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334

ALASKA

State Legislative Committee

1990 FACTS & LEGISLATIVE PRIORITIES

AARP

American Association
of Retired Persons

ALASKA STATE LEGISLATIVE COMMITTEE

The AARP State Legislative Committee (SLC) decides and promotes the legislative objectives to be sought by the Association in each state legislative session. Composed of volunteers from the AARP membership across the state, the Committee works on behalf of not only AARP members, but all older persons and the state community.

Each year, the State Legislative Committee in Alaska selects legislative priorities based on the needs of the state's residents, using guidelines developed by the AARP National Legislative Council. SLC members work with legislators to promote passage of legislation beneficial to Alaska's older population.

The Alaska SLC participates responsibly in the legislative process from discussion of concerns, to a bill's conception, to its signing into law and the translation of its intent into administrative procedures and regulations. The SLC volunteer "citizen lobbyists" are assisted by AARP legislative staff. Technical support for the state legislative program is provided by the AARP Public Policy Institute and by AARP program volunteers.

CHAIRMAN
Mr. R. W. Pavitt*
130 Seward Street
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VICE CHAIRMAN
Mrs. Marie C. MacKenzie
1620 Crescent
Anchorage, AK 99508
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Fairbanks, AK 99701
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* Member, Capital City Task Force

ALASKA CAPITAL CITY TASK FORCE

CCTF COORDINATOR
Mr. R. W. Pavitt*

MEMBERS

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Mr. Warren Wild
P.O. Box 32036
Juneau, AK 99803
(907) 789-7628

Most State Legislative Committees have recognized that they need additional volunteers to help promote the AARP legislative program to lawmakers, legislative staff, executive branch officials and other organizations. This need to strengthen the AARP presence in the state capital city has prompted many SLCs to create a Capital City Task Force (CCTF).

The primary role of the CCTF is to help the SLC promote and defend AARP legislative interests before the state legislature. The SLC may also rely on CCTF members to monitor and participate in the regulatory and rulemaking processes of the state. The duties of Task Force members range from testifying before legislative committees to preparing legislative updates to researching issues.

To ensure appropriate policy oversight of the CCTF's activities the SLC Chairman designates a SLC member to coordinate the group. Capital City Task Force members belong to AARP and reside close to the Capitol.

* Member, State Legislative Committee

AMERICAN ASSOCIATION OF RETIRED PERSONS

AARP was founded in 1958 as a voluntary nonprofit and nonpartisan organization to help improve the quality of life of not only its members, but all older people. It is dedicated to helping its members meet the challenges of pre-retirement and retirement living and achieve a dynamic maturity of independence and purpose.

In Alaska, more than 33,947 individuals belong to the American Association of Retired Persons. AARP volunteers serve their communities through a variety of programs, from free tax counseling to support for newly widowed persons. The Association also offers a variety of educational and advocacy programs for older workers, who make up one-fourth of AARP's total membership.

AARP, the largest membership organization of older Americans, totals more than 30 million nationwide. There are more than 3,500 local AARP chapters.

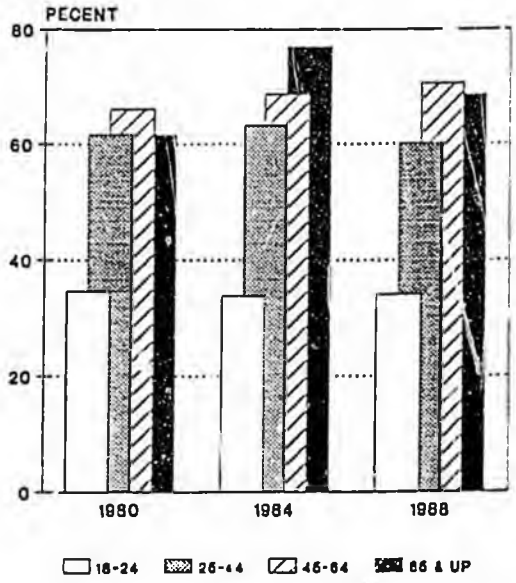
AARP initiatives marshal Association resources to address health care concerns, the status of minority elderly and issues concerning mid-life and older women. A new emphasis has been placed on helping mid-life and older Americans cope more effectively with managing their personal financial resources.

OLDER VOTERS

Older people are generally eager to participate in all facets of political life. Older persons are often involved in registering voters, assisting voters in traveling to polls, and actually conducting poll operations on election day. They believe in the Eisenhower adage, "Politics should be the part-time profession of every citizen."

The voter turnout graph illustrates the participation rate of four age groups of Alaska voters in elections held between 1980 and 1988.

VOTER TURNOUT GRAPH



Prepared for AARP by Election Data Services

1990 ALASKA LEGISLATIVE PROGRAM

PRIORITIES

- Strengthen programs that foster independence and dignity for older Alaskans
- Increase access to appropriate and affordable health care for all Alaskans

SUPPORT ITEMS

- Support development of housing options for older Alaskans
- Support legislation to help eliminate spousal impoverishment with respect to long-term care
- Support legislation to provide lifeline telephone service to low-income individuals
- Support continuation of the present longevity bonus program; or, if changed, support the annuity concept
- Support development of comprehensive state health policy
- Support legislation for a statutory post-retirement pension adjustment for the teachers' retirement system
- Support legislation and appropriations to develop a comprehensive and coordinated program of home-, community-, and institutionally-based services that would serve the unique needs of Alaskans

SL1003AK(1189)

SENATE COMMITTEE REPORT
FIRST COMMITTEE OF REFERRAL

DATE: January 8, 1990

FURTHER: Finance

Date of 5-Day Notice: 1/11/90
(in accordance with Uniform Rule 23)

DATE TURNED INTO OFFICE: 1/12/90

HESS Committee considered SENATE BILL NO. 334

"An Act directing the Department of Health and Social Services to seek permission to use options and receive waivers under the Medicaid program for the cost of home or community-based services for developmentally delayed children, developmentally disabled persons, disabled adults, and older Alaskans; directing other agencies to assist in that process; efd."

and recommended:

[ ] replace with _____ CS _____ [ ] same title [ ] new title

[ ] attached amendment(s)

[ ] _____ letter of intent adopted

[ ] do pass

[ ] do not pass

[ ] no recommendation

(X) individual recommendations

[ ] further referral to _____

ATTACHES NEW FISCAL NOTE(S):

Department(s)/Date:

(X) fiscal note(s) (3)
Health #55, Med Assist.
Health #55, Admin
Admin, OAC

[ ] zero fiscal note(s)

[ ] appropriation-no fiscal note

[ ] Governor's bill w/fiscal note

SIGNING DO PASS:

OTHER RECOMMENDATIONS:

Al Adams - No Rec

Paul Fischer Do Pass
Chair: Signature and Recommendation

STATE OF ALASKA
1990 LEGISLATIVE SESSION

Bill Version: SB 334
Publish Date:

FISCAL NOTE

REQUEST:

Revision Date:
Title: Directing DHSS to seek permission, options, waivers under Medicaid Program
Sponsor: Uehling, Fahrenkamp, and Duncan
Requestor: Uehling

Agency Affected: Administration
BRU: Older Alaskans Commission
Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	66.0	68.3	70.2	0	0	0
TRAVEL	24.8	11.8	7.2	0	0	0
CONTRACTUAL	46.1	16.5	13.5	0	0	0
SUPPLIES	1.5	1.5	1.5	0	0	0
EQUIPMENT	5.5	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	143.9	98.1	92.4	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER I/A (RSA)	143.9	98.1	92.4	0	0	0
TOTAL	143.9	98.1	92.4	0	0	0

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary) (Back-up Detail Attached)

The funding will come from a budgeted Reimbursable Services Agreement (RSA) from the Division of Medical Assistance, Department of Health and Social Services. The source of the RSA funds will be 50/50 State General Fund and federal funds.

Prepared by: James A. Fot for Connie J. Sipe
Phone: 465-3250
Division: Older Alaskans Commission
Date: 01/11/90

Approved by Commissioner: Frank S. Baxter
Date: 1/16/90
Agency: Department of Administration

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

4/15D1/011103-0

Rev: 11/89

STATE OF ALASKA

ROUTE SLIP

TO: Mail Station	Department	Division
3100		
Attention: Sen (HESS)		

- ☐ Approval
- ☐ Signature
- ☐ Comment
- ☐ Contact Me
- ☐ Prepare Reply
- ☐ For Your File
- ☐ Note & Return
- ☐ Initial & Return
- ☐ Return as Requested
- ☐ Return for Approval
- ☐ Necessary Action
- ☐ For Your Information

Remarks:
This replaces the FN sent over earlier today. Please discard the other one.

FROM: Mail Station	Department	Division
	Admin	
By: Frank Baxter		Date: 1-16

02-002 (REV 3-84)

Department of Administration Older Alaskans Commission
January 12, 1990

Detail of Fiscal Note on SB 334

FY 91

OPERATING

100	Personal Services	
	1 PFT Health Planner II (Range 19 C) 12 mos. Juneau	$ 58,027.
	1 PPT Clerk IV (Range 9 C)--3 months Juneau	8,031.
Sub-Total		$ 66,058.
200	Travel	
	OUTSIDE	
	3 trips to other states with Medicaid Waivers x 2 people	9,300.
	1 trip x 2 to Region X HCFA (Medicaid)-Seattle	1,480.
	1 trip x 2 to Medicaid Waiver National conference	3,200.
	ALASKA	
	4 trips to Anchorage, 2 x 2, 2 x 1	3,264.
	Fairbanks, one rural site 1 trip each	1,514.
	TRAVEL TO ALASKA FOR CONSULTANTS	
	3 trips, 3--5 days, x $ 2,000	6,000.
Sub-Total		$ 24,758.
300	Contractual	
	Public Seminar/Conference on Home Care Options	12,000.
	Teleconferences within Alaska & with consultants	4,800.
	Telephone, toll charges	4,800.
	Consultants Fees, 45 staff days x $ 300 day	13,500.
	Word Processing Support (RSA)	3,000.
	Postage, advertising, printing	8,000.
Sub-Total		$ 46,100.
400	Supplies	1,500.
500	Equipment	
	1 computer, modem, printer, software	4,000.
	Desk, chair, etc.	1,500.
Sub-Total		$ 5,500.
FY 91 OPERATING TOTAL:		$ 143,916.

Department of Administration Older Alaskans Commission
January 12, 1990

Detail of Fiscal Note on SB 334

FY 92

OPERATING

100	Personal Services	
	1 PFT Health Planner II (Range 19 D) 12 mos. Jnu	$ 60,034.
	1 PPT Clerk IV (Range 9 D) 3 mos. Juneau	8,249.
Sub-Total		$ 68,283.
200	Travel	
	OUTSIDE	
	1 trip x 2 to National Waiver Conference	3,400.
	1 trip x 2 to Seattle Region X HCFA	2,000.
	ALASKA	
	4 trips to Anchorage (2 x 2, 2 x 1)	3,200.
	1 trip to Fairbanks x 2 people	1,230.
	CONSULTANT TRAVEL	
	1 Consultant to work with 1992 Legislature	2,000.
Sub-Total		$ 11,830.
300	Contractual	
	Teleconferences within Alaska & with consultants	3,200.
	Telephone, toll charges	4,800.
	Consultants Fees, 10 days x $ 300 day	3,000.
	Word Processing Support	1,500.
	Postage, advertising, etc.	4,000.
Sub-Total		$ 16,500.
400	Supplies	1,500.
500	Equipment	0.
FY 92 OPERATING TOTAL		$ 98,113.

Department of Administration Older Alaskans Commission
January 12, 1990

Detail of Fiscal Note on SB 334

FY 93

OPERATING

100 Personal Services	
1 PFT Health Planner II (Range 19 E) 12 mos. Jnu	$61,742.
1 PPT Clerk IV (Range 9 E) 3 mos. Juneau	8,481.
Sub-Total	$70,223.
200 Travel	
OUTSIDE	
1 trip to National Waiver Conference	1,800.
1 trip to Seattle Region X HCFA	1,000.
ALASKA	
4 trips to Anchorage (2 x 2, 2 x 1)	3,200.
1 trip to Fairbanks x 2 people	1,230.
Sub-Total	$ 7,230.
300 Contractual	
Teleconferencing within Alaska & with consultants	3,200.
Telephone, toll charges	4,800.
Word Processing Support	1,500.
Postage, advertising, etc.	4,000.
Sub-Total	$13,500.
400 Supplies	1,500.
500 Equipment	0.
FY 93 OPERATING TOTAL	$92,453

JAN 16 1990

STATE OF ALASKA
1990 LEGISLATIVE SESSION

Bill Version: SB 334
Publish Date:

FISCAL NOTE

REQUEST:

Revision Date:
Title: Directing DHSS to seek permission, options, waivers *
Sponsor: Uehling, Fahrenkamp, and Duncan
Requestor: Uehling

Agency Affected: Administration
BRU: Older Alaskans Commission
Components:

* under Medicaid Program....

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	66.0	68.3	70.2	0	0	0
TRAVEL	24.8	11.8	9.2	0	0	0
CONTRACTUAL	46.1	16.5	16.0	0	0	0
SUPPLIES	1.5	1.5	1.5	0	0	0
EQUIPMENT	5.5	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	143.9	98.1	96.9	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER I/A (RSA)	143.9	98.1	96.9	0	0	0
TOTAL	143.9	98.1	96.9	0	0	0

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary) (Back-up Detail Attached)

The funding will come from a budgeted Reimbursable Services Agreement (RSA) from the Division of Medical Assistance, Department of Health and Social Services. The source of the RSA funds will be 50/50 State General Fund and federal funds.

Prepared by: Connie I. Sipe
Division: Older Alaskans Commission
Phone: 465-3250
Date: 01/11/90

Approved by Commissioner: Frank S. Baxter
Agency: Department of Administration
Date: 1/16/90

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

4/15D1/011103-0

Rev: 11/89

Department of Administration Older Alaskans Commission
January 12, 1990

Detail of Fiscal Note on SB 334

FY 91

OPERATING

100	Personal Services	
	1 FFT Health Planner II (Range 19 C) 12 mos. Juneau	$ 58,027.
	1 PPT Clerk IV (Range 9 C)--3 months Juneau	8,031.
Sub-Total		$ 66,058.
200	Travel	
	OUTSIDE	
	3 trips to other states with Medicaid Waivers x 2 people	9,300.
	1 trip x 2 to Region X HCFA (Medicaid)-Seattle	1,480.
	1 trip x 2 to Medicaid Waiver National conference	3,200.
	ALASKA	
	4 trips to Anchorage, 2 x 2, 2 x 1	3,264.
	Fairbanks, one rural site 1 trip each	1,514.
	TRAVEL TO ALASKA FOR CONSULTANTS	
	3 trips, 3--5 days, x $ 2,000	6,000.
Sub-Total		$ 24,758.
300	Contractual	
	Public Seminar/Conference on Home Care Options	12,000.
	Teleconferences within Alaska & with consultants	4,800.
	Telephone, toll charges	4,800.
	Consultants Fees, 45 staff days x $ 300 day	13,500.
	Word Processing Support (RSA)	3,000.
	Postage, advertising, printing	8,000.
Sub-Total		$ 46,100.
400	Supplies	1,500.
500	Equipment	
	1 computer, modem, printer, software	4,000.
	Desk, chair, etc.	1,500.
Sub-Total		$ 5,500.

FY 91 OPERATING TOTAL: $ 143,916.

Department of Administration Older Alaskans Commission
January 12, 1990

Detail of Fiscal Note on SB 334

FY 92

OPERATING

100	Personal Services	
	1 PFT Health Planner II (Range 19 D) 12 mos. Jnu	$ 60,034.
	1 PPT Clerk IV (Range 9 D) 3 mos. Juneau	8,249.
Sub-Total		$ 68,283.
200	Travel	
	OUTSIDE	
	1 trip x 2 to National Waiver Conference	3,400.
	1 trip x 2 to Seattle Region X HCFA	2,000.
	ALASKA	
	4 trips to Anchorage (2 x 2, 2 x 1)	3,200.
	1 trip to Fairbanks x 2 people	1,230.
	CONSULTANT TRAVEL	
	1 Consultant to work with 1992 Legislature	2,000.
Sub-Total		$ 11,830.
300	Contractual	
	Teleconferences within Alaska & with consultants	3,200.
	Telephone, toll charges	4,800.
	Consultants Fees, 10 days x $ 300 day	3,000.
	Word Processing Support	1,500.
	Postage, advertising, etc.	4,000.
Sub-Total		$ 16,500.
400	Supplies	1,500.
500	Equipment	0.
FY 92 OPERATING TOTAL		$ 98,113.

Department of Administration Older Alaskans Commission
January 12, 1990

Detail of Fiscal Note on SB 334

FY 93

OPERATING

100	Personal Services	
	1 PFT Health Planner II (Range 19 E) 12 mos. Jnu	$ 61,742.
	1 PPT Clerk IV (Range 9 E) 3 mos. Juneau	8,481.
Sub-Total		$ 70,223.
200	Travel	
	OUTSIDE	
	1 trip to National Waiver Conference	1,800.
	1 trip to Seattle Region X HCFA	1,000.
	ALASKA	
	4 trips to Anchorage (2 x 2, 2 x 1)	3,200.
	1 trip to Fairbanks x 2 people	1,230.
	CONSULTANT TRAVEL	
	1 Consultant to work on implementing options	2,000.
Sub-Total		$ 9,230.
300	Contractual	
	Teleconferences within Alaska & with consultants	3,200.
	Telephone, toll charges	4,800.
	Consultants Fees, 5 days x $ 300 day	1,500.
	Word Processing Support	1,500.
	Postage, advertising, etc.	4,000.
Sub-Total		$ 15,000.
400	Supplies	1,500.
500	Equipment	0.
FY 93 OPERATING TOTAL		$ 95,953.

STATE OF ALASKA
1990 LEGISLATIVE SESSION

Bill Version: SB 334
Publish Date:

FISCAL NOTE

REQUEST:

Revision Date:
Title: Directing DHSS to seek permission, options, waivers under Medicaid Program
Sponsor: Uehling, Fahrenkamp, and Duncan
Requestor: Uehling

Agency Affected: Administration
BRU: Older Alaskans Commission
Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	66.0	68.3	70.2	0	0	0
TRAVEL	24.8	11.8	7.2	0	0	0
CONTRACTUAL	46.1	16.5	13.5	0	0	0
SUPPLIES	1.5	1.5	1.5	0	0	0
EQUIPMENT	5.5	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	143.9	98.1	92.4	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER I/A (RSA)	143.9	98.1	92.4	0	0	0
TOTAL	143.9	98.1	92.4	0	0	0

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary) (Back-up Detail Attached)

The funding will come from a budgeted Reimbursable Services Agreement (RSA) from the Division of Medical Assistance, Department of Health and Social Services. The source of the RSA funds will be 50/50 State General Fund and federal funds.

Prepared by: James L. Fot for Connie J. Sipe
Phone: 465-3250
Division: Older Alaskans Commission
Date: 01/11/90

Approved by Commissioner: Frank S. Baxter
Date: 1/16/90
Agency: Department of Administration

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

FISHER
143.9 =
71.95 GF
71.95 FF

4/15D1/011103-0

Rev: 11/89

Department of Administration Older Alaskans Commission
January 12, 1990

Detail of Fiscal Note on SB 334

FY 91

OPERATING

100	Personal Services	
	1 PFT Health Planner II (Range 19 C) 12 mos. Juneau	$ 58,027.
	1 PPT Clerk IV (Range 9 C)--3 months Juneau	8,031.
Sub-Total		$ 66,058.
200	Travel	
	OUTSIDE	
	3 trips to other states with Medicaid Waivers x 2 people	9,300.
	1 trip x 2 to Region X HCFA (Medicaid)-Seattle	1,480.
	1 trip x 2 to Medicaid Waiver National conference	3,200.
	ALASKA	
	4 trips to Anchorage, 2 x 2, 2 x 1	3,264.
	Fairbanks, one rural site 1 trip each	1,514.
	TRAVEL TO ALASKA FOR CONSULTANTS	
	3 trips, 3--5 days, x $ 2,000	6,000.
Sub-Total		$ 24,758.
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	Public Seminar/Conference on Home Care Options	12,000.
	Teleconferences within Alaska & with consultants	4,800.
	Telephone, toll charges	4,800.
	Consultants Fees, 45 staff days x $ 300 day	13,500.
	Word Processing Support (RSA)	3,000.
	Postage, advertising, printing	8,000.
Sub-Total		$ 46,100.
400	Supplies	1,500.
500	Equipment	
	1 computer, modem, printer, software	4,000.
	Desk, chair, etc.	1,500.
Sub-Total		$ 5,500.

FY 91 OPERATING TOTAL: $ 143,916.

Department of Administration Older Alaskans Commission
January 12, 1990

Detail of Fiscal Note on SB 334

FY 92

OPERATING

100	Personal Services	
	1 PFT Health Planner II (Range 19 D) 12 mos. Jnu	$ 60,034.
	1 PPT Clerk IV (Range 9 D) 3 mos. Juneau	8,249.
Sub-Total		$ 68,283.
200	Travel	
	OUTSIDE	
	1 trip x 2 to National Waiver Conference	3,400.
	1 trip x 2 to Seattle Region X HCFA	2,000.
	ALASKA	
	4 trips to Anchorage (2 x 2, 2 x 1)	3,200.
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	CONSULTANT TRAVEL	
	1 Consultant to work with 1992 Legislature	2,000.
Sub-Total		$ 11,830.
300	Contractual	
	Teleconferences within Alaska & with consultants	3,200.
	Telephone, toll charges	4,800.
	Consultants Fees, 10 days x $ 300 day	3,000.
	Word Processing Support	1,500.
	Postage, advertising, etc.	4,000.
Sub-Total		$ 16,500.
400	Supplies	1,500.
500	Equipment	0.
FY 92 OPERATING TOTAL		$ 98,113.

Department of Administration Older Alaskans Commission
January 12, 1990

Detail of Fiscal Note on SB 334

FY 93

OPERATING

100 Personal Services	
1 PFT Health Planner II (Range 19 E) 12 mos. Jnu	$61,742.
1 PPT Clerk IV (Range 9 E) 3 mos. Juneau	8,481.
Sub-Total	$70,223.
200 Travel	
OUTSIDE	
1 trip to National Waiver Conference	1,800.
1 trip to Seattle Region X HCFA	1,000.
ALASKA	
4 trips to Anchorage (2 x 2, 2 x 1)	3,200.
1 trip to Fairbanks x 2 people	1,230.
Sub-Total	$ 7,230.
300 Contractual	
Teleconferencing within Alaska & with consultants	3,200.
Telephone, toll charges	4,800.
Word Processing Support	1,500.
Postage, advertising, etc.	4,000.
Sub-Total	$13,500.
400 Supplies	1,500.
500 Equipment	0.
FY 93 OPERATING TOTAL	$92,453

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: _____
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: SB 334

Agency Affected: Health & Social Services
BRU: Administrative Services

Sponsor: Uehling, Fahrenkamp, Duncan
Requestor: Uehling

Components: Governor's Council H & G

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	74.1	76.5	78.7			
TRAVEL	43.8	19.8	7.2			
CONTRACTUAL	110.1	18.5	13.5			
SUPPLIES	1.5	1.5	1.5			
EQUIPMENT	5.5	-0-	-0-			
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	235.0	116.3	100.9			
CAPITAL	-0-	-0-	-0-			
REVENUE	-0-	-0-	-0-			

FUNDING: (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-			
FEDERAL FUNDS	-0-	-0-	-0-			
OTHER	235.0	116.3	100.9			
TOTAL	235.0	116.3	100.9			

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)

Back-up information is attached. The funding will come from a Budgeted RSA from the Division of Medical Assistance, Department of Health and Social Services. The source of the RSA Funds will be 50/50 State General Funds and federal funds.

Prepared by: Dorothy J. Truran
Phone: 474-2240
Division: Governor's Council for the Handicapped/Gifted
Date: January 11, 1990

Approved by Commissioner: Myra Munson
Date: _____
Agency: Health and Social Services

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

Department of Health and Social Services
January 12, 1990

Governor's Council for the Handicapped and Gifted

Detail on Fiscal Note on SB 334

FY91
OPERATING

100 Personal Services	
1 FTE Health Planner II (Range 19C) 12 mo. Fairbanks	58.0
1 PPT Clerk IV (Range 9C) 6 mo.	16.1
Sub-Total	74.1
200 Travel	
OUTSIDE	
3 trips to other states with Medicaid Waivers x 2 people	9.3
1 trip x 1 to Region X HCFA Medicaid/Seattle	.7
1 trip x 2 to Medicaid Waiver National Conference	3.2
1 trip to MRDD or Early Intervention Meeting and consultation with NADDC/NAPRFMR/UCPA	2.6
ALASKA	
4 trips to Anchorage, 2 x 2, 2 x 1	3.3
Juneau, Ketchikan, Sitka, Valdez and one rural site, 1 trip each	3.7
TRAVEL TO ALASKA FOR CONSULTANTS	
3 trips, 3-5 days, x $2,000	6.0
CONSUMER TRAVEL	
Consumer Advisory Group, 2 meetings	15.0
Sub-Total	43.8
300 Contractual	
Teleconferences within Alaska and with consultants	4.8
Telephone, toll charges	4.8
Consultant Fees, 45 staff days x $500/day	22.5
Word Processing Support (RSA)	3.0
Postage, advertising, printing	8.0
Study	67.0
Sub-Total	110.1
400 Supplies	1.5
500 Equipment	
1 computer, modem, software	4.0
Desk, chair, etc.	1.5
Sub-Total	5.5
FY91 OPERATING TOTAL	235.0

Department of Health and Social Services
January 12, 1990

Governor's Council for the Handicapped and Gifted

Detail on Fiscal Note on SB 334

FY92
OPERATING

100	Personal Services	
	1 FTE Health Planner II (Range 19D) 12 mo. Fairbanks	60.0
	1 PPT Clerk IV (Range 9D) 6 mo.	16.5
Sub-Total		76.5
200	Travel	
	OUTSIDE	
	1 trip x 1 to Region X HCFA Medicaid/Seattle	2.0
	1 trip x 2 to Medicaid Waiver National Conference	3.4
	ALASKA	
	4 trips to Anchorage, 2 x 2, 2 x 1	3.2
	1 trip to Juneau x 2 people	1.2
	CONSULTANT TRAVEL	
	1 Consultant to work with 1992 Legislature	4.0
	CONSUMER TRAVEL	
	Committee to Review Proposals	6.0
Sub-Total		19.8
300	Contractual	
	Teleconferences within Alaska and with consultants	3.2
	Telephone, toll charges	4.8
	Consultant, 10 staff days x $500/day	5.0
	Word Processing Support (RSA)	1.5
	Postage, advertising, printing	4.0
Sub-Total		18.5
400	Supplies	1.5
500	Equipment	-0-
FY92 OPERATING TOTAL		116.3

Department of Health and
Social Services
January 12, 1990

Governor's Council for the
Handicapped and Gifted

Detail on Fiscal Note on SB 334

FY93
OPERATING

100	Personal Services	
	1 FTE Health Planner II (Range 19E)	
	12 mo. Fairbanks	61.7
	1 PPT Clerk IV (Range 9E) 6 mo.	17.0
Sub-Total		78.7
200	Travel	
	OUTSIDE	
	1 trip x 1 to Region X HCFA Medicaid/Seattle	1.0
	1 trip x 2 to Medicaid Waiver National Conference	1.8
	ALASKA	
	4 trips to Anchorage, 2 x 2, 2 x 1	3.2
	1 trip to Juneau x 2 people	1.2
Sub-Total		7.2
300	Contractual	
	Teleconferences within Alaska and with consultants	3.2
	Telephone, toll charges	4.8
	Word Processing Support (RSA)	1.5
	Postage, advertising, printing	4.0
Sub-Total		13.5
400	Supplies	1.5
500	Equipment	-0-
FY93 OPERATING TOTAL		100.9

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: _____
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: SB 334

Agency Affected: Health & Social Services
BRU: Medical Assistance

Sponsor: Uehling, Fahrenkamp, Duncan, etc.
Requestor: Uehling

Components: _____

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	198.4	203.7	210.4	217.1		
TRAVEL	16.8	11.4	4.7	5.3		
CONTRACTUAL	437.5	273.1	253.6	59.1		
SUPPLIES	6.0	6.2	6.4	6.7		
EQUIPMENT	22.0	.5	.5	-0-		
LAND & STRUCTURES	-0-	-0-	-0-	-0-		
GRANTS, CLAIMS	-0-	-0-	-0-	-0-		
MISCELLANEOUS	-0-	-0-	-0-	-0-		
TOTAL OPERATING	680.7	494.9	475.6	288.2		
CAPITAL	-0-	-0-	-0-	-0-		
REVENUE	-0-	-0-	-0-	-0-		

FUNDING: (Thousands of Dollars)

GENERAL FUND	340.3	247.4	237.8	144.1		
FEDERAL FUNDS	340.4	247.4	237.8	144.1		
OTHER	-0-	-0-	-0-	-0-		
TOTAL	680.7	494.9	475.6	288.2		

POSITIONS:

FULL-TIME	4	4	4	4		
PART-TIME	0	0	0	0		
TEMPORARY	0	0	0	0		

ANALYSIS: (Attach a separate page if necessary)

Contractual funds include RSA's to Governor's Council for the Handicapped and Gifted and Older Alaskan's Commission. These RSA's have been included in this fiscal note so that federal match can be secured. Although these contractual funds appear in the DHSS fiscal note, the Department has incorporated the OAC and Governor's Council request as submitted.

Prepared by: Kim Busch, Director Kim Busch Phone: 465-3355
Division: Medical Assistance Date: 1-12-90

Approved by Commissioner: Myra Munson Myra M Munson Date: 1/16/90
Agency: Health and Social Services

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

Cut off - Medical
& setting on Table

Fiscal Note

Department of Health and Social Services — Division of Medical Assistance

January 12, 1990

Detail of Fiscal Note on SB 334

FY91
OPERATING

100 Personal Services	
1 PFT Health Planner III (Range 21B) 12 mos. Juneau	62.4
2 PFT Research Analyst III (Range 18C) 12 mos. Juneau	107.6
1 PFT Clerk Typist III (Range 8A) 12 mos. Juneau	28.4
Sub-Total	198.4
200 Travel	
OUTSIDE	
3 Trips to other States with Model Programs x 2 People	9.3
1 Trip x 2 People to Region X HCFA (Medicaid) - Seattle	1.5
1 Trip x 1 Person to Medicaid Waiver National Conference	1.6
ALASKA	
4 Trips to Anchorage x 3 People	1.6
1 Trip to Fairbanks x 3 People	1.8
1 Trip to Rural Site x 1 Person	1.0
Sub-Total	16.8
300 Contractual	
DMA	
Office Space 400 sq. ft. x 4 x $1.70/sq. ft. x 12	32.6
Other Contractual	
Risk Management, telephone, etc. 5.0 x 4	20.0
FOCUS: National Association of State Units on Aging (NASUA) computerized projection of functional disabilities of adults based on the 1980 census detail tapes of the Census Bureau. Purchase entitles the State to the software which can produce updates after the 1990 census.	6.0
RSA's	
Older Alaskans Commission	143.9
Governor's Council for Handicapped and Gifted (See separate fiscal notes)	235.0
Sub-Total	437.5
400 Supplies 1.5 x 4	6.0
Sub-Total	6.0
500 Equipment	
Microcomputer hardware and software 4.0 x 4	16.0
Desks, chairs, etc. 1.5 x 4	6.0
Sub-Total	22.0
FY91 OPERATING TOTAL	680.7

Department of Health and
Social Services
January 12, 1990

Division of
Medical Assistance

Detail of Fiscal Note on SB 334

FY92
OPERATING

100	Personal Services	
	1 PFT Health Planner III (Range 21C) 12 mos. Juneau	63.6
	2 PFT Research Analyst III (Range 18D) 12 mos. Juneau	111.0
	1 PFT Clerk Typist III (Range 8B) 12 mos. Juneau	29.1
Sub-Total		203.7
200	Travel	
	OUTSIDE	
	1 Trip to Medicaid Waiver National Conference x 1 Person	1.8
	1 Trip to Region X HCFA x 3 Persons	2.2
	4 Trips to Anchorage x 3 Persons	1.6
	1 Trip to Fairbanks for 3 Persons	1.8
	2 Trips for Consultants 3-5 days x 2.0	4.0
Sub-Total		11.4
300	Contractual	
	DMA	
	Office Space	33.9
	Other Contractual	
	Risk Management, telephone, etc.	20.8
	Consultants for drafting and costing of waivers	
	20 days x $200/day =	4.0
	RSA's	
	Older Alaskans Commission	98.1
	Governor's Council for Handicapped and Gifted (see separate fiscal notes)	116.3
Sub-Total		273.1
400	Supplies 1.5 x 4	6.2
500	Equipment	
	Computer Software	.5
FY91 OPERATING TOTAL		494.9

Department of Health and
Social Services
January 12, 1990

Division of
Medical Assistance

Detail of Fiscal Note on SB 334

FY93
OPERATING

100	Personal Services	
	1 PFT Health Planner III (Range 21D) 12 mos. Juneau	66.2
	2 PFT Research Analyst III (Range 18E) 12 mos. Juneau	114.4
	1 PFT Clerk Typist III (Range 8C) 12 mos. Juneau	29.8
Sub-Total		210.4
200	Travel	
	OUTSIDE	
	1 Trip to Medicaid Waiver National Conference x 1 Person	1.6
	1 Trip to Region X HCFA x 2 Persons	1.5
	ALASKA	
	4 Trips to Anchorage x 3 Persons	1.6
Sub-Total		4.7
300	Contractual	
	DMA	
	Office Space	35.2
	Other Contractual	
	Risk Management, telephone, etc.	21.6
	RSA's	
	Older Alaskans Commission	95.9
	Governor's Council for Handicapped and Gifted (see separate fiscal notes)	100.9
Sub-Total		253.6
400	Supplies 1.5 x 4	6.4
500	Equipment	
	Computer Software	.5
FY91 OPERATING TOTAL		475.6

Department of Health and
Social Services
January 12, 1990

Division of
Medical Assistance

Detail of Fiscal Note on SB 334

FY 94
OPERATING

100	Personal Services	
	1PFT Health Planner 111 (Range 21E)	68.1
	2PFT Research Analyst 111 (Range 18F)	118.4
	1PFT Clerk Typist 111 (Range 8D)	30.6
Sub-Total		217.1
200	Travel	
	OUTSIDE	
	1 trip to Medicaid Waiver National Conference x 1 person	1.6
	1 trip to Region X HCFA x 2 persons	1.5
	ALASKA	
	4 trips to Anchorage x 1 person	2.2
Sub-Total		5.3
300	Contractual	
	DMA	
	Office Space	36.6
	Other Contractual	
	Risk Management, Telephones, etc.	22.5
Sub-Total		59.1
400	Supplies	6.7
500	Equipment	0.0
FY 94 OPERATING TOTAL		288.2

Senator Rick Uehling

Downtown, Elmendorf, Northeast Anchorage

Co-Chairman, Senate Finance Committee
International Trade & Tourism Committee
State Affairs Committee

MEMORANDUM

TO: Senator Paul Fischer
Chair, Senate HESS Committee

FROM: Senator Rick Uehling

DATE: January 8, 1990

RE: **The Home Care Initiative,**

SB 344: "An Act directing the Department of Health and Social Services to seek permission to use options and receive waivers under the Medicaid program for the cost of home or community-based services for developmentally delayed children, developmentally disabled persons, disabled adults, and older Alaskans; directing other agencies to assist in that process; and providing for an effective date."

I have asked staff to provide the following background and analysis to SB 334, which has been referred to the Health, Education and Social Services Committee. At this time, I respectfully request that this bill be scheduled for hearing.

Senate Bill 334 directs the Department of Health and Social Services to apply for federal approval to modify Alaska's medicaid program to allow for home care services for medicaid eligible Alaskans.

Attachment

P.O. BOX V, JUNEAU, AK 99811 (907) 465-4821 • 3111 ST. #515, ANCHORAGE, AK 99503 (907) 561-7613

Senator Rick Uehling

Downtown, Elmendorf, Northeast Anchorage

Co-Chairman, Senate Finance Committee
International Trade & Tourism Committee
State Affairs Committee

BILL SUMMARY

SB 334

"AN ACT DIRECTING THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES ... TO SEEK ... WAIVERS UNDER THE MEDICAID PROGRAM"

This bill directs DHSS to apply for federal approval to modify Alaska's medicaid program to allow for home care in place of institutional care.

Alaska's current medicaid program does not provide home care benefits for those patients who qualify for institutional care. This program if adopted will allow Alaskans who qualify for medicaid to choose home care rather than institutional care.

Home care can provide many benefits. The federal program caps the cost of home care so that it cannot exceed the cost of institutional care. In many cases the home care alternative will save the state money. In addition, for certain patients the recovery process is more rapid when the patient is in a home environment, supported by family.

The bill works by requiring DHSS, the Older Alaskans Commission, and the Governor's Council for the Handicapped and Gifted to survey client needs and to coordinate the list of potential home care services. DHSS will then serve as the lead agency to prepare an application to the federal government to modify Alaska's medicaid program to include home care services.

Alaskans who benefit from this legislation include senior citizens, parents of disabled children, disabled adults, and Alaskans experiencing a developmental disability.

P.O. BOX V, JUNEAU, AK [illegible] 99503 (907) 561-7613

Bill Summary

Uehling

SECTIONAL ANALYSIS
SENATE BILL 334

The following is a sectional analysis of SB 334, a bill which directs the Department of Health and Social Services to seek approval for certain options and waivers under the federal medicaid program.

In general, the bill requires DHSS to coordinate the application with information obtained from the Older Alaskans Commission and the Governor's Council on Gifted and Handicapped.

Section 1

Subsection (a-b) provides a descriptive basis for mandating a medicaid operated home care program.

Subsection (c) names the Department of Health and Social Services as the lead agency for preparing the federal application after taking into consideration priorities recommended by the Older Alaskans Commission and the Governors Council for the Handicapped and Gifted.

Section 2

Subsection (a) describes preliminary research activities to be conducted by the Governor's Council for the Handicapped and Gifted, and the Older Alaskans Commission.

Subsection (b) sets June 1, 1991 as the deadline for the submission of a written report to DHSS and the Legislature to detail the results of the activities in Subsection (a) above.

Section 3

Subsection (a) directs the Department of Health and Social Services to submit a report to the Legislature by January 15, 1992 which estimates the cost of implementing particular options and waivers for which it plans to seek approval from the federal government under this Act.

Subsection (b) defines the costs to be used by the administration in preparing the fiscal note for this bill as those necessary for the researching, writing, negotiating and obtaining approval of the application to the federal government and the costs of preparing the fiscal analysis under this section.

Section 4 provides for Legislative review of the applications for options and waivers prior to submission by the Department of Health and Social Services. This section also directs DHSS to consult with the Governor's Council for the Handicapped and Gifted and the Older Alaskans Commission during the preparation of the applications.

Section 5 requires the Department of Health and Social Services, the Governor's Council for the Handicapped and Gifted, and the Older Alaskans Commission to prepare an interagency agreement for carrying out this Act.

Section 6 sets out the definitions in this Act for "developmentally delayed children", developmentally disabled person", "disabled adult", and "older Alaskans".

Section 7 names the effective date of this act as July 1, 1990.

this subchapter) can obtain medical care services (other than in emergency circumstances), if such restriction does not substantially impair access to such services of adequate quality where medically necessary,

(2) to allow a locality to act as a central broker in assisting individuals (eligible for medical assistance under this subchapter) in selecting among competing health care plans, if such restriction does not substantially impair access to services of adequate quality where medically necessary,

(3) to share (through provision of additional services) with recipients of medical assistance under the State plan cost savings resulting from use by the recipient of more cost-effective medical care, and

(4) to restrict the provider from (or through) whom an individual (eligible for medical assistance under this subchapter) can obtain services (other than in emergency circumstances) to providers or practitioners who undertake to provide such services and who meet, accept, and comply with the reimbursement, quality, and utilization standards under the State plan, which standards are consistent with access, quality, and efficient and economic provision of covered care and services, if such restriction does not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services.

(c) Waiver respecting medical assistance requirement in State plan; scope, etc.

(1) The Secretary may by waiver provide that a State plan approved under this subchapter may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) the State will provide, with respect to individuals who—

(i) are entitled to medical assistance for skilled nursing facility or intermediate care facility services under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based care under such waiver,

for an evaluation of the need for such skilled nursing facility or intermediate care facility services;

(C) such individuals who are determined to be likely to require the level of care provided in a skilled nursing facility or intermediate care facility are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of skilled nursing facility or intermediate care facility services;

(D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

(E) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1396a(a)(1) of this title (relating to statewideness) and section 1396a(a)(10) of this title. A waiver under this subsection shall be for an initial term of three years and, upon the request of a State, shall be extended for additional three-year periods unless the Secretary determines that for the previous three-year period the assurances provided under paragraph (2) have not been met.

(4) A waiver granted under this subsection may, consistent with paragraph (2)—

(A) limit the individuals provided benefits under such waiver to individuals with respect to whom the State . determined that there is a reasonable expectation that the amount of medical assistance provided with respect to the individual under such waiver will not exceed the amount of such medical assistance provided for such individual if the waiver did not apply, and

(B) provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve.

(d) Period of waivers; continuations

No waiver under this section (other than a waiver under subsection (c) of this section) may extend over a period of longer than two years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary denies such request in writing within 90 days after the date of its submission to the Secretary.

(e) Monitor of implementation of waivers; termination of waiver for noncompliance; report

(1) The Secretary shall monitor the implementation of waivers granted under this section to assure that the requirements for such waiver are being met and shall, after notice and opportunity for a hearing, terminate any such waiver where he finds noncompliance has occurred.

(2) The Secretary shall report, not later than September 30, 1984, to Congress on waivers granted under this section.

(f) Time limitation for action on requests for plan approval, amendments, or waivers

A request to the Secretary from a State for approval of a proposed State plan or plan amendment or a waiver of a requirement of this subchapter submitted by the State pursuant to a provision of this subchapter shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

(Aug. 14, 1935, c. 531, Title XIX, § 1915, as added Aug. 13, 1981, Pub.L. 97–35, Title XXI, § 2175(b), 95 Stat. 809, and amended Aug. 13, 1981, Pub.L. 97–35, Title XXI, §§ 2176, 2177(a), 95 Stat. 812, 813; Sept. 3, 1982, Pub.L. 97–248, Title I, § 137(b)(19)(A), (20)–(25), 96 Stat. 380; Jan. 12, 1983, Pub.L. 97–448, Title III, § 309(b)(17), 96 Stat. 2409.)

Historical Note

Codification. In the original of subsec. (c)(1), "this subchapter" read "this part". However, since this subchapter does not contain part designations but does contain provisions for approval of a State plan, "this part" was editorially translated as "this subchapter" as the probable intent of Congress.

1983 Amendment. Subsec. (c)(2)(B). Pub.L. 97–448 substituted in text following cl. (iii) "need for such skilled nursing facility or intermediate care facility services" for "need for such services".

1982 Amendment. Subsec. (b). Pub.L. 97–248, § 137(b)(19)(A), struck out "and section 1396b(m) of this title" following "section 1396a of this title".

Subsec. (b)(1). Pub.L. 97–248, § 137(b)(20), inserted "primary care" preceding "case-management system", and substituted "medical care services" for "primary care services".

Subsec. (c)(1). Pub.L. 97–248, § 137(b)(21), inserted "payment for part or all of the cost of" following "may include as 'medical assistance' under such plan".

Subsec. (c)(2)(B). Pub.L. 97–248, § 137(b)(22), redesignated existing provisions as cls. (i) and (ii), and added cl. (iii).

Subsec. (c)(3). Pub.L. 97–248, § 137(b)(23), substituted "section 1396a(a)(1) of this title" for "subsection (a)(1) of this section" and "section 1396a(a)(10)" for "subsection (a)(10) of section 1396a".

Subsec. (c)(4). Pub.L. 97–248, § 137(b)(24), substituted "subsection" for "section".

Subsec. (f). Pub.L. 97–248, § 137(b)(25), inserted "approval of" preceding "a proposed State plan".

1981 Amendment. Subsec. (e). Pub.L. 97–35, § 2176(2), added subsec. (e). Former subsec. (e) was redesignated (d).

Subsec. (d). Pub.L. 97–35, § 2176(1), (2), redesignated former subsec. (c) as (d), and in subsec. (d) as so redesignated inserted "(other than a waiver under subsection (e) of this section)".

(B) under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.

(b) Waivers to promote cost-effectiveness and efficiency

The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title as may be necessary for a State—

[See main volume for text of (1) to (4)]

No waiver under this subsection may restrict the choice of the individual in receiving services under section 1396d(a)(4)(C) of this title.

(c) Waiver respecting medical assistance requirement in State plan; scope, etc.; "habilitation services" defined; imposition of certain regulatory limits prohibited; computation of expenditures for certain disabled patients; coordinated services; substitution of participants

(1) The Secretary may by waiver provide that a State plan approved under this subchapter may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

[See main volume for text of (A)]

(B) the State will provide, with respect to individuals who—

(i) are entitled to medical assistance for inpatient hospital, skilled nursing facility, or intermediate care facility services under the State plan,

[See main volume for text of (ii) and (iii)]

for an evaluation of the need for such inpatient hospital, such skilled nursing facility or intermediate care facility services;

(C) such individuals who are determined to be likely to require the level of care provided in a hospital or skilled nursing facility or intermediate care facility are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of inpatient hospital services or skilled nursing facility or intermediate care facility services;

(D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

[See main volume for text of (E)]

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability), and section 1396a(a)(10)(C)(i)(I-II) of this title (relating to income and resource rules applicable in the community). A waiver under this subsection shall be for an initial term of three years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.

(4) A waiver granted under this subsection may, consistent with paragraph (2)—

[See main volume for text of (A)]

(B) provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.

(5) For purposes of paragraph (4)(B), the term "habilitation services", with respect to individuals who receive such services after discharge from a skilled nursing facility or intermediate care facility—

(A) means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings; and

(B) includes (except as provided in subparagraph (C)) prevocational, educational, and supported employment services; but

(C) does not include—

(i) special education and related services (as defined in section 1401(16), (17) of Title 20, which otherwise are available to the individual through a local educational agency; and

(ii) vocational rehabilitation services which otherwise are available to the individual through a program funded under section 730 of Title 29.

(6) The Secretary may not require, as a condition of approval of a waiver under this section under paragraph (2)(D), that the actual total expenditures for home and community-based services under the waiver (and a claim for Federal financial participation in expenditures for the services) cannot exceed the approved estimates for these services. The Secretary may not deny Federal financial payment with respect to services under such a waiver on the ground that, in order to comply with paragraph (2)(D), a State has failed to comply with such a requirement.

(7)(A) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with a particular illness or condition who are inpatients in, or who would require the level or care provided in, hospitals, or in skilled nursing or intermediate care facilities, the State may determine the average per capita expenditure that would have been made in a fiscal year for those individuals under the State plan separately from the expenditures for other individuals who are inpatients in, or who would require the level of care provided in, those respective facilities.

(B) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with developmental disabilities who are inpatients in a skilled nursing facility or intermediate care facility and whom the State has determined, on the basis of an evaluation under paragraph (2)(B), to need the level of services provided by an intermediate care facility for the mentally retarded, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals under the State plan on the basis of the average per capita expenditures under the State plan for services to individuals who are inpatients in an intermediate care facility for the mentally retarded, without regard to the availability of beds for such inpatients.

(8) The State agency administering the plan under this subchapter may, whenever appropriate, enter into cooperative arrangements with the State agency responsible for administering the program for children with special health care needs under subchapter V of this chapter in order to assure improved access to coordinated services to meet the needs of such children.

(9) In the case of any waiver under this subsection which contains a limit on the number of individuals who shall receive home or community-based services, the State may substitute additional individuals to receive such services to replace any individuals who die or become ineligible for services under the State plan.

(10) The Secretary shall not limit to fewer than 200 the number of individuals in the State who may receive home and community-based services under a waiver under this subsection.

(d) Home and community-based services for the elderly

(1) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this subchapter shall include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) which are provided pursuant to a written plan of care to individuals 65 years of age or older with respect to whom there has been a determination that but for the provision of such services the individuals would be likely to require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) with respect to individuals 65 years of age or older who—

(i) are entitled to medical assistance for skilled nursing or intermediate care facility services under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based services under such waiver,

the State will provide for an evaluation of the need for such skilled nursing facility or intermediate care facility services; and

(C) such individuals who are determined to be likely to require the level of care provided in a skilled nursing facility or intermediate care facility are informed of the feasible alternatives to the provision of skilled nursing facility or intermediate care facility services, which such individuals may choose if available under the waiver.

Each State with a waiver under this subsection shall provide to the Secretary annually, consistent with a reasonable data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability), and section 1396a(a)(10)(C)(i)(III) of this title (relating to income and resource rules applicable in the community). Subject to a termination by the State (with notice to the Secretary) at any time, a waiver under this subsection shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under the waiver, that the maximum amount of the individual's income which may be disregarded for any month is equal to the amount that may be allowed for that purpose under a waiver under subsection (c) of this section.

(4) A waiver under this subsection may, consistent with paragraph (2), provide medical assistance to individuals for case management services, homemaker/home health aide services and personal care services, adult day health services, respite care, and other medical and social services that can contribute to the health and well-being of individuals and their ability to reside in a community-based care setting.

(5)(A) In the case of a State having a waiver approved under this subsection, notwithstanding any other provision of section 1396b of this title to the contrary, the total amount expended by the State for medical assistance with respect to skilled nursing facility services, intermediate care facility services, and home and communi-

ty-based services under the State plan for individuals 65 years of age or older during a waiver year under this subsection may not exceed the projected amount determined under subparagraph (B).

(B) For purposes of subparagraph (A), the projected amount under this subparagraph is the sum of the following:

(i) The aggregate amount of the State's medical assistance under this subchapter for skilled nursing facility services and intermediate care facility services furnished to individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of—

(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the beginning of the base year and the beginning of the waiver year involved, plus

(II) the percentage increase between the beginning of the base year and the beginning of the waiver year involved in the number of residents in the State who have attained the age of 65, plus

(III) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(ii) The aggregate amount of the State's medical assistance under this subchapter for home and community-based services for individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of—

(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the beginning of the base year and the beginning of the waiver year involved, plus

(II) the percentage increase between the beginning of the base year and the beginning of the waiver year involved in the number of residents in the State who have attained the age of 65, plus

(III) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(iii) The Secretary shall develop and promulgate by regulation (by not later than October 1, 1989)—

(I) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise both skilled nursing facility services and intermediate care facility services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (i)(I);

(II) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise home and community-based services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (ii)(I); and

(III) a method for projecting, on a State specific basis, the percentage increase in the number of residents in each State who are over 65 years of age for any period.

The Secretary shall develop (by not later than October 1, 1989) a method for projecting, on a State-specific basis, the percentage increase in the number of residents in each State who are over 75 years of age for any period. Effective on and after the date the Secretary promulgates the regulation under clause (iii), any reference in this subparagraph to the "lesser of 7 percent" shall be deemed to be a reference to the "greater of 7 percent".

(iv) If there is enacted after December 22, 1987, an Act which amends this title and which results in an increase in the aggregate amount of medical assistance under this title for nursing facility services and home and community-based services for individuals who have attained the age of 65 years, the Secretary, at the request of a State with a waiver under this subsection for a waiver year or years and in close consultation with the State, shall adjust the

projected amount computed under this subparagraph for the waiver year or years to take into account such increase.

(C) In this paragraph:

(i) The term "home and community-based services" includes services described in sections 1395d(a)(7) of this title and 1395d(a)(8) of this title, services described in subsection (c)(4)(B) of this section, services described in paragraph (4), and personal care services.

(ii)(I) Subject to subclause (II), the term "base year" means the most recent year (ending before December 22, 1987) for which actual final expenditures under this subchapter have been reported to, and accepted by, the Secretary.

(II) For purposes of subparagraph (C), in the case of a State that does not report expenditures on the basis of the age categories described in such subparagraph for a year ending before December 22, 1987, the term "base year" means fiscal year 1989.

(iii) The term "intermediate care facility services" does not include services furnished in an institution certified in accordance with section 1395d(d) of this title.

(6)(A) A determination by the Secretary to deny a request for a waiver (or extension of waiver) under this subsection shall be subject to review to the extent provided under section 1316(b) of this title.

(B) Notwithstanding any other provision of this chapter, if the Secretary denies a request of the State for an extension of a waiver under this subsection, any waiver under this subsection in effect on the date such request is made shall remain in effect for a period of not less than 90 days after the date on which the Secretary denies such request (or, if the State seeks review of such determination in accordance with subparagraph (A), the date on which a final determination is made with respect to such review).

(e) Waiver for children infected with AIDS or drug dependent at birth

(1)(A) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this subchapter shall include as "medical assistance" under such plan payment for part or all of the cost of nursing care, respite care, physicians' services, prescribed drugs, medical devices and supplies, transportation services, and such other services requested by the State as the Secretary may approve which are provided pursuant to a written plan of care to a child described in subparagraph (B) with respect to whom there has been a determination that but for the provision of such services the infants would be likely to require the level of care provided in a hospital or nursing facility the cost of which could be reimbursed under the State plan.

(B) Children described in this subparagraph are individuals under 5 years of age who—

(i) at the time of birth were infected with (or tested positively for) the etiologic agent for acquired immune deficiency syndrome (AIDS),

(ii) have such syndrome, or

(iii) at the time of birth were dependent on heroin, cocaine, or phencyclidine,

and with respect to whom adoption or foster care assistance is (or will be) made available under part E of subchapter IV.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

Home Care
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POSITION PAPER
ON SENATE BILL 334

Senate Bill 334, the Home Care Bill, will commit the State to a two year process of planning and applying for federal Medicaid programs to pay for home and community based support services for the elderly, and disabled adults and children who need such services to avoid placement in nursing homes or other institutions.

Alaska is almost the only state that does not now use Medicaid dollars for home care programs for functionally disabled citizens. Many states use a combination of Medicaid "optional services" and a Home Care "Waiver" to complete the continuum of care available to persons with disabilities.

Although institutional care will always be needed for some clients, a range of "home and community care" Medicaid programs can be used by the state to provide less costly and higher quality-of-life alternatives to nursing homes for many people. Home care optional services assist family caregivers to extend the time when a frail senior or other disabled family member can stay at home, or avoid nursing home placement altogether.

Over thirty other states now use Medicaid to augment medical care for the elderly with "social" services to support home or community care. These include services such as adult day care, in-home respite care, hospice care, homemaker and home health service, case management, and adult foster care.

Older Alaskans have very limited or no access to these types of services; only a few of these options are available through OAC services to the elderly, and only in a few towns. What services do exist are fragmented, provided by six different state agencies (or their local contractors), and there is no one entry point to home care, nor any one person who allocates the care resources among those in need or helps to coordinate the different services to make an overall effective care package for the family and client. When a person is 85, frail, ill, and home-bound, dealing with six bureaucracies is an overwhelming burden--perhaps the most important optional Medicaid service Alaska could start would be managed care, or "case management" of home service for the most frail and disabled.

SB 334 authorizes the OAC and the Governor's Council for the Handicapped and Gifted to each conduct a year of research into the needs of their populations, and by June, 1991 to issue a report recommending the best combination of Medicaid services for the populations each represents.

The Medical Assistance Division of the Department of Health and Social Services is mandated by SB 334 to respond to the OAC and GCHG reports with cost studies and its own recommendations for the 1992 Legislature. If the 1992 Legislature approves the plans, the State would submit applications to the federal Medical agency by late 1992. Services would be phased in, starting in 1993.

SB 334 instructs the three agencies, Medical Assistance, OAC, and the GCHG to coordinate their work through an inter-agency committee. The three agencies are already planning a "team" approach to this multi-year project, and have tried to coordinate their fiscal notes in such a way as to use one-half federal Medicaid dollars to fund the project.

The Older Alaskans Commission strongly endorses SB 334. Alaska must seek all available federal dollars to help fill the serious gaps in Alaska's "continuum" of care for the elderly and disabled. Although the Medicaid programs will not serve all seniors, a base of Medicaid dollars to fund home and community services would free other state resources for similar services to moderate income, at-risk elderly living at home.

Although Alaska earlier made bold initiatives to set up Pioneers' Homes and the Longevity Bonus to assist seniors who wish to stay in the state, Alaska has not kept up with the state-of-the-art in elder (or disabled) care in other states. As a state, Alaska has not yet responded to the strong desire of seniors to stay at home as long as possible--a desire repeated in every senior survey and demonstrated by the current ages of admission to the Pioneers' Homes, where the average age upon entry is over 80.

Many, many Alaskan seniors are looking for a reassurance that home care or community assistance will be there when they need it. In addition to the Older Alaskans Commission endorsement of this bill, the Legislature will find support from the Alaska chapter of the American Association of Retired Persons and the Older Persons Action Group. The OAC is also sure that most local senior groups will support this bill, as the Commission is constantly informed by seniors throughout the state of the pressing need for home and community care.

MEDICAL CARE

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MEDICAID: MEDICAL ASSISTANCE PROGRAM

Purpose

This program (often referred to as "Title 19" because of its authorizing legislation) provides federal financial assistance to states for medical services furnished on behalf of public assistance recipients and, in some states, on behalf of other medically needy persons who, except for income and resources, would be eligible for cash assistance. The federal matching rate varies by state and is determined under a complex formula geared to state per capita personal income. The federal share of program costs ranges from 50% to 80% (new matching rates for federal FY 1989-90 were issued by HCFA on October 27, 1988). The Medicaid program is administered by a state's "single state agency," and the agency must operate under a Medicaid state plan approved by the Secretary of the Department of Health and Human Services and comply with all federal regulations governing aid and medical assistance to the needy.

Eligibility

There are numerous categories of persons who are eligible for Medicaid. Federal law mandates that states must serve some categories of persons. Other categories of persons are eligible for Medicaid at state option and if they are listed in the state Medicaid plan. In some cases, if a state opts to include certain optional categories of persons in their Medicaid plan there are federal requirements that restrict the eligibility of those groups. Overall, the federal Medicaid statute encompasses a wide-range of eligibility options aimed at the extension of Medicaid services to children with severe disabilities who are members of low-income households or who have had financial deeming requirements waivered. Careful review of each state's Medicaid state plan is necessary to determine the range of eligible groups that are covered in a particular state and, consequently, the role Medicaid benefits might play in meeting the needs of such children.

The following pages describe the mandatory and optional eligibility groups.

This section was prepared with the assistance of Kathleen Blume of the Health Care Financing Administration; Gary Smith of NASMRPD; and Harriet Fox of Fox Health Policy Consultants

MANDATORY COVERAGE

AFDC Recipients

All persons who are recipients of payments under the Aid to Families with Dependent Children (AFDC) program are automatically eligible for Medicaid benefits (referred to as "categorically" eligible). Generally, the regular AFDC cash assistance program extends eligibility to children under age 18 (or 19 at state option) "where the child is deprived of the support of at least one parent (i.e., at least one parent is dead, disabled, continually absent from the house, or, in some states unemployed)" (Congressional Research Service, 1988) and who have caretakers with very low income. Family composition and financial eligibility standards for AFDC payments vary from state-to-state.

Adopted or foster care children receiving cash assistance under Title IV-E of the Social Security Act are considered to be AFDC recipients for purposes of the Medicaid program and are eligible for benefits.

"Qualified" Pregnant Women and Children

Pregnant women and children up to age 7 (or age 8 at state option) who meet the financial requirements of the state AFDC plan (or would be eligible for AFDC if the state AFDC plan included an unemployed parent program) are required to be covered by the state Medicaid plan. These groups, referred to as "qualified" eligibles, who meet AFDC financial requirements, do not have to meet family composition or "deprivation" requirements. At state OPTION, this coverage can be extended to children up to ages 18 through 21. (These recipients are referred to as Ribicoff children after the Senator who sponsored this legislation).

Poverty Related Pregnant Women and Children

Effective July 1989, all pregnant women and infants (up to age 1) whose family income is up to 100% of the federal poverty level ($9,690/year for a family of three in 1988) are eligible for benefits. Pregnant women are eligible only for pregnancy related Medicaid services and the infants are eligible for all Medicaid services available under the state plan. (This provision will be phased-in through July 1990).

SSI

In all but 13 states, all children (including adopted children) and other aged, blind, and persons with disabilities who receive cash payments under the federal Supplementary Security Income (SSI) program are also eligible for Medicaid. The remaining 13, states referred to as "209(b)" states, may choose to limit Medicaid eligibility to individuals who meet requirements that are more restrictive than those for SSI. The thirteen states are: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, and Virginia.

When determining whether a child with handicaps is eligible to receive SSI, federal law requires that a certain portion of the family's income be "deemed" available to the child. This excludes many children in low to moderate income households from receiving SSI and Medicaid. However, if a child is institutionalized a full calendar month, the parent's income is not counted in determining SSI eligibility and resultant Medicaid eligibility. As a consequence, federal policies are often criticized as creating a bias toward out-of-home placement rather than supporting families.

OPTIONAL COVERAGE

Children Receiving State Supplements

States may provide supplemented payments to SSI recipients and persons with income in excess of SSI income standards. States have the option to extend Medicaid eligibility to children receiving the Supplemental payment. The income limits to receive a state supplemental payment vary by state.

Medically Needy

This refers to individuals and families who do not meet the financial eligibility limits for AFDC, SSI or state supplement, but who lack the resources to pay for their medical bills (usually because of inadequate private health insurance). In such instances, a individuals must "spend down" income for medical expenses until countable income falls to a level specified by the state. "Medically needy" individuals must satisfy special income and resource limits set in the state's Medicaid plan. Federal regulations require that a state set its medically needy income standards no higher than 133% of its AFDC payment standard. AFDC income limits and "medically needy" income limitations vary by state. In 1987, medically needy levels for a family of four varied from $267 in Tennessee to $1,009 in California. Thirty-six states currently operate medically needy programs. The numbers of persons served by a medically needy program vary widely and are dependent upon the level of the state AFDC payment (Fox & Yoshpe, 1987b).

Foster and Adoptive Children

This includes all foster care and adoptive children who have incomes and resources within certain prescribed limits and, who were placed by the state, but were not eligible for AFDC cash assistance prior to placement.

Pregnant Women and Children

This options includes all pregnant women and infants up to age one, whose family income is under a state established threshold that does not exceed 185% of the federal poverty level, and incrementally on an annual basis to children up to age 8 whose family income does not exceed 100% of the federal poverty level. Additionally, states may: omit testing for assets or resources (i.e. only test for income); use the more relaxed resource tests used by the SSI program; and/or disregard changes in income once a pregnant woman is determined to be eligible. Low income pregnant women and young children are not required to meet the family standards, other categorical criteria, or financial criteria of AFDC. Also, pregnant women and infants with family income above 150 percent (and up to 185%) of the poverty level, can at state option, be charged a monthly premium. This premium cannot exceed 10 percent of their gross income, less child care expense.

Waiver Recipients

States can opt to provide all Medicaid services to all persons with disabilities who meet the SSI disability criteria and who are receiving services through an approved home and community-based waiver or through a model waiver program.

Services covered

All states are required to provide the following Medicaid funded services:

* in and out-patient hospitalization;
* laboratory and X-ray;
* skilled nursing home for persons over age 21;
* home health services for persons over age 21;
* rural health clinic services;
* nurse midwife services in those states where midwifery is licensed or allowed by law;
* family planning;
* physician; and
* early and periodic screening, diagnosis and treatment (EPSDT) for children under age 21 (see below).

A state may also cover a wide variety of up to 32 optional service categories at its discretion, (e.g., preventive and rehabilitative services; home care or nursing care; home and community-based waivers; medical equipment and appliances; private duty nursing; home respiratory care services; and case management). States have wide latitude to limit the "frequency, scope, and duration" of Medicaid-covered services (e.g., by limiting the number of physician visits that will be reimbursed). Services under Medicaid except for home and community-based waivers and targeted case management must meet criteria of a "statewideness and comparability" (meaning that services must be equally available and of equal scope across all groups of Medicaid eligible). In most of these areas the state sets the standards for services. States also have broad flexibility in determining payment rates for covered services. Some states have elected to provide comprehensive and often unlimited coverage for all, o nearly all, of the federally allowed Medicaid services, while other states provide more limited benefits and may exclude extended home care, speech and occupational therapies. Moreover, a state can opt to exclude "medically needy" eligibles from optional Medicaid benefits. If a state offers home care they are required to provide nursing visits, medical equipment and supplies. Cost reimbursement methods (e.g., capitation through prepaid health plans) will affect the amount of reimbursement for care.

Of special interest is the fact that every state must provide EPSDT services to Medicaid eligible children under age 21. The Congressional Research Service (1988) describes this program.

> The EPSDT program is designed to assure the availability and accessibility of required health resources and to help eligible children use them effectively. Under EPSDT, states are required not only to finance services, but also to conduct outreach activities that link Medicaid-eligible children with providers. Each state's Medicaid program must (1) inform all eligible children about EPSDT services, (2) provide screening and diagnostic services, and (3) provide treatment to correct or ameliorate any discovered health problems.
>
> Each state must provide, at a minimum, the following EPSDT services: assessments of health, developmental, and nutritional status; unclothed physical examinations; immunizations appropriate for age and health history; appropriate vision, hearing, and dental services found necessary by the screening....
>
> States are permitted to provide services to children under EPSDT even if they are otherwise not available, or available on a limited basis, to other Medicaid beneficiaries (e.g., vision, hearing, and dental services that may not otherwise be available from that state's Medicaid program). (p. 322)

This enables a state to target an enriched array of services to children without risking financial exposure in the remainder of its program.

The Omnibus Reconciliation Act of 1986 (OBRA '86) also authorized state Medicaid coverage of at-home respiratory care services to ventilator-dependent individuals. Individuals must be medically dependent on a ventilator for life support at least six hours per day, and require inpatient respiratory care for which Medicaid would pay, if home respiratory care services were not available. The coverage permits a state to serve Medicaid eligible ventilator-dependent children at home without having to utilize a "2176" home and community based waiver (see the following).

The myriad of service options a state may elect under federal law as well as the special limitations a state may impose on covered services render it practically impossible to draw general conclusions about coverage, independent of each state's program. A careful review of a state Medicaid plan is required to determine the scope of service coverages and their potential applicability to furnishing home services to children with disabilities.

RECENT LEGISLATIVE CHANGES

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

Purpose

TEFRA allows states to amend their Medicaid state plans to provide regular Medicaid services (but not non-medical support services) to *all* children with disabilities under age 19 living at home, who because of SSI income eligibility rules, (i.e., the undeeming of parental income) would be Medicaid eligible only if institutionalized. Relevant statutory provisions are contained in Section 1902(e)(3) of the Social Security Act. "TEFRA 134" coverage represented one outgrowth of the so-called "Katie Beckett" waiver program.

Eligibility

The individual must both meet the usual categorical criteria for disability under the SSI program and must require the level of care provided in a hospital, ICF, ICF/MR, or SNF. The state must ascertain for each child that home care is appropriate, and that the cost of this care does not exceed the cost for institutional care. Unlike the "waiver" program, this state option requires the state to cover *all* children with disabilities who meet the criteria on a statewide basis, whether or not they are institutionalized. The number of children that the amendment will actually affect depends on the restrictiveness of the state's interpretation of requirements of institutional care. States are free to develop their own implementing rules and to discontinue coverage for this group at any time.

Services Provided

Persons made eligible under the TEFRA state plan amendment are eligible for all Medicaid services provided by the state comprehensiveness plan. The amount and types of care available to the children depends on the of the state's Medicaid program and the willingness of states to expand Medicaid options. TEFRA does not provide authorization to furnish alternative or other optional Medicaid services. To offer such services, a state could seek approval for a Medicaid waiver (discussed later in this report). A Medicaid waiver can be operated in conjunction with a TEFRA amendment.

State Participation

As of 1988, only 22 states have amended their state Medicaid plans to add the TEFRA-134 coverage option. The reluctance of the majority of states to select this eligibility option reflects wariness concerning the costs of adding a new entitled service population (Allan Bergman, UCPA, personal communication).

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA '85)

This act added a new section to the Social Security Act under which states were authorized to cover targeted case management as an optional service under their Medicaid plan. Case management is defined as services that will assist eligible individuals "in gaining access to needed medical, social, educational, and other services." Once such services are approved for coverage in a state's plan, federal financial participation in the cost of targeted case management services is made available at the state's regular federal assistance percentage. Case management can be targeted to specific populations without having to meet Medicaid "statewideness" or comparability provisions. The group may be identified by age, type or degree of disability, illness or condition "or other identifiable characteristic or combination thereof."

Medicare Catastrophic Coverage Act of 1988

The Congressional Research Service (1988) reports:

> The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) provides that state Medicaid plans which impose day limits on payments for inpatient hospital services must establish exceptions to those limits for medically necessary inpatient services for infants (up to age 1) in hospitals which serve a disproportionate share of low-income patients,... These changes have the practical effect of increasing compensation for the treatment of premature infants, infants with acquired immunodeficiency syndrome (AIDs), and other disabled infants in hospitals located in states with Medicaid programs that impose durational limits. (p. 330)

Omnibus Budget Reconciliation Act of 1988 (OBRA 1988)

As of January 1988, all residents of federally funded nursing homes who have mental retardation or developmental disabilities must be screened to determine if they require 24 hour nursing care. By 1990 alternative appropriate arrangements must be made for residents who do not require such care. States must also screen all new admissions by January 1989 and cannot admit an individual to a nursing home unless s/he has been determined to require the level of care provided by the nursing home (Bergman, 1988c).

MEDICAID: WAIVER PROGRAMS

HOME AND COMMUNITY BASED WAIVER

Purpose

This program (sometimes referred to as "2176 waivers" based on its authorizing statute) enables states to finance a variety of home and community based, non-medical support services not usually covered by Medicaid for recipients who would otherwise need more costly institutional care. Unlike service options available within the state Medicaid plan, coverage of home and community-based (HCB) services under the waiver requires the submission of a special application to HCFA. Once approved, waivers are effective for a three year period and can be renewed for a five year period. In its application, a state must designate which types of services it wishes to cover, how the services are to be covered, the target populations for the services, eligibility requirements, and other assurances. There is no limit on the number of waivers that can be granted to a state. The federal share of the program ranges from 50% to 80% depending on the state federal Medicaid assistance percentage.

Eligibility

The Task Force on Technology Dependent Children (1987) provides the following discussion:

> Eligibility is limited to Medicaid recipients who, in the absence of HCB services, would require long term care in a hospital, skilled nursing facility, or ICF/MR. States may restrict eligibility for waiver participation to recipients residing in certain geographic areas in the state; to individuals being deinstitutionalized; or to particular individuals for whom the Medicaid cost of providing HCB services is less than the cost of providing institutional care. States may expand income eligibility for the target population in two ways: 1) by not deeming a certain portion of the family's income to be available to the individual receiving care at home; or 2) by raising the Medicaid income limit to a level equal to three times the maximum payment made to an individual under the SSI program... [This is referred to as the "300%" rule.] Individuals becoming eligible under this higher income standard are required to contribute to the cost of their care. (Task Force, 1987, p.102)

Substantial portions of this section were prepared by Gary Smith of the National Association of State Mental Retardation Program Directors.

The "300% rule" may be used for persons who, because of excess income, are not eligible for SSI; would be eligible for Medicaid if institutionalized; and will receive the HCB services. A state may employ the 300% rule (or a variation thereof) only to the extent it applies a similar standard to determine eligibility for institutionally-based services, (i.e. income levels for waiver services can be no more generous than for institutional services). The SSI payment for a couple in June 1989 is $553 per month. The 300% rule therefore allows eligibility for a couple with income up to $1,659 per month.

Unlike a TEFRA state Medicaid plan amendment, a waiver (both the 2176 "regular" waiver and the "model" waiver described next) permits a state to limit the waiver of the deeming of a portion of a family's income to a discrete population.

Services provided

States may provide services under the Home and Community Based Waiver that are otherwise not covered by Medicaid, such as homemaker, respite care, personal care services, minor home modifications, non-medical transportation, emergency response systems, family consultation, habilitation and supported employment programs, as well as augmented regular Medicaid services, (i.e., beyond the extent, scope, and duration of the states Medicaid services) such as hourly shift nursing, personal care, medical supplies, durable medical equipment, and other services as approved. Under a waiver, a state may relax limits established for regular state plan services when such services are furnished to a waiver recipient; a state is not required to meet medicaid "statewideness" or "comparability" requirements; and a state may authorize Medicaid services it does not cover under the state plan. Where it can be shown to be cost effective, the waiver may also be used to pay for an individual's private insurance premiums. Recent amendments to the waiver include employment related services and supported employment as allowable HCB services.

Restrictions on Waiver Programs

In adopting Section (1915)(c) of the Social Security Act, Congress mandated that a state must demonstrate that the average annual per capita costs of HCB waiver services would not exceed the average costs of institutional services (e.g., ICF/MR, hospital, or nursing home payments) that would otherwise be furnished to waiver recipients. In its implementing regulations for Section 1915(c), the Health Care Financing Administration (HCFA) promulgated a complex formula, designed to assure that a state's proposed HCB waiver program was cost-effective. The essence of this formula is that, in order to gain HCFA's approval of its HCB waiver application, a state must demonstrate that spending on long-term care services (HCB waiver and institutional services) while a waiver is in effect will not exceed expenditures that would have occurred in the absence of a waiver program.

HCFA provisions permit a state to develop waivers specific to individuals with specific conditions and gauge cost-effectiveness against the costs of institutional services furnished to this subset of clients. Hence, in targeting waiver services to

ventilator dependent children the costs of furnishing hospital-based services to such children may be employed rather than the average costs of all hospital services.

In practice, HCFA requires that a state demonstrate that: (a) not only will long-term care per capita expenditures under a waiver not exceed those projected to occur in the absence of offering waiver services, but also that (b) the number of persons receiving long-term care services in a state will be no greater as a result of offering waiver services. HCFA's waiver request/renewal process includes considerable negotiation concerning projected long-term care caseloads. In the end, the projected caseload constitutes a "cap" on a state's utilization of long-term care services on behalf of the target population. If, with a waiver, a state failed to effect a reduction in long term hospitalization, HCFA would question the effectiveness of the program.

As a consequence, the HCB waiver program is an anomaly among Medicaid-reimbursable services. Whereas for other services, a state may not overtly limit provision of services to a fixed number of recipients, a state must do so in its HCB waiver program. Consequently, an HCB waiver program is not immediately expandable due to increased recipient demand. Federal review criteria also place a large premium on the deactivation of state institutional beds in order to expand waiver services. Finally, the HCFA formula itself creates a substantial financial disincentive to offering lower cost services to waiver recipients. The waiver formula does not permit states to realize the savings of offering lower cost services and then to offer these savings to new persons. Therefore states tend to develop waivers for relatively higher cost services, thereby obtaining more federal dollars, rather than opting to offer the less expensive in-home services. This a key factor behind explaining why in-home services typically do not command a significant share of HCB waiver spending in most states.

State Participation

Presently 39 states operate HCFA-approved HCB waiver programs targeted to serving persons with developmental disabilities. The scope and range of services offered under these programs varies enormously. As a consequence, determining whether services are available under a state's waiver program that could play a role in meeting the needs of children at home requires an examination of the particular state's waiver program provision.

MODEL WAIVERS

Purpose

The so-called "Model Waiver" option was developed by HCFA to create a streamlined process for a state to offer home and community-based services (under Section 1915(c) of the Social Security Act) to a relatively small number of individuals. This program was intended to replace the case-by-case waiver requests that emerged as an outgrowth of the "Katie Beckett" case which allowed states to redeploy Medicaid funds for inpatient services to the support of in-home services. However, the "Model Waiver" program establishes no special opportunities to initiate home services for children with severe disabilities apart from generalized statutory authority governing the home and community-based waiver program. Structurally, there is no substantive difference between the model and the "2176" waiver program. The chief distinguishing characteristic of "Model Waiver" programs has been their size and the types of services/individuals states typically target. The model waiver represents an opportunity for a state to more discretely target waiver services to a participating client subpopulations (e.g., ventilator dependent children living at home), and the model waiver is generally oriented to serving children living at home. Until the passage of OBRA-87 in December, 1987, HCFA restricted the size of Model Waiver programs to no more than 50 individuals. Under OBRA-87, Model Waivers serving up to 200 individuals are now permitted. A state may propose to operate two or more model waiver programs and may operate a model waiver in addition to or in lieu of a regular section 2176 waiver. If a state already has a 2176 waiver, the model waiver application form permits the state to avoid repeating some material in its request.

Eligibility

Model Waiver eligibility criteria parallel those employed for the 2176 home and community-based waiver program. HCFA encourages a state to utilize the Model Waiver mechanism when it is seeking to cover a relatively small number of individuals. In addition, where coverage of children living at home is desired, HCFA also encourages (but does not mandate) that a state consider concurrently applying for a waiver of the "deeming" of parental income as a means of broadening eligibility for Model Waiver services. A state, however, may apply for a waiver of "deeming" when it is seeking HCFA approval of a "regular" HCB waiver program application.

Services Provided

While a state may propose to include an array of medical and non-medical services in a Model Waiver program application, HCFA guidelines urge states to restrict Model Waiver programs to a limited set of services. As with a "regular"

This section was largely prepared by Gary Smith of the National Association of State Mental Retardation Program Directors.

waiver program, a state may propose to cover medical services not otherwise furnished under its state Medicaid plan and to augment the extent, scope and services available under the state plan.

Other Notes

In most instances, states have employed the Model Waiver program to extend Medicaid coverage to relatively discrete, low-incidence target populations. Since utilization of home and community-based services is capped, some states have found the Model Waiver program to be a preferable alternative in covering home care services for children with severe disabilities to opting to add TEFRA 134 coverage under the state Medicaid plan. Like "regular" waiver programs, however, the Model Waiver program cannot be viewed as a means of achieving broad-based Medicaid coverage of non-institutional services. A "model" waiver may be appropriate in the case where the services a state wishes to furnish vary markedly from those that would be furnished under its regular waiver or if the institutional costs that would be incurred in the absence of a waiver are differentially higher than settings such as an ICF/MR.

WAIVER PROGRAM FOR "BOARDER BABIES"

The Congressional Research Services reports (1988):

> The Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) establishes a new waiver program targeted at "boarder babies," children who are infected with the acquired immunodeficiency syndrome virus (AIDS) virus or who are drug dependent at birth and who may remain in hospitals indefinitely because of problems in finding an alternative placement. The new 1915(e) waivers will allow states to provide services to such children, as well as to any children with AIDS, who (i) are under age 5, (ii) are receiving or are expected to receive federally funded adoption or foster care assistance, and (iii) would be likely, in the absence of waivered services, to require the level of care provided by a hospital or nursing facility. Covered services could include nursing care, physicians services, respite care, prescription drugs, medical devices and supplies, transportation, and any other service requested by the state and approved by the Secretary.
>
> As with other home and community-based services waivers, the state is required to provide assurances that the health and safety of waiver participants will be protected, that there will be financial accountability for program funds, and that the projected per capita cost of the program will not exceed the costs that the Medicaid program would have incurred for the same individuals in the absence of a waiver. (p. 343)

DIVISION OF MEDICAL ASSISTANCE

Prior Year Expenditures

ACCT	CATEGORY OF SERVICE	FY 86 ACTUALS	FY 87 ACTUALS	FY 88 ACTUALS	FY89 ITD ACTUALS	FY90 Authorized
	MEDICAID FACILITIES	44,828.1	46,831.6	59,574.1	71,284.7	78,280.5
	MEDICAID HOSPITALS	19,884.2	21,284.8	32,598.0	36,711.4	44,397.4
	MEDICAID NURSING HOMES	24,943.9	25,546.8	26,836.7	34,434.5	33,623.1
	MEDICAID TPL RECOVERY	0.0	0.0	139.4	138.8	260.0
	MEDICAID STATE FACILITIES	0.0	0.0	0.0	3,227.6	3,805.1
	MEDICAID NON-FACILITY	20,246.2	22,731.3	33,192.3	40,124.7	45,706.3
	MEDICAID PHYSICIAN SERVICES	11,006.0	11,477.4	18,182.4	19,510.7	22,801.9
	MEDICAID OTHER	5,902.8	7,113.3	10,892.1	16,747.5	17,104.4
	MEDICAID EPSDT	3,337.4	4,140.6	4,056.8	3,844.0	5,696.0
	MEDICAID TPL RECOVERY	0.0	0.0	61.0	22.5	104.0
	MEDICAID INDIAN HEALTH SERVICE	1,793.8	4,956.0	4,902.5	5,145.9	5,957.7
	TOTAL ALL MEDICAID SERVICES	66,868.1	74,518.9	97,668.9	119,782.9	133,749.6
	GENERAL RELIEF MEDICAL					
	GRM HOSPITAL	4,617.4	2,396.4	2,974.3	3,098.0	4,069.5
	GRM PHYSICIANS SERVICES	2,119.5	740.4	949.9	1,088.6	1,045.8
	GRM OTHER SERVICES	4,612.0	3,371.2	4,626.7	3,523.1	1,233.7
	GRM TPL RECOVERY	0.0	0.0	6.9	4.1	36.0
	TOTAL ALL GRM SERVICES	11,348.9	6,508.0	8,557.8	7,713.8	6,385.0
	CATASTROPHIC ILLNESS	513.7	0.0	0.0	0.0	0.0
	ALASKA LONGEVITY BONUS H.H.	0.0	19.5	675.3	1,001.3	1,236.6
	PERMENANT FUND DIVIDEND H.H.	0.0	353.6	740.4	910.2	1,300.0
	TOTAL MEDICAL ASSISTANCE	78,730.7	81,400.0	107,642.4	129,408.2	142,671.2

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DIVISION OF MEDICAL ASSISTANCE

Prior Year Expenditures

ACCT	CATEGORY OF SERVICE	FY 86 ACTUALS	FY 87 ACTUALS	FY88 ACTUALS	FY89 ITD ACTUALS	FY90 Authorized
MEDICAID						
	MEDICAID HOSPITALS					
800	Inpatient Hospital	16,295.1	17,619.7	27,275.0	27,898.9	36,700.7
803	Inpatient Psych Hospital				3,594.1	1,942.8
805	Outpatient Hospital	3,412.9	3,438.5	4,995.0	5,022.6	5,624.1
807	Outpatient Surgical Centers	176.2	226.6	328.0	195.8	129.8
	TOTAL M. HOSPITALS	19,884.2	21,284.8	32,598.0	36,711.4	44,397.4
809	PFDHH RSA	0.0	353.6			
811	TPL Recovery Contract			139.4	138.8	260.0
MEDICAID STATE FACILITIES						
802	Inpatient Psych - API				353.2	400.0
890	Harborview ICF/MR				2,619.8	3,405.1
895	Harborview ICF				254.6	0.0
	TOTAL MEDICAID STATE FACILITIES				3,227.6	3,805.1
	MEDICAID PHYSICIAN SERVICES					
815	Physician Services	10,908.4	11,393.7	18,066.2	19,444.5	22,722.0
816	Rural Health Clinics	97.6	83.7	116.2	66.2	79.9
	TOTAL M. PHYSICIAN SERVICES	11,006.0	11,477.4	18,182.4	19,510.7	22,801.9
	MEDICAID OTHER					
820	Other Services	52.8	52.2	82.8	0.0	71.5
821	Speech Language Therapy	84.8	86.3	79.0	43.9	72.7
822	Mental Health Clinics	1,909.7	2,258.5	3,248.1	3,881.5	3,769.6
824	Home Health Care	59.5	87.9	172.5	145.6	231.7
825	Transportation	1,653.0	1,597.8	2,370.5	3,462.5	2,495.8
826	Glasses Non-EPSDT	650.0	606.2	790.7	972.4	849.8
827	Family Planning	135.6	123.6	112.6	52.7	82.7
828	Laboratory & Xray	96.7	90.6	27.5	323.6	235.3
829	Medicaid Pharmacy				1,159.1	3,909.4
830	Hysterectomy	96.5	367.8	183.3	626.8	536.0
831	Abortion	0.0	1.5	3.2	0.0	0.5
832	Sterilization	133.4	352.3	562.1	664.7	558.6
835	Physical Therapy	156.4	167.0	189.3	140.4	146.9
836	Occupational Therapy	51.9	55.7	101.4	335.4	195.8
837	Pros. Devices-Medical Equip	287.1	339.4	529.2	970.2	641.7
838	Part B Buy-In	535.4	517.2	834.9	1,494.4	1,613.1
839	Hearing Services/Equipment			2.6	115.5	77.4
840	Adult Dental	0.0	24.0	581.7	1,035.4	760.6
841	Personal Care	0.0	281.8	616.9	821.5	814.4
842	Chiropratic	0.0	103.5	399.7	424.5	0.0
860	Disability/Blindness Exams			4.1	42.4	36.7
861	Disability Determination RSA				35.0	4.2
	TOTAL M. OTHER SERVICES	5,902.8	7,113.3	10,892.1	16,747.5	17,104.4

	MEDICAID EPSDT					
846	Labratory & X-Ray	0.1			0.0	0.0
950	Other Services	0.5		0.5	1.1	1.4
851	EPSDT RSA	1,336.9	1,342.3	1,370.7	1,370.7	2,781.6
852	EPSDT Dental Care	1,689.3	2,546.6	2,369.5	2,124.0	2,495.3
854	EPSDT Physician	53.9	49.4	52.2	133.3	91.0
855	EPSDT Glasses	0.1			0.0	0.0
857	Therapy	0.0			0.0	0.0
858	Pros. Devices-Medical Equip	0.0			0.0	0.0
859	EPSDT Transportation	256.6	202.3	263.9	214.9	326.7
	TOTAL M. EPSDT	3,337.4	4,140.6	4,056.8	3,844.0	5,696.0
812	TPL Recovery Contract			61.0	22.5	104.0
	MEDICAID NURSING HOMES					
870	Nursing Home Skilled	2,385.2	4,122.5	2,629.4	3,611.5	2,848.2
871	Nursing Home Intermediate	19,788.1	17,572.8	21,012.2	26,478.0	25,810.3
872	Nursing Home Hope ICF MR	2,770.6	3,748.6	3,195.1	4,340.4	3,327.8
875	Nusring Home Interim Payment	0.0	102.9		4.6	1,636.8
	TOTAL M. NURSING HOMES	24,943.9	25,546.8	26,836.7	34,434.5	33,623.1
	MEDICAID INDIAN HEALTH SERVICE					
880	IHS Clinic	126.2	313.7	398.9	245.4	377.1
881	IHS Inpatient	894.0	3,487.2	2,935.9	2,916.4	4,192.0
882	IHS Outpatient	773.6	1,155.1	1,567.7	1,984.1	1,388.6
	TOTAL M. IHS	1,793.8	4,956.0	4,902.5	5,145.9	5,957.7
	TOTAL ALL MEDICAID SERVICES	66,868.1	74,518.9	97,668.9	119,782.9	133,749.6

GENERAL RELIEF MEDICAL						
	GRM HOSPITAL					
900	Inpatient Hospital	4,009.8	2,218.9	2,929.3	3,094.0	3,889.9
905	Outpatient Hospital	607.6	177.5	45.0	4.0	179.6
	TOTAL GRM HOSPITAL	4,617.4	2,396.4	2,974.3	3,098.0	4,069.5
930	GRM PHYSICIANS SERVICES	2,119.5	740.4	949.9	1,088.6	1,045.8
	GRM OTHER SERVICES					
939	GRM Other Services	10.2		0.1	0.0	0.0
940	Pharmaceuticals XIX	2,327.8	2,544.9	3,781.1	2,658.3	0.0
941	Pharmaceuticals GRM	248.6	84.8	103.2	104.7	142.4
942	Transportation	128.0	66.0	85.0	98.6	85.5
943	Dental Care XIX	671.6	21.2	1.0	0.0	0.0
944	Dental Care GRM	231.7	50.5	23.6	19.7	0.0
945	Other Services	0.0			0.0	0.0
946	Glasses & Hearing Aids	106.3	22.2	0.8	0.0	0.0
947	Pros Device-Medical Equipmen	31.9	8.9	1.2	10.8	0.0
948	Therapy	44.8	11.6	0.1	0.0	0.0
950	Independent Labs	9.0	2.0	3.9	5.1	0.0
951	Nursing Home Care	595.6	268.5	219.4	243.4	519.7
955	Family Planning	9.3	0.5	1.1	0.7	1.4
956	Abortion XIX	167.3	262.8	376.6	325.1	440.3
957	Sterilization (ALL OTHER)	4.6	1.5	12.9	46.4	0.0
958	Abortion GRM	25.3	25.8	16.7	10.3	44.4
	TOTAL GRM OTHER SERVICES	4,612.0	3,371.2	4,626.7	3,523.1	1,233.7
910	TPL Recovery Contract			6.9	4.1	36.0
	TOTAL ALL GRM SERVICES	11,348.9	6,508.0	8,557.8	7,713.8	6,385.0
CATASTRIPHIC ILLNESS		513.7	0.0	0.0		
ALASKA LONGEVITY BONUS H.H.		0.0	19.5	675.3	1,001.3	1,236.6
PERMENANT FUND DIVIDEND HOLD HARMLESS						
809	PFD Hold Harmless Non-Facility			647.1	199.5	567.5
810	PFD Hold Harmless Facilities			93.3	710.7	732.5
	TOTAL PFD HOLD HARMLESS			740.4	910.2	1,300.0
	TOTAL MEDICAL ASSISTANCE	78,730.7	81,400.0	107,642.4	129,408.2	142,671.2

MEDICAID SERVICES STATE BY STATE

October 1, 1987

Basic Required Medicaid Services

Medicaid recipients receiving federally supported financial assistance must receive at least these services:

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic services
- Other laboratory and X-ray services
- Skilled nursing facility services and home health services for individuals 21 and older
- Early and periodic screening, diagnosis, and treatment for individuals under 21
- Family planning services and supplies
- Physician services
- Nurse Midwife services

Federal financial participation is also available in States electing to expand their Medicaid Programs by covering additional services and/or by including people eligible for medical but not for financial assistance. For the latter group, States may offer the services required for financial assistance recipients or may substitute a combination of seven services.

Definitions and limitations on eligibility and services vary from State to State. Details are available from local welfare offices and State Medicaid agencies.

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on the chart.

Optional Services in State Medicaid Programs

FMAP[1]	Basic Required Medicaid Services See Above		Prescribed Drugs	Optometrists' Services	Chiropractors' Services	Case Management Services	Primary Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing and Language Disorders	Prosthetic Devices	Eyeglasses	Podiatrists' Services	Diagnostic Services	Screening Services	Preventive Services	Rehabilitation Services	Services for Age 65 or Older in Medical Institutions: a. Skilled Nursing Facility	b. ICF	c. ICF/MR	Intermediate Care Facility Services	ICF for Mentally Retarded	Psychiatric Services for under Age 22	Christian Science Nurses	Christian Science Sanatoria	Inpatient Psychiatric Services for Age 65 and Over in Institutions for Mental Diseases	Emergency Hospital Services	Personal Care	Transportation Services	Case Management Services	Hospice Services	Total Additional Services	
73.00	o	Alabama		o				o					*			o					*	*	*						o					15	AL
50.00	o	Alaska		o	o				o	o	o	o	o			o	o				*			*	o	o				o	o			16	AK
50.00		American Samoa[2]																																	AS
50.12	o	Arizona[3]	o	o				o	o	o		o	o	o	o	o													o		o			12	AZ
71.21	o	Arkansas		o	o	o		o	o				o	o	o	o				o	o	o	o	o	o				o	o	o	o		21	AR
50.00	o	California	o	o	o	o	o	o	o	o	o	o	o	o		o				o	o	o	o	o		o			o	o				20	CA
50.00	o	Colorado	o	o		o		o	o				o			o				o	o	o	o	o					o		o			16	CO
50.00	o	Connecticut	o	o	o	o	o	o	o	o		o	o	o	o	o	o	o	o	o	o			o	o				o		o			20	CT
51.00	o	Delaware	o	o		o	o	o					o			o				o	o	o	o	o	o				o		o			16	DE
50.00	o	D.C.	o	o		o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o				o	o				20	DC
54.00	o	Florida	o	o		o		o	o				o	o	o					o	o			o	o				o		o		o	17	FL
50.00	o	Georgia	o	o		o		o	o				o	o	o	o					o			o	o					o		o	o		16	GA
50.00	o	Guam						o	o				o																o					4	GU
50.71	o	Hawaii	o	o		o		o	o	o	o	o	o	o	o	o	o	o	o	o				o	o	o				o		o			20	HI
70.17	o	Idaho	o	o	o	o		o	o				o							o	o			o	o					o		o			14	ID
50.00	o	Illinois	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o				o	o				20	IL
50.71	o	Indiana	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o			o	o	o	o	o	o	o	o	o		20	IN
50.72	o	Iowa	o	o	o	o		o	o	o	o	o	o	o	o	o				o	o			o	o	o				o		o			16	IA
50.00	o	Kansas	o	o	o	o		o	o	o	o	o	o			o				o	o	o		o	o					o	o				15	KS
70.77	o	Kentucky	o	o		o		o	o	o	o	o	o			o	o	o	o	o	o			o	o					o		o	o		16	KY
50.00	o	Louisiana		o				o	o				o	o						o	o			o	o					o		o			14	LA
57.00	o	Maine	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o			o	o					o	o	o			17	ME
50.00	o	Maryland	o	o		o		o	o				o	o						o				o	o					o	o				16	MD
50.00	o	Massachusetts	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o			o	o	o				21	MA
50.00	o	Michigan	o	o	o	o		o	o	o	o	o	o	o	o	o	o	o	o	o	o	o		o	o					o	o	o	o		19	MI
50.00	o	Minnesota	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o					o	o	o			20	MN
70.00	o	Mississippi		o				o	o				o	o		o				o	o			o	o					o		o			14	MS
50.71	o	Missouri	o	o				o	o				o	o		o				o				o	o					o	o				11	MO
50.00	o	Montana	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o					o	o	o			20	MT
50.72	o	Nebraska	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o					o	o	o			20	NE
50.00	o	Nevada	o	o	o	o	o	o	o	o	o	o	o	o	o	o				o	o	o		o	o					o	o	o			16	NV
50.00	o	New Hampshire	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o				o	o	o			21	NH
50.00	o	New Jersey[4]	o	o	o	o		o	o	o	o	o	o	o	o	o	o	o	o	o	o	o		o	o					o	o	o			19	NJ
71.54	o	New Mexico	o	o		o		o	o	o			o	o	o	o				o				o	o					o	o	o			14	NM
50.00	o	New York	o	o		o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o			o	o					o	o	o			18	NY
50.00	o	North Carolina	o	o	o			o	o	o	o	o	o	o	o	o	o	o	o	o	o	o		o	o					o	o	o			18	NC
64.07	o	North Dakota	o	o	o		o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o		o	o					o	o	o			18	ND
50.00	o	N. Mariana Islands						o	o				o	o	o	o														o	o				6	MP
50.12	o	Ohio	o	o	o	o	o	o	o	o	o	o	o	o	o	o				o	o	o		o	o		o			o	o	o			19	OH
50.00	o	Oklahoma	o	o		o		o	o				o	o	o	o		o		o	o			o	o					o	o				17	OK
50.11	o	Oregon	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o			o	o			o	o		o			o	o				17	OR
53.03	o	Pennsylvania	o	o	o			o	o				o	o	o	o				o	o			o	o					o	o				17	PA
50.00	o	Puerto Rico						o																											1	PR
54.00	o	Rhode Island	o	o					o				o	o	o	o				o	o	o		o	o					o		o	o		17	RI
70.00	o	South Carolina	o	o				o	o				o	o	o	o				o	o	o		o	o					o		o			17	SC
70.45	o	South Dakota			o			o	o	o		o	o	o	o	o				o	o	o		o	o					o	o	o			17	SD
70.24	o	Tennessee						o	o				o	o		o				o	o	o		o	o					o		o			15	TN
50.71	o	Texas	o	o	o	o							o	o		o				o	o	o		o	o					o	o	o			16	TX
70.75	o	Utah	o	o		o		o	o	o	o	o	o	o		o				o	o	o		o	o					o	o	o			18	UT
50.00	o	Vermont	o	o	o	o		o	o	o	o	o	o	o		o				o	o	o		o	o					o	o	o	o		19	VT
50.00	o	Virgin Islands[5]						o																											1	VI
51.34	o	Virginia	o	o				o	o	o	o	o	o	o		o				o	o	o		o	o					o		o			17	VA
50.71	o	Washington	o	o	o	o	o	o	o	o	o	o	o	o		o	o			o	o	o		o	o					o	o	o			19	WA
74.04	o	West Virginia	o	o	o	o	o	o	o	o			o	o		o				o	o	o		o	o					o	o	o			17	WV
50.00	o	Wisconsin		o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o		o	o					o	o	o			17	WI
57.00	o	Wyoming		o				o					o	o		o				o				o	o					o		o			9	WY
*	50	*	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50		
*	50	*	51	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50		
Total	50		51	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50		

[1] Federal Medical Assistance Percentage (FMAP). Rate of Federal Financial Participation in a State's Medical Assistance Program under Title XIX of the Social Security Act. Effective October 1, 1987 through September 30, 1988 (Fiscal Year 1988).

[2] Categorically needy: individuals receiving maximum supplemental assistance payments.

[3] Medically needy: individuals who are eligible for medical but not for financial assistance.

[4] American Samoa operates a special Medicaid waivered program.

[5] Arizona operates a federal assistance program under a Section 1115 Demonstration Project.

[6] All services are provided through public health facilities.

[7] Services indicated as available to the Medically Needy are not available to all Medically Needy Groups.

The data shown were supported by Individual Regional Offices and compiled by the Office of Intergovernmental Affairs.

HCFA Pub. No. 03134-86

U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Intergovernmental Affairs

ALASKA NURSING HOMES CENSUS

As of June 30, 1989

	Per Diem Rate	Certified Capacity SNF/ ICF	Certified Capacity Swing Beds	Occupancy by Payment Source: Medicaid/GRM Placements ICF	Medicaid/GRM Placements SNF	Non-DMA Placements Medi-care	Non-DMA Placements Other**	Total Census	Vacant Beds	% Occupancy of Total Beds Overall	% Occupancy of Total Beds Medicaid
Cordova Hospital LTC	$282.40	10	4	9	2	n/a	0	11	3	79%	79%
Denali Center (Fairbanks)	148.19	101	0	41	13	4	11	69	32	68%	53%
Heritage Place (Soldotna)	213.46	45	0	19	0	1	5	25	20	56%	42%
Island View Manor(Ketchikan)	232.28	46	0	23	1	0	4	28	18	61%	59%
Kodiak Island Hospital LTC	211.34	19*	4	17	0	0	2	19	4	83%	74%
Mary Conrad Center (Anch)	234.31	66*	0	61	n/a	n/a	1	62	4	94%	92%
Quyaana Care Center (Home)	222.09	15*	0	12	n/a	n/a	0	12	3	80%	80%
Our Lady (Anchorage)	168.80	224	0	129	45	14	25	213	11	95%	78%
Petersburg Hospital LTC	263.90	14	4	12	0	0	1	13	5	72%	67%
Sourdough Place (Valdez)	154.62	16*	0	16	n/a	n/a	0	16	0	100%	100%
South Penin.Hosp.LTC (Homer)	244.33	18	0	15	0	n/a	1	16	2	89%	83%
St. Ann's (Juneau)	165.35	45	0	25	9	0	4	38	7	82%	76%
Wesleyan (Seward)	117.52	66	0	45	0	n/a	5	50	16	76%	68%
Wrangell Gen. Hosp. LTC	222.09	14	4	8	1	0	4	12	6	67%	50%
Swing Beds (Acute to LTC):											
Cent. Pen. Hosp.(Soldotna)	162.57	0	4	0	0	1	0	1	3	25%	0%
Seward General Hospital	162.57	0	2	0	0	0	0	0	2	0%	0%
Sitka Community Hospital	162.57	0	2	0	0	0	0	0	2	0%	0%
Valdez Community Hospital	162.57	0	4	2	0	0	0	2	2	50%	50%
Valley Hospital (Palmer)	162.57	0	4	0	0	2	0	2	2	50%	0%
TOTAL:		731		434	71	22	63	589	142	81%	69%

*beds are certified for ICF only

Karen Martz
Division of Medical Assistance

7/21/89
Date
(907) 561-2171

As of: June 30, 1989

ICF/MR and IMH Census

Psychiatric Beds	Per Diem Rate	Certified Beds	Current Occupancy					
			Medicaid Total	Medicaid Under 22	Medicaid Over 65	Non-Medicaid	Current Census	Vacant Beds
Alaska Psychiatric Institute, Anchorage	274.28	160	25	17	8	82	107	53
Charter North Anchorage	N/A	60	15	15	0	32	47	13

ICF/MR Beds	Per Diem Rate	Certified Beds	Current Occupancy		Total Census	Vacant Beds
			Medicaid	Non-Medicaid		
Harborview Developmental Center, Valdez	302.00	64	57	0	57	7
Hope Cottages, Anchorage	261.49	40	40	0	40	0

7/21/89
Date

Karen Martz
Division of Medical Assistance
(907) 561-2171

Janet

MEMORANDUM

State of Alaska

TO: Commissioner John M. Andrews
Department of Administration

THRU: James J. Fox, Deputy Commissioner
Department of Administration

FROM: Barbara Bathony, Director BB
Division of Pioneers' Benefits
Department of Administration

DATE: February 2, 1989

FILE NO:

TELEPHONE NO: 465-4400

SUBJECT: Pioneers' Homes Occupancy Report
December 27, 1988 through
January 26, 1989

	Available Beds					Not Available	Total Beds	Occupied Beds				% Occupancy of Available Beds	
	R	R2	N	=	I	V	=	R	R2	N	=	this mo.	last mo.
SIT	45	*	39	84	2	41	127	36	*	35	71	85	87
FBX	56	*	46	102	2	0	104	54	*	46	100	98	99
PMR	18	17	53	88	2	4	94	18	16	53	87	99	97
ANC	113	25	88	226	6	0	232	96	24	88	208	92	92
KTN	19	*	28	47	2	0	49	17	*	28	45	96	96
JUN	20	*	32	52	2	0	54	18	*	31	49	94	96
TOTAL	271	42	286	599	16	45	660	239	40	281	560	93	94

	ADMITTANCES			DISCHARGES			DEATHS			IN-HOUSE TRANSFERS					
	R	R2	N	R	R2	N	R	R2	N	R-R2	R2-R	R-N	N-R	R2-N	N-R2
SIT	0	*	2	0	*	1	1	0	2	*	*	1	1	*	*
FBX	0	*	0	0	*	0	1	*	0	*	*	1	0	*	*
PMR	0	2	3	0	*	0	0	0	4	2	1	0	0	3	*
ANC	1	0	0	0	0	0	0	1	2	0	0	0	0	0	0
KTN	0	*	0	0	*	0	0	*	0	*	*	0	0	*	*
JUN	0	*	0	0	*	0	0	*	1	*	*	1	0	*	*
TOTAL	1	2	5	0	0	1	2	1	9	2	1	3	1	3	0

	Awaiting In-House Transfer						Waiting List			
	R-R2	R2-R	R-N	N-R	R2-N	N-R2	R	R2	N	=
SIT	*	*	0	2	*	*	10	*	4	14
FBX	*	*	14	0	*	*	7	*	18	25
PMR	0	0	0	0	1	0	2	2	29	33
ANC	4	0	2	0	0	0	0	2	53	55
KTN	*	*	0	0	*	*	12	*	10	22
JUN	*	*	10	0	*	*	47	*	18	65
TOTAL	4	0	16	2	1	0	78	4	132	214

	Stipend				Infirmary Beds		Residents receiving Nursing	
	R	R2	N	=	Days	Residents	#/residents	#/hours
SIT	2	*	5	7	31	4	37	666
FBX	2	*	17	19	35	2	30	375
PMR	0	0	14	14	0	0	0	0
ANC	1	1	21	23	104	5	79	512
KTN	1	*	8	9	21	2	17	106
JUN	0	*	8	8	21	4	1	16
TOTAL	6	1	73	80	212	17	164	1675

R = Residential care level
R2 = Residential II care level
N = Skilled Nursing level
I = Infirmary Beds
V = Vacant beds due to renovation/construction
* = Not applicable

C/8901

02-001A(Rev 10/79)

LOOKING BACK — LOOKING AHEAD

The First Three Years

of the

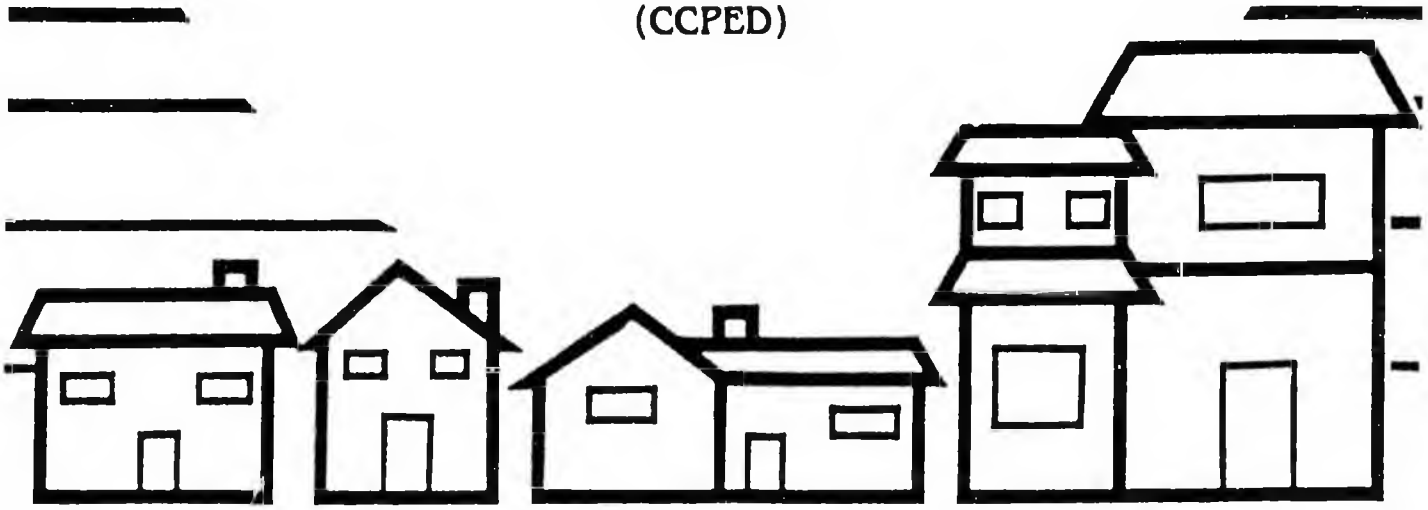
New Jersey

Community Care Program

for the

Elderly and Disabled

(CCPED)



LOOKING BACK
LOOKING AHEAD

The First Three Years of the

COMMUNITY CARE PROGRAM FOR THE ELDERLY AND DISABLED (CCPED)

(October 1, 1983 through September 30, 1986)

STATE OF NEW JERSEY
THOMAS H. KEAN, *Governor*

DEPARTMENT OF HUMAN SERVICES
DREW ALTMAN, *Commissioner*

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
THOMAS M. RUSSO, *Director*

ACKNOWLEDGEMENTS

We wish to thank the County Boards of Social Services/County Welfare Agencies, Medicaid District Offices, Case Management Sites, and providers for their dedication and commitment to serving elderly and disabled individuals under the Community Care Program for the Elderly and Disabled. This report could not have been produced without their input and assistance, and CCPED would not be an alternative to institutional care without their enthusiastic support of the program.

The report was prepared by staff from the Division of Medical Assistance and Health Services' Office of Home Care Programs, which provides centralized administration of CCPED. Carol H. Kurland is the administrator of this program.

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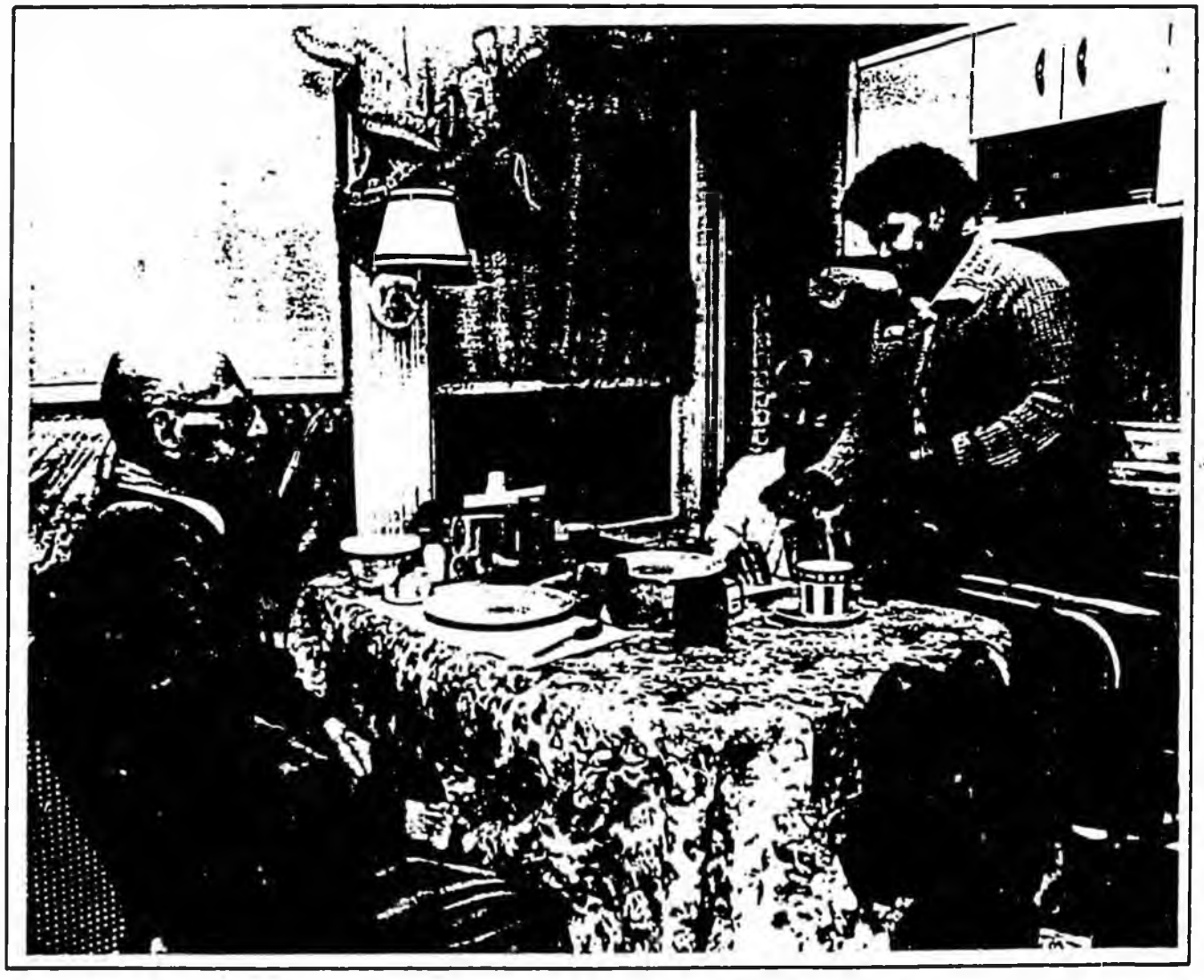
INTRODUCTION

The Community Care Program for the Elderly and Disabled (CCPED) is in its fifth year of operation. With the combined efforts of County Boards of Social Service/County Welfare Agencies, Medicaid District Offices, Case Management Sites, service providers, families, other support persons, and other committed individuals in government, CCPED has served more than 5,000 elderly and disabled individuals in New Jersey since October 1, 1983.

The intent of this report is to look back at the first three years of CCPED to see how the program has evolved, identifying its strengths and successes as well as areas that may require change or attention in the future. The report also contains statistical data concerning the population served. By reviewing the data collected and issues that have been raised by program participants, we can plan more effectively and responsibly for the future.



LOOKING BACK—
HISTORY AND EVOLUTION OF CCPED

Governor Kean in his SFY 1984 budget included a $10.5 million appropriation from the State's Casino Revenue Fund to finance two major initiatives in home and community-based long-term care:

- The Community Care Program for the Elderly and Disabled
- Medicaid's Personal Care Assistant Services Program

The funding of these two programs represented a major shift in State policy toward developing a more balanced long-term care system—one without the "institutional bias" which forced elderly and disabled into nursing homes, but rather one oriented toward helping families care for their kin. It was an effort on the part of New Jersey to provide a full continuum of care so that individuals could have access to services and settings more appropriate to their needs and circumstances, as well as more cost-effective for the State.

The Community Care Program for the Elderly and Disabled (CCPED) was created in New Jersey in response to the Omnibus Budget Reconciliation Act of 1981, Section 2176, Public Law 97-35, which encouraged the development of home and community-based services rather than institutional programs. The Sixth Omnibus Budget Reconciliation Act of 1985 provided the basis for program revisions.

CCPED was initially approved in June of 1983 for a three-year period by the United States Department of Health and Human Services, Health Care Financing Administration (HCFA) with an effective date of October 1, 1983. Jointly funded by Federal Title XIX monies and the State of New Jersey Casino Revenue Account funds, CCPED was phased in throughout the state over the three-year period. CCPED was designed to serve a maximum of 1,800 individuals at any one time at home by the end of the third year, offering a limited package of home and community-based services. These individuals otherwise would have been eligible to receive Medicaid services only in a nursing home setting.

Phase-In

The first phase of CCPED began in seven counties on October 1, 1983, with nine counties added on October 1, 1984, and the final five counties added on October 1, 1985 (See Chart 1). This phase-in of counties and population allowed time to implement the program effectively. Important aspects of the phase-in were: outreach to the communities; the training of staff involved in the enrollment process; recruiting, enrolling and training providers; training individuals who would provide comprehensive case management services to each client; and the development and implementation of a uniform assessment and service delivery system.

Services

Phase One of CCPED offered a package of eight services consisting of case management, home health services, medical day care, pharmaceuticals, non-emergency medical transportation, social adult day care, homemaker, and respite care to eligible individuals. These services were selected as most necessary to assist individuals remain home and to complement services available under Medicare. Phase Two, effective October 1, 1984, eliminated pharmaceuticals as part of the service package. Since most clients also met the eligibility requirements for New Jersey's Pharmaceutical Assistance for the Aged and Disabled (PAAD) Program, it had been administratively difficult to terminate their PAAD and offer pharmaceuticals under CCPED.

The client received a monthly Medicaid card from Blue Cross/Blue Shield Insurance Company attesting to CCPED eligibility. This card listed the seven CCPED services to which the client was entitled.

Cost-Effectiveness

In order to comply with Federal cost-effectiveness requirements which stated that the cost of home and community-based services could not exceed the cost of institutional care, a 70% of nursing home cost-cap was imposed on each individual's service package. This meant that the total amount of services paid for by Medicaid under CCPED could not exceed 70% of what Medicaid would have paid for that individual in a nursing home.

The removal of pharmaceuticals from the service package enabled CCPED clients to receive more home care services, such as homemaker and home health aide services, under this service cost-cap.

In 1986, New Jersey amended the CCPED program to allow 10% of the caseload to be served at 100% of nursing home costs, with 90% of the caseload remaining at the 70% cost-cap. This was done to accommodate sicker clients who needed more services to remain at home than could be provided within the 70% cost limit.

Initiated in the fourth waivered year, this change meant a change from a 70% service cap of $770.80 - $1,063.86 to a 100% service cap of $1,101.15 - $1,519.80 a month (the high and low figures representing the skilled and intermediate "B" nursing home levels of care).

Cost-Share Requirements

Federal regulations required that all recipients shared in the cost of the services received when their income exceeded maintenance needs. Medical expenses not subject to payment by a third party were considered deductibles from this cost-share. Maintenance needs were defined by the Federal government as the Social Security Income (SSI) standard. This amount changed from $333.47 a month in 1983 to $367.25 a month in 1986.

New Jersey felt that this regulation posed a hardship on many individuals who had much higher living costs, and served as a deterrent to apply for CCPED and needed services. New Jersey petitioned the Federal government to allow an additional $150 for maintenance needs but the request was denied. New Jersey then opted to use state funds to allow

up to an additional $75 per client for maintenance costs so that more individuals could choose CCPED as an alternative to nursing home care. With assistance from New Jersey Senator Bill Bradley through the mechanism of an amendment to the Consolidated Omnibus Budget Reconciliation Act of 1985, states were allowed to raise the maintenance needs deductible. In 1986, New Jersey elected to add an additional $75 or a total of $150 to the SSI standard as the allowable maintenance deductible for the cost-share. This meant that clients could deduct up to $150 for maintenance, plus medical and remedial expenses from their income before paying the cost-share for CCPED.

Eligibility Requirements

The eligibility criteria for CCPED in 1983 were as follows:

- Individuals had to be 65 or over, *OR* determined disabled under the Social Security Act and receiving Social Security disability payments, *AND* be eligible for Medicare.
- Individuals had to meet Medicaid's skilled or intermediate nursing home level of care

requirements (even though the choice was home care).

- Individual incomes had to exceed the SSI community standard up to the institutional cap ($1,008 as of 1/1/86), or individuals had to be ineligible in the community because of SSI Deeming Rules. (This meant that individuals were determined financially eligible on the basis of their own income.) Parental and spousal income were not considered (deemed) in determining eligibility.
- Individual assets could not exceed the amount allowed to receive Medicaid services under the institutional program. Again, parental and spousal resources were not deemed in determining eligibility.
- Cost of services could not exceed an established amount which reflected 70% of nursing home costs to Medicaid.

In 1986, these criteria were modified as follows:

- Individuals not determined disabled by the Social Security Administration could be determined disabled by the Bureau of Medical Affairs, Division of Public Welfare, Department of Human Services.
- Individuals who were not eligible for Medicare but had other health insurance coverage, which included hospital and physician coverage, could qualify for CCPED.
- Services for 10% of the CCPED slots could cost up to 100% of Medicaid nursing home costs, rather than 70%. For example, an Intermediate Care Facility (ICF) Level A at 70% was $985.98 and at 100%, it was $1,408.55, allowing an additional $422.57 to be spent for service needs. This increase became effective in the beginning of the fourth year.

Expenditures Under CCPED

The cost-effective features of CCPED, namely, the use of case management as the pivotal service to orchestrate the service plan and the utilization of the 70% service cost cap for most recipients, has resulted in considerable savings to the State. As evidenced in Chart 15, the cost of providing services to CCPED recipients in the home was considerably less than if they had been institutionalized. Although the average costs increased each year of the program, at its highest level in Year Three, the cost of serving the CCPED recipient was only one-third of what it would have been in a nursing home, $3,889 as compared to $11,631. Chart 9 demonstrates that CCPED recipients are much the same as nursing home residents. Therefore, CCPED not only is appropriately targeting those who are at risk of institutionalization but is serving them at less cost.

Final Note

We are pleased to conclude this section with the information that CCPED has been renewed for an additional five years, to September 30, 1991. Upon our request, HCFA also approved an annual increase in community care slots for each new waivered year in order to meet the continuing demand for services. The allowable slots will reach 2,900 in 1991.

The following sections of this report discuss in more detail the application and enrollment process, demographic and fiscal data and observations and recommendations concerning CCPED.

APPLICATION AND ENROLLMENT

The overall administration of CCPED is carried out by the Department of Human Services, Division of Medical Assistance and Health Services, within the Office of Home Care Programs. The application and enrollment is performed locally by the County Board of Social Services/County Welfare Agency and the Medicaid District Office in the applicant's county of residence. This process, described in this section and summarized on Chart 2, has not changed since the program began in 1983.

Applicant

At the time of application, the individual may live at home in the community, alone or with others; in a hospital or nursing home; in a rooming or boarding home. The individual can be referred to the County Board of Social Services/County Welfare Agency by a variety of sources.

County Board of Social Services/County Welfare Agency (CBSS/CWA)

The individual makes formal application at the CBSS/CWA serving the county of residence. The CBSS/CWA explains CCPED to the applicant, and in accordance with existing policies and procedures, determines the applicant's financial eligibility. The information regarding income and resource is verified as well as other eligibility factors such as age, residence and citizenship. The CBSS/CWA also determines the applicant's maximum cost-share liability and ensures that disability has been determined if the applicant is under 65 years of age.

Medicaid District Office (MDO)

When the applicant has been determined financially eligible for CCPED, a referral is made to the MDO serving the county of residence. A Medicaid Regional Staff Nurse and Medical Social Care Specialist visit the applicant to assess the level of care required, evaluate the appropriateness of CCPED for the applicant and discuss the choices of care (home or institutional care).

The Nurse and Social Care Specialist then discuss the case with a Medicaid Physician Specialist. If the applicant has been determined to be medically in need of care and the cost of home care to be reimbursed by Medicaid is projected to not exceed the institutional service cost-cap established for the individual, the applicant is enrolled in CCPED and referred to the Case Management Site within the county.

Case Management Site (CMS)

Upon receipt of the referral, the case manager visits the client and, with input from the client, family member, attending physician, Medicaid staff, and service providers, prepares a service plan to meet the client's needs. The case manager then assists the client in securing services approved in the service plan. The client's needs and service program are continuously monitored by the case manager while the client remains in CCPED.

Delivery of Services

CCPED provides access to seven services: case management, home health, homemaker, medical day care, social adult day care, respite care, and non-emergency medical transportation.

A description of each service area, an analysis of service utilization, quality assurance, and other service issues follow.

Case Management

Each CCPED recipient receives case management services from a case manager based in a designated case management site approved by the Division of Medical Assistance and Health Services. Case management sites are located in home health agencies, county boards of social services/county welfare agencies, Medicaid District Offices, homemaker/home health aide agencies, and one area office on aging. The Department of Human Services emphasizes an interdisciplinary approach to case management so that the client's total needs can be evaluated and addressed. This means sites must employ case managers who are both nurses and social workers. In sites where a small number of cases only warrants one case

manager, either a nurse or a social worker can be employed.

Included in the responsibilities of the case manager are assessment of the client, preparation of a service plan (which includes formal and informal supports), cost-share determination, coordination of service delivery, monitoring of services, and assisting and advocating for the client and/or family as needed. Case managers have performed exceptionally well in meeting clients' needs in a cost-effective manner while ensuring that quality care is given.

This report concludes with segments of unsolicited letters sent to case managers by families of clients served under CCPED. These letters attest to the quality of case management provided under this program.

Home Health Services

Home Health services include skilled nursing, homemaker/home health aides, physical and occupational therapies, speech-language pathology, medical social work services and certain medical supplies.

Licensed certified home health agencies under contract to the Division of Medical Assistance and Health Services provide these services. These agencies have provided excellent home care to clients and have been an invaluable part of the CCPED service package.

Prospective reimbursement of home health services established for the program remains a major problem in CCPED. Fees are based upon audited data secured from Medicare cost reports, since New Jersey Medicaid piggybacks Medicare principles of reimbursement. Agencies are particularly concerned that the visit rate paid under Medicare does not accommodate the chronic care required by CCPED clients. To remedy this problem, an hourly fee for home health aide services was suggested by the industry and implemented upon the choice of the agency in November 1987.

Another growing problem is the insufficient number of certified homemaker/home health aides, particularly in some geographical areas, to meet the demands for home care. Inadequate transportation systems compound the problem and in some instances aides are unable to get to a client's home to provide the services.

The New Jersey Department of Human Services and Department of Health have formed an interdepartmental task force to discuss issues related to the homemaker/home health aide shortage. A report will be presented to both Commissioners, perhaps forming the basis for increase in the availability of staff in the home care arena. It is felt that the demand for services under CCPED has provided a mechanism for identifying this developing need in New Jersey.

Homemaker Service

Homemaker Service has been the backbone of CCPED and has grown from 43% of total service payments in the first year of CCPED to 62% of total payments in the third year. Homemaker service provides both basic personal care such as bathing, grooming and dressing, and household tasks such as light housekeeping, meal preparation and shopping. The reimbursement rate, generally lower than for home health aide service, makes this the most sought after service in CCPED. However, agencies continually feel that Medicaid is not meeting true service costs and annually request fee increases.

A new group of agencies was enlisted to become approved Medicaid providers of this service area. About 57 proprietary and 18 non-profit agencies have been enrolled since

1983. Required to meet Division standards, they also were trained in the billing process and, in turn, developed a new set of relationships with MDOs and case managers.

Due to the growing number of agencies and a need to assure continuing quality of care, accreditation by the industry was supported by the Division as a requirement for Medicaid participation of these agencies. All agencies providing homemaker service are now required to become accredited by the National HomeCaring Council (of the Foundation of Hospice and Home Care) or the Commission on Accreditation for Home Care, based in New Jersey, by January 1, 1988 for proprietary agencies and June 30, 1988 for non-profit agencies. The shortage of paraprofessionals is particularly significant with these agencies since homemaker service is their primary agency service.

Medical Day Care

Medical Day Care offers a variety of health, social and supportive services in forty-nine Medicaid approved centers located in nursing homes, freestanding settings, or affiliated with hospitals. Although only 4% of CCPED payments were made for medical day care, the comprehensive package of services is beneficial to clients able to leave their own home for one to five days a week. An average medical day care per diem is considerably less than other home care services purchased separately for the same time frame. Medical Day Care offers not only medical and nursing supervision for the very frail or disabled person, but it also provides needed socialization and peer contacts.

Social Adult Day Care

Social Adult Day Care emphasizes social and recreational activities in a group setting, with some health monitoring. Clients attending social day care do not usually need medical attention during the day but may need close general supervision to prevent such behaviors as wandering. Less than 1% of the total expenditures are for this service. All social day care centers must be publicly funded and monitored to participate in CCPED. They also require a Medicaid provider agreement.

Respite Care

Respite Care is a temporary service offered on an as needed basis to relieve families caring for individuals at home. It can be provided at home by a homemaker/home health aide,

employed by approved agencies or in nursing homes by facilities which have a Medicaid provider agreement. The reimbursement of respite care in a nursing home equals either the facility's skilled or intermediate care rate.

There is a need for more nursing homes to provide respite care. The service has been limited because facilities cannot predict when a bed will become available for respite care. Therefore, families who need to be away at a specific time usually cannot be guaranteed the availability of a bed when needed.

Respite care in the home by a homemaker/home health aide is not always feasible due to the shortage of aides willing to work weekends or evenings.

Medical Transportation

Medical Transportation is non-emergency transporting of clients by a suitable vehicle to obtain health services. This service is provided by traditional Medicaid approved medical transportation providers, using, for example, invalid coaches, or by vehicles provided through the county welfare agencies Medicaid-funded transportation programs.

LETTERS OF SUPPORT

We have received numerous unsolicited letters from families of clients sent to case management sites and to the Division of Medical Assistance and Health Services (DMAHS). The following are excerpts from these letters.

TO: *Bergen County Board of Social Services, October 20, 1986.*

TO WHOM IT MAY CONCERN:

"My mother was a recipient of the CCPED Program for almost three years. She passed away on August 22, 1986, but she died in her own home, which is what she wanted. She was 87 years old and was terrified (as I think most older people are) of not being able to take care of herself and having to go to a nursing home. Your Program enabled her to stay in her own home and her own surroundings, and for that I am very, very grateful."

TO: *Passaic County Board of Social Services, November 13, 1986.*

"I want to re-emphasize what I expressed to you in our recent telephone conversation concerning my very deep appreciation for your many kindnesses.

There is little question in my mind that you went out of your way to be helpful to my mother and my sister, in assisting them in their needs. In a day and age when the general public is oftentimes critical of those who serve in the public sector, I can attest to the fact that you personify, in the highest sense,

a dedicated public servant who has a deep concern for the public citizen."

TO: *MCOSS Nursing, Inc., January 30, 1987.*

"On behalf of my mother and myself, we would like to express our appreciation and gratitude regarding the CCPED program, and to you, in particular, for your continued guidance and help.

As you well know, this program has enabled my elderly mother to remain at home, in familiar and comfortable surroundings and still receive the care and attention so vital to someone of ninety-one.

The case management has been thoroughly professional, whether it be on a medical, financial or emotional level.

You have always been there "in the wings" ready to help . . . thank you for the program . . . and thank you for being part of it."

TO: *Division of Medical Assistance & Health Services, Office of Home Care Programs, November 25, 1986.*

"My father-in-law became an active participant in the Community Care Program for the Elderly and Disabled on November 19, 1986. I would like to express our appreciation for his acceptance into the program.

I was very impressed by, and wish to acknowledge with deep appreciation, the very courteous and efficient manner in which we were interviewed by your staff. Each one was friendly, warm and interested.

Thank you not only for your assistance but also for this very positive experience in human services."

TO: *The Administrator of the DMAHS, Office of Home Care Programs from a Regional Staff Nurse employed in a Medicaid District Office.*

"Since I have started doing reassessments on my assigned CCPED cases, I have found the clients to be happy and improved physically and mentally.

It was heartwarming to me, particularly when I saw a recipient yesterday that I had not seen in a year. She looked so much better and was friendly and chatty. Last year, when I saw her, I doubted that she would be able to be kept at home.

This proved to me that this program really works. The family is pleased with the services and only ask that they stay the same.

Three cheers for CCPED!"

POPULATION SERVED

The following is an analysis of data compiled on population served during the first three years of CCPED, representing 4,075 recipients.

Sex

Of the 4,075 clients served, 76% were females; 24% were males (Chart 3).

Age

The numbers of individuals served over age 65 increased from 80% to 87% from 1983 to 1985, with the preponderance of the recipients in the 75-84 age group. It is interesting to note that a sizeable group, an average of 27%, were over the age of 85 in 1985. (Chart 4).

All three years of the program reflected a similar age picture. It is felt that CCPED's limited service package discouraged the younger disabled who need more extensive service coverage and were better accommodated under Medicaid's Home and Community-based Services Waivers for Blind or Disabled Children and Adults, known as Medicaid's Model Waivers.

Race

Race variations as illustrated in Chart 5 appeared to be unusual to staff, until they were compared to the population in New Jersey nursing homes. Seventy-nine percent of individuals served under CCPED were white, with 17% black recipients, and 2% Hispanic re-

cipients in 1985. Medicaid residents in nursing homes in 1986 were 84% white, 10% black and 1% Hispanic, revealing that the racial variation of the population enrolled in both programs was similar.

Living Arrangements

Other characteristics of CCPED recipients were examined. Chart 6 shows the living arrangement of enrollees. The largest number, 39.4%, resided with adult children, 30.3% lived alone, 23.2% lived with a spouse and 7.1% had other arrangements, such as living with a sibling, friend, or other relative. Since the support network is so important in this program, the availability of an adult child or spouse provided the needed support for the limited service received under CCPED. The fact that about 1/3 of the recipients lived alone, although difficult to accept by concerned professionals, attests to the strength of the freedom of choice given to all individuals electing this program. Many persons refused to enter nursing homes, despite the unavailability of family and the limitation of services. However, a number of these "loners" did have friends or children who lived nearby and looked in on the recipient on a regular basis.

Income Level and Cost Share

Income levels of CCPED clients as seen in Chart 7 were restricted by the eligibility requirements of the program. Whereas most (45%) had incomes from $368 to $521 a month, a considerable number (26%) had higher incomes, from $522 to $899 a month and lower incomes (27%) under $367 a month (yet were ineligible for regular Medicaid because of spousal or parental incomes). Few had incomes which exceeded $900 a month, although the maximum income eligibility was $1,008 a month. The primary reason for this can be attributed to the cost-share liability requirement. All recipients were required in accordance with Federal regulation to share in the cost of care. The cost-share was determined by deducting a standard maintenance allowance plus medical and remedial expenses from the client's gross income. Those clients with high incomes had a high cost-share, thereby discouraging participation in the program. Those individuals would purchase services directly rather than through CCPED.

Diagnosis

Primary diagnoses of CCPED recipients are illustrated in Chart 8. The most common physical problem was a circulatory disorder, found in 49% of the population served. Remaining disorders, occurring at equal distribution, were difficulties with nervous system, respiration, metabolism, musculoskeletal problems, cancer and mental disorders. All disorders appeared to not only be reflective of the elderly population in the program, but descriptive of a similar population residing in long-term care facilities. Therefore, this information appeared to confirm the appropriate targeting of the population.

Level of Care

Federal regulations require that clients served under CCPED must require a level of care provided in a nursing home, although they may choose to remain home with services. (See Attachment A for a description of the three levels of nursing home care.) Chart 9 clearly demonstrates that CCPED is attracting the appropriate population. The level of care of individuals served under CCPED over the three years compares favorably to the

Medicaid population served in New Jersey nursing homes. Note that in Year One, 16% of CCPED clients were assessed Skilled Nursing Facility (SNF) Level compared to 8% of patients assessed SNF in nursing homes; 59% of CCPED clients were assessed Intermediate Care Facility (ICF) A level compared to 69% ICFA patients in nursing homes, and 25% CCPED clients were at Intermediate Care Facility (ICF) B level compared to 23% ICFB patients in nursing homes. All three years indicated there was great similarity between the levels of care required by CCPED recipients to those in nursing homes. Since the same level of care criteria was utilized by Medicaid Medical Evaluation Teams to determine medical eligibility for CCPED and for nursing home placement, it is concluded that CCPED has indeed appropriately targeted individuals who without home and community-based care would have been candidates for nursing home admission.

As an added note, it appeared that the individuals served in CCPED could in some instances have been sicker than those served in nursing homes, since the SNF percentages are considerably higher in the CCPED population.

Termination

Chart 10 delineates the principal reasons for termination from CCPED. With the majority of clients in the age group of 75-84, having numerous chronic illnesses and matching patients who are institutionalized, it is understandable that termination from CCPED results from death or admission to a nursing home.

Length of Stay on Program

Chart 11 illustrates the length of time clients remained on CCPED. Although considered a long term care services program, it is interesting to note that 59.8% were served in CCPED under six months. Very few, 17.1%, remained on CCPED over a year. The frailty of the population served attributed to a shortening of program involvement.

Payment of Services

Charts 12-14 demonstrate the change in payments made for services over the three years. There was a noticeable growth in funds expended for homemaker services. All other service expenditures remained about the same. Total payments grew from almost $700,000 in Year One to more than $8.5 million in Year Three as the program became better known and served a larger population statewide.

Chart 15

Chart 15 compares expenditures under CCPED to nursing home expenditures. Although the average costs per CCPED recipient increased each year of the program, at its highest cost in Year three, it was still only one-third of nursing home costs.

CHART 1

THREE YEARS OF CCPED PHASING IN THE COUNTIES

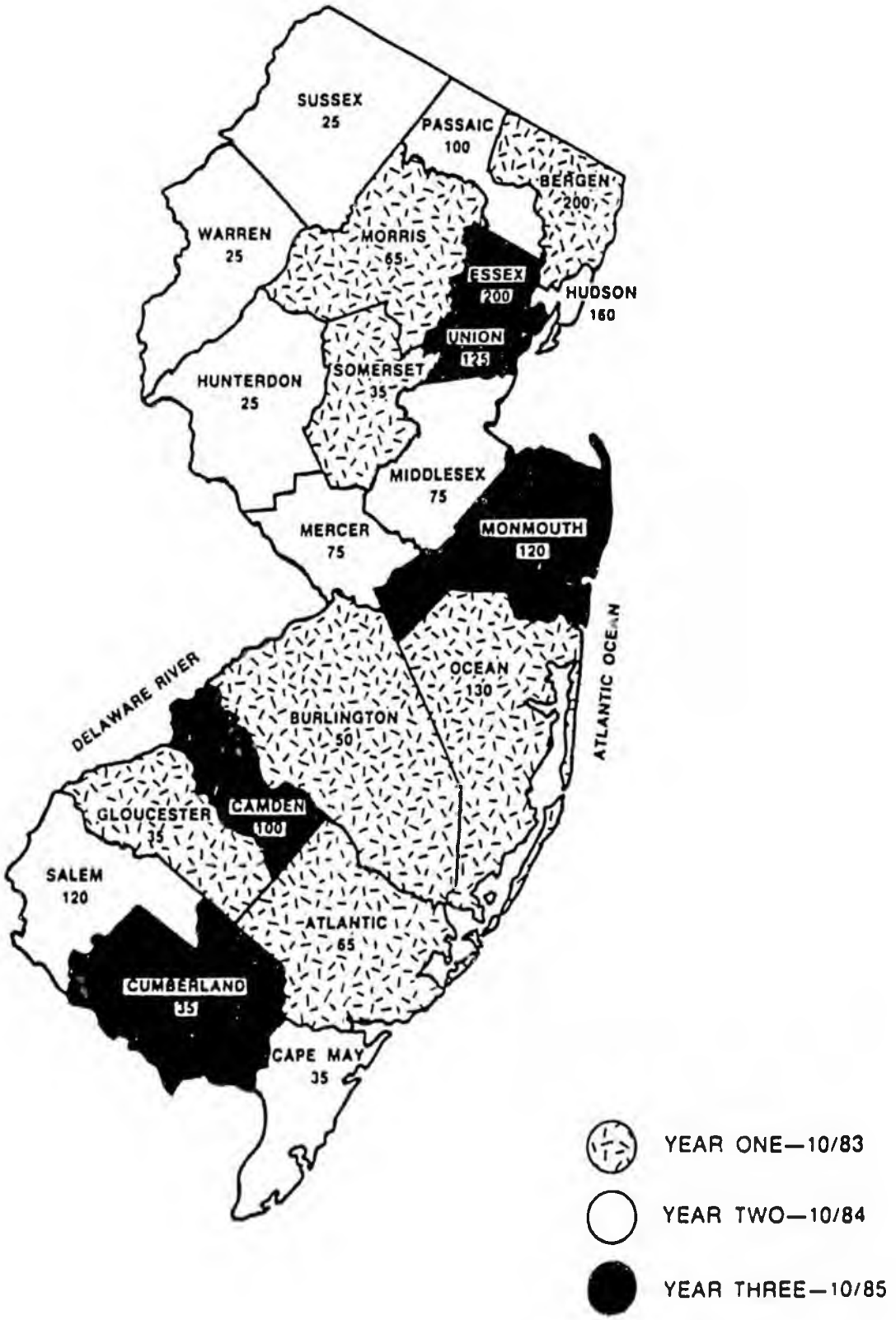
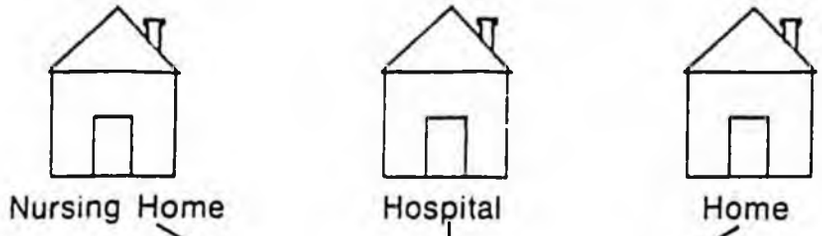


CHART 2

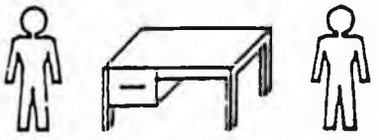
CCPED Enrollment Process



Applicant

- Financial Eligibility
- Disability Determination (if under age 65)

CBSS

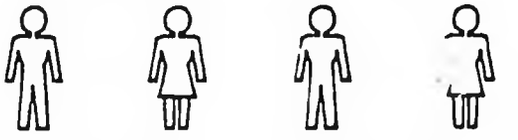


Income Maintenance Technician — Applicant

(Assessment)

- Medical Eligibility
- Appropriateness of CCPED
- Choice of Care
- Authorization of Services

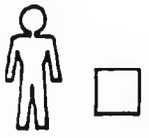
MDO



Caregiver — Nurse — SW — Applicant

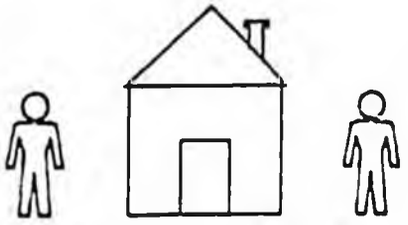
- Service Plan
- Arrange Services
- Monitor Care

CMS



Case Manager

Service Providers

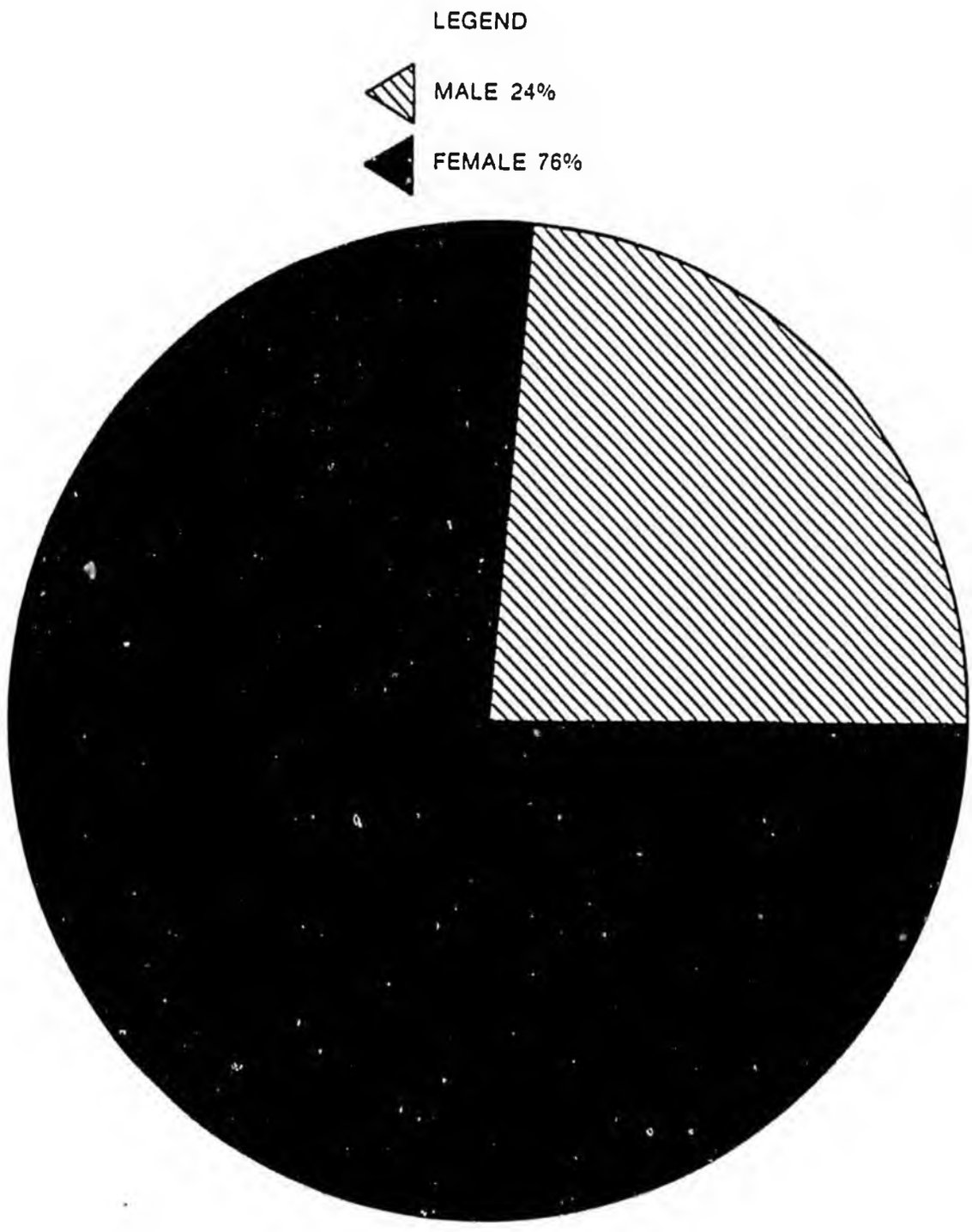


Caregiver/Client "Home"

CBSS—County Board of Social Services or County Welfare Agency
MDO—Medicaid District Office
CMS—Case Management Site

CHART 3

PERCENTAGE MALE/FEMALE CLIENTS



4,075 CLIENTS SERVED

CHART 4

AGE VARIATION OF CLIENTS

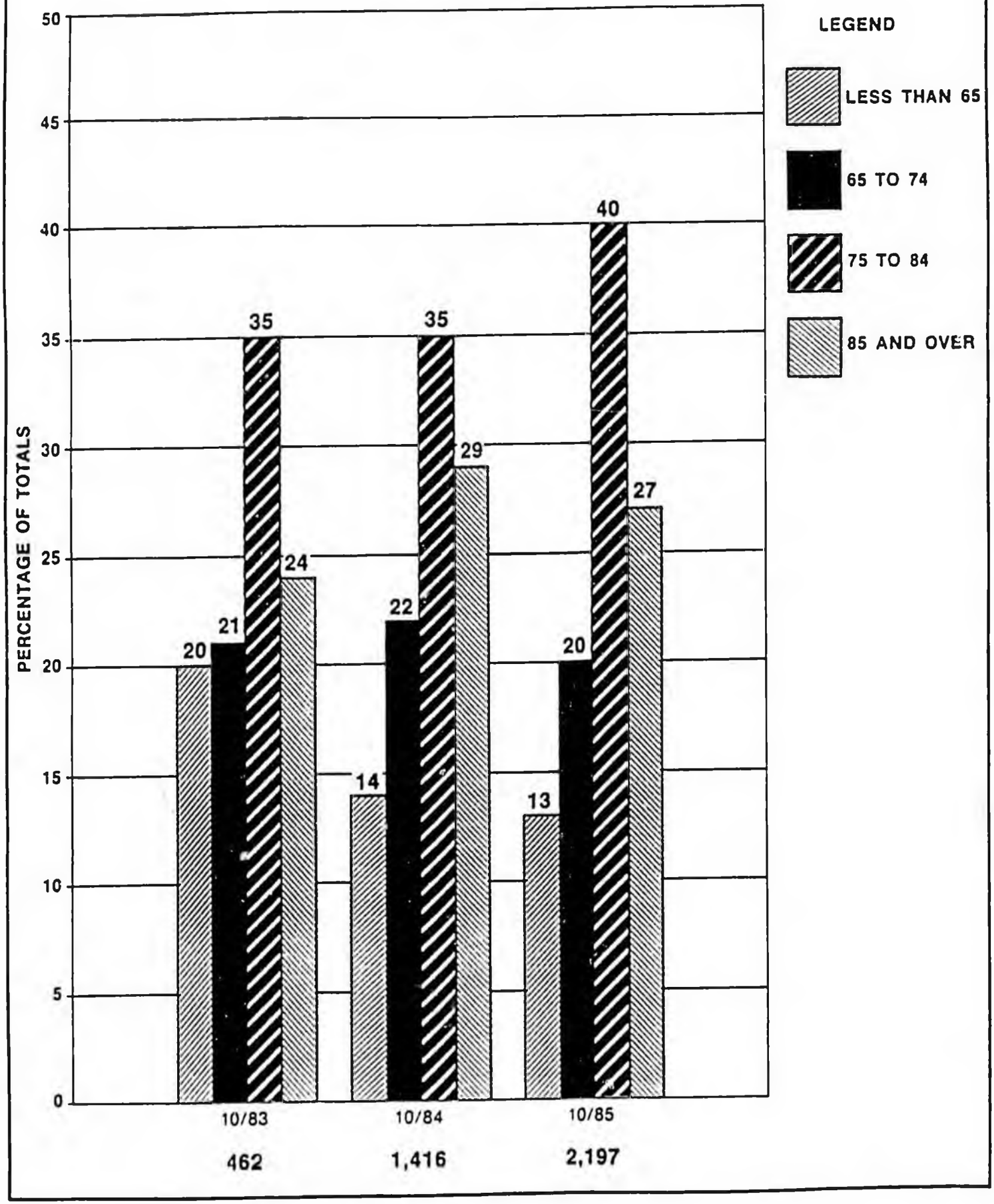


CHART 5

RACE VARIATION OF CLIENTS

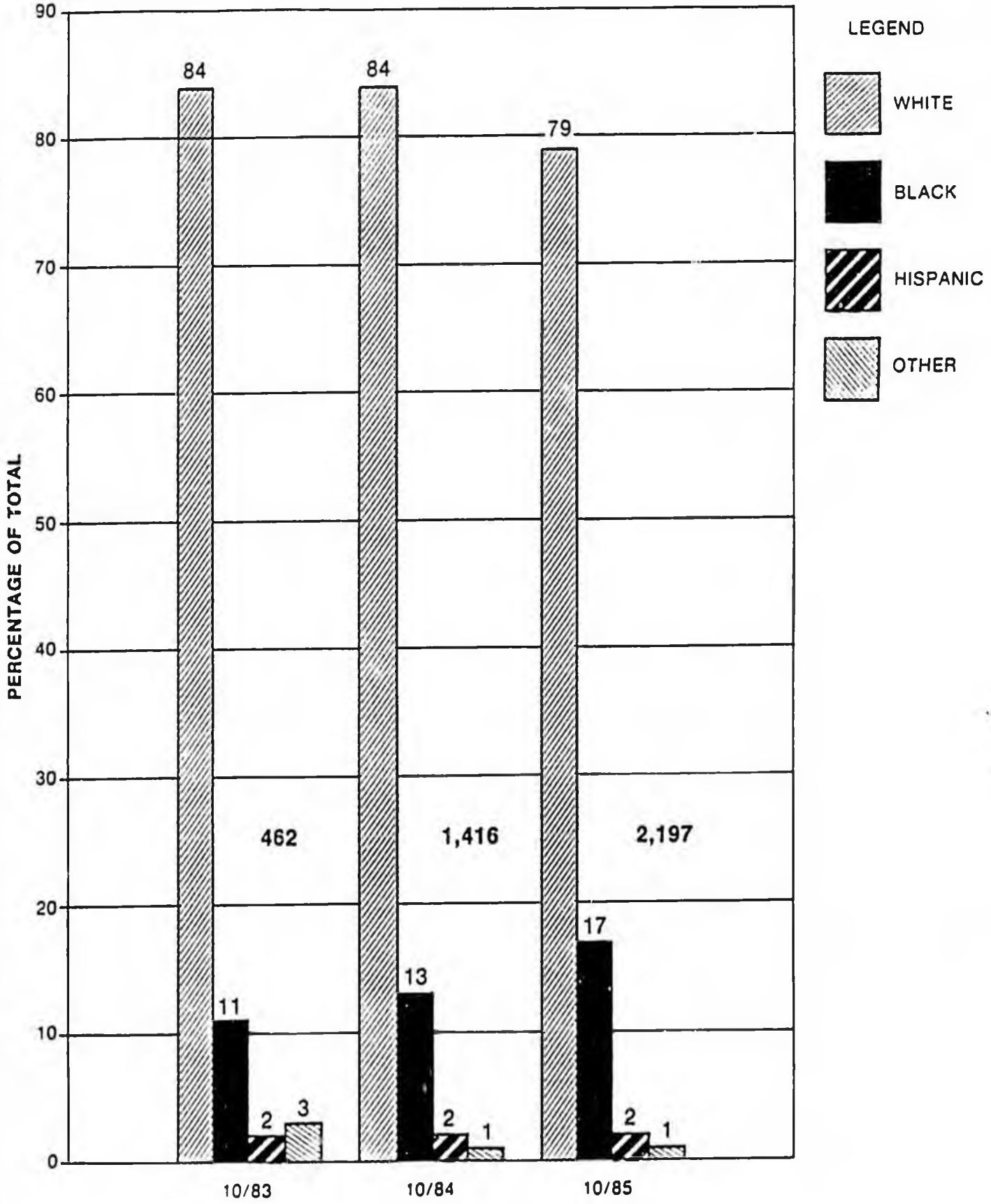


CHART 6

LIVING ARRANGEMENT OF CLIENTS

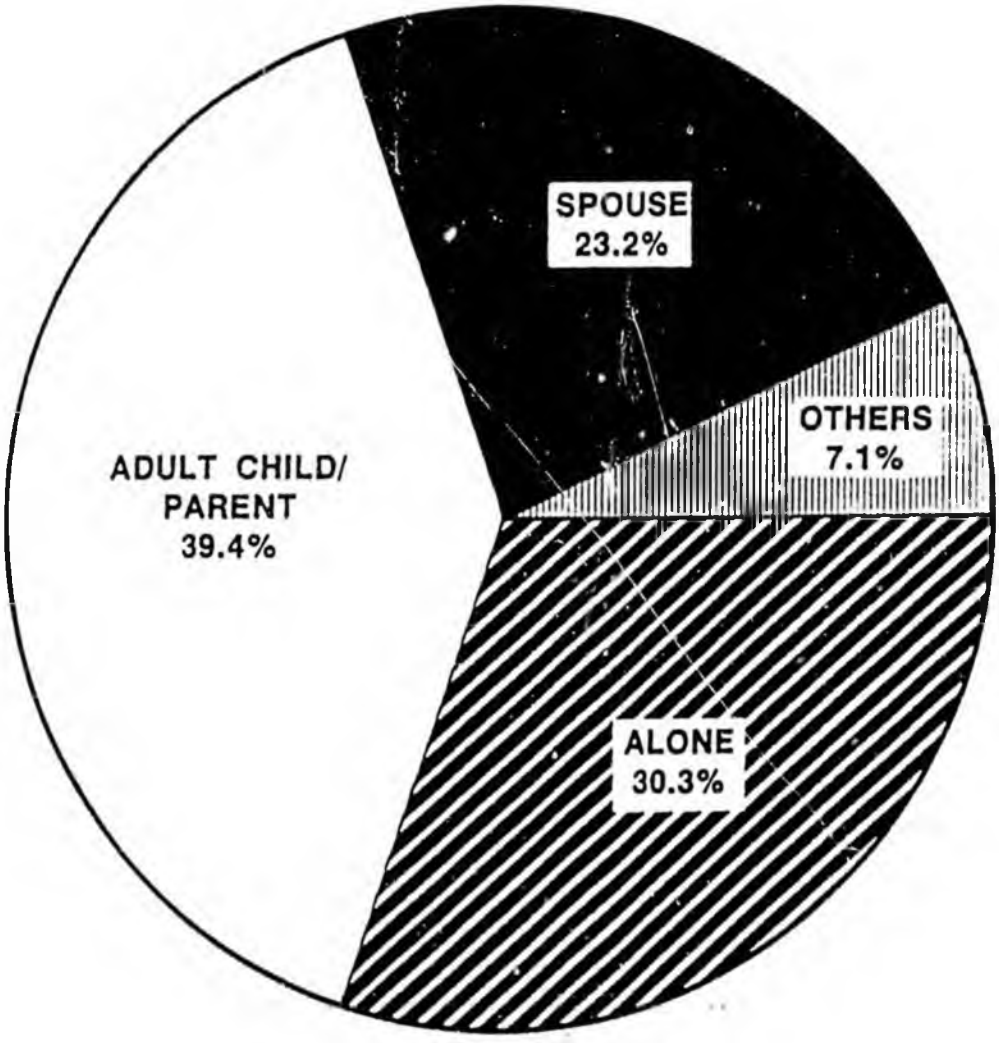


CHART 7

MONTHLY INCOME OF CLIENTS

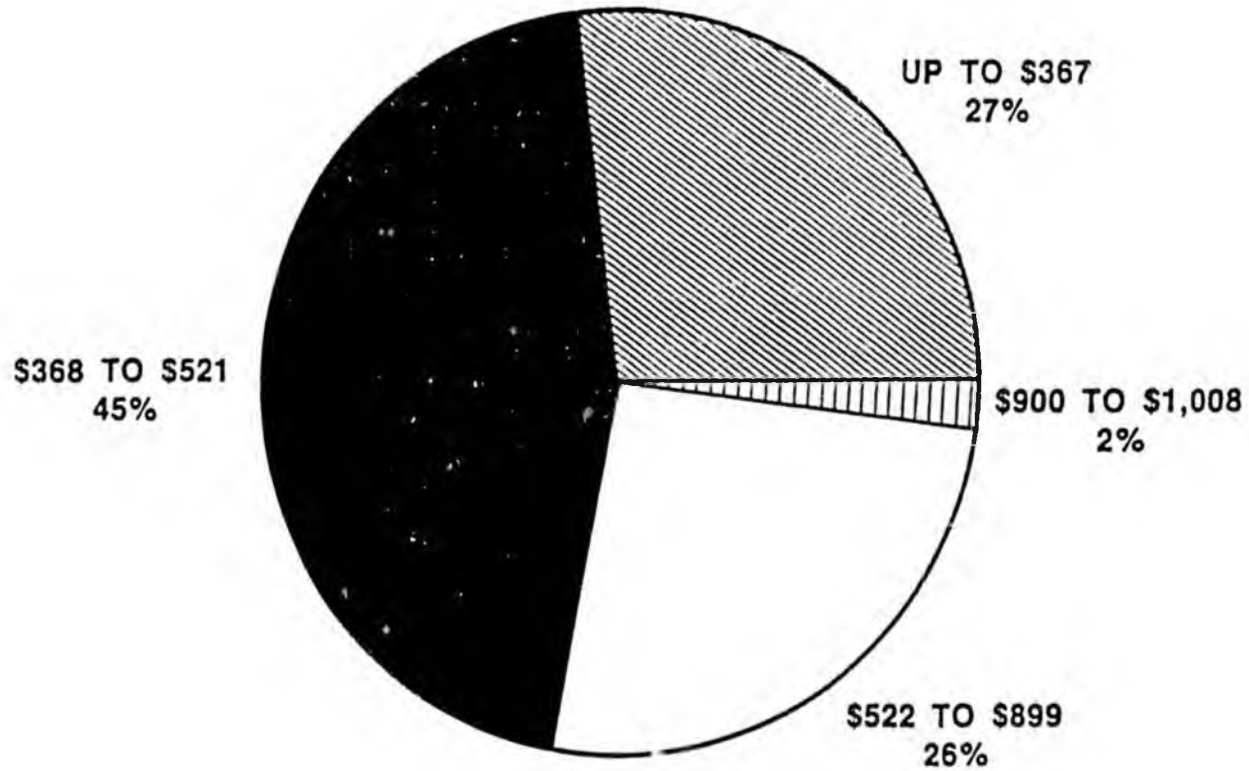


CHART 8

PRIMARY DIAGNOSIS OF CLIENTS

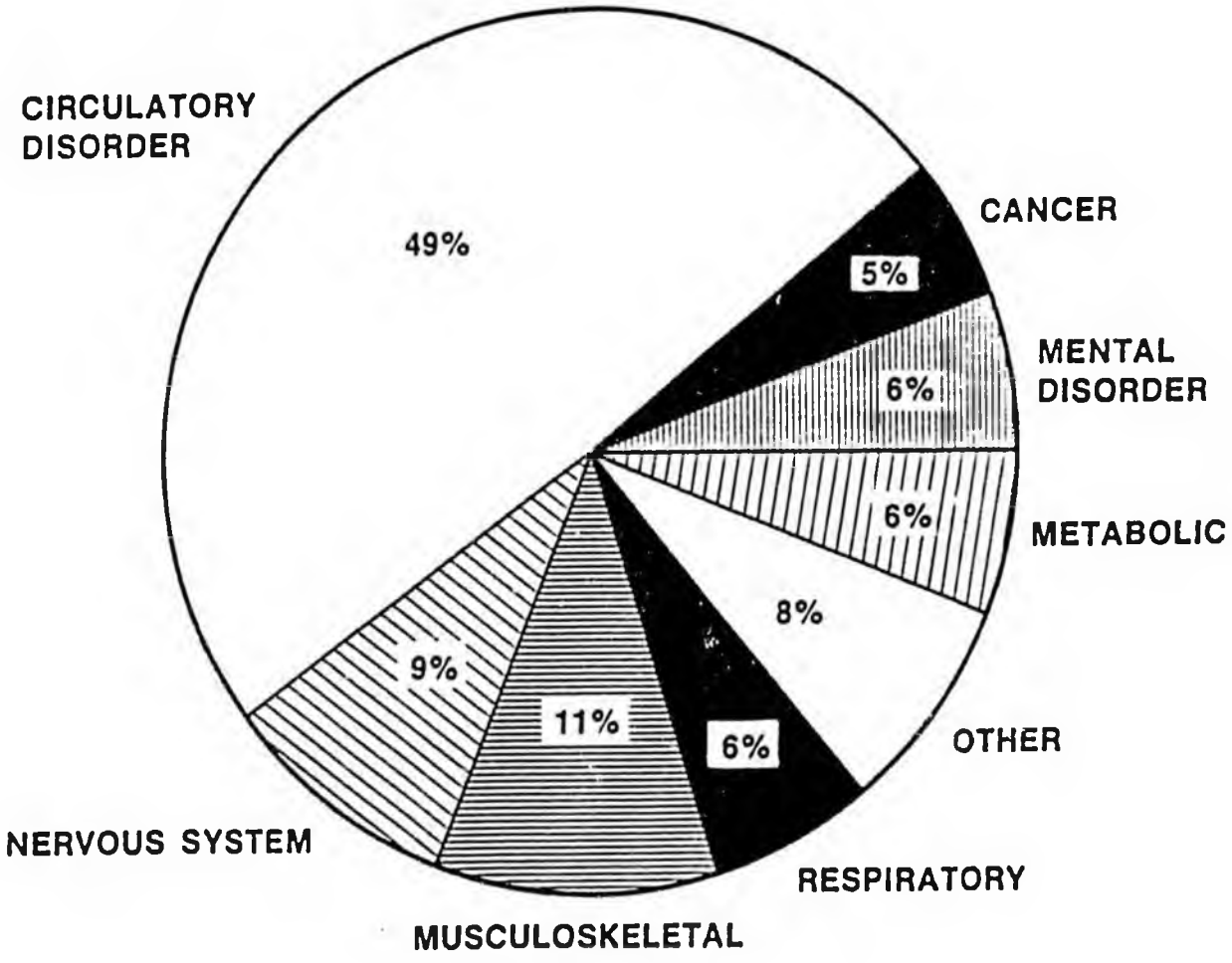


CHART 9

LEVEL OF CARE
CCPED COMPARED TO NURSING HOME (NH)

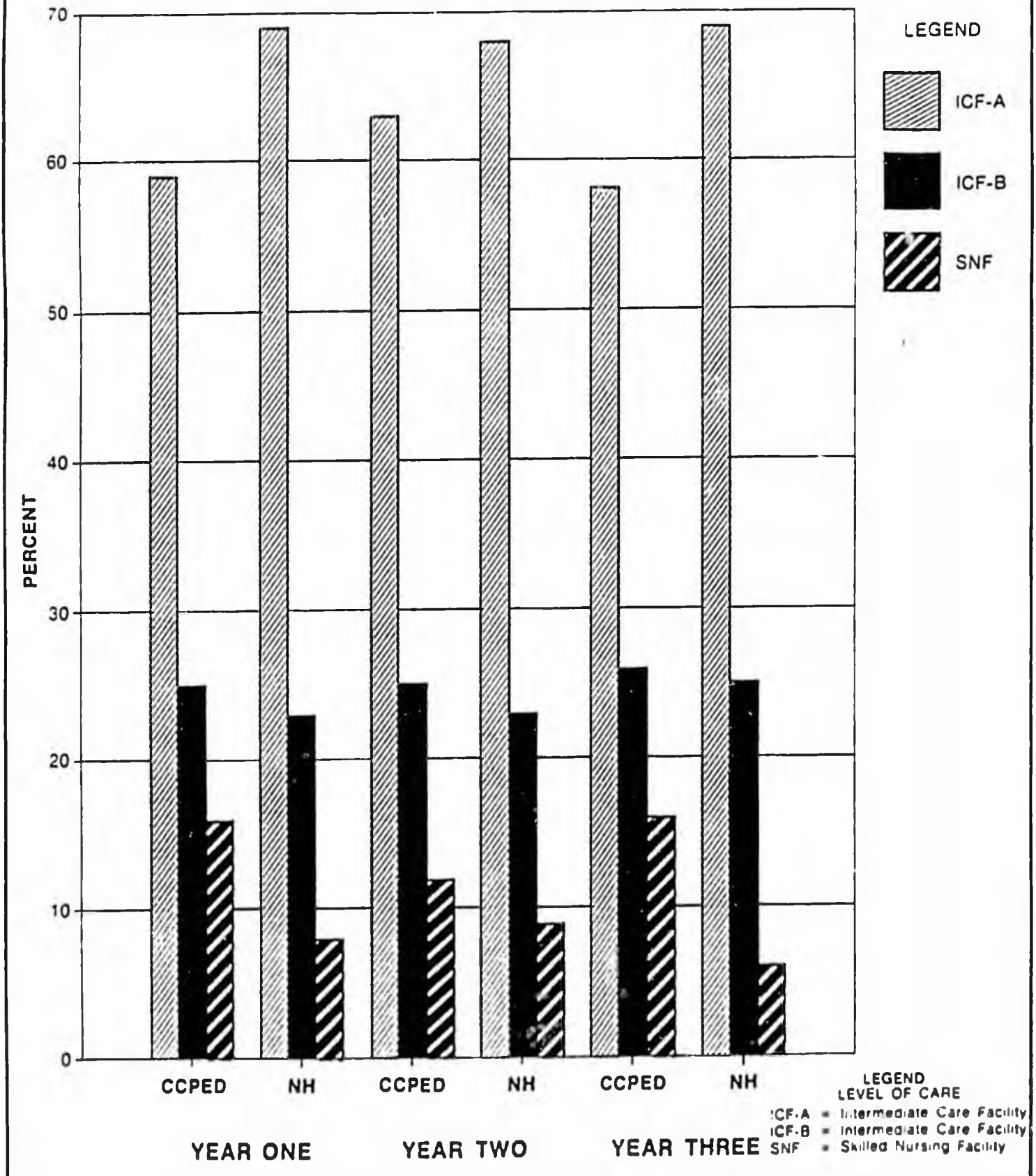


CHART 10

REASONS FOR TERMINATION

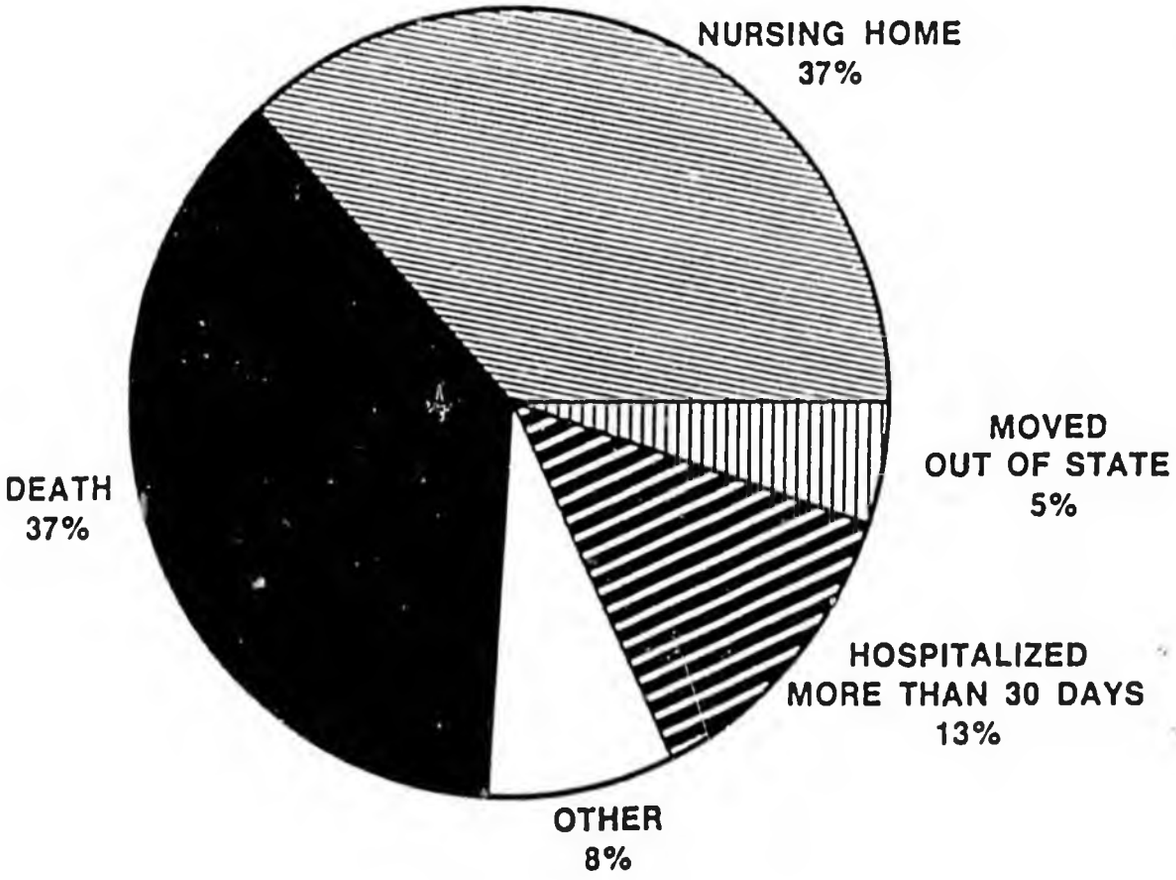


CHART 11

LENGTH OF STAY IN PROGRAM

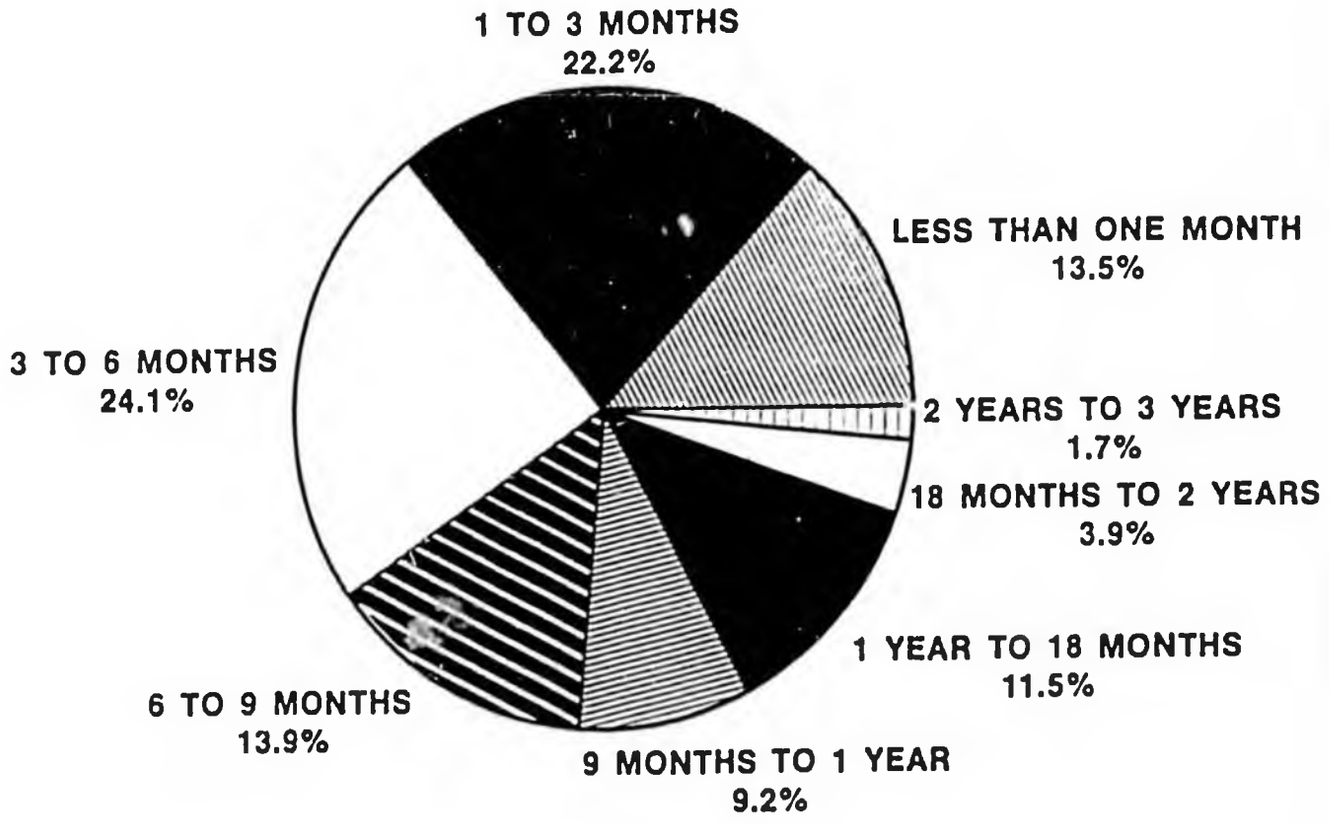
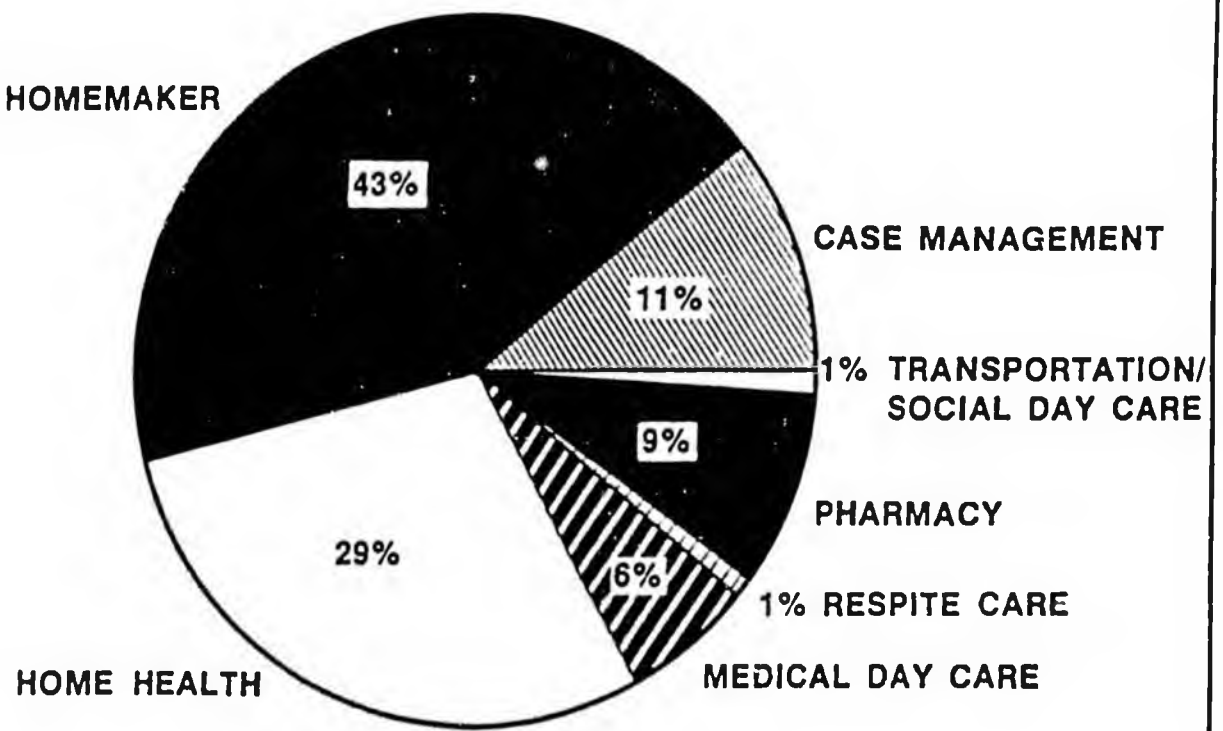


CHART 12

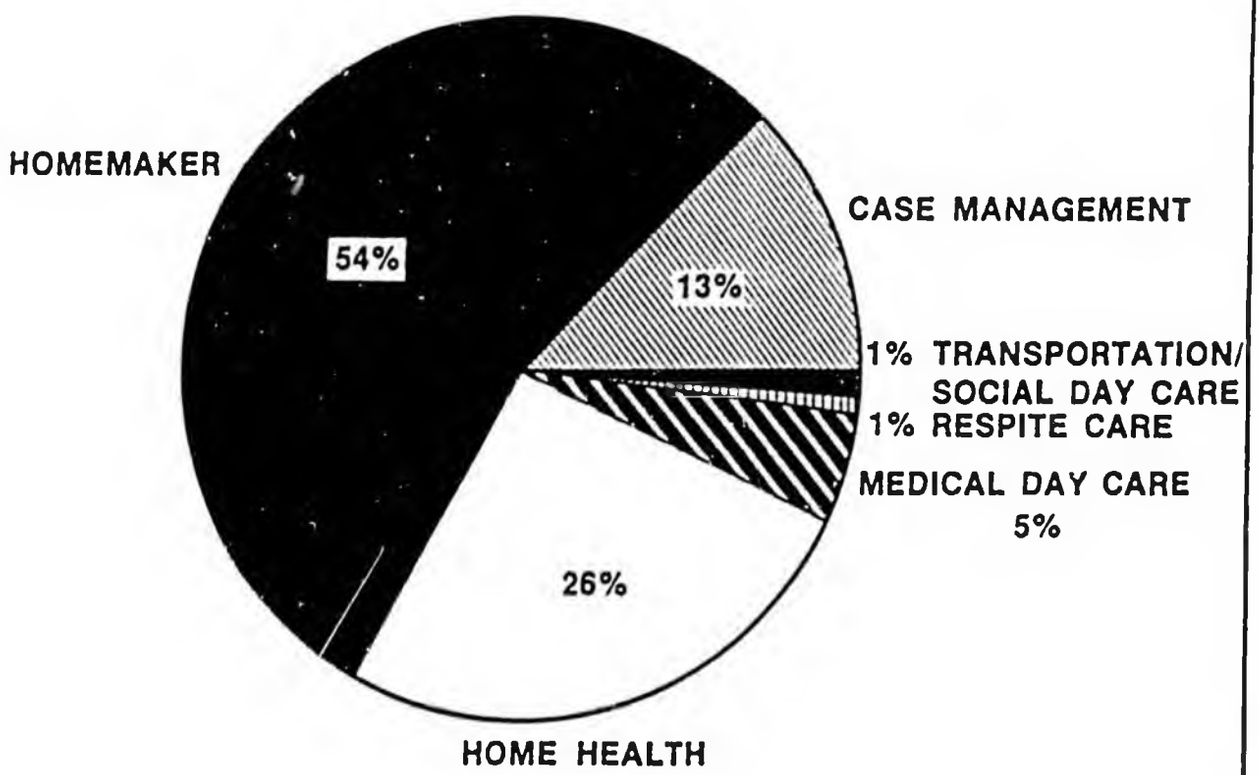
TOTAL AMOUNT PAID FOR SERVICES
YEAR ONE
$690,197.00



SERVICES/PERCENTAGE OF TOTAL PAYMENT

CHART 13

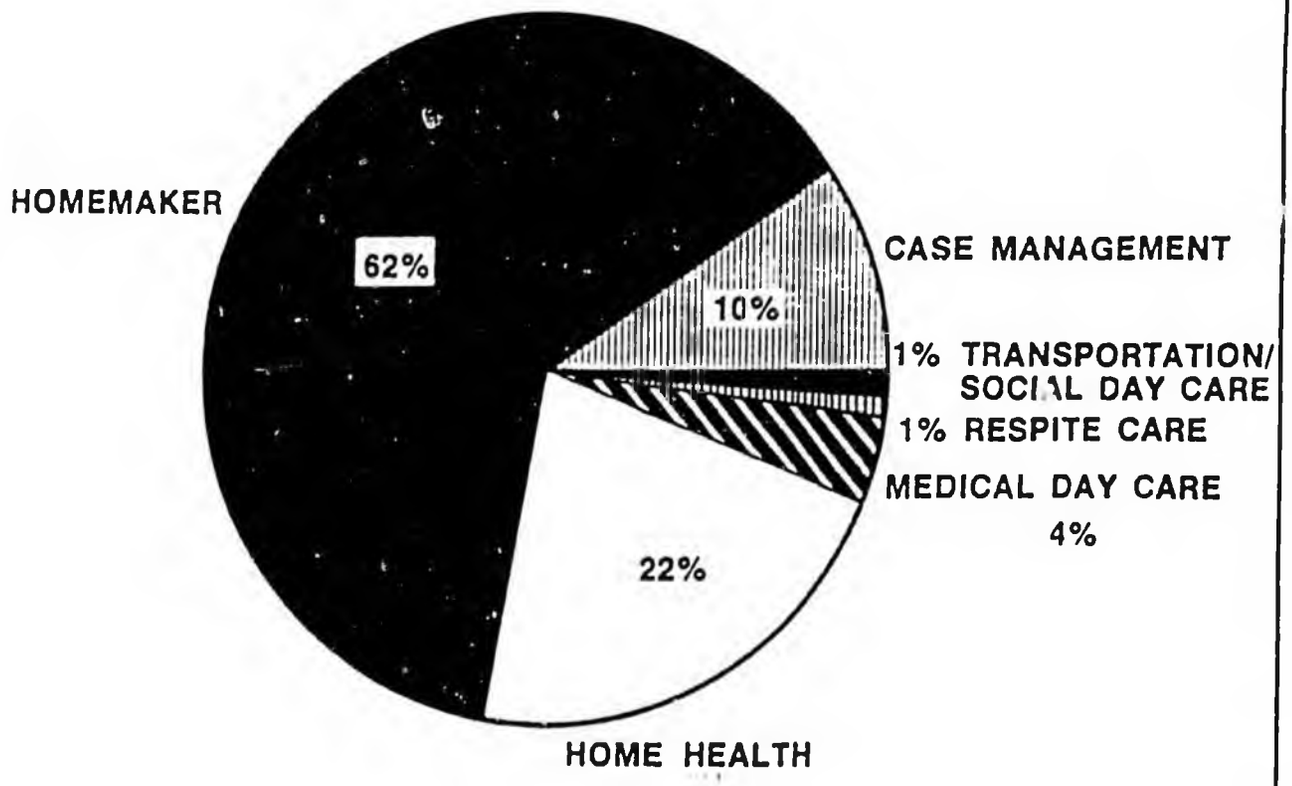
TOTAL AMOUNT PAID FOR SERVICES
YEAR TWO
$4,060,389.00



SERVICES/PERCENTAGE OF TOTAL PAYMENT

CHART 14

TOTAL AMOUNT PAID FOR SERVICES
YEAR THREE
$8,544,333.00



SERVICES/PERCENTAGE OF TOTAL PAYMENT

CHART 15

*EXPENDITURES AND AVERAGE PER CAPITA COSTS CCPED vs. NURSING HOME

YEAR ONE—10/83 THROUGH 09/84

	EXPENDITURES	RECIPIENTS	AVG. COST/RECIP.
CCPED	$ 690,197.00	462	$ 1,478.00
NURSING HOME	$332,063,329.00	29,157	$11,389.00

YEAR TWO—10/84 THROUGH 09/85

	EXPENDITURES	RECIPIENTS	AVG. COST/RECIP.
CCPED	$ 4,060,389.00	1,416	$ 2,868.00
NURSING HOME	$363,338,654.00	30,521	$11,905.00

YEAR THREE—10/85 THROUGH 09/86

	EXPENDITURES	RECIPIENTS	AVG. COST/RECIP.
CCPED	$ 8,544,333.00	2,197	$ 3,889.00
NURSING HOME	$375,460,917.00	32,281	$11,631.00

*SOURCE EXTRACTED FROM ANNUAL FEDERAL REPORTS

NURSING HOME LEVEL OF CARE CRITERIA

The following definitions were taken from the Long Term Care Services Manual, N.J.A.C. Title 10, Chapter 63, Subchapter 1, 9/79:

"Level III, skilled nursing patient" means a person with acute or subacute medical and/or mental dysfunction requiring skilled nursing, psycho-social and restorative care during a 24-hour period. The Level III patient requires continuous 24-hour availability of nursing personnel at the licensed nurse level under the general direction of a registered professional nurse and will require other skilled services on an intensive basis including rehabilitation. The dysfunction may involve one or several physiological systems, may be stabilized or not, with symptoms subsiding or increasing. The patient may be bedfast, chair-fast, semi-ambulant or ambulant (with or without assistive devices). Determination of this level of care requires an identification of skills required and evidence that as a practical matter such care can only be provided in a Long Term Care Facility setting.

"Level IV-A, intermediate care patient" means a person with physical and/or mental and/or social dysfunction requiring on a daily basis substantial assistance with personal care needs involving activities of daily living. Nursing care at Level IV-A must be provided 24 hours a day by licensed and nonlicensed personnel under the general direction of a registered professional nurse. These patients require continued restorative and psycho-social services which as a practical matter can only be provided in a Long Term Care Facility setting.

"Level IV-B, intermediate care patient" means an ambulant or semi-ambulant person with physical and/or mental dysfunction requiring minimal assistance with personal care needs on a daily basis. The Level IV-B patient requires continuous onsite availability of licensed and nonlicensed personnel for each 24-hour period under the general direction of a licensed practical nurse. The patients at this level of care will require continuing restorative, preventive and maintenance care which as a practical matter can only be provided in a Long Term Care Facility setting. The Level IV-B patient is usually fairly self-sufficient in activities of daily living with or without self-help devices and his/her needs usually have greater social than medical significance.