ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672 735
6531 SENATE RESOURCES

STATE OF ALASKA
GENERAL FUNDS AUTHORIZED FOR MENTAL HEALTH PROGRAMS

	AUTHORIZED								GOV REQ
	1983	1984	1985	1986	1987	1988	1989	1990	1991
HEALTH & SOCIAL SERVICES									
Foster Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	400.0
Manilaq Mental Health	0.0	0.0	218.6	278.1	249.9	207.8	207.8	207.8	207.8
Norton Sound Mental Health	0.0	0.0	211.0	385.5	276.7	229.3	229.3	229.3	229.3
TCC Mental Health	0.0	0.0	0.0	249.0	236.6	196.6	196.6	196.6	196.6
YKHC Mental Health	0.0	0.0	0.0	0.0	0.0	0.0	436.9	436.9	436.9
Public Health Admin	0.0	0.0	0.0	0.0	0.0	0.0	134.0	0.0	0.0
Vital Statistics	0.0	0.0	0.0	0.0	0.0	0.0	150.0	150.0	150.0
Infant Learning Program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	280.0	480.0
SOADA/Admin	1,364.5	1,240.3	1,140.4	1,193.5	1,142.4	883.3	948.5	1,085.5	1,056.2
Alcohol Abuse Grants	11,008.8	9,495.6	10,176.0	10,338.4	9,789.0	8,126.0	7,687.0	8,830.4	9,630.4
Comm Mental Health Grants	4,428.9	4,512.1	7,256.3	8,270.2	6,917.9	7,181.9	10,449.9	10,542.1	10,761.2
Fairbanks Comm Mental Health	0.0	0.0	0.0	0.0	1,562.6	1,573.9	2,271.9	0.0	0.0
Svc/Chronically Mentally Ill	0.0	0.0	0.0	0.0	489.1	3,270.1	6,545.1	9,758.0	11,314.3
Designated Eval & Treatment	0.0	0.0	0.0	0.0	0.0	0.0	0.0	588.3	588.3
Comm Dev Disability Grants	4,634.2	4,874.6	7,449.2	8,732.9	8,485.1	7,490.4	9,231.5	11,543.1	12,443.1
Mental Health Admin	1,422.7	2,331.6	1,059.4	1,562.2	1,078.3	1,453.3	2,275.0	2,496.4	2,634.8
API	12,777.9	12,836.6	13,123.1	13,577.6	11,467.1	11,349.6	12,515.4	13,244.8	13,561.1
Harborview	5,544.2	5,490.5	5,522.4	5,291.6	4,945.2	5,141.3	4,151.4	4,151.4	4,151.4
Ak Youth Initiative	0.0	0.0	0.0	0.0	0.0	502.2	687.2	793.8	1,097.0
Office of Prevention	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	209.8
Ak Mental Health Board	0.0	0.0	0.0	0.0	0.0	193.1	327.5	313.6	313.6
Hlth Benefits Supplemental							401.7		
H&SS TOTAL	41,181.2	40,781.3	46,156.4	49,879.0	46,639.9	47,798.8	58,846.7	64,848.0	69,861.8
ADMINISTRATION									
Older Alaskans' Commission	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	996.0
CORRECTIONS									
Cook Inlet Pre-Trial	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	189.0
STATEWIDE TOTAL	41,181.2	40,781.3	46,156.4	49,879.0	46,639.9	47,798.8	58,846.7	64,848.0	71,046.8
% Change		-0.97%	13.18%	8.07%	-6.49%	2.48%	23.11%	10.20%	9.56%
% Change FY83 to FY91									72.52%

The following components are shown as attributable to Mental Health Programs even though the funding source may not reflect it: Alcohol Abuse Grants, Community DD Grants, Harborview Dev Center, and a portion of SOADA Admin. associated with alcohol grants.

LFD 3/19/90

STATE OF ALASKA
GENERAL FUNDS AUTHORIZED FOR MENTAL HEALTH PROGRAMS

	AUTHORIZED								GOV REQ
	1983	1984	1985	1986	1987	1988	1989	1990	1991
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Norton Sound Mental Health	0.0	0.0	211.0	385.5	276.7	229.3	229.3	229.3	229.3
TCC Mental Health	0.0	0.0	0.0	249.0	236.6	196.6	196.6	196.6	196.6
YKHC Mental Health	0.0	0.0	0.0	0.0	0.0	0.0	436.9	436.9	436.9
Comm Mental Health Grants	4,428.9	4,512.1	7,256.3	8,270.2	6,917.9	7,181.9	10,449.9	10,542.1	10,761.2
Fairbanks Comm Mental Health	0.0	0.0	0.0	0.0	1,562.6	1,573.9	2,271.9	0.0	0.0
Svc/Chronically Mentally Ill	0.0	0.0	0.0	0.0	489.1	3,270.1	6,545.1	9,758.0	11,314.3
Designated Eval & Treatment	0.0	0.0	0.0	0.0	0.0	0.0	0.0	588.3	588.3
Mental Health Admin	1,422.7	2,331.6	1,059.4	1,562.2	1,078.3	1,453.3	2,275.0	2,496.4	2,634.8
API	12,777.9	12,836.6	13,123.1	13,577.6	11,467.1	11,349.6	12,515.4	13,244.8	13,561.1
Ak Mental Health Board	0.0	0.0	0.0	0.0	0.0	193.1	327.5	313.6	313.6
TOTAL	18,629.5	19,680.3	21,868.4	24,322.6	22,278.2	25,655.6	35,455.4	38,013.8	40,243.9
% Change - Annual		5.64%	11.12%	11.22%	-8.41%	15.16%	38.20%	7.22%	5.87%
% Change FY83 to FY91									116.02%

ALPHA CENTERPIECE
A Report on Health Policy Issues

OCTOBER 1986

REDIRECTING STATE DOLLARS TO BUILD COMMUNITY-BASED MENTAL HEALTH SYSTEMS

In 1955 the number of inpatients in state mental hospitals in the United States reached a peak of 560,000, after a period of steady increase, and then began to decline. Today, the state hospital population is about 120,000, almost an 80 percent drop, according to 1985 National Institute of Mental Health (NIMH) data. At the same time that the inpatient population in state institutions was shrinking, the total number of seriously mentally ill persons treated as outpatients was increasing dramatically, the result of the expanding community mental health care movement. While in 1955 about 75 percent of all mental health episodes were treated in mental hospitals, today the situation is reversed: an estimated 80 percent or more of mental health episodes are now handled on an outpatient basis.

The move toward state hospital depopulation began shortly after World War II, triggered mainly by advances in drug therapy and other treatment approaches, humanitarian concerns, and changes in reimbursement policies. The federal government gave a significant impetus to community-based treatment with the establishment in 1965 of the Community Mental Health Center (CMHC) program, aimed at reducing the utilization of public mental hospitals and developing community alternatives.

Today the concept of comprehensive and community-based mental health service systems has been further bolstered by studies showing that nonhospital alternatives are more effective and less expensive than inpatient care.

But in practice mental health policy throughout the country still focuses on hospitalization. Despite the fact that the vast majority of mentally ill patients are now treated in community settings, about 65 percent of state mental health dollars go to support public psychiatric institutions. Of the $7.1 billion spent by state mental health agencies in FY 1983, only $2.11 billion was directed to community-based services, or about 30 percent, while $4.65 billion was spent on state mental hospitals, the National Association of State Mental Health Program Directors (NASMHPD) reports; the remainder went for prevention, research, training and administration.

As their budgets are squeezed tighter each year and as the cost of operating public mental hospitals continues to go up, state mental health officials will find it increasingly difficult to fund the development and expansion of community-based programs. The challenge they face is how to reduce the share of resources going to state institutions, without jeopardizing the quality of inpatient care, and to shift the savings to underfunded community alternatives.

This issue of ALPHA CENTERPIECE reviews some of the strategies states can adopt to achieve a more balanced and more cost-effective mental health system that gives priority to meeting the total needs of persons with serious and long-term mental disorders. Although many states continue to emphasize inpatient treatment in their practices, some have made considerable progress in shifting the focus from facility-based care to community treatment, rehabilitation, and support services. The examples in this report describe the innovative approaches some of these states have taken to restructure their public mental health systems.

Deinstitutionalization and Development of Community Programs

The deinstitutionalization movement began in the 1950s in response to public concerns about the quality of care provided in state mental hospitals. State-administered institutions tended to be overcrowded, poorly maintained and understaffed. Often, seriously mentally ill patients were involuntarily committed to a restrictive hospital environment far away from their communities.

While public attention was being drawn to the serious deficiencies in mental hospitals, interest in community-based care was spreading. The concept of community mental health care was based on the premise that people with serious mental disabilities should be treated in their communities rather than "warehoused" in distant state facilities. The concurrent development of new psychoactive drugs and new modes of psychotherapy enabled the theory to be put into practice by making it possible for the first time for many patients to function outside the institutional environment.

The 1961 report of the Joint Commission on Mental Illness and Health gave further support to the community care movement, pointing to the problems with state psychiatric hospitals and recommending the development of community alternatives. Two years later Congress adopted the Community Mental Health Centers Act, which provided funding to develop community mental health centers (CMHCs) throughout the country.

From 1965, when the first CMHCs were funded, through 1981, when the final project grants were awarded, NIMH supported 768 centers in all 50 states, the District of Columbia and Puerto Rico. After 1981, NIMH began providing mental health funds to the states in the form of block grants. Although state mental health agencies (SMHAs) were given more latitude in the use of the funds, state and local agencies received less total federal support than under the categorical grant program.

The national policy of deinstitutionalization and community-based care, new therapeutic approaches, court decisions mandating treatment in the least restrictive setting, changes in third-party payment policies -- all of these factors contributed to a dramatic decline in the use of state and county mental hospitals. In 1955 the number of inpatient episodes in state psychiatric hospitals was about 819,000 compared to just under 500,000 in 1981, according to NIMH. During this same period, the number of outpatient episodes (which includes outpatient treatment in all types of hospitals as well as in CMHCs and other public or private facilities) increased from 379,000 to 4.4 million.

Mixed Success of Deinstitutionalization

In terms of the significant depopulation of state hospitals since the 1950s, and the simultaneous increase in the number of people with severe mental illness being served in the community, deinstitutionalization has been successful. But in terms of its implementation, deinstitutionalization has not always achieved the policymakers' expectations. The public mental health systems developed during this era of deinstitutionalization have varied widely throughout the country. A basic problem, as government, consumer, and professional critiques have found, was that many communities did not develop an adequate array or amount of support services to meet the mental health as well as other health, human service, and community living needs of seriously mentally ill patients discharged from, or denied admission to, state hospitals. CMHCs varied in their capacity and efforts to address this challenge, and James Stockdill, director of NIMH's Division of Education and Services System Liaison, has noted that "many times they could not and should not have been expected to provide for the other comprehensive health and social services that were necessary for community life."

Often the process of hospital depopulation has not resulted in a commensurate increase of resources in the community or a proportional decrease and consolidation of inpatient capacity. In many cases the myriad federal, state and local agencies have not coordinated their activities, resulting in diffusion of responsibilities and fragmentation of services. Further, some of the most innovative approaches developed during the late 1960s and early 1970s, providing more cost-effective and higher quality treatment, were not rapidly disseminated and adopted throughout the nation's public mental health systems.

In brief, many mentally disabled individuals have been deinstitutionalized over the last 30 years, but essential funds and professional staff have not been deinstitutionalized to develop comprehensive, community-based service systems that could assure the successful transition to community life.

To accelerate the development and dissemination of the innovative community approaches, and to address problems associated with deinstitutionalization, NIMH launched the Community Support Program in 1977. The program's objective is to help states and communities develop systems offering a full range of services to seriously mentally ill persons in the community. All 50 states have received grants to stimulate the development of community support systems.

Conflicting Policies on Mental Hospitalization

Although the national mental health policy is deinstitutionalization, says researcher Charles Keisler of Vanderbilt University, in practice the policy is hospitalization. Nationally, about 70 percent of public and private mental health dollars are spent for inpatient care and 25 percent of all hospital inpatient days are for mental disorders, he reported in an April 1982 article in American Psychologist. While the number of episodes in state and county mental hospitals dropped substantially between 1955 and 1975, the number of inpatient episodes in all other types of hospitals (except Veterans Administration psychiatric hospitals) increased during that period, from 477,000 to 1.2 million. Forty percent of all inpatient episodes for mental problems occur in general hospitals without psychiatric units, resulting in direct costs of almost $6 billion annually, he added.

Similarly, as the population in public mental institutions has gone down, the number of mentally ill patients in nursing homes has risen, according to William Gronfein of Rutgers University. In 1963 about 42 percent of the 356,000 mentally ill elderly receiving institutional care were in state hospitals, compared to 53 percent in nursing homes, he said in a September 1985 article in the Journal of Health and Social Behavior. By 1969, 23 percent of the almost 500,000 institutionalized mentally ill elderly were in state hospitals and 75 percent were in nursing homes and related facilities. According to recent estimates, 750,000 out of the 1.7 million persons with chronic mental illness are in nursing homes.

Researchers have attributed this "transinstitutionalization" of mentally ill persons to third-party reimbursement programs that undercut national deinstitutionalization policy. Most private and public insurance plans, especially medical assistance, provide fiscal incentives for institutional care, hampering state efforts to develop community programs and discouraging beneficiaries from seeking nonhospital alternatives where they do exist. In addition, the current exemption of psychiatric services from Medicare's diagnosis-related groups (DRGs) gives hospitals further incentive to increase the supply of psychiatric beds and thus the demand for services. Many general acute care hospitals, faced with declining utilization and empty beds, are converting excess capacity to psychiatric units, where Medicare continues to reimburse for services on the basis of cost. (See the May 1986 ALPHA CENTERPIECE.)

Another factor accounting for the increase in mental hospitalization, Keisler explains, is public attitude. Many people still look upon mental illness with fear and oppose any move to place seriously mentally disturbed individuals in their neighborhoods. Also, there is a widespread belief by the public, and by some mental health professionals as well, that serious mental problems, like serious medical problems, should be treated primarily, or even exclusively, in hospitals. For some families and other persons dealing with seriously mentally ill individuals, hospitalization may be the easiest or most feasible answer to a difficult-to-handle situation.

Research Shows Cost-Effectiveness of Alternatives to Hospital Care

The national trend toward increased funding for mental hospitalization continues today in spite of recent research documenting the benefits of nonhospital alternatives for persons with severe mental disorders. Keisler, for example, reviewed 14 studies conducted by several researchers over the last 20 years, comparing hospital treatment of seriously mentally ill patients with alternative treatment approaches, which involved psychological and social interventions, usually with some drug therapy. "In no case has mental hospitalization produced better treatment outcomes than any alternative care," he told a Senate appropriations subcommittee in 1984.

Keisler also found evidence of the "self-perpetuation" of mental hospitalization: hospital-treated patients were more likely to be readmitted to the hospital than nonhospital-treated patients ever to be admitted. In addition, most of the studies he reviewed showed that the alternative treatment cost less than hospital care. In one study the alternative care was significantly more effective and 40 percent less expensive. Research reviews by others have come to similar conclusions.

State Budgets Skewed Toward Public Mental Institutions

Even with these findings on the benefits of alternatives to hospital treatment, many states

have not developed sufficient community programs for seriously mentally ill persons. A 1978 NIMH review of surveys on state hospital populations found that although over 50 percent of inpatients did not require institutional care, they remained hospitalized only because alternative treatment was not available in their communities.

The biggest deterrent to the large-scale development of community treatment is inadequate funding. Most states devote more of their mental health budgets to their state hospitals than to community programs, even though the majority of patients are served in community settings. In FY 1983 the average SMHA spent about two-thirds of its budget on its public psychiatric hospitals and slightly less than one-third on community-based programs, according to NASMHPD statistics. (See Figure 1 on the following page for a breakdown of SMHA-controlled expenditures by service setting, and Figure 2 for a breakdown by major program type.) But the share allotted to community services varies widely among the states, ranging from roughly 15 percent to about 65 percent.

The dilemma facing state mental health authorities is how to develop needed community services when state hospitals consume a greater share of limited public funds each year. Publicly funded inpatient treatment facilities, victims of the vicious cycle of declining occupancy and rising fixed costs, are often overbedded and inefficient. Further, they are subject to increasing competition from more cost-effective nonhospital treatment alternatives as well as from general acute care hospitals and private psychiatric facilities. Eventually, states may be forced to develop more community alternatives because these "large, obsolete and outmoded" facilities will no longer be able to provide quality care, and states won't be able to afford "to rebuild or update them," said NIMH's Stockdill in a 1984 speech to mental health planners in Nashville, Tennessee.

But the immediate solution to the problem lies in lowering inpatient utilization and costs in such a way that savings are channeled to cost-effective community-based alternatives. As health care competition increases while federal and state revenues for human services decline, states have a growing awareness of trade-offs between inpatient and community-based services and recognize the difficulties in shifting resources. By redirecting state resources to priority service gaps, SMHAs can not only address unmet service needs, but can also help contain overall state health care expenditures at a time of growing fiscal constraint.

Strategies for Resource Shifting

In seeking ways to move mental health resources from hospitals to community alternatives, states must develop strategies for reshaping their mental health systems. Three years ago NIMH and the Center for Public Representation sponsored a conference in Madison, Wisconsin, to discuss some strategies that states can adopt.

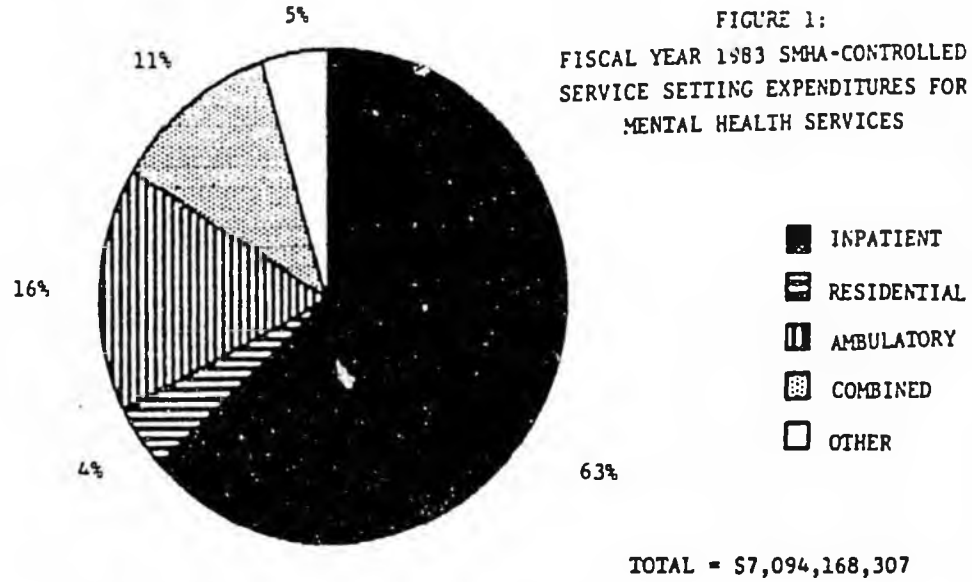
Policymakers, planners and other participants from the eight states represented outlined a common strategic planning process for successful change. The first step is to define the future direction of the mental health system. The system envisioned should provide an array of services, community-based but including facility care, to address the multiple needs of different population groups. Planning should involve both the public and private sectors.

Next, state policymakers must identify and analyze all funding sources so that they can be coordinated and redirected to strengthen community alternatives. There must also be "a critical mass of resources" developed in every mental health service area to assure the provision of a full range of services. Finally, strategies for changing the systems should be coordinated among federal, state, and local government to promote community-based programs.

Looking at the experiences of states that have made significant progress in shifting to a community-based system, conference participants identified the following as successful strategies in redirecting resources to community care:

- strong state leadership, with a policy commitment to quality community-based services;
- strong advocacy groups willing to work with state and local governments to expand community services;
- development of a consensus among key actors -- government, providers, consumers, families, and other advocacy groups -- on the future shape of the system;

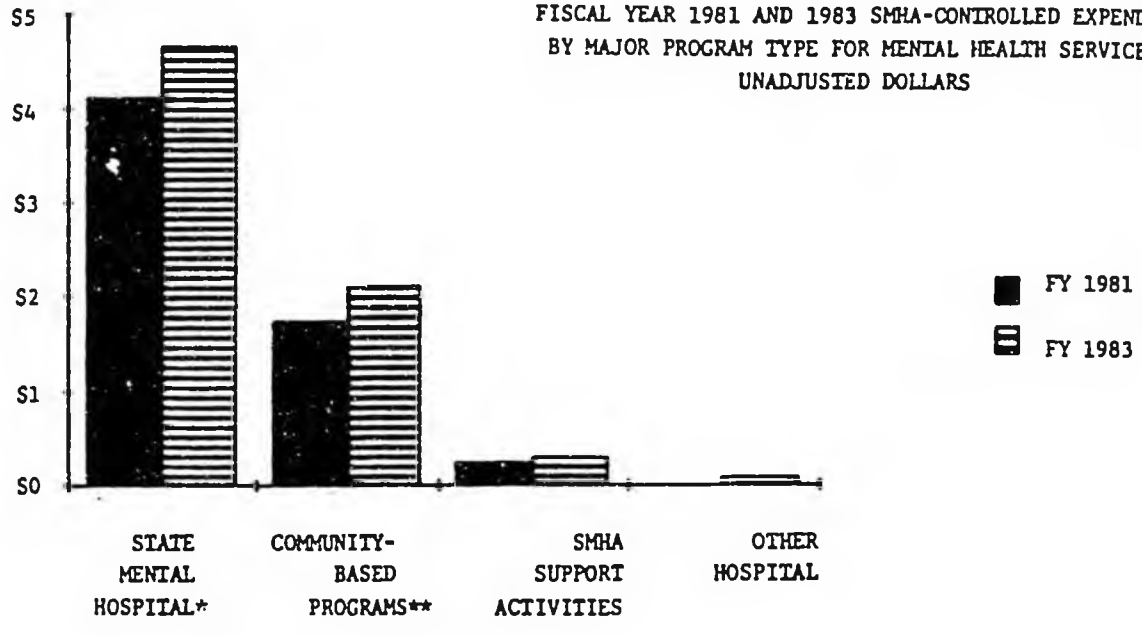
FIGURE 1:
FISCAL YEAR 1983 SMHA-CONTROLLED SERVICE SETTING EXPENDITURES FOR MENTAL HEALTH SERVICES



TOTAL = $7,094,168,307

EXPENDITURES IN BILLIONS

FIGURE 2:
FISCAL YEAR 1981 AND 1983 SMHA-CONTROLLED EXPENDITURES BY MAJOR PROGRAM TYPE FOR MENTAL HEALTH SERVICES: IN UNADJUSTED DOLLARS



* In a few states, expenditures for state hospitals include hospital-based outpatient services.

** Some states use community-based program allocations for inpatient services in general hospitals as well as in county- and state-operated psychiatric facilities.

Source: Funding Sources and Expenditures of State Mental Health Agencies: Revenue/Expenditure Study Results, Fiscal Year: 1983. June 1985. The study was conducted by NASMHPD for NIMH.

- knowledge about the legislative process and ability to work with state legislators;
- development of a single point of authority, either state, regional or local, over all government funds and over the delivery of all services, both institutional and community-based;
- creating additional incentives for decreasing inpatient utilization;
- targeting funds for particular services, such as Community Support Programs (CSPs);
- knowledge about the process of hospital closure or consolidation; and
- technical assistance and consultation on shifting resources.

In moving beyond deinstitutionalization, SMHAs can take additional steps to expand community-based services. Some measures adopted or under development in a number of states include the following:

1. allow local managers and clinicians to act as prudent brokers of services -- This increases the likelihood that they will neither exclude clients from community treatment nor place them unnecessarily in hospital settings.
2. develop gate-keeping mechanisms -- Such mechanisms permit a careful review of clients' clinical needs and available community resources before considering inpatient services and also establish a single point of entry into the community-based mental health system.
3. give highest service priority to individuals who are seriously mentally disabled or who are most at risk of placement in hospitals.

Innovative efforts to expand community-based mental health services are being made in all state mental health systems. For instance, all states, as well as the District of Columbia and Puerto Rico, have received CSP development grants to expand comprehensive community-based services to persons with severe and persistent mental disabilities. Further, most SMHAs are engaged in activities to contain or reduce the proportion of funds allocated for inpatient treatment and to expand community-based treatment alternatives. Among the states that have taken such action are California, Colorado, Connecticut, Florida, Kentucky, Michigan, New Hampshire, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Washington and Wisconsin.

But each state faces unique obstacles and opportunities for redirecting state dollars to build its community-based mental health system; many may be able to adapt some of the approaches described above.

The four states in the examples below -- Colorado, Ohio, Vermont and Wisconsin -- have been selected because they either have developed a strong community-based mental health system, or they are in the process of making major changes in the structure and functioning of their mental health service systems. They are recognized by advocates and policymakers at the state and national levels for expanding community mental health services. For instance, the Public Citizen Health Research Group's recent report describing and ranking state programs for seriously mentally ill people rated Wisconsin and Colorado among the top public mental health systems. The four states are also developing innovative mechanisms and incentives for reducing inpatient utilization and capacity to clinically appropriate levels and for investing saved resources in expanding community alternatives to inpatient treatment. Some of the means used by these states in successfully shifting resources and building community-based treatment systems may be useful in other states' planning efforts.

Two other elements in the planning and policy development process found in all four states, as well as others that have been successful in expanding their community programs, are strong state mental health agency leadership as well as consumer and family involvement. Many states are increasingly involved in building coalitions with families, consumers, advocates, professional associations, and other groups interested in more responsive and comprehensive community-based mental health services.

Wisconsin
COUNTIES CONTROL MANAGEMENT, FUNDING OF MENTAL HEALTH SERVICES

Wisconsin's community-based mental health system, with its emphasis on serving people with serious and persistent mental disabilities, is widely

regarded as a highly successful and efficient public mental health system. And yet Wisconsin spends far less per capita for mental health than most other states ($20.32 in FY 1983, compared to the national average of $30.27, according to NASMHPD data).

Like other states, Wisconsin has seen a significant reduction in the number of inpatients in its public hospitals; today, it has one of the lowest inpatient utilization rates in the nation. But unlike many others, Wisconsin has also succeeded in dramatically reducing inpatient capacity in its state and county-administered psychiatric hospitals. In 1970, the state had over 13,000 public inpatient psychiatric beds; today, there are about 1,100, in a state with a population of approximately 5 million. By reducing inpatient capacity, Wisconsin has been able to decrease the share of state expenditures going to its public hospitals and to shift the savings to community-based programs. The $96.4 million SMHA budget for FY 1983 was split about 50-50 between inpatient and community services.

The key to Wisconsin's more balanced approach, according to mental health professionals both inside and outside the state system, was the transfer of mental health service funding and management authority from the state government to the counties and local mental health service providers. Under legislation enacted in 1973, every county must either provide or contract for a full range of inpatient and outpatient services. The local programs are financed mainly through state appropriations, allocated to each county based on a distribution formula, and through county funds. Because the county governments have control over mental health funds, they have financial incentives to keep inpatient treatment to a clinically appropriate minimum. Extensive and inappropriate use of expensive public or private hospitals means that fewer dollars will be available for community-based programs.

The change in focus in Wisconsin's mental health system was also due to the state's early backing of Community Support Programs. Through NIMH-funded research at Mendota State Hospital in the early 1970s, the pioneer Program for Assertive Community Treatment (PACT) demonstrated the effectiveness, improved quality of life, and cost savings from community treatment of people with serious and long-term mental disabilities. PACT later provided technical assistance and contributes to the establishment of more than 20 CSPs during the mid-1970s, and it continues to contribute to state CSP development. As interest in community care for the seriously mentally ill population grew in the state agency and the mental health community, the legislature authorized additional funding to encourage the expansion of CSPs. Then in 1984, Wisconsin became the first state to require all of its counties to establish CSPs. Today, 56 CSPs serve more than 5,000 severely mentally disabled persons throughout the state.

This legislative mandate grew out of an ongoing debate over the application of the state's involuntary civil commitment laws. The statute was revised in 1974 to include strict dangerousness criteria, which made involuntary inpatient admissions more difficult and thus led to an overall decrease in hospitalization. State agency officials, local providers, families, and legal advocates who opposed a nondangerous criterion for involuntary inpatient admissions formed a coalition to work for the expansion of Community Support Programs in every part of the state.

While Wisconsin as a whole contributes a greater share of state mental health funds to community treatment than most other states, the proportion is even higher in Dane County: about 85 percent for community-based services and 15 percent for inpatient care. Dane County is nationally recognized for its system of comprehensive, high-quality community-based services for several hundred adults with severe mental disabilities, but the county receives less per capita in mental health dollars than the average Wisconsin county. The county is able to achieve such a high level of quality and efficiency by concentrating its limited resources on the population most in need -- people in crisis and people with severe and persistent mental disabilities.

Another reason for the program's success is that the county's budget process offers financial incentives for the providers under contract to treat these patients in the least restrictive and least expensive setting, explained Drs. Leonard Stein, medical director of the Dane County Mental Health Center, and Leonard Ganser, state mental health commissioner during the 1960s and 1970s. Because of the availability of a full range of community services, hospital utilization, length of stay and readmission rates have declined

dramatically over the last 10 years, they concluded in their 1983 report on Wisconsin's system, published in Unified Health Systems: Utopia Unrealized.

Colorado

DATA SYSTEM IS DRIVING FORCE BEHIND BED ALLOCATION, PERFORMANCE CONTRACTING

Like Wisconsin, Colorado spends less for mental health services ($24.88 per capita in FY 1983) than the national average, but it has also been able to build a highly acclaimed public mental health system. Despite the pressures from decreasing revenues and rising service demands, Colorado's mental health system is on a forward track. The state has been particularly successful in identifying the seriously mentally ill population and in planning for the development of services to meet those needs. According to the Division of Mental Health's (DMH's) three-year plan for the chronically mentally ill population, over half of the approximately 20,000 adults with chronic disabilities are not being served. One of the reasons for Colorado's success in addressing the needs of seriously mentally ill people is its sophisticated data system. The comprehensive, statewide database contains a wide range of information on every client served by the state's two public hospitals -- Colorado State Hospital (CSH) and the Fort Logan Mental Health Center (FLMHC) -- and its 20 community mental health centers. The data allow DMH to determine which type of service each type of patient is receiving and to estimate what kinds of services are still needed by different population groups. The information can then be used to develop new or expanded programs to meet those needs. The most important feature of Colorado's data system is that the information feeds into the division's planning, policy and program management decisions, said Nancy Wilson, Director of Program Information, Evaluation and Research.

Colorado's innovative bed allocation program is another example of how the system depends on data. Bed allocation was devised as a solution to two related problems facing the Denver area CMHCs: increasing difficulty in admitting clients to state hospital inpatient beds and sharply rising costs of inpatient services at local general and private psychiatric hospitals. Under the program first implemented in 1981 at FLMHC, which serves the Denver area, and later at CSH, each center is allotted a certain number of hospital beds annually. The beds are assigned on the basis of the needs assessment data for the center's service area. Local agencies may negotiate for utilization of each other's bed allocations. To be admitted to a hospital, a patient must be referred by a CMHC and a bed must be available either from that center's allotment or through that center's arrangement with another center. Patients are discharged by the hospital psychiatrist, with the advice of the center.

Bed allocation has been considered generally successful. In the Fort Logan service area, nonstate hospital inpatient costs declined by 34 percent and in the CSH area, by 7 percent. In addition, efficiency improved at FLMHC, with admissions per bed per month going up by almost 100 percent. Length of stay at both hospitals also decreased because of the more direct involvement of the CMHCs in the treatment and discharge of patients, said DMH's Richard Ellis in a recent paper describing the bed allocation program.

But the most important effect of bed allocation, Ellis said, was that communications and cooperation among the mental health agencies improved. All components of the system -- DMH, the hospitals and the centers -- were drawn together to plan and implement the program. In the process, they "learned more about each other, gaining mutual respect, trust and confidence in each other's abilities and motives," explained a 1984 DMH report evaluating the program.

Another example of Colorado's use of data is performance contracting. Every year DMH negotiates a contract with each CMHC, establishing specific targets on the number of persons admitted to the center's service programs. Separate targets are set for each of several different populations: children, adolescents, the elderly, minorities, and persons who are either seriously, critically, or chronically mentally ill. The information system's needs assessment data are used to determine the target levels for each population classification.

The centers can renegotiate the contracts after six or nine months if they are having trouble meeting the requirements; DMH then suggests remedial action to improve performance. But if a center still fails to meet a target, the division can levy financial penalties. DMH also uses the data system to evaluate the performance of the centers in meeting the requirements of their contracts.

Ohio

MULTISOURCE FUNDING IS A KEY ELEMENT IN SHIFT TO COMMUNITY-BASED SYSTEM

Ohio is widely recognized for the rapid improvements it has made in its system of services for seriously mentally disabled persons. The Department of Mental Health (DMH) is making major strides in transforming the mental health system from a traditional, hospital-based approach to one based on a network of community support services, especially for people with severe and long-term mental disabilities.

The state hospital patient population has dropped from over 20,000 in 1960 to about 4,200 in 1986, part of the national deinstitutionalization trend. During this same period the outpatient average daily census of community mental health agencies rose from around 12,000 to close to 140,000. Yet in FY 1985 DMH spent almost 53 percent of its $392 million budget to operate its 17 hospitals, while only 29 percent went to the 53 community boards that plan, fund, monitor, and contract for comprehensive mental health services, with the remainder for debt retirement and administrative expenses. One of the major policy issues the department is addressing in reshaping the mental health system is how to manage the changing, and sometimes diminishing, sources of mental health funds and redirect them to where the clients are, said DMH Director Pamela Hyde in testimony before the state legislature in January 1985.

A crucial element in the department's plan to shift resources to a community-based system is the use of funding from other federal, state and local agencies. The rationale for pursuing multisource funding is that persons with serious mental disorders have a wide range of mental health, residential, human services, health and vocational needs that can be addressed by a variety of public agencies. Sharing responsibility, information, and funds with other agencies helps to fill in service gaps, reduce duplication and fragmentation, and improve treatment effectiveness and cost-efficiency, DMH explains.

An example of department efforts to utilize the expertise and resources of other authorities is in the area of housing. Most of the severely mentally disabled population live in the community and are served by the approximately 350 community nonprofit agencies under contract with the mental health boards to provide an array of treatment, rehabilitation and support services. These clients have varied and changing residential needs, ranging from living alone or with friends, to living with families, to structured, supervised living. But for many, housing conditions may be inadequate, substandard or inappropriate. In 1984 DMH Director Hyde named a 35-member Housing Task Force, with funding from NIMH, to study the housing needs of mentally disabled people and to recommend policies and programs to meet their needs. The task force's 1985 final report emphasized that federal, state and local agencies should collaborate and pull together their resources to help solve the problems of persons with mental disabilities. DMH is now implementing the panel's 49 recommendations.

In response to one task force proposal, DMH is working with other state agencies to maximize the entitlements of hospital inpatients preparing for discharge to the community. Persons released from mental hospitals often experience delays in receiving the financial support they are entitled to, such as food stamps, medical assistance, general relief, Social Security Disability Insurance (SSDI), or housing. By ensuring that patients receive the aid they are due upon hospital discharge, the department hopes to reduce recidivism as well as to improve their quality of life. Recently the Department of Human Services agreed to revise its rules on general relief so that persons could receive assistance immediately upon release instead of having to wait a month. In addition, DMH was able to increase substantially medical assistance support for mental health when the medical assistance agency agreed to allow reimbursement for case management services for seriously mentally disabled persons in the community.

DMH is also working on a plan to require that one staff person in each local service area be responsible for keeping up with the complicated and ever changing income entitlement requirements administered by numerous government agencies. This staff person would advise case managers on the support available to their clients and would serve as liaison to the other agencies.

Another example of multisource funding is Ohio's Interdepartmental Cluster for Services for Youth, established in 1984 by Governor Richard Celeste. Under the cluster approach, local agencies involved with youth cooperate to plan and jointly fund services for individual children and adolescents with

mental health problems. But if an individual's multiple needs cannot be fully met through such collaborative efforts, or if the local agencies do not reach agreement on the joint allocation of resources, the case may be referred to the state level cluster, composed of representatives of the Departments of Mental Health, Mental Retardation and Development Disabilities, Youth Services, Health, Human Services, and Education. These six agencies then pool their funds to provide the services needed. Representatives of the six departments also meet regularly to develop jointly-funded special programs for the target population.

In another initiative, DMH and the Bureau of Disability Determination have recently completed a series of training sessions for case managers and other mental health personnel. The aim of the program is to upgrade the quality of reports used to support disability determination: improved reports increase the likelihood that clients will receive disability benefits for which they are eligible, said DMH's Rick Tully.

DMH also has an agreement with the Rehabilitation Services Commission to provide matching funds to enhance federal support for vocational rehabilitation and to target case services for persons with severe and long-term mental disabilities. A total of $2.5 million became available in FY 1985 through 's cooperative effort.

Vermont

PLAN UNDERWAY TO DECENTRALIZE STATE HOSPITAL, REGIONALIZE SERVICES

Vermont is among the smallest states, with a population of 500,000, more of whom live in rural areas than any other state, and it is among the poorest, with a per capita income of about $10,000. Yet the state is willing to spend almost $50 per capita on mental health, far more than the national average and more than all but three other states.

Vermont has also long been committed to a community-based mental health system, devoting a higher proportion of its mental health resources to community services than any other state. Of the $20.8 million spent by the Department of Mental Health (DMH) for mental health services in FY 1983, $11.8 million, or about 58 percent, went for community services. In addition, the state has chosen to concentrate over 75 percent of its mental health budget on services for adults with severe and chronic mental disabilities. Further, Vermont supports and funds more consumer-operated mental health service alternatives than any other state.

Now the department is in the first stages of implementing a plan to regionalize the system even further. An integral part of Vermont's regionalization plan is to reduce the size of its only public inpatient facility, the Vermont State Hospital (VSH). Bed reductions during the past 20 years have decreased VSH's capacity from 1,100 to 180 beds; the new plan would reduce it further to 80 beds, including a 25-bed forensic unit. The hospital would then be used only to care for certain groups of long-term, difficult-to-manage mentally ill patients (in addition to the forensic patients): the frail elderly, those with medical problems, brain-damaged individuals, and patients with multiple diagnoses. All other patients would receive mental health care and other rehabilitation and support services through the state's 10 community mental health centers.

The rationale for decentralizing the state hospital is based not only on the mental health system's view that community care for the seriously mentally ill is more effective and more humane than institutional care, but on important cost considerations as well. Anticipated cuts in federal and state funding over the next five years mean that the department's limited resources must be targeted to the most cost-effective services: community programs. Another major cost concern was that "longstanding treatment problems at Vermont State Hospital will require substantial investment of funds if improvement is to be achieved, and costly improvements would compete for funds for community services," said the state's five-year mental health plan, "Mental Health Directions for the Future, 1986-1991." The plan was prepared by a 15-member steering committee following a series of public hearings throughout the state.

Although the current plan is to maintain VSH for a certain patient population, earlier the state legislature considered shutting down the hospital entirely, except for the forensic unit. In December 1984 a joint legislative study committee on Vermont's mental health system ordered DMH to examine the feasibility of developing regional service alternatives to VSH. The committee was concerned about the quality of care at the hospital, but also questioned whether community alternatives would be available if the seriously mentally

disabled patients were no longer treated at the state hospital.

Paul Carling, La Vonne Daniels, and Fran Randolph of Boston University's Center for Psychiatric Rehabilitation, with assistance from other consultants including the Alpha Center, studied the issue and concluded that the development of a regionalized system based on the rehabilitation approach, and the closure of VSH, except the forensic unit, is both feasible and desirable. The legislature then adopted a resolution supporting the concept of regionalization. The Governor and the Agency of Human Services agreed with the concept, but, reluctant to endorse closure, proposed a compromise aimed instead at greatly reducing the system's use of VSH. The plan is widely endorsed by parent and consumer groups and by mental health providers.

According to the five-year planning document, many of the community services needed for the patients now served at VSH are available because the state has already developed an extensive community-based system in response to previous bed reductions at the hospital. But the further decentralization of the hospital will require the development or expansion of some kinds of services to meet all the needs of this population. For example, based on the feasibility study, the plan projected the need for about 14 to 17 new inpatient beds for involuntary and voluntary patients, about 31 to 36 new nursing home beds, and approximately 15 nonhospital crisis beds, plus additional voluntary and involuntary residential options, intensive day treatment programs, emergency and crisis services, vocational programs and legal advocacy services. With the exception of one-time start-up funds in the first years of development, a regionalized system is not expected to cost the state any more in the long run than it pays now for care of these patients at VSH; overall costs may increase, but these costs should be offset by increased revenues from Medicaid and other third-party reimbursements, the study said.

Some progress has already been made in providing these needed services, said Andrea Blanch, DMH's coordinator of training. In some parts of the state, additional day services, residential units, and case management services are being developed. In addition, two CMHCs are working on proposals to provide for involuntary inpatient care in local general hospitals; such treatment is now available only at VSH.

The next step is for the department to find out about local program and funding needs. DMH asked each CMHC to submit information on projected VSH utilization, a description of its existing services, and proposals for new and expanded local and regional services that would be needed to reduce the VSH census for the area even further. The department will then use the centers' estimates on the costs and revenues for each program to prepare its budget request for FY 1988, to be presented next January.

The Alpha Center recently received a grant from the National Institute of Mental Health to train state mental health agency program directors and their key management and planning staff in strategic planning, with an emphasis on expanding community-based mental health service systems. Persons interested in applying strategies on shifting funding and workforce resources from inpatient facilities to community-based mental health services may contact David Goodrick, Ph.D., Associate Director of the Alpha Center, for further information.

A "Mental Health System Strategic Planning Guide," prepared under contract with NIMH's Division of Education and Service System Liaison, is also available from the Alpha Center for $5 per copy prepaid.

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PUBLIC HEALTH CARE FOR THE CHRONICALLY MENTALLY ILL: FINANCING OPERATING COSTS
Issues and Options for Local Leadership

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ABSTRACT: Revenue sources for mental health care for the chronically mentally ill are fragmented, and services limited. What services are provided are frequently underfunded, and gaps in the "safety net" undermine a continuum of care. Given this situation, what can local units of government do to leverage multiple funding streams in a way that makes optimal use of scarce resources? The authors describe different types of reimbursement, noting that every method of health care reimbursement carries different response incentives and disincentives for providers and patients. They frame an analysis of long term care financing models that may have heuristic value for systems of public care for this special population.

INTRODUCTION: ISSUES IN FINANCING

The purpose of this paper is to review the issues that relate to the financial structure that supports services to the chronically mentally ill. It is intended to assist local policy-makers weigh the implications of different fiscal alternatives and strategies. The issue for local planners is how to develop a financial structure at the local level that will encourage clinically sound care and incorporate appropriate incentives for both providers and clients.

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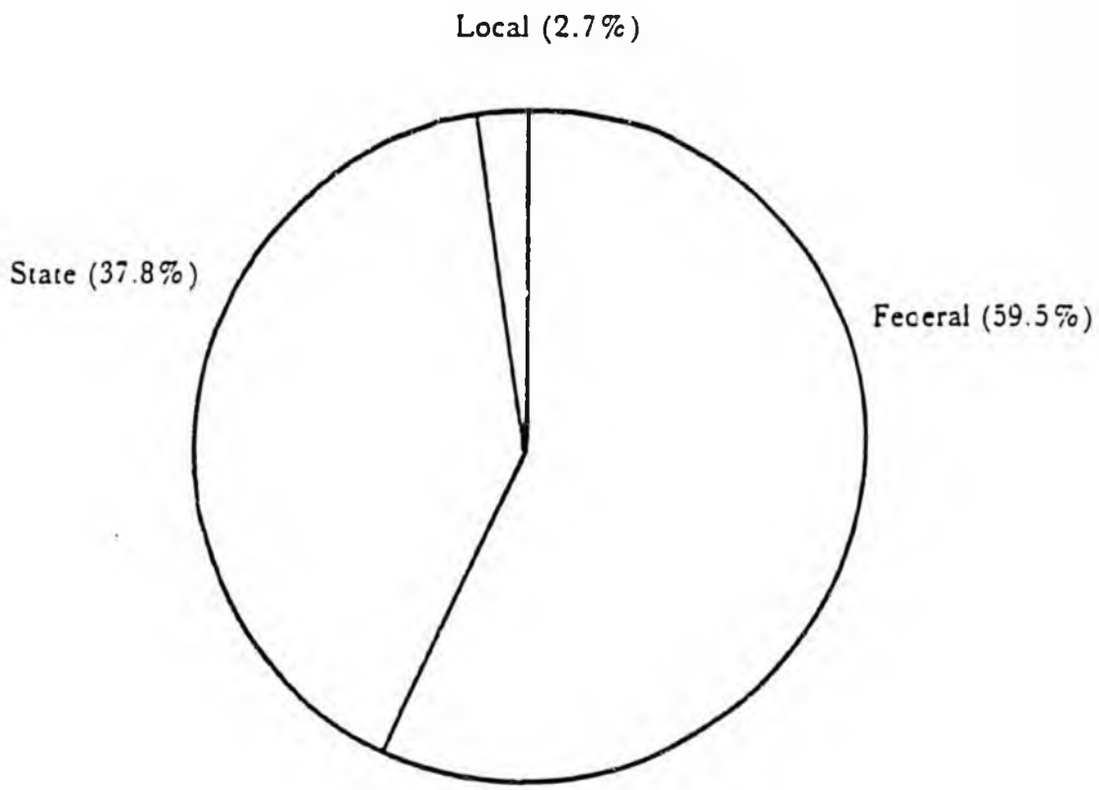
It is evident that if local units of government want to improve the current delivery system of care to the chronically mentally ill, localities must have greater financial control of their resources available to them for that purpose (see Figure 1). When we consider who pays for the care of the chronically mentally ill, we arrive at an inescapable conclusion: counties play only a small role and cities almost none.

Furthermore, at other levels of government, there are multiple categorical aid and entitlement programs that form an uneven patchwork of support for this neediest segment of the mentally ill. These multiple funding sources contribute to the problems in the system today: diffusion of authority, weak

Figure 1
ESTIMATED EXPENDITURES FOR THE CMI
by Governmental Level, 1983



Total expenditures = $11.1 billion. Federal category includes expenditures for the following programs: Medicare, Medicaid, SSI, SSDI, block grants, Title XX, and housing. State category includes Medicaid and direct allocations.

accountability structures, inadequate product definition, inflexibility in the management of cash flow and limited ability to generate capital. The chronically mentally ill, least able to advocate on their own behalf, are the ones most likely to suffer the consequences of this situation: disruption in continuity of care, inadequate or inappropriate provision of services, neglect and abandonment. It is the cities, however, that must pay for the inadequacies of the system through their fire, police, courts and welfare support.

The complexity of the issues that must be considered is linked to the fact that for the chronically mentally ill, mental health care is only one type of service required. Housing, social and rehabilitation services, medical care and basic minimum maintenance needs also have to be met. Multiple funding sources support these needs, some more adequately than others, within a maze of regulations, eligibility criteria, and benefits. The resources available to meet these needs vary by state and locality, but barriers to using these resources optimally exist everywhere.

The central theme of this paper is that a reconsideration of how to surmount those barriers must include examination of how public mental health care is reimbursed. We know that with greater control of financial resources there should be increased efficiency. This control might be accomplished by channeling the multiple revenue streams into one pool where the local agency can redistribute the funds according to whatever distributive model is most appropriate for the locality. It is the structure of the model that interests us here. We assume that each type of payment mechanism has particular economic incentives and disincentives; therefore these mechanisms will drive the system in different ways. The goal would be to come as close as possible to the ideal payment mechanism, which would result in a system that would balance provider and client interests at the lowest possible cost. The next section of the paper describes different types of payment mechanisms and the implications for the provision of public services.

In the final section of the paper we will review some ways in which others have considered these same issues and proposed solutions. Each model for financing long term care that we describe has considerable strengths, but some weaknesses as well. These models illustrate some of the inherent tensions in the delivery of public services. A delicate balance must be struck between the civil rights of the chronically mentally ill and society's right to manage cost-effective services thought necessary for this population. The manner in which the different revenue streams are brought together and redistributed plays an important role in striking that balance.

This paper will address the financial issues related only to the operating costs for the care of the chronically mentally ill. Raising capital for public facilities is at least as difficult a problem for local communities, but the issues are somewhat different and we save them for future study.

PAYMENT MECHANISMS: USING REVENUES EFFICIENTLY

As a framework for considering financial models for long term care, this section summarizes the three major methods of paying for mental health services. As we review different options in payment—direct allocation, cost-based or fee-for-service reimbursement, and prospective payment—we will comment on the incentives embedded in the method, and the likely consequences for quality of care and service demand by chronically mentally ill clients.

Direct Allocation

Historically, the public provision of mental health services has been in the form of state supported services-in-kind, most notably state hospitals. Budget allocations are determined by the legislature, and set independently of actual service utilization. In most states, the budget process does not specify the number of units of service to be delivered, nor do state legislators rely on product definition to determine the allocation.

Because of the direction of the flow of funds, i.e., typically, through the state department of mental health (SDMH) directly to service programs, continued allocations to agencies are dependent on their ability to design services to fit the SDMH's current funding priorities. These may be heavily influenced by political or social pressures; therefore, service provision at any given time may be an expedient response to these priorities. Some states have recognized this problem and have experimented with a number of different payment methods to minimize it.

At least three-quarters of the states do have a systematic mathematical formula for distributing the appropriations among counties or areas (Stephen Leff, personal communication concerning work in progress). Leff, in categorizing resource allocation models, has been able to identify models that fall into three general types: equity models, efficiency models and mixed equity/efficiency models. Most states use equity models that rely on determination of what clients need and what resources exist to serve those needs. Efficiency models, on the other hand, make allocations based on provider performance and production. Because client outcome is difficult to measure and product definition is hazy, only a small percentage of states use this concept. New Jersey is one example of a successful statewide implementation. Some states use a mix of equity and efficiency models. For example, in Pennsylvania (Miller, 1985), each CMHC receives a portion of its allocation based on relative need for services, and the remainder is determined by a number of performance factors, such as prevention of state hospital admissions.

Virtually every state has developed some financial mechanism for reducing dependence on state hospitals for the provision of services. In Texas, for example, the reduction of state hospital bed days is encouraged by returning $35.50 to

CMHCs for every bed day less than their annual baseline number of days. The funds accrued through this mechanism are expected to be used for community-based services for those at greatest risk for rehospitalization. In Rhode Island, allocations to CMHC's are based, in part, on the number of discharged state hospital patients they admit to their systems. For every former patient, the center is allotted $500 a month, which they lose if the patient is returned to the hospital for more than thirty days.

Cost-based Reimbursement and Fee-for-Service

Cost based-reimbursement for hospitals and fee-for-service for physicians have been described by some as a "blank check" rewarding providers for high utilization of services. For this type of reimbursement, the fee charged is directly related to the demonstrated costs to provide the service to the patient. Hospital charges have been based on patient-specific resource use calculated after the services have been delivered. The physician's fees are established through a normative process by insurance companies, although physicians can, of course, choose to set their fee at any level. To deviate from the "usual and customary" range of charges for a service is to put reimbursement by a third party payer at risk.

The strength of these approaches to payment lies in the choice they provide consumers, which is thought to provide beneficiaries with sufficient leverage to ensure high quality care. However, these payment mechanisms have come under heavy criticism for their open ended-nature and influence on the cost and delivery of services. Spiralling health care costs have resulted, in part, from economic incentives to provide more services than are thought to be necessary. These types of payment mechanisms are not exclusive to private insurance: over 95 percent of all those eligible for Medicare or Medicaid select (or change) providers with the same freedom as those with private insurance.

Preferred Provider Organizations (PPOs). Faced with escalating costs, policymakers, insurers, and providers have devised various cost containment strategies. The most widely discussed method of reducing costs while keeping the fee-for-service system intact is the preferred provider organization (PPO). In a PPO, a group of providers, e.g., physicians or hospitals, join together and provide care at a discounted rate negotiated with an insurance carrier or other third party payer. The PPO's appeal is that it preserves the choice of providers associated with traditional health care delivery while minimally disrupting the provision and billing of services. Payers save through discounted rates, and providers benefit from increased volume.

PPO-type arrangements between state or local governments and vendors of mental health care would work best when there is an oversupply of providers, which would be an incentive for providers to accept a reduced fee in exchange for a greater share of patients. PPOs identify certain providers with enough financial flexibility to absorb the discounted rate that characterizes PPO contracts.

Typically, vendors of services to the chronically mentally ill are scarce and underfunded, conditions which suggest that PPOs would be difficult to arrange.

Prospective Payment

In prospective payment systems (PPS), the level of payment is determined before services are provided. The level of payment may be derived by a number of means, but it is always independent of the cost of services for a particular case. Paying prospectively requires that the "product" be defined, that is, by a description of the type of service or services, including some temporal characteristic. Payments might be for a hospital admission, for an episode of illness, or for some specified length of time, irrespective of illness or treatment considerations. Prospectively-determined fixed payments have incentives to increase the efficiency of service delivery, but utilization controls may result in underserving the chronically mentally ill.

Hospital Admissions. Since 1983, Medicare psychiatric admissions, in general acute care hospital scatter-beds have been paid prospectively at a predetermined rate. The rates vary depending on the patient's discharge diagnosis and within which Diagnostic-Related-Group (DRG) it falls. Because the hospital is at risk for costs that exceed the reimbursement, there is a clear financial incentive to minimize costs.

Unfortunately, there is also a clear financial incentive to increase the volume of admissions, especially those admissions that are likely to be the least costly to treat, since hospitals retain the entire reimbursement for each admission, irrespective of the cost of the admission. Although the average length of stay for disabled adults paid for by Medicare is no longer than that for the elderly, there is a widely held assumption that this is not the case. Although evidence is to the contrary, the perception is that chronic mental patients often present more, rather than less, complex treatment problems, and are thought to be bad financial risks. This may be true over the course of a year, but it is not true for each hospital stay. This perception probably leads to undertreatment and premature discharge. It is already known that limits on stay in general hospitals lead to increased admissions to state hospitals (Frank and Lave, 1985).

Medicare's PPS was the subject of intensive study in 1985, as Congress considered whether or not specialized psychiatric and substance abuse facilities or units in general hospitals should be included and, if so, under what conditions. HCFA's report to Congress at the end of the year recommended that more research be undertaken before including psychiatric and substance abuse admissions in speciality settings under PPS.

Episode of Illness. We know of no reimbursement mechanisms that make payments at the level of episode of illness, but health policy researchers have begun to use this concept in their analysis of mental health care utilization. The way in which an episode of illness is defined is shaped by whether the concept

is going to be used by researchers, reimbursers of treatment, or monitors of quality of care. For the chronically mentally ill, the task of setting parameters around "episode of illness" may be so difficult and of such limited value that this approach to reimbursement does not hold much promise.

Capitated Payments. Capitated payments are a prospective rate for health care per member (or per family) per year, regardless of the level of use. In capitated systems, the payment to the provider is in the form of annual premiums, derived in part from actuarial data that determine the level of financial risk borne by the provider relative to a given population. Whether the payment is defined as a fixed annual per-patient rate or as an annual per-member premium, providers enter into a contract to deliver comprehensive services and assume financial risk. This arrangement has appeal both to large purchasers of services hoping to contain costs and to providers in areas where their oversupply has lead to competitive efforts to gain a share of the market. Health Maintenance Organizations (HMOs) are the most common example of capitated payment systems.

Under a provision of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, Medicare eligibles can enroll in federally-qualified HMOs for their care. The Health Care Financing Administration negotiates an annual (adjusted) premium rate with the HMO; this represents about a five percent saving over equivalent fee-for-service treatment.

In order to enroll Medicare beneficiaries in a prepaid managed health care project, the project must be a federally qualified health maintenance organization, a health insuring organization that subcontracts services, or a formal demonstration project under Section 1115 of the Social Security Act, which permits waivers of federal Medicare requirements for demonstration purposes.

The usefulness of a capitated system as a mechanism for providing long-term care for the chronically mentally ill is limited by the nature of the benefits (acute and short-term) offered by Medicare and HMOs. Furthermore, there are incentives to limit access to these expensive patients, and if enrolled, incentives to underserve.

In a recent review, Bonanno and Wetle (1984) identified two additional problems. HCFA regulations for Medicare enrollment in federally qualified HMOs result in two major disincentives to enroll the chronically mentally ill: first, the method of arriving at the rate of reimbursement means that some HMOs may systematically incur financial losses; and second, HMOs that do realize savings, must return them in the form of increased benefits or reduced premiums rather than use them to establish a reserve fund to cover risk exposure.

Another critic of prepaid settings for chronic illness is Schlesinger (1985), who argues that the quality of care will decrease, not increase, for chronic patients treated in these settings for two reasons: health care professionals consider it more prestigious and satisfying to treat acute illness, and the financial incentives

embedded in the prepaid setting lead to the likelihood that the chronically mentally ill will be underserved. He points out, as have others, that the services most needed by this population are non-medical in nature and not likely to be offered within the HMO benefit package.

Schlesinger also makes another point: being able to use vouchers to purchase from among several capitated plans is thought to guard against reductions in the quality of care. For the chronically mentally ill, however, the advantages of such choice seem illusory. There is evidence that the chronically mentally ill undervalue long-term care coverage, and that they are ill-equipped to weigh the differential advantages of complex benefit plans.

EXAMINING LONG-TERM CARE FINANCING MODELS

Each of the following models is an example of pooled revenue streams combined with payment mechanisms designed to accomplish certain goals of the system. The Somers, Ruchlin and Santiago models are proposals made by health policy researchers and planners. The S/HMO model is currently in a HCFA demonstration phase and the Marshall model is a pilot project, about to become operational. The Dane county model has been operational for many years. Only evaluation of the projects in operation will answer questions about their utility, but their promise to provide mental health, medical and social services deserves attention.

Somers: Increased, Locally Administered Medicare Coverage

Of the models presented, this one proposes the fewest changes in the current system: pooling existing resources, paying them out in a capitation mechanism, and adding long term care to the benefits to those already established. This proposal, first presented to the National Council on Aging in 1981 (Somers, 1982) suggests that both acute and long-term care for the elderly and disabled could be covered by Medicare. Within guidelines established by HHS, the program would be administered by a public or private body in the local community.

The program would have three primary functions: 1) to ensure co-ordination among health-care institutions, agencies, and other programs for the elderly and disabled, 2) to allocate resources, equitably and effectively, and 3) to provide assessments, placement, and case management for patients. The program would be supported by transferring funds, currently budgeted under Medicaid and Title XX, to Medicare. All Medicare providers would be paid fixed rates prospectively as a cost control measure. Cost-sharing formulas for various long term benefits would be developed by HHS.

The author states that

> [the proposed program] aims to retain the proven strengths of Medicare, including its nearly universal entitlement for the elderly and seriously disabled, its requirement for physician

> responsibility, its quasi-insurance type of financing, its tremendous resources and its high standards of quality, while suggesting new restraints on provider payments for all types of benefits. . . . To private health-insurance carriers, it offers a new market for supplementary coverage for long-term care, even more extensive than the Medigap market opened up in 1965, because cost sharing will inevitably be required. To . . . others who may fear the "medical model" it offers a piece of the action in the mainstream rather than an illusory independence in a peripheral program.

While this model appears to have something for everyone, it may benefit consumers the least and providers the most.

Ruchlin, Morris and Eggert: Local Area Management Organization (LAMO)

This proposal is designed for the frail elderly and the portion of the disabled population that requires institutional care (Ruchlin, *et al.*, 1982). It differs from the preceding model by identifying a sub-population where needs are primarily non-medical and best met through a set of comprehensive support services which include acute medical care when it is needed. Local boards, comprised of individuals representing public and private interest, make policies but delegate operational authority to the LAMO. In turn, each LAMO has the power to determine which individuals are eligible for public services, which services they should receive and for how long, and which providers will be certified to receive reimbursement from public funds. The LAMO is at risk for all necessary medical, rehabilitative, and maintenance services for its enrollees, thus encouraging cost-effective care and placement. It proposes a community level program with four functions: gate-keeping and service allotment, case-management, quality of care assessment, and payment of care.

Initially, funds for operating costs would come from pooling federal block grants, SSA Titles XIX (Medicaid), and XX (Social Services) revenues, and turning over in the form of a capitated annual payment, a lump sum payment to each LAMO. The authors argue for gradual privatizing of the programs.

Ruchlin, *et al.* see LAMOs as benefitting not simply the medically indigent but all those who need its services. To accomplish this, they suggest that private support for LAMOs might supplement public funds by operating in much the same way as individual retirement accounts. Employers and employees would make regular contributions to an account (a "medical" IRA) and an employee, on retirement, would annually receive a set of vouchers earmarked for the purchase of long-term care, either for the employee or his/her relatives. These long-term care accounts would have characteristics similar to IRAs, e.g., tax credits for contributions, provision for disposition of unused vouchers, and penalties for early withdrawal of contributions.

The authors contend that the advantage of encouraging private enrollment in a LAMO is that it avoids the development of a second class system of care for the indigent. Vouchers would be used to purchase the minimum package

of services (or more, if additional vouchers had been accumulated), encouraging competition among LAMOs with the presumed benefits that are believed to accompany competition.

The authors acknowledge that setting up such a system like the one described carries with it some difficult problems: excessive or unplanned start-up costs, delays in seeking waivers or negotiating necessary agreements and contracts, and resistance from care-givers or family members who are reluctant to agree to moving institutionalized patients into less resource-intensive settings. Critics of the proposal have pointed out that setting up a special program for a small segment of the population may make it too vulnerable to political pressures to be financially viable.

Diamond and Berman: Social and Health Maintenance Organizations (S/HMOs)

S/HMOs (Diamond and Berman, 1981) are designed to provide a comprehensive package of social, medical, and personal care services to anyone over age sixty-five and are currently being tested in Medicaid demonstration projects around the country. The service packages offered are similar to those that would benefit chronic mental patients: inpatient and outpatient medical and mental health services; physical and occupational therapy; home health services including skilled nursing care and home health aides; homemaker and chore services; prescription drugs; and transportation. The inclusion of long-term care services with case management is thought to improve continuity of care and reduce costly inpatient utilization.

Capitation payments would come from pooled Title XIII (Medicare) and Title XX (Social Services) monies, with additional premiums for Medigap-equivalent coverage and for personal services. Enrollment would be voluntary. The financial viability of the plan rests on selecting a target group which spans a wide range of conditions and needs so that the risk pool is large enough to absorb the costs of the most vulnerable enrollees. Analysis of the pilot projects have not yet reported whether adverse selection (i.e., the enrollment in a plan of a disproportionate share of "bad risks") has resulted in financial overruns. While dependence on a target group with a varied range of conditions is not very realistic if the only enrollees are the chronically mentally ill, the program might work if they were a small subset of all enrollees. The following plan addresses this problem directly by establishing a different mechanism for assigning annual payments.

Marshall: Integrated Mental Health, Inc.

This unusual public-private system, designed specifically for the chronically mentally ill, has joined local businessmen, community providers, and state public planners and bureaucrats (Marshall, 1986). It is now in the final planning stages in Monroe and Livingston counties, New York. A public corporation, Integrated Mental Health Inc., (IMH) was set up five years ago to plan for and ultimately

administer services to the chronically mentally ill under an annual reimbursement plan.

A lead agency (usually a local CMHC) would receive a budget allocation determined by number of enrollees and their levels of need. Four or five lead agencies are expected to compete for enrollees. All must offer a comprehensive set of services. Direct mental health services are likely to be provided by the agency (probably a CMHC), and all other services, such as housing, social, or rehabilitation services will be purchased from other local agencies. The lead agency would also pay for state hospital admissions and all medical care.

IMH has identified about 1800 chronically mentally ill eligible for services based on utilization over the past three years. They are categorized into three levels of expected need: those with a long history of state hospital use, those who have a history of "revolving door" hospital treatment, and those who are at risk for hospital admission and have high need for ambulatory care. The estimated annual allocations by category (in 1982 dollars) are $32,000, $8,000 and $5,000 per person.

These annual payments would cover all the enrollees' needs. Budget allocations would be adjusted annually for inflation and for changes greater than five percent in enrollment figures. Adjustments that do occur will be made only on that portion of the budget accounting for variable (rather than fixed) costs.

Lead agencies benefit in a number of ways from this plan. The predictable income level provides increased stability which permits long range planning, efficient expenditure of funds and management of cash flow. The agencies are protected from unpredictable catastrophic expenses through reinsurance provided by IMH and paid for by ten percent of the total annual allocation.

The provision of cost-effective care is encouraged by allowing agencies to retain ten percent of their net revenues. The agencies return additional excess to IMH for redistribution to other lead agencies with deficits. Redistribution might be necessary because of unexpected population shifts or other factors, beyond the control of the lead agency, that affect income levels. Excess revenues returned to IMH might also be used to start up needed services.

This system was designed to provide sufficient financial incentives to drive itself without bureaucratic oversight and monitoring constraints. Any revenues generated from third party reimbursement or categorical aid are collected by the agency that delivers the service and are returned to the lead agency. The lead agency returns the state and county share to the respective governmental units, but the federal share is returned to the state for redistribution to IMH later as a portion of their budget allocation.

Santiago: Regional Authorities for Comprehensive Care

The Arizona legislature has approved a plan to provide all the care for the chronically mentally ill through nine public corporations with regional responsibility (Santiago, 1986). Funding for each Regional Authority will be

pooled from county, state and federal sources and distributed across the state regions by a formula that may be weighted to take case mix into account. The Regional Authority will fund multi-disciplinary clinical teams who in turn will arrange for the provision of all services needed by chronically mentally ill clients assigned to them by the authority.

Services are rank-ordered in the proposal as essential, necessary, or helpful to ensure that state planning priorities are consistently followed and the neediest patients are cared for adequately. The continuum of care described in the proposal begins with food, shelter, and clothing as essential. Institutionally based services, including acute and long term hospitalization are purchased by the team, but other services such as outreach, evaluation, and family education and support are provided by team members.

The proposal outlines a number of principles that guide the plan: dollars follow the client; the Regional Authority, the clinical team, and the institutional providers must be independent of each other to ensure that there is no conflict of interest; families and clients must be represented by advocates and actively encouraged to participate in the system; special emphasis must be on very low functioning and difficult clients; and the system must be flexible to accomodate individual, local and regional variations in culture.

Quality of care will be subject to scrutiny by an external evaluation agency that will report to the Governor. Another feature of the plan expected to ensure quality of care is that each Regional Authority will select the teams through a competitive review and, once selected, each team will have its performance reviewed before contract renewal. The team, in turn, will be selective in purchasing services. Where more than one provider offers the same service(s), presumably the team will select the provider that offers the best value for the money.

Stein and Ganser: Dane County, Wisconsin Mental Health Services

In Wisconsin, the provision of public mental health services is the responsibility of counties, rather than being centalized at the state level. Each county must pay for the inpatient stays of its residents as well as community-based services using state allocated funds supplemented by local monies. This type of financial structure exemplifies the money following the patient, in a system that encourages (but does not guarantee) cost-effective case management through the use of hospital alternatives. The assignment of total responsibility to the county for the comprehensive care of the mentally ill has centralized both clinical responsibility and financial accountability in the same administrative structure. The state has gradually reduced its share of the funding, forcing counties to increase their contribution. This has had the effect of further solidifying the responsibility within the county structure.

Dane County, which has a population of 300,000, has identified 1,002 individuals with chronic mental illness. County officials have developed several

mechanisms to reduce the use of inpatient care: Crisis Intervention Service, which provides crisis intervention and acts as a "gatekeeper" to hospital treatment; Mobile Community Treatment Team, which helps patients develop and maintain support systems and encourages work activity; Support Network, a day activity program with comprehensive services that support disabled adults to live more fulfilling lives in the community; and specialized living arrangements for over two hundred of the chronically mentally ill.

In Dane County, about eighty-three percent of the mental health dollars go for community-based services. However, some Wisconsin counties have not developed community alternatives to inpatient care and have hospital expenditures as high as seventy percent of their total budget. Merely assigning responsibility to the county will not guarantee cost-effective programs. Commitment to the development of services and housing in the community must be a priority with the management team.

Model Building and Conflicting Assumptions. The models described illustrate some of the implicit choices that planners must make in devising new financial structures. These models tend to highlight current trends in the health care field, trends that have come about because of past failures in existing systems. The trends most apparent here are cost-containment, usually in the form of capitation or capped budget allocations; competition among providers for market share; and the designation of case management as a function distinct from service provision.

Cost-containment Strategies. Capitation, as a cost containment strategy, is a powerful tool for limiting expenditures, especially when there is some financial incentive for the capitated providers. Only one of the models described, the S/HMO, is a true capitation model, opening enrollment to all those who think that they may some time in the future need the services the S/HMO offers at a fixed premium, not those actually needing services at the time of enrollment. In capitated systems, if the expenditures exceed the revenues in any given year, the annual premium can be raised the following year. This is not the case with budget allocations, as in Wisconsin and New York, which have some of the same cost-containment effect, but the incentives are somewhat different: more a stick than a carrot. New York allows the lead agencies to keep ten percent of the "excess" after expenditures as an incentive to providers. In general, however, the notion of "excess" in public agencies implies poor allocation planning and is unlikely to be viewed favorably by taxpayers. Publicly funded services are not designed to be profit-making, although competitive salaries and attractive facilities may be attained if it can be shown that reimbursable services (i.e., revenue generation) can be provided in settings that meet private sector standards.

Client Choices. Pressures to reconsider traditional health care financing mechanisms (e.g., fee-for-service) have led policymakers to look closely at alternative approaches. Two themes that reoccur in many of the proposed payment systems

currently being considered are fiscal incentives and marketplace competition. Current thinking favors systems that are in line with our commercial economic values: marketplace incentives will keep "product" costs competitive while informed "consumers" shop around for the best value for their money.

Implicit in the theory of free markets is the notion of informed choice on the part of the consumer, which results in shifts away from the purchase of overvalued products. Although the idea of informed choice in health care is appealing, there is little evidence that the forces described have operated as predicted. Therefore, we are not optimistic about the ability of the chronically mentally ill, whose judgment may be impaired, to be more discerning consumers than other segments of society.

It has been acknowledged by those who favor competition of some kind that there are some potential dangers in this approach. Attracting and keeping members enrolled may lead to excesses in promised but undelivered services. However, changing providers to improve the quality of care (or to save money) is likely to be in conflict with assumptions about the need for continuity of care and the importance of stable relationships to the chronically mentally ill.

Related indirectly to client choice is the geographic site of the provider(s), important to the chronically mentally ill who may have difficulty with transportation. Even when transportation is not a special problem, it is not uncommon for all health care consumers to limit their actual choice to the provider most conveniently located.

Case Management and Service Provision. Each of these models offers a somewhat different approach to solving the inherent conflict of interest in traditional models of care, where the same provider identifies and assesses the (mental) health care problem, prescribes treatment and delivers the treatment. The Santiago model is the most explicit in its statements about separating case assessment and management from service provision. Dane County and the LAMO proposal appear to be structured in this way as well. While this issue of who controls service delivery may seem to be removed from the financial aspects of system planning, control of expenditures is a key factor and, depending on where the control resides, both revenues and costs will be affected. Case management teams add a level of bureaucracy to the system that is an additional expense, but may be necessary when the administration of multiple providers is unable to ensure continuity and quality of care.

SUMMARY

Problem-solving must begin with identifying the available resources, taking maximum advantage of them, and exploring avenues for generating new revenue. Once all possible revenues and resources have been identified, the methods by which they can be most efficiently used is the next step in the problem-solving

process. The ability to determine the method of payment is not contingent on pulling all the revenues and resources into a pool managed by a single administrative structure. However, if local units of government are to be held accountable for the efficient expenditure of those resources, they must have the capability to manage their resources.

Clearly, a large part of the challenge will be the political barriers that surround the process just described. Although we must leave the discussion of the political issues to others, we do not want to appear to underestimate them. Of singular importance is the fact that the segment of the population with the greatest need, the chronically mentally ill, is also the population least able to leverage the political system and has the fewest advocates.

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Senator John B. (Jack) Coghill
Alaska State Legislature

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Juneau, Alaska 99811
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North Pole, Alaska 99705
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MEMORANDUM

DATE: March 17, 1990

TO: Senator Bettye Fahrenkamp
Senate Resource Committee Chair

FROM: Senator Jack Coghill

SUBJECT: Sponsor Statement: CS SB 493; Mental Health Trust.

BILL SUMMARY
This legislation basically does three things:

1) it establishes a value for the Mental Health Trust Lands, as required by SLA 1987 Ch. 48;
2) it reconstitutes the corpus of the Mental Health Lands Trust; and
3) it establishes an indexed, revaluation process.

FISCAL IMPACT
The Department of Natural Resources has given this bill a zero fiscal note. The Department of Health & Social Service gave the original bill a zero fiscal note, and we have not received an updated version, but we anticipate that it has not changed.

ABOUT THE BILL
The Senate HESS committee made several technical changes to the original bill. Page 2 of this memorandum contains those changes.

The purpose of the bill is rectify the impasse that was reached in November of 1989, regarding the value of the Mental Health Trust Lands, between the interim mental health trust commission and the commissIoner of natural resources. The source of the impasse is the value placed on mental health lands as established under SLA 1987 CH. 48. Two members of the interim mental health commission endorsed the $ 2.2 billion arrived at through their process. The third member, DNR, believes the valuation process was flawed. In DNR's minority opinion, the bench mark value should be approximately $ 622,525,043.00. The largest area of disagreement is the value of mineral resources. DNR places a value of $ 73.4 million and the independent appraisers estimate a value of $ 1.5 billion.

SENATE HESS AMENDMENTS TO SB 493

Page 1, line 11: Delete, "fair".

Page 1, line 12: Delate, "market".

Page 1, line 12: After "land" insert,

"selected or patented to the state under sec. 202 of the Alaska Mental Health Enabling Act."

Page 1, line 20: After "Act" insert,

"that is located in municipalities that assess land for property tax purposes;"

Page 1, line 24: After "municipality" delete the comma and insert,

"since that municipality's assessed values were used to revalue land selected or patented to the state under sec. 202 of the Alaska Mental Health;"

STATE OF ALASKA
THE LEGISLATURE

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
907·465·3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M April 25, 1990

SUBJECT: Mental health trust
(CSSB 493 (HESS))

TO: Senator Jack Coghill

FROM: Richard A. Bradley
Legislative Counsel

Bruce Geraghty has requested a sectional analysis that points out the differences between SB 493 as introduced and CSSB 493 (HESS).

Section 1 of both bills repeals and reenacts AS 37.14.011(c).

In the introductory paragraph of (c), the words "fair market" are deleted in CSSB 493 from the phrase "fair market value of the land" on lines 11 - 12 of SB 493. Similarly, after the "value of the land" on line 12 in SB 493, the phrase "selected or patented to the state under sec. 202 of the Alaska Mental Health Enabling Act" is added in the CS.

In [illegible] after the phrase "acres of land selected or patented to the state under sec. 202 of the Alaska Mental Health Enabling Act" in SB 493 at line 20 is added the phrase "that is located in municipalities that assess land for property tax purposes" in the CS.

In (c)(2), after the phrase "the average percentage change in assessed values for that municipality" in SB 493 at line 24 is added the phrase "since that municipality's assessed values were used to revalue land selected or patented to the state under sec. 202 of the Alaska Mental Health Enabling Act;" in the CS.

There are no other revisions from SB 493 to the CS.

If I may be of further assistance, please advise.

RAB:gc
G14/032

MEMORANDUM

State of Alaska

Community and Regional Affairs

TO: G. Thomas Koester
Asst. Attorney General
Department of Law

DATE: April 26, 1990

FILE NO: 0526T/MW/cbs/1410.12

TELEPHONE NO: 465-4750

THRU:

SUBJECT: CS HB 493 (HESS)

FROM: Michael Worley
State Assessor
Municipal and Regional
Assistance Division

You have requested my comments with regard to the revaluation formula contained in CS HB 493 (HESS).

Under the proposed formula, the actual assessed value for land in property taxing municipalities would be used to develop the ratios and resulting "revaluation factor" for time-adjusting the estimated values for these lands. That approach raises three concerns:

1. Municipalities have the flexibility under AS 29.45.050 to exempt property from local taxation by local option. Property values which are optionally exempted, or for which an optional exemption is removed, would change the levels of actual local assessed values. Changes in assessed land values resulting from these actions would skew the ratios and factors set out in the current version of the revaluation procedure.

2. The proposed revaluation procedure does not provide for geographic differentials in the increases (or reductions) in land values. The proposal calls for land value changes only in property taxing jurisdictions to serve as a basis for all of these lands statewide. In fact, there are often wide disparities in the rates of property value changes, based on their geographic location within the State. In addition, Alaska's property taxing jurisdictions tend to be more highly populated than other jurisdictions and areas of the State. In highly populated areas, supply and demand generally causes annual property appreciation rates to be higher than those in lower populated areas. Therefore, under the current proposal, remote properties would likely be revalued using rates which are too high, and therefore inaccurate.

3. The proposal calls for these properties to be revalued every five years. In the five year period from 1980 through 1985, taxable property values in Alaska experienced a change equal to plus 64.25%. In the four year period from 1986 through 1989, those values dropped 24.23%. Because Alaska's boom and bust history, it is likely similar drastic changes in property values will occur in the future. To reflect a true picture of the rises or drops in property values, a revaluation of these lands should be conducted annually.

Each of three concerns noted above could be successfully addressed if, instead of using the actual local assessed values in the proposal procedure, the Full Value Determination (under AS 14.17.140) were used. The Full Value Determination takes into account locally exempted property values and is estimated virtually for all areas of the State, not just for those municipalities which levy a property tax. Therefore, the Full Values could, and should be, geographically segregated to reflect more accurate adjustments to these lands according to their location. In addition, the Full Value Determination is already required under statutes to be developed annually. Therefore, an annual revaluation of the lands would be relatively simple to accomplish.

In the event the Full Value Determination were used for this purpose, and assuming geographic differential adjustment factors were established in regulations, the cost to the Department of Community and Regional Affairs for the public hearing process would be approximately $5,000.

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM February 13, 1990

SUBJECT: Mental health trust (SB 493)

TO: Senator Jack Coghill

FROM: Richard A. Bradley
Legislative Counsel

Bruce Geraghty has requested a sectional analysis of the above described bill.

As a preliminary matter, note that a sectional analysis or summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1 of the bill repeals and reenacts AS 37.14.011(c). AS 37.14.010 - 37.14.050 establishes the "Mental Health Trust Income Account; AS 37.14.011 also establishes the "mental health trust income account." The subsection now provides:

> (c) The fair market rental value of the land constituting the mental health trust corpus is equal to eight percent of the fair market value of the land. Following the initial determination of the fair market value of the land selected by and patented to the state under sec. 202 of the Alaska Mental Health Enabling Act, the commissioner of natural resources shall redetermine the fair market value of the land constituting the mental health trust corpus at least every five years and provide the redetermined value to the commissioner of revenue and the board established under AS 47.30.661.

As repealed and reenacted (it would not have been possible to "amend" it), the section continues the value at "eight

percent of the fair market value of the land" but it affirmatively establishes a mathematical formula for that valuation. I believe that since that formula is all critical to the definition, it would be inappropriate to recast the language in a "sectional analysis" format and I believe that the four paragraphs of (c) should be read directly. While they are technical, they are understandable.

Section 2 of the bill adds a new subsection (d) to AS 37.14.011; the subsection directs the commissioner of natural resources to "calculate the redetermined value of the trust under (c) and provide the redetermined value to the commissioner of revenue and the board."

Section 3 of the bill provides for the "reconstitution and administration of mental health land trust." Note that Section 4 of the bill repeals AS 38.05.800, a section with the same caption; in drafting this section, I made the judgement that it was not possible to "amend" existing AS 38.05.800 and hence the suggested approach was taken. In the nature of things, it will be necessary to quote much of the language directly-- and then to comment on it. I do not want to misstate any of the language in this analysis.

Sec. 38.05.801(a) states that the "value of all land selected by or patented to the state under the Alaska Mental Health Enabling Act as of September 7, 1987, is $2,243,000,000." I do not know the source of the figure but I believe that the date is the effective date of ch. 48, SLA 1987 (CSHB 92 (Fin) am), the Act that responded to the Alaska Supreme Court's decision invalidating the earlier legislative management of the land received under the Alaska Mental Health Enabling Act, P.L. 84- 839, 70 Stat. 709.

Sec. 38.05.801(b) provides that "[a]ll land within legislative designations on the effective date of this Act and all land made subject to legislative designations in the future constitute the corpus of the mental health land trust." As I understand the usage, a "legislative designation" is an Act by the legislature that withdraws land for a particular purpose. The land established for parks, state forests, public use areas, recreational rivers, and so forth, primarily within AS 41 but also within AS 16.20 (sanctuaries, critical habitats, etc.) would be within these "designations."

The term "corpus" is legalese for the "body" or the substance of the trust.

Thus, if this section is enacted, the future establishment of land within a "legislative designation" would, by that act, commit the land to the corpus of the trust.

Sec. 38.05.801(c) provides that "[o]n the reconstitution of the trust under this section," the remainder of the land of the state "that is not within legislative designations is removed from trust status." The provision seems self-explanatory.

Sec. 38.05.801(d) provides that the land within the "legislative designations" shall be managed under the provisions of law now governing them. The trust will be compensated under AS 37.14.011; see existing law as amended by Sections 1 and 2 of this bill.

Sec. 38.05.801(e) provides that "[b]efore the state may remove land [from a legislative designation], replacement land equal in value at the time of replacement shall be designated mental health land and added to the trust corpus." What this means is that land may not be withdrawn from a legislative designation (park, state forest, etc.) until equal value land is added to a legislative designation. The latter portion of the section outlines this procedure.

While it seems that there is a Catch 22 here in that when land is established as a legislative designation, by that designation it becomes part of the trust corpus and thus not available for use as replacement land, it seems that there may be an option for the state to establish the new legislative designation conditionally; that is, to create it subject to its use as matching land for land removed from designation. While the legislature has not removed land from a legislative designation very often, the legislature may wish to avail itself of this option prospectively to protect itself and to maintain flexibility.

Section 4 of the bill repeals AS 38.05.800. Note my comments on the repeal under Section 3.

If I may be of further assistance, please advise.

RAB:pl
WKP2/037

ALASKA MENTAL HEALTH BOARD

STEVE COWPER, GOVERNOR
STATE OF ALASKA

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February 28, 1990

Senator Jack Coghill
Room 30, Capitol
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Juneau, AK 99811

Honorable Senator Coghill,

The Alaska Mental Health Board(AMHB) had the opportunity to review your legislation, SB493, "An Act relating to the reconstitution and administration of the mental health trust." The AMHB Legislative Committee reviewed the bill and the full board heard comment on the legislation this past weekend. The AMHB took action in support of the intent of SB493 including that:

(1) the Legislature recognize the trust value of $2,243,000,000 established under procedures approved by the Interim Mental Health Trust Commission,

(2) land and resources in legislatively designated areas be identified as security for the trust corpus, and

(3) revaluation procedures be established which effectively continue to reflect the value of the original trust lands over time.

In actions related to the AMHB discussion of SB493, the Board re-affirmed its prior action supporting appointment of an independent trustee for the mental health trust and urging the appointment of an interim trustee pending final resolution of issues in the Weiss v. State litigation.

On behalf of the Alaska Mental Health Board I convey their support for the intent of SB493. Your continued efforts to resolve the long standing problems caused by the state's breach of the mental health trust are greatly appreciated.

Sincerely,

Dennis M. Scholl, Ph.D.
Executive Director

cc.
AMHB
Rep. Miller

selected by and patented to the state under sec. 202 of the Alaska Mental Health Enabling Act that is not within legislative designations is removed from trust status.

(e) The land within legislative designations that constitutes the mental health land trust shall continue to be administered for the legislatively designated purposes. The trust shall be compensated for the continued use of the mental health trust land for the legislatively designated purposes as provided in AS 37.14.011.

(f) Before the state may remove land that is part of the mental health trust corpus from trust status, and in addition to any other requirements of law, the commissioner of natural resources, consistent with the state's trust responsibilities, shall identify replacement land, equal in value at the time of replacement, within legislative designations and incorporate them into the mental health trust corpus. The commissioner of natural resources annually shall report any actions under this subsection to the board established under AS 47.30.661.

* Sec. 5. AS 39.25.120(c)(9) is amended by adding a new subparagraph to read:

(L) Alaska Mental Health Board;

* Sec. 6. AS 47.30 is amended by adding new sections to read:

Sec. 47.30.661. ALASKA MENTAL HEALTH BOARD. The Alaska Mental Health Board is established. For budgetary purposes, the board is located within the Department of Health and Social Services. The board is the state planning and coordinating agency for the purposes of federal and state laws relating to the mental health program of the state. The purpose of the board is to assist the state in ensuring an integrated comprehensive mental health program.

Sec. 47.30.662. COMPOSITION. (a) The board consists of the

Table 1 - MENTAL HEALTH TRUST LANDS
Inventory by status as of October 4, 1985

		Acres	Acres Remaining
1.	Trust Land Base (as corrected 1/23/87)		
	Patented to state	845,838.84	
	Approved for patent	159,872.00	
	Possible overconveyance	(5,710.84)	1,000,000[a]
2.	Conveyed Out of Trust and State Ownership		
	Land sales to individuals	46,137.49[b]	
	Condemned for Chena River Lakes Project (1978)	5,148.86	
	Total Out of Trust and State Ownership	51,286.35	948,713.65
3.	Conveyed Out of Trust & State, by Exchange and Settlement of Litigation[c]		
	Native Corporation land exchanges		
	- CIRI/USA (1979)	34,507.70	
	- Saldovia (1979)	1,768.11	
	U of A Settlement (1982)	2,993.37	
	Total Out Of Trust & State	39,269.08	909,446.27
4.	Conveyed Out of Trust to Municipalities[d]		
	- Patented to municipalities	22,680.73	
	- Approved for patent	20,407.01	
	Total Conveyed to Municipalities, Ownership in Question	43,087.74	866,358.53
5.	Conveyed Out of Trust, In State Ownership for Non-trust Purposes		
	State Refuge & Habitat Areas	85,709.61	
	State Forests	131,955.00	
	State Parks	150,576.35	
	Interagency Land Management/Transfer Agreements (ILMA's & ILMT's)	4,027.27	
	Total former M.H. Lands Designated For Non-trust Purposes	372,268.23	494,090.30
6.	Immediately Returnable to Trust, Encumbered with Lease & Sale Contracts		
	Land Leases	1,913.74	
	Mining Claims[e]	61,825.71	
	Coal Leases	54,563.22	
	Oil & Gas Leases	131,904.40	
	Material & Timber Sale Contracts	29,815.63	
	Permits	1,767.87	
	Total Returnable with Encumbrances	281,790.57	212,299.73
6.	Immediately Returnable Unencumbered[f]	212,299.73	

[a] The state--and therefore the trust-- retains all mineral rights on former mental health trust lands, except the 36,275 acres conveyed to Native corporations.

[b] Includes 19,797.52 acres conveyed prior to 7/19/78. Includes patented lands and lands under sales contracts in which vested interests exist.

[c] Lands received by state in exchange not readily identifiable.

[d] State may have legal authority to rescind, in which case title uncertain.

[e] Not tied to revenue production for trust. Holders required only to perform $200 of "annual labor."

[f] Includes 12,552.33 acres selected by municipalities but not yet approved for patent.

SOURCE: Alaska Department of Natural Resources, Inventory of Land Activities On Mental Health Lands, July 19, 1978 - October 4, 1985.

BREAKING THE MENTAL HEALTH LAND IMPASSE

As a possible means of breaking the current impasse over mental health land, the state could ask the court for instructions before taking further legislative action to resolve the controversy. Unlike the normal situation where the courts only decide whether legislative action is legal after the Legislature acts, courts will give advisory opinions when a trust is involved. Trustees can obtain such advisory opinions by asking the court for instructions with respect to trust administration. See Restatement (Second) of Trusts § 259 (1959); AS 13.36.035(a), especially subsection (3).

The obvious advantage to asking the court for instructions is that the court can answer all of the legal questions surrounding various policy options before the Legislature decides, as a policy matter, which option is most appropriate. By limiting its consideration to those options which the court will already have ruled are consistent with the state's powers and duties as trustee, the Legislature will know that, whatever option it chooses, it will be acting consistently with the trust.

The attached possible committee substitute for CSSB 493 (HESS) would (1) direct the attorney general to seek such instructions from the court, and (2) make clear that, while sales, leases, and exchanges of mental health trust land would continue to be precluded because of the interim mental health trust commission's disapproval, the commissioner of natural resources can approve proposals for other kinds of actions on mental health lands, including the granting of rights-of-way, permits, and other authorizations, as long as provision is made for any additional compensation to which the trust may be entitled beyond that already provided by the state through the interim allocation of five percent of unrestricted general fund revenues to the mental health trust income accoutn.

The result of the possible committee substitute would be that the Legislature would know what possible resolutions of this controversy are legal before it acts, and not be subject to judicial second-guessing after-the-fact, and certain limited actions with respect to mental health land could go forward without jeopardizing either the trust or the state's economy.

C. C. HAWLEY

Mining Geologist

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January 10, 1990

Lydia Selkregg and James Gottstein, Esq.
c/o Law Offices of James B. Gottstein
406 G St.
Anchorage, Alaska 99501

Re: Mental Health Land mineral evaluation reports

Dear Lydia and Jim:

This letter responds to a meeting on January 8, 1990 where I volunteered to review the various reports on mineral evaluation in the light of an act, "Relating to the Alaska Mental Health Trust; and providing for an effective date" in Chapter 48 AS, and give you the benefits of my opinions on these reports and any suggestions as how the apparent gap on mineral value between the Mental Health Commission and DNR could be narrowed.

The mineral evaluation is significant because it is a component of the fair market value; an actual dollar amount is necessary because the legislation establishes that an annual rental amount is to be appropriated by the legislature yearly to the mental health trust income amount and the fair market rental value of the land is valued at 8 % of the fair market value of the land.

The fair market value is the sum of three components, surface estate, forestry value and mineral value. Surface estate and forestry value have been agreed to by the parties in the issue, but there is a large gap on mineral value.

At issue, also is the means of establishing mineral value; two approaches have been advocated, comparable sales, and net present value of the mineral resource on the lands in question. It is my opinion that the net present value is the proper choice, largely because of two reasons, both already cited in the dispute, namely the sparcity of comparable sales, and secondly, that outright sales are not ordinarily the means of transfer of mineral interest.

But, the determination of net present value is difficult almost to the point of impossibility because of the sparsity of data on the mineral estate. The consultants were really asked to carry out a more or less theoretical exercise: To provide the net present value of mineral resources that could exist and be

developed on a analogue of 1,000,000 acres with some existing known resources and an approximately known geologic framework under Alaska cost and operating conditions. They were also given this task with a relatively low budget and tight time frame. This in itself can be argued to be an error, but it is also possible that the product might not have been much better if more rigorous methods were used and a great deal more money expended.

Harris (a reviewer and commentor for DNR) proposes a more rigorous methodology and would change some assumptions, as to the timing of development of the mineral estate, but his approach would also have been theoretical. From my point of view, the results are always going to be highly uncertain because it is a long extrapolation of what resource modeling can and should do.

Agencies like the USGS, ADDGS, certain Universities and consulting groups with good mineral economic capabilities are often asked to do mineral resource appraisals. Generally these are broad in scope, deal with resources not reserves, and serve to answer public policy questions like land closures rather than to quantify the dollar value of mineral estate for transfer purposes.

These agencies and groups are also commonly most qualified to deal with the broad issues, not whether a deposit can actually be produced at a profit; they rarely have current mineral knowledge and they have only a general knowledge of cost of production; therefore even if it is necessary to use them because they are without conflicts in commercial transactions, they are likely to be very limited in their ability to ascribe real dollars to their models.

In summary so far, I've endorsed net present value as the means to be used, but have tried to point out why its difficult to get good numbers out of the process. There just has be a lot of uncertainty.

Assuming we operate under the existing legislative guidelines, I would suggest using a panel of experts to examine and adjudicate the differences and to suggest a reasonable range of mineral values which would then be finally compromised by the Commission. The panel would be composed of engineers, Mining Company CEOs, and geologists from the private sector that have the operating experience and investment background to place the mineral evaluation on a firmer footing. They would have to be given only a certain amount of material and asked one or two questions. They would have no direct conflicts of interest on mental health lands and would be convened and give their results in a 3-5 day period; ideally it would include some Alaska experts and some that are mainly "outside", but with Alaska background.

As possible panelists I would suggest:

C. P. Herbert, P.E.
Richard Hughes, P.E.
Paul Glavinovich, Mining Geologist
Norm Anderson, former CEO of Cominco
Hugh Matheson, President of CoCa Mines, Denver, and former VP of Placer Development
Stan Dempsey, President of Royal Gold, Denver

I believe such a panel would be competent to evaluate and recommend within the range of values already established. It is important to have input from the type of people that will actually develop the resources, yet deferring the final decision to the judgement of the Commission.

I further have the opinions that the State's mineral valuation is unreasonably low, but that MDA is overly optimistic on most grounds, including:

1. Number of economic discoveries per unit area

2. Value of discoveries, in relation to tonnage and grade percentile

3. Cost of capital development and production in Alaska (ie, assumptions are that things don't cost as much as they do)

4. NSR obtainable from mineral production.

I would disagree that a 4 % NSR is a low royalty figure on hard rock deposits. 4-6 % NSRs are obtainable on precious metal deposits, but large base metal deposits could easily go at 1-3 percent. Even if 4-5 percent was obtainable, there would likely be clauses to recover capital first or to allow for reductions depending on metal price which would actually reduce the average royalty available.

In regard to coal land evaluation, I would regard both the State and MDA as being too low, although I recognize that the time factor of evaluation would perhaps need to be addressed. Many tens of millions of dollars have been spent in the last 25 years on evaluation of Alaska's subbituminous coal resource; leases are still being held and the companies holding the leases actively pursue marketing. Even if this coal doesn't enter into the next round of steam coal contracts, it has immense future value for synthetic uses and chemical feedstocks; because the coal hasn't been dehydrogenated to the extent of bituminous coal, it ultimately could have a premium value with respect to harder coal.

Finally, I would still propose that a better long term solution might be to go back to royalty production from actual trust lands, to use the existing coal and 6i schedules (5 and 3%) to be

paid into a working trust, but I'm also aware that the courts, legislature, and all parties have got a solution going that doesn't use this approach, and that it is critical to get a solution that the parties can agree to in place.

Sincerely,

Chuck Hawley

Mining Geologist

MINORITY RECOMMENDATION

TO THE COMMISSIONER OF NATURAL RESOURCES

Regarding Procedures to Determine the
Fair Market Value of Alaska's Mental Health
Trust and Replacement Lands

Submitted by: Rod Swope
Commissioner's Designee to the
Interim Mental Health Trust Commission
February 1, 1990

CONTENTS

EXECUTIVE SUMMARY

This minority report documents my dissent from the majority report of the Interim Mental Health Trust Commission (IMHTC) regarding procedures to be used by the Commissioner of the Department of Natural Resources (Commissioner) to determine the fair market value of both the original one million acre mental health trust land grant and the replacement lands in accord with Chapter 48, SLA 1987. In addition, I have set out the procedures which I believe should be used in order to comply with Chapter 48 and the land and resource values which those procedures produce.

I do not take this step lightly. Since joining the IMHTC as the Commissioner's designee in January, 1988, my goal has been to reach consensus with my fellow IMHTC members if and whenever possible.

While I believe my fellow IMHTC members also shared this goal, that approach was abandoned with respect to the valuation procedures finally adopted in the IMHTC majority report. By adopting, in large measure, valuation procedures urged by the attorneys for the plaintiffs and intervenors in the Weiss case, procedures designed to maximize value and not to produce fair market value as required by Chapter 48, the majority left me with no alternative but to dissent.

I dissent from the IMHTC majority report for the following reasons:

1. **The IMHTC exceeded its statutory authority by proposing and adopting its own valuation procedures instead of reviewing and approving only those procedures proposed by the Commissioner**.

Chapter 48 specifies that the IMHTC is to review and approve valuation procedures proposed by the Commissioner. As contemplated by the Legislature, the valuation procedures accordingly would be acceptable to both the plaintiffs' and intervenors' representatives on the IMHTC and to the Department of Natural Resources ("department"). Certain procedures contained in the majority report, however, were not proposed by the Commissioner, are unacceptable to the department, and therefore should not have been approved by the IMHTC majority. By proposing and adopting valuation procedures over the department's objections, the IMHTC has ignored the legislative requirement that, in effect, there be consensus as to the valuation procedures to be employed.

2. **The procedures proposed and adopted by the IMHTC in the majority report do not produce fair market value, as required by Chapter 48; instead, they produce a value substantially greater than fair market value.**

The importance of the value determinations used to determine fair market value cannot be overstated because of the dramatic effect they will have on the overall state budget. Under the valuation procedures adopted by the majority of the IMHTC, the total value of the original one million acre mental health trust land grant would exceed $2.2 billion. Under AS 37.14.021(c), this would result in more than $178 million in otherwise unrestricted state general funds being restricted in the Mental Health Trust Income Account. Under the valuation procedures I believe should be employed, the fair market value of the original one million acre grant equals just over $564 million, resulting in more than $45 million annually in the Mental Health Trust Income Account.

While the remainder of this minority report documents the fact that the procedures adopted by the IMHTC in the majority report do not produce fair market value, the point can be illustrated with three examples.

> Example 1: Surface Estate. The IMHTC initially defined "fair market value," the value required by Chapter 48, as "the most probable selling price in a free and open market," a standard definition in the real estate business. Panels of independent expert appraisers were then given instructions (prepared jointly by the majority of the IMHTC, the lawyers for the plaintiffs and intervenors and the department) to determine fair market value as defined. The lawyers for the plaintiffs and intervenors retained consultants (at state expense and without formal approval of the IMHTC) who were not asked to determine fair market value as defined by the IMHTC and required by Chapter 48. Instead, they were directed to determine "the highest value that can be supported in the market." Following review by those consultants, the panels increased their initial values, on the average, by about 20 percent. The procedures adopted by the IMHTC majority require that those values be further increased by splitting the difference between the final fair market values as determined by the panels and "the highest values that can be supported in the market" as determined by the consultants for the plaintiffs and intervenors.

Example 2: Hardrock Minerals. The procedures adopted by the IMHTC majority to determine the fair market value of the hardrock mineral estate, among many other shortcomings, begin with the assumption that all mineral deposits on mental health lands were developed on the date of valuation. That, of course, is not the case. In fact, there is very little mineral production from mental health lands even today. The consultants hired by the lawyers for the plaintiffs and intervenors acknowledge that this assumption alone produces value many times higher than would be produced if it was assumed that mineral deposits on mental health lands are not developed until sometime in the future:

A. Deposits are developed as of 2006 - the net present value (NPV) is $225 million.

B. Deposits are developed as of 1996 - the NPV is $585 million.

C. Deposits are developed as of 1987 - the NPV is $1.5 billion.

The procedures adopted by the IMHTC majority value the mineral estate at the $1.5 billion figure. It's also conceivable that major deposits will never be discovered in which case the NPV would be zero.

Example 3: Integration. The procedures adopted by the IMHTC combine the various value components -- surface estate, timber, oil and gas, hardrock minerals, coal, and sand and gravel--by simply adding them up. A prospective purchaser in the real world, of course, would not simply add up all the values. He or she would instead determine which uses, if any, are compatible. For example, residential subdivision development and strip mining for coal are not compatible.

3. **The procedures proposed and adopted by the IMHTC in the majority report create substantial problems with respect to reconstituting the trust and periodically redetermining its value.**

Chapter 48 contemplated an exchange of some original mental health lands for other state lands on the basis of equal value. The procedures adopted by the majority of the IMHTC have been used to value the original mental health lands, but they have not been used to value the pool of potential exchange lands. This precludes the exchange contemplated by the Legislature. In

addition, Chapter 48 contemplated periodic revaluation of the lands following the exchange. If the exchange cannot go forward, the legislatively contemplated revaluation also cannot go forward.

In my opinion, the failure of the IMHTC to reach consensus on valuation procedures makes it impossible for the Commissioner to comply with Chapter 48. The procedures approved by the IMHTC majority were not proposed by the Commissioner as required by law; the procedures I believe should be used have not been approved by the IMHTC as required by law. For this reason, I believe the Commissioner should transmit both the majority and minority IMHTC reports to the Legislature, explain that she is unable to comply with Chapter 48 at present, and list three options for legislative consideration: (1) change the law to accept the value determined under the procedures adopted by the IMHTC majority; or (2) change the law to accept the value under the procedures I believe should be used to comply with Chapter 48; or (3) appropriate additional funds to permit the IMHTC to continue seeking consensus. I believe the Commissioner should recommend that the Legislature choose option (2), accepting the value determined under the procedures I believe should be used to comply with Chapter 48.

BACKGROUND

The IMHTC was created by the Legislature in Chapter 132, SLA 1986, to oversee state management of mental health trust lands. In Chapter 48, SLA 1987, the Legislature established a statutory framework for resolving the mental health trust land issue. The three main elements of that resolution are: (1) valuing the original one million acre land grant and all lands in legislatively designated areas (parks, wildlife refuge, etc.) under procedures proposed by the Commissioner and approved by the IMHTC; (2) "exchanging" those original mental health trust lands not in legislatively designated areas for "replacement" lands of equal value in such areas; and (3) "renting" the original mental health trust lands in such areas and the equal value "replacement" lands for 8 percent of their fair market value annually.

Following the passage of Chapter 48, SLA 1987, the Governor appointed Dr. George Rogers of Juneau and Dr. Lidia Selkregg of Anchorage to join the Commissioner to compose the membership of the IMHTC. Dr. Rogers was then selected chairman of the IMHTC. Originally, Deputy Commissioner Lennie Gorsuch represented the Commissioner on the IMHTC, followed later (after January, 1988) by Deputy Commissioner Rod Swope. Assistant Attorney General Tom Koester of the Department of Law served as legal counsel to the IMHTC, while representatives of the Department of Natural Resources (department) provided staff support.

The IMHTC met on August 19 and 20, 1987, and continued to meet regularly through January, 1990. Since passage of Chapter 48, a total of thirty-five (35) IMHTC meetings have been held in either Anchorage or Juneau following at least fourteen (14) days prior public notice.

Although not part of the IMHTC, the attorneys for the plaintiffs and intervenors in the Weiss lawsuit, David Walker and Jim Gottstein, attended almost every IMHTC meeting and actively participated in all aspects of the discussions and valuation process, even to the point of proposing valuation procedures and resultant values. The IMHTC allowed the plaintiffs and intervenors to join in all discussions during IMHTC meetings.

At times, this degree of participation made it extremely difficult to differentiate between IMHTC conclusions and those of the lawyers for the plaintiffs and intervenors. The plaintiffs' and intervenors' lawyers also independently hired appraisal

consultants to review the work of contractual appraisers, retained by the department under procedures developed by the department, the IMHTC, and the lawyers for the plaintiffs and intervenors, and working under instructions developed in the same way, to compose the opinion of value panels for the surface estate valuation. In addition, the plaintiffs and intervenors, acting without formal IMHTC authorization, hired independent mineral consultants, Paul Metz and Colin Dixon, to compile a value for hardrock minerals, coal, and material sources (within the mental health trust land portfolio) using a procedure not previously recommended by the Commissioner or formally discussed or approved by the IMHTC. Mr. Metz and Mr. Dixon also attended several meetings of the IMHTC to present their information and viewpoints.

The most difficult aspect of the entire valuation process proved to be the development and approval of specific procedures under which the department would value mental health trust lands. On several occasions the IMHTC chose to adopt a new valuation methodology even after the department had already completed, at considerable time and expense, the valuation process using the original IMHTC approved methodology. Development of a new valuation methodology frequently seemed to be motivated more by the desire to produce a higher value than to correct the original methodology. As a result, procedures were adopted by the IMHTC that were not proposed by the Commissioner (as required under Chapter 48) and which do not produce fair market value (as Chapter 48 also requires).

Throughout my participation in this process, I strived toward achieving consensus and a common resolution of the various issues with my fellow IMHTC members. However, as it became apparent that the majority of the IMHTC was dissatisfied with the results of the initially approved procedures and began amending them to produce higher values, the consensus approach began to erode. This became particularly apparent in discussions regarding the results of the opinion of values for the surface estate and values for the mineral estate. Thus, as a dissenting member of the IMHTC, I felt it was necessary to submit a minority report.

FINDINGS

1. **The IMHTC exceeded its statutory authority by proposing and adopting its own procedures instead of reviewing and approving only those procedures proposed by the Commissioner.**

The Legislature contemplated and specified that the Commissioner propose valuation procedures which then would be approved by the IMHTC. Section 90 of Chapter 48, SLA 1987 repealed and reenacted section 2(a) of Chapter 132, SLA 1986 to read: "The commission shall approve procedures proposed by the Commissioner of Natural Resources to determine the fair market value, as of the effective date of AS 38.05.800, of all lands selected by and patented to the state under sec. 202 of the Alaska Mental Health Enabling Act, and review the final determination of the fair market value determined under those procedures." (Emphasis added.)

Under AS 38.05.800(a), also enacted as part of Chapter 48, the Commissioner is to determine the fair market value of the original mental health land grant "under procedures approved by the Interim Mental Health Trust Commission."

Simply stated, the Commissioner is to propose valuation procedures to be reviewed and approved by the IMHTC. Once a set of procedures have been approved by the IMHTC, the application of those procedures to the valuation of the mental health land grant and replacement lands is the responsibility of the Commissioner, with the results then reviewed by the IMHTC. The Legislature thus contemplated a three-step process: (1) consensus would be reached as to the procedures to be followed; and (2) the Commissioner would unilaterally implement those procedures to determine fair market value; and (3) the IMHTC would review the final fair market value determined by the Commissioner.

Although the IMHTC initially approved certain valuation procedures proposed by the Commissioner, the IMHTC majority eventually proposed and adopted many of its own procedures not proposed by the Commissioner. Specifically, the procedures adopted by the IMHTC majority for the surface valuation and for the mineral valuation were not proposed by the Commissioner. These actions removed from the Commissioner all discretion and thereby effectively excluded the Commissioner from the valuation process, a result certainly not intended by the Legislature.

Furthermore, the IMHTC in its majority report adopted not only procedures, but also an actual set of resultant values. As mentioned above, only the Commissioner has the authority and responsibility to determine the fair market value of the land. Therefore, the IMHTC again clearly exceeded its statutory authority.

2. **The procedures proposed and adopted by the IMHTC in the majority report do not result in fair market value, as required by Chapter 48; initially they produce a value substantially greater than fair market value.**

AS 38.05.800(a) requires the Commissioner to "determine the fair market value, as of September 6, 1987 of all land selected by and patented to the state under the Alaska Mental Health Enabling Act." At its September 21-22, 1987 meeting, the IMHTC initiated the valuation process by adopting, as proposed by the department, the definition of fair market value found in American Institute of Real Estate Appraisers/Society of Real Estate Appraisers, Real Estate Appraisal Terminology (rev. ed. 1981). This definition specifies "The most probable price in terms of money which a property should bring in a competitive and open market under all conditions requisite to a fair sale." Employing that definition and procedures, the department determined the fair market values for the surface estate and resources associated with the mental health and replacement lands (timber, oil and gas, coal, material sources, and hard rock minerals). Those procedures and values are outlined in this section.

The surface estate of all mental health trust and replacement land was valued by the department using the opinion of value approach. This approach, as amended by the IMHTC to make adjustments for certain disputed values submitted by the lawyers for the plaintiffs and intervenors, was approved by the Commissioner and became the accepted procedure for valuing the surface estate. However, the IMHTC majority report reflects a surface estate valuation procedure and value different from that developed by the IMHTC, approved by the Commissioner, and employed by the department. As a result of this significant departure from accepted and approved procedures, the resulting value does not reflect fair market value and is inconsistent with the fair market value requirement. Once the opinion of value panels completed their work, the plaintiffs and intervenors hired their own appraisal consultants to examine the results. The review appraisers, however, did not employ the same valuation approach used by the department. Instead, the plaintiffs' and intervenors' appraisal consultants were given the following

written instruction: "For all parcels that appear to have been undervalued, provide your estimate of the highest value that can supported in the market." [Walker letter to MacSwain, Olson, Sopp, dated July 19, 1988.] In State v. Alaska Continental Development Corp., 630 p.2d 977, 991 (Alaska, 1980), the Alaska Supreme Court specifically disapproved of a valuation process reflecting "the high end of the market spectrum," stating that such an approach "is contrary to the law in Alaska" that fair market value," or the price a willing buyer would pay a willing seller for the property, is the appropriate measure of just compensation. There was no mention in the instructions to the appraisal consultants of fair market value or most probable selling price. The values determined by the review appraisers, therefore, have no relevance to the task with which the Legislature charged the Commissioner, that of determining the fair market value and not "the highest value that can be supported in the market" of the original one million acre mental health land grant.

The IMHTC also approved the department's recommendation that determination of resource values would employ a two step approach. The first step was to quantify the particular resource(s) in place. The second step was to determine the value to the landowner of that quantity of the particular resource(s) in place.

For the hardrock portion of the mineral valuation, the IMHTC majority report simply adopted the procedures and value contained in the Report by Paul Metz and Colin Dixon ("MDA Report"). The MDA approach employed procedures not recommended by the Commissioner or previously discussed or approved by the IMHTC. Furthermore, it produced a value which is substantially too high for the hardrock mineral component, and suggests a hardrock mineral endowment considerably greater than the facts support.

The resultant surface and resource values then were integrated by the department, recognizing that values could be added where use of the surface was compatible with other resource development, but not where surface use was incompatible with resource development. This was in accord with integration procedures already approved by the IMHTC. However, the majority report uses a different integration approach which involves simple addition of all values--a process totally inconsistent with standard valuation procedures. The issues of parcelization, integration,

replacement lands, redetermination of values, and the valuation process used to determine fair market value for the various resources, are described in more detail in the sections that follow.

Parcelization

The department began the valuation process by proposing procedures for the parcelization of all land. After review by the lawyers for the plaintiffs and intervenors and their "expert appraisers" regarding the parcelization procedures, the department's proposed parcelization procedures were approved by the Commissioner and the IMHTC. Department personnel then parcelized approximately 7.5 million acres of land (mental health trust and replacement land) into over 10,000 parcels.

This parcelization process used the standard larger parcel criteria set out by the courts for determining fair market value in condemnation litigation. The criteria include: unity of ownership, unity of use, and contiguity. There was one exception to this rule. Where an approved survey was in existence identifying separate lots, tracts, or metes and bounds surveys, those surveyed tracts were segregated out from the larger into separate individual parcels.

Surface Estate Valuation

In accordance with the intent of the Legislature, as reflected in the fiscal note accompanying the bill that became Chapter 48, an opinion of value process was to be used to determine the value of the surface estate.

During the legislative discussion concerning Ch. 48, SLA 1987, the department explained the opinion of value process to the Legislature and submitted two different fiscal notes, one to cover the cost of individual standard appraisals and one for the opinion of value process. The Legislature recognized the potential costs and lack of available money to fund individual appraisals for all mental health and replacement lands. Therefore, money was appropriated for the department to conduct the fair market valuation through an opinion of value process, consisting of three panels of appraisers. In other words, funds were appropriated to cover only the cost of an opinion of value process.

This opinion of value process involved three panels comprised of three very experienced and knowledgeable independent appraisers from each of three geographic areas of the state (Southeast, Southcentral, and Northern). These appraisers sat as a panel according to geographic area, examined plats, maps and legal descriptions of mental health land, and rendered an opinion of value for each parcel of property examined. They brought a variety of work experience and market knowledge with them to contribute to the opinion of value panel process. The use of a three member panel for each geographic area provided an optimum cross section of local market conditions, market demand, and varied sales data. The comprehensive appraisal files of the department were also made available to each panel.

The IMHTC and the lawyers for the plaintiffs and intervenors approved, word by word, the "Request for Proposal" (RFP) sent out by the department to all appraisers in the state in order to solicit interest in being a member of one of the opinion of value panels. Two department employees and the two IMHTC members representing the plaintiffs and intervenors, after consultation with their respective attorneys, evaluated all of the RFP's submitted. They scored each proposal and selected nine appraisers to compose the three separate panels of the most qualified appraisers in the respective regions (i.e, Southeast, Southcentral and Northern).

The process used by the panels was not an "appraisal" in the strictest accepted definition of the term. Appraisal reports were not required nor were field inspections conducted for every parcel. However, this was fully recognized by both the Legislature and IMHTC.

The theory of the opinion of value process is that some parcels may be valued high and some parcels may be valued low, but they average themselves out. This theory was given credibility when the IMHTC conducted a check of the results of an earlier opinion of value process (one panel of three appraisers for all three regions of the state with only one appraiser representing each region) on all original mental health land that had been selected by the state or conveyed to municipalities. The IMHTC selected parcels, in the Northern, Southcentral and Southeast regions, that it felt were most likely to be valued too low, and had them appraised under standard appraisal procedures. The result of this exercise was that, on total, the actual appraised values and the opinions of value for the parcels the IMHTC believed were the most undervalued were within 4 percent. While some differences were dramatic--the IMHTC majority report notes one 800 percent difference (interestingly, the high value was produced by the opinion of value process) they balanced out overall as expected. This is contrary to the IMHTC majority report which infers that the opinion of value process produces values which are uniformly too low.

As soon as contracts were awarded, the department convened the three opinion of value panels for each region to render their best collective professional opinions of fair market value for each parcel. The opinion of value panels were instructed to determine fair market value using the definition found in the American Institute of Real Estate Appraisers/Society of Real Estate Appraisers, Real Estate Appraisal Terminology, adopted by the IMHTC at its September, 1987 meeting. The opinion of value panels also were instructed to consider reparcelizing if, in their best professional judgement, reparcelization was necessary to enable them to determine the land's fair market value.

The panel's findings were recorded on forms provided by the department and approved by the IMHTC and attorneys for the plaintiffs and intervenors. The forms contained all available information relative to the parcels and were supplemented by land status plats and maps. At least two members of each three member panel signed signature blocks on each form indicating panel concurrence with the specific value for each parcel.

The IMHTC had, in the RFP, provided that the plaintiffs and intervenors could review and challenge any of the values established by the panels. The lawyers for the plaintiffs and intervenors independently hired their own "appraisal review consultants" to review the work of the opinion of value panels (paid for by the state as court-ordered costs in the Weiss case).

The appraisal consultants hired by the lawyers for the plaintiffs and intervenors were directed to determine "the highest value supported by market data." (Walker letter to Mac Swain, Olson, et.al., dated July 19, 1988). They were not instructed to determine what, in their best professional opinion, they considered to be fair market value (using the definition adopted by the IMHTC). Under their instructions, they valued the surface estate at $833,280,096 compared to the opinion of value panels' initial value of $392,000,000.

Their review took approximately nine months and resulted in approximately two-thirds of the values of original mental health trust parcels being questioned.

Due to the large number of questioned values by the appraisal consultants and limited funding, the department proposed a sampling strategy which was adopted by the IMHTC. Certain groups of disputed values along with a computer-generated random sample of the remaining disputed values, were identified and returned to the Southeast panel for review. A representative sampling of large (over 1,000 acres) parcels was submitted to the Southcentral panel for review. The review of these disputed values by the panels resulted in a small increase in the value of some of the parcels. This occurred only after the lawyers for the plaintiffs and intervenors and the chairman of the IMHTC instructed the panels on how to value certain classes of parcels.

The method of applying the sampling results to all three regions resulted in a 30 percent increase in the opinion of value panels' initial $392 million value for the surface estate, thus increasing it to a final value of $511,949,467. The value determined by the plaintiffs' and intervenors' review appraisers, however, was not similarly revised downward, but instead was held at $833,280,096; no downward adjustment in their value was made.

The IMHTC, acting without a recommendation from the Commissioner, adopted the procedure to determine the value of the surface estate by simply splitting the difference between the revised value determined by the opinion of value panels (which was

increased by 30 percent over the initially determined value) and the unadjusted total determined by the appraisal consultants retained by the lawyers for the plaintiffs. This resulted in an arbitrary value of $672,614,782., halfway between the panels' final recommended surface value of $511,949,467. and the review appraisers' initial value of $833,280,096.

The basic flaw in the procedures adopted by the IMHTC majority is that those procedures incorporate, in large measure, the values determined by the plaintiffs' and intervenors' review appraisers. The appraisal consultants were instructed to determine the "highest value that can be supported in the market," a value which is not the same as fair market value. Using the value those procedures produce is not consistent with fair market value specified in Chapter 48. Instead it is simply the average of the fair market value determined by the opinion of value panels as the Legislature contemplated and "the highest value supported by market data" as determined by the review appraiser. The fair market value of the surface estate should be the final value determined by the opinion of value panels, which was $511,949,467.

Hard Rock Mineral Evaluation

The procedures proposed and adopted by the IMHTC to assess and value hard rock mineral resources (MDA Report) produced a value which is substantially greater than the facts support.

The initial hardrock mineral assessment was completed, using available information, by the department's Division of Geological and Geophysical Survey (DGGS). However, DGGS did qualify their assessment with the observation that there are inadequate data to perform a comprehensive mineral assessment. In addition, the parcels being studied were too scattered and too varied in size to make any very specific quantitative determinations without a great deal of expense. The department also sought assistance from the U.S. Bureau of Mines, WGM (a private mineral consulting firm), and the department's Division of Mining to quantify these resources. These sources also indicated that there are insufficient data and the parcels are too scattered.

The DGGS did, however, identify the potential for mineral occurrences on mental health trust lands and the pool of potential replacement lands by ranking them from 1 (low potential) to 5 (high potential), with category 5 subsequently broken down by DGGS at the request of the IMHTC to identify the lands with the highest high potential ("Super 5s"). No consideration was given, however, to quantity of potential mineral resources or the economic feasibility of their development. The Super 5 category identified only the highest potential for occurrence of a mineral deposit, not the highest probability of a commercial discovery.

The IMHTC, at a March 17 - 18, 1988 meeting, determined that it was impracticable to determine mineral value in light of the information from DGGS, the U.S. Bureau of Mines, WGM, and the Division of Mining. The department was, therefore, originally instructed by the IMHTC to consider the potential of the land (according to the DGGS assessment) only for replacement purposes.

The department continued, however, to seek procedures to present to the IMHTC that would reflect, to the extent possible, the fair market value of the hardrock minerals on both the original mental health land and the potential replacement land. Eventually, a small number of comparable sales of patented and unpatented mining claims in the state were identified for that purpose.

When presented to the IMHTC, however, the comparable sales approach was rejected. The initial value determined --$16 million--admittedly seemed quite low.

Unknown to the IMHTC minority, the lawyers for the plaintiffs and intervenors retained two consultants, Paul Metz and Colin Dixon, to estimate the value of the hardrock minerals on the original one million acre grant using a discounted cash flow methodology. Employing a variety of assumptions and probability analyses, Metz and Dixon concluded that the hardrock mineral value of the original grant was $1.51 billion. The lawyers for the plaintiffs and intervenors presented this information to the IMHTC in the form of a report ("MDA Report").

The MDA Report was criticized by a variety of expert analysts.

The department's natural resource economist, Ed Phillips of the Division of Oil and Gas, reviewed the MDA Report from an economic standpoint and concluded that the methodology, assumptions and judgments were so manipulated that the values are excessively high.

The DGGS geologists responsible for developing the geological data reviewed the MDA report. Their review raised substantive questions relating to the assumed probabilities of discovery and the range of estimated deposit sizes.

The University of Alaska's Institute for Social and Economic Research (ISER) conducted a thorough review and analysis of the MDA Report. Their analysis concluded that <u>if</u> the geologic assumptions, probabilities and costs in the MDA Report are found to be valid, the economic considerations are not. The ISER economists (Dr. Bradford H. Tuck and Dr. Matthew Berman) who reviewed the MDA Report estimated that the net present value of the original one million acre grant would not exceed between 10 and 30 ($177,000,000. and $460,000,000. respectively) of the value contained in the MDA Report, and would be in the 10 to 30 percent range <u>only</u> if the geologic assumptions, probabilities and costs are valid. Thus, only under the optimum set of circumstances--i.e., all of the analysts' expectations are realized--would the values even approach one-third of the total estimate in the MDA Report?

The following is the "<u>Summary</u>" from the ISER report (dated March 22, 1989):

"In summary, our review has identified a number of points that question some of the assumptions underlying the Metz appraisal. The three that are critical relate to the assumed probabilities of discovery, the assumed net smelter return, and the timing of the income stream. The assumed values in the appraisal result in projected revenue and production estimates that do not currently exist and are highly improbable in the future.

"The test of an appraisal, as mentioned above, is whether it approximates fair market value. Fair market value is what the asset would bring in a competitive market disposal held today. The historic levels of mining industry activity in Alaska, coupled with long term trends in world mineral markets, simply do not support the notion that the mineral rights on the Mental Health Trust Lands would command 1.5 billion dollars today, or at any time in the foreseeable future."

Perhaps more telling, the MDA Report used a number of works by Dr. DeVerle P. Harris of the University of Arizona for its methodological basis and to justify the numbers that were produced. Dr. Harris was recognized by the IMHTC as one of the leading authorities in the nation in the area of discounted case flow valuation methodology. To determine if the MDA report properly interpreted his own works, the department entered into a contract with Dr. Harris to review and analyze the report. In his critique of the MDA Report, Dr. Harris found numerous problems with the report and its ultimate value estimate.

Because of Dr. Harris's preeminence in the field, I have included extensive excerpts from his summary as follows:

"The least equivocal judgment that can be made about the analysis performed by MDA is that there can be little confidence that the fair market value of the Alaska Mental Health lands is $\$1.5 \times 10^9$ because of (1) great uncertainties that exist about critical factors, e.g., mineral endowment, probability for discovery, costs of development and production, and future markets, (2) subjective judgments made, and (3) rough approximations employed in computation of fair market value..."

"Those who use the number, particularly when uninformed about evaluation and estimation practices, ascribe to it much greater confidence than it deserves. Intelligent decision making requires a description of uncertainties about the estimate of a highly uncertain quantity. Clearly, the fair market value of Alaska Mental Health Lands is a highly uncertain quantity. Representing so uncertain a quantity as the fair market value of unseen mineral deposits by a single-point estimate (1.5×10^9) begs some explanation, for such analysis clearly is not best practice, nor even usual practice, in evaluation of a complex and uncertain quantity.

"There is another dimension to the neglect of uncertainty besides that of information to the user, namely, the implication of uncertainty to fair market value as perceived by those who would purchase the rights to explore for and exploit the mineral resources. In this case, these buyers are private corporations. Corporations behave generally as though they are risk averse, meaning that the investment value (fair market value) of a highly uncertain venture is less than its expected monetary value. The greater the uncertainty about the outcome, the greater the expected value is discounted by the investor. Thus, <u>fair market value</u> to a private corporation of a highly uncertain venture, such as exploration, development, and exploitation of unseen mineral deposits, is not independent of the magnitude of uncertainty; consequently, a comprehensive evaluation itself requires a probability distribution of the uncertain quantity, which in this case is the fair market value of MHL.

"One may agree with the foregoing but still press the question of whether or not $\$1.5 \times 10^9$ is a "reasonable" single-point estimate of fair market value when risk is not explicitly accounted for. Responding to this question in an absolute sense is nearly impossible because of the great uncertainties mentioned above, the subjective judgments made, and the approximations employed.

"A more answerable question is whether within the context of the approach used by MDA there were judgments made or procedures employed which, everything

else being equal, tend to over or underestimate fair market value. Clearly, as indicated in the body of the report, such can be identified. The most obvious of these is the ignoring of lead times in the computation of net present value. This neglect leads to overestimation by a factor of 2 or 3. Similarly, neglect of market impacts leads to overestimation. Ascribing to every discovery the 90th percentile tonnage and grade also leads to overestimation, perhaps a large overestimation, unless compensating adjustments are made in discovery probabilities. There is no documentation of such adjustment, but the selection of discovery probabilities by MDA is heavily subjective and especially vague, making it difficult to draw firm conclusions. If, as suggested by the MDA report, the discovery probabilities selected were predicated in part upon the CRA analysis of regions in Alaska that were appraised by the U.S. Geological Survey, then the discovery probabilities probably are considerably too large, because these (CRA) numbers of deposits are expectations for occurrence (not discovery) of deposits of all sizes and grades (not just 90th percentile value).

"The treatment of exploration and mineral potential is particularly vague and unrationalized. This is a serious deficiency of the report, because analysis of value is so sensitive to the treatment of these factors. The effect of this neglect is to create low confidence in the specified probabilities for discovery and in the computed expectations for fair market value. The fact that discovery probabilities were estimated directly using exploration outcomes from other regions, and that these were subjectively adjusted to reflect mineral potential rankings, makes a careful description of the estimation even more important and necessary if the resulting estimate of fair market value is to be credible, because the very foundation upon which the process rests (exploration outcomes) is very difficult to interpret. This is especially the case when these outcomes are to serve as the basis for discovery probabilities for a host of different mineral commodities and different deposit types. The use of constant discovery probabilities for all deposit types and all metals for a given mineral potential ranking is at best a crude approximation and lacks credibility when the objective is fair market value.

"Finally, a fair market value as large as $1.5 x 10^9$ does not seem consistent with economic conditions and factors. As fair market value, $1.5 x 10^9$ represents an estimate of the net present value of profits (net of all costs, royalties, and taxes) that firms could earn by acquiring rights to exploration for and exploitation of minerals on the Alaska Mental Health Lands. Such a large value, if correct, would be a strong incentive for acquisition of tenure and exploration of these lands. While the author has little first-hand knowledge about recent metal resource development on the Mental Health Lands, or in Alaska in general, it is his understanding that such activity is and has been at a low level (Tuck and Berman, March 22, 1989; Paul Metz, May 20, 1989, personal communication). Such circumstances challenge a value as large as $1.5 x 10^9$ as a credible estimate of the fair market value of metal resources of the $1 x 10^6$ acres of Mental Health Lands. Moreover, rationalizing inactivity by institutional impediments or by stringent tenure requirements does not lend credence to such a high value. Unless such impediments and stringent tenure provisions are to be altered, fair market value appropriately reflects the impact of current conditions on profitability of resource development."

The foregoing expert critiques, questioning the credibility of the MDA Report's $1.51 billion estimate for the value of the original one million acre grant, are supported by a number of objective considerations. WGM, a private mineral consulting firm, determined in March, 1988 that the market value of 2.2 million acres of Bering Straits Native Corporation land in Northwest Alaska was $343 million, an average of $156 per acre. That land is located in the vicinity of the Seward Peninsula, historically the most productive mineral province in the state. While some mental health land was specifically selected for its mineral potential (as was a considerable portion of the Bering Straits Native Corporation's selections), more was selected for other values (e.g., residential, timber, etc.). Given those facts, I cannot accept the MDA Report's average mineral estate value of $1,510 per acre for mental health lands. This is particularly true as the Bering Straits Native Corporation lands are in large continuous tracts, which a prospective purchaser could evaluate through appropriate and efficient exploration

strategies. The mental health lands are generally in much smaller parcels scattered throughout the state and could not be explored in as cost-effective a manner.

Furthermore, the MDA Report's conclusions regarding total mineral production from mental health lands appears extremely optimistic in light of existing mineral production in Alaska. The MDA Report used the following formula to estimate the mineral estate value of the original one million acre grant: net present value (NPV) equals the gross value of annual production (GVAP) times the landowner's royalty, measured as a percentage of the net smelter return (NSR), times a uniform series present worth factor (PWF) to discount future income to present value:

NPV - GVAP x NSR x PWF (see MDA Report, p. C-1)

Working backwards, the gross value of annual production necessary to produce a given net present value can be determined as follows:

GVAP = NPV (NSR X PWF)

Under the assumptions in the MDA Report (4 percent NSR, 10 percent discount rate for 20 years for a PWF of 8.514), the gross value of annual production required to produce the MDA Report's $1.51 billion net present value is more than $4.43 billion:

GVAP = $1.51 billion (0.04 x 8.514) = $4.43 + billion

Total mineral production for the entire state in 1987 was $202,389,898. A production increase of 14.7 percent was seen in 1988, and further development of projects such as Greens Creek and Red Dog (none of which, incidentally, are on state or mental health land; furthermore, a third "world-class" deposit, Quartz Hill, also not on state or mental health land, is not commercially viable at this time) undoubtedly will result in further annual increases. However, $4.43 billion in gross value of annual production statewide is unrealistic given the current status and most optimistic projection by the mining industry in this state. I simply cannot accept that the gross annual value of production from mental health lands alone (one-third of one percent of the state's land mass) would exceed $4.43 billion.

A survey of fifteen other states with trust lands (including Texas, where the Texas Railroad Commission administers a substantial quantity of oil-rich lands for the University of Texas' benefit) reveals that the subsurface income from those

lands averages $4.57 per acre per year based on 1987 returns. Under the analysis in the MDA Report, the mental health lands would produce $120.80 per acre per year based on the eight percent per year rental provision of AS 37.14.011(c) although differences certainly exist between Alaska and other states. I cannot accept that even the most aggressive trust management could produce results so dramatically different from those in other states, including even those states with substantial known subsurface resources (unlike the Alaska mental health land situation) and where transportation and infrastructure systems are much more developed and extensive than in Alaska.

In responding to the various expert critiques of the MDA Report, Metz and Dixon argue that the current lack of mineral production from mental health lands is not a consequence of a lack of interest on the part of industry but instead is the result of state mismanagement. Their report states that, "The failure of the State of Alaska to fully implement a mineral location/leasing system and the various types of land withdrawal and restrictions, have acted as a major disincentive to investment in prospecting and exploration on state land in general and the mental health land (MHL) in particular."

The fact, of course, is that most mental health lands have been available for claim-staking--i.e., the mineral rights were available <u>for free</u> from the time they were selected until they were closed to mineral entry by order of the Commissioner following the <u>Weiss</u> decision in 1985. While some claims were staked, industry interest in mental health lands was not great. It is hard to imagine that a vigorous state leasing program, where industry would have to <u>pay</u> for mineral rights, would result in increased industry interest, particularly where (as Dr. Harris noted) there is a world market in rights to mineral lands and substantial amounts of state and federal land would continue to be open to claim-staking for free.

At the request of the department, Dr. Harris also outlined the activities required to produce a credible estimation of the market value of the mineral resources using the discounted cash flow analysis and the costs of these activities. Dr. Harris estimated that the costs of estimating the market value of the original mental health land and replacement land would be about $350,000, plus funding for additional DGGS work.

Given the amount of time and money expanded to date in an effort to value mental health lands has taken to date, I cannot recommend that additional funds be requested from the Legislature to continue the process.

As an alternative, department staff have suggested employing a comparable sales approach to determine the value of the mineral estate of both the original one million acre mental health land grant and the pool of potential replacement land. The department has received information regarding sales of the mineral rights to certain lands in DGGS's classes 4, 5, and Super 5s for which the mineral endowment is unknown (although suspected), which is the case with the land to be valued. Those sales revealed the following per acre market values:

Super 5	$2,000/acre
5	1,135/acre
4	108/acre

Using those figures, the value of the mineral estate of the original grant would equal $73,403,459.

In my opinion, this is a more than reasonable value for the mineral estate. Under the MDA Report assumptions (four percent net smelter return, ten percent discount rate for 20 years), the gross value of annual production from mental health lands would have to exceed $215 million to produce a net present value of $73 + million. That is more than the total of statewide mineral production in 1987. In addition, the eight percent annual rent required under AS 37.14.011(c) would result in the subsurface income from mental health lands equalling $5.87 per acre, substantially greater (more than 28 percent) than the $4.57 per acre earned on average by trust lands in the 15 lower 48 states surveyed.

The IMHTC majority has made it clear they do not believe a comparable sales approach is a valid method for determining the value of the mineral estate. Even though I believe the foregoing comparisons to current statewide mineral production and subsurface income from trust lands in other states reveal that the result of this approach is eminently fair to the trust, it has been suggested that a panel of Alaska mineral consultants could quickly and inexpensively provide an additional review of both the MDA Report and this comparable sales approach. You may wish to consider that option.

In my opinion, however, the final value of the mineral estate should be that produced by the comparable sales approach which is $73,403,459.

Timber Valuation

A timber resource valuation was prepared at the request of the IMHTC and the Commissioner. The valuation considered all original mental health trust lands, which total approximately one million acres, and all legislatively designated replacement pool lands, which encompass over six and one half million acres.

A detailed process to delineate and value lands suitable for commercial timber activities was developed in concert with the IMHTC and the consultants hired by the plaintiffs and intervenors. The results of this process are a series of 123 forestry potential maps, published as overlays to the USGS one inch-per-mile quadrangles, inventory estimates of commercial standing crop on these lands, and estimates of timber resource values reported on a parcel-by-parcel basis.

The conclusion of this process was that the one million acres of original mental health trust land contained $36,243,253. in commercial timber. I agree with the timber valuation procedures employed and the value derived.

Oil and Gas Valuation

At the request of the IMHTC, a report was written to describe the geology and exploration activity pertinent to establishing a "best estimate" of the oil and gas potential of the legislatively designated replacement pool lands and the original mental health trust lands within Alaska.

For general evaluation, the state was divided into four regions: (1) Gulf of Alaska (including Southeast, Prince William Sound, and the Kodiak area), (2) Alaska Peninsula and Southwestern Alaska, (3) Central and East-Central Interior, and (4) Cook Inlet and Susitna Basins (including the Talkeetna and Chugach Mountains and a portion of the Copper River Basin). Each of these was assigned to a petroleum geologist or geophysicist. These four regions were further subdivided in order to produce a more precise and detailed evaluation. Information from surface geologic mapping and from nonconfidential drilling well logs was utilized. Confidential well log information and data from proprietary seismic surveys were not included in this study.

Of the four areas studied, only the Cook Inlet Basin contains known natural gas fields which underlie some of the mental health and legislatively designated parcels. Where sufficient data were available, an economic analysis was completed for those parcels.

There are no known oil fields beneath any of the parcels.

This process concluded that the oil and gas value of the one million acres of original mental health trust land was $495,998. I concur with the oil and gas valuation procedures employed and the value derived.

Coal Value

At the request of the IMHTC, a coal valuation was prepared by the department. The valuation considered all original mental health trust land and all legislatively designated replacement pool land.

The conclusion of this process was that, although coal is present in a number of areas, it is currently economic to produce in only two areas (Nenana and Wishbone Hill). The value of this coal on original mental health trust land was determined by the department to be $432,866.

The IMHTC proposed and adopted the MDA Report as its procedures and resultant value. The MDA Report states that a current market does not exist for coal other than that identified in the DNR coal valuation. The authors then hypothesize that "several large scale open pit metal mines" in the railbelt and Kenai Peninsula areas could serve to diminish the "current excess electrical generating capacity" and provide additional coal marketing opportunities, with similar opportunities arising elsewhere. The MDA Report then makes a number of assumptions about the mines to produce figures for a cash flow analysis. One of these assumptions is that "The entire production would come from the subject land (i.e. mental health trust land)."

Using the hypothetical developments and related assumptions, the MDA Report concludes that "the net present value of the cash flow" from coal on mental health land would be $3,200,000. The MDA Report then states: "With the large quantities of coal on adjacent state and federal land in Alaska, it is probably unrealistic to expect more than 10 percent of the model production to come from trust lands."

This statement from the MDA Report infers that under that analysis, the best estimate of net present value is $320,000. I believe $432,866. should be used as the value for coal on the original one million acres.

Material Sources

The DGGS conducted a review of all mental health trust land and replacement pool land in order to assess potential mineral sources. Unfortunately, there is little detailed inventory information available. The DGGS estimated the cost of data gathering sufficient to enable them to determine material sources volumes and quality to be between $65.4 and $85.2 million. However, this would still be inadequate data upon which to base a value determination because material source values are heavily influenced upon their proximity to the market. Also, prices fluctuate upon demand. If there is no demand, then there is no value.

At a June, 1989 meeting of the IMHTC, Dick Rieger of DGGS presented three options available for material source valuation. At that meeting, the IMHTC determined that the valuation of material sources was simply not a fruitful exercise, given the uncertainty over material source location, quality and volume. As a result, the IMHTC approved a process whereby the value of the material sources on mental health land would be addressed through the designation of equal potential replacement lands.

However, the IMHTC reversed itself when it adopted the MDA Report. The MDA Report established a range of value between $2.5 million and $25.4 million for material sources, with a most likely value of $13 million. This value was based upon an average of 14 million cubic yards consumption per year statewide, with the original mental health trust land producing 24 percent, or 3.5 million cubic yards. Unfortunately, these assumptions cannot be substantiated since, in reality, only 1.275 million cubic yards were produced in that timeframe (425,000 cubic yards/year) from mental health lands. In fact, if the average annual production level of 425,000 cubic yards were to be maintained into the future, the discounted cash flow for 20 years would be approximately $420,000/year.

For the above reasons, I reject the MDA Report as a basis for material source value determination. However, I also conclude that we do not presently have sufficient data to produce a meaningful value for this resource. Because there are

insufficient funds available to produce these data, at least at this time, it is impossible to produce fair market value for this resource. Alternately, the trust should be protected if lands of equal material source potential are designated as replacement lands.

Integration Procedure and Valuation

On October 21, 1987, the full IMHTC approved the department's recommendation for integrating the various land values (e.g., surface estate value, timber value, mineral value, etc.). Under those approved procedures, values for compatible uses--e.g., a subdivision for residential or commercial use and oil and gas development (i.e. North Kenai area--would be simply added together. Where uses would be incompatible--e.g. subdivision for residential use and coal development (i.e. Beluga area)--the highest value (i.e., the value for the highest and best use) would be used. Generally, those initially approved procedures could result in one of three possible values being selected: (1) the sum of the surface value and the resource value, where extraction or removal of the resource would not affect the surface value; or (2) the resource value where it exceeds the surface value and extraction or removal would diminish the surface value; or (3) the surface value where it exceeds the resource value and extraction or removal of the resource would diminish the surface value.

The IMHTC majority, however, substituted an integration process which simply adds the various value elements, with no consideration given to whether the various uses are compatible or not.

I initially went along with this revised integration procedure, despite objections by department staff, in the spirit of compromise and my desire to achieve consensus. It is well-recognized, however, that a proper valuation procedure cannot simply add separate value elements where use of the property to exploit one element is incompatible with use of the property to exploit another. See, e.g., W. Mason, Jr., M. Azar, and G. Anderson, "Condemnation Value: The Taking of Mineral Bearing Lands," Mining Engineering 10986 (November 1989).

In my opinion, the integration procedures first determined by the IMHTC are the only ones which can produce a credible integrated value. I therefore believe that the following procedures should be used:

(1) Add the surface value and the oil and gas value;

(2) Add the mineral value, timber value, oil and gas value, coal value, and material source value; and

(3) for each parcel, select the highest value developed under (1) and (2) as the fair market value for that parcel.

Using those integration procedures and the per parcel values for each value element as outlined above, the total integrated fair market value for the original one million acre grant equals $564,700,728. Using the same integration procedures, the pool of potential replacement lands would have a fair market value of $910,103,205.

Replacement Pool Lands

As stated earlier, the IMHTC majority report failed to address the replacement land valuation requirements altogether. Using the procedures included in the majority report, the trust simply cannot be reconstituted by the Commissioner as contemplated by the Legislature and required by AS 38.05.800(b) and (c).

The procedures that I recommend will allow the trust to be reconstituted with equal value land from the replacement pool of legislative designations. Each of the procedures that I recommend has been followed for the replacement pool land on a parcel by parcel basis (with exception of material sources).

Redetermination of Values

AS 37.14.011(c) provides for the redetermination of the fair market value of the land constituting the mental health corpus at least every five years. The statute does not provide any further guidance on how this revaluation shall be accomplished.

This requirement can be fulfilled in any number of ways. I feel that the least desireable is to repeat a valuation process modeled on the one that we have just finished. I feel that the time, effort, and continual disagreement with the results would not be productive for all concerned.

I therefore recommend the following revaluation process.

1. Valuation of mental health corpus land will be conducted on an 18 month basis by region. Each of three regions, Northern, Southcentral and Southeast will be valued during successive 19-month periods. The same criteria previously recommended will be used to integrate values and to determine the fair market value of the parcels and the trust corpus as a whole.

2. Surface valuation will consist of an indexing of value increases, or decreases, within each region and application of the appropriate increase or decrease in market value occurring in each area since the previous valuation. Municipal property assessment records (for lands within municipalities) and paired market sales data (for lands outside municipalities or where property taxes are not levied) will be used to determine land value increases or decreases in each area.

3. Mineral values will be indexed to the mineral production in Alaska with the appropriate increases or decreases made for each region on a parcel-by-parcel basis.

4. Coal and oil and gas values will be indexed to the world market with appropriate increases or decreases made statewide on a parcel-by-parcel basis.

5. Timber values will be indexed to the market and conditions for the region with appropriate increases or decreases made regionally on a parcel-by-parcel basis.

3. **The procedures proposed and adopted by the IMHTC create substantial problems with respect to reconstituting the trust and periodically redetermining its value.**

AS 38.05.800(b) specifically states:

> "The Commissioner of natural resources, with the approval of the Interim Mental Health Trust Commission, shall identify land within legislative designations that is equal in value to all land selected by and patented to the state under Sec. 202 of the Alaska Mental Health Enabling Act that is not in legislative designation."

The value of the original mental health land trust is so high under the procedures specified in the majority report of the

IMHTC, that the trust cannot be reconstituted as contemplated by the Legislature. The value of the mental health trust, as established in the majority report, exceeds the value of all possible replacement lands.

Under AS 38.05.800(b) and (c), moreover, the trust is to be reconstituted with land in legislatively designated areas (e.g., parks, wildlife refuges, etc.) which is equal in value to the original mental health land grant. To do this, both the original grant and the pool of potential replacement land must be valued under the same procedures. The majority report of the IMHTC fails to address the replacement land valuation requirement altogether.

Because it is unnecessary to replace every parcel of original trust land (since some trust lands are already within legislative areas), and because the procedures proposed and adopted by the IMHTC make no attempt to value parcels individually, the trust simply cannot be reconstituted through the majority report approach.

Under AS 37.14.011(c), moreover, the trust as reconstituted under AS 38.05.800(b) and (c) must be periodically revalued at least once every five years. Therefore, because the pool of potential replacement land has not been valued under the same procedures used to value the original grant and therefore cannot be reconstituted, it also cannot be periodically revalued as contemplated by the Legislature.

CONCLUSIONS AND RECOMMENDATIONS

For the foregoing reasons, I have concluded that the Commissioner simply cannot comply with the applicable provisions of law at this time. The valuation procedures set out in the IMHTC majority report were adopted over my objection on behalf of the department, and therefore are not the product of consensus as contemplated by the Legislature and specified by law. The procedures that I believe should be employed, on the other hand, have not been approved by the IMHTC as required by the Legislature and specified by law.

I therefore recommend that the Commissioner send letters to both the Speaker of the House of Representatives and the President of the Senate explaining that she is unable to comply with the law as currently written, enclose copies of both the IMHTC majority and minority reports, and list three options for legislative consideration: (1) change the law and accept the $2.2 + billion value determined under the procedures adopted by the IMHTC majority; or (2) change the law and accept the $564 + million value determined under the procedures I believe should be used to comply with Chapter 48; or (3) appropriate additional funds to permit the IMHTC to continue seeking consensus.

I believe that the Commissioner should recommend to the Legislature that they adopt option (2) and accept the 564 + million value for the original one million acre mental health trust land grant. The procedures used to determine that value have been subject to review by outside professional experts and developed, reviewed, and approved by department staff who have a wide variety of expertise in valuing the various resources found on mental health lands. Furthermore, the Attorney General's Office advises that such a procedure would be legally defensible since the United States Supreme Court ruled that it is permissible to use "procedures established by the Commissioner's rules, or any other procedures reasonably calculated to assure the integrity of the trust and to prevent misapplication of its lands and funds." Lassen V. Arizona Highway Department, 385 U.S. 758, 465 (1967).

It also would be eminently fair to both the trust and the state. It would establish the various elements of value as follows:

Surface Estate	$511,949,467.00
Hardrock Minerals	73,403,459.00
Timber	36,243,253.00
Oil and Gas	495,998.00
Coal	432,866.00
Material Sources	undetermined

Following the integration procedures outlined above, the total integrated fair market value of the original one million acre grant would equal $564,700,782.82.

As an objective measure of the fairness of this value to the trust, the eight percent of this amount which the Commissioner of Revenue annually must allocate to the mental health trust income account under AS 37.14.011(c) until revaluation takes place equals $45,176,058. or $45.18 per acre per year; this compares very favorable to the national average of $8.97 per acre per year returned for trust lands in other states.

At first blush, this figure might appear unfair to the state. After all, it is more than five times the national average, and exceeds even Washington which, at $45.68 per acre (as a consequence of its prime and easily accessible timber resources), has the highest average in the nation. At the same time, it must be remembered that, following the exchange contemplated by Chapter 48, all of the newly reconstituted mental health trust will consist of land within legislatively designated areas which the state will continue to administer for legislatively designated purposes. In other words, unlike the case in most states, the state here will be using every acre of the newly constituted mental health trust for its own purposes. It therefore is only fair that the state compensate the trust for that use. One consequence of this is that, unlike the case in other states, every acre of the mental health trust will be productive in terms of generating revenue. That has the effect of raising the per acre earnings of the entire trust, a result which I believe is not inappropriate.

SENATE SPECIAL COMMITTEE ON MENTAL HEALTH

SECOND SESSION

16TH ALASKA STATE LEGISLATURE

Senator Pat Pourchot, Chairman

Senator Jack Coghill
Senator Paul Fischer

Report to the Senate

January 1990

Alaska State Legislature

Sen. Pat Pourchot, Chairman

Sen. Jack Coghill
Sen. Paul Fischer

P.O. Box V
State Capitol
Juneau, Alaska 99811

907-465-3712

Senate Special Committee on Mental Health

January 8, 1990

The Honorable Tim Kelly
President, Alaska State Senate
Post Office Box V
Juneau, Alaska 99811

Dear Senator Kelly:

Passage of SR 10 by the 1989 Legislature established the Senate Special Committee on Mental Health and charged it with the following:

-- conducting oversight hearings on the implementation of the settlement of the mental health trust litigation and

-- facilitating resolution of the problems hindering settlement.

The Committee is authorized to meet during and between sessions of the Legislature, and terminates upon convening of the First Session of the Seventeenth Legislature. The Committee conducted two public hearings during the past interim and met individually with many of the participants in this issue. At this time, we are submitting an interim report that provides an overview and status of the mental health trust issue.

The work of the groups involved in resolving the litigation (primarily the Interim Mental Health Trust Commission, the Department of Natural Resources, and the Alaska Mental Health Board) is ongoing, so final recommendations are not contained in this report. The Senate Special Committee will continue to work with these groups during the upcoming session, and will bring before the Senate any items requiring legislative action or oversight.

The Committee would like to extend special thanks to Sandra Schubert, who was instrumental in the drafting of this report.

Sincerely,

Pat Pourchot
Senator Pat Pourchot, Chairman

Senator Jack Coghill

Paul Fischer
Senator Paul Fischer

MENTAL HEALTH TRUST LANDS SETTLEMENT

BACKGROUND

THE FEDERAL GRANT

In 1956 the U.S. Congress passed the Alaska Mental Health Enabling Act (PL 84-830). The Act authorized the Territory of Alaska to administer a mental health program and, to ensure that the territory had adequate financial resources to do so, granted Alaska 1 million acres of land. The Act required that the land be administered as a public trust and that the income from the land "first be applied to meet the necessary expenses of the mental health program of Alaska". The land was selected but no trust fund was established.

THE LEGISLATIVE REDESIGNATION

In 1978, public pressure to make state land available for use and development prompted the legislature to abolish the land trust and redesignate all mental health land as general grant land. A monetary trust fund, to be financed by 1.5% of revenues from all state lands, was established in its place. No revenues were ever appropriated to the fund.

THE WEISS LAWSUIT

In 1982 a suit was filed on behalf of Carl Weiss and Earl Hilliker, two Alaskans in need of mental health services not available in Alaska. The suit contended that the law which abolished the land trust was a breach of the federally-created trust.

THE COURT DECISION

In 1984 the Alaska Superior Court ruled in favor of the plaintiffs; the state appealed. The Alaska Supreme Court agreed with the Superior Court and held that the 1978 redesignation law was invalid. The Court directed the state to reconstitute the 1 million acre trust as nearly as possible, reimbursing the trust for land which had been sold, offset by mental health expenditures made by the state since 1978. At the time of the court decision 90,000 of the original 1 million acres had been patented to private parties, 43,000 acres had been conveyed to municipalities, 370,000 acres were in legislative designations (parks, refuges, forests, public use areas), and 290,000 acres were under special use (rights-of-way, timber sales, mining claims, oil and gas leases, etc.).

THE SETTLEMENT PROPOSAL

In 1986 the legislature appointed a special committee to develop a means of implementing the Court's decision. The committee's proposal, introduced as HB 92 and signed into law as Chapter 48, SLA 87:

1. Directed the Department of Natural Resources (DNR) to reconstitute the trust with land currently in state parks, refuges, forests, and public use areas that is equal in value to the original 1 million acres of land. "Value" was defined as the July 1987 fair market value as determined by DNR under procedures approved by an Interim Mental Health Trust Commission.

2. Required, in lieu of managing the replacement lands for maximum revenue generation as is required under general trust law, that the state annually allocate an amount equal to 8% of the fair market value of the land to the Mental Health Trust Income Account in the state's general fund. These "trust earnings" would be appropriated first to meet the necessary expenses of the state's mental health program, and then for other public purposes. Pending reconstitution of the land trust, 5% of the state's annual unrestricted revenue would constitute the trust earnings.

3. Established the Alaska Mental Health Board (9-12 members who represent consumers, providers, and the public at large). The Board was charged with determining the need for mental health services in Alaska, reviewing the state's mental health program, and reporting its findings to the Legislature and the Governor.

The settlement proposal was seen by the parties to the lawsuit and the Legislature to have the following advantages:

1. Satisfies state's legal obligation under federal law to create a permanent funding source for mental health while retaining the Legislature's discretion in appropriating funds.
2. Allows the original 1 million acres to continue to be used for general public purposes, removing the "cloud" on title and/or use of trust lands selected by municipalities and purchased by third parties.
3. Provides immediate financial support for the mental health program but doesn't require a major cash outlay.
4. Avoids further costly and time consuming litigation.
5. Is relatively easy to administer.

MENTAL HEALTH TRUST LANDS SETTLEMENT

STATUS

DETERMINATION OF LAND VALUE

DNR hired appraisers who, using an opinion-of-value methodology and procedures approved by the Interim Mental Health Trust Commission, calculated the surface value of the original 1 million acres to be $499.8 million. This figure was disputed by appraisers hired by the plaintiffs' attorneys who, asserting that DNR's appraisers had not properly interpreted the Commission's procedures, calculated a value of $833.3 million.

DNR calculated the value of the timber resource on the original 1 million acres to be $41.0 million. This figure was disputed by the plaintiffs' attorneys who objected to the deduction of reforestation costs.

The federal land grant included the subsurface estate. DNR calculated the value of the minerals/coal/aggregate on the original 1 million acres to be $16 million. The minerals/coal/aggregate figure was disputed by geologists hired by the plaintiffs' attorneys who calculated the value at $1.5 billion. DNR calculated the mineral value based on "comparable sales" -- the plaintiffs argue this does not accurately reflect the development potential of the resources; DNR argues that comparable sales is the established procedure for determining fair market value.

DNR calculated the value of the oil/gas to be somewhere between $135,953 and $856,040. The plaintiff's attorneys did not submit an oil/gas valuation, but asserted that DNR's range was grossly low.

THE NEGOTIATIONS

Because of the large discrepancy between the values determined by DNR's procedures and the plaintiffs'procedures, the Commission requested that the state and the plaintiffs attempt to negotiate a value that would be acceptable to both parties. On October 27, 1989 the negotiators reported to the Commission that they were at impasse. The plaintiffs' final offer was $2.325 billion; the state's final offer was undisclosed, but at least $1.5 billion less than the plaintiffs' offer.

THE COMMISSION'S FINAL DECISION

Unable to reach consensus, on November 7, 1989 the Commission adopted by a 2-1 vote a resolution approving final procedures for determining the value of the land. The DNR representative voted no, the plaintiffs' and intervenors' representatives voted yes. The procedures lead to the following values:

Surface		$ 666.5 million
Minerals/Coal/Aggregate		1,534.7 million
Oil/Gas		.5 million
Timber		41.0 million
	TOTAL	$2,242.7 million

(The Alaska Mental Health Board has endorsed these values.)

THE DNR COMMISSIONER'S FINAL DETERMINATION

The settlement proposal requires that the Commissioner of DNR determine the fair market value of the land based on the Commission's procedures. The Commission submitted its final procedures to Commissioner Gorsuch on November 7, 1989. Before responding, Gorsuch requested a written justification of the procedures from the Commission, which was submitted on December 20, 1989.

If the Commissioner does not endorse the Commission's procedures (which the Department of Law has advised she can do if she finds the procedures to be arbitrary or capricious), it is unclear what the next step would be. The parties could request legislative clarification of "fair market value", legislative confirmation of a particular value, judicial intervention, or possibly some other action.

RECONSTITUTION OF THE TRUST

Once the value of the original 1 million acres is determined, lands of equal value from legislatively designated areas (parks, refuges, forests, and public use areas) are to be identified by DNR and approved by the Commission; these replacement lands would constitute the trust corpus. There has not been a formalized appraisal process for the replacement land as there was for the original 1 million acres. As of this writing, the Commission has not finalized its recommendation on valuation of replacement lands.

Once the trust is reconstituted, the DNR Commissioner must certify the reconstitution to the Revenue Commissioner, the Alaska Mental Health Board, and the Lieutenant Governor. Upon certification, an amount equal to 8% of the land value will be segregated in the state's general fund as the Mental Health Trust Income Account.

Every five years, the fair market value of the replacement land is to be reappraised and the 8% adjusted accordingly. As of this writing, the Commission is considering recommending that the reevaluation be of the original 1 million acres, not the replacement land, and that it be tied to a cost-of-living index, rather than an actual reappraisal.

MENTAL HEALTH TRUST INCOME ACCOUNT
Until the trust is reconstituted, an amount equal to 5% of the state's annual unrestricted revenue constitutes the Mental Health Trust Income Account. In FY 89, 5% was $97.7 million. The Department of Revenue's November 1989 mid-case revenue forecast projects 5% to be $114.8 million in FY 90 and $113 million in FY 91.

The Legislature has appropriated from the Mental Health Trust Income Account what, in its collective judgment, has been necessary to fund the mental health program. The appropriations have been less than the Alaska Mental Health Board's recommendations and significantly less than the funds in the Account.

	5%	Board Recommendation	Appropriation
FY 89	$ 97,724,965	$ 54,992,300	$ 39,596,800
FY 90	$114,800,000(est.)	$ 54,260,800	$ 43,426,100

(NOTE: Not all state mental health services are included in the "appropriation" figure. Only services for the "traditional" mentally ill and FY 90 budget increments for the developmentally disabled, senile, and chronic alcoholics are currently being funded from the trust account. See program discussion following.)

Each year the unappropriated balance of the Mental Health Trust Income Account has been transferred in accordance with Chapter 48 to the state's general fund for general expenditure.

THE MENTAL HEALTH PROGRAM

Although not a part of the Supreme Court's ruling or the settlement proposal embodied in Chapter 48, the plaintiffs and intervenors have made it clear that the determination of "the necessary expenses of the mental health program of Alaska" is integral to settlement. Clearly, the goal of the 1956 enabling act, the Weiss lawsuit, and the settlement proposal is to provide a funding source for mental health services. However, none provide a definition of "necessary expenses" or "mental health program". Some guidance has come from the court, but many questions remain unresolved.

THE GREENE DECISION

The Weiss lawsuit was filed on behalf of chronically mentally ill individuals. After the Supreme Court ruled in the plaintiffs' favor, additional groups intervened in the lawsuit, wanting to be recognized as beneficiaries of the mental health trust. In 1988 Superior Court Judge Greene ruled that Congress intended that the trust benefit the recipients of the services of a "comprehensive mental health program".

Prior to passage of the Alaska Mental Health Enabling Act and the concomitant assumption of mental health responsibilities by the Territory, Alaskans in need of mental health services were sent to Morningside Hospital in Oregon. Judge Green ruled that Alaska's program must serve, at a minimum, those populations that were treated at Morningside -- the mentally ill who may require hospitalization, the mentally retarded (developmentally disabled), chronic alcoholics suffering from psychoses, and persons who suffer mental illness as a result of senility. Judge Greene's decision did not preclude the addition of other populations.

THE GREENE GROUP

The ad hoc "Greene Group", consisting of state officials and representatives of each of the four beneficiary groups named by the court, was formed to make recommendations to the Alaska Mental Health Board on which specific programs should benefit from the trust. Their final report, issued in April 1989, provides a definition of each of the four beneficiary groups. The definitions are based on clinical diagnoses and functional limitations that effectively limit the beneficiaries to the most severely ill in each group. The position of the Greene Group is that these "core beneficiaries" must have their needs met before additional beneficiaries may be served.

The Greene Group did not reach a consensus on what specific services should be provided or whether additional beneficiaries should be included.

THE ALASKA MENTAL HEALTH BOARD

The Alaska Mental Health Board issued a policy paper in July 1989 supporting funding of a "comprehensive mental health program", which would serve a broader group of beneficiaries than that identified by the Greene Group. For example, under the Board's definition, services provided by the state's Community Mental Health Centers to persons who are not severely ill would be funded from the trust.

At its December 1989 meeting the Board recommended that the following guidelines be used to determine what specific services should be funded from the trust:

1. The service must be included in the most current approved State Mental Health Plan or the Governor's Council Plan for Services to People Who Experience Developmental Disabilities;
2. The service is not one for which eligibility is determined on a basis other than trust beneficiary status (e.g. age, income);
3. The service is not one to which beneficiaries are otherwise entitled under state law; and
4. The service has been determined by the Alaska Mental Health Board or in statute to be a necessary expense of the state's mental health program.

THE ADMINISTRATION

As of this writing, the administration has not taken a position on who the trust beneficiaries should be and has not responded to the Board's recommended guidelines for identifying services. The state's current operating budget appropriates from the trust only for "traditional" mental health services and for FY 90 budget increments for the developmentally disabled, senile persons, and chronic alcoholics.

Appropriations from the trust are done simply by identifying the trust as the funding source in the state's operating budget. Identification of the traditional mental health program was done in FY 89 prior to the Greene decision. Since the decision, additional programs in the base budget have not been identified because of a lack of consensus over what services are "necessary". Once these issues are resolved, the budget will be revised to show the trust as the funding source for all eligible programs.

TRUST APPROPRIATIONS IN FY 89 AND FY 90

	FY 89	FY 90
Chronically Mentally Ill	8,003.0	9,758.0
Community Mental Health Centers	11,263.9	10,542.1
API/AYI/Designated BRUs/Administration	17,479.9	18,557.5
Developmentally Disabled	0	1,653.5
Alcohol Abuse	0	1,064.0
Alzheimers	0	325.0
Capital projects	2,850.0	1,526.0
TOTAL	39,596.8	43,426.1

TOTAL PROGRAM FUNDING IN FY 89 AND FY 90

	FY 89	FY 90
Chronically Mentally Ill	9,058.0	9,758.0
Community Mental Health Centers	11,248.3	11,967.3
API/AYR/Designated BRUs/Administration	18,527.2	19,965.1
Developmentally Disabled	17,248.7	18,998.9
Alcohol Abuse	14,479.3	15,905.7
Alzheimers	0	325.0
Capital projects	2,850.0	1,526.0
TOTAL	73,411.5	78,446.0

MENTAL HEALTH TRUST LANDS SETTLEMENT

DISCUSSION

THE GOAL

The common goal of the federal enabling act, the Weiss lawsuit, and the settlement agreement is to provide a funding source for mental health services. Under the settlement proposal, the amount of funds available is tied directly to the value of the original 1 million acres of land. Under both the federal enabling act and the settlement proposal, the amount of funds actually appropriated is tied directly to the "necessary expenses of the mental health program". This has led to there being two major unresolved issues:

1. The value of the land trust.
2. The determination of "necessary expenses", which involves both a determination of who the trust beneficiaries are and the services to be provided to each beneficiary group.

THE LAND VALUE

A basic conclusion at the time the settlement statute was enacted was that returning the original 1 million acres to trust status would create too many conflicts with current land uses. Hence, the concept of selecting replacement lands of equal value was endorsed. As is standard procedure in any equal value land exchange conducted by the state, both the original and replacement lands need to be appraised. As is also fairly standard, the land valuation process has become very controversial.

Because the amount of money in the Mental Health Trust Income Account will be a direct result of the land value (through the 8% payment mechanism), there is a tremendous interest on the part of the plaintiffs in a "high" land value. The administration asserts that its interest is in the "correct" value. It has voiced concern that "fair market value" has a specific meaning in its determination on a wide variety of land management actions, and that a different approach for mental health lands could set a detrimental precedent. However, because there are many approaches to land appraisal and because appraising involves some subjectivity, it is hard to say what is "correct". What can be said is that the value supported by the administration is much lower than that supported by the plaintiffs.

One might argue that the land value itself is irrelevant, because it simply generates a revenue stream that is available for appropriation by the Legislature; it is not a dedicated fund and hence there is no mandate to spend the full stream on mental health. The administration has asserted throughout the settlement negotiations that Congress, by allowing trust revenues not needed for the mental health program to be spent on other public purposes, intended that the determination of "necessary expenses" be the prerogative of the Legislature.