

ALASKA LEGISLATURE COMMITTEE FILES 1993-1994 8672

8284 SENATE HEALTH EDUCATION & SOCIAL SERVICES

HEB

171

Alaska State Legislature

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Representative Ronald L. Larson
District 27

MEMORANDUM

TO: Senator Steve Rieger, Chairman
Senate HESS Committee

FROM: Representative Ron Larson *R.L.*

DATE: April 8, 1993

RE: Request for a hearing - HB171

I respectfully request that HB171, An Act providing coverage for hospice care under the Medicaid program; reordering the priorities given to optional services under the Medicaid program; and providing for an effective date, be scheduled for a hearing in the Senate HESS Committee.

Hospice care is already a Medicaid-covered service for children and is available to people who qualify for Medicare. This bill would extend that coverage of Hospice service to Medicaid-eligible adults who do not qualify for Medicare.

Hospice care allows a terminally-ill person to receive medical care and psychological, social, and/or spiritual counseling through a single agency, the hospice care provider.

I am attaching a fiscal note, Department Position Paper, and additional back-up information for your packets.

Thank you for your consideration of this request.



Alaska State Legislature

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Representative Ronald L. Larson

District 27
HB 171- Hospice Care
Sponsor's Statement

Hospice care is already a Medicaid-covered service for children and is available to people who qualify for Medicare.

This bill would extend coverage of hospice service to Medicaid-eligible adults who do not qualify for Medicare. Medicaid eligible adults are the aged, blind, disabled, and families with dependent children, as well as pregnant women. The "optional eligibles" also included, in Alaska are individuals under 21 who don't qualify for Aid to Families with Dependant Children because they aren't dependent children, and institutionalized individuals under a specified income level.

To qualify as a hospice care provider, a hospice care agency must be Medicare-certified.

Hospice care allows a terminally-ill person to receive medical care and psychological, social and/or spiritual counseling through a single agency, the hospice care provider. Lacking hospice care, an individual may require extensive hospital and/or nursing facility care or have to rely on the sometimes fragmented or piecemeal provision of supportive services in the community.

- In addition to meeting physical needs, Hospice care offers a wealth of emotional, spiritual and practical supports to the patient and the family. Quality of life is maximized through an interdisciplinary team of physicians, nurses, physical, occupation and speech therapists, home health aides, social workers, chaplains, and volunteers. The patient and family are actually a part of the team, helping to plan and prioritize care.

- It will be the role of Hospice to provide all medications, medical equipment and supplies necessary for management of the terminal illness.



- Bereavement care is also available to the family for a period of 13 months after the death. Hospice offers written resources, phone calls, visits from volunteers, a support group and, as needed, bereavement counseling.

- Most important are the trained Hospice volunteers who give a wide range of services from staying with a patient while the caregiver takes a break to nursing care, homemaking services, or a listening ear.

In addition to all the positive services that Hospice care can offer a family, crucial facts make the Medicaid Hospice option a wise decision. **Hospice is a budget-neutral program.** Hospice care is one of the few programs existing in our present health care structure that models fiscal responsibility and cost-effective quality care. Hospice offers the resources to allow terminally ill persons to spend the rest of their lives, or at least more of their lives, at home.

Quite often, the alternative to Hospice care is costly nursing home placement or frequent hospitalization.

POSITION PAPER

STATE OF ALASKA * DEPARTMENT OF HEALTH & SOCIAL SERVICES

Position Paper CSHS 171 (FIN)

The Department of Health and Social Services supports CS for House Bill 171 (FIN), which would include coverage of hospice care under the Medicaid program.

Hospice care is already a Medicaid-covered service for children and is available to people who qualify for Medicare. This bill would extend coverage of hospice service to Medicaid-eligible adults who do not qualify for Medicare. To qualify as a hospice care provider, a hospice care agency must be Medicare-certified. There are currently no Medicare-certified hospices in Alaska.

Hospice care allows a terminally-ill person to receive medical care and psychological, social, and/or spiritual counseling through a single agency, the hospice care provider. Lacking hospice care, an individual may require extensive hospital or nursing facility care or have to rely on the sometimes fragmented or piecemeal provision of supportive services in the community.

The Department supports this effort to expand the availability of a valuable alternative for terminally ill people. It also concurs with the placement of hospice services on the Medicaid priority list. Under CSHB 171(FIN), in the case of a budget shortfall, hospice care would be eliminated before most other long term care services, but after most optional Medicaid services.

Recommended by:

Kimberly B. Busch

Kimberly B. Busch
Director
Div. of Medical Assistance

Date:

4-12-93

Approved by:

Theodore A. Maia

Theodore A. Maia, MD, MPH
Commissioner

Date:

13 April 1993

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. CE112171(FIN)

Effective Date: 02/23/93 Dept. Affected: Health and Social Services
 Title: An Act providing coverage for hospice care BRU: Medical Assistance Administration
 Component: Claims Processing
 Sponsor: Larson
 Requestor: _____ COMPONENT SERIAL NO. 00243

Expenditures/Revenues:

(Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	10.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	10.0	0.0	0.0	0.0	0.0	0.0

CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
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REVENUE FUND SOURCE						
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FUNDING:

(Thousands of Dollars)

1002 Federal Receipts	5.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	5.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1006 GF/MHTIA	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	10.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY93) impact: 0.0

ANALYSIS: (Attach a separate page if necessary)

FY 94 funds are required to modify the Medicaid Management Information System to allow the payment of claims for hospice care.

Studies suggest that hospice care tend to be cost neutral or produce cost savings. Hospice care is already available to children covered by Medicaid and to Medicare-eligible adults. There are currently no Medicare-certified hospice providers in the state. We anticipate that only a small number of recipients will use hospice care as a result of this bill. Therefore, no other fiscal impact is projected.

Prepared by: Kimberly Busch, Director
 Division: Medical Assistance

Phone: 465-5826
 Date: 03/01/93

Approved by Commissioner: Theodore A. Mala, MD, MPH
 Agency: Department of Health & Social Services

Date: 4/13/93

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WHAT DOES HOSPICE MEAN?

PHYSICIAN INFORMATION SHEET

WHAT IT MEANS TO THE PATIENT

When a patient elects the Medicare hospice benefit, they revoke their other part A benefits for treatment of their terminal illness? The hospice becomes the sole provider for their service needs, and whatever products are necessary for palliation and symptom control. This includes:

- professional services,
- pharmaceuticals
- DME
- in-patient respite
- in-patient care for symptom management

The hospice becomes a managed care program for the patient.

Benefit periods: 2 90-day periods, 1 30-day period,
Indefinite 4th period

The fourth indefinite period was recently enacted. They do not go off the benefit if they fail to die in 7 months.

Revocation of benefit is possible during any benefit period, but there are limitations regarding reelection of benefit.

Admission criteria:

- * Certified by physician that terminal illness with 6 months or less life expectancy.
- * Choose palliative care; treatment mode past

When a person has a terminal illness, consider Hospice as an information resource on options--to patient & physician. The ultimate choice regarding treatment options (including hospice enrollment) is made by client.

WHAT IT MEANS TO THE FAMILY

The family is included as client in the plan of care:

- Support
- Respite
- Bereavement program
- Assessment
- Care

WHAT IT MEANS TO THE HOMECARE PROGRAM STAFF

Philosophy of approach to care.

- Emphasis on living fully
- Self determination
- Palliation --complete
- Totality of care

HOSPICE AND YOUR OTHER MEDICARE BENEFITS

Hospice under Medicare is designed to be more than just a collection of existing benefits with a new name. Many items and services are covered under hospice that are not covered through any other type of facility or provider.

This chart shows a comparison between hospice benefits and benefits available through hospitals and home health agencies.

SERVICE ITEM	MEDICARE COVERED IN		
	HOSPICE	HOSPITAL	HOME HEALTH AGENCY
Drugs for pain & symptom control to be used at home	YES	YES	NO
Services covered whether or not the patient is homebound	YES	---	NO
Deductibles waived	YES	NO	NO
Inpatient care to provide respite for family caring for the patient at home	YES	NO	NO
Continuous care at home during periods of crisis	YES	NO	NO
Counseling services at home for both the patient and the family	YES	NO	NO
Home Health Aides	YES	NO	YES
Bereavement Counseling	YES	NO	NO
Volunteers must be available	YES	NO	NO
Care must be continued if benefits run out	YES	NO	NO
Inpatient unit must have homelike decor	YES	NO	---

Standard of Hospice Program, Care Recommended by the National Hospice Organization



For more information, contact the American Hospice Association, 1000 ...

Standards For A Hospice Program

A DEFINITION

A hospice program is a coordinated program of palliative and supportive services provided in both home and inpatient settings which provides for physical, psychological, social and spiritual care for dying persons and their families. Services are provided by a medically directed interdisciplinary team of professionals and volunteers. Bereavement care is available to the family following the death of the person.

HOSPICE PHILOSOPHY

Hospice provides support and care for persons in the last phases of incurable disease so that they may live as fully and comfortably as possible. Hospice recognizes dying as part of the normal process of living and focuses on maintaining the quality of remaining life. Hospice affirms life and neither hastens nor postpones death. Hospice exists in the hope and belief that through appropriate care, and the promotion of a caring community sensitive to their needs, patients and their families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them.

ACCOUNTABILITY

Principle: The hospice operates as an integral part of the health delivery system at the community level and is accountable to the community it serves and the public at large. In order to provide care in this system, a hospice must meet the fundamental requirements for operation and delivery of health services, as regulated by local, state and federal laws.

Standard 1: The hospice program establishes and maintains appropriate reports, policies and procedures to assure that the hospice is accountable to the community for the services it provides.

Standard 2: The hospice program complies with applicable local, state and federal laws and regulations governing the organization and delivery of health care to patients and families.

ACCESS TO HOSPICE CARE

Principle: Admission to the hospice program is based on an assessment of the patient and family needs, their desire for services and the program's specific admission criteria. The level of care received, including the frequency and type of services provided, is based on both initial and subsequent assessments of the patient and family's needs. Care may be provided on either a part time, intermittent basis, a regularly scheduled basis, or a continuous basis, depending upon the needs of the patient and family as reflected in ongoing assessments.

Standard 3: Access to hospice medical and nursing services is available to identified hospice patients on a 24 hour basis, 7 days a week. During hours covered by on-call staff, hospices provide for at least a minimum of medical and nursing coverage, with visit capability should further assessment or treatment be needed. Provisions are made to assure that on-call staff are informed and updated regarding care plans and level of care. Reporting mechanisms are in place to assure continuity and coordination among members of the hospice interdisciplinary team.

Standard 4: The hospice program has admission criteria that reflect the patient/family's desire and need for hospice care; the extent and role of physician participation; and diagnosis and prognosis. To the maximum extent possible, the hospice program will admit patients regardless of their diagnosis or ability to pay for services.

CONTINUITY OF HOSPICE CARE

Principle: Hospice patients and their families may experience physical, social, emotional and spiritual concerns and problems. Hospice addresses these by providing a comprehensive and coordinated program of care which includes an ongoing assessment of needs and determination of the level of care and scope of services necessary. Continuity implies that services, whether provided directly or contracted for, are coordinated in both home and inpatient settings. Services are reflective at all times of patient/family needs, and that the hospice is accountable for its care and services in both home and inpatient care settings.

Standard 5: The hospice program organizes its services to respond to patient/family needs whenever they arise. It provides both structure and staff to ensure continuation of the hospice care plan in all settings.

ACCESS TO HOSPICE INPATIENT CARE

Principle: Not all patients can be maintained at home throughout their terminal illness; some may require short term inpatient care. When such a need arises, hospice care is provided in an inpatient hospice unit. The hospice provides access to hospice inpatient services which reflect the hospice philosophy and emphasizes symptom control and enhancement of a quality of life acceptable to dying patients and their families.

Standard 6: Access to hospice inpatient care is available either directly by the hospice or through contract or arrangement with an inpatient facility. This hospice inpatient unit must comply with all applicable local, state and federal regulations, including fire and safety code regulations.

Standards For A Hospice Program

Standard 7: At a minimum, the hospice inpatient unit provides for: medical direction and coverage for all patients either directly or through agreement with the patient's personal physician; staffing coverage by an interdisciplinary team available to meet the needs of the patient/family on a 24 hour basis as needed; and, specific policies and procedures, as well as personal comfort amenities and courtesies that support and encourage a non-institutional, "home-like" environment for the patient/family. All hospice inpatient personnel must be appropriately trained in the provision of hospice interdisciplinary team care.

PATIENT/FAMILY AS THE UNIT OF CARE

Principle: Inclusion of the family in the hospice care program is essential. The wishes and desires of the patient/family are reflected in assessments and plans of care developed by the interdisciplinary team. The family members are seen both as primary caregivers and as needing care and support so that their own stresses and concerns may be addressed. Attention is also given to assisting with the development of a community support network when family and friends are not available and a patient needs and wants that support.

Standard 8: The patient/family is the unit of care in hospice and support is provided to both the patient and the family. The hospice program encourages patient/family participation in the development of the interdisciplinary team plan of care and in the provision of hospice services.

Standard 9: The hospice program acknowledges that each patient/family has its own values and beliefs and is respectful of them.

Standard 10: The hospice program seeks to identify, teach, coordinate and supervise those persons acting as primary caregivers for the patient. If a primary care person is not available, the hospice program seeks to develop a substitute network. If the hospice program does not accept patients without primary caregivers, then it must provide adequate information about community resources available to them.

PAIN AND SYMPTOM CONTROL

Principle: For the hospice program, the goal of all interventions is to maximize the quality of the remaining life through the provision of palliative therapies that control and symptoms and minimize the negative side effects of interventions. Hospice programs recognize that when a patient and a family are faced with terminal disease, stress and concerns may arise in many aspects of their lives. Optimum symptom control includes addressing these stresses and concerns, in addition to the use of appropriate therapies.

Standard 11: The goal of hospice care is to provide optimum relief of pain and control of symptoms through appropriate palliative therapies.

Standard 12: Symptom control includes assessing and responding to the physical, emotional, social and spiritual needs of the patient/family.

VOLUNTEERS

Principle: An essential component of hospice care is the direct personal support for the patient/family by volunteers. Volunteers provide important perspectives in developing the interdisciplinary team plan of care

and in the provision of significant hospice services.

Standard 13: A hospice program offers volunteer support to each patient/family admitted to its program of care.

Standard 14: A hospice program has an organized training program and procedures for the selection, supervision and continuing evaluation of volunteers.

HOSPICE INTERDISCIPLINARY TEAM

Principle: Hospice care is provided by an interdisciplinary team which includes at least the following members: patient and patient's family, physician, nurse, social worker, volunteer, and clergy. Ancillary staff are added to the team when appropriate. The team meets regularly to develop and maintain an appropriate plan of care.

Standard 15: The hospice identifies and maintains an appropriately qualified interdisciplinary team of health professionals and lay persons.

Standard 16: Emotional support for staff/volunteers is provided as an integral part of a hospice program.

Standard 17: Inservice training and continuing education are offered on a regular basis to both paid and volunteer staff.

INTERDISCIPLINARY TEAM PLAN OF CARE

Principle: Documentation of services is necessary for the delivery of quality hospice care. Of critical importance is the development of an integrated plan of care which records assessments, proposed interventions by all

Standards For A Hospice Program

interdisciplinary team members and documents all services provided to the patient/family and their outcomes. Hospice clinical records reflect the full range of problems identified; services provided by level of care across both the home and inpatient settings; and progress notes documenting the care given on a day-to-day basis.

Standard 18: The hospice program has a written, interdisciplinary team plan of care for each patient/family unit that includes assessments, identified problems, proposed interventions, level and frequency of services and their outcomes.

Standard 19: The hospice program maintains accurate, current, integrated clinical records for all patient/family units and provides assurances for the confidentiality of these records.

Standard 20: These clinical records must include a signed informed consent form completed by the patient or a designated representative. The consent form must inform the patient/family of the palliative nature of hospice care; the avoidance, if at all possible, of injections, diagnostic testing and curative measures; and the non-use of heroic measures to prolong the dying process.

Standard 21: These clinical records must include specific, signed instructions regarding actions to be taken when life threatening situations occur to the patient. These instructions should be prepared by the physician and the interdisciplinary team, following consultation with the patient/family, and must be consistent with the patient/family's wishes.

BEREAVEMENT

Principle: Death of a family member may result in a wide range of physical, emotional, social, familial, economic and spiritual disruptions. Grief and bereavement are normal reactions to loss and death. Grief is the highly personal response to loss; bereavement is the extended period of deprivation following the loss of a loved one.

Grieving may precede an anticipated death or may be delayed for a considerable period of time. Grief may manifest itself in emotional and/or physical distress and may affect family members in different ways at different times. Some persons can resolve grief with time and their own resources; others may require formal assistance and support over an extended period of time.

An important element of hospice care is an assessment of the needs of the bereaved family, and the development of a care plan that meets these needs, both prior to, and following, the death of the patient. Hospice encourages the expression of grief, recognizes social/religious and ethnic variables in bereavement and supports staff and family participation in meaningful funeral services and rituals.

Standard 22: The hospice program provides bereavement services to the surviving family members for at least one year after the death of the patient.

Standard 23: The hospice program maintains a process of risk assessment for surviving family members that identifies those individuals at risk of pathological grief. For those individuals at high risk, appropriate referrals are made to mental health professionals in the community.

QUALITY ASSURANCE AND UTILIZATION REVIEW

Principle: Hospice is committed to developing methods to measure and assure the quality of patient/family care and the appropriate utilization of hospice resources.

Standard 24: The hospice program has quality assurance and utilization review programs that include the following: statement of goals and objectives and established policies for conducting an ongoing assessment program that reflects the interdisciplinary nature of hospice services; designation of person(s) responsible for implementing policies and procedures; provisions for addressing specific problems identified in the quality assurance and utilization review processes.

Standard 25: At a minimum, the hospice program conducts on a regular basis the following activities: evaluation of services provided by both professionals and volunteers, audit of patient charts for outcomes of interventions, organizational review of hospice program, interdisciplinary team care plan review, evaluations provided by patient/families of care received, a review of appropriate/inappropriate use of services, facilities and personnel.

A Hospice Glossary

This glossary was prepared using a variety of source materials to provide definitions. These include: *NHO Standards of Care* (1983), *Joint Commission on Accreditation of Healthcare Organizations* (manuals, 1985), *Introduction to Health Education* (Bates, Wynder, 1984) and *Webster's New Collegiate Dictionary* (1986).

Ability to pay: A phrase used to describe a patient's capability to pay for health services received. Some health providers limit their services to patients who can pay for their services.

Access: An individual's or group's ability to obtain health care. Access has geographical, financial, social, ethic and psychological elements. Many health programs have as their goal improving access to care for specific groups or equity of access for the whole population.

Accountability: To provide for an organization substantial reasons or convincing explanations for actions; to be accountable means to furnish a justification or detailed explanation of financial activities or responsibilities. Accountability entails an obligation to periodically disclose, in adequate, detailed and consistent form the purposes, principles, procedures, relationships, results, incomes, and expenditures involved in any activity, enterprise, or assignment, so that they can be evaluated by interested parties.

Accreditation: A voluntary process, generally developed and implemented by a non-governmental body composed of professionals within the field, with input from providers, and based on optimal standards of quality care.



Administration: The fiscal and general management of a hospice program, as distinct from the general policies and procedures of the hospice program.

Admissions: Numbers of patients/families that enter a hospice program and agree to accept the services provided by a hospice program.

Admission criteria: Guidelines or policies of a hospice program that specify the conditions under which a patient/family will be admitted. The purpose of the criteria is to control entry/admission to services, e.g., most hospices require a diagnosis of terminal illness by a physician as a prerequisite for admission.

Ancillary staff: Health professionals who provide additional services to support or supplement hospice interdisciplinary team services, including physical therapy, occupational therapy, speech therapy, nutritional counseling, respiratory therapy, and other services.

Appropriate: Descriptive of an action or policy that is suitable or compatible with a hospice program's objectives and philosophy.

Approved: Acceptable to the appropriate authority.

Assessment: Procedures by which strengths, weaknesses, problems, and needs are identified and addressed.

Audit, financial: An independent review of a hospice program's financial records that accurately reflects its financial status.

Bereavement: An important element of hospice care is an assessment of the needs of the bereaved family, and the development of a care plan that meets these needs, both prior to, and following the death of a patient. Hospice encourages the expression of grief, recognizes social/religious and ethnic variables in bereavement and supports staff and family participation in meaningful funeral services and rituals.

Bereavement services: The hospice program makes available bereavement services to the surviving family members for a period of at least one year after the death of the patient. They may include: cards to families; home visits; phone calls; group counseling; individual counseling; newsletters; and social activities.

Bylaws: The rules, regulations, or laws adopted by a hospice program for the regulation of its internal affairs and its dealings with other persons and the community at large.

Certification: A voluntary mechanism used to qualify organizations to receive public funds. If a provider chooses to participate in Medicare, for example, it must comply with a set of conditions of participation based on laws and regulations.

Chemotherapy: Provision of drugs (i.e., chemicals) taken orally, injected, inserted, topically applied, or otherwise administered to control pain and symptoms in hospice patients.

Clergy: A person who has met the requirements of a religious

A Hospice Glossary

organization or system to serve the constituency of that religious organization or system.

Clergy services: See spiritual services.

Clinical privileges: Authorization by the governing body to provide specific patient/family care and treatment services in the organization, within well-defined limits, based on the individual's license, education, training, experience, competence, and judgment.

Community: The individuals, groups, agencies, facilities, or institutions within the locality served by the hospice program.

Confidentiality: The relationship between the hospice staff patients/families in which information is shared and exchanged with the understanding that this information is used appropriately and with respect to the patient/families' wishes and rights to privacy.

Continuing education: Education beyond initial professional preparation that is relevant to the type of patient/family care delivered in the organization, that provides current knowledge relevant to the individual's fields of practice, and that is related to findings from quality assurance activities.

Continuity of care: Services that are organized, coordinated and provided in a way that is reflective at all times of patient/family needs, and which are structured to assure that the hospice is accountable for its care and services regardless of home or in-patient setting.

Continuous basis: Hospice care is provided in the home setting on a 24



hour basis until care is no longer needed. Usually this occurs when the patient/family goes into a medical crisis, but does not need or wish to return to an inpatient setting.

Contracted services: Services provided through a formal agreement with any organization, agency or individual. The agreement, which is approved by the governing body, specifies the services, personnel, and/or space to be provided to or on behalf of the hospice program and the consideration to be expended in exchange.

Counseling: A relationship in which a person endeavors to help another understand and cope with problems.

Curative: Medical interventions used to ameliorate the cause of a disease.

Dietetic services: Services that meet the nutritional needs of patients, with emphasis on patients who have special dietary needs.

Dietitian: A person who is registered by the Commission on Dietetic Registration of the American Dietetic Association or who has the documented equivalent in education, training and/or experience.

Discharge: The point at which the patient's active involvement with the hospice program is ended and the program no longer maintains active responsibility for the care of the patient.

The actual point of discharge is determined by the hospice program in accordance with the continuum of home care and inpatient services provided.

Documentation of services: The process of writing, recording and maintaining appropriate records of services that are provided by a hospice interdisciplinary team. This process is very important to assure continuity of services, high quality of care and to justify those services that have already been provided.

Dying: The progressive failure of body systems to retain normal functioning, thereby limiting the remaining life span.

Emotional: The feeling aspect of consciousness which is subjectively experienced and expressed by physiological reactions.

Emotional support: The provision of psycho-social services that assist and support the patient/family during that period of time when they cope with their feelings and responses to the loss, grief and change in their family structure which occurs when the patient dies.

Employees: Individuals who agree to work and provide their services under the administrative direction of the hospice program. Employees may receive wages and other compensation in exchange for their work, or they may provide their services without payment, as an in-kind contribution to the hospice program.

Facility: The building(s), equipment and supplies necessary for the

A Hospice Glossary

implementation of inpatient services for hospice patients/families.

Family: The relatives and/or other significantly important persons who provide psychological, emotional and spiritual support of the patient. The "family" need not be blood relatives to be an integral part of the hospice care plan.

Fiscal management: The policies and procedures used to plan and control a hospice program's overall financial operations.

Goal: An expected result or condition that takes time to achieve and is specified in a statement of relatively broad scope that provides guidance in establishing intermediate objectives directed toward attainment of that goal.

Governing body: The individual(s), group or agency that has ultimate authority and responsibility for the overall operation of the organization.

Grief: The highly personal response to loss. Grieving may precede an anticipated death or may be delayed for a considerable period of time. Grief may manifest itself in emotional and/or physical distress and may affect family members in different ways at different times. Some persons can resolve grief with time and their own resources; others may require formal assistance and support over an extended period of time.

Home: The patient's place of residence. Home is the place where most terminally ill patients choose to spend their remaining days.

Home care services: Formally organized services designed to provide and coordinate hospice interdisciplinary team services to

patients/families in the home.

Home health agency: An organization that provides services to individuals in their place of residence. Many home health agencies receive compensation for their services provided to Medicare beneficiaries. Some home health agencies operate a hospice program as a separate division of their total program.

Home health aide services: Personal care services provided in the home. Services may include assistance in the activities of daily living (e.g., helping the patient bathe, care for his or her hair or teeth, exercise and retain necessary self-help skills). Services may also include specific household tasks to maintain a safe environment in areas of the home used by the patient (e.g., changing the bed and doing laundry essential to the cleanliness of the patient).

Homemaker services: Services that are provided to assist patients to remain in their homes. Services may include assistance in personal care (e.g., assisting the patient to the bathroom or in and out of bed); maintenance of a safe and healthy environment (e.g., cleaning the patient's bedroom, bath and kitchen, doing personal laundry and preparing meals); and other services, as appropriate to the homemaker's responsibilities.

Hospice care: Care provided by a hospice program that is designed to meet the physical, social, emotional and spiritual needs of dying patients and their families.

Hospice program: A hospice program is a coordinated program of palliative and supportive services provided in both home and in-patient

settings which provides for physical, psychological, social and spiritual care for dying patients and their families. Services are provided by a medically-directed interdisciplinary team of professionals and volunteers. Bereavement care is available to the family following the death of the patient. Hospice provides support and care for persons in the last phases of incurable disease so that they may live as fully as comfortably as possible.

Hospice philosophy: Hospice recognizes dying as part of the normal process of living and focuses on maintaining the quality of life. Hospice affirms life and neither hastens nor postpones death. Hospice exists in the hope and belief that through appropriate care and the promotion of a caring community sensitive to their needs, patients and their families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them.

Hospice program director: The chief administrative officer of the hospice program who provides overall policy direction, is responsible for the fiscal operations, and implements work plans and procedures.

Incident report: Documentation of an event of action that is likely to lead to adverse effects and/or that varies from established policies and procedures pertaining to patient/family care.

Infection control program: Organized, on-going activities within a hospice program to control and monitor the spread of infectious diseases within the hospice, including both home and in-patient settings. Part of this program involves establishing and maintaining specific policies and procedures proper

A Hospice Glossary

procedures for proper disposal of human discharges and surveillance of staff and patients for infections acquired during their contact with a hospice program.

Informed consent: A full understanding by a competent body of the risks and benefits of particular medical procedure or set of procedures. Prior to admission to hospice, the patient/family must sign an agreement that states they understand the nature and scope of hospice care, including the fact that hospice care is palliative and not curative, and that they agree to cooperate in the provision of care.

Inpatient services: Formally organized services designed to provide and coordinate hospice interdisciplinary team services to patients/families in an inpatient setting.

Inpatient settings: Services provided in a setting where the needs of acutely ill patients/families can be met. This care is provided on a 24 hour basis and involves the full hospice interdisciplinary team. During the last months of life, a dying patient may have episodes of acute illness that require the intensive services capability of an in-patient setting.

In-service education: Organized education designed to enhance the skills of interdisciplinary team members or teach them new skills relevant to their responsibilities and disciplines.

Interdisciplinary team: Hospice care is provided by an interdisciplinary team which includes at least the following members: patient and patient's family, physician, nurse, social worker, volunteer, and clergy. The team is coordinated by a qualified health care professional and is

medically supervised. The team meets regularly to develop and maintain an appropriate plan of care. (See Interdisciplinary team services.)

Interdisciplinary team conference: A meeting during which interdisciplinary team members review one or more interdisciplinary team care plans to update patient/family physical and/or psychological status and initiate any changes in the care plan.

Interdisciplinary team plan of care: Documentation of services is necessary for the delivery of quality hospice care. Of critical importance is the development of an integrated plan of care which records assessments, proposed interventions by all interdisciplinary team members and documents all services provided to the patient/family and their outcomes. Hospice clinical records reflect the full range of problems identified, services provided by level of care across both the home and inpatient settings, and progress notes documenting the care given on a day-to-day basis.

Interdisciplinary team services: A group composed of individuals from various professions and disciplines who interact on a regular basis and have a working knowledge of the assessment and care of the patient/family by each member of the team. The team services are characterized by the ability by all members and disciplines to allow their roles to overlap while simultaneously providing emotional support to each other and maintaining a respect for each other's skills, training and interventions.

Intermittent basis: Provision of hospice services at intervals as they are needed by the patient/family. During the final six months of life, the patient/

family may go through a number of crises that require a higher level of intensity of hospice services than at other times.

Interventions: Specific actions designed to interfere, stop or ameliorate the natural course of an illness or human disease. In hospice, interventions are limited to those that are palliative and not curative. These interventions may, however, address a range of patient/family needs, including physical, spiritual, social and emotional concerns.

License: Authorization to practice in the professional discipline by an individual may be mandated by state law. The state grants permission to a provider organization to operate or individual to practice. It is a matter of specific state law and violation imposes a penalty.

Licensure: Licensure standards are the minimum standards which must be met to provide service as a hospice. In contrast to accreditation and certification, licensure is mandatory if specified by state law. The state grants permission to a provider organization to operate or individual to practice. It is a matter of specific state law, and violation imposes a penalty.

Medical director: A fully licensed physician who is charged with the responsibility of acting as consultant to the interdisciplinary team and, as requested, to attending physicians with regard to pain and symptom management, as well as acting as liaison with physicians in the community.

Medical records: Specific records maintained by a hospice that document all services provided by the

A Hospice Glossary

interdisciplinary team to a patient/family.

Medical staff: A single organized body that is accountable to the governing body and has the overall responsibility for the quality of professional services provided by individuals with clinical privileges.

Medication: Any substance, whether prescription or over-the-counter drug, that is taken orally, injected, inserted, topically applied, or otherwise administered to the patient.

Nursing services: Patient/family care services pertaining to the palliative, curative, rehabilitative and preventive aspects of nursing, performed and/or supervised by a registered nurse pursuant to interdisciplinary team care plans.

Objective: An expected result or condition that takes less time to achieve than a goal, is stated in measurable terms, has a specified time for achievement and is related to the attainment of that goal.

Outcomes: The final results or consequences from specific interventions taken. In hospice, the death of the patient is anticipated and is not defined as an outcome. Appropriate hospice outcomes focus on control of pain and symptoms and quality of the remaining days that the patient/family spends together.

Pain and symptom control: For the hospice program, the goal of all interventions is to maximize the quality of the remaining life through the provision of palliative therapies that control pain and symptoms and minimize the negative side effects of interventions. Hospice programs

recognize that when a patient and a family are faced with terminal disease, stress and concerns may arise in many aspects of their lives. Optimum symptom control includes addressing those stresses and concerns, in addition to the use of appropriate therapies. Symptom control includes assessing and responding to the physical, emotional, social and spiritual needs of the patient/family.

Palliative care: Intervention that focuses primarily on reduction or abatement of the physical and psychosocial symptoms of terminal illness.

Patient/family as unit of care: The specific unit for whose needs hospice is organized. In hospice, this unit is the patient/family. Services are structured (e.g., record/keeping) and then delivered (e.g., visits at home with family members). In contrast, most health providers have, as their unit of care, the individual patient.

Personal care: Assistance rendered to the patient in bathing, dressing, mobility, or any other activities of daily living and personal hygiene.

Pharmacist: A person who has a degree in pharmacology and is licensed and registered to prepare, preserve, compound and dispense drugs and chemicals in the state in which he or she practices.

Physical: Relating to the body, its structure, characteristics and functions.

Physician: A doctor of medicine or doctor of osteopathy who is fully licensed to practice medicine in conformity with applicable law.

Physician, attending: The primary physician selected by the patient to be

responsible for his or her medical care.

Physician, hospice: Any licensed medical practitioner on the hospice staff (compensated or not) who is knowledgeable about hospice principles and active in the development and implementation of interdisciplinary team plans of care for patients and families.

Primary caregivers: The person designated by the patient to give emotional support and/or physical care to the patient. This person may be an individual who has personal significance to the patient but no blood or legal relationship (e.g., significant other), such as a neighbor, friend or other person. If the patient has no designated primary careperson, the hospice may, according to individual program policy, make an effort to designate a primary careperson.

Prognosis: The prospect of recovery, or a forecast of the natural history of a disease or illness. In hospice, usually prior to admission, a patient must have been given a prognosis by a physician of less than six months to live.

Program director: The person who has the authority and responsibility, as delegated by the governing body, to accomplish program-specific goals and objectives, implement program policy and manage personnel and resources.

Psychological/social work services: Counseling and/or therapy, as appropriate, that assists the patient/family in minimizing stresses and problems that arise from social, economic or psychological situations and assists the patient/family in maximizing positive aspects and opportunities for growth. Services are provided, as appropriate to the skill's

A Hospice Glossary

required, by the persons who have education, training and/or experience in the care of hospice patients/families and demonstrated ability in counselling and casework.

Psychosocial assessment: The evaluation of a patient's/family's environment, religious background, financial status, and other pertinent psychosocial information that may contribute to the development of an interdisciplinary team care plan.

Qualified: Having the experience, education and demonstrated competence deemed appropriate by the hospice program to meet the requirements and fulfill the responsibilities of a specific function or duty.

Quality assurance: Ongoing assessment program that measures the quality of the interdisciplinary hospice services provided; It includes provisions for addressing specific problems identified and followup to determine the effectiveness of corrective actions.

Registered nurse: A nurse who is a graduate of an approved school of nursing and who is licensed to practice as a registered nurse.

Risk assessment: The hospice program maintains a process of risk assessment for surviving family members that identifies those individuals at risk of pathological grief. For those individuals at high risk, appropriate referrals are made to mental health professionals in the community.

Service: A functional division of a program or an interdisciplinary team. Also, the delivery of care.

Social: The interactions of persons with their families and communities.

Social services: See (Psychological/social work services.)

Spiritual service: Spiritual support provided by a member of the interdisciplinary team, community clergy, or a person identified by the patient/family as supportive with regard to spiritual or religious matters.

Staff: Paid or volunteer interdisciplinary team members who provide hospice services.

Staff support: Organized activities designed to provide psychological/social support to hospice employees as they respond personally to the loss, grief and change experienced by patients and their families.

Supervision: The direction of the provision of services and the individuals who provide the services, and the review of the services provided, in accordance with written program policies, procedures and job descriptions.

Terminal disease: An illness for which treatment directed toward cure or control of the disease process is no longer possible or effective.

Terminally ill: Individuals suffering from a disease with a prognosis of six months or less to live.

Transfer: Movement of the patient/family from one service or location to another (e.g., the patient and family or designated primary careperson).

Unit: A functional division of a facility or institution. Also, a person or group regarded as a whole (e.g., the patient and family or designated primary careperson.)

Utilization review: The process of using predefined criteria to evaluate whether the hospice's services and resources are necessary, cost efficient and effectively utilized.

Volunteer: An individual who agrees to provide services to a hospice program without monetary compensation. More specifically, a patient care volunteer is an individual who agrees to serve on an interdisciplinary team as a companion of the patient/family and provide psycho-social support to the patient/family during the remaining days of the patient's life. A bereavement care volunteer agrees to provide psycho-social support to the surviving family following the patient's death.

Volunteer support: Activities designed to assist and support volunteers as they work in their roles as patient care and bereavement volunteers.

Written agreement: A formal agreement with any organization, agency, or individual specifying the services, personnel and/or space to be provided to or on behalf of the hospice program, as well as the monies to be expended, if any, in the exchange. The agreement is approved by the governing body, in accordance with hospice program policy.



National Hospice Organization

Addendum to

Standards of a Hospice Program of Care
Recommended by the National Hospice Organization

Original Standard:

Standard 14

A hospice program has an organized training program and procedures for the selection, supervision and continuing education of volunteers.

Revised Standard:

Standard 14 (A)

The hospice program has an organized training program which covers at a minimum the following topics: introduction to hospice, concepts of death and dying, communication skills, care and comfort measures, understanding diseases and conditions, psychosocial and spiritual dynamics of death and dying, the hospice family, managing personal stress, the bereavement process, and the role of the volunteer in hospice.

Standard 14 (B)

The hospice program has established policies and procedures for the selection, retention and continuing education of hospice volunteers and volunteers are regularly evaluated using performance criteria defined by the hospice.

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NATIONAL HOSPICE ORGANIZATION

ABOUT HOSPICE

Hospice is a philosophy and concept of care for the terminally ill that is now one of the most frequently used terms in discussions of innovative approaches to health care. In 1990, the American College of Physicians presented to the National Hospice Organization the Richard & Hinda Rosenthal Foundation Award in recognition of the "recent original approach in the delivery of health care or in the design of facilities for its delivery [which] will increase its clinical and/or economic effectiveness." However, most people are unaware that the significant recent growth of hospice in the United States and internationally is nurtured by ancient roots.¹

The modern hospice can trace its roots to the Irish Sisters of Charity who established St. Joseph's Hospice at London in 1905. The hospice most often recognized as the model of contemporary hospice philosophy and care is St. Christopher's in London. Started by Dame Cicely Saunders, M.D. in 1968, St. Christopher's laid the basis for a philosophy that emphasizes palliative care, i.e., pain and symptom control rather than curative care for the terminally ill.

A community based service, hospice care is provided by an interdisciplinary team of health care professionals and volunteers including physicians, nurses, counselors, therapists and aides. Using a comprehensive case management approach, hospice care is guided by a plan of care which is developed by the interdisciplinary team in conjunction with the patient and family. The goal of the plan is to care for the patient and family as the "unit of care," to provide an alert, pain-free life and to manage other symptoms so that individuals can "live until they die" with personal dignity and quality of life at home or in a home-like setting.

Responding to the directives of the Medicare Hospice Benefit Conditions of Participation², as well as the National Hospice Organization and JCAHO standards, most hospices offer the

¹ The first references to "hospice care" can be found in the ancient writings of Constantine in A.D. 335, and later with the sixth century Benedictine monks and in the ninth century under the emperor, Charlemagne.

² Congress first added the hospice benefit to Medicare in TEFRA 1982. In 1986, Congress made the Medicare benefit permanent and established hospice as an optional Medicaid benefit.

following services to terminally ill patients with a prognosis of six months or less: Physician and nursing services on an intermittent basis; social work services, physical, occupational and speech-language therapy; home health aides; volunteers; drugs and medical supplies; spiritual, dietary and other counseling; short-term inpatient care; continuous home nursing care during periods of medical crisis; and bereavement care for surviving family members. Most services are available, as needed, 24 hours per day, seven days per week.

HOSPICE REIMBURSEMENT AND SAVINGS

As noted, hospice care is a covered Part A benefit under Medicare. Additionally, hospice care is a covered Medicaid Benefit in thirty-three states. Medicare and Medicaid directly pay hospices an all-inclusive, prospective daily rate based on a particular level of care delivered on that day. The four levels of care are: Routine Home Care, Continuous Home Care, Inpatient Respite Care and General Inpatient Care. No more than 20 percent of a hospice's aggregate days may be furnished at the inpatient level of care, and there is an annual aggregate expenditure cap per hospice, calculated on a per patient basis, of \$11,551 (1992). For 1992, the Congressional Budget Office projected a \$600 million Medicare outlay for hospice care. Approximately 60 percent of all hospice patients are Medicare beneficiaries.

Estimated expenditures for hospice care are not available from private payers; however, according to the Health Insurance Association of America, more than 80 percent of employees in medium and large companies have hospice care as a covered benefit. In 1984, only 11 percent of such employees had coverage for hospice care.

Health Care Financing Administration (HCFA) research suggests that approximately 28 percent of annual Medicare expenditures are associated with services, many of which are inappropriate and unwanted, provided to Medicare beneficiaries in their last year of life. Medicare beneficiaries electing hospice services waive their right to standard Medicare benefits for treatment of the terminal illness although their attending physician continues to bill Medicare Part B directly.

A 1988 HCFA commissioned report by ABT Associates suggested a savings of \$1,248 per patient in the last year of life, when hospice care is elected. Kaiser Permanente, an Oakland, California-based HMO, conducted a hospice cost-effectiveness study in the late 1980's focusing on non-Medicare and non-Medicaid terminally ill patients who entered hospice care. The study showed an average cost savings per hospice patient of about \$1,430 to the HMO.

A STATISTICAL PROFILE OF HOSPICE CARE

- First Hospice in the United States, New Haven, CT. 1974
- Current number of U.S. hospices, 1830 including planned and non-comprehensive programs. NHO estimates 1700 comprehensive programs, as described above.
- Approximately two-thirds of the comprehensive hospices are Medicare certified.
- Over 90 percent of hospices are non-profit or government affiliated programs. Four percent are for-profit entities.
- Hospices served approximately 210,000 patients in 1990.
- The average daily census of the typical hospice program is 25 patients per day. The average length of stay is 59 days. Approximately 90 percent of all patient days were provided in the patient's home.
- Approximately two out of three patients served are over the age of 65. One percent are under the age of 18, representing 71 percent of pediatric cancer deaths.
- Eighty-four percent of hospice patients have cancer, accounting for approximately 33 percent of all cancer deaths as reported by the American Cancer Society. People living with AIDS and those with cardiovascular disease constitute the bulk of remaining hospice patient census.
- Over 20,000 people are employed nationwide in hospices and include physicians, nurses, social workers, administrators, home health aides, clergy, therapists and bereavement specialists.
- Approximately 68,000 people volunteer in hospice programs, contributing more than 5 million hours of service annually. Two out every three hours are direct patient care hours. The Medicare Hospice Benefit Conditions of Participation require that a minimum of five percent of patient service hours be provided by volunteers.

II. Studies Showing Savings and Benefits of Hospice Care:

Through the national hospice demonstration projects conducted by the federal government, it was learned that not only was hospice care a more humane alternative of care but it resulted in cost savings as well. As a result of its cost effectiveness, the Medicare hospice benefit was created by the Tax Equity and Fiscal Responsibility Act of 1982 as a more humane alternative to the hi-technology care traditionally provided to the terminally ill. In 1986, hospice was made an option under Medicaid and the number of states offering the hospice benefit rose to 34 states by 1992.

- Savings can be realized by substituting the high cost of conventional care with the home-oriented approach of hospice care. A study by Abt Associates (Medicare Hospice Benefit Program Evaluation, Final Summary Report, July 21, 1989) stated that comparisons of hospice benefit and conventional care expenditures in the last month of life showed that conventional care was 30% higher in FY85 and 43% higher in FY86. The hospice savings were even more significant for non-cancer beneficiaries who cost \$3,135 for hospice care in the last month of life compared to \$4,730 for conventional care.

- Major savings in the cost of providing care to the terminally ill are directly related to the percentage of time patients are at home during the final months of life. Based on 1986 mortality data from the National Center for Health Statistics, an article in the Health Care Financing Review/Fall 1990, stated that there was an increase of 10% in the shift in place of death for cancer patients from hospitals to patients homes, and because about 94% of all hospice patients have cancer, the data suggests a possible impact of hospice use.

- A survey of hospital based hospices conducted by the American Hospital Association in 1986 identified a major reduction in the number of inpatient days for those patients cared for under the Medicare hospice benefit: the average

patient on the Medicare hospice benefit spent 68 days at home and 7.7 days in the hospital; the traditional Medicare patient spent an average of 58.1 days in home care and 21.3 days in the hospital; and the non-Medicare patient spent an average of 53.4 days at home and 13.8 days in the hospital.

- According to the most recent statistics gathered from Medicare certified hospice programs by the Health Care Financing Administration, the average length of stay was 48.38 days in a hospice program in 1990, and 96% of all patient days were spent in the home rather than in conventional health care settings. Additionally, the number of Medicare certified hospices in the country increased to 1,072 by April of 1992.

- Employee benefit packages surveyed by the Bureau of Labor Statistics showed 23% carrying hospice coverage in 1985 and 31% in 1986.

- General Motors Corporation covers hospice care on a per diem basis for all of its employees (Blue Cross is the intermediary for this reimbursement) and Metropolitan Life Insurance Company also uses a per diem system for all of its subscribers.

- Sixty-nine percent of Health Maintenance Organizations (HMOs) offer hospice care as surveyed by the Group Health Association of America in 1988.

- A survey conducted by Foster Higgins & Company, a benefits consulting firm, showed that 80% of major employers nationwide included hospice as an employee benefit in 1989. The survey represented over 12.5 million employees of 1,943 public and private-sector employers.

HEB

178

8-LS0680K
Lauterbach
4/15/93

SENATE CS FOR HOUSE BILL NO. 178(HES)
IN THE LEGISLATURE OF THE STATE OF ALASKA
EIGHTEENTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): HOUSE LABOR AND COMMERCE COMMITTEE

A BILL

FOR AN ACT ENTITLED

1 "An Act adding children under the age of 21 who are eligible for adoption
2 assistance because of special needs to the optional Medicaid coverage list and
3 revising the order of priority in which groups eligible for optional Medicaid
4 coverage are eliminated; and providing for an effective date."

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

6 * Section 1. AS 47.07.020(b) is amended to read:

7 (b) In addition to the persons specified in (a) of this section, the following
8 optional groups of persons for whom the state may claim federal financial participation
9 are eligible for medical assistance:

10 (1) persons eligible for but not receiving assistance under any plan of
11 the state approved under 42 U.S.C. 601 - 615 (Title IV-A, Social Security Act, Aid to
12 Families with Dependent Children) or 42 U.S.C. 1381 - 1383c (Title XVI, Social
13 Security Act, Supplemental Security Income);

14 (2) persons in a general hospital, skilled nursing facility, or intermediate

1 care facility, who, if they left the facility, would be eligible for assistance under one
2 of the federal programs specified in (1) of this subsection;

3 (3) persons under age 21 who are under supervision of the department,
4 for whom maintenance is being paid in whole or in part from public funds, and who
5 are in foster homes or private child-care institutions;

6 (4) aged, blind, or disabled persons, who, because they do not meet
7 income and resources requirements, do not receive supplemental security income under
8 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act), and who do not receive a
9 mandatory state supplement, but who are eligible, or would be eligible if they were not
10 in a skilled nursing facility or intermediate care facility to receive an optional state
11 supplementary payment;

12 (5) persons under age 21 who are in an institution designated as an
13 intermediate care facility for the mentally retarded and who are financially eligible as
14 determined by the standards of the federal aid to families with dependent children
15 program;

16 (6) persons in a medical or intermediate care facility whose income
17 while in the facility does not exceed 300 percent of the supplemental security income
18 benefit rate under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act) but who
19 would not be eligible for an optional state supplementary payment if they left the
20 hospital or other facility;

21 (7) persons under age 21 who are receiving active treatment in a
22 psychiatric hospital and who are financially eligible as determined by the standards of
23 42 U.S.C. 601 - 615 (Title IV-A, Social Security Act, Aid to Families with Dependent
24 Children);

25 (8) persons under age 21 and not covered under (a) of this section, who
26 would be eligible for benefits under the federal aid to families with dependent children
27 program, except that they have the care and support of both their natural and adoptive
28 parents;

29 (9) pregnant women not covered under (a) of this section and who meet
30 the income and resource requirements of the federal aid to families with dependent
31 children program;

1 (10) persons under age 21 not covered under (a) of this section who
2 the department has determined cannot be placed for adoption without medical
3 assistance because of a special need for medical or rehabilitative care and who the
4 department has determined are hard-to-place children eligible for subsidy under
5 AS 25.23.190 - 25.23.220;

6 (11) persons who can be considered under 42 U.S.C. 1396a(e)(3)
7 (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect
8 to whom a supplemental security income is being paid under 42 U.S.C. 1381 -
9 1383c (Title XVI, Social Security Act) because they meet all of the following
10 criteria:

11 (A) they are 18 years of age or younger and qualify as
12 disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security
13 Act);

14 (B) the department has determined that

15 (i) they require a level of care provided in a hospital,
16 nursing facility, or intermediate care facility for the mentally
17 retarded;

18 (ii) it is appropriate to provide their care outside of
19 an institution; and

20 (iii) the estimated amount that would be spent for
21 medical assistance for their individual care outside an institution is
22 not greater than the estimated amount that would otherwise be
23 expended individually for medical assistance within an appropriate
24 institution;

25 (C) if they were in a medical institution, they would be
26 eligible for medical assistance under other provisions of this chapter; and

27 (D) home and community-based services under a waiver
28 approved by the federal government are either not available to them under
29 this chapter or would be inappropriate for them [REPEALED].

30 * Sec. 2. AS 47.07.030 is amended by adding a new subsection to read:

31 (c) Notwithstanding (b) of this section, the department may offer a service for

1 which the department has received a waiver from the federal government if the
2 department was authorized, directed, or requested to apply for the waiver by law or by
3 a concurrent or joint resolution of the legislature. The department shall annually
4 submit to the legislature its recommendations about where a service offered under this
5 subsection should be placed on the priority list in AS 47.07.035.

6 * Sec. 3. AS 47.07.035 is amended to read:

7 Sec. 47.07.035. PRIORITY OF MEDICAL ASSISTANCE. If the department
8 finds that the cost of medical assistance for all persons eligible under this chapter will
9 exceed the amount allocated in the state budget for that assistance for the fiscal year,
10 the department shall eliminate coverage for optional medical services and optionally
11 eligible groups of individuals in the following order:

- 12 (1) clinical social workers' services;
- 13 (2) psychologists' services;
- 14 (3) chiropractic services;
- 15 (4) advanced nurse practitioner services;
- 16 (5) adult dental services;
- 17 (6) emergency hospital services;
- 18 (7) treatment of speech, hearing, and language disorders;
- 19 (8) optometrists' services and eyeglasses;
- 20 (9) occupational therapy;
- 21 (10) mammography screening;
- 22 (11) prosthetic devices;
- 23 (12) medical supplies and equipment;
- 24 (13) targeted case management services;
- 25 (14) rehabilitative services for substance abusers and emotionally
26 disturbed or chronically mentally ill adults;
- 27 (15) clinic services;
- 28 (16) physical therapy;
- 29 (17) personal care services in a recipient's home;
- 30 (18) prescribed drugs;
- 31 (19) long-term care noninstitutional services;

- 1 (20) inpatient psychiatric facility services;
- 2 (21) intermediate care facility services for the mentally retarded;
- 3 (22) intermediate care facility services;
- 4 (23) individuals described in AS 47.07.020(b)(11);
- 5 (24) individuals under age 21 who are not eligible for benefits under
- 6 the federal aid to families with dependent children program because they are not
- 7 deprived of one or more of their natural or adoptive parents;
- 8 (25) [(24)] skilled nursing facility services for persons under age 21;
- 9 (26) [(25)] aged, blind, and disabled individuals who, because they do
- 10 not meet the income requirements, do not receive supplemental security income under
- 11 Title XVI of the Social Security Act, but who are eligible, or would be eligible if they
- 12 were not in a skilled nursing facility or intermediate care facility, to receive an
- 13 optional state supplementary payment;
- 14 (27) [(26)] individuals in a hospital, skilled nursing facility, or
- 15 intermediate care facility whose income while in the facility does not exceed 300
- 16 percent of the supplemental security income benefit rate under Title XVI of the Social
- 17 Security Act, but who, because of income, are not eligible for the optional state
- 18 supplementary payment;
- 19 (28) [(27)] individuals under age 21 under supervision of the
- 20 department, for whom maintenance is being paid in whole or in part from public
- 21 money and who are in foster homes or private child-care institutions;
- 22 (29) individuals under age 21 who the department has determined
- 23 cannot be placed for adoption without medical assistance because of a special
- 24 need for medical or rehabilitative care and who the department has determined
- 25 are hard-to-place children eligible for subsidy under AS 25.23.190 - 25.23.220.

26 * Sec. 4. (a) AS 47.07.020(b)(11), added by sec. 1 of this Act, and AS 47.07.035(23),

27 amended by sec. 3 of this Act, take effect on the 180th day after the effective date of

28 Medicaid plan amendments approved by the federal government under which the state would

29 implement a waiver for home and community-based services under 42 U.S.C. 1396n for

30 persons who are Medicaid eligible and who would otherwise require a level of care provided

31 in a hospital, nursing facility, or intermediate care facility for the mentally retarded in the

1 absence of home and community-based services.

2 (b) The Department of Health and Social Services shall notify the revisor of statutes
3 as to the effective date of the plan amendments referred to in (a) of this section.

4 * Sec. 5. Section 2 of this Act takes effect immediately under AS 01.10.070(c).

5 * Sec. 6. Except as provided in secs. 4 and 5 of this Act, this Act takes effect July 1, 1993.

STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC ASSISTANCE

WALTER J. HICKEL, GOVERNOR

P.O. BOX 110640
JUNEAU, ALASKA 99811-0640
PHONE: (907) 465-3317

April 13, 1993

Honorable Steve Rieger, Chairman
Senate Health, Education and
Social Services Committee
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182

Dear Senator Rieger:

House Bill 178, relating to Medicaid coverage for adopted children, is currently in the Senate Health, Education and Social Services Committee. This bill was introduced by the House Labor and Commerce Committee and contains material previously included in HB 65 and SB 99, bills relating to the financial administration of state government introduced at the request of the Governor. The provisions of HB 178 were removed from the original Governor's bill due to concerns by the House Labor and Commerce Committee that HB 65, as introduced, violated the single subject rule.

At this time the Department respectfully requests a hearing in the Senate Health, Education and Social Services Committee on HB 178. Attached are two fiscal notes and a position paper which were previously submitted to the House.

Your favorable consideration of this request will be appreciated. If you have any questions regarding HB 178, please contact my legislative liaison, Mr. Lindstrom, at 465-3030.

Sincerely,



Theodore A. Mala, MD, MPH
Commissioner

Position Paper
HB 178

"An Act adding children under the age of 21 who are eligible for adoption assistance because of special needs to the optional Medicaid coverage list and revising the order of priority in which groups eligible for optional Medicaid coverage are eliminated; and providing for an effective date."

This bill will add a new group to the list in AS 47.07.020 of persons eligible for coverage under Medicaid in Alaska. This new group consists of children under the age of 21 who have special medical needs, who are therefore difficult to place for adoption, and for whom there is in effect a state adoption assistance agreement. The bill would make this new group the last to be eliminated from Medicaid coverage under AS 47.07.035 if there are insufficient appropriations to cover all optional services and groups.

ANALYSIS

At present, adoptive parents of these children are subsidized by the state under AS 25.23.190 -- AS 25.23.210. State money often pays for some or all of the costs of medical care provided to these children.

The bill would authorize Alaska to add the Medicaid option to provide medical coverage for state-subsidized adoptive children who are not otherwise eligible for Medicaid. Medicaid would then pay for these children's medical needs eliminating the need for the DFYS payments to cover those medical costs in their subsidies, and accessing federal Medicaid funding available to the state at a 50 percent match rate.

Future subsidy agreements for hard-to-place children will allow for the Medicaid coverage available under the bill. Subsidy agreements already in force, however, do not provide for an offset for the cost of medical care that may be paid under the bill. For this reason the Department only considers federal participation to be available for the medical care cost for future adoptions.

If adoptive parents with an existing adoption subsidy agreement want to replace that agreement to access Medicaid coverage, the Department will evaluate the child's medical costs and other eligibility criteria pertinent to the option. If the child meets the Medicaid requirements for the option, a new subsidy agreement will be written considering the availability of Medicaid funding.

It is our estimate that this bill will save the state \$17.7 the first year; an amount equal to the federal matching funds received for new adoptions for children with special medical needs. This amount will grow over the following years as new children are placed and existing subsidy agreements are replaced.

POSITION PAPER

STATE OF ALASKA ★ DEPARTMENT OF HEALTH & SOCIAL SERVICES

POSITION

The Department supports the passage of this bill. Given Alaska's short and long-term revenue picture, it is important that we take advantage of every legitimate opportunity we have to reduce state expenditures by claiming new federal matching funds for the necessary medical services we furnish to needy Alaskans.

Recommended by: Kimberly B. Busch
Kimberly B. Busch
Director
Div. of Medical Assistance

Date: 3/3/93

Recommended by: for Deborah R. Wing, acting
for Deborah R. Wing
Director
Div. of Family and Youth Services

Date: 3/3/93

Approved by: Theodore A. Mala
Theodore A. Mala, MD, MPH
Commissioner

Date: 3/4/93

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. HB179

Revision Date: _____ Dept. Affected: Health and Social Services
 Title: *An Act adding children under the age of 21 who are eligible for adoption...to the optional Medicaid BRU: Purchased Services
 Component: Foster Care
 Sponsor: HOUSE LABOR & COMMERCE
 Requestor: _____ COMPONENT SERIAL NO. 0252

Expenditures/Revenues:

(Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	-35.4	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS						
TOTAL OPERATING	(35.4)	0.0	0.0	0.0	0.0	0.0
CAPITAL						
REVENUE FUND SOURCE						

FUNDING:

(Thousands of Dollars)

FUNDING	FY94	FY95	FY96	FY97	FY98	FY99
1002 Federal Receipts						
1003 GF Match						
1004 GF	(35.4)	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	(35.4)	0.0	0.0	0.0	0.0	0.0

POSITIONS:

POSITIONS	FY94	FY95	FY96	FY97	FY98	FY99
FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year (FY93) impact: \$0.0

ANALYSIS: (Attach a separate page if necessary)

This fiscal note represents a one-time transfer of funding responsibility from DFYS component #0252 to DMA component #0229. See attached analysis for more.

Prepared by: *fa* Deborah R. Wing, Director Phone: 465-3191
 Division: Family & Youth Services Date: 03/03/93
 Approved by Commissioner: Theodore A. Mala, MD, MPH Date: 3/4/93
 Agency: Department of Health and Social Services

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Fiscal Note Analysis continuation
HB 178

"An Act adding children under the age of 21 who are eligible for adoption assistance because of special needs to the optional Medicaid coverage list and revising the order of priority in which groups eligible for optional Medicaid coverage are eliminated; and providing for an effective date."

The Division of Family and Youth Services currently pays a direct monthly subsidy to adoptive parents of hard-to-place children. A hard-to-place child is a child who is not likely to be adopted or to obtain a guardian by reason of physical or mental disability, emotional disturbance, recognized high risk of physical or mental disease, age, membership in a sibling group, racial or ethnic factors, or any combination of these.

The monthly subsidy is considered a reimbursement for costs of supporting hard-to-place children. AS 25.23.190 provides for continuation of the subsidy if necessary to assure placement of a hard-to-place child. The subsidy covers many ongoing maintenance costs including, food, shelter, clothing, school supplies, recreation and transportation costs, counseling or other types of therapy, as well as medical costs.

The bill would authorize Alaska to add the Medicaid option to provide medical coverage for state-subsidized adoptive children who are not otherwise eligible for Medicaid. Medicaid would then pay for these children's medical needs eliminating the need for the DFYS payments to cover those medical costs in their subsidies, and accessing federal Medicaid funding available to the state at a 50 percent match rate.

Future subsidy agreements for hard-to-place children will allow for the Medicaid coverage available under the bill. Subsidy agreements already in force, however, do not provide for an offset for the cost of medical care that may be paid under the bill. For this reason the fiscal note only considers the coverage available for future adoptions of hard-to-place children with special medical needs.

The experience under the program shows that the number of new subsidy agreements have begun to lessen. For FY91 new agreements for children with special medical needs totaled 46. After FY92 there have been 14 placements that have special medical needs. The projected number of special needs placements and the associated medical cost is anticipated to show only slight growth in future years.

A December 1992 review of DFYS files established a FY 93 base year average medical cost per child of \$2,400. The current medical inflation rate of 5.5% is assumed to continue. Medical costs for FY94 are calculated to be 35.4 (14 placements X \$2,400 X 1.055 medical inflation rate = \$35,448). There will be a one time transfer of funding for medical costs associated with subsidized adoptions.

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. HB 178

Revision Date: _____ Dept. Affected: Health and Social Services
 Title: An Act adding children under the age of BRU: Medial Assistance
21 who are eligible for adoption...to the optional Medicaid Component: Medicaid Non Facility
 Sponsor: House Labor & Commerce
 Requestor: _____ COMPONENT SERIAL NO. 0229

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	35.4	40.2	43.0	48.2	53.2	58.2
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	35.4	40.2	43.0	48.2	53.2	58.2

CAPITAL						
REVENUE FUND SOURCE						

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	17.7	20.1	21.5	24.1	26.6	29.1
1003 GF Match	17.7	20.1	21.5	24.1	26.6	29.1
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	35.4	40.2	43.0	48.2	53.2	58.2

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year (FY93) impact: \$0.0

ANALYSIS: (Attach a separate page if necessary)

See attached for more.

Prepared by: Dave W. Williams *Dave Williams* **VB** Phone: 907-465-5826
 Division: Medical Assistance Date: 3/2/93
 Approved by Commissioner: Theodore A. Mala, MD, MPH *Theodore A. Mala* Date: 3/4/93
 Agency: Department of Health and Social Services

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Fiscal Note Analysis continuation
HB 178

"An Act adding children under the age of 21 who are eligible for adoption assistance because of special needs to the optional Medicaid coverage list and revising the order of priority in which groups eligible for optional Medicaid coverage are eliminated; and providing for an effective date."

The Division of Family and Youth Services currently pays a direct monthly subsidy to adoptive parents of hard-to-place children. A hard-to-place child is a child who is not likely to be adopted or to obtain a guardian by reason of physical or mental disability, emotional disturbance, recognized high risk of physical or mental disease, age, membership in a sibling group, racial or ethnic factors, or any combination of these.

The monthly subsidy is considered a reimbursement for costs of supporting hard-to-place children. AS 25.23.190 provides for continuation of the subsidy if necessary to assure placement of a hard-to-place child. The subsidy covers many ongoing maintenance costs including, food, shelter, clothing, school supplies, recreation and transportation costs, counseling or other types of therapy, as well as medical costs.

The bill would authorize Alaska to add the Medicaid option to provide medical coverage for state-subsidized adoptive children who are not otherwise eligible for Medicaid. Medicaid would then pay for these children's medical needs eliminating the need for the DFYS payments to cover those medical costs in their subsidies, and accessing federal Medicaid funding available to the state at a 50 percent match rate.

Future subsidy agreements for hard-to-place children will allow for the Medicaid coverage available under the bill. Subsidy agreements already in force, however, do not provide for an offset for the cost of medical care that may be paid under the bill. For this reason the fiscal note only considers the coverage available for future adoptions of hard-to-place children with special medical needs.

The experience under the program shows that the number of new subsidy agreements have begun to lessen. For FY91 new agreements for children with special medical needs totaled 46. After FY92 there have been 14 placements that have special medical needs. The projected number of special needs placements and the associated medical cost is anticipated to show only slight growth in future years.

A December 1992 review of DFYS files established a FY 93 base year average medical cost per child of \$2,400. The current medical inflation rate of 5.5% is assumed to continue. Medical costs for FY94 are calculated to be 35.4 (14 placements X \$2,400 X 1.055 medical inflation rate = \$35,448). There will be a one time transfer of funding for medical costs associated with subsidized adoptions.

Position Paper
SCS HB 178 (HES)

"An Act adding children under the age of 21 who are eligible for adoption ... to the optional Medicaid coverage list...."

Subsidized Adoption

This bill will add a new group to the list in AS 47.07.020 of persons eligible for coverage under Medicaid in Alaska. This new group consists of children under the age of 21 who have special medical needs, who are therefore difficult to place for adoption, and for whom there is in effect a state adoption assistance agreement. The bill would make this new group the last to be eliminated from Medicaid coverage under AS 47.07.035 if there are insufficient appropriations to cover all optional services and groups.

At present, adoptive parents of these children are subsidized by the state under AS 25.23.190 -- AS 25.23.210. State money often pays for some or all of the costs of medical care provided to these children. The bill would authorize Alaska to add the Medicaid option to provide medical coverage for state-subsidized adoptive children who are not otherwise eligible for Medicaid. Medicaid would then pay for these children's medical needs eliminating the need for the DFYS payments to cover those medical costs in their subsidies, and accessing federal Medicaid funding available to the state at a 50 percent match rate. This shift in funding source will be accomplished with a one-time transfer of fiscal responsibility from DFYS to DMA.

It is our estimate that this bill will save the state \$17.7 the first year; an amount equal to the federal matching funds received for new adoptions for children with special medical needs. This amount will grow over the following years as new children are placed and existing subsidy agreements are replaced.

Eligibility for Children Who Need Long Term Care

The department supports the delivery of health care to children in need of long term care in the environment of the the family's choice. Currently in Alaska, if a child is receiving long term care in an institution, only that child's income is used to determine whether he or she qualifies for Medicaid. However, if that same child lives at home, the income of the child's parents is also considered. As a result, some children who need long term care can qualify for Medicaid in institutions, but not if they live at home.

This bill would amend AS 47.07.020(b) so that children age 18 and younger who would qualify for Medicaid in institutions qualify at home. To qualify, children must: 1) require a level of long term care provided by an institution; 2) be served appropriately outside of the institution; 3) cost no more to serve outside the institution; 4) be eligible for

PROPOSITION PAPER

STATE OF ALASKA * DEPARTMENT OF HEALTH & SOCIAL SERVICES

Medicaid were they in institutions; and 5) not qualify for Medicaid home and community-based services under a federally approved waiver.

The department recently received federal approval to offer home and community-based services under waivers, effective July 1, 1993. The waivers allow the state to pay for home and community-based services for Medicaid eligible people who need an institutional level of care and allow people who qualify for Medicaid in an institution to qualify for Medicaid on a waiver, living in the community. While the federal government limits the number of people that a state can serve under waivers, the department anticipates being able to serve all children qualify for the optional coverage added by this bill by the third year of waiver operation.

The Department supports the passage of this bill. Given Alaska's short and long-term revenue picture, it is important that we take advantage of every legitimate opportunity we have to reduce state expenditures by claiming new federal matching funds for the necessary medical services we furnish to needy Alaskans through subsidized adoptions. The department also supports the addition of the children's long term care coverage option to the state's Medicaid program. While the department will use home and community-based waivers to provide Medicaid coverage to children who would qualify for this option, the option extends basic Medicaid coverage to all children who qualify while the waivers are being fully implemented. Once waivers are implemented, the option ensures that eligible children have basic Medicaid coverage regardless of federally-imposed limits on the number of waiver recipients. It will allow some families to obtain Medicaid coverage for their children without requesting any waiver services.

Recommended by: Kimberly B. Busch
Kimberly B. Busch
Director
Div. of Medical Assistance

Date: _____

Recommended by: Deborah R. Wing
Deborah R. Wing
Director
Div. of Family and Youth Services

Date: 4/16/93

Approved by: Jay Luma for
Theodore A. Mala, MD, MPH
Commissioner

Date: 4-16-93

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SCS HB 178 (HES)

Revision Date: _____ Dept. Affected: Health and Social Services
 Title: An Act adding children under the age of BRU: Public Assistance Administration
21 who are eligible for adoption Component: Eligibility Determination
 Sponsor: House Labor & Commerce
 Requestor: Senate HES COMPONENT SERIAL NO. 270

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	46.8	48.2	49.7	51.1	52.7	54.3
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	5.0	5.0	5.0	5.0	5.0	5.0
SUPPLIES	0.5	0.5	0.5	0.5	0.5	0.5
EQUIPMENT	3.5	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	55.8	53.7	55.2	56.6	58.2	59.8
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE FUND SOURCE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	27.9	26.8	27.6	28.3	29.1	29.9
1003 GF Match	27.9	26.9	27.6	28.3	29.1	29.9
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1006 GF/MHTIA	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	55.8	53.7	55.2	56.6	58.2	59.8

POSITIONS:

FULL-TIME	1	1	1	1	1	1
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY93) impact: NONE

ANALYSIS: (Attach a separate page if necessary)

SCS HB 178 (HES) expands Medicaid eligibility to cover severely disabled children in home and community-based care. The Division of Medical Assistance estimates that 139 disabled children who do not currently receive Medicaid would become eligible in FY94 under SCS HB 178(HES) and the Governor's amended budget. This caseload would grow to 148 in FY95 and 163 in FY96.

Additional public assistance field eligibility staff would be required to process applications and maintain Medicaid cases for these additional clients. One additional Eligibility Technician I/II would be necessary to cover the increased caseload.

Prepared by: Jan L. Hansen, Director
 Division: Division of Public Assistance
 Approved by Commissioner: Theodore K. Malin, MD, MPH
 Agency: Department of Health & Social Services

Phone: 465-2680
 Date: 4/16/93
 Date: 4-16-93

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Position Title Eligibility Technician II		No. of Positions 1	Range/Step 14B	Bargaining Unit GGU
Time Status PFT	Staff Months 12.0	Location Anchorage		Election District House 15
TYPE of EXPENDITURE		AMOUNT		
Salary		32.8		
Benefits		14.0		
Premium Pay				
Other				
Total Personal Services		46.8		
Travel				
Contractual		5.0		
Commodities		0.5		
Equipment		3.5		
Other				
Total Cost		55.8		
FUNDING SOURCE for TOTAL COST				
1002	Federal Receipts	27.9		
1003	GF Match	27.9		
1004	General Fund			
1005	GF/Program Receipts			
1006	GF/Mental Health Trust			
1007	I/A Receipts			
1061	CIP Receipts			
Other				
<p>Justification</p> <p>SCS HB 178 (HES) expands Medicaid eligibility to cover severely disabled children in home and community-based care. The Division of Medical Assistance estimates that 139 disabled children who do not currently receive Medicaid would become eligible in FY94 under SCS HB 178 (HES) and the Governor's amended budget. This caseload would grow to 148 in FY95 and 163 in FY96.</p> <p>Additional public assistance field eligibility staff would be required to process applications and maintain Medicaid cases for these additional clients. One additional Eligibility Technician I/II would be necessary to cover the increased caseload.</p>				

REQUEST for
NEW POSITION

AGENCY: Health and Social Services
 BRU: Public Assistance Administration
 COMPONENT: Eligibility Determination (270)

FY94

Page 1 of 1

Revised Date:

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SCS HB 178 (HES)

Revision Date: 04/16/93 Dept. Affected: Health and Social Services
 Title: An Act adding children under the age of BRU: Medical Assistance
21 who are eligible for adoption...of the optional Medicaid Component: Medicaid Non-Facility
 Sponsor: House Labor and Commerce
 Requestor: Senate HESS Committee COMPONENT SERIAL NO. 229

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	1,165.7	692.2	0.0	0.0	0.0	0.0
MISCELLANEOUS						
TOTAL OPERATING	1,165.7	692.2	0.0	0.0	0.0	0.0

CAPITAL						
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REVENUE FUND SOURCE						
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FUNDING: (Thousands of Dollars)

1002 Federal Receipts	582.8	346.1	0.0	0.0	0.0	0.0
1003 GF Match	582.9	346.1	0.0	0.0	0.0	0.0
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	1,165.7	692.2	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY93) impact: 0.0

ANALYSIS: (Attach a separate page if necessary)

The fiscal impact of this bill results from adding new Medicaid recipients. Cost calculations are shown on attached page. Cost per recipient and number of new recipients are taken from home and community-based services waiver applications and supporting documents. The Department of Health and Social Services has submitted a budget amendment for Medicaid home and community-based service waivers. The cost of serving new eligibles who would also be covered under a waiver is not included in this fiscal note. Some of the cost impact of this bill would be increased if that amendment is not fully funded. The Department has limited experience identifying children living in the community who need an institutional level of care. Any variance with the predicted number of those eligible will impact costs.

The cost impacts of the subsidized adoption provisions of this bill are addressed in a separate fiscal note.

Prepared by: Jon Sherwood
 Division: Division of Medical Assistance

Phone: 465-3355
 Date: 04/16/93

Approved by Commissioner: Theodore A. Maki, MD, MPH
 Agency: Department of Health & Social Services

Date: 5-16-93

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ANALYSIS (cont.):

Cost Estimate (thousands of dollars)

FY 94:

FY 94 Medicaid service costs per recipient needing hospital or nursing facility level of care:	\$102.2
Number of new recipients, not on waivers, in FY 94 needing hospital or NF level of care:	21
Percent of time in FY 94 recipients are covered in FY 94	50%
Total FY 94 cost of Medicaid services for new recipients needing hospital or nursing facility level of care:	
$\$102.2 \times 21 \times 50\% =$	<u>\$1,073.1</u>

FY 94 Medicaid service costs per recipient needing ICF/MR level of care:	\$32.9
Number of new recipients, not on waivers, in FY 94 needing ICF/MR level of care:	36
Percent of time in FY 94 recipients are covered in FY 94	50%
Total FY 94 cost of Medicaid services for new recipients needing ICF/MR level of care:	
$\$32.9 \times 36 \times 50\% =$	<u>\$592.2</u>

Total FY 94 cost of Medicaid services for all new recipients:	
$\$1,073.1 + \$592.2 =$	<u>\$1,665.3</u>

Component Breakout:

Medicaid Non-Facility (70 percent of total costs)	\$1,165.7
Medicaid Facility (30 percent of total costs)	\$499.6

FY 95

FY 95 Medicaid service costs per recipient needing hospital or nursing facility level of care:	\$111.1
Number of new recipients, not on waivers, in FY 95 needing hospital or NF level of care:	6
Percent of time in FY 95 recipients are covered in FY 95	100%
Total FY 95 cost of Medicaid services for new recipients needing hospital or nursing facility level of care:	
$\$111.1 \times 6 \times 100\% =$	<u>\$666.6</u>

FY 95 Medicaid service costs per recipient needing ICF/MR level of care:	\$35.8
Number of new recipients, not on waivers, in FY 95 needing ICF/MR level of care:	9
Percent of time in FY 95 recipients are covered in FY 95	100%
Total FY 95 cost of Medicaid services for new recipients needing ICF/MR level of care:	
$\$35.8 \times 9 \times 100\% =$	<u>\$322.2</u>

Total FY 95 cost of Medicaid services for all new recipients:	
$\$666.6 + \$322.2 =$	<u>\$988.8</u>

Component Breakout:

Medicaid Non-Facility (70 percent of total costs)	\$692.2
Medicaid Facility (30 percent of total costs)	\$296.6

FY 96 - FY 99:

It is assumed that all new eligibles covered under this bill in FY 96 or after would receive coverage under waivers if this bill did not pass.

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SCSHB 178 (HES)

Revision Date: 04/16/93 Dept. Affected: Health and Social Services
 Title: An Act adding children under the age of 21 who are eligible for adoption....to the optional Medicaid BRU: Medial Assistance
 Component: Medicaid Non Facility
 Sponsor: House Labor & Commerce
 Requestor: Senate HESS Committee COMPONENT SERIAL NO. 0229

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	35.4	40.2	43.0	48.2	53.2	58.2
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	35.4	40.2	43.0	48.2	53.2	58.2

CAPITAL						
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REVENUE FUND SOURCE						
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FUNDING: (Thousands of Dollars)

1002 Federal Receipts	17.7	20.1	21.5	24.1	26.6	29.1
1003 GF Match	17.7	20.1	21.5	24.1	26.6	29.1
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	35.4	40.2	43.0	48.2	53.2	58.2

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year (FY93) impact: \$0.0

ANALYSIS: (Attach a separate page if necessary)

This fiscal note represents a one-time transfer of funding responsibility from DFYS component #0252 to DMA component #0229. This fiscal note addresses the parts of this bill dealing with "subsidized adoptions". The sections of this bill dealing with the long term care eligibility provisions are addressed in a separate fiscal note on this component.

Prepared by: Dave W. Williams *Dave Williams*
 Division: Medical Assistance

Phone: 907-465-5826
 Date: 04/16/93

Approved by Commissioner: Theodore A. Mala, MD, MPH *Theodore A. Mala*
 Agency: Department of Health and Social Services

Date: 4-16-93

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Fiscal Note Analysis continuation
Sen CSHB 178 (HES) -- Subsidized Adoption Provisions

"An Act adding children under the age of 21 who are eligible for adoption assistance because of special needs to the optional Medicaid coverage list and revising the order of priority in which groups eligible for optional Medicaid coverage are eliminated; and providing for an effective date."

The Division of Family and Youth Services currently pays a direct monthly subsidy to adoptive parents of hard-to-place children. A hard-to-place child is a child who is not likely to be adopted or to obtain a guardian by reason of physical or mental disability, emotional disturbance, recognized high risk of physical or mental disease, age, membership in a sibling group, racial or ethnic factors, or any combination of these.

The monthly subsidy is considered a reimbursement for costs of supporting hard-to-place children. AS 25.23.190 provides for continuation of the subsidy if necessary to assure placement of a hard-to-place child. The subsidy covers many ongoing maintenance costs including, food, shelter, clothing, school supplies, recreation and transportation costs, counseling or other types of therapy, as well as medical costs.

The bill would authorize Alaska to add the Medicaid option to provide medical coverage for state-subsidized adoptive children who are not otherwise eligible for Medicaid. Medicaid would then pay for these children's medical needs eliminating the need for the DFYS payments to cover those medical costs in their subsidies, and accessing federal Medicaid funding available to the state at a 50 percent match rate.

Future subsidy agreements for hard-to-place children will allow for the Medicaid coverage available under the bill. Subsidy agreements already in force, however, do not provide for an offset for the cost of medical care that may be paid under the bill. For this reason the fiscal note only considers the coverage available for future adoptions of hard-to-place children with special medical needs.

The experience under the program shows that the number of new subsidy agreements have begun to lessen. For FY91 new agreements for children with special medical needs totaled 46. After FY92 there have been 14 placements that have special medical needs. The projected number of special needs placements and the associated medical cost is anticipated to show only slight growth in future years.

A December 1992 review of DFYS files established a FY 93 base year average medical cost per child of \$2,400. The current medical inflation rate of 5.5% is assumed to continue. Medical costs for FY94 are calculated to be 35.4 (14 placements X \$2,400 X 1.055 medical inflation rate = \$35,448). There will be a one time transfer of funding for medical costs associated with subsidized adoptions.

Calculation of Medical Costs for New Placements under the Bill
and
Anticipated Federal Revenue to Offset General Fund Spending.

	New Place- ments	X	Base Year Medical Cost	X	Medical Infla- tion Rate	=	Total Annual Medical Costs	÷	2	=	New Federal Revenue & GF Offset
FY 94	14	X	\$2,400	X	1.055	=	\$35,448	÷	2	=	\$17,724
FY 95	16	X	\$2,400	X	1.055	=	\$40,512	÷	2	=	\$20,256
FY 96	17	X	\$2,400	X	1.055	=	\$43,044	÷	2	=	\$21,522
FY 97	19	X	\$2,400	X	1.055	=	\$48,108	÷	2	=	\$24,054
FY 98	21	X	\$2,400	X	1.055	=	\$53,172	÷	2	=	\$26,586
FY 99	23	X	\$2,400	X	1.055	=	\$58,236	÷	2	=	\$29,118

Cross ref: Fiscal note by the Div. of Family and Youth Services

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SCS HB 178 (HES)

Revision Date: 04/16/93 Dept. Affected: Health and Social Services
 Title: An Act adding children under the age of BRU: Medical Assistance
21 who are eligible for adoption...of the optional Medicaid Component: Medicaid Facilities
 Sponsor: House Labor and Commerce
 Requestor: Senate HESS Committee COMPONENT SERIAL NO. 230

Expenditures/Revenues:

(Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	499.6	296.6	0.0	0.0	0.0	0.0
MISCELLANEOUS						
TOTAL OPERATING	499.6	296.6	0.0	0.0	0.0	0.0

CAPITAL						
---------	--	--	--	--	--	--

REVENUE FUND SOURCE						
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FUNDING:

(Thousands of Dollars)

1002 Federal Receipts	249.8	148.3	0.0	0.0	0.0	0.0
1003 GF Match	249.8	148.3	0.0	0.0	0.0	0.0
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	499.6	296.6	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY93) impact: 0.0

ANALYSIS: (Attach a separate page if necessary)

The fiscal impact of this bill results from adding new Medicaid recipients. Cost calculations are shown on attached page. Cost per recipient and number of new recipients are taken from home and community-based services waiver applications and supporting documents. The Department of Health and Social Services has submitted a budget amendment for Medicaid home and community-based service waivers. The cost of serving new eligibles who would also be covered under a waiver is not included in this fiscal note. Some of the cost impact of this bill would be increased if that amendment is not fully funded. The Department has limited experience identifying children living in the community who need an institutional level of care. Any variance with the predicted number of those eligible will impact costs.

This fiscal note addresses the long term care eligibility provisions of the bill, the subsidized adoption provisions are addressed in a separate fiscal note.

Prepared by: Jon Sherwood
 Division: Division of Medical Assistance

Phone: 465-3355
 Date: 04/16/93

Approved by Commissioner: Theodore A. Maltz, MD, MPH
 Agency: Department of Health & Social Services

Date: 4-16-93

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ANALYSIS (cont.):

Cost Estimate (thousands of dollars)

FY 94:

FY 94 Medicaid service costs per recipient needing hospital or nursing facility level of care:	\$102.2
Number of new recipients, not on waivers, in FY 94 needing hospital or NF level of care:	21
Percent of time in FY 94 recipients are covered in FY 94	50%
Total FY 94 cost of Medicaid services for new recipients needing hospital or nursing facility level of care:	
$\$102.2 \times 21 \times 50\% =$	<u>\$1,073.1</u>

FY 94 Medicaid service costs per recipient needing ICF/MR level of care:	\$32.9
Number of new recipients, not on waivers, in FY 94 needing ICF/MR level of care:	36
Percent of time in FY 94 recipients are covered in FY 94	50%
Total FY 94 cost of Medicaid services for new recipients needing ICF/MR level of care:	
$\$32.9 \times 36 \times 50\% =$	<u>\$592.2</u>

Total FY 94 cost of Medicaid services for all new recipients:	
$\$1,073.1 + \$592.2 =$	<u>\$1,665.3</u>

Component Breakout:

Medicaid Non-Facility (70 percent of total costs)	\$1,165.7
Medicaid Facility (30 percent of total costs)	\$499.6

FY 95

FY 95 Medicaid service costs per recipient needing hospital or nursing facility level of care:	\$111.1
Number of new recipients, not on waivers, in FY 95 needing hospital or NF level of care:	6
Percent of time in FY 95 recipients are covered in FY 95	100%
Total FY 95 cost of Medicaid services for new recipients needing hospital or nursing facility level of care:	
$\$111.1 \times 6 \times 100\% =$	<u>\$666.6</u>

FY 95 Medicaid service costs per recipient needing ICF/MR level of care:	\$35.8
Number of new recipients, not on waivers, in FY 95 needing ICF/MR level of care:	9
Percent of time in FY 95 recipients are covered in FY 95	100%
Total FY 95 cost of Medicaid services for new recipients needing ICF/MR level of care:	
$\$35.8 \times 9 \times 100\% =$	<u>\$322.2</u>

Total FY 95 cost of Medicaid services for all new recipients:	
$\$666.6 + \$322.2 =$	<u>\$988.8</u>

Component Breakout:

Medicaid Non-Facility (70 percent of total costs)	\$692.2
Medicaid Facility (30 percent of total costs)	\$296.6

FY 96 – FY 99:

It is assumed that all new eligibles covered under this bill in FY 96 or after would receive coverage under waivers if this bill did not pass.

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SCS HB 178 (HES)

Revision Date: 04/16/93 Dept. Affected: Health and Social Services
 Title: An Act adding children under the age of BRU: Medical Assistance Administration
21 who are eligible for adoption...ot the optional Medicaid Component: Claims Processing
 Sponsor: House Labor and Commerce
 Requestor: Senate HESS Committee COMPONENT SERIAL NO. 243

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	25.1	9.0	0.0	0.0	0.0	0.0
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	25.1	9.0	0.0	0.0	0.0	0.0

CAPITAL						
---------	--	--	--	--	--	--

REVENUE FUND SOURCE						
---------------------	--	--	--	--	--	--

FUNDING: (Thousands of Dollars)

1002 Federal Receipts	12.5	4.5	0.0	0.0	0.0	0.0
1003 GF Match	12.6	4.5	0.0	0.0	0.0	0.0
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	25.1	9.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY93) impact: 0.0

ANALYSIS: (Attach a separate page if necessary)

The fiscal impact of this bill results from an increase in claims processing charges due to increasing new recipients. Cost calculations are shown on the attached page. In addition, FY 94 impact include one-time changes to the Medicaid Management Information System to add a new category of eligibility.

The Department of Health and Social Services has submitted a budget amendment for Medicaid home and community-based service waivers. Failure to fully fund this amendment would increase the cost of this bill.

This fiscal note addresses the cost of the long term care eligibility provisions of the bill; the subsidized adoption provisions are addressed in another fiscal note.

Prepared by: Jon Sherwood
 Division: Division of Medical Assistance

Phone: 465-3355
 Date: 04/16/93

Approved by Commissioner: Theodore A. Mala, MD, MPH
 Agency: Department of Health & Social Services

Date: 4-16-93

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FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SEN CS HB 178 (HES)

Revision Date: April 16, 1993 Dept. Affected: Health and Social Services
 Title: *An Act adding children under the age of 21 who are eligible for adoption...to the optional Medicaid BRU: Purchased Services
 Component: Foster Care
 Sponsor: HOUSE LABOR & COMMERCE
 Requestor: SENATE HES COMMITTEE COMPONENT SERIAL NO. 0252

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	-35.4	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS						
TOTAL OPERATING	(35.4)	0.0	0.0	0.0	0.0	0.0

CAPITAL						
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REVENUE FUND SOURCE						
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FUNDING: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	(35.4)	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	(35.4)	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year (FY93) impact: \$0.0

ANALYSIS: (Attach a separate page if necessary)

This fiscal note represents a one-time transfer of funding responsibility from DFYS component #0252 to DMA component #0229. This fiscal note addresses the "subsidized adoption" provisions of this bill and the long term care provisions are addressed in a separate fiscal note. See attached pages for additional analysis.

Prepared by: Deborah R. Wing, Director *Deborah R. Wing* Phone: 465-3191
 Division: Family & Youth Services Date: 04/16/93

Approved by Commissioner: Theodore A. Mala, MD, MPH *Theodore A. Mala* Date: 4-16-93
 Agency: Department of Health and Social Services

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Fiscal Note Analysis continuation
Sen CSHB 178 (HES) -- Subsidized Adoption Provisions

"An Act adding children under the age of 21 who are eligible for adoption assistance because of special needs to the optional Medicaid coverage list and revising the order of priority in which groups eligible for optional Medicaid coverage are eliminated; and providing for an effective date."

The Division of Family and Youth Services currently pays a direct monthly subsidy to adoptive parents of hard-to-place children. A hard-to-place child is a child who is not likely to be adopted or to obtain a guardian by reason of physical or mental disability, emotional disturbance, recognized high risk of physical or mental disease, age, membership in a sibling group, racial or ethnic factors, or any combination of these.

The monthly subsidy is considered a reimbursement for costs of supporting hard-to-place children. AS 25.23.190 provides for continuation of the subsidy if necessary to assure placement of a hard-to-place child. The subsidy covers many ongoing maintenance costs including, food, shelter, clothing, school supplies, recreation and transportation costs, counseling or other types of therapy, as well as medical costs.

The bill would authorize Alaska to add the Medicaid option to provide medical coverage for state-subsidized adoptive children who are not otherwise eligible for Medicaid. Medicaid would then pay for these children's medical needs eliminating the need for the DFYS payments to cover those medical costs in their subsidies, and accessing federal Medicaid funding available to the state at a 50 percent match rate.

Future subsidy agreements for hard-to-place children will allow for the Medicaid coverage available under the bill. Subsidy agreements already in force, however, do not provide for an offset for the cost of medical care that may be paid under the bill. For this reason the fiscal note only considers the coverage available for future adoptions of hard-to-place children with special medical needs.

The experience under the program shows that the number of new subsidy agreements have begun to lessen. For FY91 new agreements for children with special medical needs totaled 46. After FY92 there have been 14 placements that have special medical needs. The projected number of special needs placements and the associated medical cost is anticipated to show only slight growth in future years.

A December 1992 review of DFYS files established a FY 93 base year average medical cost per child of \$2,400. The current medical inflation rate of 5.5% is assumed to continue. Medical costs for FY94 are calculated to be 35.4 (14 placements X \$2,400 X 1.055 medical inflation rate = \$35,448). There will be a one time transfer of funding for medical costs associated with subsidized adoptions.

Calculation of Medical Costs for New Placements under the Bill
and
Anticipated Federal Revenue to Offset General Fund Spending.

	New Place- ments	X	Base Year Medical Cost	X	Medical Infla- tion Rate	= Annual Medical Costs	÷ 2 =	New Federal Revenue & GF Offset
FY 94	14	X	\$2,400	X	1.055	= \$35,448	÷ 2 =	\$17,724
FY 95	16	X	\$2,400	X	1.055	= \$40,512	÷ 2 =	\$20,256
FY 96	17	X	\$2,400	X	1.055	= \$43,044	÷ 2 =	\$21,522
FY 97	19	X	\$2,400	X	1.055	= \$48,108	÷ 2 =	\$24,054
FY 98	21	X	\$2,400	X	1.055	= \$53,172	÷ 2 =	\$26,586
FY 99	23	X	\$2,400	X	1.055	= \$58,236	÷ 2 =	\$29,118

Cross ref: Fiscal note by the Div. of Family and Youth Services

HB

195

SENATE COMMITTEE REPORT

Handwritten initials

DATE: 2/2/94

FURTHER: JUDICIARY
FINANCE

DATE TURNED INTO OFFICE: 2/23/94

HESS Committee considered CS FOR HOUSE BILL NO. 195(FIN)

"An Act authorizing youth courts to provide for peer adjudication of minors who have allegedly committed violations of state or municipal laws, and renaming the community legal assistance grant fund and amending the purposes for which grants may be made from that fund in order to provide financial assistance for organization and initial operation of youth courts."

and recommends:

- replace with _____ CS _____ ()
- or adopt previous _____ CS _____ ()
- attaches amendment(s)

- same title
- new title
- technical title change (HB only)

adopts _____ Letter of Intent

further referral to the _____

do pass

do not pass

no recommendation

individual recommendations

NEW FISCAL NOTES

Department	Date	Zero	Fiscal

PREVIOUS FISCAL NOTES

Department	Date	Zero	Fiscal
CE + A	1/21/94	✓	
HSS	1/21/94	✓	

Appropriation No Fiscal Note

DO PASS:

OTHER RECOMMENDATIONS:

Ray Thomas No Rec
Karen D. Thomas No Rec
Judith E. Sabo No Rec
J. D. ... No Rec

Steve King No Recommendation

Chair: Signature and Recommendation

Alaska State Legislature

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Representative Joe Sitton

Sponsor Statement

House Bill 195 - relating to the establishment of youth courts

by

Representative Joe Sitton

House Bill 195 establishes the authority for the establishment of a youth program as a juvenile diversion program under the Department of Health and Social Services. Under the provisions of this legislation, youths under the age of 18 who have allegedly committed an offense may choose to go through a youth court proceeding instead of through the regular court system, provided they have the approval of the juvenile intake authorities and the consent of their parents.

While other states have youth (or teen) courts, in Alaska, only Anchorage has developed such a program; it has been in existence since 1989. It has enjoyed a tremendous success and is highly supported by the community. Out of a total of 69 cases, only four juveniles were arrested for a second offense.

Perhaps one of the greatest reasons for its success is the close working relationship between the different agencies involved: the Department of Health and Social Services, the Alaska Court System, the Alaska Bar Association, the Anchorage Bar Association, the school district, and law enforcement agencies.

In the Anchorage program, cases are referred by juvenile probation officers. Referrals may also be made by other entities, such as a store alleging shoplifting.

Defendants and their parents must agree to allow the Youth Court to hear the case and the Youth Court must accept jurisdiction. Court proceedings insure them the right to be represented by a lawyer, the right to trial by jury, the right to cross-examine witnesses, the right against self-incrimination, and the right to appeal.

The court is composed of students under 18 years of age who volunteer as judges, jurors, bailiffs, clerks, prosecutors and defense attorneys. To be

eligible to sit on the court, students must attend an 8-10 week class and pass a youth court bar examination. Legal advisors are available to assist student prosecutors and defense lawyers in preparing their cases for trial.

House Bill 195 would provide a similar mechanism for other communities in Alaska, both rural and urban. Each community would be able to tailor the youth court system to its own unique needs and resources. A great deal of effort has gone into crafting legislation which would provide a structure for a youth court program while at the same time providing maximum flexibility for communities to create a program which would work best for them.

This legislation provides for the establishment of a youth court program under the aegis of the Department of Health and Social Services; it is this department's juvenile intake officers who have jurisdiction over juvenile offenders.

In addition, the legislation amends AS 44.47.200, the community legal assistance grant fund to provide for "juvenile justice" grants to communities and to non-profit corporations to establish and organize a youth court program in a community. The grant amount may not exceed \$5,000 and the grant must be matched by cash or in-kind contributions. The burden of success thus lies with a community's commitment.

FISCAL NOTE

REQUEST:

Revision Date: _____ Dept. Affected CR&A
 Title: An Act Authorizing Youth Courts
 BRU: Administration & Support
 Sponsor: Sitton, Ulmer Components: Administrative Services
 Requestor: House Finance Committee #684

EXPENDITURES/REVENUES: (THOUSANDS OF DOLLARS)

OPERATING	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	0.0	0.0	0.0	0.0	0.0	0.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0
Grants, Claims	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES						
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FUNDING: (THOUSANDS OF DOLLARS)

1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	0.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1006 GF/MHTIA	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

ESTIMATE OF ANY CURRENT YEAR (FY 94) COST \$

none

POSITIONS:

Full-Time	0	0	0	0	0	0
Part-Time	0	0	0	0	0	0
Temporary	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary)

Rep. Ron Larson
Rep. Ron Larson, Co-Chair

465-3878

Prepared By: Rep. Eileen MacLean, Co-Chair

Phone: 465-4833

Division: House Finance Committee

Date: 4/25/93

Approved By: _____

Date: _____

Agency: _____

Alaska State Legislature

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While in Juneau
State Capitol
Juneau, AK 99801-1182
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Representative Joe Sitton

SECTIONAL ANALYSIS CS HOUSE BILL 195 (Fin) - Youth Courts

This analysis outlines the principal features of CS House Bill 195 (Fin), a measure authorizing youth courts in order to provide for peer adjudication of minors charged with violations of state laws or municipal ordinances. The bill also proposes to broaden (and rename) the use of the community legal assistance grant fund as a source of financial support for new youth courts.

The major difference between the House Finance CS and the original bill consists in the elimination of references to the court system. It is the juvenile intake unit of the Department of Health and Social Services, rather than the court system, which provides for waivers to diversion programs and it was at the request of the court system that the references to the court system have essentially been deleted.

Section 1 and 2. Sets out the purpose and background of this legislation.

Section 3. This bill section, the measure's principal operative provision, adds a new section to codified law. AS 18.05.100 is added as a part of the title concerned generally with health and safety matters. The section authorizes establishment of youth courts. Specifies that only one youth court may be established within the boundaries of a municipality. Subsection (c) establishes nonprofit corporations as entities which may serve as youth courts.

Bill Sections 4-8 rename and revise the objectives of the existing Community Legal Assistant Grant Fund.

Section 4. AS 44.47.200 [COMMUNITY] LEGAL ASSISTANCE AND JUVENILE JUSTICE GRANT FUND.

The amendments proposed to AS 44.47.200 by this bill section change the name of the fund and authorize use of money in the fund to help nonprofit corporations start operations as youth courts.

Section 6. The addition of AS 44.47.210(b) proposed by this bill section permits nonprofit corporations planning to operate youth courts to apply for a grant

from the fund, direct that the grant be matched, but permit waiver of the match requirement under the circumstances noted.

Section 8. The addition of AS 44.47.220 (b) proposed by this bill section sets limits on the amount that may be awarded as a grant from the fund to a nonprofit corporation planning to operate a youth court, and limits on the proper use by the grantee of the money received by the grant.

Sections 5 and 7. The changes made by these two bill sections are technical changes to existing law made in light of the proposed additions set out in bill sections 4, 6, and 8



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Alaska State Legislature

State Capitol
Juneau, AK 99801-1182

QUESTIONS THAT ARE COMMONLY ASKED ABOUT YOUTH COURT LEGISLATION

QUESTION: What is the difference between a youth court program and other diversion programs?:

Juvenile intake refers youths to diversion programs and the youth court program is simply one other diversion program, similar to a "shoplifting class," for example. However, one unique characteristic which sets the youth court program apart from other diversion programs is that when a youth participates in a youth court proceeding, he/she is getting a taste of what adult court would be like; it is truly a mirror image of the adult court, except for the fact that the participants are peers.

QUESTION: Who decides whether or not a youth is referred to the youth court?

Under the Anchorage Youth Court Program, the youth and the parents must both agree to a youth court referral. In addition, the juvenile intake officer must also decide that this is an appropriate action.

QUESTION: What offenses are eligible for youth court proceedings?

Under current law, the juvenile intake officer, within the Department of Health and Social Services, Division of Family and Youth Services, is the sole referring agency. The juvenile intake officer decides on the disposition of all cases. When the Anchorage Youth Court Program was first established, only first-time misdemeanors were referred to the youth court; now, however, because the program has been so effective, the youth court does hear certain felonies - such as concealed weapons.

QUESTION: Could a youth court program hear a murder case?

Under the current provisions of law, it is technically possible but realistically, the juvenile intake officer would not refer such a case to the youth court, even if the youth and the parents requested this.

QUESTION: What is the role of the Court System in a youth court program?

In Anchorage, the Court System provides the space for the youth court to hold its proceedings. Otherwise, the Court system is not

directly involved in juvenile offenses; it is totally within the purview of the Division of Family and Youth Services

QUESTION: What groups need to be involved in order to truly effect community support?

The Department of Health and Social Services, the Alaska Court System, the Alaska Bar Association, the local bar association (if there is one), law enforcement agencies, the school district, parent organizations.

QUESTION: How old are the youths that are referred to a youth court program and how old are the youth court attorneys, jurors, judges, etc.?

Any youth under the age of 18 is eligible for referral to the program and youths under the age of 18 may volunteer to sit on the youth court. In this way, it is really peer adjudication.

QUESTION: Don't the youth courts tend to "go easy" on offenders because they are peers?

While that might seem to be a reasonable assumption, in reality, the youth court generally tends to be extremely "tough on crime" and has a reputation for being extremely strict in its sentencing.

QUESTION: What is the youth court recidivism rate and how does this compare to other proceedings?:

Out of a total of 69 cases before the Anchorage youth court, only four juveniles were arrested for a second offense. This compares with an approximately 50% recidivism rate for minor offenders.

QUESTION: Why does the legislation only specify "nonprofit corporations" as recipients of the \$5,000 grant?

House Bill 195 was modelled after the Anchorage Youth Court Program which was administered as a non-profit corporation. This was done to ensure the protection of the corporate veil, among other things. There is no reason that the legislation could not be expanded to include other entities.

QUESTION: Would House Bill 195 conflict or undermine legislation which requires minors to be treated as adults for certain offenses?

No, the youth court program only applies to minors in juvenile court and if legislation is enacted requiring a minor to be tried in adult court, he/she would no longer be within the purview of juvenile intake.

QUESTION: How will youth court programs work for the rural as or small Alaskan communities?

House Bill 195 has been developed specifically in an attempt to make it possible for rural communities to establish youth court programs. Of course, each program may well be different. Under this legislation, it would be possible for one small community to have its own youth court program or for several villages to "link together" and form a youth court program to serve several communities.

QUESTIONS: Under the grant program established under the Department of Community and Regional Affairs, how will one community be selected over another, assuming there is a limited amount of money?

First of all, under House Bill 195, an applicant will only be able to receive a one-time only grant for setting up a youth court program. The Department will establish criteria by regulation. One of the criteria will have to be for the applicant to show a 50% in-kind or monetary match.

Alaska State Legislature

Legislative Research Agency



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October 25, 1990

MEMORANDUM

TO: Senator Jay Kerttula

FROM: Maureen Weeks ^{MW}
Legislative Analyst

RE: Teen Courts in Alaska and Other States
Research Request 90.364

You asked for information about teen courts (courts in which young defendants charged with minor offenses appear before juries of their contemporaries). This memorandum begins with information about teen courts in general and continues with brief descriptions of teen courts in Anchorage, Alaska; Hillsborough County, Florida; Denver, Colorado; Odessa, Texas; and Pasco County, Florida. For comparison, selected characteristics of the five model courts are presented in the attached table.

Background

Most youthful, first-time offenders who commit misdemeanors do not go to court, do not appear before a jury and are not sentenced by a judge. Instead, they receive a letter warning them not to offend again and they may be ordered to attend several hours of class for shoplifters or substance abusers. Teen courts are an effort to change this. They replace the "slap on the wrist" of a letter with the intimidating formality of a court appearance. Furthermore, they ask young people to appear before juries composed of other young people--tribunals which juvenile justice experts say tend to be harder on young offenders than adult jurors would be. By giving young, first-time offenders a glimpse of "real life" before judge and jury, these courts function as juvenile diversion, early intervention programs. Their purpose is to stop the progress from misdemeanor to felony by asking young offenders to take responsibility for their acts and accept sanctions determined by their peers.

Teen courts are composed of student volunteers who act as jurors and sometimes lawyers, clerks and bailiffs. Most are conducted by volunteer adult judges. Cases are generally screened. Defendants may be referred by the police, school officials, judges and, sometimes, private businesses. Most cases involve petty crimes. Teen courts are not recognized as courts of original or appellate jurisdiction.

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Although the five courts we have chosen as models for discussion in this memorandum differ in many ways, all offer teen-age defendants the right to trial by their peers--defined in these courts as trial by one's contemporaries. Three carry this principle further by also using young people as prosecutors, defense lawyers, clerks and bailiffs. One (the Anchorage Youth Court) expands the concept to its fullest by allowing students to preside as judges.

All five teen courts hold their proceedings in local courtrooms to impress upon defendants that the session is "real." How court is conducted varies, however. For example, while the East Pasco Juvenile Court stresses the authenticity of the hearing by seating teens as jurors in regular juvenile court proceedings (presided over by a sitting judge and argued by actual prosecutors and public defenders), the Anchorage Youth Court asks teen-age defendants to accept verdicts and fulfill sentences determined solely by what many young people consider the most formidable of forums--other teen-agers.

The role of the jury also varies with the court. Three of the five courts we studied accept only defendants who are willing to admit guilt. In these courts, the teen-age jury hears arguments before determining an appropriate sentence. Two teen courts, however, allow not-guilty pleas. In one (East Pasco County Juvenile Court), young jurors recommend a verdict and, where appropriate, a sentence to the sitting juvenile court judge. In another (Anchorage Youth Court), young people are allowed much more authority. Here, after listening to arguments by youthful prosecutors and defense lawyers, teen juries determine a verdict and teen judges pronounce sentence.

Teen courts differ from each other in other ways. The Odessa Teen Court, begun in 1983 and the oldest of the courts we studied, emphasizes family responsibility by requiring parents of teen-age defendants to attend parent training workshops. The Denver Teen Court, which opens next month, is designed to replace school suspension and expulsion (which many students perceive as rewards) with community service and restitution. The Hillsborough County Teen Court stresses a variety of sentencing options by allowing student jurors to impose modified house arrest and restrict a defendant's driving privileges.

The advantages of teen courts are several. First, they place young, first-time misdemeanants before a court, a forum they take seriously. Second, they allow young people to be tried and sentenced by juries of their peers. Third, they allow defendants to pay their debts to society without incurring criminal records. Fourth, sentences by youth courts encourage a sense of responsibility by stressing redress to the community. Fifth, teen courts allow young people--defendants and court officials--to learn court proceedings first hand. And sixth, teen courts reduce the volume of cases brought before regular juvenile courts.

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Teen Courts

Anchorage Youth Court

Contact: Blythe Marston
Chair, Youth Court Advisory Committee
Bogle & Gates
907-276-4557 or

Sharon Leon, Coordinator
Anchorage Youth Court
274-5986 (between 1 p.m. and 5 p.m.)

The court is composed of middle school and high school students (ages 12 to 18) who volunteer as judges, jurors, bailiffs, clerks, prosecutors and defense attorneys. To be eligible to sit on the court, students must attend an eight-to-ten week class and pass a Youth Court Bar Examination. About 100 students are members of the bar, with another 200 in preparation classes where they are taught constitutional law, criminal law and procedure, ethics and advocacy. Legal advisors prepare student prosecutors and defense lawyers before their cases go to trial.

Judges are elected by members of the Youth Bar Association. They must have argued twice as prosecutors and twice as defense attorneys. The chief judge and assistant chief judge must have served at least once as associate judge.

Defendants, who are also between the ages of 12 and 18, are usually first offenders charged with petty crimes. They have been referred through the juvenile probation department, but they may be referred by other organizations, such as a store alleging shoplifting. Defendants and their parents must agree to allow the Youth Court to hear the case. Court proceedings insure them the right to be represented by a lawyer, the right to trial by jury, the right to cross-examine witnesses, the right against self-incrimination and the right to appeal.

At arraignment, defendants may plead guilty or not guilty. Student jurors and judges hear arguments before they determine the verdict and set the sentence.

Offenses include petty crimes, but the Youth Court has also heard felonies and civil suits.

Sentences include community service and restitution. A defendant who wishes to appeal a verdict or sentence must submit the appeal within three days of the sentence. Once a sentence is served satisfactorily, the record is expunged.

Miscellaneous: This court is the most developed of teen courts we studied. It is the only court in which students serve as judges, the only court in which student lawyers argue cases for defendants who have pleaded not guilty, and the

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only court which requires students to pass a bar examination before qualifying to sit on the court.

The court has heard between 30 and 40 cases in the three years it has existed. (Juvenile probation officers have begun to refer cases increasingly frequently, according to Ms. Marston.) Trials are conducted at the Anchorage Courthouse in the evening.

The court is administered by two groups. A 16-member administrative board of lawyers, judges, police officers and students meets quarterly to oversee funding. This board is composed equally of adults and students. In addition, the Anchorage Youth Court Bar Association, composed of students who have passed the bar examination, meets weekly. The court was originally funded solely by the Anchorage Bar Association. Recently, funds have been appropriated from the Interest On Lawyers' Trust Association (IOLTA) funds. Private individuals also contribute to the court.

We will send under separate cover an Anchorage Youth Court video tape of the case of *State v. Pat O'Shea*, in which the defendant is accused of "minor assault" the night of March 23, 1989, after an evening of dancing at the Flaming Turban. The tape shows a three-judge panel presiding with youthful lawyers arguing before an attentive jury in procedures modeled after state court proceedings.

Hillsborough County, Florida

Contact: Bob Sleczkowski,
Director, Juvenile Services,
Thirteenth Judicial Circuit, Florida
813-272-5110

The court is composed of students from area high schools who volunteer to serve as prosecutors and defense attorneys, as well as bailiffs, court clerks and jurors. They must complete a three-hour orientation and training before they are allowed to participate on the court.

The judge is a volunteer from the Young Lawyers Association.

Defendants, who are between 13 and 17 years old, participate voluntarily in teen court. No defendant appears before court officials from his or her own high school. Defendants are referred by the police through the state's attorney. First-time misdemeanants who do not qualify for teen court hearings may go to juvenile arbitration.

Defendants are required by statute to plead guilty. Jurors hear arguments and decide the sentence.

Offenses heard in teen court include school offenses (e.g. battery, trespassing) and alcohol offenses.

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Sentences last for five weeks. They include community service, modified house arrest, driver's license restriction, attendance at Alcoholics Anonymous meetings, written apologies, essays and jury duty. Sentences must be served exactly as determined by the teen court. After five weeks, the director of juvenile services rehears the case and, if the sentence is completed satisfactorily, the record is expunged.

Miscellaneous: The Hillsborough County teen court was established in March 1990. It meets Tuesday and Thursday nights in a county courtroom. Four cases are heard each night. Nineteen area high schools participate in teen court on a rotating basis (each school sends a teen court once every six weeks). Adult staff includes the teen court coordinator, counselor, a secretary and director of juvenile services for the Thirteenth Judicial Circuit.

Denver, Colorado

Contact: Jan Church
Chair, Teen Court Advisory Board
1700 Lincoln, Suite 4100
Denver, Colorado 80203
303-861-7000

The court is composed of students who volunteer to serve as jurors and prosecutors and defense attorneys.

The judge is a volunteer retired judge.

Defendants are students in trouble in middle school and high school who have committed acts for which they would be suspended or expelled from school (but not serious enough to warrant a criminal charge). They participate in teen court voluntarily, although court organizers ask school principals to "strongly encourage" young people to choose teen court over traditional punishments which keep them out of school.

To appear in court, a teen must sign a contract admitting guilt. Jurors hear arguments and set the sentence.

Offenses heard by teen court include stealing, fighting, trespassing and possessing alcohol on campus.

Sentences include community service, apology to the victim and restitution. Those who do not comply with the teen court sanction are referred to the school or the police department.

Miscellaneous: The purpose of this program is to replace traditional negative school punishment, such as suspension and expulsion, with sanctions which keep the student in school and encourage him or her to serve the community. It is an attempt to intervene before students commit more serious offenses for which

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they will be charged. Teen court, sponsored by the Denver Bar Association, holds its first hearing in November 1990. This court replaces a teen court begun in the 1970s and disbanded in the mid-1980s.

Odessa, Texas

Contact: Natalie Rothstein
201 N. Grant
Odessa, Texas 79761
415-333-3641

The court is composed of teen-agers who volunteer to act as jurors, bailiffs, clerks, prosecutors and defense lawyers. A master jury trained in interview and assessment skills hears traffic cases; other juries hear miscellaneous cases. Student court officials are trained during pre-trial and post-trial meetings with the judge and the teen court director.

The judge is a volunteer retired district court judge.

Defendants are referred by police, local courts, the justice of the peace courts and the schools. They participate in teen court voluntarily. No defendant may go through the teen court twice.

To qualify for teen court, defendants must plead guilty. Jurors hear arguments before determining the sentence.

Offenses heard in teen court include traffic offenses and Class C and B misdemeanors, including some drug possession cases.

Sentences include community service and jury duty. Alcohol or drug offenders must take a chemical abuse workshop. The parents of all offenders must take a parenting workshop. If the sentence is satisfactorily completed, the record is labeled "dismissed through Teen Court."

Miscellaneous: The Odessa Teen Court was established in November 1983. It meets every Tuesday night in the county courthouse, with seven juries hearing 21 trials. One "master jury" hears 15 traffic cases each night, while six other juries hear other cases. Parent participation is mandatory. Parents must be present at the initial interview with the teen court director, as well as at the trial. In addition, parents must attend three-hour parenting workshops, taught by the court director and by her husband, a professor at the University of Texas. The director says this parent training is vital to the program's success. The program is sponsored by the Junior League of Odessa. Two-thirds of the program's funding is from the city council and one-third is from the schools.

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Pasco County, Florida

Contact: Judge Lynn Tepper
East Pasco Juvenile Court
813-996-7341

The court is composed of students from the local high school (Zephyrhills High School). Jurors, selected from the school's law studies class, sit as the jury in actual cases heard by the East Pasco Juvenile Court. Jurors are trained by the law studies teacher, who discusses jury instructions in class, and by the sitting judge, who appears before the class once each semester to discuss the state's juvenile justice system. The judge also asks the state's attorney, the public defender and a pre-trial case worker to speak to the class. During court, jurors sit in the jury box. The trial proceeds as with a non-jury trial, except that all objections by lawyers must be made and argued on the floor where the jurors can hear them. Bench conferences, voir dire and objection to particular jurors are not allowed.

The judge is Circuit Court Judge Lynn Tepper (replacing Judge Maynard F. Swanson, Jr., who began the program).

Defendants are juveniles whose cases are on the regular docket; cases are not screened.

Defendants may plead guilty or not guilty. Jurors recommend the verdict by majority vote and, if the verdict is guilty, jurors also recommend sentencing. (Judge Swanson says his verdict differed from the jury's only once; he attributes that anomaly to his mistake in not properly instructing the jury.)

Offenses include any offense on the juvenile court docket.

Miscellaneous: This is the only court we studied in which jurors serve under a sitting judge. It has received national publicity on both the *N* *Today Show* and *NBC Nightly News*.

We attach an article describing the Pasco County Teen Court ("Pasco Juvenile Justice Program Wins National Fame," *Florida Bar News*, May 15, 1990); a description of the Hillsborough County Teen Court ("Teen Court," provided by Bob Sleczkowski, director of juvenile services in Tampa, Florida); and an article describing the Odessa Teen Court (Robert Rothstein, "Teen Court: A Way to Combat Teen-age Crime and Chemical Abuse," *Juvenile & Family Court Journal*, 1987, p. 1-4). In addition, we attach several documents from the Anchorage Youth Court. The documents include step-by-step instructions in how to set up similar courts in other areas ("Anchorage Youth Court: Trial by Peers") and the Anchorage Youth Court Constitution.

I hope this information is useful. If you have any questions, or want additional information, please contact this agency.

Youth court could help

We're intrigued by an idea that could help more of Alaska's young people decide to go straight instead of falling into a life of crime.

Already in place in Anchorage, youth courts in which first-time young offenders are tried and judged by other teens could be set up in other Alaska communities under legislation under consideration by Rep. Joe Sitton, D-Fairbanks.

Sitton's proposal, which has not been introduced yet, would provide \$5,000 state grants to communities that want to set up a youth court to handle first-time misdemeanor crimes committed by young people ages 12-18.

The Anchorage Youth Court has been operating since 1989. The American Bar Association recently gave the program its top awards for outstanding partnership programs and outstanding public education programs.

Under the program, volunteer attorneys train teen prosecutors, defense attorneys, judges, clerks, bailiffs and jurors in grades seven through 12. They represent and judge their peers in actual criminal cases of first-time offenders referred from Anchorage's juvenile court intake.

Youths prosecuted in these courts have a significantly lower rate of recidivism than defendants who participate in the traditional juvenile justice system, according to the bar association.

Youths serving on the court gain an awareness of their legal responsibilities to society in a way unmatched in a classroom setting.

If youth courts could be set up in other Alaska communities, Rep. Sitton believes law-breaking would lose some of the glamor it now has among some groups of young people who apply peer pressure in negative ways. Students would be more likely to take their actions seriously if they are being judged in a court of their peers, he believes.

We think the idea has merit, and encourage lawmakers to give it serious consideration.

2/20/92 J.D.W.

JOURNAL of LAW

Section **B**

1993

Section B to THE ALASKA JOURNAL OF COMMERCE

Justice Kotzebue

forced the court to expensive and time-consuming change of venue he said.

er editor Desiree they wrote the story onal. She said they to routine news covered by the public's now, and her readers expect more of the

say the town's judiciary and newspaper compass that could be in the future.

dict started when a Kotzebue store charged with six sexual assault of charges reflected acts of sexual assault of 6-year-olds, two alleged sexual assault of s and two alleged continued on Page 4B

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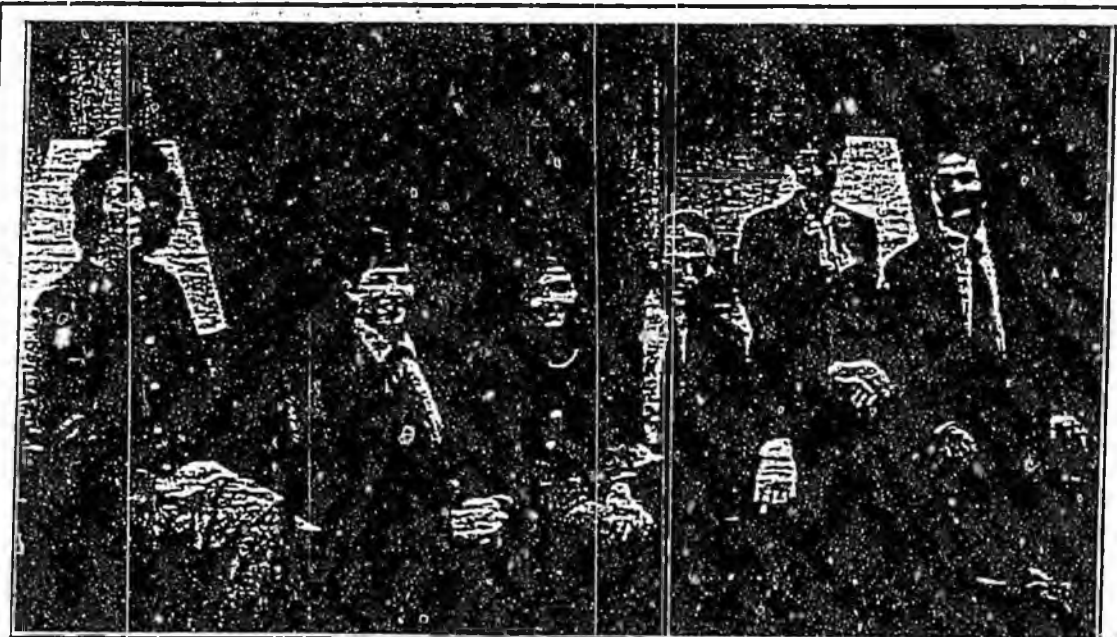


Photo by Naomi W. Klouda

Attorney Donna Willard, who will accept the award in Boston for the Youth Court, celebrates with Jesse Kahl, Youth Court Chief Justice; Mina Kumar, Youth Court Mediator, Bryan Clark, Youth Bar President; and attorney volunteers Blythe Marston and Jon Ealy.

Anchorage Youth Court wins national ABA award

By Naomi Warren Klouda
For the Journal of Commerce

Anchorage Youth Court has won the 1993 American Bar Association/Information America Public Education Project award for working in partnership with the justice system to produce a program involving teen lawyers, judges and defendants.

Donna Willard, local attorney and ABA board gov-

ernor for the di- includes Alaska will accept the award on behalf of the teen winners Feb. 5 in Boston at the National Conference of Bar Presidents luncheon. Some 188 teens, ranging from 7th to 12th graders are recipients of the award, which came with a \$5,000 cash grant as well as the Outstanding Partnership Award.

After finishing a 10-week law class, the students worked in actual courtroom settings with juvenile first-offenders arrested for misde-

crimes. Youth clients were represented and prosecuted by teenage lawyers - and sentenced by teenage judges. No adults are allowed to speak in the court, though teen attorneys can consult adult counsel present in the courtroom. Teen jurors were called in to decide some cases.

Sharon Leon, executive director of the four-year-old Youth Court, says the Anchorage program was

firm of

**DW & SHARROCK
CORPORATION**

announce that

Laughner, Esq.

of the firm,

ll, Esq.

**White & McAuliffe,
of the firm.**

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533
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the loan is paid back). This theory was used in many of our eastern states.

b. *Lien Theory*: Under the "lien" theory, the owner/mortgagor keeps both legal title and possession, and only gives the mortgagee a lien on the land which can be foreclosed upon in the event of a default under the loan. The lien theory is used in most western states, and is used today in Alaska.

the mortgagor may have built up a substantial investment in the pay-off of the loan. The law changed in order to protect those who had paid a sizeable amount of the installment debt before the default occurred, usually by giving the mortgagor either a "right to cure" the default, or a "right to redeem" the property.

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Youth Court effective deterrent for first-time offenders

Continued from Page 1B
judged as unique in that it is the only one which gives teens "such a tremendous responsibility."

"It's also the most complete program — we even have a Youth Court Bar Association," Leon said.

Leon directs the program and is aided by a volunteer administrative board composed of attorneys, judges, police officers, businessmen, mediators and juvenile intake officers.

Peer advising and sentencing techniques seem to be working Leon said. Out of a total of 69 cases involving first-time offenders, only four were arrested for a second time.

"Juvenile intake officers are pretty happy about that because the recidivism rate is usually 50 percent. All

the offenders are ordered to write an essay as part of their sentence reflecting on what they had done," Leon said.

"All of them said they never want to see the inside of a courthouse again." Some of them do, however. But the

"All of them said they never want to see the inside of a courthouse again."

next time they appear in court it is as youth court judges, lawyers, prosecutors or jurors as other offenders are brought into Youth Court.

On Jan. 25, 1993, another 119 young people were inducted into Anchorage Youth Court, joining the 188 already on the roster.

THE ALASKA JOURNAL OF COMMERCE

We Mean Business

ANCHORAGE YOUTH COURT:
TRIAL BY PEERS

I. PROJECT DESCRIPTION

The Anchorage Youth Court ("AYC") is a court in which the roles of attorneys, judges, bailiffs, clerks and jurors are filled by young people between the ages of twelve and eighteen. Defendant youths are afforded a chance via trial by their peers to resolve legal problems without receiving a criminal record. Simultaneously, the community benefits by receiving valuable work service as partial redress for the wrongs committed. Attorneys also have the opportunity to provide a service to their community. Most importantly, however, young people and adults work together through youth court to resolve conflict.

II. PLANNING

A. Needs Assessment

Often the juvenile justice system does not work for first time offenders. Two problems arise. First, due to the lack of resources, first time offenders are rarely punished. Juveniles become aware that the justice system will not follow through if an offense is committed. The result is a high recidivism rate. By the time the justice system takes action, many youthful offenders have established a lawbreaking behavior pattern.

Second, many juvenile defendants who maintain they are innocent cannot afford to hire legal counsel. They thus feel compelled to admit guilt to crimes they have not committed. They pay restitution as a cheaper alternative to hiring a lawyer.

A youth court can provide a solution to both problems. Attorneys, parents, school officials and students can join together to implement a court that will promptly respond to juvenile legal problems.

B. Determining Specific Objectives and Program Design

1. Decisions to be Made
 - a. Options - Objectives

The objectives of a youth court are four fold. First, a youth court provides a municipal wide alternative court where teenagers can be represented, prosecuted, and tried by a jury of their peers without incurring a record. Second, youth gain an awareness and respect for their legal responsibilities to society and are afforded the opportunity to play a positive role in the administration of justice. Third, a youth court reduces the volume of cases burdening a judicial system. Finally, attorneys are able to provide a service to the public by instructing youth about substantive and procedural criminal law.

- b. Options - Program Design

The AYC allows young people complete judicial authority. Young people are attorneys, judges, bailiffs, clerks, and jurors. Trials take place in the state courthouse. Defendants are referred by a referring authority, which for AYC is Alaska's Juvenile Intake Office. Once a defendant is referred to AYC, the defendant is arraigned. If he pleads guilty, he is tried by a jury or panel of judges. AYC confirms with the community service placement office that each defendant who is sentenced serves his sentence. If the defendant refuses to comply with the AYC process, AYC can return the case to Juvenile Intake for disposition. At completion of the case, the AYC closes the file and returns it to the referring authority. A criminal record is not accrued upon a finding of guilt.

2. Decision Making Process

AYC began with an ad hoc group of concerned attorneys, students, teachers, juvenile authorities and

parents who believe in and are committed to establishing a youth court. This group contacted the Anchorage Bar Association, Young Lawyers Section for help with funding and for access to its resources in the community. They Young Lawyers have been involved ever since.

A group should use the following analysis to determine whether a youth court is appropriate for its community:

a. Make a rough needs assessment. Determine how many offenders enter the juvenile justice system each year and how each is handled. Determine whether diversion programs are currently in operation. If so, determine what kind of diversion programs exist. If not, determine whether the court system needs a youth court diversion as an alternative.

b. Identify one or more persons who are interested in helping start a youth court. There may be people involved in the local bar association, local law related education projects, the school system, or the juvenile justice system. Encourage such people to enlist support for the program and to attend initial meetings. Often judges, attorneys, local bar association members, probation personnel, police officers, teachers, students, and parents are interested in supporting a youth court.

c. Identify the target group of defendants based on the needs of the juvenile system, i.e. age, type of offense and usual disposition of case.

d. Learn the procedures that are followed with a juvenile from arrest until final disposition of the case. Is there a diversion mechanism already in place? What happens to first offenders? This information is necessary in order to formulate workable procedures for selecting appropriate cases for the youth court.

e. Meet with the chief judge of the trial court, the proposed referring authorities, the director of social services and community work services, and prosecuting and public defense attorneys. Such meetings should be designed to foster support for the program and to compile suggestions for implementation.

3. Considerations in Project Planning

a. Personnel Available

Four types of personnel are required for a youth court: (1) volunteer students willing to become bar association members and attorneys; (2) volunteer attorneys willing to be instructors and advisors; (3) community members willing to support the youth court including judges, police officers, school officials, and juvenile officers; and (4) advisory staff.

The ABA affiliate group should provide access to potential volunteer attorneys. The AYC contacted schools and other community leaders directly to solicit student involvement, community support, and staff help.

The advisory staff of the AYC consists of a Coordinator and Legal Advisor. Both jobs are time consuming. The Coordinator's position is a paid one and is currently part time, but could become full time.

The Coordinator is responsible for review and approval of referrals to the AYC. S/he also establishes, oversees, and directs the procedures and duties required to ensure the smooth and proper operation of the youth court. Further, the Coordinator must maintain accurate youth court records of costs and expenses and act as a liaison between the AYC Bar Association, Administrative Board, and Alaska Court system at large.

The Legal Advisor should be an attorney volunteer. His duties and responsibilities are to review and approve, together with, advise and direct AYC staff and members as requested, required or needed.

AYC has considered employing a law student intern to assist both the Coordinator and legal advisor. Because no law schools are located in Alaska, such a program is difficult in Alaska. Nonetheless, a law student intern could assist the Coordinator and legal advisor in his or her activities.

B. Revenue Availability

The first source for information about funding should be the local bar association. There are several funds set up for the specific purpose of starting and operating law related education programs.

The second source of information is the local library. Most libraries have a resource section which provides information about private foundations that donate money to legal programs. Some cities also have foundation centers. These centers are clearing houses for information about corporate and private foundations.

Another form of funding is self-generating. Fund raisers, seminars, and requests for donations can generate funds. An especially good private source of funds is private law firms. It is possible to run a youth court entirely on donations. The only items needed for a youth court are time, office space and operating expenses. These can all be donated. Private law firms in Anchorage have donated hundreds of hours of time to AYC. They have also donated office space and copying. Further, The Alaska State Court System has donated the use of their courtrooms for AYC hearings and trials. Similarly, the local library has donated the use of its theater for meetings.

Even though personnel and funding are the usual stumbling blocks associated with establishing and operating a youth court, the essential element is dedicated individuals who are committed to a youth court. Although a great deal of funding is not necessary for starting a program, individuals who are dedicated to starting a youth court are essential.

C. Evaluation Design

It is important to evaluate the youth court periodically. Regular evaluations allow for the youth court to be revised as needed. A timetable should be set up for evaluation. Items to be evaluated include: the status of pending cases, available personnel and available resources.

Statistics should also be kept throughout the tenure of the court. Some statistics that should be kept are: number of inquiries about the youth court, number of students who register to take the youth court training course, number of students who pass the youth court bar examination, number of cases referred to the youth court, the number of cases returned to the referring authority, the number of cases in which defendants have been found not guilty or guilty, and the sentences served by defendants found guilty.

Finally, the year's goals should be reviewed and compared with the status of the program. If any disparity exists, the youth court goals and methods should be re-examined for possible change.

III. IMPLEMENTATION

A. Timetable

To establish a youth court, a timetable of at least six months is advisable before trials commence. Six months allows sufficient time to organize volunteers and arrange for courtrooms, community support, community work service, and cooperation of schools, court system, attorneys, and police officers. The following provides a loose outline of the chronology of events:

1. Formalize the proposed youth court by preparing a youth court constitution. This constitution should outline the responsibilities of each organization and the procedure and roles of student members. The constitution should be reviewed and adopted by students.
2. Formalize the proposed youth court by preparing a youth court constitution. This constitution should outline the responsibilities of each organization and the procedure and roles of student members. The constitution should be reviewed and adopted by students.
3. Establish a curriculum and bar exam for new members of the youth court bar association.
4. Begin to enroll students in the bar review course.
5. When at least ten to twenty students have enrolled, set the date classes are to begin.

6. Start the eight to ten week bar review course.
7. Set the bar examination and swear in all students passing the bar as members of the youth court bar association.
8. Begin the youth court bar association monthly business meetings and continuing legal education program.
9. Ask the referring authority to refer its first case to youth court.

B. Fund Raising

Look for all avenues of funding. Funding can come from grants, donations, and fundraisers. Even though grants are the best kind of funding available, it must be noted that grant applications take a great deal of time to prepare. Secondly, foundations that award grants may make disbursements only once or twice a year.

AYC approached the Young Lawyers division of the American Bar Association for an initial grant. AYC was awarded \$1,700.00 to begin its project.

Subsequently, AYC approached the Anchorage Bar Association. It funded the first year of AYC by providing a grant of \$11,000.00. Private individuals, law firms and corporations have donated office space, equipment and time. In-kind donations have been essential to AYC's first year.

C. Recruitment and Training

AYC's organization consists of cooperation between local high schools, juvenile intake, the court system, and volunteer attorneys and paralegals. The AYC has three arms. The first arm is the AYC non-profit corporation. It is directed by an Administrative Board. The second arm is the AYC Bar Association which is directed by student bar members. The third arm is the AYC court system which is directed by the AYC Coordinator. Volunteers are needed to staff all three arms.

The AYC Constitution establishes that the Administrative Board consists of residents of the Municipality of Anchorage. An equal number of members represents the youth community and the adult community. Each member serves for a term of one year. Student representatives are selected from each school which has a student participating in AYC. Adult nominees are selected from and represent the following: the judiciary, juvenile probation, law enforcement, education, the Anchorage Bar Association, the adult community at large and parents of youths over whom the AYC has jurisdiction.

The duties of the Administrative Board include, but are not limited to, fiscal matters, appointing staff members, maintaining liaison between the AYC and law enforcement agencies of the State of Alaska, the Municipality of Anchorage, as well as general supervision of AYC. Members of the Administrative Board receive no training, but usually come to the Board with an expertise or interest which is important to the functioning of AYC.

The AYC Bar Association consists of members of the AYC who are enrolled in grades seven through twelve and in a public or private school in the Municipality of Anchorage. The students must successfully complete an eight to ten week training course and pass an AYC bar examination. In order to hold any elected or appointed position, a member must have active standing. In order to qualify as an active member must have attended a majority of AYC Bar Association meetings held within the last three months and attend continuing legal education classes.

The AYC Bar Association has a president, vice president, secretary, judges, and clerk, all of whom are elected. Further, bailiffs, attorneys and jurors are appointed on a case by case basis.

A significant amount of time must be spent by volunteer attorneys to educate students about substantive and criminal procedures, evidence, constitutional law and trial advocacy. Much of the training is done during the eight to ten week training course.

D. Publicity

The AYC uses two types of publicity; one is intended to gain the participation of AYC students and the other is intended to gain community support for AYC. AYC has waged a successful public relations campaign on both fronts. Stories have appeared in the "Anchorage Daily News", the "Anchorage Times", Alaska Bar Association publications, and the "ABA/YLD Affiliate". The AYC Coordinator has appeared before numerous public and private organizations, corporations and schools. The Anchorage community is extremely supportive and interested in the program. Speaking opportunities are easily available. A youth court should ensure that its coordinator is willing to submit press releases and speak publicly as opportunities arise.

The student members should also participate in the campaign. Each fall AYC students ensure that other students in the Anchorage community are aware of the AYC program by writing newspaper articles notifying students of the AYC bar review registration. Students deliver similar notices to local radio stations, T.V. stations and schools.

E. Day to Day Operations

The AYC organization operates as follows: After a preliminary investigation, a referring authority, usually juvenile intake, refers the case to AYC. The referring authority meets with the defendant and his or her custodial parent or guardian to explain the purposes of AYC, and its procedures including sentencing. After the opportunity to confer with counsel, the defendant is given the choice of proceeding to AYC or being handled through regular juvenile intake channels which may include a formal court hearing and a criminal record. If the defendant and his or her parent or guardian agrees to proceed with AYC, they will sign a voluntary agreement with the understanding that their case will be held open for 90 days to complete the youth court process. This voluntary agreement states that failure to comply with AYC and other established conditions, once agreed to, may result in having the case handled in a formal court proceeding.

The AYC Coordinator receives a copy of the defendant's signed voluntary agreement to participate in AYC, available arrest reports and other related documents. If the case is not accepted by AYC, the case is returned to the referring authority together with all documents relating to the case. If the case is accepted, proceedings in AYC are conducted in substantial conformity with the rules and statutes governing normal adult criminal proceedings. The rules and statutes are applied and modified as necessary to promote the prompt and just resolution of cases and legal education. At all times, AYC proceedings are conducted to ensure confidentiality.

The chief judge or his appointee presides over all courtroom proceedings of the AYC with the assistance of two associate judges. If the defendant pleads guilty or is found guilty at trial, the judges determine an appropriate sentence at a sentencing hearing to be held within five days of the verdict or plea. Sentencing is in accordance with the informal sentencing guidelines established by the referring authority.

If the defendant chooses to exercise his right to appeal, he must submit a written statement including reasons for appeal to the chief judge within three days following the sentencing hearing. If the defendant does not submit a written appeal within this time frame, his right to appeal is waived. Upon receipt of the appeal, the chief judge appoints a three member appeals panel. If the appeals panel finds for the defendant on any point of appeal, the case is remanded accordingly. The Coordinator oversees the defendant's compliance with AYC sentencing orders and provides status reports to the referring authority as required.

Once a year, the AYC recruits new members. In order to become a member of AYC, young people complete a legal training course whereby they learn basic legal principals and practices. The course covers such topics as constitutional law, criminal law, criminal procedure, evidence, trial advocacy, and ethics. After having completed the course, students take a bar examination. Once students pass the bar examination, they become AYC Bar Association members. They are then qualified to serve on the court as bailiffs, clerks, attorneys, and judges. They will also be able to participate in AYC Bar Association meetings through which they continue their legal education. At the meetings members participate in activities designed to give broader perspective of the justice system, such as workshops, mock trials, speakers, and movies about the judicial system. The initial and ongoing training require regular attention by the Coordinator.

IV. EVALUATION

As a result of AYC, Anchorage youth have gained an awareness and respect for their legal responsibilities to society. They are afforded the opportunity to play a positive role in administration of justice. The volume of cases

burdening the judicial system has been lightened and Anchorage lawyers have been able to provide a service to the public by educating students about substantive and procedural criminal law. Meanwhile, the community has received valuable service and redress for the wrongs committed.

AYC students, however, provide probably the best evaluation of AYC. A question on their first bar examination was, "What is Anchorage Youth Court?" Their responses were as follows:

A Tenth Grader's response:

The Anchorage Youth Court provides the benefits of citizenship to the youth of Anchorage by providing an alternative system of judgement and sentencing. It will allow those who commit misdemeanors, early in life, a chance to pay for their damage without incurring a criminal record. It shall also attempt to be fair in the proceedings by providing these defendants with a jury, judge, and lawyers composed of their peers. By modeling itself after the real court system, Anchorage Youth Court will attempt to foster a spirit of respect for the law.

A Twelfth Grader's response:

The Anchorage Youth Court is an opportunity for youth to constructively exercise their responsibility to themselves and society in securing and promoting a just legal system. It provides youth offenders with an alternate method to pay for the consequences of their actions - by having a trial by their peers, but not incurring any criminal record, and by paying back their community with restitution and community service hours. Anchorage Youth Court also provides active members with hands-on experience in the legal field and participation that could not be gained by any other source. The community as a whole benefits by the service Anchorage Youth Court provides.

An Eleventh Grader's response:

Anchorage Youth Court is essentially an opportunity. It is an opportunity for students of all kinds to come together in a healthy environment to learn about the laws that govern them. It is an opportunity for youth of Anchorage to help better their community. But mostly, it is an opportunity for kids who have made mistakes to have another shot, not so much to go unpunished, but to have another chance to reconsider the consequences of their actions without having a criminal record follow them through life.

AYC is essentially an opportunity, an opportunity for young people and adults to work together to resolve problems in their community.

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**REGISTRATION MATERIALS PAID FOR THROUGH A GRANT FROM
 J.C. PENNEY CO. INC**

**AYC CLASS SCHEDULE
 FALL 1992**

Sat. 9/12	2 - 4 P.M.	Open House, registration	AYC Office
Thu. 9/17	7 - 8:30	Class registration	West High Cafeteria
Mon 9/14	5 - 7:00	Vol. teacher preparation meeting	Hughes Thorsness

CLASSES:

(Classes will meet once a week on the same day, in the same location for two hours)

09/21 - 09/26	Wk 1	Courts and Jurisdiction
09/28 - 10/02	Wk 2	Substantive Criminal Law
10/05 - 10/10	Wk 3	Criminal Procedure and Constitutional law
10/12 - 10/17	Wk 4	Evidence
10/19 - 10/23	Wk 5	Real and Demonstrative Evidence
10/26 - 10/30	Wk 6	Trial Advocacy (Mock Trial Preparation)
11/02 - 11/07	Wk 7	Trial Advocacy (Mock Trial Preparation)
11/09 - 11/14	Wk 8	Mock Trial
11/16 - 11/21	Wk 9	Bar Review
11/23 - 11/27	Wk 10	No Class -- Thanksgiving week

AYC Bar Exam:

A.M. 12/05	Bar Exam	West High Cafeteria
P.M. 12/06	Make-up Bar Exam -- By arrangement only	
12/07 - 12/12	Review corrected exam in regular classroom with students	
12/14	Exams returned to AYC office	
A.M. 01/09	Review/exam retake -- By arrangement only	
P.M. 01/24	Swearing in/reception -- attendance mandatory to become an AYC attorney	



Anchorage Youth Court

P.O. Box 102735

Anchorage, Alaska 99510

Phone: (907) 274-5986 • Fax: (907) 272-0491

**AYC LAW CLASS
STUDENT REGISTRATION FORM**

- Please complete this form, then present it to the AYC student registrar.
- Wait until the registrar has transferred this information to the master sheet.
- The registrar will give you the Class Information Letter and Assent Form.
- If your parent/guardian is here, have her/him sign the Assent Form and present it to the registrar.
- If your parent/guardian is not here, be sure to bring the signed Assent Form to your **FIRST CLASS.**

STUDENT NAME: _____

BIRTH DATE (MONTH/DAY/YEAR): _____

ADDRESS: _____ (ZIP) _____

MAILING ADDRESS, IF DIFFERENT: _____ (ZIP) _____

PHONE: _____

SCHOOL: _____ GRADE: _____

PARENT/GUARDIAN NAME: _____

PLACE OF EMPLOYMENT: _____

WORK TELEPHONE: _____

PARENT/GUARDIAN NAME: _____

PLACE OF EMPLOYMENT: _____

WORK TELEPHONE: _____

PLACE AN "X" IN THE SPACE OF YOUR CHOICE BELOW:

Please do () do not () include my name, address and phone number on the AYC membership list that is available to all members.