a transitional living facility which provided stable housing to about 40 individuals who had been cycling through hospital emergency rooms and psychiatric facilities.

During the 2007 legislative session, Gov. Sarah Palin issued an Administrative Order maintaining and expanding the Alaska Council on the Homeless, which was formed in 2004 to address homelessness in Alaska. The governor also included directions to develop a framework for the housing trust and legislation that will enact it. This legislation has been drafted and is ready for release once the Council, AHFC, the Alaska Housing Trust steering committee and the state administration determine the best mechanism to move the legislation ahead.

In recognition that the Alaska Housing Trust is moving forward, The Trust allocated \$1 million in FY07 to support the housing trust and the Rasmuson Foundation granted a matching \$1 million. In addition, the Alaska Housing Trust Coalition formed in FY07 in support of the Alaska Housing Trust and has nearly 70 members, including representatives from United Way organizations across the state, the Municipality of Anchorage, social service providers, private housing developers and the Alaska Chapter of AARP.

AHEAD FOR '08:

As a first step in administering the \$2 million in pilot funds contributed in FY07 to support the housing trust, AHFC, the Municipality of Anchorage and The Trust combined application processes for AHFC's FY08 capital projects. This improved procedure gives applicants access to state and local funding, plus the housing trust pilot money, in a single competitive bid, demonstrating how the housing trust model streamlines the funding process.

Already several communities have begun examining how the Alaska Housing Trust may assist in meeting their need for housing for special populations, including plans for a pilot project in Anchorage to support the chronic homeless, and coordination of services in Juneau and Fairbanks to ensure seasonal housing demands are met.

WORK HOURS NEEDED TO PAY RENT

Area	Work hours per week at minimum wage needed to afford 1 bedroom	Work hours per week at minimum wage needed to afford 2 bedroom	Work hours per week at minimum wage needed to afford 3 bedroom	Work hours per week at minimum wage needed to afford 4 bedroom
	Alaska minimum wage = \$7.14/hour			
Anchorage	81	101	146	178
Fairbanks	72	92	134	141
Mat-Su Borough	67	86	122	148
Bethel	108	131	156	229
Juneau	94	118	159	199
Kenai Peninsula	65	79	108	138
Ketchikan	86	104	151	182
Kodiak	85	111	160	169

Disability Justice Focus Area

THE PROBLEM OR COMMUNITY NEED:

A 1997 study showed that 37 percent of persons under the supervision of the Department of Corrections had a mental illness and most also had a co-occurring substance abuse disorder for either drugs or alcohol. By 2006 the statistics had not improved and a large number of Trust beneficiaries continued to be incarcerated, spurring The Trust to form the Disability Justice Focus Area. This focus area has two primary goals: (1) reduce the involvement and recidivism of Trust beneficiaries in the criminal justice system and (2) increase the criminal justice system's ability to effectively accommodate the needs of victims and offenders who are Trust beneficiaries.

Trust beneficiaries are at increased risk of involvement with the criminal justice system both as defendants and as victims. Each year, hundreds of Trust beneficiaries, who have committed no crime, are incarcerated for their safety because appropriate service alternatives are not available. Thousands more are arrested, prosecuted and incarcerated for status offenses resulting from behaviors associated with the symptoms of their mental disorders.

COMMITTED PARTNERS:

Several strong partnerships were formed to address this issue with The Trust, including the Alaska Court System, the departments of Corrections, Health and Social Services, Law, and Public Safety, the University of Alaska, local governments, law enforcement, and behavioral health treatment providers.

STRATEGIC THINKING:

The partners quickly identified cross system communication, early identification of beneficiaries when they enter the criminal justice system, and training as the key components needed to assist Alaska's criminal justice and health and social service systems in preventing the inappropriate or avoidable arrest, prosecution, and incarceration of Trust beneficiaries.

RESULTS FOR BENEFICIARIES:

In FY07, The Trust and its partners focused on two key areas: training criminal justice personnel to be more familiar with beneficiaries and their needs, and discharge planning for

beneficiaries exiting the corrections system and re-entering Alaska's communities as a strategy to reduce recidivism among beneficiaries.

The Alaska Court System, the Alaska Bar Association, the Public Defender Agency and The Trust partnered to develop and implement a six-part Continuing Legal Education (CLE) series entitled "Managing Cases Involving Persons with Mental Disorders." The curriculum assists judges, lawyers and other professionals in understanding and more effectively handling legal cases involving Trust beneficiaries. There were 450 participants in the CLE series, of which 262 worked in the legal field. The training sessions were videotaped and are available for those who were unable to attend or for new lawyers entering the field who are unfamiliar with mental health disorders and law.

The departments of Corrections and Health and Social Services, behavioral health treatment providers and other stakeholders from around the state developed and implemented a discharge planning program for beneficiaries who leave corrections and re-integrate into Alaska's communities. It is based on a national best-practice model called Assess, Plan, Identify, Coordinate (APIC). The program was operational in the fourth quarter of FY07 in Anchorage, Fairbanks, Juneau and Palmer.

AHEAD FOR '08:

Goals for FY08 include release of a comprehensive, four-year, retrospective analysis of beneficiaries who entered, were served within, and were released from the Department of Corrections. This data will assist the Disability Justice Focus Area partners to strategically plan and develop effective programs that will divert and reduce the number of Trust beneficiaries who are incarcerated. The Trust has also committed funds in FY08 for additional training on disorders experienced by beneficiaries and intervention techniques for law enforcement officers in Anchorage and Fairbanks. Planning will begin for introduction of additional therapeutic courts in Southeast Alaska.

Finally, The Trust plans to develop, in partnership with the departments of Corrections and Health and Social Services, local governments and stakeholders, an enhanced continuum of detoxification and treatment services in several locations that will reduce the inappropriate and avoidable incarceration of beneficiaries under Alaska's protective custody laws.



District Court Judge Stephanie Rhoades presides over the Anchorage Mental Health Court.



Law enforcement and correctional officers completed Trust funded Crisis Intervention Team training.



Prosecutors are key team members of therapeutic courts in Anchorage, Fairbanks, Palmer, Bethel, Juneau and Ketchikan.



District Court Judge Greg Heath presides over the Palmer Mental Health Court.

Beneficiary Projects Initiative Focus Area

What better way to demonstrate The Trust's commitment to improving the lives and circumstances of Trust beneficiaries than putting funds directly into beneficiaries' hands for beneficiary-directed projects they conceive and operate.

THE PROBLEM OR COMMUNITY NEED:

Involving consumers in defining and mapping out their recovery is a well-known treatment tactic and may forestall the need for more intensive traditional service. While plenty of beneficiaries and their family members have been interested in developing consumer-driven services, not all have the expertise or training to organize, manage and sustain the programs they envision.

In FY07, the Beneficiary Projects Initiative Focus Area committed about \$1.3 million for Trust beneficiaries to develop grassroots projects that focus on peer-to-peer support. This means beneficiaries are helping each other find and maintain their individual path to recovery and wellness. The Trust also funded a \$1.2 million mini-grant program for projects that provide Trust beneficiaries with a broad range of equipment and services essential to directly improving their quality of life and increasing independent functioning. In addition, The Trust allocated \$250,000 for The Trust's Small Projects program, which provided small amounts of one-time funding for more than 30 beneficiary-directed projects in FY07.

COMMITTED PARTNERS:

The most significant partners in this focus area are the beneficiary grantees, of which there has been 25 since the program began in 2006, including 15 who received funding in FY07. They all have committed to delivering safe, effective services and running stable, well-managed organizations. They are succeeding because of the help they receive from a host of committed partners, including The Trust's advisory boards, federal agencies such as SAMHSA, state agencies such as the Division of Behavioral Health, Native organizations

such as First Alaskans Institute, major foundations such as the Rasmuson Foundation, and national and state technical assistance providers.

STRATEGIC THINKING:

Among the goals for this focus area are providing grantees with seed money and technical assistance so their projects get off the ground, operate smoothly and are sustainable. The program is administered through a contract with The Foraker Group where staff can answer basic operating questions, help develop business plans, or assist beneficiaries in getting a program started and running effectively.

RESULTS FOR BENEFICIARIES:

Some of the services initiated by Trust beneficiaries include peer-support services, clubhouses and drop-in centers, community outreach, and illness self-management in communities that range from Nenana to Ketchikan. By funding these projects, The Trust has helped increase the capacity of the state's mental health treatment delivery system for beneficiary-directed services. But more importantly, these projects and services are improving beneficiaries' lives by creating a sense of empowerment and promoting recovery among both the beneficiary providers and the recipients. In 2007, more than 1,600 Trust beneficiaries received both direct and indirect services through the Beneficiary Projects Initiative Focus Area, nearly all of which were provided by fellow beneficiaries and/or family members.

AHEAD IN '08:

In FY08 an "incubator" program will assist beneficiaries in developing their project ideas more thoroughly. Overall initiative capacity building will take two distinct forms. First, through leadership training, we want to grow the expertise of individual beneficiaries who are already serving; and, second, we will recruit other skilled individuals who have interest in serving their communities. Finally, an evaluation of the initiative will be conducted to provide focus area guidance and establish appropriate performance measures.



Beneficiaries participating in a community meeting.



Beneficiaries participating in a community meeting.



Beneficiaries participating in a community meeting.



Beneficiaries participating in a community meeting.

Workforce Development Focus Area

THE PROBLEM OR COMMUNITY NEED:

Having an available and competent workforce are enormous challenges for all Trust beneficiary service providers. A shortage of health care workers in Alaska has been at a near-crisis level for many years, yet the health services industry is the fastest growing sector of Alaska's economy, employing more than 7 percent of the state's workforce, according to a 2007 study commissioned by The Trust. Much of the reason for this worker shortage lies in Alaska's remoteness, harsh climate, rural isolation, low population density, high cost of living and scarce training resources. Exacerbating this already difficult situation is a burgeoning demand now for increased health services for the state's steadily growing and aging population, some of whom are among The Trust's beneficiaries. The Workforce Development Focus Area is aimed specifically at increasing the available pool of qualified employees in Alaska who serve Trust beneficiaries and keeping that workforce adequately trained.

COMMITTED PARTNERSHIPS:

More than 20 partners worked in FY07 to develop strategies that will address the goals set out by this focus area. These partners included service providers, the departments of Health and Social Services and Labor and Workforce Development, non-profit and faith-based organizations, and educational institutions such as the University of Alaska system, including the campuses in Anchorage, Fairbanks and Sitka.

STRATEGIC THINKING:

After studying data around the workforce issues it became clear that there are many dimensions to the problem and that multiple strategies are needed to reduce the problems. We have developed strategies around recruitment, retention and training issues to accomplish our goal of having a competent workforce to serve Trust beneficiaries. The strategies address a diverse array

of problems including adequate pay and benefits, affordable housing, access to training and professional development, and competent supervision.

RESULTS FOR BENEFICIARIES:

The Trust partnered with the University of Alaska to conduct a state-wide vacancy study in 2007 to assess the number and length of time positions have been open in a broad array of physical and behavioral health organizations. The results were staggering, especially among the occupations that serve Trust beneficiaries. The vacancy study shows the most severe shortages in the behavioral health field were for occupations that fell under the category of human service worker, with both extremely high vacancy numbers and high vacancy rates. Overall, all behavioral health occupation vacancies were high – around 29 percent of all estimated vacancies – and ranked higher than any other occupational group. This means organizations that serve other beneficiaries are understaffed, which results in delayed treatment or no services available to some people, resulting in negative impacts to individuals, families and communities.

AHEAD FOR '08:

Because the Workforce Development Focus Area is the newest of The Trust's focus areas, most of the work was just being planned in 2007 so many of the strategies are expected to gain traction or launch in FY08. A new Trust Training Cooperative formed in 2007 will address training needs in the field, helping to tie together and maximize available on-the-job training and necessary continuing education for the workforce. Additionally, new recruitment and retention strategies are beginning or expanding in FY08 in a wide variety of venues. For instance, a demonstration project for a new Student Loan Repayment Program for behavioral health professionals is expected to commence in 2008 that will serve as a recruitment and retention tool.

REGIONAL VACANCY RATES

Occupational Group	Regions (Study Sample - n = 476)						
	NorthWest (n=10)	Southwest (n=17)	Interior (n=72)	Anchorage Mat-Su (n=232)	Gulf Coast (n=69)	Southeast (n=70)	Statewide Multiregional (n=6)
Physicians	26.7%	21.2%	21.6%	12.6%	10.4%	6.8%	30.3%
Professional Nurses	26.0%	21.6%	5.9%	11.1%	8.0%	5.9%	12.1%
Other Nursing Staff	18.6%	18.8%	5.8%	6.2%	4.6%	2.3%	8.8%
Dentists/Pharmacists/Therapists	32.4%	32.4%	20.7%	15.9%	16.5%	16.3%	12.4%
Behavioral Health	19.0%	22.7%	13.1%	8.3%	7.1%	11.1%	11.6%
Allied Health	17.0%	24.6%	7.3%	6.5%	8.4%	7.7%	8.6%
Public Health/Nutrition	30.0%	6.3%	0.0%	4.0%	18.9%	0.0%	10.5%
Other Primary Care (PA & CHNP)	19.7%	18.6%	24.5%	9.0%	9.1%	4.0%	0.0%
Managers	13.8%	2.4%	3.5%	3.2%	6.4%	11.7%	4.0%
Health Information/Reimbursement	15.9%	16.7%	2.0%	5.3%	6.6%	2.8%	7.2%
All Occupations	20.1%	20.3%	9.0%	8.6%	8.1%	7.7%	10.2%

Trust Fund Experiences Record Growth in FY07

Due to strong investment markets throughout the 2007 fiscal year, the cash assets of the Alaska Mental Health Trust Authority reached a record high balance. Investments with the Alaska Permanent Fund (APFC) increased 13.8 percent, rising from \$385,366,600 at the end of FY06 to \$438,513,700 at the end of FY07.

Income from these investments was \$62,448,000 for FY07 and \$36,046,700 for FY06. Statutory net income determined by APFC (which does not include unrealized gains) was \$31,756,200 for FY07 and \$39,733,300 for FY06. Statutory net income increases the Budget Reserve and can be used to fund the mental health budget, while unrealized net income can only be applied to inflation proof our Principal investment.

The Budget Reserve is set at 400 percent of the annual payout, to allow for disbursements during market downturns without eroding Trust Principal. The Budget Reserve investment is split between the Alaska Permanent Fund and the Treasury Division of the Alaska Department of Revenue.

The Treasury Division Budget Reserve investments were reallocated during FY07 according to the recommendation of financial consultants Callan Associates, Inc. Due to this change, combined with strong investment performance, the earnings

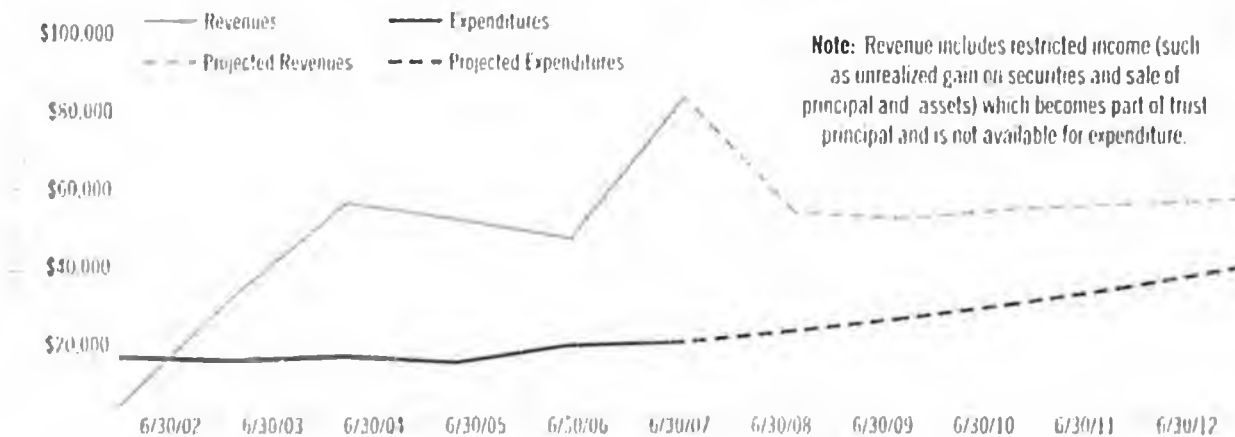
on this portion of the Budget Reserve soared tenfold from \$445,740 in FY06 to \$4,586,200 in FY07.

The Trust's payout rate, which is used to calculate the disbursement (or payout) for the mental health budget, was increased at the end of FY06 from 3.75 percent to 4.0 percent beginning with the FY07 budget. This rate is applied to the balance in the Trust Fund (Principal and Budget Reserve) at the end of a fiscal year to calculate the payout for the subsequent year.

The following financial performance from FY07 is available for funding in FY08:

- Disbursement (payout) rate of 4.0 percent, for a payout of \$19,085,054. This represents an increase of 14.8 percent over FY06.
- Resource management revenue allocated as income was \$3,428,312.
- Interest on the Income Account at Treasury Division was \$1,620,108.
- Lapsed funds from prior fiscal years were \$2,770,922.
- Total funding available for FY08 is \$26,904,396. This is a 17 percent increase from FY07 availability of \$23,032,672.

REVENUES AND EXPENDITURES



TRUST CASH ASSETS AT END OF FY07

Settlement (41.94%)
\$200,000,000

Inflation (27.32%)
\$130,261,906



Payout (4.00%)
\$19,085,054

Reserves (13.95%)
\$66,509,587

Land (12.79%)
\$60,980,594

Trust Land Office Generated \$8.1 Million

Revenue-generating uses of Trust land include land leasing and sales; commercial timber sales; mineral exploration and production; coal, oil and gas exploration and development; sand, gravel and rock sales; and other general land uses.

The Trust Land Office (TLO) is a small 11-person unit in the Department of Natural Resources that manages approximately one million acres of land and non-cash assets throughout Alaska on behalf of the beneficiaries of the Alaska Mental Health Trust. Gross revenue in FY07 totaled about \$8.1 million, of which about \$3.3 million was Spendable Income and about \$4.7 million was Principal revenue.

Revenue-generating uses of Trust land include land leasing and sales; commercial timber sales; mineral exploration and production; coal, oil and gas exploration and development; sand, gravel and rock sales; and other general land uses. Rents, fees and 15 percent of timber revenue from Trust land uses are considered "Spendable Income" and are available to The Trust for use in the following fiscal year. Land Sale revenue, hydrocarbon and mineral royalties, and 85 percent of timber revenue are considered "Principal" and are deposited in The Trust corpus, which is held and managed by the Alaska Permanent Fund Corporation.

FY07 HIGHLIGHTS:

- Completed subdivision and re-plat of The Trust's Juneau waterfront parcel known as The Subport, and sold a parcel adjacent to Centennial Hall to the City and Borough of Juneau for \$2.93 million.
- Fairbanks Gold Mining Inc. paid The Trust a royalty of more than \$700,000 for its 2006 calendar year production from its mine located on Trust land north of Fairbanks.
- Sold 67 parcels in The Trust's annual land sale for a value of \$2.17 million.
- Responded quickly to approve an authorization for the

expedited recovery of spilled fuel from a DC-4 that crashed on Trust land near Nenana carrying 3,000 gallons of heating oil.

- Worked with the Department of Natural Resources to establish a new replacement land list, and prioritized conveyances of the lands owed to The Trust under the Settlement Agreement for lands that were originally conveyed to The Trust in error or had other encumbrances that significantly affected the land.
- After a 10-year hiatus, the Board of Land Management began adjudication of the remaining Mental Health Enabling Act selections as part of the agreement to close out The Trust's federal entitlement.
- Talon Gold began mineral exploration on Trust land near Livengood. Early results from that program continue to provide encouraging news for the precious metals prospect.
- Worked with various communities throughout Alaska on issues affecting management of Trust lands.

AHEAD IN '08:

The TLO will begin long-term planning for Trust timber lands, commercial real estate and resort properties. In addition, the office will strive to build or rebuild relationships with local communities or individuals that live or work near lands managed by The Trust.

Key projects will include:

- Planning for development of the Juneau Waterfront Property (formerly titled the Juneau Subport);
- Researching potential timber land exchanges in Southeast Alaska with the U. S. Forest Service;
- Developing a long-term property and land management program for use by TLO staff;
- Resolving a back log of land use issues;
- Developing a preliminary feasibility study for monitoring resort quality properties;
- Offering for sale potential subdivision lots; and
- Continuing to offer oil, gas and mineral properties for lease.



Trust land along Juneau's waterfront is being redeveloped.



Typical timberland owned by The Trust in Southeast Alaska.



Saw logs waiting to be processed at Silver Bay Mill in Wrangell.



Yellow cedar dimensional lumber waiting for shipment in Wrangell.

TRUST

The Alaska Mental Health
Trust Authority

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2/5/08

The **TRUST**
The Alaska Mental Health
Trust Authority

A Study of Trust Beneficiaries in the Alaska Department of Corrections

Funded by
The Alaska Mental Health Trust Authority

Produced for
The Alaska Department of Corrections

Produced by
Hornby Zeller Associates, Inc.

December 2007

ON FILE



A Study of Trust Beneficiaries in the Alaska Department of Corrections



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Funded by:

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Alaska Department of Corrections

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In particular, we would like to thank Linda Walsh and Ron Hollar from the Alaska Department of Health and Social Services, Division of Health Care Services, for dedicating the time to generate a data extract from the State's Medicaid Management Information System. We would also like to thank Stephen Schneider from the Alaska Psychiatric Institute and Mike Gimm from the Department of Corrections for generating the data extracts from their respective data warehouses. We would not have been able to produce many of the outcomes in this report had it not been for their cooperation and assistance. We would also like to thank all the key officials within the Alaska Department of Corrections, Alaska Department of Health and Social Services and the Alaska Mental Health Trust Authority. We particularly acknowledge Steve Williams and Colleen Patrick-Riley for their guidance and detailed reviews of previous drafts. Without this collaborative support, this report simply would not have been possible.

This project is funded by the Alaska Mental Health Trust Authority under contract with the Alaska Department of Corrections. Colleen Patrick-Riley from the Alaska Department of Corrections and Steve Williams from the Mental Health Trust Authority served as the primary officials involved in the study. Its contents are the sole responsibility of the authors and do not represent the opinions of the funding agency.

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Executive Summary

People with mental illness and cognitive impairments are over-represented in the correctional system compared to their prevalence in society. This has been shown in previous research. However, the impact of over-representation both on the correctional system itself and on the individuals affected remained largely unexplored.¹ Therefore, the Alaska Mental Health Trust Authority (AMHTA) in conjunction with the Alaska Department of Corrections commissioned this study to obtain a more in-depth and comprehensive understanding of the experiences of this population. They wanted answers to questions such as: Are people with mental illness and cognitive impairments more or less likely to be incarcerated than others who commit similar crimes? Are they identified and treated while incarcerated? Do they stay longer? Do they recidivate more? What kinds of mental illnesses and cognitive impairments do they have and how do these relate to the kinds of offenses committed? How long does it take for them to get services in the community once they are released? Are there particular service models that have been shown to be effective and could reduce recidivism?

Performed by Hornby Zeller Associates, Inc. (HZA), the study examines four years of data using a unique methodology which matches information from multiple agencies and information systems within Alaska. The sources include Medicaid data from the Alaska Department of Health and Social Services, Division of Health Care Services (DHSS), psychiatric history from the Alaska Psychiatric Institute (API) and correctional history from the Alaska Department of Corrections (ADOC). The methodology allows, for the first time, the identification of individuals who were known to have a history of mental health treatment but who may not have been identified as needing treatment by ADOC during their period of incarceration. It also provides the ability to track Medicaid funded and hospital services received in the community during periods of diversion or post-incarceration.

Results of the study provide the State of Alaska with a unique opportunity to explore a critical and yet largely neglected dimension in correctional research – the impact of those with mental illness¹ or cognitive impairments on the statewide correctional systems as well as the impact of state services and correctional detainment on the individual. More importantly, the report provides key baseline information from which changes in the system can be assessed.

The report reveals the consequences of not adequately treating the needs of Trust Beneficiaries² in the community. It costs the State of Alaska millions of dollars each year in added prison costs and loss of Federal entitlements to have people recycle through the corrections system. Many Trust Beneficiaries are not identified as having mental health or substance abuse problems while incarcerated; as a result, a large proportion of these individuals are not receiving the mental health and behavioral health-related services they need upon release. For others there is a delay in time to resume Medicaid-funded services upon release. Consequently, Trust Beneficiaries as a whole are far more likely to return into the custody of ADOC and stay in custody longer than other offenders in the general population.

Additional correctional resources, improved systems integration, and better linkages with community health care providers will undoubtedly assist in alleviating the burden of care for Trust Beneficiaries on Alaska's criminal justice system. Should the State of Alaska invest in more diversionary strategies and implement

¹ As defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). See Appendix C for the list of multi-axial classifications.

² Trust beneficiaries are those experiencing: 1) mental illness; 2) developmental disabilities; 3) chronic alcoholism with psychosis; and, 4) Alzheimer's disease, related dementias and other cognitive impairments. See Appendix B for a more complete definition of Beneficiaries that fall under the purview of the Alaska Mental Health Trust Authority.

more evidence-based service programs, the State should ultimately realize net institutional savings while at the same time improving public safety and generating better quality-of-life outcomes for Trust Beneficiaries in Alaska's communities.

Major findings from the study indicate that approximately 42 percent of all inmates in custody ADOC are Beneficiaries of the Alaska Mental Health Trust Authority. Among those identified, Trust Beneficiaries are more likely to recidivate, recidivate sooner and spend more time in custody of the ADOC than other inmates.

The following highlights other key findings presented in the report:

- Over a four year time frame, a total of 11,631 people within the ADOC were identified as Beneficiaries of the Alaska Mental Health Trust Authority.
- On June 30, 2006, of the 3,628 people who were in the custody of one of Alaska's thirteen correctional institutions, 1,524 people (42 percent) constituted AMHTA Beneficiaries³.
- Approximately 62 percent of Trust Beneficiaries in the Alaska Department of Corrections were identified from sources provided by the Department of Health and Social Services as opposed to databases maintained by the ADOC. Most of these had Axis I substance-related disorders and generalized mood disorders such as depression. Only a small proportion of Trust Beneficiaries with severe mental disorders such as schizophrenia or other psychotic disorders were identified as not having been known to both agencies.
- With the exception of those with more severe mental illnesses, there was an overall decline in mental health service utilization among previously Medicaid-funded Trust Beneficiaries exiting the ADOC. Medicaid-eligible Trust Beneficiaries with more severe mental illness (e.g., schizophrenia and other psychotic disorders) received more services after exiting the ADOC than they did prior to entry.
- The overall rate of recidivism for the Trust Beneficiary population is 1.6 times higher (36.2%) than for other offenders released from the ADOC (21.9%). Trust Beneficiaries are significantly more likely to re-enter the ADOC sooner than others released who did not have a mental illness. On the whole, Trust Beneficiaries with severe mental illness were less likely to recidivate than Trust Beneficiaries with mild mental illness or substance-related disorders, who had a far higher rate of recidivism.
- Trust Beneficiaries who are either Alaska Native or Black are significantly more likely to recidivate than Whites or other races.
- Trust Beneficiaries with Axis I disorder(s) and Axis II personality disorder(s) are 1.6 times more likely to recidivate than Trust Beneficiaries who do not have both disorder.
- Trust Beneficiary populations most likely to recidivate are young, Black or Alaska Native males who have Axis I disorder(s) and Axis II personality disorder(s) but not an adjustment disorder.
- Trust Beneficiary populations least likely to recidivate are older, white females presenting mild mental health disorders who do not have Axis I disorder(s) and Axis II personality disorder(s).

³ This does not include individuals in custody of the ADOC either in community residential centers or the contracted facility in Arizona.

- Sixty-one percent of Trust Beneficiaries with a psychiatric admission in the year preceding entry into the ADOC were re-admitted to a psychiatric facility in the one-year period following release from the ADOC.
- More than half of Trust Beneficiary clinical recidivists had at least two Axis I mental health disorders and nearly three-quarters had a co-occurring substance-related disorder.
- Trust Beneficiaries who receive mental health services upon release from the ADOC have a lower rate of recidivism than Trust Beneficiaries who did not receive any mental health services.

As a result of the major findings presented throughout the report, HZA encourages the Alaska Department of Corrections and key Stakeholders within the State to consider the following recommendations:

Recommendation 1:

Review and revise screening and assessment protocols for mental health to capture a higher, more accurate portion of the population.

Approximately two-thirds of all Trust Beneficiaries incarcerated within the Alaska Department of Corrections were identified by administrative data sources not maintained by the ADOC. Although the clinical characteristics of these unidentified Beneficiaries constitute mostly those with alcohol, drug and mild mental disorders such as anxiety or depression, the ADOC should consider reviewing its screening and assessment protocols because many of these Beneficiaries are continually recycling in and out of its correctional institutions. Current DOC screening provides identification of individuals with severe or obvious mental illness, but relies on self report to identify other Beneficiaries. It would be useful to develop screening tools to systemically identify moderate mental illness, brain injury, fetal alcohol spectrum disorder (FASD) and other brain disorders. Better identification will enable the ADOC to increase the number of potential Beneficiaries appropriate for referral to substance abuse or other institutional programming or for diversion into community-based services, thereby reducing recidivism and related costs while at the same time preserving public safety.

Recommendation 2:

Consider replacing the CONCON system with one that is more standardized, would allow entry of information pertaining to clinical screens and would be online so that contracted service providers in remote areas could also have access to it.

The Alaska Department of Corrections database (referred to as CONCON) used to maintain records on the Trust Beneficiary population it serves is antiquated, designed largely for qualitative purposes, and the information it contains cannot be quantified without reading narrative summaries and hand counting, a particularly onerous task for staff within the ADOC as there are thousands of records maintained in that system.

In addition, information pertaining to the Trust Beneficiary population is entered into the CONCON database only for those individuals who assessed positively for a mental illness while in custody at one of Alaska's 13 correctional facilities. If an individual received a positive *screening* for mental illness but was released from the ADOC before he or she could receive a full assessment, the information would not be captured (screening results exist on paper copy only.)

There is also missing information in the CONCON database about Trust Beneficiaries being served among the remote facilities where the ADOC uses contractors to provide clinical services. These service providers do not enter information into the CONCON database; rather, they maintain assessment and clinical information on paper copy form only.

The number of Trust Beneficiaries identified by the ADOC without an electronic version of their clinical assessment in the CONCON database is estimated to be 1,124 people.

For these reasons and others, the ADOC should consider replacing the system with one that is more standardized, would allow entry of information pertaining to clinical screens, and would be online so that contracted service providers in remote areas can also have access to the system. The new system should also include the ability to identify specific Trust Beneficiary populations particularly those with traumatic brain injury, fetal alcohol spectrum disorder, borderline intellectual functioning, and mental retardation, to name a few. This system should also identify and track individuals appropriate for or participating in diversion programs, therapeutic courts, and DOC mental health release programs.

This new system should also be designed in such a way to facilitate cross-referencing against DHSS systems to identify current or former clients of the behavioral health system. As previously noted, the cross-referencing activity in this study yielded a significant number of Trust Beneficiaries who were not identified by the Department of Corrections. Although it is recognized that this cross-referencing activity will not identify every inmate with a mental illness (e.g., an inmate who received private, grant, or other public or federally funded mental health care), it does represent a starting point from which to gather more reliable baseline data. Alaska would benefit from exploring other ways of exchanging information between DHSS divisions and DOC so as to best identify and serve the Trust Beneficiary population.

Recommendation 3:

Identify Trust Beneficiaries entering the ADOC who are Medicaid-eligible so that upon release assistance can be provided to help ensure continuity of care. Use ADOC liaisons with local Social Security and State Medicaid offices to facilitate reinstatement of Federal disability benefits (SSI, SSDI, Medicaid) for a broad diagnostic population of Trust Beneficiaries just prior to their release.

Individuals can qualify for Medicaid-funded mental health services in one of four ways, either through a qualifying mental health diagnosis that meets the Social Security definition of disability, as a side treatment for a qualifying physical disability that meets the Social Security definition of disability, as a side treatment for individuals who qualify for Medicaid because they are age 65 or older, or as a side treatment for individuals who qualify for Medicaid as the caretaker relative of a family with dependent children. While the primary reason for initial eligibility was not available, the study found that many Medicaid-eligible Trust Beneficiaries who were receiving mental health services prior to entering the ADOC, 28 percent were not receiving any Medicaid-funded mental health services after release. Among those not re-engaged in services, the State of Alaska is potentially losing the equivalent of an eight percent match in supplemental federal funds that might otherwise be used to pay for additional mental health services. As a result, there needs to be better identification of Trust Beneficiaries entering the ADOC who were receiving Medicaid or are Medicaid-eligible so that upon release assistance can be provided to help ensure continuity of care.

Since 2004, there has been a Memorandum of Understanding in place with the ADOC, the Social Security Administration and the Alaska Division of Public Assistance that allows the ADOC to facilitate Pre- and Post-Release Applications for severely mentally ill Trust Beneficiaries. ADOC mental health has a 100 percent approval rate for SSI/SSDI applications. ADOC could expand this working relationship to provide application assistance to individuals with other eligible diagnoses with additional staffing resources.

Recommendation 4: Implement more evidence-based services such as Forensic Assertive Community Treatment Teams or Forensic Intensive Case Managers (FACT/FICM) for the severely mentally ill Trust Beneficiary population exiting the ADOC.

Alaska's criminal justice system currently diverts Trust Beneficiaries from incarceration through a variety of avenues such as therapeutic mental health and addictions courts and some specialized release programs. The

ADOC should continue to sustain and expand the existing APIC Reentry and other DOC mental health release programs for misdemeanors and felons. The ADOC should also consider expanding its partnership with community agencies to divert more Trust Beneficiaries from incarceration by implementing additional evidence-based services targeted to the population most at risk.

For example, national evidence-based best practice research suggests that Forensic Assertive Community Treatment (FACT) and Forensic Intensive Case Management (FICM) are the most promising approaches to managing correctional populations with severe mental illness. The main difference between the two FACT/FICM models primarily involves organizational structure. FACT operates within the domain of a self-contained team providing direct services, whereas FICM has case managers with individual caseloads who refer out to psychiatric treatment services in the community. Both models have generated positive results for correctional populations with severe mental illness.

Improving its efforts to ensure that Medicaid eligibility is sustained upon release and implementing evidence-based services (such as Forensic Assertive Community Treatment Teams or Forensic Intensive Case Managers (FACT/FICM) for the high-risk Trust Beneficiary population, the State would ultimately realize net institutional savings while at the same time improving public safety and generating better quality-of-life outcomes for the seriously mentally ill Trust Beneficiary population.

While there is clear and convincing evidence that incorporating diversion and best practice models does promote success, it is important to carefully identify appropriate candidates for diversion. Some individuals require a period of incarceration before release to appropriate programs in the community. Others could effectively be diverted pre or post charge.

Recommendation 5:

Expand more culturally sensitive programs for Alaska Natives.

Alaska Native Trust Beneficiaries receiving mental health care services after release from the ADOC have the highest rate of criminal recidivism. When compared to the general population of Alaska, the prevalence of Alaska Native Trust Beneficiaries sentenced to the ADOC (36%) is significantly higher than their prevalence in the general population (16%). While there are a number of other factors that are associated with the disproportionate arrest and detainment of Alaska Natives, the ADOC and community health care providers should consider introducing more culturally sensitive programming into the services they provide. The State of Alaska could partner with Alaska Native Tribal organizations to improve the design and delivery of behavioral health services.

Recommendation 6:

Develop more community-based mental health, substance abuse treatment and support services for Trust Beneficiaries exiting the Alaska Department of Corrections.

There is a general lack of community-based mental health and substance abuse treatment services for the growing number of Trust Beneficiaries exiting the Alaska Department of Corrections. In addition, safe and sober housing is inadequate to meet the current needs of the Trust Beneficiary population. The State should consider allocating additional funding for community-based alternatives to incarceration and increase capacity to deliver essential services to Trust Beneficiary probationers and parolees, including co-occurring substance abuse treatment. Developing an appropriate spectrum of community housing will be critical to Beneficiary success, ranging from independent to supportive living situations to structured options all with an emphasis on sobriety and consumer and public safety. Key stakeholders within the criminal justice system should work closely with mental health consumers, families and advocacy groups to improve services, develop new initiatives and involve all relevant agencies.

To obtain a copy of the complete report, visit The Trust's web site at:

<http://www.mhtrust.org/documents/12-07%20Final%20DOC%20Trust%20Beneficiary%20Study.pdf>

For more information about the Alaska Mental Health Trust Disability Justice Focus Area, contact:

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Alaska Mental Health Trust Authority

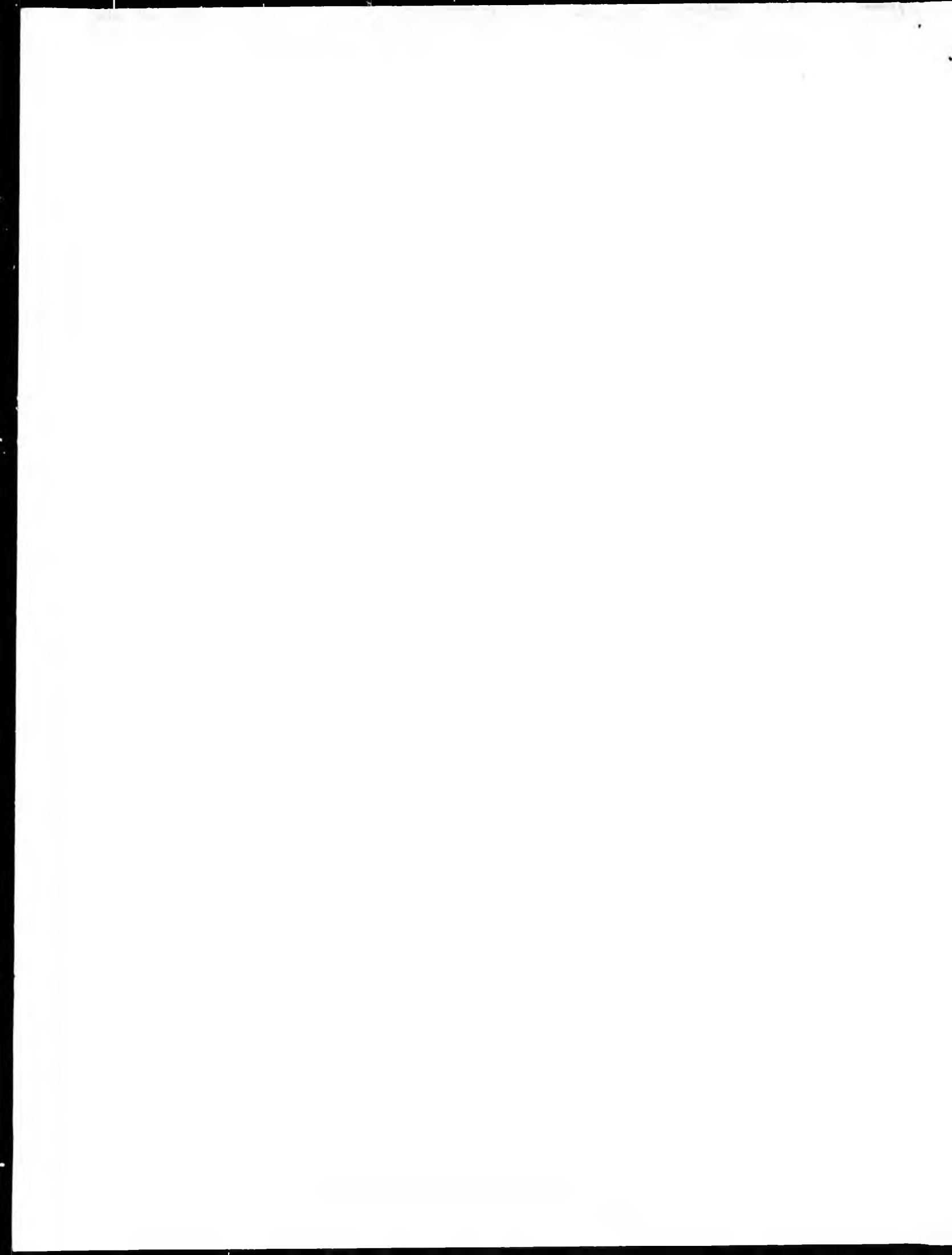
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Trust History

Prior to statehood, there were no services available in the Territory of Alaska for individuals who experienced mental illness or developmental disabilities. Instead, these individuals were sent by the federal government to live in an institution in Oregon. During Alaska's transition to a state, Congress passed the Alaska Mental Health Enabling Act of 1956 to help bring these individuals home. This act transferred the responsibility for providing mental health services from the federal government to the Territory of Alaska and ultimately the State of Alaska, by creating the Alaska Mental Health Trust. To fund The Trust, the state selected one million prime acres of land that would be managed to generate income that would pay for a comprehensive integrated mental health program.

Though the Alaska Legislature held a fiduciary responsibility to manage the land on behalf of Alaskans with mental disabilities, it did not do so. Instead, by 1982, only about 35 percent of the land remained in state ownership. The majority of the land had been transferred to individuals or municipalities, or designated by the legislature as forests, parks or wildlife areas.

In 1982, Vern Weiss filed a lawsuit on behalf of his son, who required mental health services that were not available in Alaska. Other beneficiary groups joined *Weiss v State of Alaska* in a class action suit. The case was ruled on in 1984 by the State Supreme Court, which ordered that the original trust be restored. Ten years later, in 1994, a final settlement reconstructed The Trust with 500,000 acres of original Trust land, 500,000 acres of replacement land and \$200 million in cash.

The settlement established an independent Board of Trustees appointed by the governor and confirmed by the legislature. Each year, the Trustees spend Trust income and recommend expenditures of state funds to pay for a comprehensive integrated mental health program for Trust beneficiaries.

Trust Beneficiaries

Trust beneficiaries include:

- people with mental illness,
- people with developmental disabilities,
- people with chronic alcoholism,
- people with Alzheimer's disease and related disorders,
- people with traumatic head injury resulting in permanent brain injury.

Trust Governance

The Trust is overseen by a seven-member Board of Trustees. The appointments are for five-year, staggered terms. As of January 2007, one seat is vacant, pending appointment by the Governor. Current Trustees are:

- | | |
|--------------------------------|-----------------|
| • Dr. William Doolittle, Chair | • Tom Hawkins |
| • Laraine Derr | • Margaret Lowe |
| • Paula Easley | • John Malone |

Trust Advisors

The Trust works closely with the following advocacy boards that represent Trust beneficiaries:

- Advisory Board on Alcoholism and Drug Abuse,
- Alaska Commission on Aging,
- Alaska Mental Health Board,
- Governor's Council on Disabilities and Special Education,
- Alaska Statewide Suicide Prevention Council, and
- Alaska Brain Injury Network

(over)

Alaska's Comprehensive Integrated Mental Health Program

The Trust works with the Alaska Department of Health and Social Services to coordinate planning for a comprehensive mental health program, makes recommendations to fund the program and advocates for funding and policies that support the systems serving its beneficiaries.

Trust Focus Areas

Currently The Trust is working on five focus areas that address issues with significant impact on Trust beneficiaries:

1. Bring the Kids Home – bringing home to Alaska children who experience severe emotional disturbances that are being treated in out-of-state psychiatric institutions, and increasing treatment services statewide;
2. Affordable Appropriate Housing – increasing the availability of a continuum of housing options for Trust beneficiaries;
3. Disability Justice – reducing the involvement and recidivism of Trust beneficiaries in the criminal justice system;
4. Trust Beneficiary Projects Initiative – supporting grassroots, consumer-driven programs and small, one-time projects that improve the lives of beneficiaries; and
5. Workforce Development – creating an available and competent workforce for Trust beneficiary service providers.

2008 Legislative Priorities and Advocacy Agenda

The Trust and its advisory groups have established the following five issues as priorities for this legislative session (in order of priority):

1. **Alaska Housing Trust** - The Alaska Housing Trust will reduce homelessness through the creation and retention of an adequate supply of affordable housing with supportive services. Two areas for advocacy include support for the enabling legislation to create the housing trust and passage of a FY09 \$10 million Governor's budget increment.
2. **Long-term care** - The goal of long-term care is to help seniors and individuals with disabilities maximize their independence and functioning when they cannot be fully independent, whether the need is temporary or ongoing. Long-term care includes supportive housing, assisted living and skilled nursing facilities, and home- and community-based services such as meals, transportation, care coordination, respite care and adult day services. Advocacy for FY09 will highlight the FACES Campaign (Family and Community Elder Supports), which seeks a \$1.5 million GF/MH budget increment to Senior and Disability Services Grants and \$2 million in GF/MH capital funds.
3. **Grant funding for behavioral health prevention and treatment** - Since FY04, GF/MH funded grants to private providers have dropped by 22 percent. As a result, access to prevention and early intervention services, general mental health services and substance abuse treatment have been severely restricted. Advocacy will focus on securing a budget increment of \$4.8 million GF/MH for Behavioral Health Grants.
4. **Medicaid rate adjustments** - The Medicaid rates at which providers are reimbursed for providing services have been frozen, in some areas, for more than a decade. The result is reduced services for Trust beneficiaries. A budget increment of \$24.4 million GF and \$25.4 million federal match will allow for rates to "catch-up" to the true cost of doing business.
5. **Workforce development** - The pool of qualified health and behavioral health professionals has not kept pace with the need in Alaska. The health services industry is the fastest growing sector of Alaska's economy, yet research has revealed critical shortages in key occupations such as registered nurses and human services workers. The Trust's Workforce Development Focus Area is working on strategies to increase the number of workers employed in beneficiary-related services, and has requested a Governor's budget increment of \$1,769,000 MITAAR and \$45,000 GF/MH for employee recruitment, training and retention activities.

####

**Advisory Board on Alcoholism
and Drug Abuse**



Alaska Mental Health Board

<http://www.hss.state.ak.us/abada/>

Alaska's Advisory Board on Alcoholism and Drug Abuse

Prevention & Treatment work! Recovery happens!

The Advisory Board on Alcoholism and Drug Abuse (ABADA) is a statutorily authorized Governor's advisory board charged with assisting in planning and offering oversight of Alaska's behavioral health system. Through our mandate we work to support a comprehensive, effective, and accountable behavioral health system of prevention and treatment for Alaska. The vision ABADA members serve to represent is Alaskans living healthy, productive lives. The shared plan that the board works from to achieve results towards this vision is on our web site: www.hss.state.ak.us/abada/

We welcome all Alaskans to visit this site and learn how to participate and allow your voice and concerns to be recognized in support of our vision.

Facts on substance abuse in Alaska

The National Survey on Drug Use & Health clearly shows alcohol as the drug of choice in Alaska; 50% of all Alaskans reported that they had used alcohol in the past month. Research on Alaska's newly incarcerated prisoner population reveals the strong relationship between substance abuse and criminality; 91% of the prisoners assessed had abused substances some time in their lives; 79% in the last year reported abuse severe enough to require treatment.

The 2006 National Survey on Drug Use & Health show 18-25 year olds are more likely to use alcohol, cocaine, pain relievers, illegal drugs and marijuana than any other age group. This age group is most in need of, but not receiving, treatment for substance use; they generally don't have access to Medicaid, are too old to be eligible for treatment available to children and adolescents and are not old enough to receive Medicare. Treatment costs are high and often this target group lacks insurance and/or work that offers effective health benefits.

Advocacy issues for 2008-09

Funding for prevention and treatment of behavioral health programs has not kept pace with community need. Alaska's increasing reliance on Medicaid funds for treatment excludes all but the very needy. Advocating for a comprehensive and effective behavioral health service system is a legislative priority for ABADA.

A person living with addiction has the right to live with dignity and respect as a valued member of his or her family and community. Addiction is a disease, and, like any other, such as leukemia, recovery does happen. Reducing stigma about substance use disorders is a focus area of ABADA.

Alaskans who are incarcerated and have substance use disorders would be better

served if they were able to transition from prison back into their community with effective support services. Evidence-based programs are proven to decrease recidivism when an individual is treated closer to

his/her family and community. Partnering with the Department of Corrections to implement programs for supportive housing, employment, and social/emotional skill development is another priority for ABADA

The Alaska Mental Health Trust Authority

The Advisory Board on Alcoholism & Drug Abuse is one of several boards/commissions that The Mental Health Trust Authority (The Trust) represents. Trust beneficiaries include people with mental illness, people with developmental disabilities, people with chronic alcoholism, and people with Alzheimer's disease and related disorders.

Prior to statehood, there were no services available in the Territory of Alaska for individuals who experienced mental illness or developmental disabilities. Instead, these individuals were sent by the federal government to live in an institution in Oregon. During Alaska's transition to a state, Congress passed the Alaska Mental Health Enabling Act of 1956 to help bring these individuals home. This act transferred the responsibility for providing mental health services from the federal government to the Territory of Alaska and ultimately the State of Alaska, by creating the Alaska Mental Health Trust. To fund The Trust, the state selected one million prime acres of land that would be managed to generate income that would pay for a comprehensive integrated mental health program.

Although the state legislature held a fiduciary responsibility to manage the land on behalf of Alaskans with disabilities, it did not do so. Instead, by 1982, only about 35 percent of the land remained in state ownership. The majority of the land had been transferred to individuals or municipalities, or designated by the legislature as forests, parks or wildlife areas.

In 1982, Vern Weiss filed a lawsuit on behalf of his son, who required mental health services that were not available in Alaska. Other beneficiary groups joined *Weiss v State of Alaska* in a class action suit. The case was ruled on in 1984 by the State Supreme Court, which ordered that the original trust be restored. Ten years later, in 1994, a final settlement reconstructed The Trust with 500,000 acres of original Trust land, 500,000 acres of replacement land and \$200 million.

The settlement established an independent Board of Trustees appointed by the governor and confirmed by the legislature. Annually, the Trustees, with direction from the beneficiary boards such as ABADA, spend Trust income and recommend expenditures of state funds to pay for a comprehensive integrated mental health program for Trust beneficiaries.

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alaska brain injury network

Every 15 seconds someone sustains a traumatic brain injury (TBI) in the U.S.

Thirty years ago, only half of all people with brain injury survived; now 78% survive. This means that many individuals now live with significant disability requiring a full range of services.

Every year the Alaska Department of Health & Social Services reports about 800 traumatic brain injury (TBI) cases resulting in hospitalization or fatality. The Alaska TBI rate is 28% higher than the national average. The TBI rate in rural Alaska is one of the highest in the nation.

It is estimated that at least 10,000 Alaskans are living with brain injury today.

The Alaska Brain Injury Network, Inc. (ABIN) is a non-profit organization dedicated to Alaskans whose lives have been changed by brain injury.

ABIN's Board of Directors represent all regions of Alaska and the extended brain injury community – survivors, family members, service providers, health educators, researchers and those who write laws and policy.

ABIN works with their Alaska Mental Health Trust Authority partner boards to advocate for policy changes, programs, and facilities to better serve the brain injury population.

ABIN's staff focuses on early identification, connecting brain injury survivors with services, providing support and education for families, and bringing professional training to Alaska.

The goal for every brain injury survivor is the best possible recovery for a fulfilling and productive life. Achieving that goal requires full range of services close to home. This includes...

- Prevention
- Early identification and intervention
- Access to skilled specialists
- Community-based post injury services
- Continuing rehabilitation
- Brain injury support groups and in-state resources

What you can do...

- **Be aware of the burden of brain injury nationally and to the state of Alaska**
- **Support a TBI Resolution for Brain Injury Awareness Month.**
- **Become familiar with 2008 ABIN Priorities in the GF/MH Budget; Prevention, Training, and Resource Navigation**

Upcoming ABIN Priorities

In-state rehab facility – for neurobehavioral beneficiaries.

Brain Injury Waiver - recommendations for the current Medicaid waiver system to accommodate the services needed by brain injury survivors: neuropsychological assessment, cognitive and functional therapy, case management, counseling, home modifications, transportation, respite care, and more.

TBI Screening and early intervention – promotes better recovery and saves money.



www.alaskabraininjury.net
3745 Community Park Loop, Ste 240
Anchorage, AK 99508
(907) 274-2824

Alaska Brain Injury Network, Inc. helps identify, develop, implement, and sustain needed programs and resources that promote prevention and expand treatment and service delivery to Alaskans who experience TBI and their families.

You KNOW us ...



The Public Health Burden of Brain Injury (prevalence)

5.3 million Brain Injuries

- 5 million persistent Mental Illness
- 4 million Alzheimer's
- 3 million Stroke
- 2 million Epilepsy
- 900,000 HIV/AIDS
- 500,000 Cerebral Palsy
- 400,000 Spinal Cord Injury

Brain injury accounts for more years of lost productivity than any other injury.

The Financial Burden of Brain Injury

- It is estimated that over a lifetime, it can cost between \$600,000 and \$1,875,000 to care for a survivor of severe TBI.
- Direct medical costs and indirect costs of TBI such as lost productivity totaled an estimated 60 billion dollars in the United States in 2000. (*Centers for Disease Control and Prevention*)
- Every dollar used for brain injury rehabilitation saves up to \$35 in future medical costs. (Rhode Island Brain Injury Association)

Prevention is the only cure for Brain Injury

- The three leading causes of brain injury nationally and in Alaska are:
1) motor vehicle crashes 2) falls and 3) assaults.
- One-third of all TBIs recorded in the Alaska Trauma Registry were alcohol related.
- The use of safety belts is the single most effective measure to prevent traumatic brain injuries.
- Helmets are estimated to be 37% effective in preventing fatal injuries to motorcyclists. (*National Highway Traffic Safety Administration*)
- Bicycle helmets are 85-88 percent effective in mitigating head and brain injuries. Every dollar spent on a bike helmet saves \$40 in direct medical costs and other costs to society. (*National Highway Traffic Safety Administration*)
- 60-67% of injured U.S. soldiers sent from Iraq to Walter Reed Army Medical Center have a TBI from blasts, severe falls and motor vehicle accidents. (*United Press International, July 2004*). These soldiers are now returning home to Alaska for continuing treatment and rehabilitation.

Traumatic Brain Injury is a beneficiary group promoted in the Alaska Mental Health Trust Authority "You Know Me" Anti-Stigma Campaign.

The Alaska Commission on Aging

Alaska's Seniors – a Resource and a Responsibility

Alaska's senior population is the second most rapidly growing senior population in the nation. We experienced more than a 100% increase in the 60 and older population from 1990 to 2006, with the number of older Alaskans now growing by over 5% per year. By 2030, seniors age 60 and older will comprise 17% of Alaska's population – the same proportion as Florida's age 65+ population today.

Older Alaskans provide enormous benefits to the state, their communities, and their families. Contributing over \$1.5 billion a year to the Alaskan economy (from retirement income and health care payments), seniors comprise one of the state's most basic economic "industries" – and one with many positive features, such as stability; local spending, triggering the economic multiplier effect; support of a diverse job mix year-round; an environmentally benign profile; non-enclave character where spending is distributed throughout the state); and creation of economies of scale in the provision of goods and services, especially in health care.

In addition to their economic assets, older Alaskans also contribute to their communities through high levels of volunteering, and they frequently serve as unpaid caregivers for children, other seniors, and younger adults with disabilities. The leadership and historical knowledge elders provide to our state is priceless and irreplaceable.

As the number of older Alaskans increases, the network of services for seniors must be strengthened and its capacity significantly expanded. This includes the information and referral resources upon which seniors rely to find the programs and services they need. Most seniors do not use any services – but when the need arises, they wish to have those services available and accessible.

Alaska Commission on Aging

The Alaska Commission on Aging (ACoA), formerly known as the Older Alaskans Commission, has been in existence since 1982. Its mission is to ensure dignity and independence for Alaska's seniors and to assist them, through planning, advocacy, education, and inter-agency coordination, to lead useful and meaningful lives.

What are the major challenges?

Alaska's senior population is expected to more than double by 2030, and the number of those age 85+ (the age group most likely to be affected by Alzheimer's Disease and Related Disorders – ADRD)

will more than triple. There are an estimated 5,000 older Alaskans with ADRD today. While 80% of care for individuals with ADRD is provided at home, it is essential for families to be able to rely on an effective support system comprised of government, non-profit agencies, churches, businesses, and volunteers.

According to a 2005 senior survey conducted by the ACoA, financial security was the top concern of older Alaskans, followed closely by accessible, affordable health care. The survey provided an early alert to the growing problem of access to primary care for seniors on Medicare, with more and more physicians declining to serve patients enrolled in this program (they cite very low reimbursement rates). Other important concerns identified by the survey included the need for appropriate housing, fears of inadequate funding of senior services, a growing demand for senior transportation, and a perception that government and political leaders in Alaska should be more responsive to senior issues.

State- and municipally-funded programs (for example, the Senior Benefits program, the senior municipal property tax exemption, and senior grant services) are an important part of the economic and supportive resources of many senior households. However, they by no means constitute an adequate safety net for seniors. Only about one in five older Alaskans receives Medicaid services. The remaining 80%, often of very modest income, can have great difficulty obtaining the supportive services they may need. Even those with the requisite low income are deemed ineligible for Medicaid waiver services if their primary diagnosis is ADRD. Available funds for senior grant services have increased only marginally over the past decade, while the number of seniors has grown by over 5% per year.

How has the Commission addressed these challenges?

The Alaska Commission on Aging has undertaken a number of activities related to planning, advocacy, public awareness, and inter-agency coordination to address these challenges.

The State Plan for Senior Services, FY 2008 – FY 2011, approved by the U.S. Administration on Aging in June 2007, provides a broad vision of the status and needs of Alaskan seniors and offers an extensive set of goals, objectives and strategies chosen to move this vision forward among the state's aging network and other relevant agencies. Developed with the assistance and ongoing support of multiple agency partners, the State Plan was intended to actively

guide their work for the next four years, leveraged by the synergy of annual implementation meetings in which partners share ideas and report on their plan-related activities.

In 2006, the ACoA formed the Alaska Aging Advocacy Network (AAAN), a group of about 125 individuals (seniors and senior advocates) with an interest in joining the ACoA in advocating for legislation of particular interest to Alaska seniors. In 2007, the efforts of the AAAN assisted the Commission and other advocates in successfully obtaining a Senior Benefits program and several other bills benefiting seniors.

Each year, the Commission develops a list of advocacy priorities, which it posts on its website. One of the ACoA's top priority issues, a substantial operating budget increment for senior grant services (and an accompanying capital budget item for facility upgrades for senior grant providers), remains the focal point of the Commission's advocacy work in 2008.

Each year, the ACoA holds a series of senior legislative teleconferences during session, giving seniors at host sites across the state the opportunity to learn about and discuss a wide range of bills that may potentially impact them.

In 2007, the Commission and other partner agencies published a Report on the Economic Well-Being of Alaska Seniors, a long-awaited description of the economic status of older Alaskans and the variety of State programs available to them.

The ACoA engages in a variety of public awareness campaigns ranging from an Older Americans Month celebration each May featuring posters carrying messages about healthy aging, to participation in The Trust's "You KNOW Me..." campaign and the recent launching of the Healthy Body, Healthy Brain Campaign aimed at educating seniors and baby boomers about the links between healthy lifestyles (physical activity, healthy eating, socializing, and mental challenges) and a lower risk of developing ADRI.

The Commission's popular website is frequently updated with new features and news stories of interest to older Alaskans.

The Alaska Mental Health Trust Authority

The Alaska Commission on Aging is one of several boards/commissions that represent beneficiaries of the Alaska Mental Health Trust Authority (The Trust). Trust beneficiaries include people with

mental illness, those with developmental disabilities, people with chronic alcoholism, and people with Alzheimer's disease and related disorders.

Prior to statehood, there were no services available in the Territory of Alaska for individuals who experienced mental illness or developmental disabilities. Instead, these individuals were sent by the federal government to live in an institution in Oregon. During Alaska's transition to statehood, Congress passed the Alaska Mental Health Enabling Act of 1956 to help bring these individuals home. This act transferred the responsibility for providing mental health services from the federal government to the Territory of Alaska and ultimately the State of Alaska by creating the Alaska Mental Health Trust. To fund The Trust, the state selected one million prime acres of land that would be managed to generate income that would pay for a comprehensive integrated mental health program.

Though the state legislature held a fiduciary responsibility to manage the land on behalf of Alaskans with disabilities, it did not do so. Instead, by 1982, only about 35 percent of the land remained in State ownership. The majority of the land had been transferred to individuals or municipalities, or designated by the legislature as forests, parks, or wildlife areas.

In 1982, Vern Weiss filed a lawsuit on behalf of his son, who required mental health services that were not available in Alaska. Other beneficiary groups joined *Weiss v. State of Alaska* in a class action suit. The case was decided in 1984 by the Alaska Supreme Court, which ordered that the original trust be restored. Ten years later, in 1994, a final settlement reconstructed the Trust with 500,000 acres of original Trust land, 500,000 acres of replacement land, and \$200 million.

The settlement established an independent Board of Trustees who are appointed by the governor and confirmed by the legislature for five-year, staggered terms. The Trustees are responsible for oversight of The Trust's investments and land and non-cash assets. The investments are managed by the Alaska Permanent Fund Corporation, and the land and non-cash assets are managed under a contract with the Trust Land Office, a separate unit within the Alaska Department of Natural Resources.

The Trust works with the Alaska Department of Health and Social Services to coordinate planning for a comprehensive mental health program, makes recommendations to fund the program, and advocates for funding and policies that support the systems serving Trust beneficiaries.

**Advisory Board on Alcoholism
and Drug Abuse**



Alaska Mental Health Board

<http://hss.state.ak.us/amhb/>

Alaska Mental Health Board

The Alaska Mental Health Board (AMHB) is statutorily charged with assisting in planning and offering oversight and evaluation of Alaska's behavioral health system. AMHB also provides advocacy for Alaskans, most importantly for beneficiaries of the Alaska Mental Health Trust who experience a mental illness.

Facts on mental health in Alaska

- Alaska's Juvenile Justice office has determined that in a one-day count, 40% of the youth in their custody or care have a mental health diagnosis.
- According to a one-day snapshot study conducted for the Department of Corrections (DOC) in 2007, 42% of those in the system experience a mental disorder.
- The DOC study also states, "Among those identified, findings indicate that Trust beneficiaries spend more time in custody than other inmates, are more likely to recidivate post-release, and more than ¼ do not get reconnected with community-based mental health service providers upon release."
- The Journal of the American Medical Association estimates a 20% loss of productivity for people suffering from depression. Alaska prevalence data estimates 30,000 working Alaskans suffer from depression, which results in decreased productivity equivalent to 1,500,000 days of work each year.
- 17% of Alaska's adults are veterans, the highest percentage of any state. The Veterans Administration reports that one in three veterans returning from Afghanistan and Iraq face behavioral health problems. Post traumatic stress disorders (PTSD), depression, substance

abuse, and traumatic brain injuries are very real problems for Alaska's vets. There are four Vet Centers in Alaska, all on the road system. Vets in Alaska with severe problems are sent to the Lower 48 for mental health treatment.

Advocacy issues for 2008-09

In addition to contesting the stigma of mental illness, the AMHB has identified the following issues where improved services are a priority:

- Too many Alaskans with serious mental illnesses are sent to a correction facility as a result of their illness. We need to support efforts to expand effective community-based programs to better serve these individuals when released into the community in order to reduce them returning back to prison.
- Alaska must achieve "no wrong door" access to effective behavioral health services. Our primary health providers are a great source of collaboration for better access and early identification of serious and moderate mental health problems.
- The AMHB, state agencies, and other partners are working together to expand community-based care for Alaska's children who experience severe emotional disorders to decrease the chances of them needing residential care. Effective community-based services save costs and increase family reunification.
- Partnering with Behavioral Health, Alaska Housing Finance Corporation, the Alaska Mental Health Trust, and others, AMHB is advocating for specialized state resources to develop innovative housing for individuals with a mental illness, including consumer-run programs. The AMHB supports inventive and evidence-based services such as

tele-psychiatry and on-call emergency service teams to support rural community service needs. Our rural communities are very receptive to these services so far and we want to expand these efforts.

- The older Alaskans population is growing with baby boomers coming to this

stage of life. AMHB works closely with Alaska's Commission on Aging and other partners to better define the behavioral health needs and resources for this group. Nationally, other states are also facing this challenge and are finding that depression and substance abuse are very serious problems and require specialized services.

The Alaska Mental Health Trust Authority

The Alaska Mental Health Board is one of several boards/commissions that The Mental Health Trust Authority (The Trust) represents. Trust beneficiaries include people with mental illness, people with developmental disabilities, people with chronic alcoholism, and people with Alzheimer's disease and related disorders.

Prior to statehood, there were no services available in the Territory of Alaska for individuals who experienced mental illness or developmental disabilities. Instead, these individuals were sent by the federal government to live in an institution in Oregon. During Alaska's transition to a state, Congress passed the Alaska Mental Health Enabling Act of 1956 to help bring these individuals home. This act transferred the responsibility for providing mental health services from the federal government to the Territory of Alaska and ultimately the State of Alaska, by creating the Alaska Mental Health Trust. To fund The Trust, the state selected one million prime acres of land that would be managed to generate income that would pay for a comprehensive integrated mental health program.

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The settlement established an independent Board of Trustees who are appointed by the governor and confirmed by the legislature for five-year, staggered terms. The Trustees are responsible for oversight of The Trust's investments and land and non-cash assets. The investments are managed by the Alaska Permanent Fund Corporation, and the land and non-cash assets are managed under a contract with the Trust Land Office, a separate unit within the Alaska Department of Natural Resources.

The Trust works with the Alaska Department of Health and Social Services to coordinate planning for a comprehensive mental health program, makes recommendations to fund the program and advocates for funding and policies that support the systems serving Trust beneficiaries.

#####

You KNOW me...



U.S. Navy Retired, still working and involved in my community.

I'm an alcoholic, who's been sober for 24 years.

I'm proof that treatment works and recovery is real.

We can do better, Alaska. Treat health of the mind with the same urgency we treat health of the body. Early intervention and services make a difference. For help, visit your doctor, clinic or local alcohol treatment center. (And if you are in Craig, call us at COHO—Communities Organized for Health Option at 826-3662.)

Advisory Board on Alcoholism
and Drug Abuse

www.hss.state.ak.us/abada

The TRUST

The Alaska Mental Health Trust Authority

www.mhtrust.org

You KNOW me...



I enjoy meeting people and making new friends.

I like to go out to dinner and the movies. Just like many other kids, I want to graduate from high school and find a job.

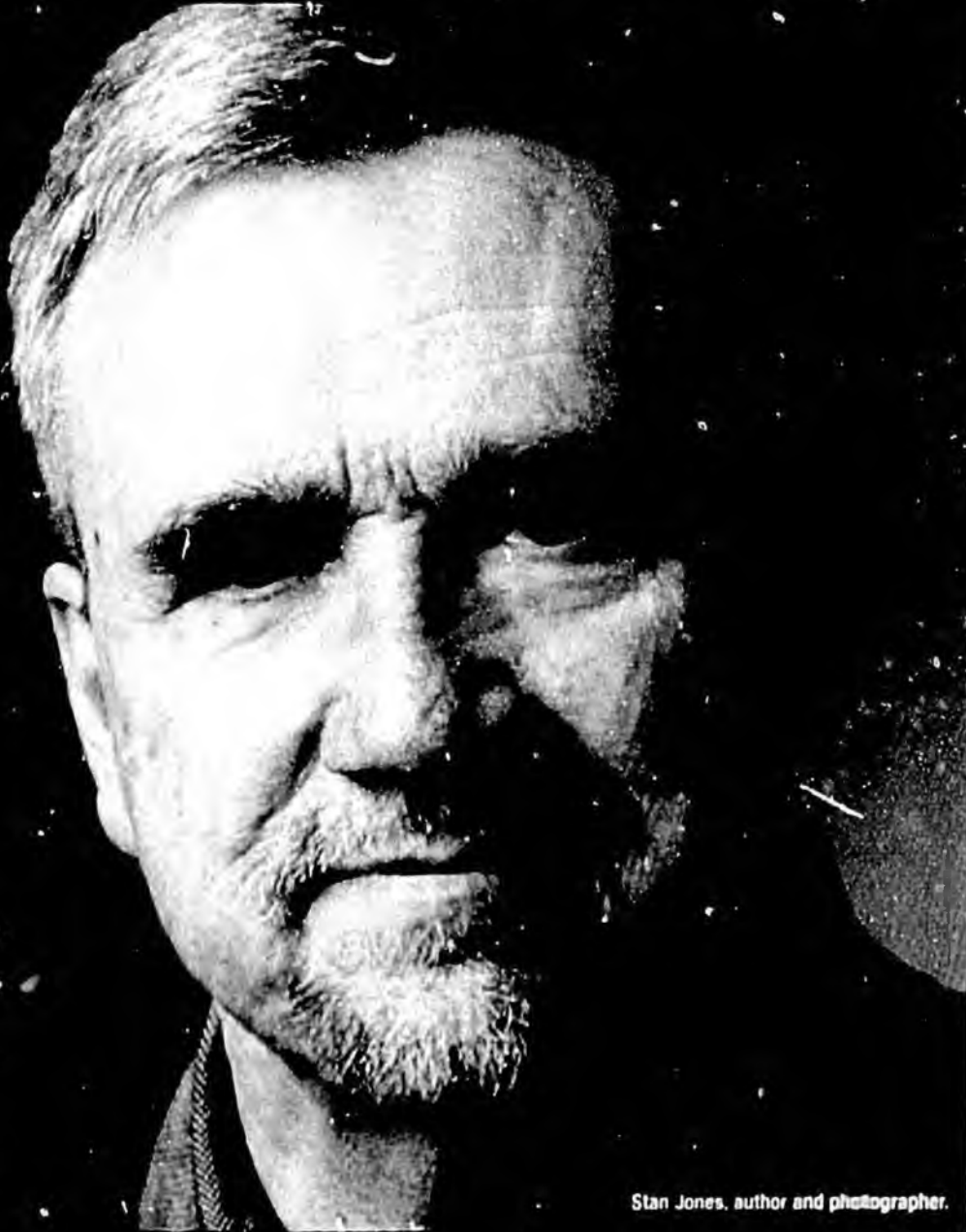
You can help increase the number of youth with disabilities who reach their potential. Get to know them. Offer them a job. Be their friend.

Youth with disabilities are part of tomorrow's workforce. Being part of the community and included in recreational and civic activities are great ways to build job skills.

For more information visit
www.hss.state.ak.us/gcdse

The **TRUST**
The Alaska Mental Health Trust Authority
www.mhtrust.org

You KNOW me...



Stan Jones, author and photographer.

I am your neighbor and, like many others my age, have a dear mother who no longer knows who I am.

Fifty percent of Americans aged 85 and older will experience Alzheimer's Disease or related disorders. In a state with the country's second fastest growing senior population, that's a challenge.

The Alaska Commission on Aging is working to ensure that when services are needed for age-related mental health issues such as Alzheimer's Disease, they will be available for all Alaskans.

For assistance and referrals, call the Senior Information Hot Line:
1-800-478-6065

The TRUST

The Alaska Mental Health Trust Authority

www.mhtrust.org

Opportunity
begins with a home

was established by the Governor in 2004, will be expanded to:

- Develop an annual housing trust plan
- Advise on the allocation of fund resources
- Report results annually to the governor and legislature

Q: Where will the money come from for the Alaska Housing Trust?

A: A legislative appropriation of state general funds will be used to create the Alaska Housing Trust and leverage existing resources.

Q: How will the Alaska Housing Trust work with existing low-income housing programs?

A: The Alaska Housing Trust will seek to maximize the capacity of existing programs by pulling together available resources and

addressing the gaps in which the poorest Alaskans fall. The Alaska Housing Trust will not—and cannot—replace the existing service providers who are already stretched to their limits. The federal government has historically provided the lion's share of housing assistance in Alaska, and will likely continue to do so. But for a number of reasons the federal programs are not adequately addressing the homeless problem:

- Federal funds fall far short of needs. HUD estimates that nationally only about 25% of households that qualify for housing assistance are receiving it.¹⁴ In Alaska, 4,000 families are on the waiting list for affordable housing.¹⁵
- Federal funds are poorly connected to homeless prevention and housing retention services.
- Federal programs do not effectively reach people with extremely low incomes.

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The Alaska Housing Trust: Preventing and ending homelessness in Alaska

Q: How many Alaskans are homeless?

A: Estimates vary; a recent AHFC survey indicated nearly 3,500 Alaskans are homeless on any given night.¹ The Alaska Department of Education and Early Development, which counts children only, reported that more than 4,000 children were homeless or inadequately housed at some time during the 2005-06 school year.² Over the last six years, an average of 88 discharges a year from Alaska Psychiatric Institute have led to homeless status.³ A 2005 Department of Corrections Homeless Offender survey found that 35% of offenders did not know where they would live upon release or planned to live in a shelter or on the street.⁴

Q: How many Alaskans are at risk of homelessness?

A: 20,000 low-income Alaskan households spend more than 50% of their income on housing costs, placing them at risk of homelessness.⁵

Q: Why are so many Alaskans homeless?

A: Homelessness results from a complex set of circumstances that require people to

choose between food, shelter, and other basic needs. Contributing factors include:

- **Inadequate income.** A 2001 study found 57% of Alaska households could not afford a median priced home and 46% could not afford the average rent.⁶ Today in Alaska, a person needs to earn \$17.90 per hour to afford a modest two-bedroom apartment at the average fair market rent of \$931.⁷
- **Inadequate supply of affordable housing.** The private housing market alone cannot supply enough affordable housing because of high land prices and other costs. The waiting list in Alaska for publicly financed housing is nearly 4,000 households.⁸
- **Catastrophic events and destabilizing forces.** A sudden economic downturn caused by illness, injury, divorce or job loss may push people into homelessness. Mental illness and addiction disorders are also destabilizing forces that can cause homelessness.
- **Insufficient supportive services.** In Alaska, homeless prevention and housing retention services are not generally available.

Footnotes

1. AHFC, *Statewide Homeless Survey, Winter 2006*. This survey is the HUD approved methodology for counting homeless people in Alaska. For a general overview, see www.alaska.gov/ahfc.

2. *Alaska Department of Education and Early Development, "Multiple Indicator Study of Student Achievement," 2005-06 School Year*. Available at www.alaska.gov/adeed.

3. *Alaska Department of Corrections, "Homeless Offender Survey," 2005*. Available at www.alaska.gov/doc.

4. *Alaska Department of Corrections, "Homeless Offender Survey," 2005*. Available at www.alaska.gov/doc.

5. *Alaska Department of Community Development, "Alaska Housing Survey," 2005*. Available at www.alaska.gov/ahfc.

6. *Alaska Department of Community Development, "Alaska Housing Survey," 2001*. Available at www.alaska.gov/ahfc.

7. *Alaska Department of Community Development, "Alaska Housing Survey," 2001*. Available at www.alaska.gov/ahfc.

8. *Alaska Department of Community Development, "Alaska Housing Survey," 2001*. Available at www.alaska.gov/ahfc.

9. *Alaska Department of Community Development, "Alaska Housing Survey," 2001*. Available at www.alaska.gov/ahfc.

10. *Alaska Department of Community Development, "Alaska Housing Survey," 2001*. Available at www.alaska.gov/ahfc.

11. *Alaska Department of Community Development, "Alaska Housing Survey," 2001*. Available at www.alaska.gov/ahfc.

12. *Alaska Department of Community Development, "Alaska Housing Survey," 2001*. Available at www.alaska.gov/ahfc.

13. *Alaska Department of Community Development, "Alaska Housing Survey," 2001*. Available at www.alaska.gov/ahfc.

14. *U.S. Department of Housing and Urban Development, "Housing Assistance Statistics," 2005*. Available at www.hud.gov.

15. *Alaska Department of Community Development, "Alaska Housing Survey," 2001*. Available at www.alaska.gov/ahfc.

Opportunity
begins with a home

Q: Who is homeless?

A: In Alaska, families with children are the largest sector.⁹ Of all homeless Alaskans:

- 45% are persons in families with children
 - 15% are victims of domestic violence
 - 9% are veterans
 - 14% are severely mentally ill
 - 24% suffer from chronic substance abuse problems
- (Some homeless individuals are counted in more than one category.)

Q: What does homelessness cost Alaska?

A: Data is not available to precisely answer this question. However, the University of California San Diego Medical Center found that, over 18 months, 15 chronically homeless inebriates were treated at the hospital's emergency room 417 times, running up bills that averaged \$100,000 each.¹¹ In Asheville, North Carolina, it was discovered that just 37 homeless men and women generated \$278,000 in jail costs over a three-year period.¹²

Q: What is a Housing Trust?

A: A housing trust is a pool of funds earmarked to provide for the housing needs of low-income families and individuals. More than 30 states have housing trusts. Experience

shows that state housing trust funds are more innovative and move quicker than federal programs to address local issues. On average, each dollar spent by a state housing trust leverages \$9.25 in additional funding for housing.¹³

Q: What will be the mission of Alaska's Housing Trust?

A: To reduce homelessness through the creation and retention of an adequate supply of affordable, long-term housing.

Q: What will be the benefits?

A: Safe, stable and affordable housing promotes strong families:

- Children are more successful in school
- Families have a foundation on which to build their dreams
- Seniors and persons with disabilities can live with independence and dignity

Home ownership promotes community stability—families are more invested in their neighborhoods and increase their civic participation. Moving people from homelessness to permanent housing reduces the amount of public funding they would otherwise use. And investing in housing creates economic opportunity in the private sector, including construction and other housing related industries.

ALASKA HOUSING TRUST



Opportunity
begins with a home

Q: What type of projects and activities will the Alaska Housing Trust fund?

A: All projects and activities must reduce homelessness and include (but are not limited to) the following:

- Construct new housing (single-family, multi-family, cooperative)
- Buy existing housing (single-family, multi-family, cooperative)
- Rehabilitate/repair existing housing (single-family, multi-family, cooperative)
- Fund affordable housing component only of mixed-income and mixed-use developments
- Buy land
- Perform accessibility modifications
- Provide down-payment assistance
- Provide rental assistance
- Fund homeless prevention services (e.g. prevent foreclosures and evictions)
- Fund housing retention services or facilitate transition from dependency on subsidized housing
- Support Community Land Trusts
- Fund capacity building in the development and operation of affordable housing and provide support services (operations and technical assistance)

- Fund predevelopment activities for affordable housing

Q: How will the Alaska Housing Trust differ from other housing programs?

A: The Alaska Housing Trust will support and complement existing efforts by working as a catalyst to pull together other funding sources in order to move families out of homelessness and help those at risk of homelessness. The Alaska Housing Trust will:

- Give a priority to those who have the greatest housing affordability gap—people with extremely low income.
- Target those in danger of becoming homeless with homeless prevention and housing retention services.
- Support those transitioning from homelessness who are confronting multiple barriers to becoming self-sufficient.
- Create and retain permanently affordable housing by reinvesting the initial public investment.

Q: Who will administer the Alaska Housing Trust?

A: The Alaska Housing Trust will be a separate capital budget fund within Alaska Housing Finance Corporation (AHFC). The duties of the Alaska Council on the Homeless, which

ALASKA HOUSING TRUST



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annually to review work and make recommendations regarding budget requests, changes to state programs, and allocations of funding that may become available during the next fiscal year.

The Council will also be responsible for making recommendations on how state resources, in addition to the fund, may be used to reduce homelessness.

Q: Who will have administrative responsibility for the housing trust?

A: AHFC will have administrative responsibility of carrying out

recommendations from the Alaska Council on the Homeless. These duties will include, but are not limited to, obtaining public input, developing procedures and policies, implementing monitoring and evaluation processes, administering grants, distributing funds and enforcing state regulations.

In addition, AHFC will be responsible for preparing an annual report on the activities of the fund, the impact of the fund on homelessness, and recommendations of the Alaska Council on the Homeless on how other state resources may be used to reduce homelessness.



*Opportunity
begins with a home*

Administration of the Alaska Housing Trust Fund

Q: Where will the Alaska Housing Trust reside within state government?

A: The Alaska Housing Trust Fund will be a program created within the Alaska Housing Finance Corporation (AHFC). It will be funded through AHFC's capital budget and administered by AHFC with guidance from the governor's Alaska Council on the Homeless. Through the appropriation process, AHFC can receive funds from many different sources, both public and private, to allocate through the program. The fund will be specifically targeted to projects that reduce homelessness, either directly or indirectly.

Q: What would the enabling legislation do?

A: The legislation statutorily creates the Alaska Housing Trust Fund as a program within AHFC as well as more flexibility within AHFC's statutory powers to address and prevent homelessness. It also codifies the governor's Alaska Council on the Homeless as an advisory body to AHFC regarding allocation of housing trust funding and to the governor regarding state policy and program changes needed to more effectively address homelessness.

Q: What is the role of the governor's Alaska Council on the Homeless?

A: The responsibilities of the Council are to make recommendations to AHFC on:

1. Housing needs and priorities, and an action plan for expenditures from the housing trust fund to address those needs and priorities
2. The budget for expenditures from the housing trust fund
3. Policies and procedures for expenditures from the fund
4. Methods to evaluate and monitor activities financed by the fund
5. Methods for reporting to the public and elected or other officials regarding the activities financed by the fund
6. Methods to coordinate the expenditure of money from the fund with other available sources of financing for housing
7. The availability of additional sources of money to support housing activities financed from the fund

It is anticipated that the Council will meet as necessary during the start-up phase, and then (at a minimum)



Opportunity begins with a home

other creative approaches can be used to assist Alaska families.

- A statewide public opinion survey found that 90% of Alaskans agree that "it is only fair that everyone has access to a decent place to live," and 89% agree that "we have a responsibility to help people who need a place to live."
- The Alaska constitution requires the state to protect the public's safety, including ensuring that all Alaskans have a safe and decent place to live.
- A housing trust is a proven model.
 - There are 600 housing trust funds operating nationwide.
 - Housing trusts generate more than \$1.6 billion a year to support critical housing needs and affordable housing across the U.S.
 - On average, each \$1 spent by a housing trust fund leverages \$7 in other funds.
- By moving people from homelessness to permanent housing, Alaska can reduce the amount of public funding it would otherwise use.
- Placing the housing trust within AHFC grows the services of the state without expanding the government's size.
- Housing trust funding would create permanently affordable housing. Community Land Trust models and other creative approaches can be used to assist Alaska families.
- Housing trust supported projects would help keep Alaska's housing construction industry strong.
- The housing trust would encourage innovative housing ideas and entrepreneurial partnerships between Alaska's social service and business sectors.

Benefits: Families, Communities and All Alaskans

- A stable home promotes community stability. When families are more invested in their neighborhoods, they increase their civic participation.
- Safe, stable and affordable housing promotes strong families.
 - Children become more successful in school.
 - Families have a foundation to grow their dreams.
 - Seniors and persons with disabilities can live with independence and dignity.

Implementation: Accountability and Results

Alaska Council on the Homeless will develop an annual housing trust fund plan, advise on allocation of fund resources, evaluate program results and report results annually.

AHFC will have administrative responsibility of carrying out recommendations from the Alaska Council on the Homeless. Duties will include obtaining public input, developing procedures and policies, implementing monitoring and evaluation processes, administering grants, distributing funding and enforcing state regulations.

ALASKA HOUSING TRUST



*Opportunity
begins with a home*

Thousands of Alaskans are Homeless.

Homelessness is one of the most important social issues facing Alaska.

- 3,500 Alaskans are homeless on any given night, including 1,600 people in families with children.
- 4,000 Alaskan households are on the waiting list for public housing programs – most are families with children.
- 20,000 low-income Alaska households spend more than half their income on housing, placing them at risk of homelessness.
- Families with children are the fastest growing segment of Alaska's homeless population.

Problem: Lack of Focus

- There are high personal and public costs associated with being homeless or living on the edge of homelessness.
 - Personal costs to individuals and families include greater family stress, lower student achievement, a higher risk of becoming a victim of crime, and increased medical and behavioral health needs.
 - Costs to local governments and the state include increased use of emergency services, medical and behavioral health services, public safety, and the courts.
 - Housing alone is not enough. People who are homeless, or at risk of being homeless, frequently need supportive services to become self-reliant, such as:
 - case management
 - financial literacy
 - treatment
 - job counseling
 - crisis intervention
 - life skills training
 - tenant education
- Current housing programs are not well connected to these supportive services.
 - Federal programs are not adequately focused on housing for the poorest Alaskans, yet these programs are the primary source of current housing assistance.
 - Alaska Housing Finance Corporation (AHFC) is the state's housing authority. Providing supportive housing is not part of its mandate. The housing trust legislation will give AHFC and its partners the flexibility they need to address homelessness in Alaska.

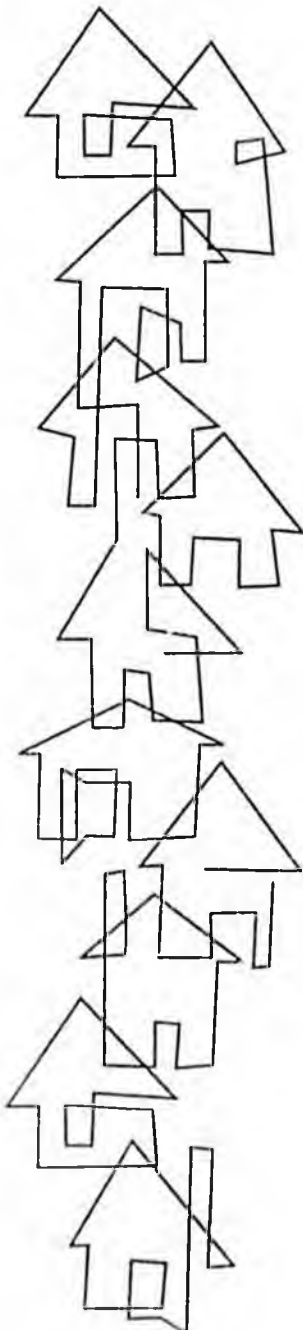
Solution: Alaska Housing Trust

- Create a fund at the AHFC using an appropriation of state general funds, plus other public/private money.
- Invest in permanently affordable housing, Community Land Trust models and



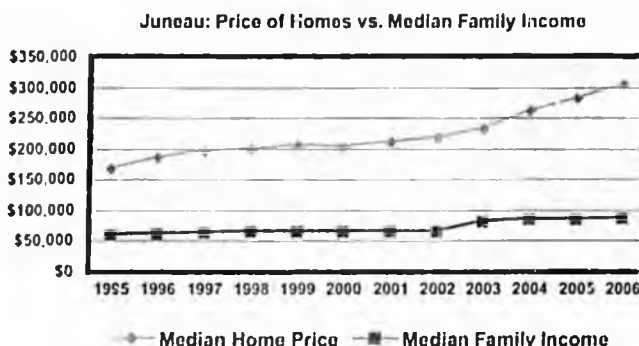
ALASKA HOUSING TRUST

In Juneau, housing prices have moved out of reach for ordinary people.



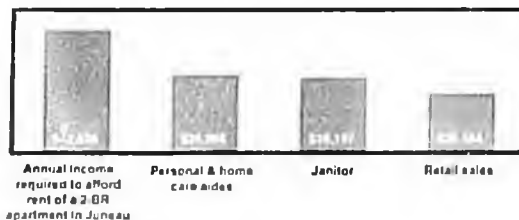
Working Alaskans in Juneau cannot afford to buy a house.

In the past ten years, the cost of a single family home in Juneau has increased by over 83%, while median family income has increased by only 43%.



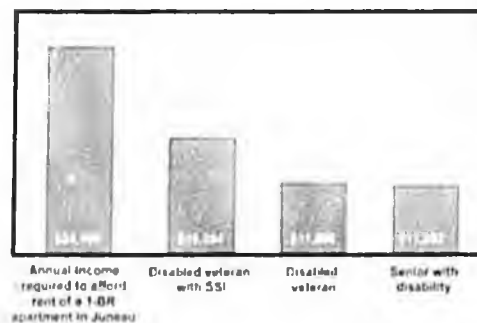
Working Alaskans in Juneau cannot afford to rent.

A person living in Juneau must earn \$20.37 per hour to afford the average fair market rent for a two-bedroom apartment of \$1096.00 monthly. A person earning minimum wage must work 114 hours to afford this rent.



Seniors, veterans, and disabled Alaskans in Juneau are at risk of homelessness.

People living on fixed incomes, like seniors, people with disabilities, and veterans, cannot afford to rent a fair market rate one-bedroom apartment in Juneau.



167

The number of schoolchildren (K-12) in Juneau who were homeless at one time in the 2005-2006 school year.

3

The number of children in preschool in Juneau who were homeless at one time in the 2005-2006 school year.

20,000

The number of low-income Alaskans spending over 50% of their income on housing.*

16%

The percentage of homeless people in Alaska who are victims of domestic violence.*

9%

The percentage of homeless people in Alaska who are veterans.

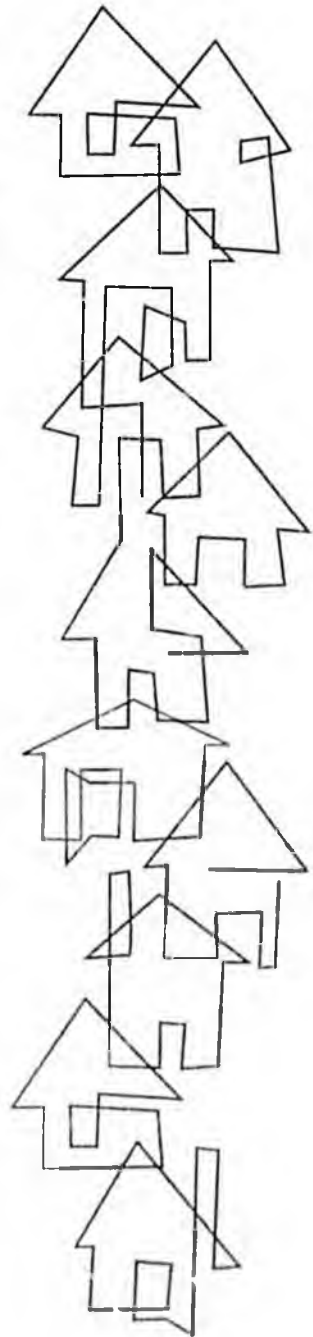


*Homeless Community Project & Shelter Options, Alaska Department of Education and Early Development, "Homeless, County by District & School Year," Alaska Department of Education and Early Development, "Alaska Housing and Community Development - 2004 Consolidated Plan," 2004, Alaska Department of Education, 2004, and HUD's National Homeless Survey, Winter 2004. *HUD's National Homeless Survey, Winter 2004. *Percentage of homeless people and veterans in Alaska Housing Trust's jurisdiction in Anchorage, Fairbanks, and Alaska Department of Education and Early Development.

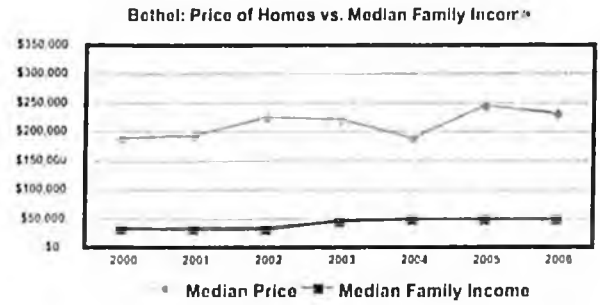
ALASKA HOUSING TRUST



In Bethel, housing prices have moved out of reach for ordinary people.

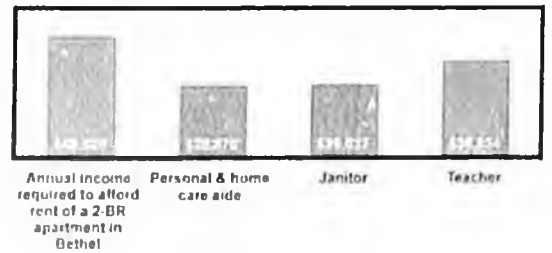


Working Alaskans in Bethel cannot afford to buy a house.
 In the past six years, the cost of a single family home in Bethel has fluctuated three times, while median family income has increased only gradually.



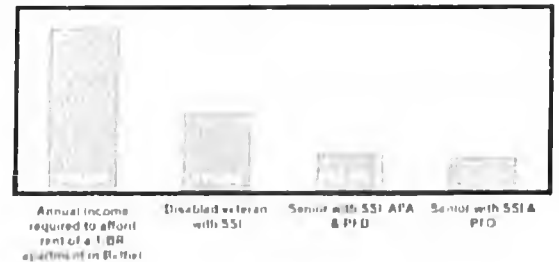
Working Alaskans in Bethel cannot afford to rent.

A person living in Bethel must earn \$22.54 per hour to afford the fair market rent for a two-bedroom apartment of \$1,213.00 monthly. A person earning minimum wage must work 128 hours to afford the rent.



Seniors, veterans, and disabled Alaskans are at risk of homelessness.

People who are frail, have no family support, people with disabilities, and low income cannot afford to rent in the market rate. Low income and frail people in Bethel.



20,000
 The number of low income Alaskans spending over 50% of their income on housing

16%
 The percentage of homeless people in Alaska who are victims of domestic violence

9%
 The percentage of homeless people in Alaska who are veterans

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ALASKA HOUSING TRUST

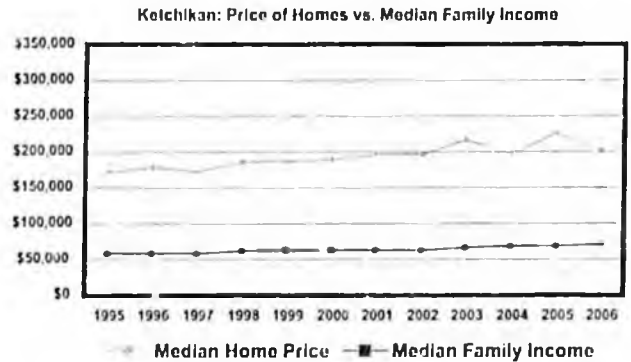


In Ketchikan, housing prices have moved out of reach for ordinary people.



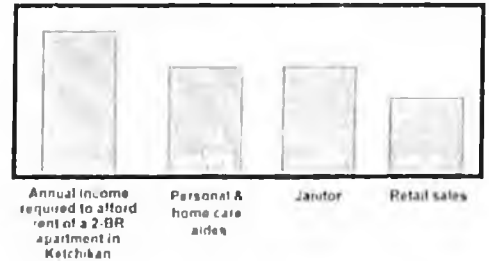
Working Alaskans in Ketchikan cannot afford to buy a house.

In the past ten years, the cost of a single family home in Ketchikan has increased by \$31,228 while median family income has increased by only \$12,800.



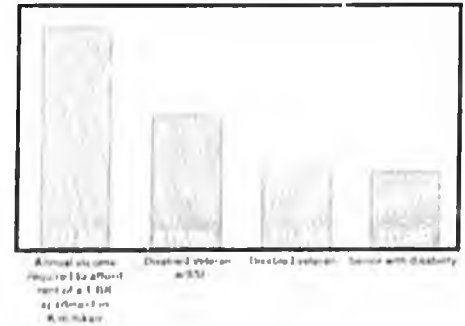
Working Alaskans in Ketchikan cannot afford to rent.

A person living on the lowest wage of \$12.50 per hour would have to pay \$208 per month for a two-bedroom apartment. \$262.00 monthly, if you are working minimum wage and paying only 10% toward utility costs.



Seniors, veterans, and disabled Alaskans in Ketchikan are at risk of homelessness.

A single retired person would have to pay \$1,000 per month for a one-bedroom apartment. \$1,200 monthly, if you are retired and paying only 10% toward utility costs.



38
The number of schoolchildren (K-12) in Ketchikan who were homeless at one time in the 2005-2006 school year.

20,000
The number of low income Alaskans spending over 50% of their income on housing.

16%
The percentage of homeless people in Alaska who are victims of domestic violence.

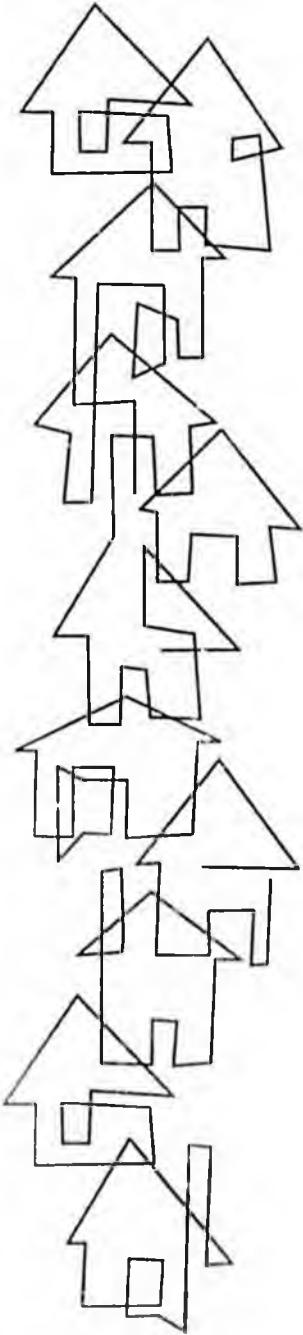
9%
The percentage of homeless people in Alaska who are veterans.¹



¹ Homeless Housing Study, 1995, U.S. Dept. of Housing and Urban Development, Housing Research Report, HUD-95-1, Washington, D.C., 1995. ² U.S. Dept. of Housing and Urban Development, Housing Research Report, HUD-95-1, Washington, D.C., 1995. ³ U.S. Dept. of Housing and Urban Development, Housing Research Report, HUD-95-1, Washington, D.C., 1995. ⁴ U.S. Dept. of Housing and Urban Development, Housing Research Report, HUD-95-1, Washington, D.C., 1995.

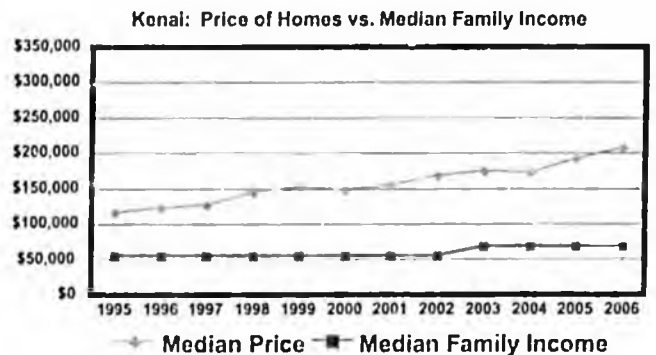


In Kenai, housing prices have moved out of reach for ordinary people.



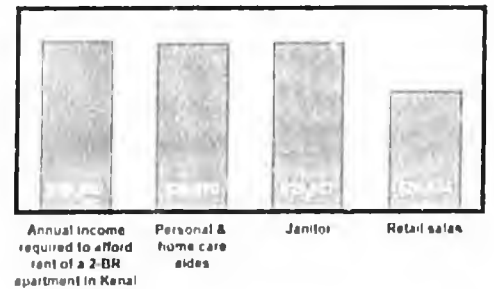
Working Alaskans in Kenai cannot afford to buy a house.

In the past ten years, the cost of a single family home in Kenai has increased by over 78%, while median family income has increased by only 25%.



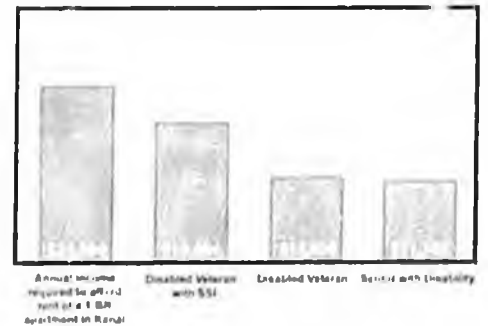
Working Alaskans in Kenai cannot afford to rent an apartment.

A person living in Kenai must earn \$13.60 per hour to afford the average fair market rent for a two-bedroom apartment of \$772.00 monthly. A person earning minimum wage must work 26 hours to afford this cost.



Seniors, veterans, and disabled Alaskans in Kenai are at risk of homelessness.

People living on fixed incomes, including seniors, youth, disabled, and veterans, cannot afford to rent a fair market rate number of an apartment in Kenai.



241

The number of schoolchildren (K-12) in Kenai who were homeless at one time in the 2005-2006 school year.

34

The number of children in preschool in Kenai who were homeless at one time in the 2005-2006 school year.

20,000

The number of low-income Alaskans spending over 50% of their income on housing.*

16%

The percentage of homeless people in Alaska who are victims of domestic violence †

9%

The percentage of homeless people in Alaska who are veterans. ‡



* "There's no one in a shelter & a shelter." Alaska Department of Education and Early Development, Homeless, Disabled, Deaf, & Low Income. Alaska Department of Education and Early Development, Alaska's Homeless and Family Development Data, dated from 2001-02 to the 5-year period from 2005-10.
 † AFDC's Statewide Homeless Survey, Winter 2006.
 ‡ AFDC's Statewide Homeless Survey, Winter 2006.
 Data on rent, public program, and income collected from Alaska Housing Finance Corporation, U.S. Census Bureau, and Alaska Department of Education and Early Development.



The TRUST

The Alaska Mental Health Trust Authority

2/5/08

September 21, 2007

To Trust Partners and Beneficiaries:

Over the past several years, The Alaska Mental Health Trust Authority (The Trust) has voiced concern over the consequences of the State of Alaska refinancing State grant funding to Medicaid. As a result, during FY 07 The Trust commissioned a study to examine the changes in funding sources for the State's Comprehensive Mental Health Program and analyze what the changes have meant to Trust beneficiaries and the providers who serve them. The resulting report, *Financial and Program Changes to Services for AMHTA Beneficiaries: FY01- FY07* was completed in August 2007 and is attached for review by our beneficiaries, statutory advisors, other partner advisory groups, and all stakeholders of the Comprehensive Mental Health Program.

The Trust will use the information in the report to initiate and frame discussions with our advisory partners, state departments, and all other stakeholders about how to address the policy issues revealed by the data in the report and to formulate strategies to address them. The following are priority policy issues and concerns from the report for The Trust:

- The report confirms that there has been a shift through refinancing to funding much of the services in the Comprehensive Mental Health Program through Medicaid. State grant funding has been reduced in all areas. This means that there is a different mix of services being provided and of those who are being served.
- Medicaid is a medical model that funds services on the more severe end of the continuum of services, often when they are more expensive, and invests little in early intervention and prevention services.
- Medicaid does not serve all Trust beneficiaries – only those with extremely low incomes. This has created a lack of funding for some services such as alcohol and substance abuse treatment and prevention programs which have limited ability to bill Medicaid. A 1997 Legislative Audit report on Medicaid Refinancing referenced the problem of creating two classes of citizens by relying heavily on Medicaid to fund state services and recommended caution in future refinancing efforts to avoid widening the gap. The Medicaid refinancing strategy was increased beginning in FY 2000 resulting in increasing gaps in those served. State grant funding for these services must be reviewed and the consequences of the lack of alcohol and substance abuse treatment availability considered, including the ramifications on other systems such as the courts, corrections, child protection and public safety.
- Agencies are struggling to maintain services because of the freeze in Medicaid rates. The increasing cost of wages and benefits and continued inflation have eroded their financial ability to operate. The report cites agencies having to lay off employees and decrease the number of people they serve in order to cope with the

rate freezes. Medicaid rate studies are underway and the concerns in the report make a case for addressing these problems in the next legislative session. Additionally administrative concerns on the timeliness of payments, increased burden of Medicaid reporting requirements and the lack of funding mechanisms for funding of employee training that state grants used to provide are contributing to agency problems.

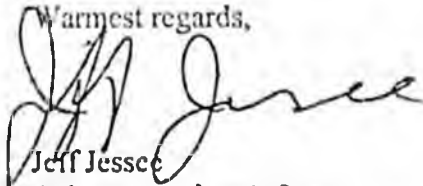
- Grant reporting improvements, that began in FY 06 need to be continued, including requirements for reporting unduplicated counts of those served in order to track effectively the number of people served in state-funded programs.
- There is a lack of discussion and planning to address quality assurance issues around how effectively programs serve Trust beneficiaries. The main dialogue recently from the Legislature and the Department of Health and Social Services has focused on managing the growth of the Medicaid program. While this is important, there are other important issues that must be addressed in order to ensure the State has a comprehensive mental health program that is effective and based on producing outcomes for beneficiaries.

These problems have limited the ability of the behavioral health system to address the needs of the beneficiaries in the community. This has resulted in a large number of beneficiaries being caught up in the criminal justice system and is contributing to the overcrowding of our prisons. We believe that investments in the state's behavioral health system can significantly help in limiting the need for expensive new prisons.

The Trust looks forward to working with all our partners to address the results of the policy concerns documented in this report as effectively as we have in our Focus Areas of Disability Justice, Affordable Housing, Bring the Kids Home, Workforce Development, and Beneficiary Initiatives. We have found that working with all systems to plan and implement priority strategies has led to solid progress in our Focus Areas and we will continue to apply these methods in our work to address the issues in this report.

We look forward to hearing your comments on the report and any strategies you believe would help address these issues. You may send those comments directly to me at the address below or via email to jeff@mhtrust.org.

Warmest regards,



Jeff Jesse
Chief Executive Officer

Alaska Mental Health Trust Authority
3745 Community Park Loop # 200
ANCHORAGE, AK 99508

**Financial and Program Changes
to Services for AMHTA
Beneficiaries: FY01 – FY07**

JULY 2007



SUBMITTED BY

Information Insights, Inc.
212 Front Street, Suite 100
Fairbanks, Alaska 99712

Financial and Program Changes to Services for AMHTA Beneficiaries: FY01 – FY07

JULY 2007

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INTRODUCTION

At the beginning of the decade, with a looming budget crisis, the Department of Health and Social Services (mental health, substance abuse and developmental disability services) and the Department of Administration (senior services) sought ways to reduce state general fund appropriations while maintaining services.

The State of Alaska has used various means to reconfigure the state budget to meet demands for more services with fewer funds. These changes in financing have brought many changes to how services are provided to Alaska Mental Health Trust beneficiaries.

The four refinancing measures that had the greatest impacts on the funding of services to beneficiaries are:

1. **Medicaid Waivers:** The federal government allows states to offer a variety of services to consumers under Section 1915(c) Home and Community-Based Services Waivers to allow long-term care services to be delivered in community settings. Home and Community Based Care (HCBC) waivers allow people who would otherwise need an institutional level of care to live in their home or community and receive the care they need. Forty-eight (48) states and the District of Columbia offer services through HCBS waivers. Alaska's first Waiver was approved in the 1990s. Alaska has four HCBC waivers:
 - Older Alaskans (OA)
 - Mentally Retarded/Developmentally Disabled (MRDD)
 - Children with Complex Medical Conditions (CCMC)
 - Adults with Physical Disabilities (APD)

2. **Medicaid Billing by Mental Health Services:** Over the past ten years, Medicaid became the primary payor for mental health services in Alaska. The State Medicaid program covers services required under 42 U.S.C. 1396 - 1396p (Title XIX of the Social Security Act), including:
 - Inpatient Hospital Services
 - Outpatient Hospital Including Rural Health Center and Federally Qualified Health Center Services
 - Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services to Children Under 21
 - Physician Services

Alaska also includes the following optional services in the State Medicaid Plan:

- Mental health clinic services
- Inpatient Psychiatric Services (for persons under the age of 21)
- Mental health rehabilitative services for children under 21
- Mental health rehabilitative services for adults
- Behavior rehabilitation services for children under 21
- Alcohol and substance abuse services
- Targeted Case Management (TCM)

ProShare: The federal ProShare program makes payments for certain medical assistance services to qualified private hospitals. The hospital in turn provides services directly or grants funds to qualified providers to secure services in rural, remote areas. ProShare helps ensure continued access to services for Alaska's citizens and makes optimum use of federal participation for inpatient hospital services and allows the state to obtain federal matching funds for what otherwise would be state general funds. A number of states, including Washington and New Hampshire, used ProShare to expand community-based services for seniors. Initially, states using ProShare were under close scrutiny from the Centers for Medicare and Medicaid services, however, there have been no recent challenges to states using ProShare in ways similar to Alaska.

ProShare has been in place in Alaska since FY00. Providence Medical Center administers ProShare for the Department of Health and Social Services and receives a 2% administrative fee. The funding dispersed to community providers is 50% federal funding and 50% state dollars. A table that provides ProShare funding amounts by DHSS division and component for FY03 through FY08 can be found in the Appendices.

3. **Alcohol and Drug Abuse Treatment and Prevention Fund:** Half (50%) of state alcohol excise taxes are deposited in the Alcohol and Drug Abuse Treatment and Prevention Fund and are available for support of programs for the prevention and treatment of alcoholism, drug abuse, and misuse of hazardous volatile materials and substances by inhalant abusers. The fund is used to support behavioral health grant programs.

In the wake of the funding shift from state grants to a greater reliance on Medicaid and other funding, the Trust contracted with Information Insights to document how the Comprehensive Mental Health Program has been affected by decreased state grant funds, increased dependence on Medicaid, and refinancing strategies since FY 2001. The purpose of this report is to look at how the refinancing of beneficiary services has impacted the mix and accessibility of services.

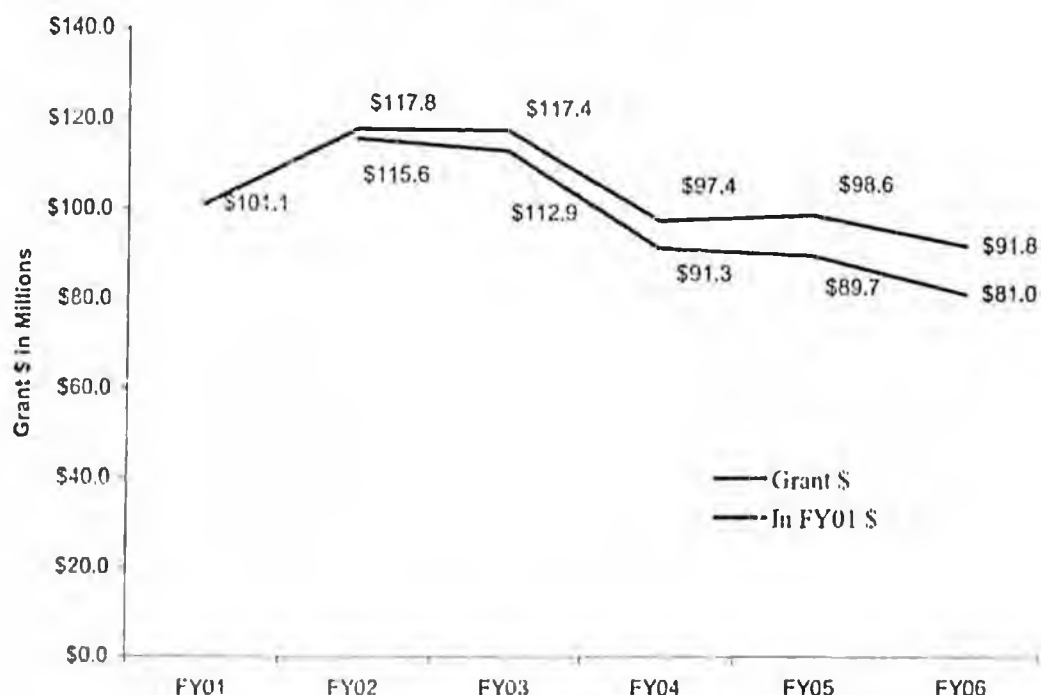
SUMMARY OF FINDINGS

Since October 2001, Alaska has relied increasingly on Medicaid to fund services for Trust beneficiaries. Approximately 20% of Alaskans are now enrolled in the state's Medicaid program. As a result of the increase in reliance on Medicaid program usage, the overall Medicaid budget has increased by almost 600 percent from FY 1997 to FY 2007. Medicaid has been pursued as a funding source because the federal government matches state dollars. This allowed the state to provide services using fewer state dollars.

However this shift in funding sources redefined many services under Medicaid definitions, often meaning a reduction in scope and flexibility of the services. At this time, the federal medical assistance percentage match (FMAP) has been continued at 57.58 percent of the total cost for most services. However, in federal FY08, effective October 1, 2007, this is planned to decrease to around 50 percent for most programs.

As can be seen on the chart below, grant funding for beneficiary services declined from \$101.1 million in FY01 to \$91.8 million in FY06. When the increasing costs of goods and services are considered¹, the FY06 grant total is \$81.0 million, a 19.9% decrease in funding.

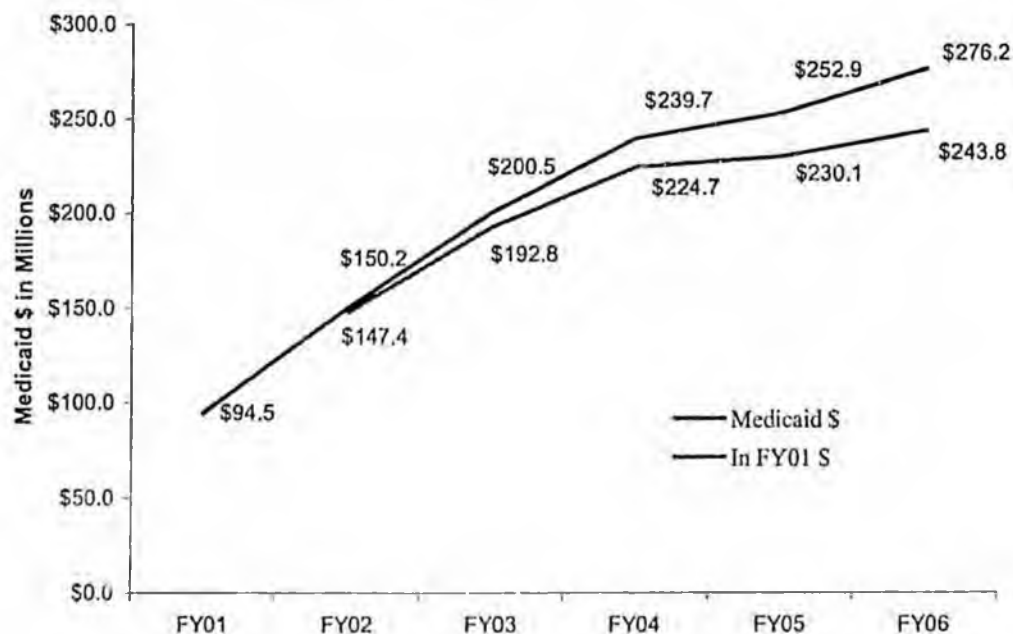
Alaska Mental Health Trust Beneficiaries
Grant Funding: FY01 – FY06



¹ Calculated with the GDP (Gross Domestic Product) deflator, which measures changes in prices of all new, domestically produced, final goods and services.

FY01 was the last year that grant funding (\$101.1 million) exceeded Medicaid (\$94.5 million) as a funding source for beneficiary services. Medicaid funding of services for Trust beneficiaries increased from \$94.5 million to \$276.2 million in FY06, which is equal to \$243.8 million FY01 dollars. This represents a 158% increase in FY01 dollars.

**Alaska Mental Health Trust Beneficiaries
Medicaid Funding: FY01 – FY06**



Other Findings:

- Between FY03 and FY04, the total authorized through General Fund/Mental Health (GF/MH) funding decreased from \$65.1 million to \$36.1 million, a decrease of 44.5%. Funding from the General Fund (SGF) decreased from \$13.7 to \$8.2 million.
- Part of the GF/MH and SGF reduction were supplanted with funding from the Alcohol and Drug Abuse Treatment and Prevention Fund and through ProShare funding.
- Between FY01 and FY06, Senior Services was the only beneficiary group that saw an increase in grant funding, increasing from \$12.5 million in FY01 to \$15.0 in FY06, an increase of 19.9%.
- Developmental Disability programs experienced the greatest decrease in grant funding, from \$25.8 million in FY01 to \$16.4 million in FY06, a decrease of 36%.
- Medicaid funds were split relatively evenly among beneficiary groups with the exception of the chronic alcoholics with psychosis beneficiary group who received only 2% of the total funding.

- Between FY01 and FY06 the traumatic brain injury beneficiary group showed the largest growth in the number of recipients receiving Medicaid services with a 133% increase. The developmental disabilities beneficiary group followed with a 56% increase, then the mental illness beneficiary group with 53%, then the Alzheimer's and related dementias beneficiary group with 22% and finally the chronic alcoholics with psychosis beneficiary group showed the smallest increase (17%).
- Consumers living in Anchorage accounted for 52% of Medicaid beneficiary expenditures from FY01 to FY05, followed by Southcentral with 23%, Southeast with 12%, Interior with 10%, Southwest with 3%, and Northwest and Outside each less than 1%.
- Recipient data show that 53% of Medicaid beneficiaries live in Anchorage, 21% in Southcentral Alaska, 10% in Southeast, 8% in the Interior, 5% in Southwest, and 1% in the Northwest and Outside.
- Key informants felt that dependence on Medicaid funding is adversely affecting beneficiary services, especially for those who are not Medicaid eligible.
- Providers are concerned that, with the current dependence on Medicaid, the State, consumers and providers have little to say about how services are provided. They also expressed concern about what might happen if there are federal cut-backs in Medicaid or if ProShare is determined to be an inappropriate method of service re-financing.
- Medicaid service unit rates have been frozen since FY04 and personal care assistance rates have been frozen since 1998.
- The regulatory and reporting requirements for Medicaid and grant services have increased administrative overhead for all providers. The service system has become more complex without additional funding to pay for the added tracking and billing.
- State grant dollars used to provide the flexibility programs needed to meet the needs of people who do not qualify for Medicaid.
- With grant funding remaining flat or decreasing and Medicaid rates frozen, providers are finding that it is becoming more and more difficult to support agency infrastructure.
- Programs feel that the partnership between agencies, consumers and the State has disappeared.
- A number of providers have taken out lines of credit to carry over their organization while waiting for state reimbursement for services. The dollars paid in interest on the lines of credit (in one case approximately \$100,000) would have gone to services.

- Providers said that they are no longer able to pay competitive wages and many have frozen salaries. They are finding it more and more difficult to recruit and retain qualified staff.

PROJECT SCOPE

The original scope of this project envisioned a longitudinal analysis of funding and access to services for Trust beneficiaries since FY01. The methodology called for the collection of financial and program information from grant files for agencies providing mental health, substance abuse, early intervention/infant learning, developmental disability and senior services.

Information Insights spent weeks searching through grantee files in the Department of Health and Social Services Grants and Contracts Office and the Department Auditor's Office collecting information from the 4th quarter grantee budget and program reports. With the assistance of Department grant and auditing personnel, the Information Insights team was able to locate all of the FY03 through FY07 files. Many of the FY01 and FY02 files were destroyed before the project began.

Information was collected on program income and expenditures by funding source, and number of people receiving services by types of services for each agency. The first files that were reviewed were the first quarter FY07 files. It was soon clear that the quality and consistency of the data dropped as the research team went further back through the records. The most serious issues were:

- **Budget Reports** - Some early year-end reports, usually small programs, were either missing or incomplete. There was inconsistency in reporting of revenues and expenditures, especially as it relates to Medicaid. Medicaid revenues were often recorded as program income, federal receipts, or not at all. There were so many inconsistencies, that the only way to be able to do an analysis would be to contact each agency and attempt to reconcile the data. This was not possible in the time allotted to the project and well beyond the scope of the contract.
- **Program Reports** – Alcohol and drug abuse programs had the best and most consistent consumer information. Until recently, mental health and early intervention programs provided quarterly totals of consumers served, but not an annual total. The FY06 reports have annual unduplicated counts for both programs. Developmental disabilities programs submit quarterly rosters of consumers detailing the types of services each consumer received. There is no unduplicated count of people receiving services on an annual basis.

While the available FY01 to FY05 grant records were incomplete and inconsistent, the good news is that by FY06, the quality of information in the quarterly reports is greatly improved. Longitudinal analysis of revenues, expenditures and consumers will be possible in the next few years. All state funded providers of beneficiary services submit quarterly reports. There are currently no data systems capable of providing the type of financial and service information included in the quarterly reports. In order to encourage the continued improvement in reporting, the Trust is encouraged to:

- Work with beneficiary boards, providers and the DHSS Grants and Contracts Office to assure that the information on the quarterly reports can provide the information needed for system monitoring and policy development.
- Provide agencies with guidance and training on completion of the quarterly budget reports so that there is consistency in entry of budget information, especially as it relates to Medicaid revenues and expenses.
- Require that all beneficiary programs provide annual unduplicated counts of consumers receiving services as part of the fourth quarter report.

Because the quality of the information in the grant records made it impossible to conduct a meaningful analysis of trends in funding or services, other sources of financial information were sought. This report relies on the Legislative Finance Office "authorized expenditures" reports for FY01 through FY05 and the FY06 Operating Budgets. These reports were available by online by Department and program.

The Department of Health and Social Services provided information on Medicaid recipients for FY01 through FY06. Key informant interviews were conducted with agency directors and others who have worked with beneficiaries for at least the past decade. They provided insights into how changes in funding affected agencies and consumers.

Grant Funding Trends: Funding by Program: FY01–FY06

Methodology: The Legislative Finance Division website provides authorized budgets for State departments and programs. Because FY06 authorized was not available, the FY06 operating budget figures were used. Information in the spreadsheets includes department, program, source of funding, grant programs and funding supporting department staff.

For analysis, programs were organized by beneficiary group for each fiscal year. All of the programs were in the Department of Health and Social Services, except senior services, which was a part of the Department of Administration in FY01 and FY02. Medicaid funding was not included in this analysis.

There are a number of large funding sources, such as General Fund/Mental Health (GF/MH), General Fund (GF) and federal receipts, and many smaller sources that were grouped together to simplify analysis. State General Funds includes General Fund, General Fund Match, General Fund/Mental Health, General Fund/Program Receipts and the Alcohol and Drug Abuse Treatment & Prevention Fund. Other Fund Sources includes Statutory Designated Program Receipts, Investment Loss Trust Fund, Receipt Supported Services, CIP Receipts, and the Tobacco Use Education and Cessation Fund.

Findings: Table 1 shows that total funding for beneficiary grant programs decreased from \$101.1 million in FY01 to \$91.8 million in FY06, a decrease of 9.2%. Funding from state general fund sources dropped from \$83.2 million in FY03 to \$61.4 million in FY04, which was the first year of funding through ProShare. Inter-agency receipts more than doubled, increasing from \$3.0 to \$8.7 million and Mental Health Trust Authority Authorized Receipts (MHTAAR) Fund increased slightly.

Table 2 shows the components of change for the combined State General Funds on Table 1. Between FY03 and FY04, the total authorized through General Fund/Mental Health funding decreased from \$65.1 million to \$36.1 million, a decrease of 44.5%. Funding from the General Fund decreased from \$13.7 to \$8.2 million. At the same time, the funding decreases were offset by an increase in funding through the Alcohol and Drug Abuse Treatment and Prevention Fund, from \$3.6 million to \$16.5 million. Grant funding through ProShare also replaced the reductions in GF and MH/GF funding.

Table 3 provides detail on grant funding through federal receipts (primarily the Substance Abuse and Mental Health Services Administration (SAMHSA) block grant and the five-year FASD project), MHTAAR funding, and Interagency Receipts. These funding sources remained relatively stable, except for the drop in Interagency Receipts in FY06.

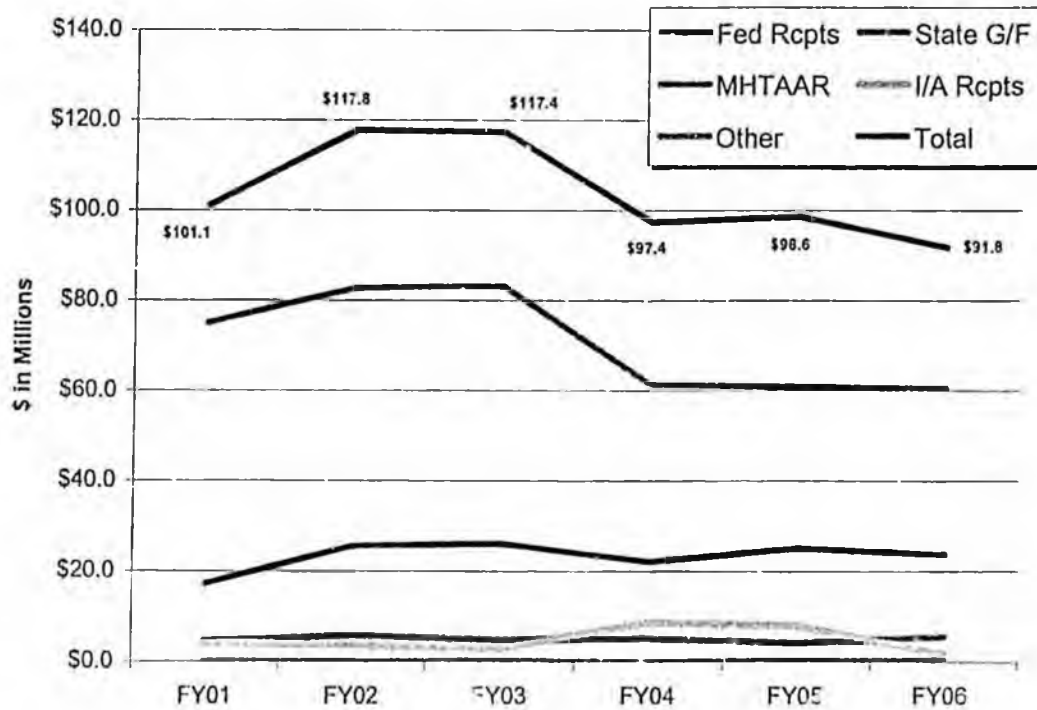
Table 4 shows the changes over time in grant funding for each beneficiary group. Starting in FY04, mental health and substance abuse services were combined into behavioral services. The FY04 budget combined what had been separate community grants into a single behavioral health line item. Programs for special services or populations, such as seriously mentally ill adults or the Alcohol Safety Action Program (ASAP) were still

separate line items and included in the analysis as either mental health or substance abuse.

The most striking aspect of Table 4 is the decrease in funding for substance abuse programs, which is mostly attributable to the integration of the community grants. However, the FY04 total for the mental health, substance abuse and behavioral health lines (\$70.7 million) is 9.2% less than the FY03 total for mental health and substance abuse (\$77.8 million).

Between FY01 and FY06, Senior Services was the only beneficiary group that saw an increase in grant funding, increasing from \$12.5 million in FY01 to \$15.0 in FY06, an increase of 19.9%. Grant funding for behavioral health services decreased by 4%, from \$62.8 million to \$60.4 million in FY06. Developmental Disability programs experienced the greatest decrease in grant funding, from \$25.8 million in FY01 to \$16.4 million in FY06, a decrease of 36%.

TABLE 1
AMHTA Beneficiary Grant Programs by Funding Source
FY01-FY05 Authorized, FY06 Operating Budget



Sources: Legislative Budget and Finance Historical Data, FY01 to FY05 Authorized and OMB DHSS FY06 Operating Budget

AMHTA Beneficiary Grant Programs by Funding Source
FY01-FY05 Authorized, FY06 Operating Budget
 (Grant program totals in \$ Thousands)

Fiscal Year	Federal Receipts	State General Fund*	MHTAAR	Inter-Agency Receipts	Other Fund Sources**	TOTAL
FY01	\$17,208.4	\$74,970.6	\$4,623.8	\$4,273.5	\$5.2	\$101,081.5
FY02	\$25,545.4	\$82,681.9	\$5,824.7	\$3,728.8		\$117,780.8
FY03	\$26,136.3	\$83,239.7	\$4,870.7	\$3,031.4	\$150.8	\$117,428.9
FY04	\$22,103.0	\$61,413.1	\$5,223.2	\$8,700.8		\$97,440.1
FY05	\$25,055.0	\$60,852.1	\$4,244.4	\$8,121.2	\$370.0	\$98,642.7
FY06	\$23,671.0	\$60,489.1	\$5,597.9	\$1,706.2	\$315.9	\$91,780.1

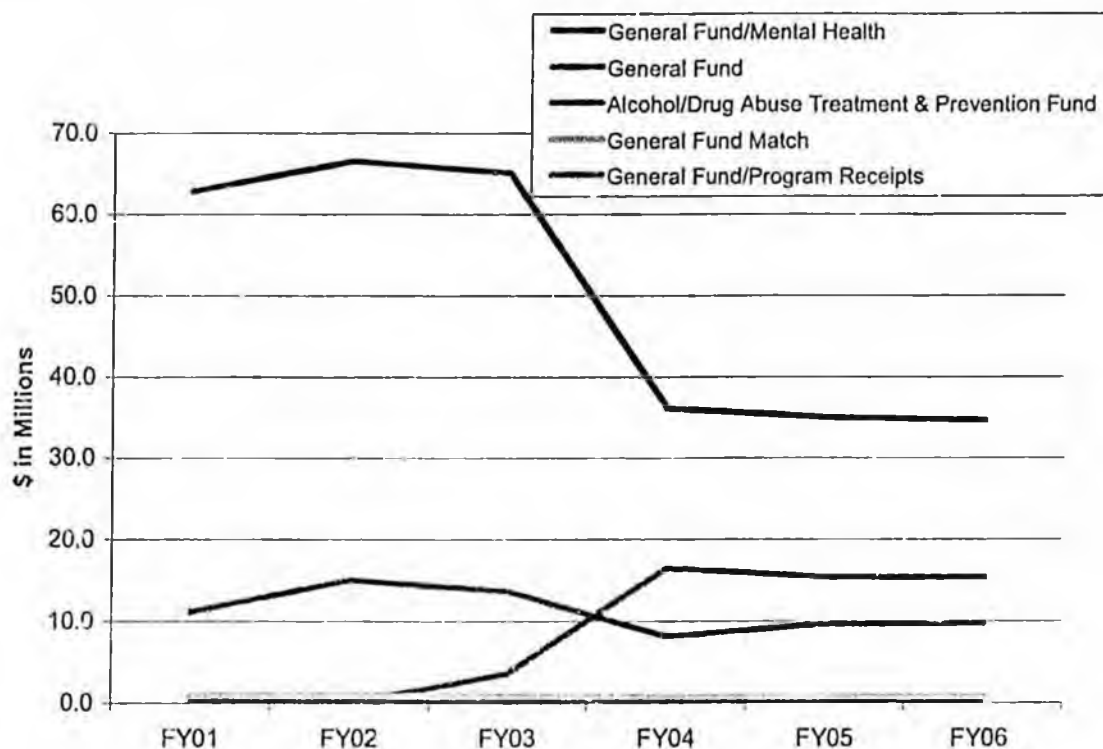
* State General Funds include:

- General Fund
- General Fund Match
- General Fund/Mental Health
- General Fund/Program Receipts
- Alcohol and Drug Abuse Treatment & Prevention Fund

** Other Fund Sources include:

- Statutory Designated Program Receipts
- Investment Loss Trust Fund
- Receipt Supported Services
- CIP Receipts
- Tobacco Use Education and Cessation Fund

TABLE 2
AMHTA Beneficiary Grant Programs: State General Fund Sources
FY01-FY05 Authorized, FY06 Operating Budget



Sources: Legislative Budget and Finance Historical Data, FY01 to FY05 Authorized and OMB DHSS FY06 Operating Budget

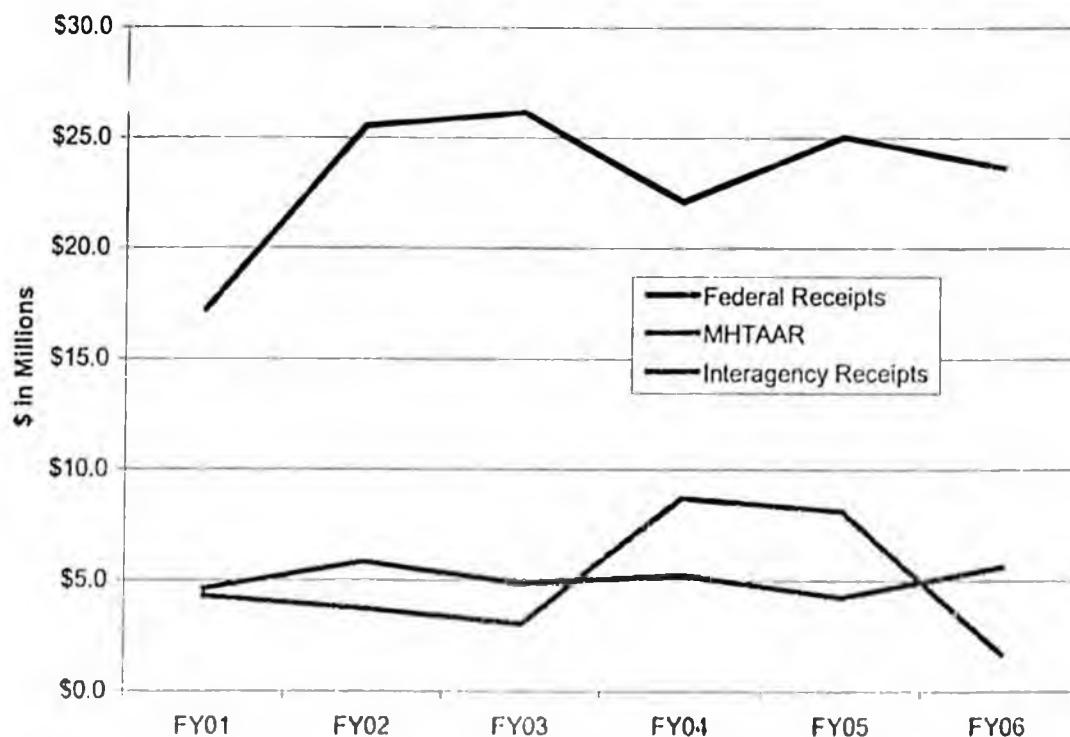
AMHTA Beneficiary Grant Programs: State General Fund Sources
FY01-FY05 Authorized, FY06 Operating Budget
(Grant program totals in \$ Thousands)

Fiscal Year	General Fund/Mental Health	General Fund	Alcohol/Drug Abuse Treatment & Prev. Fund	General Fund Match	General Fund/Program Receipts	Total
FY01	\$62,819.8	\$11,161.7		\$842.7	\$146.4	\$74,970.6
FY02	\$66,559.8	\$15,077.7		\$896.1	\$148.3	\$82,681.9
FY03	\$65,114.1	\$13,682.9	\$3,600.0	\$842.7		\$83,239.7
FY04	\$36,090.0	\$8,151.5	\$16,527.2	\$644.4		\$61,413.1
FY05	\$35,003.1	\$9,670.1	\$15,403.0	\$775.9		\$60,852.1
FY06	\$34,645.7	\$9,758.2	\$15,403.0	\$682.2		\$60,489.1

State General Funds include:

- General Fund
- General Fund Match
- General Fund/Mental Health
- General Fund/Program Receipts
- Alcohol and Drug Abuse Treatment & Prevention Fund

TABLE 3
AMHTA Beneficiary Grant Programs
Federal Receipts, MHTAAR and Interagency Receipts
FY01-FY05 Authorized, FY06 Operating Budget

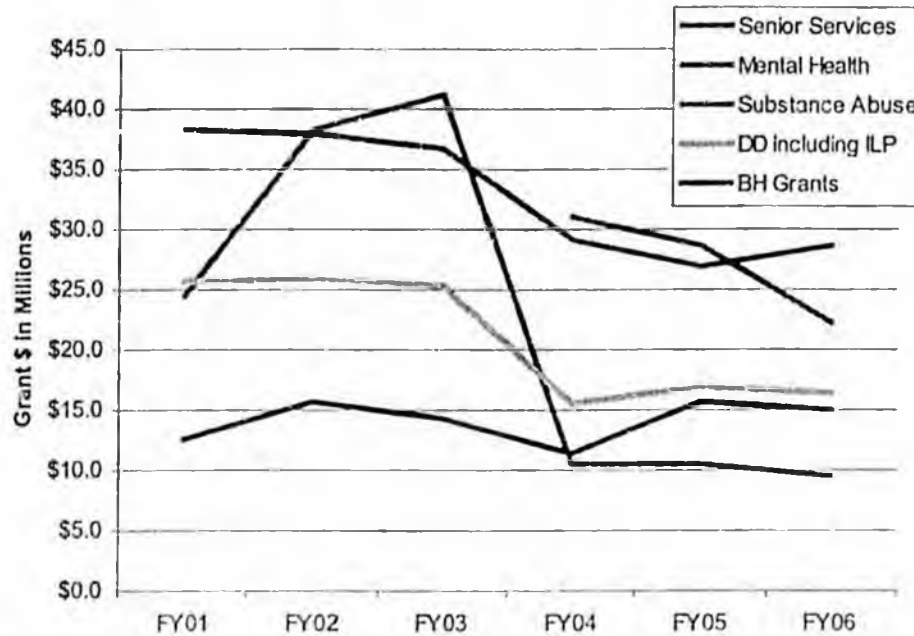


Sources: Legislative Budget and Finance Historical Data, FY01 to FY05 Authorized and OMB DHSS FY06 Operating Budget

AMHTA Beneficiary Grant Programs
Federal Receipts, MHTAAR and Interagency Receipts
FY01-FY05 Authorized, FY06 Operating Budget
 (Grant program totals in \$ Thousands)

Fiscal Year	Federal Receipts	MHTAAR	Interagency Receipts	TOTAL
FY01	\$17,208.4	\$4,623.8	\$4,273.5	\$26,105.7
FY02	\$25,545.4	\$5,824.7	\$3,728.8	\$35,098.9
FY03	\$26,136.3	\$4,870.7	\$3,031.4	\$34,038.4
FY04	\$22,103.0	\$5,223.2	\$8,700.8	\$36,027.0
FY05	\$25,055.0	\$4,244.4	\$8,121.2	\$37,420.6
FY06	\$23,671.0	\$5,597.9	\$1,706.2	\$30,975.1

TABLE 4
Grant Funding by DHSS Program: FY01 -- FY06*



Sources: Legislative Budget and Finance Historical Data, FY01 to FY05 Authorized and OMB DHSS FY06 Operating Budget

* Mental Health and Substance Abuse Community Grants were combined beginning in FY04 and recorded as Behavioral Health Grants.

Grant Funding by DHSS Program: FY01 – FY06*

Program	FY01	FY02	FY03	FY04	FY05	FY06
Senior Services	\$12,529.4	\$15,717.3	\$14,348.2	\$11,329.4	\$15,758.0	\$15,019.3
Mental Health	\$38,253.1	\$38,011.4	\$36,652.7	\$29,184.8	\$26,820.8	\$28,638.8
Substance Abuse	\$24,547.3	\$38,217.5	\$41,168.4	\$10,477.8	\$10,523.4	\$9,550.3
DD (including ILP)	\$25,751.7	\$25,834.6	\$25,259.6	\$15,519.2	\$16,949.6	\$16,394.0
Behavioral Health Grants				\$30,998.9	\$28,590.9	\$22,177.7
TOTAL	\$101,081.5	\$117,780.8	\$117,428.9	\$97,510.1	\$98,642.7	\$91,780.1

Medicaid Funding: FY01–FY06

Methodology: Information Insights requested Medicaid data from staff at the Department of Health and Social Services, Division of Health Care Services related to potential Alaska Mental Health Trust Authority clients. Since Trust beneficiaries are not identified as such in the Medicaid data, CPT codes were used to determine who was a beneficiary and who was not. The Department provided Medicaid data for those CPT codes for services likely to be provided to Trust beneficiaries. Data related to 101 original CPT service codes and 80 replacement CPT codes were provided in three Excel data files. See the appendices for a complete list of the CPT codes. Data were transferred to SPSS statistical software for analysis.

The Recipient Location file contained 4,336 records with fiscal year, provider name, provider city and state, client city and state, PCA category, whether that category was modified, procedure code, procedure code modifier, count of distinct recipients, and sum of payments. These records do not allow for a count of unique clients. A client could be counted multiple times if he or she received services from multiple providers. That client would have been counted once for each provider he or she used, however, funding totals would not be double counted since they reflect the cost of services provided. It should be noted that while the document contained 4,336 records, they reflect services to many more clients.

The Procedure Codes files contained 19,931 records with fiscal year, provider name, provider city and state, CPT code, CPT code modifier, recipients, and net payments. These records do not allow for a count of unique clients. A client could be counted multiple times if he or she received services from multiple providers. That client would have been counted once for each provider he or she used, however, funding totals would not be double counted since they reflect the cost of services provided. It should be noted that while the document contained 19,931 records, they reflect services to many more clients.

The Ethnicity and Diagnosis file contained 87,400 records with fiscal year, provider name, provider city and state, ethnicity, diagnosis 1, diagnosis 2, recipients, and net payments. These records do not allow for a count of unique clients. A client could be counted multiple times if he or she received services from multiple providers. That client would have been counted once for each provider he or she used; however, funding totals would not be double counted since they reflect the cost of services provided.

The diagnosis codes were used to determine which records belonged to Trust beneficiaries. Among the 87,400 records in the Ethnicity and Diagnosis file, there were 1,767 unique diagnoses. The definitions of the Trust beneficiary groups from the Trust's website were used to determine which diagnosis codes should be included in each beneficiary group. (See the appendices for the Trust beneficiary group definitions.) The diagnosis codes assigned to each beneficiary group were reviewed by a steering committee composed of representatives of the beneficiary boards prior to analysis. (See

the appendices for a list of diagnosis codes included in each beneficiary group for this analysis.) Using the diagnosis codes narrowed the recipient pool considerably. Clients who had received a service with a CPT code that made them likely Trust beneficiaries, but whose primary medical diagnosis was not one that would cause them to be a beneficiary were eliminated. The pool of records believed to represent Trust beneficiaries shrank to the 71,961.

Providers were assigned to regions to correspond with DHSS regions. Analyses were then conducted to determine recipient by fiscal year, spending by fiscal year by region for each beneficiary group, recipients by fiscal year by region for each beneficiary group, and PCA services by census area.

Findings: By Beneficiary Group - The smaller diagnosis-based data set was analyzed for dollars spent and for recipients. Spending data were analyzed by fiscal year, by region and beneficiary group. Total spending during the six-year period was \$1,284,657,267. Funding was split relatively evenly among beneficiary groups with the exception of the chronic alcoholics with psychosis beneficiary group who received only 2% of the total funding. The mental illness beneficiary group received 28% of the funding, followed by 27% for the Alzheimer's and related dementias beneficiary group, then 26% for the developmental disabilities beneficiary group and 18% for services that we were unable to clearly assign between the Alzheimer's and related dementias beneficiary group and the developmental disabilities beneficiary group.

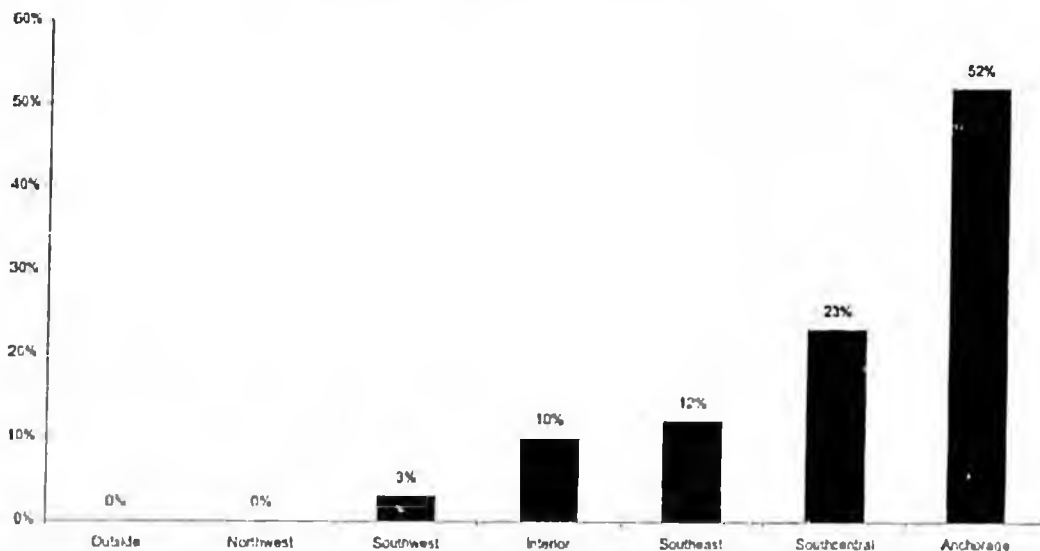
Between FY01 and FY06 there were dramatic changes in the level of funding. The growth was not at all evenly spread between beneficiary groups. The Alzheimer's and related dementias beneficiary group had the largest increase with a 701% funding increase during this six-year period. This was followed by the mental illness beneficiary group which saw a 554% increase in funding during this period. The remaining groups did not show nearly as dramatic an increase in funding. The funding for services we were unable to clearly assign between the Alzheimer's and related dementias beneficiary group and the developmental disabilities beneficiary group did not quite double during this time, increasing 92%. The chronic alcoholics with psychosis beneficiary group and the developmental disabilities beneficiary group each showed a relatively modest 14% funding increase.

Recipient data is not unique and represents unique clients at each provider, not unique clients across providers. Recipient data were analyzed by fiscal year, by region and beneficiary group. There were 150,508 recipients. The vast majority (82%) were in the mental illness beneficiary group, followed by 12% in the developmental disability beneficiary group, 5% in the chronic alcoholics with psychosis beneficiary group, 2% in the Alzheimer's and related dementias beneficiary group, and less than 1% in the traumatic brain injury beneficiary group. Between FY01 and FY06 the traumatic brain injury beneficiary group showed the largest growth in the number of recipients with a 133% increase. The developmental disabilities beneficiary group followed with a 56% increase, then the mental illness beneficiary group with 53%, then the Alzheimer's and related dementias beneficiary group with 22% and finally the chronic alcoholics with

psychosis beneficiary group showed the smallest increase during that time period with a 17% increase.

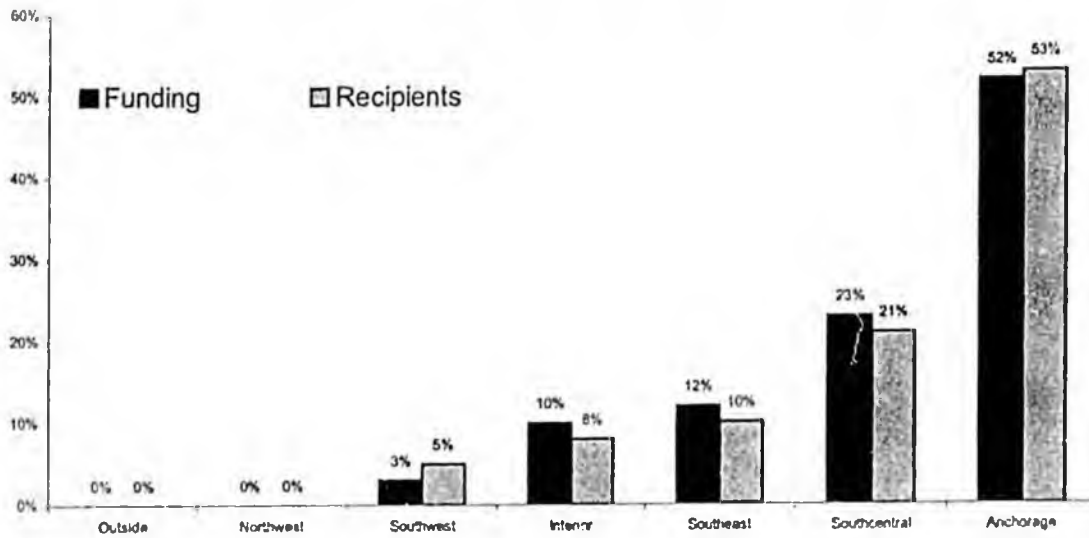
By region and fiscal year: Funding data were analyzed for all beneficiary groups by region with Anchorage receiving 52% of the funding during this period, followed by Southcentral with 23%, Southeast with 12%, Interior with 10%, Southwest with 3%, and Northwest and Outside each less than 1%.

Funding as a percentage of FY01-FY06 total by region



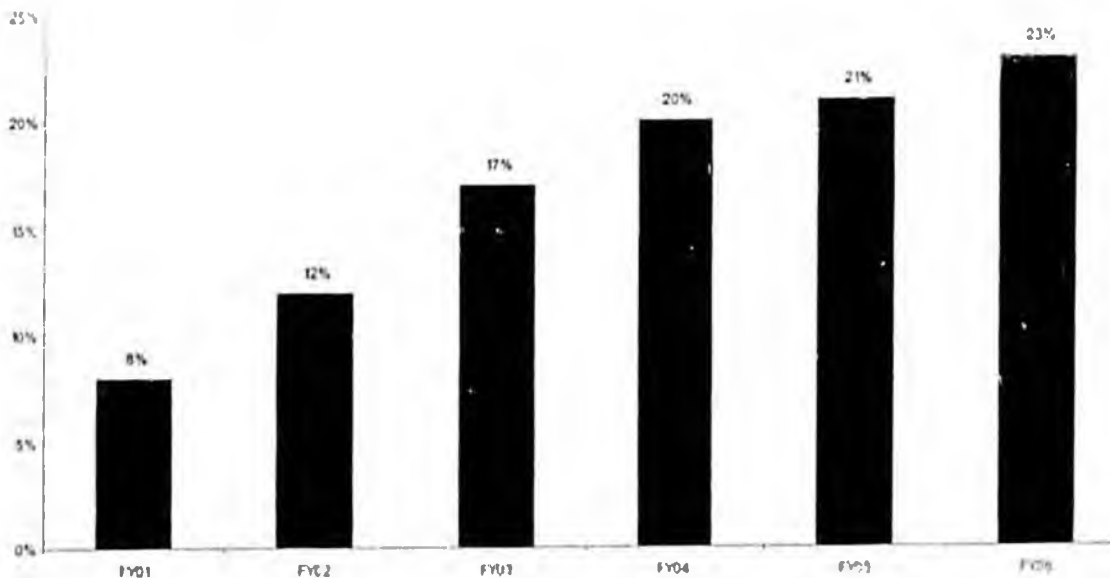
Recipient data were also analyzed by region with Anchorage accounting for 53% of recipients, Southcentral 21%, Southeast 10%, Interior 8%, Southwest 5%, and Northwest and Outside 1% each. While the funding by region is nowhere near equally split, it reflects recipients by region.

Funding & recipients as percentage of total during FY01-FY06 period



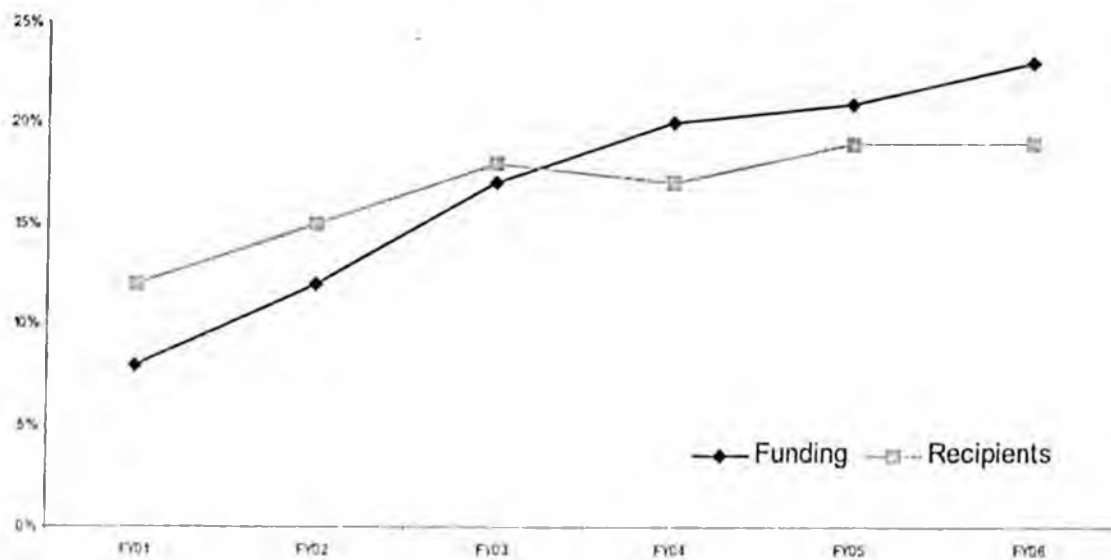
As a percentage of the total funding for the six-year period, the percentage claimed by more recent years is increasing. Eight percent of the total funding was spent in FY01 while 23% was spent in FY06. The percentage climbed each fiscal year—FY01 was 8%, FY02 12%, FY03 17%, FY04 20%, FY05 21% and FY06 23%.

Funding as a percentage of six year total by fiscal year



A similar trend can be seen among recipients. For all beneficiary groups, the trend of recipients is climbing very slowly. FY01 accounted for 12% of recipients, FY02 15%, FY03 18%, FY04 17%, and FY05 and FY06 each accounting for 19% of the total recipients during this six year period. As shown below, the rise in funding is happening much faster than the rise in recipients.

Funding & recipients as percentage of total by fiscal year



Key Informants: Changes in Funding and Access

While an analysis of program funding tells part of the story, it provides little detail for how re-financing affected services to beneficiaries. In order to give a more complete picture of how services have changed since FY01, key informant interviews were conducted with service providers for each of the beneficiary groups. Administrators who have long-term perspectives from many years as service providers were asked for their opinions and observations.

The key informant comments fell into five general categories. The following is a summary of their thoughts:

1. **Impact of Re-financing:** All of the key informants interviewed felt that dependence on Medicaid funding is adversely affecting beneficiary services, especially for those who are not Medicaid eligible. They said that Medicaid refinancing worked when there was a balance between funding sources – Medicaid, grant funding, Tricare, and private or insurance dollars. The system has tipped too far and is too dependent on Medicaid.

Medicaid Waivers and mental health funded services provide services to those with the most intensive needs. Medicaid funding does not pay for preventive treatment. One behavioral health provider noted that consumers have to get worse to get services. A developmental disabilities provider said that it was difficult to explain to families the difference between a Medicaid Waiver and a grant service, and why one person gets services and another doesn't.

Another example is the State initiative to integrate mental health and substance abuse into behavioral health. A substance abuse program provider noted that they were still not able to bill for most substance abuse services and that reimbursement rates for essentially the same units of service are higher for mental health providers.

Another concern for providers is that, with the current dependence on Medicaid, the State, consumers and providers have little to say about how services are provided. For example, many mental health providers have eliminated their residential services because Medicaid does not pay for it. This has left many consumers who need support on their own. A number of key informants expressed concern that cut backs in federal funding for Medicaid will mean loss of services if the State does not increase grant funding to replace federal dollars.

A senior services provider said that some agencies are still using Medicaid Waiver reimbursement rates negotiated in FY01 and there has been no increase in the personal care unit rate since 1998. All rates were frozen in FY04. The provider thought that most programs are probably taking a loss on Medicaid Waiver services.

- 2. Importance of Grant Dollars:** Key informants said that State grant dollars used to provide the flexibility programs needed to meet the needs of people who do not qualify for Medicaid. A director noted that 25% of developmental disability consumers are not Medicaid eligible. They felt that there is now a lack of equity in the system between Medicaid and non-Medicaid consumers.

Some of the key respondents observed that as grant dollars decreased, State control of services increased. One director noted that, if there's an opening in respite, the DSDS Regional Program Specialist goes to the wait list and awards the services to the person with the highest score, rather than someone who might have a lower score but needs the service now. He said that programs needed the flexibility to provide services to people as they come through the door in need of help.

A substance abuse provider said that the temporary nature of federal grants leads to inconsistency in services. The example the provider cited was the federally funded FASD Prevention Project, which brought \$25 million in prevention and treatment services to the state for five years. Now that the program has ended, there are a few diagnostic teams still providing services, but all of the prevention services are gone.

With grant funding remaining flat or decreasing, all of the key informants said that it is becoming more and more difficult to support their agency's infrastructure. A director of a developmental disability program said that grant funding for the program dropped 34% between FY01 and FY06. The cost of Worker's Compensation, health insurance, food and fuel increased and agencies are freezing salaries, laying off workers and tapping reserves to fund shortfalls.

- 3. Increased Regulation and Reporting Requirements:** The regulatory and reporting requirements for Medicaid services have increased administrative overhead for all providers. The service system has become more complex without additional funding to pay for the added tracking and billing. All of the programs have added new positions to handle paperwork and billing using funds that could have gone into direct services.

A developmental disability program providers pointed out that the State will soon require that grant funded services be reported on the same unit basis as Medicaid Waiver services, thereby further increasing administrative overhead costs.

- 4. The Relationship Between Consumers, Agencies and the State:** Programs feel that the partnership between agencies, consumers and the State has disappeared. The developmental disability and mental health providers noted that families have less input and control over services than they did in the past. One provider said that the role of the State should be funding, accreditation, and oversight and not micro-managing and dictating treatment.

They also felt that the State not is not providing enough technical assistance, and that if an agency makes a mistake they lose funding without an adequate explanation of

how to correct the problem. This is particularly an issue with Medicaid billing and audit requirements.

5. **Payment Issues:** A number of key informants noted that the State used to pay prospectively each quarter, with a percentage of the total set aside until all requirements were met at the end of the fiscal year. Now agencies do not receive payments until they submit their quarterly report, and sometimes months later. As a result, many agencies have taken out lines of credit. The dollars paid in interest on the lines of credit (in one case approximately \$100,000) would have gone to services. One agency exhausted their line of credit waiting for an advance from the State and had to put their building up as collateral. Many programs now receive their grant funding through Providence Medical Center and the ProShare program. All payments are now on a reimbursable basis.
6. **Workforce Issues:** All of the key informants said that they are no longer able to pay competitive wages. A developmental disabilities provider said that health insurance had increased 103% in 3 years. Another provider said that they had laid off the agency's IT coordinator, staff development director, care coordination director, facility manager, and much of the mid-management. A substance abuse director said that cuts in the Rural Human Services program resulted in reduction in hours for village Rural Human Services (RHS) Program workers and the loss of coordinator positions. The majority of people served by the RHS program receive substance abuse services.

Key informants also noted that there were no time or resources left for staff training and that they are very concerned about how this is impacting the quality of services. A mental health provider noted that their agency's 4-year salary freeze impacts their ability to recruit and retain staff.

APPENDICES

ProShare Funding by Division and Component: FY03 – FY08

Division	Component	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
OCS	Family Preservation	250,000	52,636	802,860	690,593	690,594	690,593
OCS	Human Svr Comm Match Grants	1,278,400					
OCS	Residential Child Care	1,309,148					
DPH	Community Health Grants	760,360	3,333,440	2,510,281	2,510,281	2,510,281	2,510,281
DPH	Emergency Medical Services	1,710,100	1,710,100				
DPH	Epidemiology	63,000					
DPH	Tobacco	1,498,125					
DPH	Nursing	298,844					
DSDS	Community Dev. Dis. Grants	11,216,229	12,955,709	10,314,467	10,314,457	10,314,467	10,314,467
DBH	Behavioral Health Grants	237,100	4,547,943	7,398,324	7,385,495	7,385,503	7,385,503
DBH	Substance Abuse Treatment Programs	120,000					
DBH	Psych Emergency Services	1,757,700		3,494,703	3,494,699	3,494,703	3,494,703
DBH	CMI Services	5,978,100	7,483,200	7,121,534	7,134,347	7,121,534	7,121,534
DBH	SED Youth Services	2,496,108	609,800	1,931,054	1,931,052	1,931,054	1,931,054
	Total Grants	28,973,214	30,692,828	33,573,223	33,460,924	33,448,137	33,448,135

Source: DHSS FMS, Medicaid Budget Group

**Alaska Mental Health Trust
Medicaid Study
Beneficiary Group Definitions**

Beneficiary Groups:

- People with Mental Illness
- People with Developmental Disabilities
- People with Chronic Alcoholism
- People with Alzheimer's Disease and Related Disorders
- People with Traumatic Head Injury Resulting in Permanent Brain Injury

People with Mental Illness

Beneficiary group: People with Mental Illness

Statutory definition: "The Mentally Ill" includes persons with the following mental disorders:

1. schizophrenia;
2. delusional (paranoid) disorder;
3. mood disorders;
4. anxiety disorders;
5. somatoform disorders;
6. organic mental disorders;
7. personality disorders;
8. dissociative disorders;
9. other psychotic or severe and persistent mental disorders manifested by behavioral changes and symptoms of comparable severity to those manifested by persons with mental disorders listed in this subsection; and
10. persons who have been diagnosed by a licensed psychologist, psychiatrist, or physician licensed to practice medicine in the state and, as a result of the diagnosis, have been determined to have a childhood disorder manifested by behaviors or symptoms suggesting risk of developing a mental disorder listed in this subsection.

[AS 47.30.056(d)]

People with Developmental Disabilities

Beneficiary group: People with Developmental Disabilities

Statutory definition: " *The Mentally Defective and Retarded*" includes persons with the following neurologic or mental disorders:

1. cerebral palsy;
2. epilepsy;
3. mental retardation;
4. autistic disorder;
5. severe organic brain impairment;

6. significant developmental delay during early childhood indicating risk of developing a disorder listed in this subsection;
7. other severe and persistent mental disorders manifested by behaviors and symptoms similar to those manifested by persons with disorders listed in this subsection.

[AS 47.30.056(e)]

GCDSE definition: The Governor's Council on Disabilities and Special Education uses the state's definition of a person with a developmental disability to define The Trust's beneficiaries. Alaska's definition of a developmental disability, amended in 1992, is consistent with the federal definition. According to AS 47.80.900 (7): "...person with a developmental disability?" means a person who is experiencing a severe, chronic disability that

- A. is attributable to a mental or physical impairment or combination of mental and physical impairments;
- B. is manifested before the person attains age 22;
- C. is likely to continue indefinitely;
- D. results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and
- E. reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

In addition, the Council considers infants and toddlers who have developmental delays and who are at risk of acquiring developmental disabilities to be Trust beneficiaries. These children ages birth to three have disabilities or delays which can be significantly ameliorated or whose function can be maximized at an early age, but who would otherwise require more intensive long-term services.

People with Chronic Alcoholism

Beneficiary group: People with Chronic Alcoholism

Statutory definition: "Chronic Alcoholics with Psychoses" includes persons with the following disorders:

1. alcohol withdrawal delirium (delirium tremens);
2. alcohol hallucinosis;
3. alcohol amnesiac disorder;
4. dementia associated with alcoholism;
5. alcohol-induced organic mental disorder;
6. alcoholic depressive disorder;
7. other severe and persistent disorders associated with a history of prolonged or excessive drinking or episodes of drinking out of control and manifested by behavioral changes and symptoms similar to those manifested by persons with disorders listed in this subsection.

[AS 47.30.056(f)]

ABADA definition: The Advisory Board on Alcohol and Drug Abuse has developed an operational definition of alcoholism with psychosis which translates the above data into assessment features collected in the State's Management Information System, which is collected

by all state-funded treatment programs along with those previously funded by the Indian Health Service and those private providers who choose to collect and report the data. These criteria are as follows:

- alcohol is first drug of choice (information collected from initial assessment)
- client assessed as either dysfunctional or dependent
- client reports consuming alcohol at least six days per week (this question is eliminated for persons receiving services while incarcerated in the penal system)

People with Alzheimer's Disease and Related Disorders

Beneficiary group: People with Alzheimer's Disease and Related Disorders

Statutory definition: "Senile people who as a result of their senility suffer major mental illness" includes persons with the following mental disorders:

1. primary degenerative dementia of the Alzheimer type;
2. multi-infarct dementia;
3. senile dementia;
4. presenile dementia;
5. other severe and persistent mental disorders manifested by behaviors and symptoms similar to those manifested by persons with disorders listed in this subsection.

[AS 47.30.056(f)]

ACoA definition: The Alaska Commission on Aging (ACoA) finds that, in the case of Alzheimer's Disease, there is no definitive diagnostic test and the diagnosis becomes one of exclusion. In defining the population for which they advocate, the Commission includes people with Alzheimer's disease, stroke, frail with no cognitive impairment, and other Alzheimer's Disease and other Related Dementia (ARD) including Supra Nuclear Palsy, cerebral atrophy, Huntington's chorea, brain tumor, attention deficit disorder with cognitive impairment, Pick's disease, multiple sclerosis, organic brain disorder, multi-infarct dementia, Parkinson's disease, cancer-related dementia, hydrocephalus, and hypoxia.

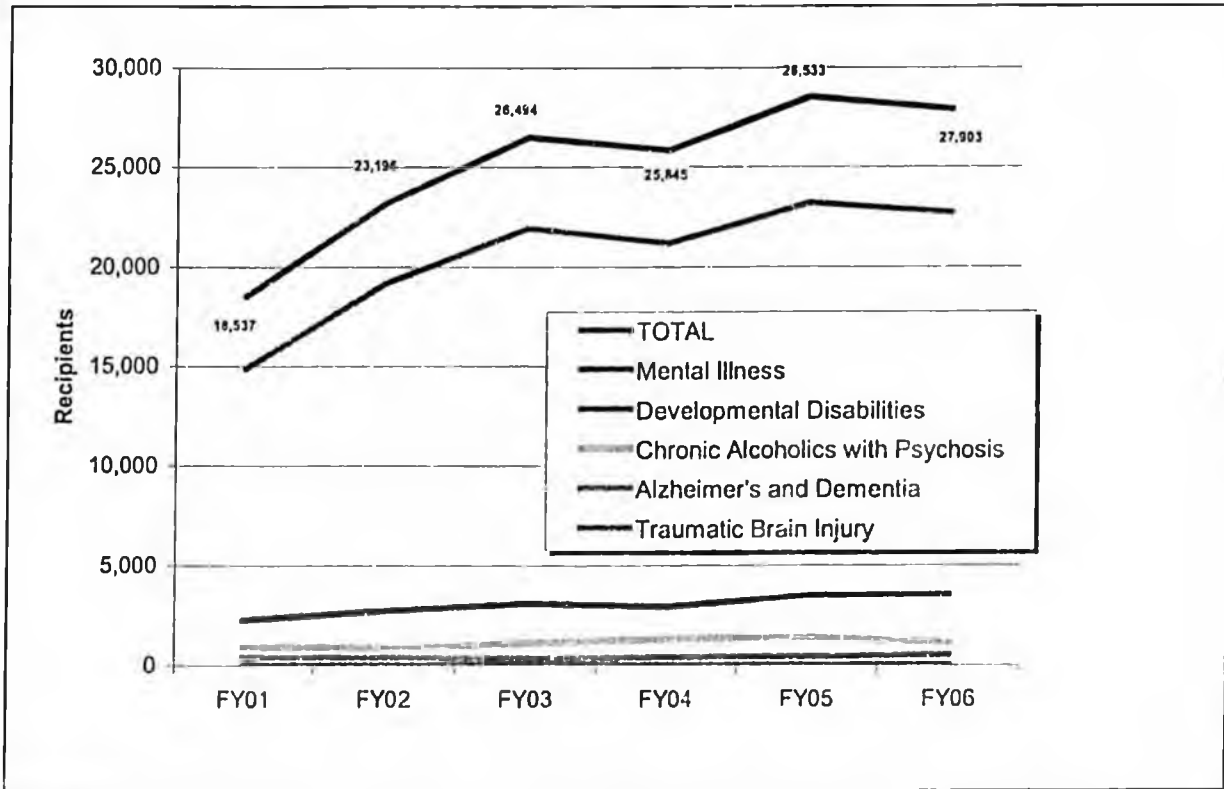
A very few people with cognitive impairments related to other diagnoses qualify in this population: people with alcohol-related dementia, chronic mental illness, major depression, brain injury, developmental disability, DD-related Alzheimer's, and AIDS-related dementia. The common denominator among these diagnoses is cognitive impairment, except for the frail category.

People with a Traumatic Head Injury Resulting in Permanent Brain Injury

Beneficiary group: People with a Traumatic Head Injury Resulting in Permanent Brain Injury

Definition: Includes head injuries that result in cognitive impairment similar to that described in the Alzheimer's Disease or Related Dementia section above.

**Medicaid Recipients by Beneficiary Group: FY01 – FY06
Duplicated at the Service Provider Level**



**Medicaid Recipients by Beneficiary Group: FY01 – FY06
Duplicated at the Service Provider Level**

Fiscal Year	Mental Illness	Developmental Disabilities	Chronic Alcoholics w/Psychosis	Alzheimer's and Dementia	Traumatic Brain Injury	TOTAL
FY01	14,889	2,272	964	406	6	18,537
FY02	19,176	2,726	888	404	2	23,196
FY03	21,924	3,109	1,124	332	5	26,494
FY04	21,179	2,936	1,316	404	10	25,845
FY05	23,213	3,495	1,402	419	4	28,533
FY06	22,715	3,552	1,125	497	14	27,903

**Medicaid Recipients by Beneficiary Group and Region: FY01 – FY06
Duplicated at the Service Provider Level**

Beneficiary Group/ Fiscal Group	Northwest	Interior	Southwest	Southeast	Southcentral	Anchorage	Outside	Total
Mental Illness								
FY01	101	1,496	728	1,170	2,984	8,295	115	14,889
FY02	147	1,665	773	1,877	4,025	10,540	149	19,176
FY03	287	1,718	965	1,967	4,281	12,426	280	21,924
FY04	202	1,845	1,209	1,971	4,499	11,064	389	21,179
FY05	256	1,965	1,280	2,579	4,392	12,466	275	23,213
FY06	327	2,089	1,130	2,649	4,287	12,015	218	22,715
Chronic Alcoholics with Psychosis								
FY01	11	80	105	187	266	315	0	964
FY02	15	91	97	203	227	254	1	888
FY03	28	63	110	230	283	410	0	1,124
FY04	32	65	161	241	289	519	9	1,316
FY05	29	77	175	305	334	472	9	1,402
FY06	37	70	145	245	241	384	3	1,125
Alzheimer's and Related Dementias								
FY01	0	24	37	57	88	184	16	406
FY02	2	29	28	32	79	224	10	404
FY03	5	23	70	44	72	114	4	332
FY04	5	28	53	29	130	158	1	404
FY05	4	23	102	28	110	150	2	419
FY06		4	78	47	176	180	7	497
Developmental Disabilities								
FY01	17	203	27	156	466	1,402	1	2,272
FY02	34	223	35	182	659	1,590	3	2,726
FY03	52	244	63	249	817	1,673	11	3,109
FY04	44	223	95	232	843	1,479	20	2,936
FY05	40	231	118	357	824	1,915	10	3,495
FY06	57	233	156	382	793	1,919	12	3,552
Traumatic Brain Injury								
FY01	0	0	0	0	1	3	2	6
FY02	0	0	0	0	0	1	1	2
FY03	0	0	0	0	1	4	0	5
FY04	0	0	0	1	1	8	0	10
FY05	0	0	0	0	0	4	0	4
FY06	0	0	0	4	2	8	0	14

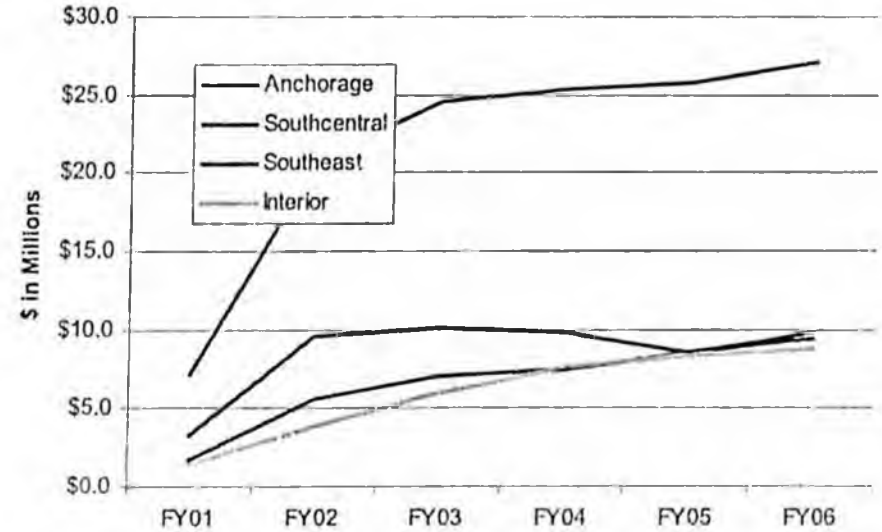
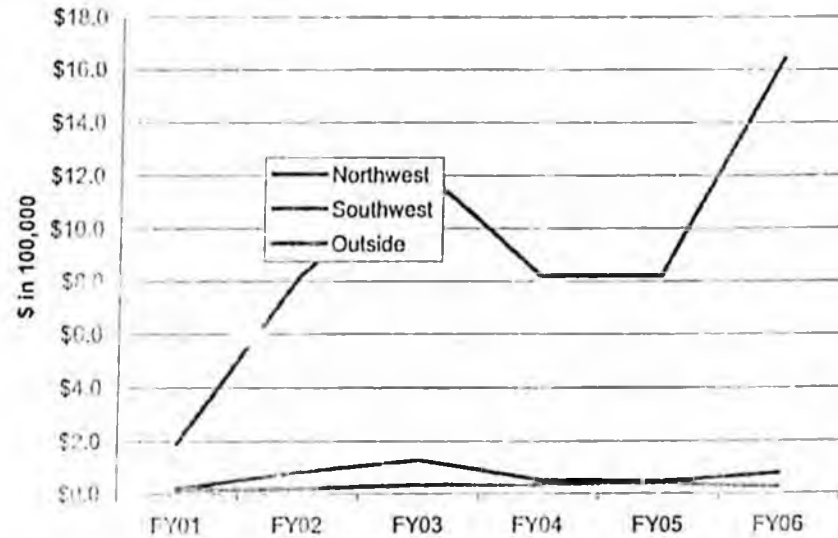
**Change in Number of Medicaid Recipients by Beneficiary Group: FY01 – FY06
 Duplicated at the Service Provider Level**

Beneficiary Group	FY01	FY06	Change FY01-06	% Change
Mental Illness	14,889	22,715	7,826	52.6%
Developmental Disabilities	2,272	3,552	1,280	56.3%
Chronic Alcoholics with Psychosis	964	1,125	161	16.7%
Alzheimer's and Related Dementias	406	497	91	22.4%
Traumatic Brain Injury	6	14	8	133.3%

**Medicaid Recipients by Beneficiary Group and Ethnicity: FY01 – FY06
Duplicated at the Service Provider Level**

Beneficiary Group/ Fiscal Group	White	AK Native/ Amer. Indian	Asian	Black	Hispanic	Pacific Islander	Other/ Unknown	Total
Mental Illness								
FY01	8754	4,319	277	889	310	69	271	14,889
FY02	11,180	5,492	354	1,232	414	95	409	19,176
FY03	12,319	6,642	459	1,284	569	128	523	21,924
FY04	11,476	6,826	490	1,215	525	149	498	21,179
FY05	12,004	8,124	466	1,436	558	193	432	23,213
FY06	11,887	7,998	472	1,257	505	178	418	22,715
Chronic Alcoholics with Psychosis								
FY01	389	534	1	19	13	0	8	964
FY02	369	470	1	16	16	0	16	888
FY03	428	622	5	34	19	1	15	1,124
FY04	436	812	1	34	11	5	17	1,316
FY05	387	959	1	20	17	3	15	1,402
FY06	321	768	2	15	10	2	7	1,125
Alzheimer's and Related Dementias								
FY01	214	143	8	26	5	0	10	406
FY02	237	103	9	34	11	0	10	404
FY03	153	139	9	16	5	0	10	332
FY04	208	146	9	16	13	0	12	404
FY05	185	187	6	19	9	2	11	419
FY06	254	184	12	18	11	4	14	497
Developmental Disabilities								
FY01	1,371	568	15	227	25	21	45	2,272
FY02	1,630	689	24	225	62	26	70	2,726
FY03	1,776	850	24	283	66	10	100	3,109
FY04	1,657	879	27	219	49	17	88	2,936
FY05	1,894	1,085	58	266	74	28	90	3,495
FY06	1,861	1,185	50	252	96	30	78	3,552
Traumatic Brain Injury								
FY01	6	0	0	0	0	0	0	6
FY02	2	0	0	0	0	0	0	2
FY03	5	0	0	0	0	0	0	5
FY04	5	0	1	0	2	0	2	10
FY05	1	2	1	0	0	0	0	4
FY06	8	5	0	0	0	0	1	14

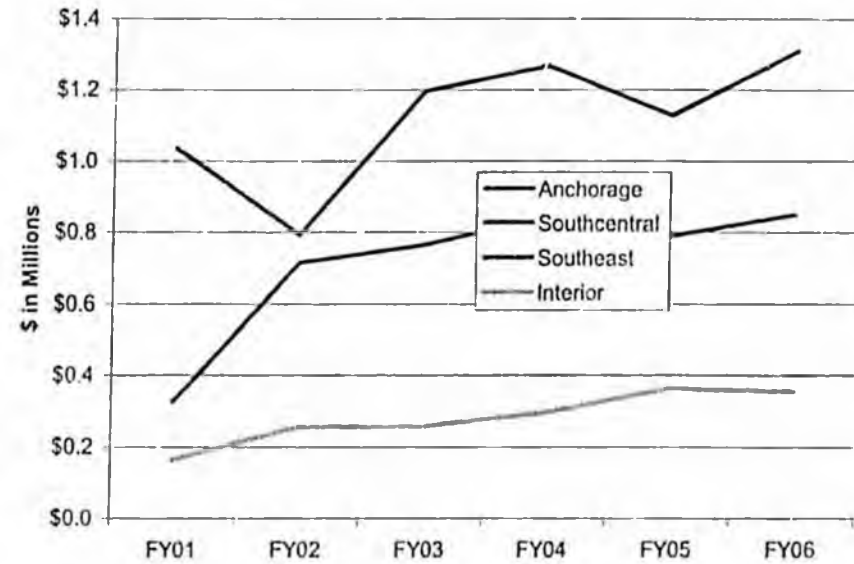
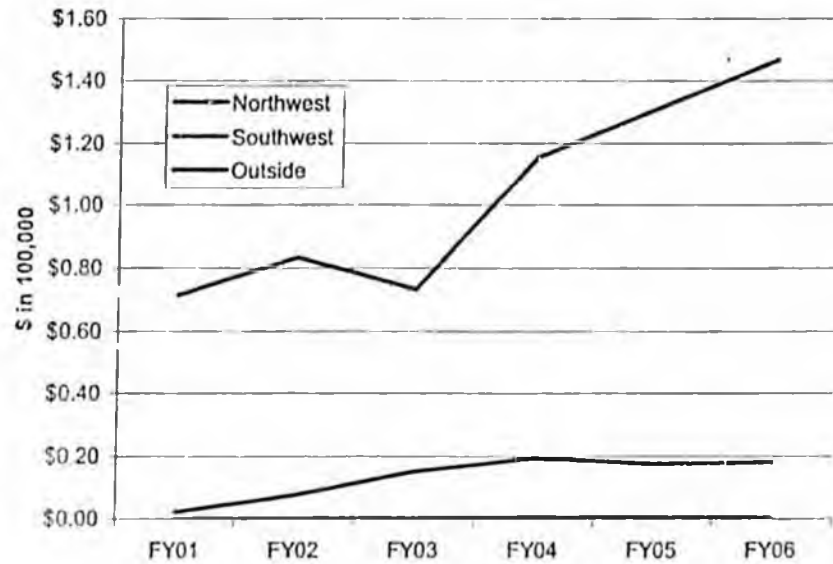
**Beneficiary Medicaid Expenditures by Region
Mental Health Beneficiaries: FY01 to FY06**



**Beneficiary Medicaid Expenditures by Region
Mental Health Beneficiaries: FY01 to FY06**

Fiscal Year	Northwest	Interior	Southwest	Southeast	Southcentral	Anchorage	Outside	Total
FY01	\$18,513.75	\$1,466,768.68	\$193,762.65	\$1,767,392.72	\$3,283,423.80	\$7,234,256.08	\$15,815.68	\$13,979,933
FY02	\$81,475.00	\$3,909,710.66	\$821,650.28	\$5,512,152.71	\$9,613,994.52	\$20,672,786.06	\$18,664.13	\$40,630,206
FY03	\$127,303.16	\$5,980,574.73	\$1,218,496.59	\$7,004,687.73	\$10,045,065.51	\$24,514,158.78	\$31,954.93	\$48,922,241
FY04	\$55,143.15	\$7,568,608.07	\$821,808.37	\$7,402,688.92	\$9,757,249.22	\$25,288,577.73	\$33,114.86	\$50,927,190
FY05	\$46,805.67	\$8,323,114.88	\$821,430.12	\$8,447,609.16	\$8,535,726.61	\$25,760,436.41	\$40,412.71	\$51,975,536
FY06	\$75,931.17	\$8,711,136.22	\$1,642,105.26	\$9,389,805.68	\$9,792,865.59	\$27,066,321.08	\$25,264.73	\$56,703,430

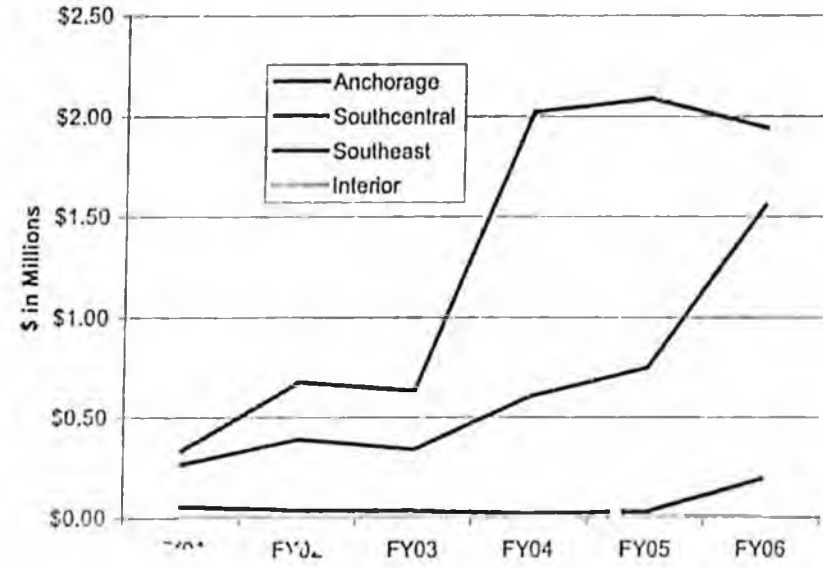
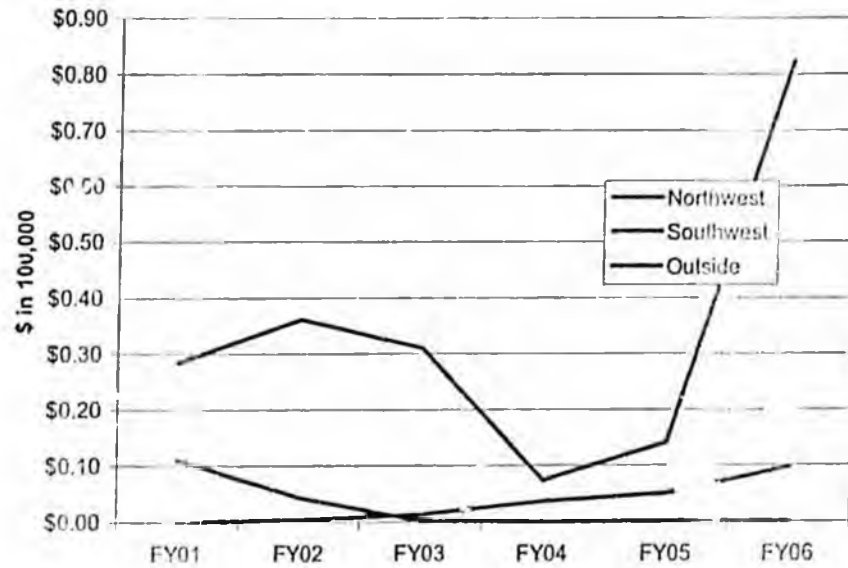
**Beneficiary Medicaid Expenditures by Region
Chronic Alcoholics with Psychosis: FY01 to FY06**



**Beneficiary Medicaid Expenditures by Region
Chronic Alcoholics with Psychosis: FY01 to FY06**

Fiscal Year	Northwest	Interior	Southwest	Southeast	Southcentral	Anchorage	Outside	Total
FY01	\$2,071.25	\$149,639.23	\$71,463.25	\$165,627.50	\$326,260.77	\$1,036,147.05	\$0.00	\$1,751,209
FY02	\$7,560.00	\$92,355.36	\$83,334.80	\$253,827.36	\$715,379.30	\$791,964.85	\$40.20	\$1,944,462
FY03	\$15,083.75	\$104,369.76	\$73,193.25	\$256,094.76	\$763,555.48	\$1,196,966.15	\$0.00	\$2,409,263
FY04	\$19,391.25	\$136,930.12	\$115,434.03	\$295,750.63	\$840,089.16	\$1,268,487.23	\$408.90	\$2,676,491
FY05	\$17,563.75	\$120,987.64	\$131,111.24	\$363,241.16	\$788,766.64	\$1,128,522.98	\$332.54	\$2,550,526
FY06	\$18,108.75	\$84,638.80	\$146,677.16	\$354,798.81	\$848,592.41	\$1,308,679.01	\$121.92	\$2,761,617

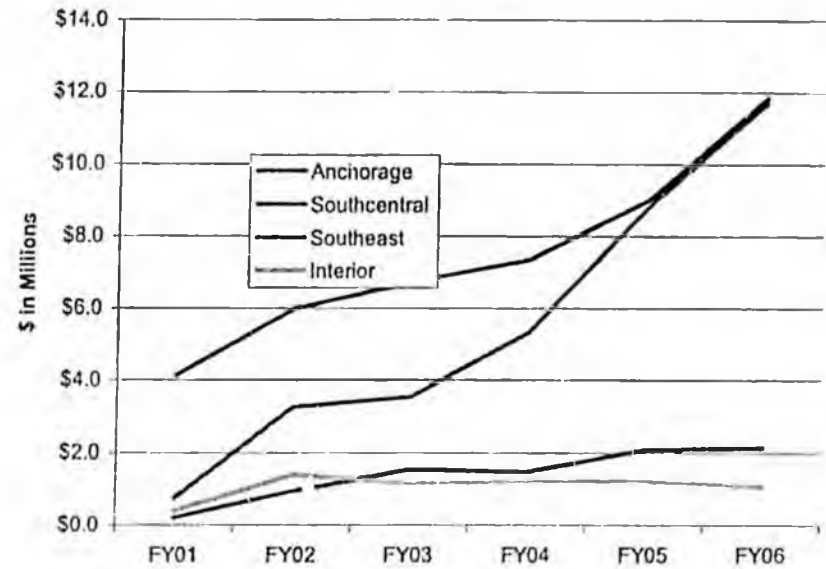
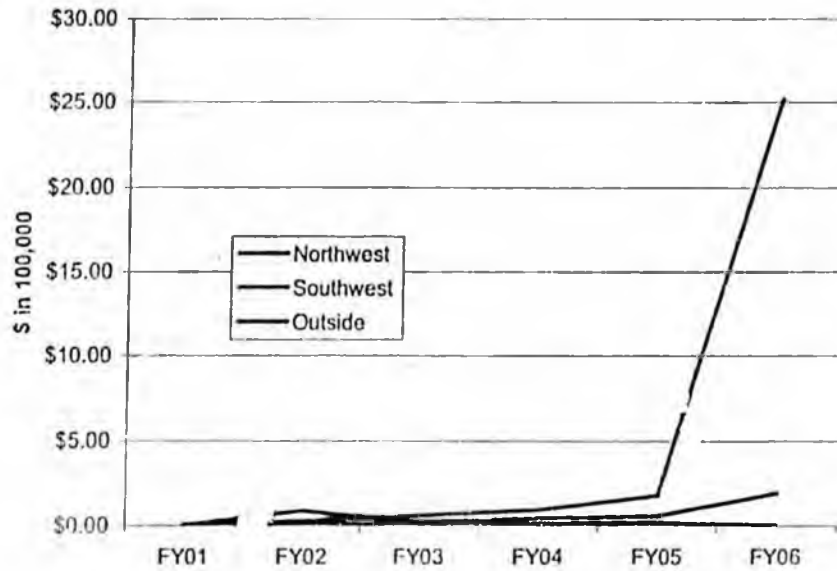
**Beneficiary Medicaid Expenditures by Region
Alzheimer's and Related Dementia: FY01 to FY06**



**Beneficiary Medicaid Expenditures by Region
Alzheimer's and Related Dementia: FY01 to FY06**

Fiscal Year	Northwest	Interior	Southwest	Southeast	Southcentral	Anchorage	Outside	Total
FY01	\$0.00	\$5,195.53	\$28,519.84	\$57,440.64	\$333,421.51	\$267,707.48	\$11,139.71	\$703,425
FY02	\$420.00	\$8,610.01	\$36,201.54	\$40,309.80	\$677,409.27	\$390,134.46	\$4,307.30	\$1,157,392
FY03	\$1,290.00	\$8,141.34	\$31,035.29	\$35,914.96	\$632,883.88	\$340,869.58	\$176.40	\$1,050,311
FY04	\$3,603.26	\$7,207.86	\$7,358.34	\$22,364.50	\$2,022,015.85	\$607,102.03	\$20.32	\$2,669,672
FY05	\$5,047.32	\$7,511.33	\$14,095.67	\$27,368.50	\$2,090,450.22	\$748,091.85	\$128.24	\$2,892,693
FY06	\$9,657.52	\$1,598.02	\$82,223.93	\$189,507.99	\$1,945,551.77	\$1,558,726.95	\$142.24	\$3,787,408

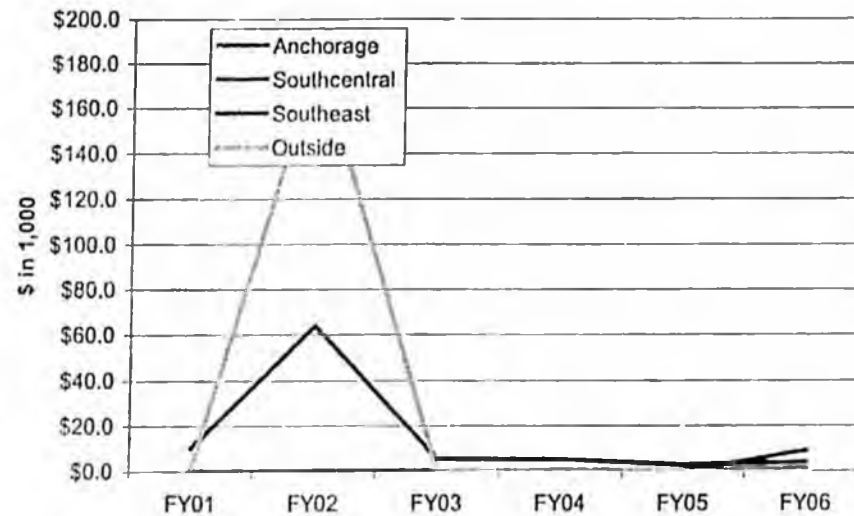
**Beneficiary Medicaid Expenditures by Region
Developmental Disabilities: FY01 to FY06**



**Beneficiary Medicaid Expenditures by Region
Developmental Disabilities: FY01 to FY06**

Fiscal Year	Northwest	Interior	Southwest	Southeast	Southcentral	Anchorage	Outside	Total
FY01	\$3,090.00	\$384,806.70	\$3,115.40	\$204,869.16	\$750,952.42	\$4,128,487.99	\$79.83	\$5,475,402
FY02	\$86,074.82	\$1,390,806.37	\$28,513.00	\$940,627.78	\$3,262,642.15	\$5,973,203.99	\$17,991.59	\$11,699,860
FY03	\$19,078.83	\$1,177,114.30	\$60,070.00	\$1,551,648.75	\$3,528,775.44	\$6,725,448.53	\$3,285.70	\$13,065,422
FY04	\$45,560.29	\$1,236,882.85	\$94,616.70	\$1,493,747.77	\$5,332,642.81	\$7,358,045.36	\$12,770.99	\$15,574,267
FY05	\$55,896.27	\$1,229,033.14	\$179,539.44	\$2,083,702.49	\$8,811,303.02	\$9,017,465.95	\$21,075.58	\$21,398,016
FY06	\$194,535.90	\$1,081,210.73	\$2,519,042.71	\$2,153,991.87	\$11,682,219.34	\$11,833,485.71	\$863.63	\$29,465,350

**Beneficiary Medicaid Expenditures by Region
Traumatic Brain Injury: FY01 to FY06**



**Beneficiary Medicaid Expenditures by Region
Traumatic Brain Injury: FY01 to FY06**

Fiscal Year	Northwest	Interior	Southwest	Southeast	Southcentral	Anchorage	Outside	Total
FY01	\$0.00	\$0.00	\$0.00	\$0.00	\$30.00	\$10,265.26	\$1,087.18	\$11,382
FY02	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$63,975.76	\$182,235.51	\$246,211
FY03	\$0.00	\$0.00	\$0.00	\$0.00	\$30.00	\$5,406.06	\$0.00	\$5,436
FY04	\$0.00	\$0.00	\$0.00	\$27.88	\$450.00	\$5,212.72	\$0.00	\$5,691
FY05	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$2,765.00	\$0.00	\$2,765
FY06	\$0.00	\$0.00	\$0.00	\$8,997.67	\$970.50	\$3,938.85	\$0.00	\$13,907

AMHTA Medicaid Study
ICD9 Codes for Beneficiaries Receiving Medicaid Services

Code	Diagnosis	Cases in data – not recipients
Mental Illness		59,654
292	Drug-induced mental disorders	194
293	Transient mental disorders due to conditions classified elsewhere	811
294	Persistent mental disorders due to conditions classified elsewhere	1,119
295	Schizophrenic disorders	4,807
296	Episodic mood disorders	17,793
297	Delusional disorders	125
298	Other nonorganic psychoses	1,106
300	Anxiety, dissociative and somatoform disorders	5,431
301	Personality disorders	1,300
304	Drug dependence	2,441
305	Nondependent abuse of drugs	2,105
306	Physiological malfunction arising from mental factors	1
307	Special symptoms or syndromes, not elsewhere classified	714
308	Acute reaction to stress	131
309	Adjustment reaction	10,740
311	Depressive disorder, not elsewhere classified	3,795
312	Disturbance of conduct, not elsewhere classified	3,591
313	Disturbance of emotions specific to childhood and adolescence	3,152
316	Psychic factors associated with diseases classified elsewhere	20
V11.8	Personal history of mental disorder	2
V15.42	History of emotional abuse	1
V71.02	Observation for suspected mental condition--childhood or adolescent antisocial behavior	23
V71.09	Observation for suspected mental condition--other suspected mental condition	249
V79.10	Special screening exam for mental disorder and developmental handicaps--depression	1
Chronic Alcoholics with Psychosis		2,446
291	Alcohol-induced mental disorders	306
303	Alcohol dependence syndrome	2,139
V79.1	Special screening exam for mental disorder and developmental handicaps-alcoholism	1
Alzheimer's and Related Dementia		1,161
191	Malignant neoplasm of brain	3
272	Pick's Disease	8
290	Dementia	227
310	Specific nonpsychotic mental disorders due to brain damage	137
331	Other cerebral degenerations	79
332	Parkinson's disease	72
333	Other extrapyramidal disease and abnormal movement disorders	58
340	Multiple sclerosis	95
356	Hereditary and idiopathic peripheral neuropathy	6
742	Congenital brain atrophy	41
799	Hypoxia	43

Code	Diagnosis	Cases in data – not recipients
Developmental Disabilities		8,658
299	Pervasive developmental disorders	1,362
314	Hyperkinetic syndrome of childhood	5,811
315	Specific delays in development	216
317	Mild mental retardation	384
318	Other specified mental retardation	439
319	Unspecified mental retardation	133
343	Infantile cerebral palsy	247
345	Epilepsy and recurrent seizures	51
V40.00	Problems with learning	9
V79.8	Special screening examination for mental disorder and developmental handicaps	6
Traumatic Brain Injury		46
803	Other and unqualified skull fractures	2
804	Closed without mention of intracranial injury	1
850	Concussion	6
852	Subarachnoid, subdural, and extradural hemorrhage, following injury	3
853	Other and unspecified intracranial hemorrhage following injury	9
854	Intracranial injury of other and unspecified nature	25
Other		6,202
001-139	Infectious and parasitic diseases	474
140-239 (except 191)	Neoplasms	154
240-279 (except 272)	Endocrine, nutritional and metabolic diseases, and immunity disorders	356
280-289	Diseases of the blood and blood-forming organs	41
302	Mental disorders (Sexual and gender identity disorders)	174
320-389 (except 331-333, 340, 343, 345, & 350)	Diseases of the nervous system and sense organs	523
390-459	Diseases of the circulatory system	741
460-519	Diseases of the respiratory system	361
520-579	Diseases of the digestive system	69
580-629	Diseases of the genitourinary system	116
630-677	Complications of pregnancy, childbirth, and the puerperium	44
700-709	Other diseases of the skin and subcutaneous tissue	27
710-739	Diseases of the musculoskeletal system and connective tissue	965
740-759 (except 742)	Congenital anomalies	222
760-779	Certain conditions originating in the perinatal period	52
780-799	Symptoms, signs, and ill-defined conditions	467
800-999 (except 803, 804, 850, 852, 853, & 854)	Injury and poisoning	513
V01-V86 (except V11.8, V15.42, V40.00, V71.02, V71.09, V79.0, V79.1, & V79.8)	Supplementary classification of factors influencing health status and contact with health services	903

Code	Diagnosis	Cases in data – not recipients
No valid diagnosis code or missing diagnosis code		9,195
None	No code	9,083
0	No such code	112

Alaska State Unique Codes and National Replacement Codes

Community Mental Health Clinics

CPT Procedure Codes: Children's Clinic Services/Community Mental Health Clinic

Service Code	Service Desc	Replacement Code	Service Desc
8011F	Psychiatric Assessment (Maximum = 4 Assessments/ Calendar Year)	90801	Psychiatric diagnostic interview[Psychiatric assessment]
8011F	Psychiatric Assessment (Maximum = 4 Assessments/ Calendar Year)	90802	Interactive psychiatric diag[Psychiatric assessment]
90801*		Unchanged	Individual psychotherapy ins
90810*		Unchanged	Individual psychotherapy int
8473F	Family Psychotherapy, Per 30 Minutes	90847	Family psychotherapy
8530F	Multiple- Family Group Psychotherapy, Per Recipient, Per 30 Minutes	90849	Multiple-family group psycho
8111F	Group Psychotherapy, Per Recipient, Per 30 Minutes	90853	Group psychotherapy
90862†		Unchanged	Pharmacologic management

*Individual, Group, and Family Psychotherapy: Combined limit of 10 hours per calendar year
 †Pharmacologic Management: No more than one visit per week during the initial month following entry to a program; then no more than one visit per month unless unusual reaction or more frequent monitoring is required.

HCPCS and ABC Procedure Codes: Children's Clinic Services/Community Mental Health Clinic

Service Code	Service Desc	Replacement Code	Service Desc
8015F	Intake Assessment, Initial, Per 15 Minutes (Maximum = 3 Hours/ Admission)	H0031	Mental health assessment, by non-physician[Intake assessment]
8115F	Intake Assessment, Semi- Annual, Per 15 Minutes (Maximum = 1 Hour, 2 Times Per Year)	H0031	Mental health assessment, by non-physician[Intake assessment]
3115F	Crisis Intervention, Per 15 Minutes (Maximum = 2Hours/ Day, 22 Hours/ Calendar Year)	S9484	Crisis intervention mental health services, per hour
6015F	Psychological Testing and Evaluation, Per 15 Minutes (Maximum = 6 Hours/ Calendar Year)	CDBAQ	Psychological testing comprehensive assessment each 15 minutes
7015F	Neuro- Psychological Testing and Evaluation, Per 15 Minutes (Maximum = 12 Hours/Calendar Year)	CDBAS	

HCPCS and ABC Procedure Codes: Children's Rehabilitation Services/CommunityMental Health Clinic

Service Code	Service Desc	Replacement Code	Service Desc
		H0018	Behavioral health; short term residential (non- hospital residential treatment program) without room and board, per diem[Daily behavioral health residential rehabilitation]
9086F	Medication Administration, on Clinic Premises, per day (Maximum = Daily Rate)	H0033	Oral medication administration, direct observation[on-premises]
9087F	Medication Administration, off Clinic Premises, per day (Maximum = Daily Rate)	H0033 /HK	Oral medication administration, direct observation[on-premises]
8210F	Case Management Services, per 15 Minutes (Maximum = 180 hours/ calendar year)	T1016	Case Management, each 15 minutes
8212F	Individual Skill Development Services, per 15 minutes (Maximum = 100 hours/ calendar year)	CDAEP	Behavior modification training, social skills, individual, Counseling
8213F	Family Skill Development Services, per 15 minutes (Maximum = 180 hours/ calendar year)	CDABF	Family-involvement training family each 15 minutes[Family skill development]
		CDAKQ	Social skills assistance group each 15 minutes[Group skill development]
		CDACM	Coping skills development assistance, individual each 15 minutes
8214F	Group Skill Development Services, per 15 minutes (Maximum = 140 hours/ calendar year)	CDAEQ	Behavior modification training, social skills, group, Counseling
8215F	Functional Assessment, Initial, Per 15 Minutes (Maximum = 4 Hours/ Admission)	CDBAP	Psychological testing brief assessment each 15 minutes
8315F	Functional Assessment, Semi- Annual, Per 15 Minutes (Maximum = 1 Hour, 2 Times Per Year)	CDBAP	Psychological testing brief assessment each 15 minutes

CPT Procedure Codes: Adult's Clinic Services/Community Mental Health Clinic

Service Code	Service Desc	Replacement Code	Service Desc
8011F	Psychiatric Assessment (Maximum = 4 Assessments/ Calendar Year)	90801	Psychiatric diagnostic inter[Psychiatric assessment]
8011F	Psychiatric Assessment (Maximum = 4 Assessments/ Calendar Year)	90802	Interactive psychiatric diag[Psychiatric assessment]
90804*		Unchanged	Individual psychotherapy ins
8473F	Family Psychotherapy, Per 30 Minutes	90847	Family psychotherapy
8520F	Multiple- Family Group Psychotherapy, Per Recipient, Per 30 Minutes	90849	Multiple-family group psycho
8415F	Group Psychotherapy, Per Recipient, Per 30 Minutes	90853	Group psychotherapy
90802*		Unchanged	Pharmacologic management

*Individual, Group, and Family Psychotherapy: Combined limit of 10 hours per calendar year

*Pharmacologic Management: No more than one visit per week during the initial month following entry to a program; then no more than one visit per month unless unusual reaction or more frequent monitoring is required.

HCPCS and ABC Procedure Codes: Adult's Clinic Services/Community Mental Health Clinic

Service Code	Service Desc	Replacement Code	Service Desc
8015F	Intake Assessment, Initial, Per 15 Minutes (Maximum = 3 Hours/ Admission)	H0031	Mental health assessment, by non-physician[Intake assessment]
8115F	Intake Assessment, Semi- Annual, Per 15 Minutes (Maximum = 1 Hour, 2 Times Per Year)	H0031	
3115F	Crisis Intervention, Per 15 Minutes (Maximum = 2Hours/ Day, 22 Hours/ Calendar Year)	S9484	Crisis intervention mental health services, per hour
6015F	Psychological Testing and Evaluation, Per 15 Minutes (Maximum = 6 Hours/ Calendar Year)	CDBAQ	Psychological testing comprehensive assessment each 15 minutes
7015F	Neuro- Psychological Testing and Evaluation, Per 15 Minutes (Maximum = 12 Hours/Calendar Year)	CDBAS	

HCPCS and ABC Procedure Codes: Adult's Rehabilitation Services/Community Mental Health Clinic

Service Code	Service Desc	Replacement Code	Service Desc
9086F	Medication Administration, on Clinic Premises, per day (Maximum = Daily Rate)	H0033	Oral medication administration, direct observation[on-premises]
9087F	Medication Administration, off Clinic Premises, per day (Maximum = Daily Rate)	H0033 /HK	Oral medication administration, direct observation[on-premises]
8210F	Case Management Services, per 15 Minutes (Maximum = 180 hours/ calendar year)	T1016	Case Management, each 15 minutes
8212F	Individual Skill Development Services, per 15 minutes (Maximum = 240 hours/ calendar year)	CDAEP	Social skills assistance individual each 15 minutes[Individual skill development]
		CDAKQ	Social skills assistance group each 15 minutes[Group skill development]
		CDAQM	Coping skills development assistance, individual each 15 minutes
8215F	Functional Assessment, Initial, Per 15 Minutes (Maximum = 4 Hours/ Admission)	CDBAP	Psychological testing brief assessment each 15 minutes
8315F	Functional Assessment, Semi- Annual, Per 15 Minutes (Maximum = 1 Hour, 2 Times Per Year)	CDBAP	Psychological testing brief assessment each 15 minutes
8214F	Group Skill Development Services, per 15 minutes (Maximum = 140 hours/ calendar year)	CDAEQ	Behavior modification training, social skills, group, Counseling
8220F	Recipient Support Services, per Hour, (Maximum = 4 hours/ day; 1,460 hours/ calendar year)	CDAJC	Coping support skill, Counseling

Substance Abuse Services

Procedure Codes: Substance Abuse Rehabilitative Services

Service Code	Service Desc	Replacement Code	Service Desc
Unchanged		80100	Drug screen, qualitative; [Multiple Drug]
7030F	Medication Management, per Visit	90862 /HF	Pharmacologic management
1041F	Individual Counseling, 15- minute Service Unit (Combined Maximum of 40 Hours or 160 Units per Consecutive 12- Month Period for Individual, Group and Family Counseling)	CDADK	Substance abuse treatment, individual, Counseling, Mental Health Service, Practice specialties[Combined maximum of 40 hours or 160 units per consecutive 12- month period for Individual, Group, and Family Counseling
1040F	Assessment/ Diagnosis (Maximum of 2 per Consecutive 12- month Period)	H0001	Alcohol and/or drug assessment[Maximum of 2 per consecutive 12-month period]
7021F	Intake Physical for Non- Methadone Recipient	H0002	Behavioral health screening to determine eligibility for admission to treatment program[Intake physical for non-Methadone recipient]
7020F	Medical Evaluation for Admission into Methadone Treatment	H0002/HF	Behavioral health screening to determine eligibility for admission to treatment program[Medical evaluation for admission into Methadone Treatment]
1042F	Group Counseling, 15- minute Service Unit (Combined Maximum of 40 Hours or 160 Units per Consecutive 12- Month Period for Individual, Group and Family Counseling)	H0005	Alcohol and/or drug services; group counseling by a clinician[Combined maximum of 40 hours or 160 units per consecutive 12-month period for Individual, Group, and Family Counseling]
7010F	Care Coordination, 15- minute Service Unit (Maximum of 32 Service Units per 6- month Period or 64 Service Units per Consecutive 12- month Period)	H0006	Alcohol and/or drug services; case management[Maximum of 32 service units per 6- month period or 64 service units per consecutive 12- month period]
1024F	Detoxification, Per Consecutive 24- hour Period	H0013	Alcohol and/or drug services; acute detoxification(residential addiction program outpatient)
1044F	Intensive Outpatient Services, 15- minute Service Unit (Minimum 3 Days or Evenings/ Week, 8 to 12 Hours or 32 to 48 Units a Week; Not to Exceed 8 Consecutive Weeks per Consecutive 12- month Period)	H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individual treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education[Minimum 3 days or evenings/week, 8 to 12 hours or 32 to 48 units a week; not to exceed 8 consecutive weeks per consecutive 12-month period]

Service Code	Service Desc	Replacement Code	Service Desc
7035F	Medication Dispensing; Methadone or Antabuse, per Visit	H0020	Alcohol and/or drug services; Methadone administration and/or service (provision of the drug by a licensed program)
1046F	Intermediate Services, 15- minute Service Unit (Maximum of 20 Hours or 80 Units/ Week or 640 Units/ Consecutive 12- month Period)	H0022	Alcohol and/or drug intervention service (planned facilitation)[Maximum of 20 hours or 80 units per week; 8 weeks or 640 units per consecutive 12-month period]
1043F	Family Counseling, 15- minute Service Unit (Combined Maximum of 40 Hours or 160 Units per Consecutive 12- Month Period for Individual, Group and Family Counseling)	T1006	Alcohol and/or substance abuse services, family/couple counseling[Combined maximum of 40 hours or 160 units per consecutive 12-month period for Individual, Group, and Family Counseling]
7011F	Medical Evaluation for Admission Into Methadone Treatment	T1007	Alcohol and/or substance abuse services, treatment plan development and/or modification
7022F	Rehabilitation Treatment, 15- minute Service Unit (Maximum of 10 Hours or 40 Units per Week, 40 Hours or 160 Units per Consecutive 12- month Period)	T1012	Alcohol and/or substance abuse services, skills development[Maximum of 10 hours or 40 units per week; 40 hours or 160 units per consecutive 12-month period]

Consumer Directed PCA Services

Procedure Codes: Personal Care Agency Services

Service Code	Service Desc	Replacement Code	Service Desc
0761P/ JQ	Personal Care Services Provided by a Personal Care Agency, Per Hour (less than 8 hours/day)	T1019/ U3	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/ MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)
0762P/ JQ	Personal Care Services Provided by a Personal Care Agency, Per Day (over 8 hours/day)	T1020/ U3	Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/ MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)

PCA Agency Services

Procedure Codes: Personal Care Agency Services

Service Code	Service Desc	Replacement Code	Service Desc
0761P	Personal Care Services Provided by a Personal Care Agency, Per Hour (less than 8 hours/day)	T1019	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/ MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)
0762P	Personal Care Services Provided by a Personal Care Agency, Per Day (over 8 hours/day)	T1020	Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/ MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)
0763P	Initial RN Evaluation by a Personal Care Agency for Client Requesting PCA Care(Includes Assessment and Development of Treatment Plan)		

Day Treatment

State Unique Procedure Codes: Children's Day Treatment Services

Service Code	Service Desc	Replacement Code	Service Desc
1002F	Children's Day Treatment Services, Full Day, Minimum of Six Hours Per Day	H2012	Behavioral Health Day Treatment, per hour
1022F	Children's Day Treatment Services, Half Day, Minimum of Three Hours Per Day	H2012	Behavioral Health Day Treatment, per hour

Mental Health Physician Clinic

CPT Procedure Codes: Children's Clinic Services/Mental Health Physician Clinic

Service Code	Service Desc	Replacement Code	Service Desc
90801*	Individual Psychotherapy - Insight Oriented	Unchanged	Individual Psychotherapy - Insight Oriented
90813*	Individual Psychotherapy - Interactive	Unchanged	Individual Psychotherapy - Interactive
90822**	Pharmacologic Management	Unchanged	Pharmacologic Management

Unique Procedure Codes: Children's Clinic Services/ Mental Health Physician Clinic

Service Code	Service Desc	Replacement Code	Service Desc
90851F	Intake Assessment, Initial, Per 15 Minutes (Maximum = 3 Hours/Admission)	H0031	Mental health assessment, by non- physician
90852F	Intake Assessment, Semi-Annual, Per 15 Minutes (Maximum = 1 Hour, 2 Times Per Year)	H0031	Mental health assessment, by non- physician
90853F	Psychiatric Assessment (Maximum = 4 Assessments/ Calendar Year)	90801 or 90802 based on service performed	90801 - Psychiatric diagnostic interview examination 90802 - Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication
6015F	Psychological Testing and Evaluation, Per 15 Minutes (Maximum = 6 Hours/Calendar Year)	CDBAQ	Psychological testing, comprehensive, Testing, evaluation and interpretation
7615F	Neuro-Psychological Testing and Evaluation, Per 15 Minutes (Maximum = 12 Hours/Calendar Year)	CDBAS	Neuropsychological testing, Testing, evaluation and interpretation
3115F*	Crisis Intervention, Per 15 Minutes (Maximum = 2 Hours/Day, 22 Hours/Calendar Year)	S9484	Crisis intervention mental health services, per hour
8013F**	Family Psychotherapy, Per 30 Minutes	90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
8530F**	Multiple-Family Group Psychotherapy, Per Recipient, Per 30 Minutes	90849	Multiple- family group psychotherapy
8411F**	Group Psychotherapy, Per Recipient, Per 30 Minutes	90853	Group psychotherapy (other than of a multiple-family group)

* Crisis Intervention; (Maximum of 2 hours per day and no more than 72 hours in one psychiatric emergency, Maximum 22 hours per calendar year)

** Individual, Group, Family Psychotherapy; Combined maximum of 10 hours per calendar year

CPT Procedure Codes: Adult's Clinic Services/ Mental Health Physician Clinic

Service Code	Service Desc	Replacement Code	Service Desc
90804*	Individual Psychotherapy - Insight Oriented	Unchanged	
90862**	Pharmacologic Management	Unchanged	

*Individual, Group, and Family Psychotherapy: Combined limit of 10 hours per calendar year

**Pharmacologic Management: No more than one visit per week during the initial month following entry to a program; then no more than one visit per month unless unusual reaction or more frequent monitoring is required.

State Unique Procedure Codes: Adult's Clinic Services/ Mental Health Physician Clinic

Service Code	Service Desc	Replacement Code	Service Desc
8015F	Intake Assessment, Initial, Per 15 Minutes(Maximum = 3 Hours/Admission)	H0031	Mental health assessment, by non- physician
8115F	Intake Assessment, Semi-Annual, Per 15 Minutes(Maximum = 1 Hour, 2 Times Per Year)	H0031	Mental health assessment, by non- physician
	Psychiatric Assessment, (Maximum = 4 Assessments/ Calendar Year)	90801 or 90802 based on service performed	90801 - Psychiatric diagnostic interview examination 90802 - Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication
8011F			
6015F	Psychological Testing and Evaluation, Per 15 Minutes, (Maximum = 6 Hours/Calendar Year)	CDBAQ	Psychological testing, comprehensive, Testing, evaluation and interpretation
7015F	Neuro-Psychological Testing and Evaluation, Per 15 Minutes (Maximum = 12 Hours/Calendar Year)	CDBAS	Neuropsychological testing, Testing, evaluation and interpretation
3115F*	Crisis Intervention, Per 15 Minutes(Maximum = 2 Hours/Day, 22 Hours/Calendar Year)	S9484	Crisis Intervention mental health services, per hour
8473F**	Family Psychotherapy, Per 30 Minutes	90847	Family psychotherapy (conjoint psychotherapy) (with patient present)
8530F**	Multiple-Family Group Psychotherapy; Per Recipient, Per 30 Minutes	90849	Multiple- family group psychotherapy
8415F**	Group Psychotherapy; Per Recipient, Per 30 Minutes	90853	Group psychotherapy (other than of a multiple-family group)

* Crisis Intervention; (Maximum of 2 hours per day and no more than 72 hours in one psychiatric emergency, Maximum 22 hours per calendar year)

** Individual, Group, Family Psychotherapy; Combined maximum of 10 hours per calendar year

HCBW

Care Coordination Waiver Services

Service Code	Service Desc	Replacement Code	Service Desc
7001M	Care Coordination Screening	T1023	Screening to determine the appropriateness of an individual for participation in a specified program, project, or treatment protocol, per encounter
7002M	Care Coordination Assessment	T2024	Service assessment/plan of care development, waiver
7003M	Care Coordination Plan of Care Development (One Per Recipient)	T2024-U2	Service assessment/plan of care development, waiver
7004M	Care Coordination Reassessment (One During Initial Waiver Year*; Two Per Year After Initial Waiver Year)	T2024-U4	Service Assessment/Plan of Care Development, Waiver
7005M	Ongoing Care Coordination, Per Month	T2022	Case Management; per month

Home and Community-Based Agency Waiver Services

Service Code	Service Desc	Replacement Code	Service Desc
Habilitation			
7101M	Residential: Individual Home, Per Day	T2017-U4	In-Home Habilitation, residential, waiver; per 15 minutes
7103M	Residential: Shared Care, Per Day	S5140-U2 and S5145-U2	S5140-U2 - Shared care services, adult (age 18 and over); per diem. S5145-U2 - Shared care services, child (through age 17), per diem
7105M	Residential: Foster Care, Per Day	S5140 and S5145	S5140 - Family habilitation home services, adult (age 18 and over); per diem. S5145 - Family habilitation home services, child (through age 17), per diem
7107M	Residential: Supported Living, Per Day	T2017	Supported Living Habilitation, residential, waiver; per 15 minutes
7111M	Residential: Group Home, Per Day	T2016	Group Home Habilitation, residential, waiver; per diem
7113M	Day Habilitation: Per Day	T2021	Day habilitation, residential, waiver; per 15 minutes
7115M	Supported Employment, Per Day	T2019	Supported Employment Habilitation, waiver; per 15 minutes
7117M	Intensive Active Treatment/Therapy, Per Day	T2034	Intensive Active Treatment, waiver; per diem
7118M	Educational Services, Per Day	Eliminated	Service not in use.

Adult Day Care (For Older Alaskans & Adult Disabled Only)

Service Code	Service Desc	Replacement Code	Service Desc
7341M	Adult Day Care, Per Day	S5101	Day care services, adult; per half day
Respite			
7201M	Hourly Respite1	S5150	Unskilled respite care, not hospice; per 15 minutes
7202M	Daily Respite1	S5151	Unskilled respite care, not hospice; per diem
		S5150-U2	(Family-directed) Unskilled respite care, not hospice; per 15 minutes
		S5151-U2	(Family-directed) Unskilled respite care, not hospice; per diem
Chore Services			
7301M	Chore Services,	S5120	Chore services; per 15 minutes
Environmental Modifications			
7401M	Environmental Modifications, Per Hour Per Recipient, Per 36-month Waiver Period	S5165	Home modifications; per service
7402M	Home and Community-Based Agency Administrative Fee for Overseeing Modifications	S5165-U2	Home modifications (admin fee); per service
Meals			
7311M	Meal in Recipient's Residence, Per Meal	S5170	Home delivered meals, including preparation; per meal
7312M	Meal in Congregate Setting, Per Meal	T2025	Meal in Congregate Setting, per Meal
Waiver Transportation			
7021M	One-way Trip, Recipient	T2003	Non-emergency transportation; encounter/trip
7022M	One-way Trip, Escort	T2001	Non-emergency transportation; patient attendant/escort

Residential Supported Living/Assisted Living Homes Waiver Services

Service Code	Service Desc	Replacement Code	Service Desc
7331M	Residential Supported Living/Assisted Living Homes, Per Day	T2031	Assisted Living, waiver, per diem

Specialized Medical Equipment and Supplies

Service Code	Service Desc	Replacement Code	Service Desc
7501M	Tumbleform	T2029	Specialized equipment, NOS (not otherwise specified)
7502M	Tumbleform Wedge	T2029	Specialized equipment, NOS
7503M	Tumbleform Floor Sitter w/wheels	T2029	Specialized equipment, NOS
7504M	Pediatric Bath chair	T2029	Specialized equipment, NOS
7505M	Wheelchair Tray	N/A	(Covered by regular Medicaid)
7506M	Pediatric Transport chair tray	T2029	Specialized equipment, NOS
7507M, 7511M	Hand controls for vehicle; Van lift	T2039	Vehicle modifications, waiver; per service
7508M	Ramp	T2029	Specialized equipment, NOS
7512M	Car seat	T5001	Positioning seat for persons w/special orthopedic needs for use in vehicle.
7513M	Pediatric Potty Chair	T2029	Specialized equipment, NOS
7514M	Pediatric Corner Chair	T2029	Specialized equipment, NOS
7515M	Floor Base	T2029	Specialized equipment, NOS
7516M	Gait Trainer	T2029	Specialized equipment, NOS
7517M	Pediatric Bed	T2029	Specialized equipment, NOS
7518M	Therapy Mat	T2029	Specialized equipment, NOS
7521M	Communication Device	NAACN	Communication enhancement, hearing deficit, common interventions, Interventions, Nursing - Working toward accepting and learning alternate methods for living with diminished hearing.
7522M	Communication Device	NAACO	Communication enhancement, speech deficit, common interventions, Interventions, Nursing - Working toward accepting and learning alternate methods for living with diminished speech.
7523M	Communication Device	NAACP	Communication enhancement, visual deficit, common interventions, Interventions, Nursing - Working toward accepting and learning alternate methods for living with diminished vision.
7524M	Eating Device	T2029	Specialized equipment, NOS (not otherwise specified)
7525M	Bib	T2029	Specialized equipment, NOS
7530M	Reclining Lift Chair	T2029	Specialized equipment, NOS
7531M	Reacher	T2029	Specialized equipment, NOS
7533M	Handheld shower	T2029	Specialized equipment, NOS
7534M	Microwave Oven	Eliminated	No longer covered

Specialized Medical Equipment and Supplies (cont.)

Service Code	Service Desc	Replacement Code	Service Desc
7542M	Rental PERS/Lifeline	S5161	Emergency Response System monthly fee
7543M	Install PERS/Lifeline	S5160	Emergency Response System installation and testing
7750M	Nutritional Supplement (Thickit) per can	Eliminated	Regular Medicald
7751M	Ensure Nutritional Supplement per can	Eliminated	Regular Medicald
7799M	Unlisted SME	T2028	Specialized supply, NOS (not otherwise specified)
7799M	Unlisted SME	T2029	Specialized equipment, NOS