SCOMM

110:2

LONG-TERM CARE TASK FORCE
August 18, 1998
9:00 a.m.
Anchorage, Alaska

COMMITTEE CALENDAR

OVERVIEW OF LONG-TERM CARE, PRESENTATIONS BY PROVIDERS OF LONG-TERM-CARE

TAPE(S)

98-1, SIDES A & B
98-2, SIDES A & B
98-3, SIDES A & B
98-4, SIDES A

NOTE:

The meeting was recorded and log notes were taken. A copy of the tape(s) and log notes may be obtained by contacting the Legislative Reference Library.

Alaska State Legislature

Official Business

Long-Term Care Task Force Meeting

Anchorage Legislative Information Office
716 W. 4th Avenue, Anchorage

Tuesday, August 18, 1998
6th Floor Conference Room

9:00	Welcome Introduction of Task Force Members
9:15	Overview of Alaska's Long-Term Care Programs Kay Burrows, Senior Services Division, Administration Jane Demmert, Alaska Commission on Aging, Administration
10:15	History/Review of SCR 11 Senator Bert Sharp, Prime Sponsor
10:30	Review of the *Legislative Working Group on LTC Report* Jane Demmert and Jackie Ortelli, Working Group participants Jay Livey, Deputy Commissioner, H&SS
11:30	Alaska's Nursing Homes Overview Jackie Ortelli, Administrator, Denali Center

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12:00	Break for Lunch

1:30	Pioneers' Home Overview Jim Kohn, Alaska Longevity Programs Division
2:30	Home and Community Based Care Overview a. Kay Burrows and Jane Demmert, Division of Senior Services b. Karl Brimner, Division of Mental Health & DD, H&SS
3:30	Medicaid Financing of Long-Term Care Overview John Sherwood, Medical Assistance Division, H&SS
4:30	General Discussion and Prepare for Wednesday's Meeting
5:00	Adjourn

Long-Term Care Task Force Anchorage Legislative Information Office August 18, 1998	
	(Mechanical problems with tape recorder prevented successful recording of the first 15 minutes of the Task Force)
Tape 1A - 000	**Welcome, Introduction of Task Force Members**
	Overview of Alaska's Long-Term Care Programs Kay Burrows (KB), Acting Director, Senior Services Division Jane Demmert (JD), Executive Director, Alaska Commission on Aging
Tape 1B - 187	**History/Review of SCR 11** Senator Bert Sharp (BS)
Tape 1B - 400	**Review of the *Legislative Working Group on LTC Report*** Jane Demmert (JD), Executive Director, Alaska Commission on Aging Jacki Ortelli (JO), Administrator, Denali Center Jay Livey (JL), Deputy Commissioner, Alaska Department of Health & Social Services
Tape 2A - 001	**Alaskas Nursing Homes Overview** Jacki Ortelli (JO), Administrator, Denali Center
Tape 2B – 223	**Pioneers' Home Overview** Jim Kohn (JK), Alaska Longevity Programs Division
Tape 3A - ~500	**Medicaid Financing of Long-Term Care Overview** John Sherwood (JS), Division of Mental Health & DD, Alaska Department of Health & Social Services
Tape 3B - 511	**Home and Community Based Care Overview** Kay Burrows (KB) Jane Demmert (JD) Karl Brimmer (KARL), Director, Division of Mental Health & DD, Alaska Department of Health & Social Services
Tape 4A – 593	**General Discussion and Prepare for Wednesday's Meeting**

Long-Term Care Task Force members

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Representative Con Bunde (CB) Alaska State Legislature 716 W. Fourth Ave., #410 Anchorage, AK 99501 907-258-8168 Phone 907-258-8168 Fax	Representative Al Kookesh (AK) Alaska State Legislature State Capitol, #114 Juneau, AK 99811 907-465-3473 Phone 907-465-2827 Fax
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Mr. Dennis Murray (DM) Heritage Place 232 Rockwell Soldotna, AK 99669 907-262-2545 Phone 907-260-4590 Fax	Ms. Karen Perdue (KP) Alaska Dept. of Health and Social Services P. O. Box 110601 Juneau, AK 99811 907-465-3030 Phone 907-465-3068 Fax

LONG TERM CARE TASK FORCE

TAPE 1A

8/18/98

0 INTRO

CB convened @ 907 individual members present

CB

GW

DENNIS

SHANNON MCCARTHY

AV

915pm KAY BURROWS - the lady in

256 more Rapid Cars

302 Home Health Aide

314 Supervisors = JAN

322 Jane Leonard

330 JH Transportation

IA

8/18/98

335 JD Information & referral

346 KB the cost of energy

352 JD Senior employment ~~prob~~ is a program

365 Independent apartments

379 KB Insurance counseling

390 JD Senior housing

397 KB Many rural housing — can you add me a bedroom

405 JD

415 JD cq More & more young people participating

437 KB

462 KB Thus is the reason we are talking about LT care

476 CB

480 KB We are second in nation for grocery 85+ pop
"5/28 study"

525 KB Id like to spend last 10-15 mins to talk about strengths,

538 KB Many more people are _____ nursing homes

8/18/98

1A

552 KB Home based & comm based care is not funded well

TAPE

1B 001 KB We have some great strengths

015 KB Now... "What we really have is fragmented care"

036 KB Its often not consumer based

064 KB Capacity development

087 KB Some of funding need

108 KB

110 GW "Qs from

114 JD all considered, were coming along — OREGON

123 KB

132 CB Panelists

140 KB Its a very intimate service

147 DENNIS Definition of community based care

8/18

~~IB~~

150 KB

156 JOHN SHERWOOD - Welcomed as a learned deputy

165 GW

~~BREAK~~ @ 10:15 AM

187 GW welcomed Sen Shay & Karen Perdue

190 BS gave overview on SCR 11

263 - CB

266 - BS Will be last tomorrow

CB

275 - BS J Barnett ... objections to it

300 GW

304 KP KAREN PERDUE

1B REVIEW OF LEGISLATIVE WORKING GROUP ON LTC REPORT 8/18

400 JD

433 JD how is SR LTC coordinated/ paid ?

$15,000 annum

468 CB Q- at what age

470 JD A- 65 Yo

492 " On short, the working group found the

515 " Guiding principles

564 " the Q is - does all this really matter
Pl. Task Force agreed - this is care home so we want to stay here

---

2A 001 expansion done

018 - " care is as near to home as possible
there are the central points

024 GW

025 CB - Gr legs, funding lacks in back of my mind
Q - your report focuses on all LT care in BY
should they be separated, how would report differ

2A

035 CB there may be documentation for Tony P to invest in L-T annuity

Q-

041 JD - 5/28 report - there is seperate analysis of 2 system

050 CB Q - should there be one L-T

053 KB ~~that~~ long term
it's a very key Q for TF to look at

059 CB ~~I~~ we are doubled @ 14 to roll out

062 KB

064 JOHN HANCHETT
~~John Hanchett~~ - your presentation spoke of multiple agencies
Q - are all these agencies necessary because of funding sources

072 JD - couple of answers - were working w/ how things evolved

084 JH statistics from a few yrs back - are we making progress

087 KB yes we are
081 HP
089 GW -

2A

092 DENNIS — what about defends

096 KB — we are different definitions

106 — DM is it fair?

107 KB some say it is, some say its not

108 KP sense of impermanence

124 GW

JACK / CRITELLI = JO

148 JO ~~[illegible]~~ LTCWG. Key Factors

184 JO, there is a cost ... comprehensive ... as well as a skilled care

192 DM ~~this is worth~~ MEDICAID does

195 JO not

198 would analysis of Medicare be

203 GW What is Jack's DENNIS

JO ST JAMES

HER S

2A

246 BS

223 JO lots of P in obstty came to Denali Crk @ end stage of terminal illness - they're generally Medicare

233 GW - what states do best job

235 JO Have to brag on AK - we had great system in '86 were pt grad field P - other states aren't more successful

249 GW is it fiscal

JO access is... you need well-trained P, & need to be able to afford the cost

257 GW Who's AK-centered

259 JO - provide SVCS IN Alaska

264 JD - "AK-Centered" services that work in small communities

274 KB - each group of elders why have separate telecom

283 KP Our weakness is that Page, penelope for planning ahead or saving in advance - if yr broke system helps immediately

2A

300 KP — right now, we require P to totally impoverish themselves

— there was no central place to go for support for home-based care

322 GW Q who has NOT had to care for P at home

333 JAY LIVEY (TLF JUNE) DAVE PEARCE CON. is either planning or regulation/CAN, CERT. OF NEED program

347 JL current law requires CON review of expenditures of +$1 mil

LTCHS fund deficits in CON law

3 STDS — Availability
— accessibility
— quality

385 " Demonstration of need

402 " Cost effectiveness

451 " more from 5/28 report —
to what degree can we consider cost-effectiveness through C.O.N. process

2A

464 GW - any q

465 KP — how would any Leg bind any future Leg

477 GW - any Qc

478 DMS Pearce — C.O.N. application
S Pan Hosp - wants 10 bed
what's ratio of acutal living beds to N.H bed

494 JL

504 CB respite beds?

514 DP were renewing St. Ann's CTR
44 Nursing beds TO 1 RESPITE Bed

526 JL reimbursement system for every NH bed & as respite bed

554 JL - issue Medicare reimbursement — DM is right we should maximize Medicare $

568 DM

579 Jim Hawkett CON are

581 JL for other levels of care

2A

593 GW

2B JO AK Nursing Home Overview

001 JACKI ORTELLI

076 GW explain one line of chart

078 JO,

[1:45 REP RYAN ARRIVED]

105 JO O did bring some more pieces & parts

? 2) 3) 4) look at pilot

REP

138 JO as planning group looks to future, O wanted to show you what we're doing @ Denali Ctr

177 Safety net

JOANNA GIESLER = JG

186 ~~JOANNA~~ ~~GIESLER~~ Q - what problems in Denali Ctr having a transition from NH → assisted living

JG

188 JO mm

2B

203 JG Dr services are always available

205 do

208 GW Well received @ 1:30

[LUNCH BREAK]

2B

223 Jim Kohn (JK) OVERVIEW OF PIONEERS HOME

330 GW ~~GARY~~ WILKEN

JK

353 CB

JK - its paid directly to resident

376 JK we had to make provision for them, or turn them away

383 JR~~KM~~ what threshold of dementia

390 JK - it took lots of staff and Alzheimers Assn to work on this

458 JK we had couple of Alzheimer events @ PH

2B

465 JK) Homelike atmosphere

520 800 P/mo receive this sheet

561 180 P/YR TURNOVER

576 DM (DENNIS MURRAY) How do P show up on ACTIVE/INACTIVE WAIT LIST

JK you apply in writing or can waited between act & wait

598 GW – pls hold

603 JR – is PH a retirement home at all

605 JK Yes, some P

3A

016 JK Will have to narrow a narrow range of P we can have in PH

030 Can't talk about program must talk up about FINANCING

060

075 State will have to subsidize PH

1994 15% realty 85% state

1998 31% " 62% "

3A

086 JK funding secretary

168 JK bathroom lights were always burning → motion sensors

Facility
legal environ
physical environment
185 organizational environ

214 Motion picture home — Taryan

255 Another group were working w/ a EDEN ALTERNATIVE
dementia treatment by normal environment

273 involvement w/ children — P w/ dementia respond to children

295 JK We're gone out to get most-credentialed people in the world to come to PH

GW
347 KP Perkins

350 CB the 80/20 NZ/new — are the P related?
JK we stop in PH as couples, easy to start place for em

3A MEDICAID FINANCING OF LONG-TERM CARE OVERVIEW

x500 JS JOHN SHERWOOD
round glasses, funny hair

557 JS Financial eligibility Cnlow

605 JS lots of ways to slice + dice the $

3B

001 JS JOHN SHERWOOD

060

090 JS < What Medicaid doesn't pay for MARK MAZZ

137 CB How can we merge need for care coordination w/

150 JS

172 JR NH are expensive

182 can't pay for room + board..."

197 KRourke KB NH eligible pays set rate to Med eligible

3B

222 JR How can LEG make this happen w/out $ appropriation

227 JS - hard to ___ w/out new revenue source
w/ new stretched Medi $

237 ~~John Hanchett~~ JOHN HANCHETT 60 / 40 % funded
FED STATE
- what can we do - will system always

247 KP Medi is funded LTC but it's not a good fit
LT is not the way we want to use it
why not Medicare paying

258 KB - private insurers can

262 JS some states have incentives for private insurance
- you should buy LT insurance @ 40-50 % (?)

280 KB particularly if you think Medi will pay for it

281 JS

289 ~~Joyce Giesler~~ JOYANNE GIESLER Lots states struggle w/ "NH as an entitlement" but assisted living is an option
to Pers Care Svcs

3B

302 JS fed law must be changed to make entitlement living into an entitlement

322 JG pls describ

324 JS Medically Needy Program:

360 KP ?

361 JS ~~trusts~~ are only for Medicaid

369 KB this is when P can $30-60 short

372 JS there's other rules — takes skilled money mgr to keep it going

386 DM Miller Trust ... has helped?

394 IT is not a

396 KP could we go over overlap of Maid's Manor — pls briefly describe niche cost shifting to Manor

408 JS (A) Home care is cost shift

417 KP

422 JS most P pay part A premium part B premiums ...

3B

437 DM Ought be good to learn what goes done w/ Medicare

461 JO ?

481 JR please get me copy of fed rules

494 GW or recall 6 entities under HBS

499 JS No -

503 GW

CB

3B HOME AND COMMUNITY BASED CARE OVERVIEW

511 KB HOME & COMM BASED CARE OVERVIEW

KAY BURROWS

533 HCB

545 CB

548 KB Medicaid 50%
Cigna 25
MHEMP 12%
GF 12%

4A

026

032 KB Respite hours 34 SRs 60 commun. 51,000 hrs

038 KB LTC - lots of dmgt svcs in communities

044 home based/delivered meals - 12-13,000 SRs
- sometimes meals prepared in schools

054 CB — how does coordination of kitchens at schools

056 KB — SR lunch prepared after school lunches

065 KB Transportation

082 CB Q-are there more applications than jobs
KB A-YES

100

123 KB Personal Care Attendant Services — is a backbone of system

144 CB Q - some P getting respite care paid 7/hr, those who earns beta paid $10/HR
are those federal or state requirements

150 JS other progs funded respite care, 6 agencies has diff rates

163 KB sliding fees diff for each system

168 CB dont want to document labor pool

4A

245 KR LTC Design Team

260 $45/nt $60/nt $90/nt $200/nt 2

277

336 So that's to allow us to get to here

340 KARL KARL BRIMMER DIV Mental Health & DD, HSS

483 KARL end presentation

485 JR JOE RYAN Q) does dept have a QA checklist? are we pro active re-active

KARL A) no - not for assisted home

504 DM re small group home - w

506 KARL Next Levels LVL 1 $30/day LVL 2 $40/day

DM

KARL

525 DM Q

Q

4A

533 KP — p contributes down on $

550 KARL — st $70/pro very low
552 KP — were working to improve

564 KB — MHT must be working on mixed payment

576 GW

580 JD

KARL — 427pm signed off DNS TCP

593 CB — TOMORROW on 2nd floor

606 KB

GW

4B

8/18/98

Alaska State Legislature
Long-Term Care Task Force
August 18-19, 1998 Meeting

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Please PRINT the above information. Thank you for participating in this task force meeting.

Alaska State Legislature

Long-Term Care Task Force

August 18-19, 1998 Meeting

8/18/98 8/18/98

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Please PRINT the above information. Thank you for participating in this task force meeting.

LONG-TERM CARE TASK FORCE
August 19, 1998
9:00 a.m.
Anchorage, Alaska

COMMITTEE CALENDAR

CONTINUATION OF 8/18/98 MEETING - OVERVIEW OF LONG-TERM CARE, PRESENTATIONS BY PROVIDERS OF LONG-TERM CARE

TAPE(S)

98-4, SIDE B
98-5, SIDES A & B
98-6, SIDES A & B
98-7, SIDES A & B
98-8, SIDE A

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Alaska State Legislature

Official Business

Long-Term Care Task Force Meeting

Anchorage Legislative Information Office
716 W. 4th Avenue, Anchorage

Wednesday, August 19, 1998
2nd Floor Conference Room

9:00 Presentations on Long-Term Care Services in Alaska

a. Alzheimer Association - Dulce Nobre, Executive Director
b. Tanana Chiefs Conference - Anna Fath
c. Mental Health Trust Authority - Jeff Jessee, Exec. Director
d. Independent Living Council - Patrick Reinhart, Exec. Director
e. Governor's Council on Disabilities & Special Education - David Maltman, Executive Director
f. Bristol Bay Native Association - Kay Branch
g. AARP Alaska - Marguerite Stetson, President
h. Alaska Housing Finance Corporation - Steve Ashman, Senior Housing Division
i. Senator Mike Miller - Senate Bill 321, *Assisted Living Homes*, Sharon Clark, staff

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11:30 Break for Lunch

1:00 Public Testimony via Teleconference (or in person)

2:30 Roundtable Discussion
a. Identification of Issues
b. "What to do Next?"

4:30 Organization of the Task Force

5:00 Establish Date for Next Meeting
Adjourn

Long-Term Care Task Force Anchorage Legislative Information Office August 19, 1998	
	Presentations on Long-Term Care Services in Alaska
Tape 4B - 028	a) Alzheimer Association Dulce Nobre (DN)
Tape 4B – 139	b) Mental Health Trust Authority Jeff Jessee (JJ)
Tape 4B – 309	c) Tanana Chiefs Conference Anna Fath (AF)
Tape 4B – 424	d) Independent Living Council Patrick Reinhart (PR)
Tape 5A – 010	e) Governor's Council on Disabilities & Special Education Dave Maltman (MALT)
Tape 5A – 143	f) Bristol Bay Native Association Kay Branch (KAY)
Tape 5A – 283	g) American Association of Retired Persons Marguerite Stetson (MS)
Tape 5A – 432	h) Long-Term Care Ombudsman Frances Purdy (FP)
Tape 5B – 126	i) Professional Guardian Dave Schade (DS)
Tape 5B – 298	j) Alaska Caregivers Association Monta Faye Lane (MF)
Tape 5B – 400	k) Alaska Housing Finance Corporation Steve Ashman (SA)
Tape 6A – 001	l) Sharon Clark (SC) Aide to Senator Mike Miller
	Public Testimony via teleconference (or in person)
Tape 6A – 223	Marion J. Griffin
Tape 6A – 250	Lester Westling, Alaska Chairman of Caregivers Assoc. TCF FBX
Tape 6A – 323	Marie Simmonds, TCF FBX
Tape 6A – 375	Monta Faye Lane, Alaska Caregivers Association
Tape 6A – 435	Bea Garvey, Vice President, Director of Professional Guardian Corp.
Tape 6A – 530	Kristi Ecklund, Hope Cottages
Tape 6B – 004	Ken Dean, Southeast Independent Living, TCF JNO
Tape 6B – 020	Rhynnieva Moss, Aide to Rep. Al Vezey TCF FBX
Tape 6B – 031	Ted Withrow, TCF FBX
Tape 6B – 063	Karen Hessert, C.N.A.
Tape 6B – 128	Pat Edmunds, owner, Hand in Hand Care
Tape 6B – 205	Candace Drayton, Dignified Home Life Care, Inc.
Tape 6B – 285	Kathy Emmonds, R.N.

Tape 6B – 378	Marti Margeson, Alaskans for Better Care for Seniors
Tape 6B – 470	Katherine Hayes, C.N.A.
Tape 6B – 555	Leslie Grebaugh, owner, Parkside Assisted Living
Tape 7A – 015	David Jacobson, Director, Access Alaska
Tape 7A – 058	Vicki Dodge Pamplin, M.S. Society
Tape 7A – 104	Dolly Swanson
Tape 7A – 145	Don Smith, Alaskans for Better Care for Seniors
Tape 7A – 224	Mary Ann Dearborn, Southcentral Counseling Center
Tape 7A – 303	Bonnie Barber, Alaska Division of Vocational Rehabilitation
Tape 7A – 373	Deborah Jones
Tape 7A – 401	Sue Samet, Director, Providence Horizon House
Tape 7A – 445	Brad Bernier, Access Alaska
Tape 7A – 565	Bernadine Gantert, Access Alaska
Tape 7B – 001	Joy Olmstead, TCF FBX
Tape 7B – 084	**Roundtable Discussion**
Tape 8A – 050	**Organization of the Task Force**
Tape 8A – 070	**Adjournment**

4B LONG TERM CARE TASK FORCE

9:05 8/19/98 WEDNESDAY

4B

CB 001 TCF: KET FBX DIL

JH
Stephanie Mc
KB
DM
JR
CB
GW
BS
SP
JG

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028 DULCE NOBRE - DN ALZHEIMERS ASSOC ALZHEIMER ASSOC

(A) Partners in RESEARCH
PUBLIC POLICY
PATIENT/FAMILY SVCS

AK A.A.

045 DN - only 2 statewide positions, serving 70 cnty's, 34,000 contacts in 1 yr... 400 p attend support groups

052 In home respite 50,000 hrs/yr

4B

057 We are lacking resources around state, but bigger probs in Rural

065 Medicaid choice/waiver programs - big help for lots of p
- could improve by adjusting eligibility

080 We try to emphasize quality - we also need more capacity
& pers. inc. stds.

100 Aware we recommend LTCTF addr
don't forget rural need
choice
elig for NF only patients
quality.

104 DM - share budget

106 DN Will give you annual report - $2mil/yr
Offices mostly FBIs, DNO
- employ 100 p (25 regular, rest in-home respite workers & f

124 CB invited participants to be part of Roundtable discussion
- how do we feel about
- what

MENTAL HEALTH TRUST AUTHORITY

139 JJ (B) Jeff JESTES — Mental Health Trust Authority
EX DIR
- Regular MHT

4B

160 We have 150? mm acres
that put $200 mm into Trust, managed by Penn Fed Corp
Trust generates ≃ $9mm/yr vs $129 mm in pol bond to 4 grantees

170

191 BK cancel contingency
GW's Commit
=
=

198 trustees facilitate co-ordination between planning board

208 "Harbourview problem" – consensus away from institutions
toward assisted living

224 Many of our beneficiaries need L-T Care

244 CB I'm confident there's enough work for all of us
GW I hope you're w/ us every step of the
250 JW I'll be main contact w/ you

254 DM re Harbourview – Q?

259 JW I spent a day w/ DM & learned about human resources

277 DM Medicaid Rate Advisory Commission Q –

285 GW leading state? on issue
284 JW – 10K – but we can avoid others mistakes & learn

4B

304 CB Im sure AK will make

309 AF (C) ANNA PATH – TCC FBX TCF

302 We visit elders in villages 2x/yr

402 We vision to establish services

419 CB

424 PR (D) PATRICK ~~RETENTIVE~~ RETENTIVE Indp Living Council | Independent Living Council
still Ak,

455 Center for Independent Living – 5 in AK – consumer-run
majority of decision-makers are d
4 CORE FUNCTIONS
- info & referral
- indy living skills training
- peer counseling
- individual advocacy

490 SILs in 97 served 1,400 p directly – tremendously

500 State Plan for Independent Living – I want to live indy
& NH is last choice

4B

508 JJ What do P need.

Housing – not enough accessible

Transportation – people

Personal Care & Assistance – not enough workers to provide it, mostly cuz low pay

(Agency Based Care – high turnover)

Independent PCs, but DSHS only pays $9/hr for total compensation

5A

001 JJ

008 CB – Qs

(E)

010 MALT DAVE MALTMAN – DIR GN'S COUNCIL ON DISABILITIES & SPEC ED federally funded

025 – we plan & provide SVCS to improve lives of P w/ disabilities

– few yrs ago we dev waiver for home care SVCS

– Harborview

[955pm KP SPR]

039 MALT Human Faces – interviews w/ LTC recipients

051 " Consistent msg on LTC – P want cust-directed svcs, range of svcs, svcs delivered close to home & culturally appropr, & w/ quality of svcs.

072 " Costs PCS (SERVICE PROVIDERS) make $3/hr less than other HC providers

5A

083 MMT housing
access to affordable H.C.

[10m JR ANCR]

102 sorry Q cant be @ Ranktable

105 GW - re low pay & other factors — direct service workers

107 MMT $3,500 in screening, bkgnd checks, recruitment costs
plus, unqualified P get

122 KB

123 JR Q-

132 MMT cant answer question

141 CB - please leave written

BRISTOL BAY NATIVE ASSOCIATION - KAY BRANCH

143 (F) KAY BRANCH BBNA TCP From DILLINGHAM

read letter, then testified

243 KAY % of elders are at or below poverty level
- must have adequate

249 KAY Recs for LTCTP
1) build capacity for LTC in villages - Patricia re home care
2) look beyond tried biomedical models of LTC

5A CB
275 "Photo it"

283 MS (6) AARP ~~Margaret Stoba~~ MARGUERITE STETSON AARP state president
read from statement – GOT IT

(4)
432 FP FRANCES PURDY LTC OMBUDSMAN

473 " RECCOMMENDATIONS
1) WAIVER ...
Extended Families & PCS

496 " 2) LEGISLATION re guardianships – need changes

533 " 3) we need more PCS – no viable alternatives
– SRS will accept almost ANY PCS/home svcs than go to NH.
4) need better trained CNAs cert nursing asst.
– but they're low paid & need ongoing teaching
5) better ~~svc~~ regs or enforcement of standards for assisted living

5B 001 FP

004 FP 6) there is LTC ombudsman for those under 60 Yo

014 CB constituents do complain to legs

5B

018 JH what % of complaints are kept

028 FP

032 KB 15 ave
033 FP there are no violations - many complaints are abuse/neglect complaints
043 CB when you have control over budget
045 FP but elected levy is private
050 JR Dr. 62 - I'd have prob w/ Rx rule 30%
053 FP which #, an app
≈ 500 p flood
058 KB the gap is .. 250-400 p depending on deflants
064 FP some elected levy P are getting vouchers
075 KB Public investigation into elected levy...
085 CB + public must be informed consumer
088 KP re extended family - should govt pay family to care for family member
CB - one person gets paid, one volunteer
097 FP a lot of times are case-by-case
104 KB were done that by exception -

5B

106 KP — do we have stats for roll...

113 FP — how are next stats we can use, but can't mandate...

123 CB VTS

---

126 (I) DAVE SCHADE — Professional Guardian Guardian

243 DS guardians/conservators are under court supervision

260 JR what's driving

267 DS IDK

286 CB overview of afternoon testimony

---

298 MF (J) MONITA FAY LANE — AK CAREGIVERS ASSN

READ STMNT

369 M treat us w/ respect

383 CB Sen Miller wanted to testify on SB 231 32(

---

400 (K) STEVE ASHMAN — AHFC SR HOUSING OFFICE

[11:15 am CB DEP]

5B

≈505 SA — Rural areas — no reason elders should have to come to Anch

534 JR — are _____ unoccupied
Fireweed & Lapp

544 SA — that's probably true — want sure there was need for 67 bed

560 DM — no ones having probs meeting mortgage payments

562 SA — 70% occupancy is ≈ headed — we don't want to have probs

581 GW

6A SC — SHARON CLARK aide to SEN MIKE MILLER

001 — in SB 321

036 — SB 324 — READ STMNT

053 BS

061 SC — This is our problem — everyone agrees it's needed, but no funding

092 4 — need LTCH insp/goals given to review — rural/urban

098 — extra stations/beds could be used in city of Anch retreat that should like to see get their overhead.

6A

110 SC read: 'Tanabara Elder Lillian Trett –
"An Age-Old Truth" – care for old is measure of civ.

122 GW

123 BS $50–55 mil

134 SC

136 KP I was pleased when bill came out
MH board has recommended 1.1 $500 mil?

145 KB Commission put in ... to there $2 million
76%
Hope to have — by mid

157 DM Q Medical relief is a gap program

162 SC cutoff

164 KB this gap is not Gen Relief program, it's for
those P fall thru the cracks

178 GW THKS for your testimony
will recourse @ 1pm for testimony
BREAK FOR LUNCH

187 GW 1:06pm RECONVENE
outline afternoon
were got 20 p – 5 min each
TCF FBX Rancho Park

CB
KP NOT HERE
JR
BS

GA

223 MARION J. GRIFFIN - FRX "TRI-LEVEL CARE" awaited living
on daggett pat $34.50/day insufficient
we can wait 4-6 mos for our $, forcing us to use our $

[1:11 pm RS ARR] —

250 LESTER WESTLING (WESTLING!) her he for 10 bedhome in FRX
~~CHA~~ MC CMTY CAREGIVERS ASSN
VP
- her bro high care, medicaid dependent

[CB ARR 1:13 pm]

he get reimbsd $34.50/day, but spent $130/day
lotta cases come thru HOSP ER, Medicaid gets exhausted.
then the awaited levy takes em or absorbs em

310 we need rate increase to get
plz help us to help those in CMTY, or awaited levy may
have to turn people

323 ~~MONICA FAKE~~ MARIE SIMMONDS
FOR daughter KEISHA MARIE SIMM ~~UAF student?~~
daughter was in N.H. for couple wks 2yrs ago

343 we can't get awaited living on committed basis

362 best were had is thru FBX Mem. HOSP

6A

366 CW Heather's story was POS of cg

375 MOUNTAIN PARK LANE DHS MH caregivers
and 2 assisted living homes
funding for CR must come from state

392 82-83 DPHS funding restored
it's been 15 yrs w/out a rate increase +$34.50/day INSUFFICIENT

425 ella by KB

429 CW - PBX knows you take pt rec

435 BETH GARVEY VP DIR PROF GUARDIANS CORP.
fundamental living home model

[J5 MAR 130]

516 theyre biggest bargain in town

530 KRISTY ECKLUND live in care prov
-SW HOME COTTAGE employee
read statement from her charge, CARLA

258-1261 Fn

6B

004 KEN DEAN JNU

017

---

020 RHYNEA MOSS, FBX REP. VEZEY ANNE
MH $ should be used for assisted living

---

031 SHELLY GREEN FBX

TED WITHROW - Access FBX
had accident in 1980 → Denali Ctr
wife trained as CNA.
where R need more $ for higher wages to keep 'em in jobs

---

063 KIRSTEN HESSERT KNCA
a CNA for 15 yrs - 2nd income

if you can offer incentive like emp. med. benefits
- caring for 26 R @ $7/HR vs $10/HR @ Fred Meyer
- w/ better pay & benefits, would reduce turnover
- recertification fee is rising to $165 from $55, plus costs of FBI background checks & fingerprinting

090 - could you give a tax break for home-based care - like AHFC gives low interest housing loans

GB

114 Im concerned about my generation

CR a dog UA train CNAs
& I got 2yr training in MAINE, so JOK

121 KB UNH hrs CNA class, & will start PCS class

---

128 PAT EDMONDS owned of HHA in HHA CNA
RANCH in 3rd year

169 PAT – if yr can pay good $ you get good CNAs
ED. – wants some home based training

184 – pay work ethic

GW – what's good pay

187 – PAT $8.50 – 15/HR is good pay
shows a 4-month lag in getting

201 CB – write & tell us w

---

205 CANNICE DRELSTON blonde
homo care

3 yrs in by – I can't take GEN RELIEF patients
Pros of 24hr care/work only get $107 profit
ER can't pay what it costs to provide services

68

225 now she takes Choice clients, many of whom cycled thru NH.

-30% — 92% clients

248 Depy ≈ $10/hr 1/2 took OR patients, could only have enough staff for 33% of day

— Patients thrive in small home setting, but want more $ we can't serve OR patients

262- Boomers may wake up w/ stroke

274 hospitals keep you alive
invites legs into her homes to see what lives are like

285

KATHY EMMONS BS PSYCH R.N.
today Dir Integrated Home GERIATRICS CLIN
works @ skilled care facility

Power Homes are not

297 Pare intimidated & afraid to talk, s.

311 everyone says NH. are wonderful
time for fox to stop guarding henhouse — state licensing

327 CNA 5th anniversary 7th cycle readers BUT are giving meds
Reg

GR

340 often no RN on building @ PH, & sometimes she's been only RN for 245 residents

350 Q prayer for no fire/earthquake cuz not investigate on PH behalf

368 admins are paid 25% kickback for supplies not used

---

378 MARTI MARGESON AKN, FOR RENTOR CARE
2 private citizen FOR SENIORS

we expect PH to be std of assisted living care ~~NOT~~ were investigated

- 1 bath/rob is unsafe
- we question mandatory use of pharmacy on PH (if you don't use PH pharmacy, they won't
- PH won't issue if reports on falls, medication errors.

415. can't get info on staffing @ certain times

430 not enough staff for emergencies
no testing for communicable disease

456 PH is operating under Assisted Living regs written for

GB

470 KATHERINE HAYES, CNA

home care giver

— well-trained P can't get paid from state 2 month delays

539 — so many clients

555 LESLIE OREBAUGH owns Parkside Assisted Living Green Home

state GR patients almost exclusively

584 — my pay rate is disgusting

assisted living don't keep Mom & Pop for years

7A

015 LORD LESLIE — Did post of Business tomorrow

DAVID JACOBSON Dir Aging Alaska

What a job you have...

Community

must find solution to wide range of issues probs

054

7A

058 VICKI DODGE POMPLIN MS SOCIETY

077 P thrive in own home
Medicaid/Medicare don't pay enough $ for care nec

091 Sweden gives great care
let P parks create mo

---

104 DOLLY SWANSON parents in ANCH PH
PH, scared to speak out about poor care
dad pays $3,500/mo - low staff, bad food, staff unqualified

120 - put PH under HSS
59 → 8 nurses

138 JR did you reg. complaint w/ Nursing Bd, Pharmacy

---

145 DON SMITH cousin to Dolly Swanson
for 2 yrs Dave watched as PH deteriorated
3 yrs ago at rate $700/mo it began rising $200/mo every month
it was moving toward making him a ward of state cuz of PH

7A

177 Phoebe decided to change PH from retirement home to ALZHEIMERS & Dementia care

- the PH Pare afraid, staff is demoralized

205 Harborview transfers are assaulting others patients

212 KP

---

224 MARY ANN DIEKER BORN SR RSCH COORDINATOR PROGRAM SR Seminar @ SC COUNSELING

---

303 BONNIE BARBER

STATE DVR

M.S. RENAB

B.A. PSYCH

shot @ 9 Yo FBx N.H. 14 yrs

330 you don't want to warehouse P in N.H. - children are still in NH

342 if PCA Medicaid program is not revived, I can't be out in community

362 NH/warehousing = no answer integrate P into CMTY

---

373 DEBORAH JONES mother was in PH, now at Living

poor care @ PH

7A

401 SUE SAMET ~~SAMUELSON~~ LONG TERM PRN MR, PROV HORIZON HOUSE ~~PROV EXT CARE~~ SP

later P gone to PH from PROV X-CARE — were heard none of these complaints

talk of PROV health system to help heal of

422 those big gap in ~~elder~~ GERIATRICS psych care

— P usually go to NH for S-T rehab

---

445 BRAD BERNIER Access Alaska

Samoa Bonus Rules

501 fed/state economic social mandate ...

can we generate enough of a demand for jobs in home health care

525 lots need of N.H.s to retool them to do better job

554 CB we have global concerns

---

565 BERNADINE ~~GERHART~~ only living specialist in ACCESS AK

geriatric

7A

7B

7B

~~CB~~ JODY OLMSTEAD FBX TCF

024 we need more assisted living

058 CB BRUCK
~~ON~~

CB 3:25pm
084 CB referred to SCR 11 – Leg mandate

1) propose draft leg to design actuarially sound LTC system
2) hold hearings ,

report by 12/15/98 to Leg & gov. by 21st LEG

---

(1) How do we fund the system, & get participants to pay

118 CB as we talk $, must propose system to reduce cost for FRASER

– consolidation of LTC w/ D/HSS options
– if we require contrib to annuity, will that put p over limit for other programs

7B

147 JR It seems we should have screening proces
lets make sure to include non-profits
maybe redistribute $, before adding more $ overall

167 CB – so

JR – lets make sure were getting

172 CB – if we continue current way, by 2015, still lack
$375 mil /
– w/ an pop growth

179 GW lets focus on TO-DO list

184 JOYANNA GIBSLEY Synopsis of what I heard to date
A) lets include disabled + elderly in LTC recips – wholegov
B) we need capacity building & options in Inuvik communities

201 CB TO DO – increase community-based options

206 JG c) investigate Medicare funding & either were not using it enough or they're shirking their duties

217 KP Checks & balances are important
do we have right mix of regs & non reg

225 GW – what did we do

230 KP maybe look @ assisted living licensure

7B

239 CB SB 324, a way to allocate funds but lack of info @ what funds exist for allocation

250 CB world of LTC annuity, producing a voucher good at several provider/services

we have to balance state vs personal responsibility

261 KB Funding Stream – AK must ask what funding institutions will give us reliable system

– AK hasn't looked at institutions for funding streams

281 CB – funding as multi-stream issue

look at it as Person w/ need, not service provider

295 KB

302 Frances Purdy – vouchers are good idea, but depend on ppl ability to negotiate & know the service system

– LET'S START FROM HERE

322 CB too much demand, not enough $

FF

325 DM shows lots of overlapping service

7B

360 DM Lets come up w/ cost/person for P in all 4 categories of Medicaid of top 100 p in 1997

372 — show tremendous disparities in how we allocate resources
~~TOP 100 IN EACH CATE~~
1) Complex children
2) Adults w/ Physical
3) DEV. DISABLED
4) Elderly
NH

402 CB – we do need total cost $#s
were talking direct or indirect too

415 – of contract wants to pay ahead

JR GW added to PS

425 JW make sure we get evgs, because DM / HERITAGE etc mostly at bottom

432 JR – asked series of questions

445 – CB pub not fed $, pub state seed $

7B

453 Maryann Dearborn — add mental health svcs for elders

462 KP Aurora guiding principal — Bonnie Barker taught me
— we need to let ppl make choices for selves, & have close to em, so they can choose/pay for svcs they want & can pay for
— keep it away from govt, cuz we require IMPOVERISH SELF

503 Managed care lends cost-w bus chaos

508 CB - lower cost comes @ reduced care level

515 - JS

547 CB - basic definition of LT care? 1 mo 6 mos

554 JR - Annuity.

---

573 DAVE JACOBSEN individuals must make choices
Govt must dev. PLAN before funding survey

8A

003 KP if you want special svcs

CB we want commuters + families to be responsible

012 BB Bonnie Barba – I pay my own ins

017 CB we must focus on LT care – ult goal is benefit to individ, not job creation

027 JH gotta be careful to use proper definitions, so not raise false hopes
"annuity" is purchase you can't outlive ≠ CD

062 only 50% of state employees are paying for own LTC @ retirement(?)

068 CB it'd be good to know premiums for LTC under State of Alt retirement benefits
– a buy-in would have to be mandatory

078 Jane Dammert – we all need, and myriad ways to address it
lets draw on expertise of those who've been thinking about it

094 CB – other areas ex of disparity in care exist GR + PH patients

102 FP there is pool of expertise in NS and

105 CB – 401(k) P are beginning to get covered

8A

111 Mary Anne Dearborn

124 CB

124 JR ins industry operate on large # theory
— are there even enough P in AK to make big enough pool

130 CB — there'll always be some ~~of~~ expenditures

139 KP — NH costs in AK are high, ~~but~~ coz we have smaller NH
& it's more expensive, but better quality
— we should worry about out-migration
lets reprogram savings from cuts to Long Borns

156 CB — ~~Q~~ to KB

159 KB 96 study — MHT must funded study to ass't of cuts in Long
Borns → anticipation for lower-cost svcs &

167 KB 563% growth — mid-projections

CB we have 2 tasks — 1) for those born today
2) for those who need LTC today

---

180 BRAD BERMAN any study of MILLER'S TRUST

KP

8A

187 RB

189 JS – never been formal study – we don't have lots recovery on Miller Trust

205 CB we need more info/def of Miller Trust

208 JJ – MH Trustee has int. in reprog recurring Lowe Bros savings tied into SR svcs

217 CB Lotus P felt the L.B. doesn't automatically go to SERVICES

225 JD Pam not in envolving MH trust in talks on how they could participate

CB maybe related LB to

245 Steve Ashman

(TEXT BREAK)

252 KATHY EDMONDS (website has PH baby) only about build by API

261

266 KP API vs hospital – for S-T care

269 KE

270 CB we talking about getting P vouchers so can get svcs

8A

277 DAVE JACOBSEN

290 KP the simple sum

303 VALERIE STANTON

325 – CB – if we were cruel –

328 FP we could draft leg for financial exploitation TO BSA

337 CB Remember some bill we paid

FP Am member of ASA CA – neglect/exploitation not in law

355 MARY ANN DEARBORN

Later P get letter to Anchorage for services

How are we meeting their needs

371 JR most P now getting LB now will die – better hurry

377 DM acute episodes can be from chronic causes

of current Maid funky w medicate, maybe bad to Means

mismgt that Medicare pays for LTC

Am Health Care Assn

8A

416 GW wanted to investigate x-fer of PN to HSS

425 CB - CLOSED REMOTABLE
ORG TF
SCHED MEET
OCT 26

452 SHARROW CLARK - will all LECTT mtgs be held in FBX
CB well met.
OCT 23 98 WED THRS
21-2

to del wf #4-6 on SCR 11

in interim TF members need copy of

490 CB - lets assign ones TO DO to each

8A

KB KARL FLOOD #3

#11 - JR

DM #2

JO #1

KP #5

JR #6

KP #7

BL #8 ?

JR #11

CB/GW #10

KB o MELISSA FLOOD #12

CB #14
GW #15

KB #4 -

8A

564 CB what direction would TF members

570 DM maybe get survey of only 1 choose the LOC

581 CB am I off base in thinking community is only a PART of the funding source

597 CB in near term OF

8B

001 STEVE ASHMAN bricks & mortar

008 CB about 100 this TF getting CAPITOL BUDGET

014 KP last DATE has been up

020 SA. Dates have to be updated

CB next mtg will be open public, but not much public testimony

025 JR

034 CB we may want to collect $ & reinsure w/ private insurance

8 B

CB we don't want state to compete w/

0039 STANTON what about item #13

CB

0043 JR

KP - IHS doesn't pay for any LTC are

0047 CB lets focus on what is State of Alaska role

0050 GW - law requires us to remain co-chairs

JH moves that GW & CB be elected as co chairs

KATHLEEN Perdue seconded

no dissent heard

ADJ

8/19/98 Please Sign In 8/19/98

Alaska State Legislature

Long-Term Care Task Force

August 18-19, 1998 Meeting

NAME	ADDRESS (Street Address, City, Zip)	E-MAIL ADDRESS	PHONE #	FAX #
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Marguerite Steeban AARP-State Pres	3009 Northwood St	EDK FFMAS@AURORA.ALASKA.NET	245-5259	245-5279
Steve Ashman	P.O. Box 101020, Anch 99510	SASHMAN@AHFC.STATE.AK.	330-8460	
Mary Putman	836 M 204 Anch 99501	theny@iname.com	277-9980	
Gayle Keller	Rep Fred Dyson's office		694-6683	
David W. Schade	P.O. Box 770409 Eagle River 99577	pgx@pwalaska.net	688-5530	688-5520
Patrick Cunningham	4770 Mills Dr 99508	zzzz@ptialaskacorp.net	337-8690	786-6910
David Maltman	POB 240249 Anc 99524	david_maltman@hsd.state.ak.us	269-6990	269-6995
Jeff Jessee	550 E. 7th Ave 99501	jjessee@mhtrust.org	269-7960	269-7966
Pat Edmunds	17408 Kantishna Dr 99577		696-7283	696-7286
Karen Hessert	POB 671807 Chugiak 99567	bhessert@arctic.net	688-5245	same
Bill Herman	550 W 7th Anch 99501	bherman@mhtrust.org	269-7962	269-7966
Sharon J. Clark	Sen. Miller, Leg Asst		465-3996	
Joe Sonneman	324 Willoughby Juneau 99801	senator@ptialaska.net	463-2624	PLEASE SEND VET'S HOME TESTIMONY. THANK
Maureen Coggins	Sen. Lyda Green's office			
Susan Craig	416 Birchwood Anchorage AK 99508			
Peg Stout	6208 E. 34th Ave, Anchorage 99504			
Katherine Alexander (ALSC)	1016 W. 6th Ave, Ste. 200 99501		272-9431	

Please PRINT the above information. Thank you for participating in this task force meeting.

8/19/98

Alaska State Legislature

Long-Term Care Task Force

August 18-19, 1998 Meeting

NAME	ADDRESS Street Address City Zip	E-MAIL ADDRESS	PHONE #	FAX #
Anna Stull	22424 No Birchwood Chugiak		688-2277	688 1320
~~Kathy~~				
√Brad Bernier	Access Alaska 3710 Woodland Dr Ste 900		348-4777	348-0639
√Bernadine ~~Conte~~ SANTERT	"		"	"
√Pamela Boyer	"		"	"

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8/19/98

Alaska State Legislature

Long-Term Care Task Force

August 18-19, 1998 Meeting

NAME	ADDRESS (Street Address, City, Zip)	E-MAIL ADDRESS	PHONE #	FAX #
Alaire Stanton	3817 Aurora Ketchikan		247-2358	
Deborah Green/Providence Circle of Care	P.O. Box 196604 Anchorage 99519-6604		261-4848	562-5239
Don Hoover	1029 Kodiak Palmer 99669		474-0576	474-0565
Charley Drayton	371 Bailey St. Anch, 99504		333-2838	337-4295

Please PRINT the above information. Thank you for participating in this task force meeting.

Aug-20-98 01:32P Sen. Wilken 907 465 4714 P.01

8/19/98

08/19/98 LEGISLATIVE TELECONFERENCE NETWORK SYSTEM LTN1150
13:35:57 PARTICIPANT LIST (ALL PARTICIPANTS) BY:FBX
TCN:80896 SCHEDULED FOR:08/19/98 09:00 TO 17:00 FOR:FBX
PUBLIC HEARING HOUSE LONG TERM CARE TASK FORCE

LOCATION:FAIRBANKS

ORGANIZATION A	MS.	MARIA	~~GRIFLIN~~	TRI-LOVE	Q TESTIFY
ORGANIZATION A	MR.	LESTER	~~WESTLING~~	AK CAREGIVERS	TESTIFY
ORGANIZATION A	MS.	MONTE FAYE	~~LANE~~	AK CAREGIVERS	TESTIFY
ORGANIZATION A	MS.	B.	~~JARVI~~	C. SERVICES	TESTIFY
ORGANIZATION A	MS.	RYNNIEVA	~~MOSS~~	REP.VEZEY	TESTIFY
ORGANIZATION A	MS.	JODI	OLMSTEAD		TESTIFY
	MS.	MELODIE	BYRD	DOWNTOWN CARE	TESTIFY
OFFNET FBX	MS.	MARIE	SIMMONS		
SEW	MS	CHRISTY	EKLUND		
JUNEAU	MR.	KEN	DEAN	S.E. INDEPENDENT LIVING	
~~FBX~~	~~MS.~~	~~SHELLY~~	~~GREEN~~		

8/19/98

LEGISLATIVE TELECONFERENCE NETWORK

SIGN-IN SHEET

SPONSOR: LONG TERM CARE TASK FORCE

SUBJECT:

START/END TIME: _____ DATE: 8/19/98

PLEASE PRINT

	Name/Representing	Address	Zip	Phone No.	Testify	Observe	Bill No.
1.	✓MaryAnn Dearborn Senior Psychiatric Outreach Team	Southcentral Counseling Center 4020 Folker Street Anchorage, AK	99508	261-5326	X		
2.	✓Bonnie Barber	1016 W 6th Ave, Suite 102	99501		X		
3.	✓DEBORAH JONES	4848 Bryn Mawr Ct Anch	99508	337-6211	X		
4.	✓Sue Samet	Providence Horizon House 4140 Folker #A	99508	261-4140			
5.	GENE MORGAN	3701 EUREKA #48 B	99503	562-1459		X	
6.							

	Name/Representing	Address	Zip	Phone No.	Testify	Observe	Bill No.
1.	✓Thelma P. Langdon	2363 Capt. Cook Dr	99517			✓	
2.	✓Bill Tice	9200 Independence Dr #205	99507		✓		
3.	~~Brad Bernier~~	3710 Woodland Pk Anch AK	99517	248-4777	X		
4.							
5.							
6.							
7.							
8.							
9.							

8/19/98

LEGISLATIVE TELECONFERENCE NETWORK

Public Testimony

SIGN-IN SHEET

PLEASE PRINT

SPONSOR: House Long Term Care Task Force

SUBJECT: Organization + Status Report

START/END TIME: 1:00 **DATE:** 8-19-98

	Name/Representing	Address	Zip	Phone No.	Testify	Observe	Bill No.
1.	Karen Hessert	P.O. Box 671807 Chugiak	99567	688-5245	✓		
2.	Pat Edmunds	17408 Kantishna Drive E. River	99577	696-7283	✓		
3.	Candice Dragon Dignified Home Care, Inc.	371 Bragaw St. Anch, AK	99504	333-2838	✓		
4.	Kathy Emmons	P.O. Box 770416 Eagle River	99577	694-2184	✓		
5.	ELSIE O'BRIAN	MID-VALLEY SRS				X	
6.	Mary Margeson/Alaskans for Better Care for Seniors	PO Box 90037, ~~99509~~	99509	278-9275	✓		
7.	Eugene C. Smith	423 W 29th Ave Apt 312	99501	274-7441	–		
8.	Katherine Hayes	16826 Riddell St Eagle River	99577	696-1444	✓		
9.	Lester Darbaugh Parkside Asstd Liv	309 E 24th Ave, Anch AK	99503	276-5553	✓		
10.	Pamela Eldridge	13421 Brant Way Anch. AK 9	99515	345-0485	✓		
11.	Dan D Jacobson Arctic Alaska	3550 Airport Way Ste 3 Fbks	99709	479-7440	✓		
12.	Vickie Dodge-Pamplin	511 W 41st Ave 0 99503	99503	5631112	✓		
13.	Dolly Swanson	3701 Eureka #48	99503	562-1434	.2		
14.	[redacted]						
15.	Don Smith	3002 Spenard Rd #1	99503	2264325	✓		

KAY BURROWS
JANE DEMMERT

ALASKA'S LONG TERM CARE SYSTEM

Long-Term Care Task Force Meeting
August 18 -19, 1998

ALASKANS WITH LTC NEEDS

Betty

- Living in home she's had for thirty years
- Needs help with meals, house-keeping,shopping
- Sees her doctor twice a year and takes her own heart medicine
- Has outlived her children and spouse

Tom

- He's 14 and experiences a physical disability
- He needs assistance with all of his personal care and with transfers from his wheelchair.
- He needs lots of exercise

Elma

- She fell and broke her hip recently. It has been slow to heal
- She has diabetes and takes insulin. Her eyesight is poor.
- Her family lives in town and helps her.

Harry

- He's always been very independent, until he was diagnosed with MS.
- Right now, he's in remission, but knows he may be wheelchair bound soon
- He has no job or insurance. He just applied for SSDI

Who are they?

- Young or older
- Sick or Well
- Insured or Uninsured
- Able to stay at home or needs a more supported residence

- It could be you or me -- our family or friends

What will help them?

- Residence Options
- Health Care Choices
- Personal Care Services
- Economic Assistance
- Medication Assistance
- Nutrition and Transportation Help
- Care Coordination

- Each Alaskan will want services in their community planned to meet their particular needs, and adaptable, as their needs change

Most Intensive Institutional Services

- Acute Care - Hospital
- Nursing Home Care
- Institutional Respite Care

Facility-Based Intensive HCB Services

- Assisted Living, Pioneer Homes (over 65)
- Facility Respite Care

Home-Based Services

- Home Delivered Meals
- Assisted Transportation
- Shopping Assistance
- Congregate Housing
- Home Repair
- Senior Companions
- Homemaker/Chore Services
- Medicaid Waivers
- Personal Care Attendants
- Adult Respite Care

Home-Based Intensive Health Services

- Home Health Care: Nursing/Therapies
- Hospice Care
- Home Health Aide Services

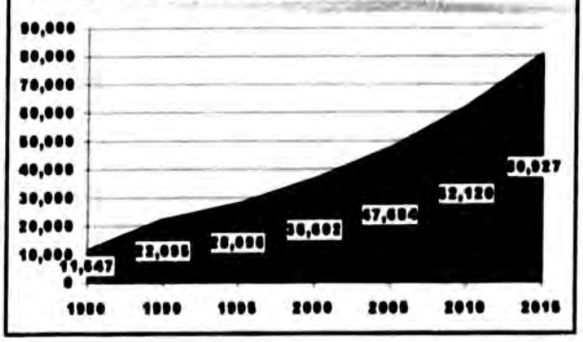
Community - Based Services

- Congregate Meals
- Transportation
- Information - Referral
- Senior Employment
- Independent Apartments
- Senior Centers
- Legal Services
- Insurance Counseling
- Senior Housing
- RSVP/Foster Grandparents
- Adult Day Services

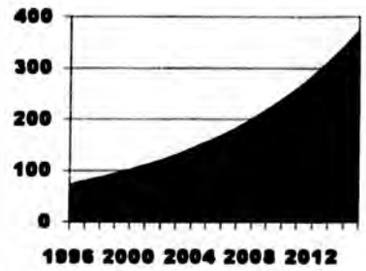
Services Across the Continuum

- Long Term Care Ombudsman: Advocacy for Long Term Care Residents
- Care Coordination: Personal Assessment, Care Plans/Follow-up
- Adult Protective and Supportive Services: Investigation and Services to vulnerable Alaskans: Abuse/Neglect Victims

Alaska's Projected Senior Population Growth 1980-2015



LTC Public Program Costs For Alaskans Over 65



ISSUES FOR LTC GROWTH

- More people are choosing to stay out of nursing homes except for rehabilitation
- Senior population growth is dramatic -- Alaska is second in the nation for growth in the 85+ group
- Home and Community-based care is not funded well by any payer other then Medicaid -- and then only by waiver

Strengths of the System

- Many private (both non-profit and for-profit) providers of services in many Alaskan communities
- LTC Care services are being financed by Medicaid and some by Medicare, private insurance
- Alaskans are able to have more choices in care, within their home communities
- Care Coordination - rapid growth

Weaknesses of the System

- Very fragmented care between private and public providers - also between state divisions
- Much paperwork, eligibility requirements, assessment and other barriers to timely access
- Costly system, without many funding sources for people not Medicaid eligible
- Often not consumer directed or focused

- Rate structures, both public and private, often do not cover costs of care
- Rates are inconsistent, and often slow in payment
- Private insurance often does not cover home and community-based services
- Medicare covers few HCB services and no medications

CAPACITY DEVELOPMENT

Capacity development needed across Alaska
- -- Assisted Living
- -- Personal Care Attendants
- -- Care Coordination
- -- Elder "gathering places"
- -- Job development for HCB programs

Funding this development will continue to be the challenge .

STATE OF ALASKA

LEGISLATIVE WORKING GROUP

ON

LONG-TERM CARE

REPORT TO GOVERNOR TONY KNOWLES

Table of Contents

Executive Summary 3

Chapter 1: Introduction 5
Background 5
Composition of the Working Group 5
Duties of the Working Group 6
List of Meeting Dates 6

Chapter 2: Statement of Long-Term Care Principles 7

Chapter 3: Alaska's Present State Funded Long-Term Care System 9
Overview 9

- Long-Term Care for Alaskan Seniors, and Adults with Physical Disabilities 10
Funding 10
Long-Term Care Services for Senior Citizens, and Adults with Physical Disabilities 12
Individual Profiles 14
Major Issues 17

- Long-Term Care for Alaskans with Developmental Disabilities 18
Funding 18
Long-Term Care Services for Alaskans with Developmental Disabilities 18
Individual Profiles 21
Major Issues 21

Chapter 4: Long-Term Care Program Usage in Alaska to 2015 23

Assumptions 23
Figure 1: Alaska's Senior Population Growth, Projected to 2015 23
Analysis 24
Table 1: Long-Term Care Services - 65 and Over Age Group- FY96 24
Table 1A: Long-Term Care Services - 65 and Over Age Group- FY96(Condensed) 24
Table 2: Long-Term Care Services - Under 65 Age Group - FY96 25
Table 2A: Long-Term Care Services - Under 65 Age Group - FY96(Condensed) 26
Figure 2: Long-Term Care Costs Under 65 Years of Age 1996-2015 27
Table 3: Long-Term Care System - Expenditures, Under 65 - Projected to 2015 28
Figure 3: Long-Term Care Program Costs, 65 and Over 29
Table 4: Long-Term Care System -Expenditures, 65 & Over - Projected to 2015 30

Chapter 5: Alternatives to the Present System **31**

Senior Alaskans And Alaskans With Physical Disabilities 31
Desired Entry Into The Long-Term Care System 31
Alaskans With Developmental Disabilities 32

Chapter 6: Certificate of Need Program **33**

How the Program Works 33
Current Standard of Review 33
Limitations of Current Standard of Review 33
Recommendations For Principles To Guide The Certificate Of Need Process 34

Appendices **37**
Appendix I 38
Appendix II 42
Appendix III 48
Appendix IV 50

References **51**

Glossary **52**

Executive Summary

CH84 SLA96 created the Legislative Working Group on Long Term Care to analyze issues relating to long term care and the certificate of need program. As mandated, this report describes the today's long term care system along with current and projected costs as well as projections for future long term care needs. It examines alternatives to nursing care and estimates the number of residents that could more appropriately be receiving home and community based care outside of nursing facilities. Finally, it recommends principles for guiding the development of the long term care system.

The long term care system in Alaska is heading for a crisis in its ability to provide services to a growing and increasingly aging population unless it can provide services in a more efficient manner. In 1996 Alaska spent $120 million in long term care services to approximately 5,000 Alaskans. Approximately two thirds of these moneys, $80 million, are State General Fund expenditures. Conservative assumptions about population and inflation would project costs for services at over $215 million by the year 2015, moderate assumptions indicate a projection at $545 million, and a robust projection would yield a demand for $1 billion in 2015. It is, therefore, the conclusion of this report that this situation demands a shift from the current heavy reliance on costly institutional care to a more balanced, continuum of community based and home services.

The long term care system provides services to a broad range of individuals: children who suffer developmental disabilities, adults under the age of 65 with physical disabilities, and seniors age 65 and over. Individual needs range from assistance with routine activities of daily living to skilled nursing care. The expenses associated with meeting these needs can rapidly deplete even the most carefully planned financial resources of impacted individuals and their families. Public funding has been used to supplement personal resources to provide these services, primarily through Medicaid reimbursement for nursing home level of services and through grants to non-profit providers for assisted living services.

Population growth in Alaska, especially the rapid growth of the over 65 age group, has strained the existing capacity of the system throughout the state. Frequently, individuals needing long term care find themselves wait-listed for services, or go without until the need is so great that institutional care may be their only option.

Providing home and community based care is often a less costly and preferred option than providing institutional levels of care. Early intervention supports an individual in a home environment and fosters a less costly yet highly desirable level of independence for the individual. However, demand for these services exceeds current capacity, not to mention the future demands of our growing population. Without an increase in the proportion of home and community based services and without tighter controls on the approval of institutional expansion, public funding will continue to be channeled into development of institutional nursing home care with its associated costly Medicaid funding entitlements.

In order to better meet current and projected demand for a better mix of long term care services, it is imperative to expand the home and community based long term care system and provide a better balance of service options.

Therefore, the Working Group supports the following:

- Guiding principles, detailed in Chapter 2, defining a philosophical basis from which to develop and implement a balanced system of long term care services;
- Services that focus on independence and wellness;
- An assessment tool to promote the right level of care, at the right time, and in the most cost effective manner;
- A revised certificate of need process, as outlined in Chapter 6, to support cost effectiveness, balance and increased choice in an appropriate mix of services; and,
- Funding to realistically support the expanded population and cost projections of a multi leveled system of care and services.

Without a concerted effort to more cost effectively manage the evolution of long term care, Alaskans in need of long term care will increasingly face a less affordable system with fewer choices to meet their needs.

CHAPTER ONE: INTRODUCTION

Background

During the 1996 legislative session Committee Substitute for House Bill 528 (Rules) passed the legislature and was signed into law. The Bill thus became Chapter 84 of the Session Laws of Alaska 1996 (CH84 SLA96). CH84 SLA96 addresses issues related to the current mix of long-term care services in Alaska as well as a process to assess the future need for long-term care services. Specifically, CH84 SLA96:

* Made legislative findings that Alaska has only recently begun to develop a system for providing long-term care for seniors through home and community based care; that the long-term care system is unbalanced at the current time because of a shortage of alternatives to nursing homes, and many nursing home residents would benefit from less intensive and less costly care such as assisted living, home health, and other home and community based services.

* Placed a two year moratorium (until May 1, 1998) on the issuance of certificates of need or licenses for any new nursing home beds in Alaska; effectively preventing any nursing home beds from being added in Alaska until the moratorium expires.

* Required the Department of Health and Social Services to accept and begin processing applications for certificates of need for new nursing home beds beginning September 1, 1997, although the certificates would not be effective until the moratorium ended on May 1, 1998. This would allow for nursing home certificates of need to be processed in time for the 1998 construction season.

* Established a six-member working group to analyze issues relating to long-term care and the certificate of need program, and to deliver a report to the Governor.

Composition Of The Working Group

As a result of CH84 SLA96, the Legislative Working Group on Long-Term Care was established. According to CH84 SLA96 the membership of the group included:

- Two individuals appointed by the governor who are involved in providing long-term care services, one of whom is a licensed nursing home administrator who operates a community nursing home in this state;
- Two individuals appointed by the governor who are receiving long-term care services, at least one of whom must be at least 60 years of age;
- The commissioner of administration, or the commissioner's designee; and
- The commissioner of health and social services, or the commissioner's designee

The following individuals were then appointed to the Group by Governor Knowles:

Alison Elgee, Deputy Commissioner of Administration
Department of Administration
Commissioner's designee

Jay Livey, Deputy Commissioner of Health and Social Services
Department of Health and Social Services
Commissioner's designee

Jackie Ortelli, Assistant Administrator, Denali Center, Fairbanks
Licensed Nursing Home Administrator

Cyndi Nation-Cruikshank, Director Home Care Services
Tanana Chiefs Conference, Inc. Fairbanks
Long-Term Care Provider

Peggy Burgin, Anchorage(Group Chair)
Long-Term Care Recipient over 60

Thea Zumwalt, Soldotna
Long-Term Care Recipient

Duties Of The Working Group

CH84 SLA96 charged the working group to produce a report which contains the following:

* A description of the current status and cost of the States system for long-term care services.

* The projected number of state residents who will be needing long-term care services through the year 2000, the year 2005, the year 2010 and the year 2015.

* The projected cost to the State, based on the projection of needs, if no changes are made to the State's present system of long-term care services.

* An estimated number of state residents who are currently receiving care in nursing facilities that could more appropriately be receiving home and community based care outside of nursing facilities.

* A description of the alternative methods available to provide nursing care for state residents and the relative cost to the state for these methods.

* Reco.nmendations for principles that should be used to guide the development of the states long-term care system, including principles that should guide the certificate of need process under AS 18.07.

List Of Meeting Dates

The Working Group on Long-Term Care held meetings on the following dates.

October 25, 1996
November 12, 1996
November 26, 1996
December 19, 1996
January 13, 1997
February 13, 1997
March 3, 1997

CHAPTER 2: STATEMENT OF LONG-TERM CARE PRINCIPLES

Primary Guiding Principle:

The long-term care system should be Alaskan centered and encourage the wise use of all resources.

1- **The Encouragement of Individual Control**: The long-term care system should encourage individuals to take control of both their personal health and the long-term care choices of provider, services and setting through:

- education and other prevention strategies that promote long-term , healthy lifestyle choices;
- consumer involvement in the design and development of services; and,
- a service system that is conceived as a part of, rather than an interruption to, living.

2 - **Emphasis on a Meaningful Life**: The long-term care system should be tailored to the individual's needs and strengths both as an individual and as a member of a family, a community, and a culture; and in doing so should work to preserve and encourage independence, usefulness, dignity and a meaningful life through:

- the development of balanced continuum of care;
- greater attention to home and community based services;
- quality care in the least restrictive setting whenever possible; and,
- providing a safety net when the need exceeds the ability of family, friends and volunteer resources.

3- **Broad Based Collaboration**: The long-term care system should encourage collaboration among providers, as well as among the individual, the service community, and the resources outside the formal system so that there is a high quality, flexible, seamless, and responsive continuum as a part of normal life through:

- incentives that encourage institutional providers to develop alternative, flexible services;
- participation of the family and the community in the design and delivery of services;
- CHOICE and similar strategies for keeping the individual as close to home as possible; and,
- service environments appropriate to age, cultural prerogatives and physical limitations.

4- **Outcome Oriented Cost Effectiveness**: The long-term care system should be outcome oriented to assure the proper monitoring of its quality and cost effectiveness through:

- a comprehensive planned approach that emphasizes quality;
- greater involvement of the consumer in articulating needs and assessing outcomes;
- encouraging greater participation of the family and local community in defining needs and designing and evaluating the quality of services;
- thorough consideration of alternative, less costly responses to long-term care needs through assessment tools and consumer input to determine the level of services required;
- standardization of data categories to better assess the cost effectiveness and quality of outcomes for clinical issues, risk factors, special needs populations, and legislative and regulatory changes.

5- **A Stable High Quality Service Delivery System**: The long-term care system should promote policies that encourage a stable, high quality service delivery system through:

- education and training to assure the desired skills among providers of services;
- maximizing the portion of health care dollars that go into services as opposed to administrative overhead or profits; and,
- holding providers, administrators, and the public sector accountable for the cost and quality of the service provided.

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CHAPTER 3: ALASKA'S PRESENT STATE-FUNDED LONG-TERM CARE SYSTEM.

Overview. This chapter describes Alaska's present state-funded long-term care services for three different populations: senior citizens (age 65+); Alaskans who are disabled due to developmental disabilities[1] and those Alaskans with physical disabilities which first occurred after the age of 21. As used in this report, "long-term care" is defined as personal care and assistance related to health and social services, given over a sustained time, to assist people of all ages and their families to achieve the highest level of functioning possible, regardless of the setting in which care is given. Long-term care consists of a range of services and informal supports. Long-term care services may be needed to assist with routine, chronic, and periodic needs, and may include service management, general medical services, in-home assistance, information and referral, community-based services (adult day, respite, and care coordination), and many other types of services.

Service systems for these three populations are at different stages of development. The contrasts are sharp. Long-term nursing facilities for the developmentally disabled such as Harborview in Valdez, and the six Pioneers' Homes which serve those 65 and over, have provided services for many years. However, the system of home and community-based long-term care for senior citizens and adults with physical disabilities is very new and remains incomplete. There are significant gaps in it: for example several regions lack even the most fundamental long-term care services for senior citizens. In contrast is the system of long-term care for the developmentally disabled: that system is recognized nationally for its comprehensiveness and responsiveness to the individualized needs of its consumers.

****

[1] AS 47.80.900 (7) defines a person with a developmental disability as one who experiences a severe, chronic disability that is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the person attains age 22; is likely to continue indefinitely; results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated. These are the criteria used to define eligibility for services from the Division of Mental Health and Developmental Disabilities, Alaska Department of Health and Social Services.

Long-Term Care for Alaskan Seniors, and Adults with Physical Disabilities

Many Alaskans approach their retirement years with the impression that their long-term care needs will be largely met through publicly funded services, should they need this type of care. There is the illusion that between Medicare, the Indian Health Service, Medicaid and private insurance, senior citizens will generally be able to cover long-term care expenses. This is generally **not** the case. In fact, most senior Alaskans **cannot** count on readily covering the costs of long-term care. Relatively few older Alaskans have the means to fully pay for long-term care, as is evidenced by data from the 1990 Alaska Census. 32.6% of those seniors age 65+ had annual incomes of less than $15,000, while an additional 19.7% had incomes which fell between $15,000 - $24,999. Thus, collectively 52.3% of Alaskan seniors age 65+ had annual incomes of less than $25,000. Yet in 1996, the average cost of nursing home care was $75,000.

Funding: The purpose of this report is to define current patterns of state-funded expenditures that support long-term care. The State of Alaska supports long-term care service delivery in home and community-based settings, and in long-term care institutions. These services are provided through a variety of funding strategies. These include:

1. Comprehensive State underwriting of direct services, augmented through user fees as occurs in the Pioneers' Homes. Beginning in FY96, the Pioneers' Homes instituted annual resident rate increases. The intent is that by FY 2003, residents able to afford it will pay for the full cost of their care. Those unable to pay the full cost will pay according to their available resources.
2. State grants to local non-profit service providers who in turn contribute local matching funds and support to underwrite the costs of operating home and community-based services, and collect consumer payments for services based on their ability to pay. In FY96, the Alaska Commission on Aging found that local community contributions accounted for 45% of the funds necessary to operate local senior services, while 55% of the funds were from State and federal sources.[2]
3. Independently financed services which rely on Medicaid (funded on a 50-50 basis by the State of Alaska and federal funds) and Medicare (fully funded federally) payments, insurance billings, and payments by individual consumers.

Seniors with long-term care needs whose income levels and medical conditions qualify them for Medicaid, receive Medicaid-funded long-term care services funded through a match of federal and state dollars. Other seniors with long-term care needs and income levels excluded by Medicaid, pay for their long-term care services through insurance reimbursements, Medicare (when it applies), and payments on a sliding fee scale.

Since 1973, Medicaid funding has paid for long-term nursing home care for low-income Alaskan senior citizens age 65+ who experienced Medicaid-eligible medical conditions which required institutional levels of care. In 1994, Alaska established four Medicaid waiver programs. These waivers allow Alaska to use Medicaid funds to pay for the delivery of long-term care services outside of nursing homes, as long as the recipients: 1) are Medicaid eligible; 2) meet the criteria for needing nursing home care and 3) care in the community costs less than nursing home care.

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2 Alaska Commission on Aging. *Annual Report: FY96.* Juneau, 1997.

These waivers enable state and federal funding to be paid for many home and community-based services that are not funded through the traditional Medicaid program. These payments are critical to the successful development of assisted living homes, and a bolstering of Alaska's limited network of care coordination, adult day services, and respite care.

The senior citizen Medicaid waiver program is known as the CHOICE program. Through a combination of in-home care, and day-time attendance in programs available in other community locations, senior citizens are successfully receiving long-term care while maintaining their independence at an average annual cost of $11,077, of which 50%, or $5,538.50 was paid by the State of Alaska. In FY96, 218 seniors received long-term care in home and community-based settings through the CHOICE program. At this time, some 70 adults with physical disabilities receive care through the Medicaid waiver program.

In the late 1980's the Alaska Commission on Aging began making grants to community agencies to provide adult day services and respite care to seniors in regional hub communities throughout Alaska. This initiative established the foundations for home and community-based long-term care for senior Alaskans.

Home Care Program. Alaska has home health services and personal care services offered through the Medicaid program. Additionally homemaker services and chore services are offered through the CHOICE home and community-based Medicaid waiver program. This program, which has been administered by the Department of Health and Social Services' Division of Public Health is now being transferred to the Division of Senior Services within the Department of Administration.

Personal Care Attendant Services. Personal Care Attendant services enable functionally disabled handicapped and elderly Alaskans to live in their own home or community instead of being placed in a long-term care institution. PCA services are typically provided in a consumer's home by trained health care paraprofessionals under clinical supervision of a supervising PCA agency. Ideally, these services are part of a continuous and coordinated system of social and medical support.

Until 1992, PCA, Homemaker and Home Health Aide services were provided by multiple agencies. Functionally dependent individuals of any age could receive services in their home on a part-time basis. In early 1992, the state issued a request for proposals to expand delivery of PCA services and chore services in 10 regions within Alaska. This was done to expand the geographic availability of services and to expand the amount of services provided by shifting costs as much as possible to other shared fund sources, especially Medicaid. State general fund money is also used to support agency costs to develop a statewide service delivery system.

This program has greatly expanded. In FY96, 17,333 hours were served by state general fund dollars and 159,736 hours were served by Medicaid funding. 1,044 consumers were served by these programs in 128 communities in Alaska. This program is being transferred to the Division of Senior Services, to continue integration with other home and community-based services.

Adults with Physical Disabilities Waiver. This program provides home and community based services to individuals between the ages of 21 and 64, who: 1) have been determined eligible for Supplemental Security Income (SSI), and 2) due to illness, injury, or other physical problems experience a severe and chronic disability that is likely to continue indefinitely and substantially limits the person's ability to obtain and maintain gainful employment. These individuals also would meet the nursing home level of care criteria and would , without the waiver, normally receive care in a facility for more than 30 days per year.

Approximately 70 individuals are currently utilizing this waiver in Alaska. The average proposed cost of care for each of these individuals for FY97 is $28,769. These individuals may also use other services discussed in this chapter, and therefore may be a part of a duplicated count of Alaskans currently receiving home and community-based services.

Long-Term Care Services for Senior Citizens, and Adults with Physical Disabilities:

- **Adult Day Centers** provide supervised group care in a social setting which offers a wide range of services for seniors needing assistance with daily living tasks. Care is provided weekdays at a central site during normal working hours.
- **Respite Care** is a service through which trained caregivers provide intermittent in-home care to seniors. During this time, the family caregivers are able to take a break from their roles as full time caregivers. While this care is usually provided in the consumer's own home, it can also be provided in facilities such as assisted living homes and nursing homes, as well as in adult day centers.
- **Care Coordination** is a service through which a trained professional assesses a frail consumer's needs. Based on this assessment and in consultation with the consumer's family, appropriate services are identified and arranged. Care coordination incorporates outreach, intake screening, initial assessment, care planning, service arrangement, ongoing monitoring, and formalized reassessment. This approach assures appropriate use and coordination of long-term care resources.
- **Personal Care** is a service which provides in-home assistance with activities of daily living such as bathing, dressing, toileting, eating, and moving from one place to another. These services can enable a person with non-technical medical care needs to remain at home rather than live in an acute or long-term care facility. Without this service, many individuals would enter nursing homes or other institutions to receive needed care.
- **At-Home Skilled Nursing** care provides skilled nursing care by licensed professionals.
- **General Relief** is a form of payment with state General Fund moneys to meet the costs of room and board in assisted living facilities for low-income people at current or potential risk of neglect or self-neglect, abandonment, abuse, or exploitation. Individuals contribute what they can to meet this cost; the State pays the balance.
- **Nursing Home Care** is a service providing daily skilled nursing or skilled nursing rehabilitation services or both in a skilled nursing facility.
- **Pioneers' Homes Assisted Living** care includes room and board, and a range of levels of assistance with daily living, with an emphasis on the needs of seniors affected by cognitive impairments such as Alzheimer's Disease.

- **The CHOICE Long-Term Care for the Elderly Medicaid Waiver Program** is an individualized payment system which covers costs of medical care necessary for an individual to remain within the community. This is available to senior citizens whose medical conditions and limited incomes fall within Medicaid eligibility guidelines. CHOICE can provide payment for home care (personal care, homemaker and chore services), adult day center services and transportation to and from the center, respite care, at-home skilled nursing care, care coordination, home-delivered meals, or assisted living care above the room and board level.
- **Hot Meals** are generally provided weekdays by Alaska Commission on Aging grantees and Native agencies receiving Older Americans Act Title VI funding. Nutritious meals are offered at central locations, and are delivered to home-bound seniors.
- **Essential Transportation** services are provided by Alaska Commission on Aging and Title VI grantees, and made available to senior citizens to assist them with essential rides to attend adult day services, meal programs, doctors appointments, and to accomplish essential shopping.
- **Long-Term Care Ombudsman** is a service through which seniors are assured their basic rights for self-determination and respectful treatment while receiving long-term care.
- **Information and Referral (I&R)** is a statewide service through which seniors and their families receive telephone consultation on issues of concern (e.g. health insurance, community-based services and resources) and are referred to appropriate resources.
- **The Division of Mental Health and Developmental Disabilities** provides services for some adults with physical disabilities. A description of the services that might be provided are on pages 16 - 18.
- **In addition** to these program supports senior citizens and disabled adults may also receive cash support through the Supplemental Security Income program (SSI), and Adult Public Assistance Programs and seniors may receive support from the Alaska Longevity Bonus Program

Access to the present long-term care system of direct services, payments for service, and grants to non-profits is very uneven across Alaska. In general, the range and quantity of available long-term care services increases with community size. Seniors in communities such as Kwethluk and Usibelli have no long-term services in their communities, while seniors in Fairbanks or Anchorage have limited access a full range of services. Appendix IV presents the geographic availability of these services.

Individual Profiles

The following profiles describe typical senior citizens and adults with physical disabilities who use Alaska's present services to receive long-term care.

Early Intervention to Delay the Need for Long-Term Care

SENIOR LIVING ALONE. Mrs. Jones was a 70 year old with multiple physical problems that were stable; however her endurance and strength were diminishing. Recently her husband and several friends had died. She had many changes to adapt to and was mildly depressed. Mrs. J. lives alone, and enjoys the *support and stimulation of services available to all seniors at the local senior center* she attends weekdays. There she has a *balanced hot lunch, receives tips on healthy foods and eating habits, is in an exercise group, and visits with other seniors. She also learns about other community services that may be helpful to her.* All of this helps her cope with her losses. Targeted interventions now delay or prevent need for more intensive services. *The services (in italics-above) Mrs. Jones uses are partially funded by Alaska Commission on Aging grants, and are available to seniors age 60+ at 103 locations across Alaska*

Home & Community Based Services for Alaskans with Moderate Impairments

Profile A. SENIOR WITH FAMILY CAREGIVER: Mr. Smith was low income, age 75, and had Alzheimer's Disease. He and his wife lived at home; he required supervision and cueing to bathe, dress, and eat. Because he wandered away from home, he needed a caregiver 24 hours a day to ensure his safety. Alaska's Medicaid law excludes Alzheimer's Disease as an allowable primary diagnosis for a nursing level of long-term care, so Mr. S. could not receive Medicaid assistance. A *care coordinator* has assessed his needs, and helped the Smiths develop a home and community based care plan. Mr. S. now *attends an adult day program* weekly. There he enjoys therapeutic recreational activities, a hot lunch, help with activities of daily living, and support adjusting to his limitations. Two week-end days a month, a *respite worker* relieves Mrs. S. from full time caregiving, so she can take a break herself. Since they don't drive, they use *senior center van rides* for essential shopping, doctors appointments, and Mr. S.'s travel to the adult day center. Mrs. S. *calls the Alzheimers' Association to learn about various aspects of dementia and attends caregiver support group* meetings. *The services (in italics - above) the Smiths use are partially funded by the Alaska Commission on Aging. The hot meal and transportation services are available to all seniors age 60+ at 103 locations across Alaska. The home and community-based services used by the Smiths are available based on care needs and available capacity: annual per consumer average General Fund costs for these services are: Care Coordination: $1,262; Adult Day Services: $4,020; Respite Care: $1,457.*

Profile B: SENIOR LIVING ALONE: Mrs. Brown, age 83, was on a low income, and had Alzheimer's Disease. She lived on her own in a modified cabin until a year ago. However with the progression of Alzheimer's, she was seriously neglecting herself, and was in serious danger of accidentally harming herself. A niece who was her guardian called the Division of Senior Services to figure out how to help her aunt. A care coordinator worked with Mrs. B. and her niece to fully assess Mrs. B.'s needs, and together they developed a plan of care. Mrs. B. is now living in an *assisted living home* with two other seniors where she is thriving on the *full time care* she now receives. Mrs. B.'s income doesn't fully meet the cost of her care. While she is not Medicaid eligible, her monthly income is being supplemented with General Relief assistance to pay for the costs of assisted living care. *The average annual General Relief long-term care General Fund payment is $4,511.*

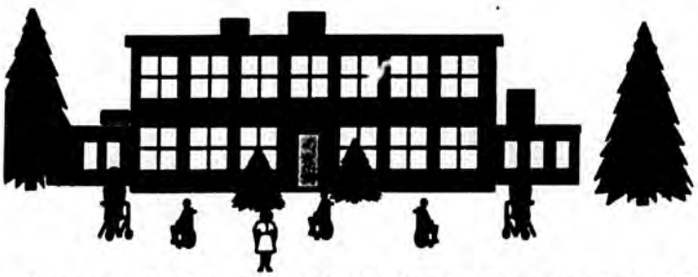
Home & Community Based Services for Alaskans with Severe Impairments

Profile A: SENIOR WITH FAMILY CAREGIVER: Mrs. Riley lived in her home of fifty years with her son who worked full time. She was 80, and lived on a low income. Last year complications from diabetes and hypertension resulted in amputation of her left leg. She was now homebound, and needed assistance with activities of daily living and monitoring for her diabetes. Mrs. R. took multiple medications, and was somewhat malnourished. Fortunately, at this point she was referred to a *care coordinator* who assessed her needs and established that she was eligible for the CHOICE program. Now her care is funded through the Medicaid CHOICE home and community-based program which enables her to continue living at home. Her care plan included *adapting Mrs. R.'s home to add an entry ramp and bathroom grab bars* to increase access and safety. Mrs. R. uses *escorted rides* to doctors, *and receives daily home-delivered meals* from the local senior center. A *home health nurse* visits Mrs. Riley weekly to check on her condition and assist in medication management. A *senior companion* visits weekly to relieve social isolation. *The average General Fund annual cost for CHOICE Medicaid services in 1996 was $5,538.50. Mrs. R's home health nurse payments are covered by Medicare. The hot meal and transportation services are available to all seniors age 60+ at 103 locations across Alaska.*

Long-Term Care Services for Consumers with a Medical Treatment Need

Profile A: Mrs. Clark had a stroke last year; she is 76. She received acute care in the hospital for a few days and then transferred to a nursing home for restorative and rehabilitative care. One side of her body is paralyzed and she has a speech impairment. In the nursing home, she began physical therapy to improve her mobility, occupational therapy to improve her ability to perform activities of daily living, and speech therapy to improve her communication. Her husband visited daily and learned to help with her rehabilitation. The nursing home social worker worked closely with a care coordinator and Mrs. C.'s family to develop a discharge plan. A wheelchair ramp, bathroom grab bars, and a shower chair were installed at the C's home prior to her return home after a four month nursing home stay. Mrs. C. uses the senior van to reach her weekly physical therapy sessions, and to attend an adult day program where she is in daily therapeutic activities tailored to her needs.

Institutional Long-Term Care Services for Alaskans with Severe Impairments



Profile A: SENIOR WITH FRAIL SPOUSE: Mr. Thomas was 83 years old. He had advanced Parkinson's Disease and needed 24 hour care. He had limited mobility, frequently had to use a wheelchair, and required assistance in eating, dressing and toileting. He also experienced moderate dementia and was unable to clearly communicate his needs. While Mr. T.'s wife of 55 years cared for him for many years at home, she was now frail and unable to provide the physical assistance he needed. Because of many health-related expenses, the Thomas's lived on a low income. Mr. Thomas' low income and primary diagnosis enabled him to be eligible for Medicaid funded long-term care. As a result, he now lives in a nursing home which is paid for by Medicaid. Mrs. Thomas visits her husband daily. *The average annual General Fund cost for this service is $37,500.*

Major Issues:

- The inadequacy of Alaska's present long-term care system for senior citizens is apparent in Appendix IV, which integrates data on present and projected regional senior populations, the prevalence of severe impairments among those seniors, and the present limitations of long-term care services available to seniors through State-funded services. At this time serious deficits exist across our State.

- Care coordination, the 'point of entry' to cohesive and cost-effective long-term care services, is presently unavailable to the general senior population on the North Slope, in Northwestern and Southwestern Alaska, on the Aleutian Chain, in the Copper River/Prince William Sound region. Other regions of the State have access to extremely limited services; e.g. 46 Interior villages have just begun to have access to care coordination through telephone-based service and one annual on-site care coordination visit through a new grant from the Alaska Commission on Aging. **In FY96, 615 seniors, of the estimated 3,933 with severe impairments, were served.**

- Adult day centers, one of the two basic home and community-based care services, now serve only 11 Alaskan communities. Sitka, Barrow, Cordova, Dillingham, Unalaska and Valdez completely lack this type of service. To date, due to funding constraints, centers are unable to provide services for the full work day; none are open weekends. This means that few caregivers are able to work full time, and yet a full time income is essential to providing the income relied upon by the caregiver and senior in care. **In FY96, 391 seniors, of the estimated 3,933 with severe impairments, were served.**

- Respite care, the second of the two basic home and community-based care services, is available on an average of 10 hours/month. **In FY96, 341 seniors, of the estimated 3,933 with severe impairments, were served.**

- At this time, long-term care residential capacity is extremely limited in many communities of our State. Recent planning grants from the Division of Senior Services are supporting the planning of the first assisted living capacity in Bethel, Dillingham, and Kodiak.

- There is a growing need to assure that long-term care consumers are aware of their rights and are able to effectively exercise them in regard to long-term care, senior housing, and other publicly funded services targeted to senior citizens.

Long-Term Care for Alaskans with Developmental Disabilities

Individuals with developmental disabilities require lifelong services. Although the type and intensity of services varies over the lifespan, the availability of ongoing support services is essential for people with developmental disabilities to assume the same roles in the community as people without disabilities.

In the last five years, service delivery for Alaskans with developmental disabilities and their families has been redirected from emphasis on facilities and programs to emphasis on consumers and families. This has reshaped the way services are provided, and altered the roles of consumers, families, service providers and funding agencies. Service providers assist consumers and/or their families to establish connections with the vast array of natural supports in local communities: friends, extended families, neighbors, churches, employers, generic community resources such as libraries and social organizations, for example. Services are brought to consumers and families in the community; they no longer have to leave their home communities to receive services. In some instances, consumers and/or their families use vouchers to purchase services, placing consumers fully in control over how they spend resources allocated to meet their needs.

Funding: Most State-funded services individuals with developmental disabilities receive are home and community-based. Institutional services have been provided by the Harborview Developmental Center and Hope Cottages' Intermediate Care facilities. Harborview will close by December 31, 1997 and the Intermediate Care Facilities will close by June 30, 1998.

These services are provided through a mix of direct services from the State, payments for individualized services and grants to non-profit agencies. Payment for these services is covered by state and federal funding. Individuals with developmental disabilities whose income and medical conditions qualify them for Medicaid, receive Medicaid-funded long-term care services funded through a match of federal and state dollars. Other individuals with long-term care needs and income levels excluded by Medicaid are funded with state dollars.

Many individuals receive multiple services. An analysis of the costs associated with one, two and three or more services as well as the percent of persons receiving one, two, or three or more services is presented in Table 1 of Appendix I.

Long-Term Care Services for Alaskans with Developmental Disabilities: Most communities are served by small local providers, local one-person branches, itinerant providers or contract employees. The one exception is Anchorage which has developed large specialty providers. Most direct services are provided by local non-profit agencies. As a result of growth over the last five years, 197 communities are now served by 32 DD providers.

The DD regions are broken out according to these Alaska Borough and Census areas:

Northern Region: North Slope, Northwest Arctic, Nome, Yukon-Koyukuk, Fairbanks North Star, Denali and Southeast Fairbanks.
Southcentral Region: Wade Hampton, Bethel, Dillingham, Bristol Bay, Lake and Peninsula, Aleutians East, Aleutians West, Kodiak, Kenai Peninsula, Matanuska-Susitna and Valdez-Cordova.
Anchorage Region: Metro area.
Southeast Region: Skagway-Yakutat-Angoon, Haines, Juneau, Sitka, Wrangell-Petersburg, Ketchikan Gateway, Prince of Wales and Outer Ketchikan.

The percent of total persons served by region is fairly consistent with state census data. (See Table 2 of Appendix I).

Services: Depending on individual need, long-term care for Alaskans with developmental disabilities may include any of the services described below. An individualized plan is developed with the person and/or his family (depending upon age, guardianship status and the desires of adults with developmental disabilities). This defines services to be used. Many persons with developmental disabilities require more than one service to achieve maximum independence in their chosen life styles. In Anchorage or Fairbanks consumers may use services from more than one provider. It is noteworthy that consumers may design their own services to meet unique needs, interests and desires.

These services are available to both children and adults:

Case Management: This service assists the individual to access medical, social, education and other services supported by various funding sources. This can include specialized services such as professionally administered medication necessary for medical stability.

Personal Assistance Services: These services include in-home health care, chore services and assistance with activities of daily living, including but not limited to bathing, grooming and feeding assistance.

Respite: This service provides relief from the everyday stress of caring for a family member who experiences a developmental disability. It is not be used to replace the services provided by regular child care or adult day care except for short-term emergency situations. Respite care for youth and adults differs from that provided for children in that is not primarily intended to give relief to families; instead, it is used as an opportunity for consumers to participate in social and recreational activities.

The following services are primarily provided to children and youth and/or their families:

Family Resource Consultants: There are five Family Resource Consultants (FRCs) serving five regions of the state who currently work with 200+ families. Parents of children with developmental disabilities serve as FRCs, and in this role, help families learn to independently navigate the provider system to build community and natural supports around individuals and families.

Foster Care: Foster care provides full-time out-of-home care, with a qualified adult or family member. Foster care is only provided in State-licensed foster homes; however, this approach

does *not* require the natural family to give up custodial or parental rights. The natural and foster families jointly agree to a written service plan and visitation schedules.

In-Home Training: This service help parents develop skills in coping and managing individual behaviors. The purpose of this service, which may be time-limited or ongoing, is to prevent or forestall out-of-home placements.

Natural Family Supports: This service assists youth and children living at home to secure assistive technology services and devices, respite care, adaptive equipment, in-home training, ramps, lifts, etc. The capacity to respond to individuals and families in this manner is one of the most cost-efficient services the State offers.

Services for Children Who Experience Special Health Care and Developmental Needs: These services are provided to children who require external supports which may include medication administered by staff to maintain their medical stability. All services are highly individualized to prevent the institutionalization of young children and to support them in family-centered, community-based environments. This service is primarily offered to children, although similar support plans may be developed for adults.

Shared Care: Two families, one of whom is usually the natural family, share the responsibility of caring for the child with a developmental disability. Arrangements are made for the second "family" to care for the child approximately 50% of the time.

The following services are primarily offered to adults and youth transitioning from school to adult life:

Group Homes: This full-time, out-of-home residential care in a group setting assists consumers in developing relationships and skills to increase their independence. Group homes have a maximum number of 6 residents and are licensed by the State.

Supported Living: Based on individual service plans, training and supervision is provided to assist individual consumers to live successfully in settings which maximize their independence.

Vocational Supports: Based upon an individually tailored plan, individuals receive training in an income-producing or subsistence setting. Ongoing support is regularly provided to maintain successful employment.

Respite is the most frequent service consumers use, although no one service is used by a majority of service recipients. (See Table 5 in Appendix I.)

A snapshot of the costs and range of costs associated with specific services in Alaska is provided in Table 6 of Appendix I. For the most part, those services which are low cost also tend to be the services that consumers most frequently receive (e.g. respite, case management, natural family supports, individualized services, supported living and vocational supports).

Individual Profiles: *A service provider helped a mother who was at risk of losing her children to the custody of the Division of Family and Youth Services. Supports were secured from three local agencies. Services provided included case management, family counseling, daily life skills training and parenting supports at an initial cost of $21,000. Long term, ongoing support is now being provided to her at an annual cost of less than $8,000.*

A family with two children with developmental disabilities needed to make their home and vehicle accessible. The family was virtually home bound since both children weighed in excess of 50 pounds and the mother could no longer physically lift the children. A family resource consultant helped the family secure funding for a platform lift, home modifications and a van lift at a cost of $7,600; the family contributed $1,000. No additional services are needed at this point in time; therefore, there are no ongoing cost to serve this family.

A 31-year old woman who lived in a nursing home for 14 years was able to move into the community after a service provider advocated for her to receive Personal Assistance Services in her own home. She is now gainfully employed and is working in the community of her choice at an annual cost of $9,000; she also pays $3,000 per year.

Major Issues: The wait list for DD services continues to grow. For example, it grew by 15% (632 to 725 individuals) from May 1996 to December 1996. (See Tables 7-10 in Appendix I.) It takes almost two years for persons on the wait list to receive services. Even then the individual may not receive all services at the intensity needed; for example, the individual may receive vocational supports but not supported living services, or the family may be offered 10 hours of respite per month when 15 hours is needed.

A huge waiting list perpetuates a crisis-driven system, in which individuals in crisis get priority for services and almost always at a high cost. This, in turn, deprives other individuals of supports and may force them into crisis. A system of lower cost early intervention and community supports reduces the frequency of crises which are expensive to resolve. The Division of Mental Health and Developmental Disabilities (DMHDD) has funded early intervention and community support services for the past five years. This has resulted in real cost savings and increased consumer satisfaction.

Funding is not available to provide full services to everyone on the wait list or even to a majority of those wait listed. Therefore, the Division (DMHDD) is exploring the potential of offering "Core Services" to wait listed persons. The "Core Services" approach will build upon proven early intervention and community strategies that reduce costs and increase consumer satisfaction. Although discussions are still in the preliminary stages, at a minimum this approach will include strategies which empower consumers to successfully negotiate service delivery systems: peer support (consumer-to-consumer and family-to-family), information and referral, natural family supports and advocacy.

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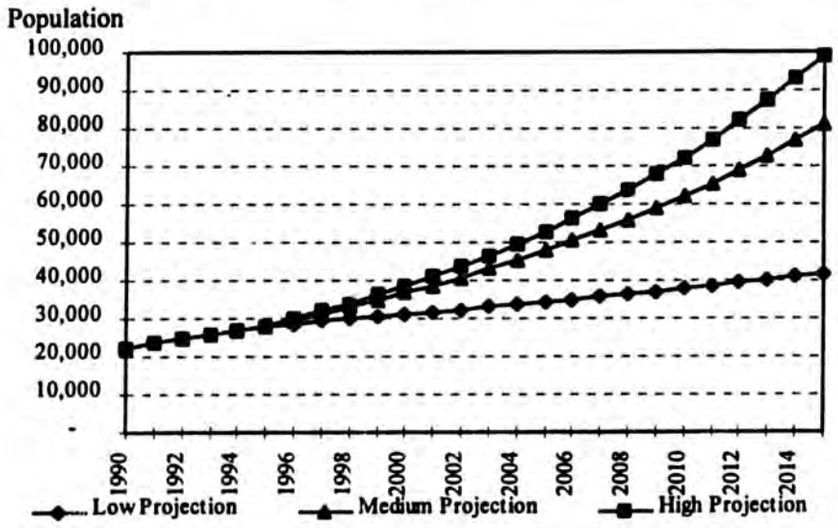
CHAPTER 4 - LONG-TERM CARE PROGRAM USAGE IN ALASKA TO 2015

Assumptions

Alaska's population has been growing, but at a decelerating rate, for the past six years. The average rate of increase for the most recent five year period was 1.75%. There is no indication that a change in this slow growth for the Alaska population will occur. A reasonable range of population growth possibilities would be 1% (low), 2.5% (medium) and 5% (high). It is assumed that the under 65 population of those needing long-term care services could grow at these rates. These rates are used here to make simple projections of Alaska's under 65 population in need of long-term care services, to the year 2015.
For Alaska's population aged 65 and above, a higher growth rate appears likely. The most recently published population data for Alaskans 65 and over shows an average yearly growth rate of 5.432% for the past five years. Information from waiting lists for Pioneers' Homes and other programs for Alaska's seniors also indicates that the population group aged 65 and above will continue to grow at a higher rate than the Alaska population as a whole. Therefore, yearly growth rates of 2%(low), 5.432%(medium) and 6.5%(high) are assumed for the population aged 65 and above. These rates will be used here to project growth of costs and service demands to the year 2015. The State Demographer uses a much more sophisticated model to generate population projections. At this time no official population projections are available. The State Demographer concurred that ours is one simple and reasonable method for projecting future population growth. He warned that there are large numbers of Alaskans who will turn 65 during the next twenty years. It should be noted that the growth recently experienced by the senior population is caused by an increase in the number of Alaska seniors remaining in Alaska.

Figure 1
Alaska's Population Aged 65 and Over, Projections to 2015



Note: 1990 is actual U.S. Bureau of Census Count, 1991-1995 are Alaska Department of Labor Estimates, 1996 - 2015 are the high, medium and low growth projections.

Figure 1 graphs three projected growth rates for Alaska's senior population to the year 2015. Figure 1 illustrates that a medium to high growth rate for Alaska's senior population will mean a dramatic increase in the number of Alaskan seniors needing long-term care services.

Analysis

Tables 1 and 2 show the long-term care service programs, number of cases, either consumer days or hours of service delivered, total expenditures and state general fund expenditures for the two age groups; ages 65 and over, and under 65 years of age. These expenditures are for Fiscal Year 1996. Every effort has been made to provide an accurate count of service delivered and funds expended for these programs. However, some individual consumers are probably double counted due to the nature of the way services are provided and the different systems used to account for services delivered.

Service Units are used in the Tables to show the amount of service delivered. Some programs measure the number of **hours** of service delivered to individuals in a program. Other programs measure the number of **days** of service an individual receives in a program. Please note the type of service units (days or hours) listed in the Source/Comments columns of Tables 1 and 2.

TABLE 1. - Long-Term Care Services - 65 and Over Age Group - FY96

Program	Service Units	Expenditures	GF Expenditures	Source/Comments
[1]Nursing Homes	151,933	$34,737,440	$ 17,368,720	MMIS-STARS/Units are consumer days
Pioneers' Homes	214,237	$30,016,400	$ 24,683,900	[2]see note below/ Units are consumer days
[1]Personal Care Services	160,965	$ 1,316,564	$ 658,282	DMA MMIS-STARS/Units = consumer days
[1]CHOICE	47,677	$ 2,946,295	$ 1,473,148	Older Alaskan Waivers/Units =consumer days
Personal Care Services	12,600	$ 1,059,100	$1,059,100	Div. Public Health/Units: hours of service[3]
DD Grant Funded	8,760	$ 235,000	$235,000	DMHDD/Units are consumer days
Commission on Aging Grants[4]	139,065	$ 115,443	$115,443	ADRD[5] Support/Units are consumer days
Commission on Aging Grants[4]	253,587	$ 2,493,949	$2,493,949	Respite Care/Adult Day Care/Care Coordination/Units are Hours of Service[3]

[1]Some payments had not been made at the time these figures were compiled. There is a possible small increase for these figures. Does not include payments to Nursing Homes by third parties or consumers (so-called co-payments).
[2]Pioneers' Homes FY96 actual expenditures, Units = estimated consumer days from a monthly snapshot count, -not actual.
[3]Based on number of seniors receiving PCS who are not funded by Medicaid
[4]Commission on Aging defines seniors as 60 years of age and over and report data by this age category
[5]ADRD is Alzheimer's Disease & Related Disorder
Please note that there are no ICF/MR costs for the 65 and over age group. All ICF/MR consumers were under 65 years of age in FY96.

TABLE 1A. Long-Term Care Services - 65 and Over Age Group - FY96 (Condensed)

Programs	Service Units	Expenditures	GF Expenditures	Cost per unit	GF Cost per unit
Nursing Homes	151,933	$34,737,440	$17,368,720	$ 228.64	$114.32
Pioneers' Homes	214,237	$30,016,400	$24,683,900	$ 140.11	$115.22
Home Based Service - Days	376,907	$ 4,613,302	$ 2,481,873	$ 12.24	$6.58
Home Based Services - Hours	266,187	$ 3,553,049	$ 3,553,049	$ 13.35	$13.35

In Table 1A, Home Based Services are reported in the two categories discussed above: consumer hours and consumer days. The lower cost and the higher number of people served in these two categories makes a strong argument for increased investment in the home based services.

It is not easy to relate hours of service to days of service. A nursing home may be reimbursed on a per diem (per day) rate for it's cost of care. A personal care service may charge a per hour fee for services to an individual. It is not possible to determine an average number of hours of home and community based services that will delay or avoid an individuals need for more expensive nursing home care. However home and community based services can be a lower cost alternative to institutional care in many cases.

A few hours a week of home based services may allow an individual to remain in his or her home and deter or delay the need for institutional care. Another individual may need more hours of home based services to remain independent and in their own home. Often, the individual will also utilize other community based services provided by various agencies within the community. This process of accessing different agencies, as well as informal resources, such as family, to cover all the needs of the individual makes it difficult to determine what amount of home and community based services and other community resources are needed to help maintain an 'average' consumers independence. Each case is unique, as each consumers needs are unique. Due to the relatively low cost of home and community based services and the relatively high cost of nursing home care the provision of ample home and community based services will often be a cost effective option for the State of Alaska. The population of those in need of services will increase over time as will the cost of services The information in this Chapter illustrates that home and community based services, because of the relatively low cost, must become an even larger part of the mix of long-term care services available to consumers in Alaska.

The following Tables, 2 and 2A, present information for long-term care services to those under 65 years of age.

TABLE 2.- Long-Term Care Services for Under 65 Age Group - FY96

Program	Service Units	Expenditures	GF Expenditures	Source/Comments
Nursing Homes*	50,233	$ 11,139,258	$5,569,629	DMA MMIS-STARS/Units are consumer days
ICF/MR - Hope*	13,843	$ 4,936,809	$2,468,405	DMA MMIS-STARS/Units are consumer days
ICF/MR - Harborview*	8,302	$ 3,453,031	$1,726,516	DMA MMIS-STARS/Units are consumer days
D.D. Grant Funded	636,925	$ 17,035,000	$7,035,000	DMHDD-units are estimated consumer days
TEFRA *	65,078	$ 1,328,422	$ 664,211	DMA MMIS-STARS/Units are consumer days
Waiver Program-ADP*	16,902	$ 1,006,778	$ 503,389	HCFA 372 Form DMA/Units are consumer days
Waiver Program-CCMC*	17,365	$ 1,181,823	$ 590,912	HCFA 372 Form DMA/Units are consumer days
Waiver Program- D.D.	44,238	$ 4,268,157	$2,134,078	HCFA 372 Form DMA/Units are consumer days
Personal Care Services(no TEFRA/Waiver)*	90,520	$ 1,639,965	$ 819,983	DMA MMIS-STARS/Units are consumer days
Commission on Aging Grants	13,989	$ 101,575	$ 101,575	Age under 60 / Units are hours of service
Personal Care Services	5,400	$ 453,900	$ 453,900	Div. Public Health/Units: hours of service**

* These numbers do not capture all expenditures since some payments for services have not been recorded and some payments have not been made.

** Estimate based on number of seniors in the program and number of Personal Care Services recipients funded under Medicaid

TABLE 2A Long-Term Care Services for Under 65 Age Group - FY96 (Condensed)

Program	Service Units	Expenditures	GF Expenditures	Cost Per Unit	GF Cost Per Unit
Nursing Homes	50,233	$11,139,258	$5,569,629	$ 221.32	$110.65
ICF/MR	22,145	$8,389,840	$4,194,920	$ 378.86	$189.43
Home Based Service - Days	871,028	$ 26,460,145	$21,747,573	$ 30.38	$24.97
Home Based Services - Hours	19,389	$ 555,475	$555,475	$ 28.65	$28.65

In Table 2A the Home Based Services are consolidated into two categories; one for Home Based Services measured by consumer hours served and the other for Home Based Services measured by consumer days.

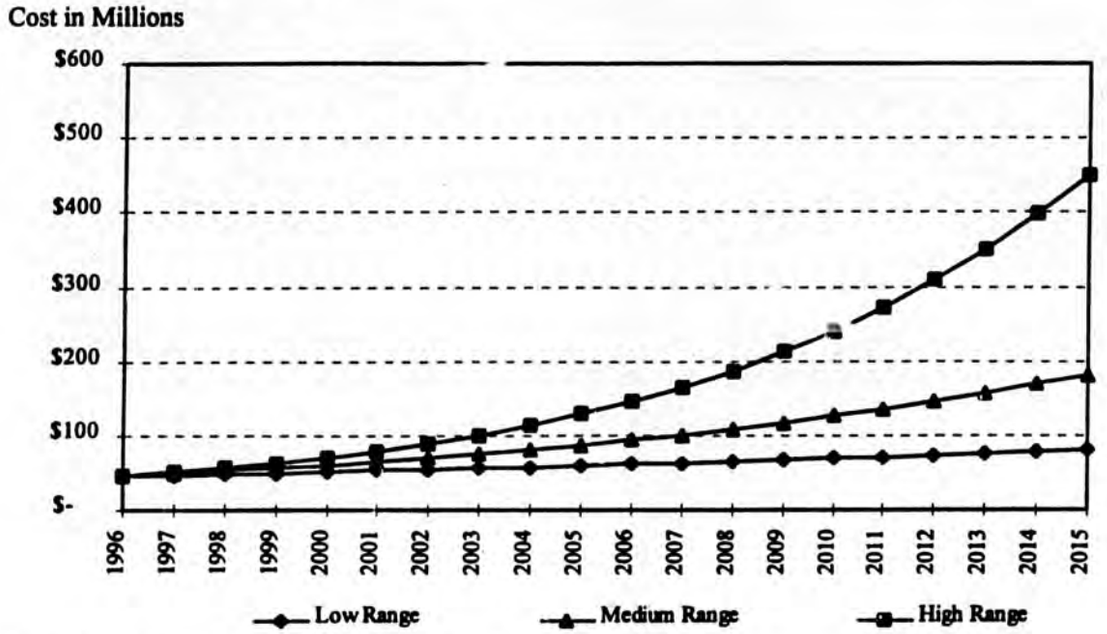
Tables 3 and 4, (pages 25 and 27), show projections of low, medium, and high growth rates for the services and costs of the long-term care system in Alaska to 2015. The population growth and inflation rates used to make these projections are described in the text. It should be noted that ICF/MR institutions are being eliminated and these consumers needs are being addressed using home based services. This results in one time transfers of consumers and costs from ICF/MR to Home Based Services in the projections for the Under 65 age group.

...the public costs of care for Alaska's senior population could grow by substantial amounts in the next twenty years...

The tables and charts on the following pages show that the public costs of care for Alaska's senior population could grow by substantial amounts in the next twenty years. When planning for the future provision of services each consumer must be provided the most efficient and cost effective mix of services to meet their needs. One strategy to do this will be to use lower cost services such as home and community based services whenever practical and try to keep the use of the higher cost services such as nursing home beds at a reasonable level. Judicious use of institutional alternatives must be considered as one strategy for keeping costs down. The State is charged with keeping costs at a minimum while providing the necessary services to all who have a need.

The Anchorage Consumer Price Index, which is the closest proxy for inflation in Alaska, has recorded increases ranging from 2.1% to 6.2% per year since 1990. Anchorage Consumer Price Index increases as high as 13.7% and as low as 0.4% have occurred in the past 20 years. The Alaska Department of Labor, Division of Administrative Services, Research and Analysis Unit is the source of this Consumer Price Index information. Inflation factors of 2% for low, 5% for medium and 8% for a high range are used in this report to project cost increases to 2015.

Figure 2
Long Term Care Costs - Under 65 Years - 1996 - 2015



The future costs for the long-term care programs for those under 65 have been lessened somewhat by the planned closure of the ICF/MR facility at the Harborview Development Center and the conversion of the ICF/MR facilities of Hope Cottages. The growth of the long-term care programs for the population under 65 will still be significant over time if costs or population grow at even a moderate rate. The projections made for this age group and for the 65 and over age group assume that the mix of services will not change (excepting the closure of the ICF/MR facilities and holding the number of available Pioneers' Home Beds constant). Thus one of the strategies for reducing future costs will be to change the mix of long-term care services used by the consumer. Nursing home care is one long-term care option that must be used efficiently by the consumer. A serious effort to use more home and community based services while maintaining a viable nursing home option must be made.

The growth of the long-term care programs for the population under 65 will still be significant *over time if costs or population grow at even a moderate rate. ...A serious effort to use more home and community based services while maintaining a viable nursing home option must be made.*

Table 3, on page 25, shows that for the low range projected increase of 1% population growth and 2% inflation growth, the cost of the long-term care service programs, for those under 65 years of age, would increase from $46.5 million to $79.7 million in 20 years. For the medium range projected increase of 2.5% population growth and 5% inflation the cost of the programs would nearly quadruple to $181.3 million in 20 years. For the high growth projected scenario, an increase of 5% population growth and 8% inflation, the cost of the programs would increase from $46.5 million to $456.1 million, nearly a ten fold increase. The higher the growth of population and cost inflation the more pressure there will be to find the most efficient and cost effective program services for those Alaskans with long-term care needs.

Table 3. Long-Term Care System - Total Expenditures for those Under 65 - Projected to the year 2015

Low Range Projection
1% Population Growth
and 2% Inflation Rate

Year	Service Units-Hours	Cost per Unit-Hour	Service Units-Days	Cost per Unit-Day	Total Expenditures
1996	19,389	$28.65	943,406	$48.75	$46,544,718
1997	19,583	$29.22	972,074	$47.79*	$47,028,347
1998	19,779	$29.81	981,794	$48.75	$48,448,603
1999	19,977	$30.40	991,612	$49.35	$49,544,175
2000	20,176	$31.01	1,001,528	$50.34	$51,040,409
2001	20,378	$31.63	1,011,544	$51.34	$52,581,829
2002	20,582	$32.26	1,021,659	$52.37	$54,169,800
2003	20,788	$32.91	1,031,876	$53.42	$55,805,728
2004	20,996	$33.57	1,042,195	$54.49	$57,491,061
2005	21,205	$34.24	1,052,616	$55.58	$59,227,291
2006	21,418	$34.92	1,063,143	$56.69	$61,015,955
2007	21,632	$35.62	1,073,774	$57.82	$62,858,637
2008	21,848	$36.33	1,084,512	$58.98	$64,756,968
2009	22,066	$37.06	1,095,357	$60.16	$66,712,629
2010	22,287	$37.80	1,106,310	$61.36	$68,727,350
2011	22,510	$38.56	1,117,374	$62.59	$70,802,916
2012	22,735	$39.33	1,128,547	$63.84	$72,941,164
2013	22,962	$40.12	1,139,833	$65.12	$75,143,987
2014	23,192	$40.92	1,151,231	$66.42	$77,413,336
2015	23,424	$41.74	1,162,743	$67.75	$79,751,218

* Decrease due to the closure of ICF/MR facility (Hope Cottages)

Medium Range Projection
2.5% Population Growth
and 5% Inflation Rate

Year	Service Units-Hours	Cost per Unit-Hour	Service Units-Days	Cost per Unit-Day	Total Expenditures
1996	19,389	$28.65	943,406	$48.75	$46,544,718
1997	19,874	$30.08	985,893	$49.61	$49,506,515
1998	20,371	$31.59	1,010,414	$51.95	$53,136,274
1999	20,880	$33.16	1,035,675	$53.37	$55,965,468
2000	21,402	$34.82	1,061,566	$56.04	$60,232,835
2001	21,937	$36.56	1,088,106	$58.84	$64,825,589
2002	22,485	$38.39	1,115,308	$61.78	$69,768,540
2003	23,047	$40.31	1,143,191	$64.87	$75,088,391
2004	23,624	$42.33	1,171,771	$68.11	$80,813,881
2005	24,214	$44.44	1,201,065	$71.52	$86,975,940
2006	24,820	$46.67	1,231,092	$75.10	$93,607,855
2007	25,440	$49.00	1,261,869	$78.85	$100,745,454
2008	26,076	$51.45	1,293,416	$82.79	$108,427,295
2009	26,728	$54.02	1,325,751	$86.93	$116,694,876
2010	27,396	$56.72	1,358,895	$91.28	$125,592,860
2011	28,081	$59.56	1,392,867	$95.84	$135,169,316
2012	28,783	$62.54	1,427,689	$100.64	$145,475,976
2013	29,503	$65.66	1,463,381	$105.67	$156,568,520
2014	30,240	$68.95	1,499,966	$110.95	$168,506,869
2015	30,996	$72.39	1,537,465	$116.50	$181,355,518

For more detailed expenditure projection see Appendix II

High Range Projection
5% Population Growth
and 8% Inflation Rate

Year	Service Units-Hours	Cost per Unit-Hour	Service Units-Days	Cost per Unit-Day	Total Expenditures
1996	19,389	$28.65	943,406	$48.75	$46,544,718
1997	20,358	$30.94	975,800	$51.22	$50,609,338
1998	21,376	$33.42	1,024,590	$55.32	$57,390,990
1999	22,445	$36.09	1,066,575	$53.38	$57,745,711
2000	23,567	$38.98	1,119,904	$58.17	$66,062,858
2001	24,746	$42.09	1,175,899	$65.82	$78,444,651
2002	25,983	$45.46	1,234,694	$71.09	$88,956,234
2003	27,282	$49.10	1,296,429	$76.78	$100,876,370
2004	28,646	$53.03	1,361,250	$82.92	$114,393,803
2005	30,079	$57.27	1,429,313	$89.55	$129,722,573
2006	31,583	$61.85	1,500,778	$96.72	$147,105,397
2007	33,162	$66.80	1,575,817	$104.46	$166,817,521
2008	34,820	$72.14	1,654,608	$112.81	$189,171,068
2009	36,561	$77.91	1,737,338	$121.84	$214,519,992
2010	38,389	$84.15	1,824,205	$131.58	$243,265,670
2011	40,308	$90.88	1,915,416	$142.11	$275,863,270
2012	42,324	$98.15	2,011,186	$153.48	$312,828,949
2013	44,440	$106.00	2,111,746	$165.76	$354,748,028
2014	46,662	$114.48	2,217,333	$179.02	$402,284,263
2015	48,995	$123.64	2,328,200	$193.34	$456,190,355

Figure 3
Long Term Care Program Costs - Age 65 and Over
1996 to 2015

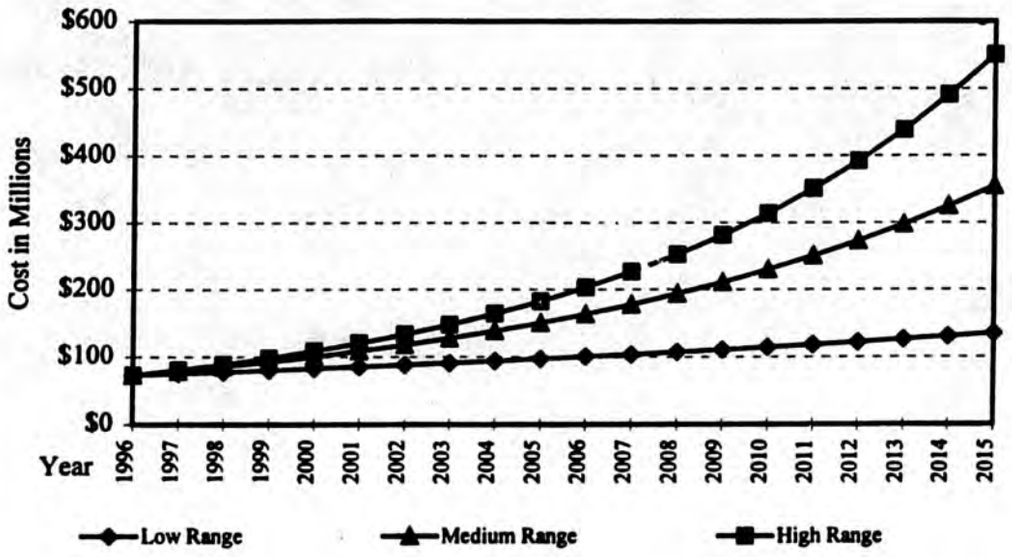


Figure 3 shows that for the population aged 65 and over the costs of long-term care services will continue to increase greatly in the future. The most optimistic projection scenario for low cost and population growth presented in Table 4, on the previous page, projects nearly a doubling in costs over 20 years. The cost projection for the high growth scenario is $550 million a year by 2015, this would cause such a demand for scarce funds for long-term care programs that many consumers could be denied needed services. This scenario must be avoided. Lower cost home and community based services could be used to reduce the demand for higher cost institutional based services when it is practical.

***... for the population aged 65 and over** the costs of long-term care services will continue to increase greatly in the future. ...Lower cost home and community based services could be used to reduce the demand for higher cost institutional based services...*

The mix of services used to fulfill consumer needs is important. With resources becoming relatively finite, the 65 and above age group population growing and costs increasing, those who deliver long-term care services to this age group must insure an adequate supply of services to the greatest number of consumers while keeping costs at a sustainable level.

Table 4. Long-Term Care System -Total Expenditures for those 65 and Over - Projected to the year 2015

Low Range Projection 2% Population Growth and 2% Inflation Rate					
Year	Service Units-Hours	Cost per Unit-Hour	Service Units-Days	Cost per Unit-Day	Total Expenditures
1996	266,187	$13.35	743,077	$ 93.35	$72,920,191
1997	271,511	$13.61	753,654	$ 94.95	$75,253,868
1998	276,941	$13.89	764,442	$ 96.57	$77,669,543
1999	282,480	$14.16	775,446	$ 98.23	$80,170,319
2000	288,129	$14.45	786,670	$ 99.91	$82,759,384
2001	293,892	$14.74	798,119	$101.63	$85,440,052
2002	299,770	$15.03	809,797	$103.37	$88,215,763
2003	305,765	$15.33	821,708	$105.15	$91,090,090
2004	311,880	$15.64	833,857	$106.96	$94,066,749
2005	318,118	$15.95	846,250	$108.80	$97,149,598
2006	324,480	$16.27	858,890	$110.68	$ 100,342,644
2007	330,970	$16.60	871,783	$112.59	$ 103,650,053
2008	337,589	$16.93	884,934	$114.54	$ 107,076,154
2009	344,341	$17.27	898,348	$116.52	$ 110,625,441
2010	351,228	$17.61	912,030	$118.55	$ 114,302,588
2011	358,253	$17.96	925,986	$120.60	$ 118,112,449
2012	365,418	$18.32	940,221	$122.70	$ 122,060,069
2013	372,726	$18.69	954,741	$124.83	$ 126,150,691
2014	380,181	$19.06	969,551	$127.01	$ 130,389,762
2015	387,784	$19.45	984,657	$129.23	$ 134,782,943

Medium Range Projection 5.432% Population Growth and 5% Inflation Rate					
Year	Service Units-Hours	Cost per Unit Hour	Service Units-Days	Cost per Unit-Day	Total Expenditures
1996	266,187	$13.35	743,077	$ 93.35	$ 72,920,191
1997	280,646	$14.02	771,804	$ 97.28	$ 79,013,298
1998	295,891	$14.72	802,091	$101.38	$ 85,672,948
1999	311,964	$15.45	834,023	$105.67	$ 92,955,538
2000	328,910	$16.22	867,690	$110.16	$100,923,253
2001	346,776	$17.04	903,185	$114.86	$109,644,706
2002	365,613	$17.89	940,609	$119.77	$119,195,621
2003	385,473	$18.78	980,065	$124.91	$129,659,576
2004	406,412	$19.72	1,021,665	$130.29	$141,128,838
2005	428,488	$20.71	1,065,525	$135.93	$153,705,275
2006	451,764	$21.74	1,111,767	$141.83	$167,501,372
2007	476,303	$22.83	1,160,520	$148.01	$182,641,353
2008	502,176	$23.97	1,211,922	$154.49	$199,262,422
2009	529,454	$25.17	1,266,117	$161.27	$217,516,138
2010	558,214	$26.43	1,323,255	$168.39	$237,569,931
2011	588,537	$27.75	1,383,497	$175.84	$259,608,789
2012	620,506	$29.14	1,447,011	$183.66	$283,837,114
2013	654,212	$30.59	1,513,975	$191.86	$310,480,784
2014	689,749	$32.12	1,584,577	$200.45	$339,789,430
2015	727,216	$33.73	1,659,014	$209.47	$372,038,957

High Range Projection 6.5% Population Growth and 8% Inflation Rate					
Year	Service Units-Hours	Cost per Unit-Hour	Service Units-Days	Cost per Unit-Day	Total Expenditures
1996	266,187	$13.35	743,077	$ 93.35	$ 72,920,191
1997	283,489	$14.42	777,452	$98.21	$ 80,436,622
1998	301,916	$15.57	814,061	$103.33	$88,815,397
1999	321,540	$16.81	853,049	$108.74	$98,163,163
2000	342,441	$18.16	894,572	$114.45	$108,600,378
2001	364,699	$19.61	938,794	$120.48	$120,263,142
2002	388,405	$21.18	985,890	$126.87	$133,305,281
2003	413,651	$22.88	1,036,047	$133.62	$147,900,712
2004	440,538	$24.71	1,089,465	$140.77	$164,246,122
2005	469,173	$26.68	1,146,355	$148.34	$182,564,016
2006	499,670	$28.82	1,206,942	$156.35	$203,106,176
2007	532,148	$31.12	1,271,468	$164.85	$226,157,582
2008	566,738	$33.61	1,340,188	$173.85	$252,040,878
2009	603,576	$36.30	1,413,375	$183.40	$281,121,425
2010	642,808	$39.21	1,491,319	$193.53	$313,813,061
2011	684,591	$42.34	1,574,329	$204.28	$350,584,625
2012	729,089	$45.73	1,662,735	$215.68	$391,967,384
2013	776,480	$49.39	1,756,888	$227.80	$438,563,453
2014	826,951	$53.34	1,857,160	$240.66	$491,055,379
2015	880,703	$57.61	1,963,950	$254.33	$550,217,019

For more detailed expenditure projections see Appendix II

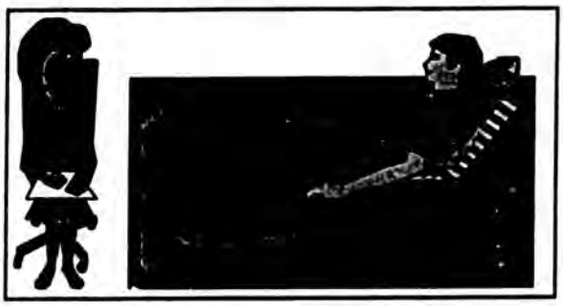
Senior Alaskans And Alaskans With Physical Disabilities. By 2015, Alaska's population of senior citizens age 65+ will increase by a projected 180% from the 1995 figure of 28,096 to 80,927, based on the medium growth projection data in this report. This will in turn propel growth in long-term health care and supportive service needs. Whereas it is estimated that 3,933 seniors now have severe impairments, by 2015 those with severe impairments will have grown to 11,225[3] .

The Working Group's goal is to advocate for long-term care that is responsive to the individual circumstances of Alaska's senior citizens and those with physical disabilities. To best meet growing long-term needs, our intent is to make **fullest use of Alaska's long-term care resources through a more flexible use of current resources, provide choice** in the types of available care, provide **access to services as close to home as is feasible,** assure that all options provide **quality services,** and expand the basic **long-term care capacity.** Our long-term care resources exist in terms of state and federal funding; families and community members who voluntarily commit their time, expertise and love to care for family and community members; non-profit agencies that meld locally-raised funding and in-kind contributions with state grants to provide home and community-based long-term care services; professional knowledge; and long-term care facilities such as assisted living homes and nursing homes.

Alaska will always need institutional care for severely medically needy individuals, and for people without families or social supports necessary to stay at home. As the community based long-term care system evolves, however, the focus of nursing homes is also changing. When people enter nursing homes now, they tend to have been discharged from a hospital and need rehabilitation services or short-term placements. Many people leave nursing homes to live at home with support from their families and home and community services.

Desired Entry Into The Long-Term Care System

Standardized Assessment and Care Coordination precedes all hospital discharges to long-term care placements.



What should be the features of a long-term care system that is responsive to the individual circumstances of Alaska senior citizens and those adults with physical disabilities?

- Home and Community-Based Care capacity is increased. Additionally, nursing homes will provide more flexible rehabilitative resources which maximize functioning and help return people to their homes, in addition to providing long-term skilled nursing care.
- They begin with a **standardized assessment of long-term care needs** used to establish the plan of care

when a senior is discharged from a hospital, and when a senior living in the community develops a need for long-term care.

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[3] Based on the rate of occurrence of severe impairments for the population age 65+, as established by the *Forecast of Service Needs of Older Persons,* Savant, Inc. & Older Alaskans Commission, Juneau, 1991.

- Linked to the adoption of a standardized assessment is the **universal availability of consistent care coordination services.** These services, offered by trained providers, will ensure that long-term care resources are used strategically. This will promote best use of limited public funding, and assure an appropriate crafting and match of services for seniors' individual circumstances. Over time, our long-term care system should be poised to provide long-term care support to seniors earlier in the progression of a chronic condition or disease than is now provided for. This will reduce crises which require more intensive and expensive interventions.
- Basic long-term care services should be available **as near to home as is economically feasible.** This will take the shape of rurally-based care coordination in all regions of the State; the development of flexible strategies and funding for adult day services and respite care to support home caregivers; and the development of regional and sub-regional assisted living homes.

Alaskans With Developmental Disabilities.

The mix of long-term care services available to Alaskans with developmental disabilities should not change much over the next twenty years, although the language used describe specific services may change. No change to the eligibility definition is anticipated.

Services will continue to be provided on an individualized basis according to each consumer's desires, interests and needs and may include any of the following services: case management; family resource specialist; foster care; group home; in-home training; natural family supports and other assistive technologies; personal assistance services; respite; services for children who experience special health care and developmental needs; shared care; supported living; and vocational supports. However, the consumer is in no way limited to these services and, in fact, may design his or her own services to meet unique desires, needs and interests.

All services will continue to be provided in home and community-based settings in the consumer's community of choice. It is anticipated that current trends impacting service delivery will be operationalized across the state as follows:

- continued transition from funding services through grants to agencies to funding services according to individualized plans with money following consumers as they re-locate or negotiate service delivery with alternative providers;
- continued emphasis on funding low-cost early intervention services which help avert high-cost crisis situations;
- continued emphasis on developing natural supports in the community and assisting individuals with developmental disabilities to be full participants and contributors in local community life;
- continued collaboration with generic and specialized community resources (e.g. with local recreation agencies or with senior centers as individuals with developmental disabilities retire from the work force;
- gradual closure of group homes as additional supported living arrangements which more closely approximate those used by persons without disabilities are developed;
- implementation and evaluation of a core services approach for persons on the wait list which at a minimum includes the following: peer counseling (consumer-to-consumer and family-to-family), information and referral, and advocacy;
- increased emphasis on supporting communities and ordinary citizens to see themselves as competent and willing to become involved in the lives of people with developmental disabilities; and
- expansion of voucher programs which give funding control to consumers and/or their families.

CHAPTER 6: CERTIFICATE OF NEED PROGRAM

How The Program Works

Alaska, like most other states, has a certificate of need review process for health facilities planning to spend $1,000,000 (one million dollars) or more for construction, expansion, or remodeling projects. Facilities that must comply with the process include hospitals and nursing homes and other facilities such as psychiatric or tuberculosis hospitals, kidney disease treatment centers, intermediate care facilities and ambulatory surgical centers.

The certificate of need review imposes a planning process to help control health care costs by requiring that a proposed project be of good quality and meet the public need, while preventing excessive, unnecessary or duplicative facilities or services. In the case of nursing homes, the certificate of need review seeks to ensure that, based on future projections, only the number of beds that are necessary be built, because of the high cost to Medicaid and the State general fund dollars that are associated with new beds.

The certificate of need review is initiated through a letter of intent sent to the Department of Health and Social Services. The letter of intent provides a project description, estimated cost and estimated starting and completion dates of a project. Based on the letter of intent, the Department of Health and Social Services determines if the proposed project requires a certificate of need review. If a certificate is required, a detailed application must be submitted. Once the application is received and declared complete, the Department of Health and Social Services provides an analysis and makes recommendations to the Commissioner of Health and Social Services who decides to approve or deny a certificate of need. Time frames for each step in the review process are provided for in law and regulation, and extensions may be granted as required. The decision to grant or deny a certificate of need may be appealed.

Current Standard Of Review

AS 18.07.041 requires the Department of Health and Social Services to grant a certificate of need if "the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services to maintain the good health of citizens of this State."

A certificate of need must be granted if the service is not available or not sufficiently accessible, and if the applicant demonstrates that the proposed services will be provided in a quality manner. Quality, for example, can be demonstrated if the applicant provides for an adequate level of staffing to operate the new services or if the applicant shows sufficient usage of the proposed service to obtain a high level of proficiency with appropriate staff training.

Limitations Of Current Standard Of Review

While availability, accessibility and quality are important, they are insufficient for assessing "a current or projected requirement for health services..." Meeting a current requirement does not mean that there is a long term need for the service or facility or that there will be the resources necessary to sustain the service or facility throughout its life cycle. Similarly, meeting a current or projected need does not mean that it is the most cost effective method for doing so; nor does it mean that the State, facing declining resources, should encourage and support a low priority service in the face of more pressing priorities. The certificate of need program requires more explicit statutory and regulatory definition in these areas to better control costs and better target the health care priorities of Alaskans.

Recommendations For Principles To Guide The Certificate Of Need Process

The Working Group believes that basing certificate of need reviews only on matters of availability, accessibility and quality, as is now required by statute, is insufficient. Other important principles should be used, including: appropriate planning, demonstration of need, and cost effectiveness when reviewing applications which impact the State's long-term care system. Therefore, the Working Group believes that the Department of Health and Social Services should seek legislative approval to strengthen the certificate of need program by adding these important principles to the certificate of need statute (AS 18.07). This will allow long-term care projects to be reviewed under the following principles:

> ***...the Working Group believes that the Department of Health and Social Services should seek legislative approval to strengthen the certificate of need program by adding these important principles...***

Appropriate Planning The Working Group believes that all certificate of need projects should be planned in the context of statewide as well as regional and community needs.

Of primary importance is the development of a State long-term care plan which outlines the existing and desired long-term care system in a comprehensive manner. Proposed projects should integrate well with the existing long-term care system. Certificate of need applicants would be required to demonstrate how well their proposal would fit with other plans, including community, agency and statewide plans, and ongoing services.

Proposed projects must reflect public participation and support. This can be demonstrated by a high level of participation in a public hearing or written support for a proposed service. In addition, for proposed community projects, support may be demonstrated by a local municipality or borough providing matching funds through local tax levies or bond referendums. The applicant must also discuss the approaches used to involve affected groups (e.g. potential recipients and family members, community service providers) in the planning process; a summary of their input; and a description of how the proposal is responsive to their input.

Finally, a proposed project should help balance out the long-term care system by ensuring a mix of services consistent with community needs and desires to have alternative choices.

Quality: As is the case with the current certificate of need statute, (AS 18.07.041) the quality of a proposed project must also be demonstrated. As mentioned above, quality can be demonstrated if the applicant provides for an adequate level of staffing to operate the new services or if the applicant shows sufficient utilization of the proposed service to obtain a high level of proficiency with appropriate staff training.

Demonstration of Need: The Working Group believes that proposed projects should convincingly demonstrate need through sufficiently high projected utilization rates to justify the expenditures. For example, projected population growth rates should be sufficient to support a proposed project. Nursing homes seeking to replace old or worn out infrastructure should have to demonstrate facility deficiencies and ongoing need. Specific review standards should be used to determine this need. These standards should include methodologies and criteria for determining bed capacities as well as thresholds for approving the expansion of the health care system. As is the case with the current certificate of need statute, (AS 18.07.041) availability and accessibility to health care services also need to be considered in demonstrating need.

Cost Effectiveness: The Working Group believes that cost effectiveness of a proposed project should be demonstrated before it is approved. Proposed projects need to be compared against feasible alternatives to determine if the proposal is the most cost effective way of achieving comparable results. The assessment of financial feasibility should address the full life of the project or at least a significant part of the life of the project and include such items as the availability of funds to pay for the project, the likelihood of private or governmental financing, and the passage of a bond referendum by a community.

The Working Group believes that it is critical to recognize the financial impact of nursing home bed expansion on the Medicaid program. Approximately 90 percent of nursing home expenditures in the State are made by Medicaid. To maintain an individual in a nursing home costs approximately $75,000 per year, consequently, expansion of nursing home beds has significant policy implications for the State. Therefore, the Working Group believes that the potential financial impact, to the consumer and the State, of expanding the number of nursing home beds warrants approval by the legislature for larger projects.

Recommendations: The Working Group recommends that in the case of a certificate of need application related to long-term care services the following actions be taken;

- if subject to the certificate of need process the application is reviewed by the Department to assure that it complies with all criteria,

- if the proposed expansion of service (through the addition of new or replacement nursing beds) is projected to cost the State more than $3,000,000 in Medicaid reimbursement for operating and capital costs[4] over the first ten years of the project, the certificate of need issued by the Department of Health and Social Services will be considered approved upon adoption of a legislative resolution approving the project and recognizing the cost impact on the Medicaid budget,

- if the proposed expansion of services (through the addition of new or replacement nursing beds) is projected to cost the State less than $3,000,000 in Medicaid reimbursement for operating and capital costs over the first ten years of the project, cost effectiveness should be considered by the department as a review criteria but a legislative resolution is not required.

The working group recognizes that there are differences in construction and operating costs between urban and rural areas. The Department should take geographical cost differences into consideration when evaluating certificate of need applications.

The following page contains a summary of the recommended Guiding Principles/Criteria to be used for reviewing certificate of need applications.

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[4] The estimated per diem rate for the facility will be used to determine whether proposed facility costs will be over the $3,000,000 threshold which require legislative approval for funding. Per diem rates may be estimated by the facility, by the Medicaid Rate Advisory Commission, or using a per diem rate of a similar size facility located in Alaska.

RECOMMENDED GUIDING PRINCIPLES/CRITERIA FOR CERTIFICATE OF NEED

Criteria and Standards are used in each Certificate of Need application review to determine findings of need or no need for a project and to make recommendations as to whether a project should be approved or not.

CURRENT LAW

Current State Certificate of Need law only allows consideration of availability, accessibility, and quality

Availability
- **Services not available**

Accessibility
- **Services not sufficiently accessible**

Quality
- **Adequate staffing**
- **Adequate resources**
- **Adequate training**
- **Adequate no. of procedures**

PROPOSED ADDITIONS

Appropriate Planning
- **Relationship to existing plans**
- **Public participation - including local financing of the project**
- **Relationship to existing health care system**
- **Consensus of community**
- **Balanced system**

Quality (in current law)
- **Adequate staffing**
- **Adequate resources**
- **Adequate training**
- **Adequate no. of procedures**

Demonstration of Need
- **Utilization**
- **Population growth**
- **Deficiencies in existing facilities**
- **Adopt specific standards of review**
- **Availability (in current law)**
- **Accessibility (in current law)**

Cost Effectiveness
- **Availability of less costly/more effective alternatives**
- **Financial feasibility**
- **Cost of similar service in area**
- **The cost impact to the consumer and the state, and**
- **Legislative resolution supporting new costs based on a financial threshold**

STATE HEALTH POLICY PLAN

There is a need to develop a state health policy plan which outlines statewide, regional and community needs. Also, if allowable, the CON law needs to include language that requires federal facilities competing for state dollars to be reviewed.

APPENDICES

APPENDIX - I

DD Services and Wait List Tables and Analysis.....38

APPENDIX - II

Long-Term Care Services , FY96 Expenditures, and Projections to 2015.....42

APPENDIX - III

Inventory of Alaska's Long-Term Care Services.....48

APPENDIX - IV

Numbers of Seniors , Seniors with Severe Impairment
Levels and Services Available, Projections to 2015 50

APPENDIX - I

Table 1: Cost of DD Services According to the Number of Services Received

NUMBER OF SERVICES	AVERAGE COST	RANGE OF COSTS	PERCENT OF TOTAL
One Service	$9,251	$200 - 81,698	79%
Two Services	$17,261	$1,849 - 54, 128	16%
Three or More Services	$18,343	$500 - 58,341	5%

Although the majority of persons receive only one service, a more detailed analysis by age indicates that 61% of adults are likely to receive more than one service. This most likely reflects their needs for both vocational supports and supported living services in order to assume adult roles within the community. The majority of persons who receive only one service are primarily receiving lower cost services such as respite, case management or natural family supports.

Table 2: DD Service Provider Overview

	NORTHERN	SOUTH CENTRAL	ANCHORAGE	S.E.	TOTAL
Number of Providers	10	11	5	6	32
# of Communities Served	111	67	1	18	197
Percent of Total Number of Persons Served	24%	24%	41%	11%	100%
Population Breakout according to State Census	20%	25%	42%	13%	100%

The percent of total persons served by region is fairly consistent with state census data. However, a separate analysis breaking down recipients by age indicates that a disproportionate amount of services are being provided to Anchorage adults (58%) and that southcentral and southeast adults are underserved, receiving 17% and 7% of the service provided, respectively. For many years, people needing DD services had to move to Anchorage to receive services. The percent of adults served in Anchorage has dropped over the past few years and will continue to drop as additional expertise is developed in the more remote areas of the state.

Children and youth residing in the Anchorage area are underserved by the DD system (28%) and those residing in the northern region are receiving more services (30% as compared to the census population of 20%). These patterns reflect two fairly recent (within the past five years) trends in service delivery:

- the development of service provider expertise in more remote areas of the state, thereby empowering children and youth, in particular, to remain home with their families rather than move to Anchorage; and
- increased use of generic resources such as Head Start, and when feasible, the use of natural supports such as friends, families and peer support groups which reduces need for formal services.

Table 3: Number of DD Services Providing Specific Types of Services

	NORTHERN	SOUTH CENTRAL	ANCHORAGE	S.E.	TOTAL
Individualized Services*	7	8	4	5	24
Case Management**	6	4	2	2	14
Foster Care	1	4	2	1	8
Group Home***	1	1	1	1	4
In-Home Supports	2	5	3	4	14
Personal Assistance Services	2	1	1	1	5
Respite	6	8	3	5	22
Shared Care	2	3	1	2	8
Supported Living	6	6	3	3	18
Vocational Supports	3	3	2	3	11

Individualized services are the most frequent services provided to consumers. (See Table 3 in the Appendix.) This reflects the trend to funding services on an individualized basis rather than through grants to non-profit agencies. It also reflects the

transition of the service delivery system from a menu-driven system (e.g. "Here's what's available. What services would you like?) to one that is consumer-driven and based on consumer rather than agency interests and needs.

The next four most frequent services are those which are less costly to provide or more easily implemented in the rural and remote areas of the state; these services include respite, supported living, case management and in-home supports. 69% of providers offer respite services, 56% provide supported living services, 44% offer case management and 44% offer in-home supports. These services are also designed to help consumers remain either at home or in their local communities. The remaining services either require specialized expertise or have higher costs associated with them.

Table 4: Percent of DD Persons Receiving Services by Age

AGE	FY95	FY96
Birth - 2	1%	2%
3 - 11	28%	26%
12 - 20	21%	20%
21 - 64	49%	51%
65+	1%	1%

Children and youth represent 50% of all persons served in FY95 and 48% of those served in FY96. When compared with state census information, it appears that they are receiving services disproportionate to the 31% of Alaskans who are less than 18 years of age. However, the services provided to most children tend to be low cost ones aimed at keeping families together and averting crisis situations which escalate into the need for higher cost, more intrusive services.

Adults between the ages of 21-64 represent 49% of those served in FY95 and 51% of those served in FY96. When compared with state census data, it appears that they are underserved since 69% of Alaskans are 18+ years of age; this may reflect the fact that most adults require high cost, intensive services as well as a combination of services in order to successfully live and work in the community.

Older adults represent 1% of those served in both FY95 and FY96 as compared to the general population of 4%. Adults with developmental disabilities usually do not live as long as the general population; however, this is changing as medical advances increase. Not only will a longer life span affect movement off the wait list, specialized expertise will need to be developed by service providers, perhaps in combination with the Division of Senior Services and the Alaska Commission on Aging.

Table 5: Percent of DD Consumers Receiving Specific Types of Services

	NORTHERN	SOUTH CENTRAL	ANCHORAGE	S.E.	TOTAL
Individualized Services*	13%	7%	18%	18%	14%
Case Management**	28%	21%	1%	12%	15%
Foster Care	.5%	2%	3%	1%	2%
Group Home***	.5%	1%	7%	2%	3%
In-Home Supports	3%	1%	7%	4%	4%
Personal Assistance Services	.5%	1%	1%	1%	1%
Respite	37%	41%	31%	42%	36%
Shared Care	.5%	1%	2%	1%	1%
Supported Living	8%	14%	18%	9%	13%
Vocational Supports	9%	11%	12%	10%	11%

Respite is the most frequent service consumers use, although no one service is used by a majority of service recipients. The remaining services either fall in the 11-15% range or are provided to less than 5% of persons served. Case management is provided to a much greater extent in the northern and southcentral regions of the state; however, in reviewing available data, it appears that case management is being used as a "stop gap" until the individual comes off the wait list. Case management is only provided as a distinct service to 1% of Anchorage consumers; however, the bigger agencies tend to "lump" case management together with other services.

Table 6: Cost of Distinct DD Services (One Service Only)

SERVICE	AVERAGE COST	RANGE OF COSTS	% OF TOTAL EXPENDITURES
Individualized Services	$11,204	$2,100-57,911	13%
Case Management	$2,526	$443-5,180	2%
Family Resource Consultant	$1,138	NA	2%
Foster Care	$31,509	$4,308-59,295	9%
Group Homes	$38,039	$3,912-69,276	17%
In-Home Training	$10,442	$2,055-70,000	5%
Natural Family Supports	$875	NA	NA
Personal Assistance Services	$9,000	$9,000	1%<
Respite	$2,557	$200-18,329	12%
Services for Children Who Experience Special Health Care and Developmental Needs	$19,795	NA	8%
Shared Care	$19,534	$3,341-30,351	1%
Supported Living	$22,483	$1,535-81,698	23%
Vocational Supports	$11,101	$2,200-51,054	8%

For the most part, those services which are low cost also tend to be the services that consumers most frequently receive (e.g. respite, case management, natural family supports, individualized services, supported living and vocational supports).

Table 7: Number of DD Persons Waiting for Services

AGE	NORTHERN	SOUTH CENTRAL	ANCHORAGE	S.E.	TOTAL
Birth - 2	1	18	11	10	40
3 - 6	13	31	28	19	91
7 - 17	38	70	45	44	197
18 - 23	41	63	51	9	164
24 - 44	35	51	68	16	170
45+	3	13	11	2	29
TOTAL	131	246	214	100	691

Many of those on the wait list are young adults between the ages of 18-27. Their needs and associated costs increase as they transition from school to adult life. While in school their education costs are covered by local school districts. The cost of respite and natural family supports is relatively low compared to the costs for the supported living services and vocational supports they need a adults.

Table 8: Number of DD Services Requested by Persons on the Wait List

	NORTHERN	SOUTH CENTRAL	ANCHORAGE	S.E.	TOTAL
1 Service Only	46	91	103	37	277
2 Services	55	94	88	48	285
3 Services	30	61	23	15	129
TOTAL	131	246	214	100	691

Individuals with developmental disabilities require intensive services to live successfully in the community. 60% of the persons on the wait list need more than one service. Low cost early intervention services such as respite care, case management or natural family support represent the majority of requests for a single service. When average costs of one, two and three or more services are calculated, it will take $9,848,159 to meet the needs of all 691 individuals on the wait list.

Table 9: Number of Persons Waiting for Specific DD Services

SERVICE	NORTHERN	SOUTH CENTRAL	ANCHORAGE	S.E.	TOTAL
Case Management	32	31	17	8	88
Foster Care	8	10	7	1	26
Group Home	4	10	8	4	26
ICF/MR	0	1	2	1	4
In-Home Support	23	70	56	39	188
Personal Assistance Services	4	8	3	2	17
Respite	34	112	67	56	269
Sexual Offender Treatment	0	0	4	0	4
Shared Care	12	16	12	17	57
Supported Living	63	86	61	22	232
Vocational Supports	66	118	110	27	321
TOTAL	246	462	347	177	1,232

Table 10: Average Time on DD Wait List

REGION	AVERAGE TIME ON WAIT LIST
Northern Region	20.21 months
South Central Region	22.16 months
Anchorage Region	24.78 months
Southeast Region	25.84 months
TOTAL	23.44 months

It takes almost two years for persons on the wait list to receive services. Even then the individual may not receive all services at the intensity needed. For example, the individual may receive vocational supports but not supported living services, or the family may be offered 10 hours of respite per month when 15 hours is needed.

* May include 1 or more of the other 9 services

** These numbers are misleading and probably understated. Many agencies provide case management services as a part of their other services and do not separate it out as a distinct service.

*** In some cases, the available data did not specify what type of residential services were being provided; therefore, there is no way of telling whether the agency was providing group home or supported living services or both.

APPENDIX - II
TABLE 1

Long-Term Care Services for Over 65 Age Group -FY96 Expenditures

Program	Units	Expenditures	General Fund	Comments
Nursing Homes	151,933	$34,737,440	$17,368,720	Medicaid MMIS - STARS units are consumer days
Pioneers' Homes	214,237	$30,016,400	$24,683,900	Div. ALP-Units are estimated using monthly census of Homes
Personal Care Services	12,600	$1,059,100	$1,059,100	DPH estimate 70% of consumers are 65+ units are hours served
Personal Care Services	160,965	$1,316,564	$658,282	Medicaid MMIS - STARS-units are consumer days
**CHOICE ("Older Alaskan" Waivers)	47,677	$2,946,295	$1,473,148	Medicaid MMIS - STARS-units are consumer days
Commission on Aging Grant-Statewide ADRD* Support	159,505	$115,443	$115,443	Commission on Aging- units are consumer-days *ADRD is Alzheimer's Disease & Related Disorder
D.D. Grant Funded	8,760	$235,000	$235,000	DMHDD- units are consumer days 24 consumers are 65+, Expenditures is estimated
Commission on Aging Grants(Respite Care, Adult Day Care, Care Coordination)	253,587	$2,493,949	$2,493,949	Commission on Aging-Units are Hours of service-60+ age group not 65+

Long-Term Care Services for Under 65 Age Group - FY96 Expenditures

Program	Units	Expenditures	General Fund	Comments
Nursing Homes	50,233	$11,139,258	$5,569,629	DMA-MMIS - STARS-units are consumer days
ICF/MR - Hope	13,843	$4,936,809	$2,468,405	DMA-MMIS - STARS-units are consumer days
ICF/MR - Harborview	8,302	$3,453,031	$1,726,516	DMA-MMIS - STARS-units are consumer days
D.D. Grant Funded	636,925	$17,035,000	$17,035,000	DMHDD units are estimated consumer days- Expenditure is FY96 budget
TEFRA	65,078	$1,328,422	$664,211	DMA-MMIS - STARS-units are consumer days
Waiver Program-Physically Disabled	16,902	$1,006,778	$503,389	HCFA-372 Form DMA 12-18-96-units are consumer days
Waiver Program-CCMC	17,365	$1,181,823	$590,912	HCFA-372 Form DMA 12-18-96-units are consumer days
Waiver Program-Developmentally Disabled	44,238	$4,268,157	$2,134,079	HCFA-372 Form DMA 12-18-96-units are consumer days
Personal Care Services(no TEFRA or Waivers)	90,520	$1,639,965	$819,983	DMA-MMIS - STARS-units are consumer days
Commission on Aging Grants	13,989	$101,575	$101,575	Commission on Aging-Units are Hours of service
Personal Care Services	5,400	$453,900	$453,900	DPH estimate 70% of consumers are 65+/Units are Hours of service

DMA-MMIS - STARS- there are outstanding payments for services that will increase all of the DMA MMIS STARS Expenditure amounts Commission on Aging numbers are approximate
DPH awarded $1.513M total, figures for age groups are approximate

TABLE 2

Long-Term Care Services for Over 65 Age Group -FY96 Expenditures (Condensed)

Program	Units	Expenditures	GF Expenditures	Cost per Unit All Expenditures	Cost per Unit GF Expenditures
Nursing Homes	151,933	$34,737,440	$17,368,720	$228.64	$114.32
Pioneers' Homes	214,237	$30,016,400	$24,683,900	$140.11	$115.22
Home Based-Consumer days of Service	376,907	$4,613,302	$2,481,873	$12.24	$6.58
Home Based-Hours of Service	266,187	$3,553,049	$3,553,049	$13.35	$13.35

Long-Term Care Services for Under 65 Age Group - FY96 Expenditures (Condensed)

Program	Units	Expenditures	GF Expenditures	Cost per Unit All Expenditures	Cost per Unit GF Expenditures
Nursing Homes	50,233	$11,139,258	$5,569,629	$221.75	$110.88
ICF/MR	22,145	$8,389,840	$4,194,920	$378.86	$189.43
Home Based-Consumer days of Service	871,028	$26,460,145	$21,747,573	$30.38	$24.97
Home Based-Hours of Service	19,389	$555,475	$555,475	$28.65	$28.65

TABLE 3. - Projecting LTC Programs for Under 65 Age Group With 2%, 5% and 8% Cost Increase and 1%, 2.5% and 5% Population Increase

2% Cost Increase and 1% Population increase

Year	Nursing Covered Days	Homes Cost	Cost Per Covered Day	ICF/MR Covered Days	Cost	Cost Per Covered Day	Home Based Covered Days	Cost	Cost Per Covered Day	Home Based Total Covered Hours	Cost	Cost Per Covered Hour	Total Covered Days	Cost	Cost Per Covered Day	Total Cost
1996	50,233	$11,139,258	$221.75	22,145	$8,389,840	$378.86	871,028	$26,460,145	$30.38	19,389	$555,475	$28.65	943,406	$45,989,243	$48.75	$46,544,718
1997	50,735	$11,475,664	$226.19	8,385	$3,522,092	$420.05	912,953	$31,458,341	$34.46	19,583	$572,250	$29.22	972,074	$46,456,097	$47.79	$47,028,347
1998	51,243	$11,822,229	$230.71	8,469	$3,628,459	$428.45	922,083	$32,408,383	$35.15	19,779	$589,532	$29.81	981,794	$47,859,071	$48.75	$48,448,603
1999	51,755	$12,179,260	$235.32	0	$-	$-	939,857	$36,757,579	$39.11	19,977	$607,336	$30.40	991,612	$48,936,839	$49.35	$49,544,175
2000	52,273	$12,547,074	$240.03	0	$-	$-	949,256	$37,867,658	$39.89	20,176	$625,677	$31.01	1,001,528	$50,414,731	$50.34	$51,040,409
2001	52,795	$12,925,995	$244.83	0	$-	$-	958,748	$39,011,261	$40.69	20,378	$644,573	$31.63	1,011,544	$51,937,256	$51.34	$52,581,829
2002	53,323	$13,316,360	$249.73	0	$-	$-	968,336	$40,189,401	$41.50	20,582	$664,039	$32.26	1,021,659	$53,505,761	$52.37	$54,169,800
2003	53,857	$13,718,514	$254.72	0	$-	$-	978,019	$41,403,121	$42.33	20,788	$684,093	$32.91	1,031,876	$55,121,635	$53.42	$55,805,728
2004	54,395	$14,132,813	$259.82	0	$-	$-	987,799	$42,653,495	$43.18	20,996	$704,752	$33.57	1,042,195	$56,786,309	$54.49	$57,491,061
2005	54,939	$14,559,624	$265.01	0	$-	$-	997,677	$43,941,631	$44.04	21,205	$726,036	$34.24	1,052,616	$58,501,255	$55.58	$59,227,291
2006	55,488	$14,999,325	$270.31	0	$-	$-	1,007,654	$45,268,668	$44.92	21,418	$747,962	$34.92	1,063,143	$60,267,993	$56.69	$61,015,955
2007	56,043	$15,452,305	$275.72	0	$-	$-	1,017,731	$46,635,782	$45.82	21,632	$770,551	$35.62	1,073,774	$62,088,087	$57.82	$62,858,637
2008	56,604	$15,918,964	$281.23	0	$-	$-	1,027,908	$48,044,183	$46.74	21,848	$793,821	$36.33	1,084,512	$63,963,147	$58.98	$64,756,968
2009	57,170	$16,399,717	$286.86	0	$-	$-	1,038,187	$49,495,117	$47.67	22,066	$817,795	$37.06	1,095,357	$65,894,834	$60.16	$66,712,629
2010	57,742	$16,894,989	$292.60	0	$-	$-	1,048,569	$50,989,869	$48.63	22,287	$842,492	$37.80	1,106,310	$67,884,858	$61.36	$68,727,350
2011	58,319	$17,405,217	$298.45	0	$-	$-	1,059,055	$52,529,764	$49.60	22,510	$867,935	$38.56	1,117,374	$69,934,981	$62.59	$70,802,916
2012	58,902	$17,930,855	$304.42	0	$-	$-	1,069,645	$54,116,162	$50.59	22,735	$894,147	$39.33	1,128,547	$72,047,017	$63.84	$72,941,164
2013	59,491	$18,472,367	$310.51	0	$-	$-	1,080,342	$55,750,470	$51.60	22,962	$921,150	$40.12	1,139,833	$74,222,837	$65.12	$75,143,987
2014	60,086	$19,030,232	$316.72	0	$-	$-	1,091,145	$57,434,135	$52.64	23,192	$948,969	$40.92	1,151,231	$76,464,367	$66.42	$77,413,336
2015	60,687	$19,604,945	$323.05	0	$-	$-	1,102,056	$59,168,646	$53.69	23,424	$977,628	$41.74	1,162,743	$78,773,591	$67.75	$79,751,218

5% Increase in Costs and 2.5% Increase in Population

Year	Nursing Covered Days	Homes Cost	Cost Per Covered Day	ICF/MR Covered Days	Cost	Cost Per Covered Day	Home Based Covered Days	Cost	Cost Per Covered Day	Home Based Hours - Total Covered Hours	Cost	Cost Per Covered Hour	Total Covered Days	Cost	Cost Per Covered Day	Total Cost
1996	50,233	$11,139,258	$221.75	22,145	$8,389,840	$378.86	871,028	$26,460,145	$30.38	19,389	$555,475.00	$28.65	943,406	$45,989,243	$48.75	$46,544,718
1997	51,489	$11,988,626	$232.84	8,510	$3,539,357	$415.93	926,019	$33,380,702	$36.05	19,874	$597,829.97	$30.08	986,017	$48,908,685	$49.60	$49,506,515
1998	52,776	$12,902,759	$244.48	8,722	$3,718,537	$426.33	949,169	$35,925,981	$37.85	20,371	$643,414.50	$31.59	1,010,668	$52,547,277	$51.99	$53,190,691
1999	54,095	$13,886,595	$256.71	0	$-	$-	981,579	$41,440,817	$42.22	20,880	$692,474.86	$33.16	1,035,675	$55,327,411	$53.42	$56,019,886
2000	55,448	$14,945,447	$269.54	0	$-	$-	1,006,119	$44,600,679	$44.33	21,402	$745,276.07	$34.82	1,061,566	$59,546,126	$56.09	$60,291,402
2001	56,834	$16,085,038	$283.02	0	$-	$-	1,031,272	$48,001,481	$46.55	21,937	$802,103.37	$36.56	1,088,106	$64,086,518	$58.90	$64,888,622
2002	58,255	$17,311,522	$297.17	0	$-	$-	1,057,053	$51,661,593	$48.87	22,485	$863,263.75	$38.39	1,115,308	$68,973,115	$61.84	$69,836,379
2003	59,711	$18,631,525	$312.03	0	$-	$-	1,083,480	$55,600,790	$51.32	23,047	$929,087.61	$40.31	1,143,191	$74,232,315	$64.93	$75,161,403
2004	61,204	$20,052,179	$327.63	0	$-	$-	1,110,567	$59,840,350	$53.88	23,624	$999,930.54	$42.33	1,171,771	$79,892,529	$68.18	$80,892,460
2005	62,734	$21,581,158	$344.01	0	$-	$-	1,138,331	$64,403,177	$56.58	24,214	$1,076,175.24	$44.44	1,201,065	$85,984,335	$71.59	$87,060,510
2006	64,302	$23,226,721	$361.21	0	$-	$-	1,166,789	$69,313,919	$59.41	24,820	$1,158,233.61	$46.67	1,231,092	$92,540,640	$75.17	$93,698,874
2007	65,910	$24,997,759	$379.27	0	$-	$-	1,195,959	$74,599,105	$62.38	25,440	$1,246,548.92	$49.00	1,261,869	$99,596,864	$78.93	$100,843,413
2008	67,558	$26,903,838	$398.23	0	$-	$-	1,225,858	$80,287,287	$65.49	26,076	$1,341,598.27	$51.45	1,293,416	$107,191,125	$82.87	$108,532,723
2009	69,247	$28,955,255	$418.15	0	$-	$-	1,256,504	$86,409,193	$68.77	26,728	$1,443,895.14	$54.02	1,325,751	$115,364,448	$87.02	$116,808,344
2010	70,978	$31,163,094	$439.05	0	$-	$-	1,287,917	$92,997,894	$72.21	27,396	$1,553,992.15	$56.72	1,358,895	$124,160,988	$91.37	$125,714,980
2011	72,752	$33,539,280	$461.01	0	$-	$-	1,320,115	$100,088,983	$75.82	28,081	$1,672,484.05	$59.56	1,392,867	$133,628,263	$95.94	$135,300,747
2012	74,571	$36,096,650	$484.06	0	$-	$-	1,353,118	$107,720,768	$79.61	28,783	$1,800,010.96	$62.54	1 427,689	$143,817,418	$100.73	$145,617,429
2013	76,435	$38,849,019	$508.26	0	$-	$-	1,386,946	$115,934,477	$83.59	29,503	$1,937,261.79	$65.66	1,463,381	$154,783,496	$105.77	$156,720,758
2014	78,346	$41,811,257	$533.67	0	$-	$-	1,421,619	$124,774,481	$87.77	30,240	$2,084,978.01	$68.95	1,499,966	$166,585,738	$111.06	$168,670,716
2015	80,305	$44,999,365	$560.36	0	$-	$-	1,457,160	$134,288,535	$92.16	30,996	$2,243,957.58	$72.39	1,537,465	$179,287,900	$116.61	$181,531,858

8% Increase in Costs and 5% increase in Population

Year	Nursing Homes Covered Days	Costs	Cost Per Covered Day	ICF/MR Covered Days	Costs	Cost Per Covered Day	Home Based Covered Days	Costs	Cost Per Covered Day	Home Based Hours - Total Covered Hours	Cost	Cost Per Covered Hour	Total Covered Days	Cost	Cost Per Covered Day	Total Cost
1996	50,233	$11,139,258	$221.75	22,145	$8,389,840	$378.86	871,028	$26,460,145	$23.51	19,389	$555,475.00	$28.65	943,406	$45,989,243	$48.75	$46,544,718
1997	52,745	$12,631,919	$239.49	8,385	$3,173,004	$378.41	914,670	$34,174,507	$37.36	20,358	$629,908.65	$30.94	975,800	$49,979,430	$51.22	$50,609,338
1998	55,382	$14,324,596	$258.65	8,804	$3,598,187	$408.69	960,404	$38,753,890	$40.35	21,376	$714,316.41	$33.42	1,024,590	$56,676,673	$55.32	$57,390,990
1999	58,151	$16,244,091	$279.34	0	$-	$-	1,008,424	$40,691,585	$43.58	22,445	$810,034.81	$36.09	1,066,575	$56,935,676	$53.38	$57,745,711
2000	61,059	$18,420,800	$301.69	0	$-	$-	1,058,845	$46,723,479	$47.07	23,567	$918,579.47	$38.98	1,119,904	$65,144,279	$58.17	$66,062,858
2001	64,111	$20,889,187	$325.83	0	$-	$-	1,111,788	$56,513,795	$50.83	24,746	$1,041,669.12	$42.09	1,175,899	$77,402,982	$65.82	$78,444,651
2002	67,317	$23,688,338	$351.89	0	$-	$-	1,167,377	$64,086,643	$54.90	25,983	$1,181,252.78	$45.46	1,234,694	$87,774,981	$71.09	$88,956,234
2003	70,683	$26,862,575	$380.04	0	$-	$-	1,225,746	$72,674,254	$59.29	27,282	$1,339,540.66	$49.10	1,296,429	$99,536,829	$76.78	$100,876,370
2004	74,217	$30,462,160	$410.45	0	$-	$-	1,287,033	$82,412,604	$64.03	28,646	$1,519,039.10	$53.03	1,361,250	$112,874,764	$82.92	$114,393,803
2005	77,928	$34,544,090	$443.28	0	$-	$-	1,351,385	$93,455,893	$69.16	30,079	$1,722,590.34	$57.27	1,429,313	$127,999,982	$89.55	$129,722,573
2006	81,824	$39,172,998	$478.75	0	$-	$-	1,418,954	$105,978,982	$74.69	31,583	$1,953,417.45	$61.85	1,500,778	$145,151,980	$96.72	$147,105,397
2007	85,915	$44,422,180	$517.05	0	$-	$-	1,489,902	$120,180,166	$80.66	33,162	$2,215,175.39	$66.80	1,575,817	$164,602,345	$104.46	$166,817,521
2008	90,211	$50,374,752	$558.41	0	$-	$-	1,564,397	$136,284,308	$87.12	34,820	$2,512,008.89	$72.14	1,654,608	$186,659,060	$112.81	$189,171,068
2009	94,722	$57,124,968	$603.08	0	$-	$-	1,642,617	$154,546,405	$94.09	36,561	$2,848,618.08	$77.91	1,737,338	$211,671,374	$121.84	$214,519,992
2010	99,458	$64,779,714	$651.33	0	$-	$-	1,724,747	$175,255,624	$101.61	38,389	$3,230,332.91	$84.15	1,824,205	$240,035,338	$131.58	$243,265,670
2011	104,431	$73,460,196	$703.43	0	$-	$-	1,810,985	$198,739,877	$109.74	40,308	$3,663,197.52	$90.88	1,915,416	$272,200,073	$142.11	$275,863,270
2012	109,652	$83,303,862	$759.71	0	$-	$-	1,901,534	$225,371,021	$118.52	42,324	$4,154,065.98	$98.15	2,011,186	$308,674,883	$153.48	$312,828,949
2013	115,135	$94,466,579	$820.49	0	$-	$-	1,996,611	$255,570,737	$128.00	44,440	$4,710,710.82	$106.00	2,111,746	$350,037,317	$165.76	$354,748,028
2014	120,892	$107,125,101	$886.12	0	$-	$-	2,096,441	$289,817,216	$138.24	46,662	$5,341,946.07	$114.48	2,217,333	$396,942,317	$179.02	$402,284,263
2015	126,936	$121,479,865	$957.01	0	$-	$-	2,201,263	$328,652,723	$149.30	48,995	$6,057,766.85	$123.64	2,328,200	$450,132,588	$193.34	$456,190,355

TABLE 4. Alaska Long-Term Care Programs Ages 65 and over - Cost increases of 2%, 5% & 8% Population Growth rates of 2%, 5.432% and 6.5%

2% Cost Increase and 2% Population Growth (Low Range Projection)

Year	Nursing Homes Covered Days	Cost	Cost Per Covered Day	Pioneers' Homes Covered Days	Cost	Cost Per Covered Day	Home Based cost per day Covered Days	Cost	Cost Per Covered Day	Home Based cost per hour Covered Hours	Cost	Cost Per Covered Hour	Total Covered Days	Cost	Cost Per Covered Day	Total Cost
1996	151,933	$ 34,737,440	$228.64	214,237	$30,016,400	$140.11	376,907	$4,613,302	$12.24	266,187	$3,553,049	$ 13.35	743,077	$69,367,142	$93.35	$72,920,191
1997	154,972	$ 36,140,833	$233.21	214,237	$30,616,764	$142.91	384,445	$4,799,679	$12.48	271,511	$3,696,593	$ 13.61	753,654	$71,557,276	$94.95	$75,253,868
1998	158,071	$ 37,600,922	$237.87	214,237	$31,229,099	$145.77	392,134	$4,993,586	$12.73	276,941	$3,845,935	$ 13.89	764,442	$73,823,608	$96.57	$77,669,542
1999	161,233	$ 39,119,999	$242.63	214,237	$31,853,681	$148.68	399,977	$5,195,327	$12.99	282,480	$4,001,311	$ 14.16	775,446	$76,169,008	$98.23	$80,170,318
2000	164,457	$ 40,700,447	$247.48	214,237	$32,490,755	$151.66	407,976	$5,405,219	$13.25	288,129	$4,162,964	$ 14.45	786,670	$78,596,421	$99.91	$82,759,384
2001	167,746	$ 42,344,746	$252.43	214,237	$33,140,570	$154.69	416,136	$5,623,589	$13.51	293,892	$4,331,147	$ 14.74	798,119	$81,108,905	$ 101.63	$85,440,052
2002	171,101	$ 44,055,473	$257.48	214,237	$33,803,381	$157.78	424,458	$5,850,782	$13.78	299,770	$4,506,126	$ 15.03	809,797	$83,709,637	$ 103.37	$88,215,762
2003	174,523	$ 45,835,314	$262.63	214,237	$34,479,449	$160.94	432,948	$6,087,154	$14.06	305,765	$4,688,173	$ 15.33	821,708	$86,401,917	$ 105.15	$91,090,090
2004	178,014	$ 47,687,061	$267.88	214,237	$35,169,038	$164.16	441,607	$6,333,075	$14.34	311,880	$4,877,575	$ 15.64	833,857	$89,189,174	$ 106.96	$94,066,749
2005	181,574	$ 49,613,618	$273.24	214,237	$35,872,418	$167.44	450,439	$6,588,931	$14.63	318,118	$5,074,630	$ 15.95	846,250	$92,074,968	$ 108.80	$97,149,597
2006	185,205	$ 51,618,009	$278.71	214,237	$36,589,867	$170.79	459,448	$6,855,124	$14.92	324,480	$5,279,645	$ 16.27	858,890	$95,062,999	$ 110.68	$100,342,645
2007	188,910	$ 53,703,376	$284.28	214,237	$37,321,664	$174.21	468,636	$7,132,071	$15.22	330,970	$5,492,942	$ 16.60	871,783	$98,157,111	$ 112.59	$103,650,053
2008	192,688	$ 55,872,992	$289.97	214,237	$38,068,097	$177.69	478,009	$7,420,207	$15.52	337,589	$5,714,857	$ 16.93	884,934	$101,361,297	$ 114.54	$107,076,153
2009	196,542	$ 58,130,261	$295.77	214,237	$38,829,459	$181.25	487,569	$7,719,983	$15.83	344,341	$5,945,737	$ 17.27	898,348	$104,679,704	$ 116.52	$110,625,440
2010	200,472	$ 60,478,724	$301.68	214,237	$39,606,049	$184.87	497,321	$8,031,870	$16.15	351,228	$6,185,945	$ 17.61	912,030	$108,116,643	$ 118.55	$114,302,587
2011	204,482	$ 62,922,064	$307.71	214,237	$40,398,170	$188.57	507,267	$8,356,358	$16.47	358,253	$6,435,857	$ 17.96	925,986	$111,676,592	$ 120.60	$118,112,448
2012	208,571	$ 65,464,116	$313.87	214,237	$41,206,133	$192.34	517,413	$8,693,955	$16.80	365,418	$6,695,866	$ 18.32	940,221	$115,364,204	$ 122.70	$122,060,069
2013	212,743	$ 68,108,866	$320.15	214,237	$42,030,256	$196.19	527,761	$9,045,191	$17.14	372,726	$6,966,379	$ 18.69	954,741	$119,184,312	$ 124.83	$126,150,690
2014	216,998	$ 70,860,464	$326.55	214,237	$42,870,861	$200.11	538,316	$9,410,616	$17.48	380,181	$7,247,821	$ 19.06	969,551	$123,141,941	$ 127.01	$130,389,761
2015	221,338	$ 73,723,227	$333.08	214,237	$43,728,278	$204.11	549,082	$9,790,805	$17.83	387,784	$7,540,633	$ 19.45	984,657	$127,242,310	$ 129.23	$134,782,942

5% Cost Increase and 5.432% Population Growth (Mid-Range Projection)

Year	Nursing Homes Covered Days	Cost	Cost Per Covered Day	Pioneers' Homes Covered Days	Cost	Cost Per Covered Day	Home Based cost per day Covered Days	Cost	Cost Per Covered Day	Home Based cost per hour Covered Hours	Cost	Cost Per Covered Hour	Total Covered Days	Cost	Cost Per Covered Day	Total Cost
1996	151,933	$ 34,737,440	$228.64	214,237	$30,016,400	$140.11	376,907	$4,613,302	$12.24	266,187	$3,553,049	$ 13.35	743,077	$ 69,367,142	$ 93.35	$ 72,920,191
1997	160,186	$ 38,455,597	$240.07	214,237	$31,517,257	$147.11	397,381	$5,107,091	$12.85	280,646	$3,933,354	$ 14.02	771,804	$ 75,079,945	$ 97.28	$ 79,013,298
1998	168,887	$ 42,571,730	$252.07	214,237	$33,093,120	$154.47	418,966	$5,653,734	$13.49	295,891	$4,354,364	$ 14.72	802,091	$ 81,318,584	$101.38	$ 85,672,948
1999	178,061	$ 47,128,438	$264.68	214,237	$34,747,776	$162.19	441,725	$6,258,887	$14.17	311,964	$4,820,438	$ 15.45	834,023	$ 88,135,100	$105.67	$ 92,955,538
2000	187,734	$ 52,172,877	$277.91	214,237	$36,485,164	$170.30	465,719	$6,928,813	$14.88	328,910	$5,336,398	$ 16.22	867,690	$ 95,586,855	$110.16	$100,923,253
2001	197,931	$ 57,757,253	$291.80	214,237	$38,309,423	$178.82	491,017	$7,670,446	$15.62	346,776	$5,907,585	$ 17.04	903,185	$103,737,121	$114.86	$109,644,706
2002	208,683	$ 63,939,358	$306.39	214,237	$40,224,894	$187.76	517,689	$8,491,460	$16.40	365,613	$6,539,909	$ 17.89	940,609	$112,655,712	$119.77	$119,195,621
2003	220,019	$ 70,783,172	$321.71	214,237	$42,236,138	$197.15	545,810	$9,400,352	$17.22	385,473	$7,239,915	$ 18.78	980,065	$122,419,661	$124.91	$129,659,576
2004	231,970	$ 78,359,519	$337.80	214,237	$44,347,945	$207.00	575,458	$10,406,528	$18.08	406,412	$8,014,846	$ 19.72	1,021,665	$133,113,992	$130.29	$141,128,838
2005	244,571	$ 86,746,809	$354.69	214,237	$46,565,343	$217.35	606,717	$11,520,401	$18.99	428,488	$8,872,723	$ 20.71	1,065,525	$144,832,552	$135.93	$153,705,275
2006	257,856	$ 96,031,840	$372.42	214,237	$48,893,610	$228.22	639,674	$12,753,498	$19.94	451,764	$9,822,424	$ 21.74	1,111,767	$157,678,948	$141.83	$167,501,372
2007	271,862	$ 106,310,704	$391.05	214,237	$51,338,290	$239.63	674,421	$14,118,582	$20.93	476,303	$10,873,777	$ 22.83	1,160,520	$171,767,576	$148.01	$182,641,353
2008	286,630	$ 117,689,777	$410.60	214,237	$53,905,205	$251.61	711,056	$15,629,778	$21.98	502,176	$12,037,663	$ 23.97	1,211,922	$187,224,759	$154.49	$199,262,422
2009	302,200	$ 130,286,819	$431.13	214,237	$56,600,465	$264.20	749,680	$17,302,727	$23.08	529,454	$13,326,126	$ 25.17	1,266,117	$204,190,012	$161.27	$217,516,138
2010	318,615	$ 144,232,199	$452.68	214,237	$59,430,488	$277.41	790,403	$19,154,742	$24.23	558,214	$14,752,501	$ 26.43	1,323,255	$222,817,429	$168.39	$237,569,931
2011	335,922	$ 159,670,237	$475.32	214,237	$62,402,013	$291.28	833,337	$21,204,989	$25.45	588,537	$16,331,550	$ 27.75	1,383,497	$243,277,239	$175.84	$259,608,789
2012	354,170	$ 176,760,701	$499.08	214,237	$65,522,113	$305.84	878,604	$23,474,686	$26.72	620,506	$18,079,614	$ 29.14	1,447,011	$265,757,500	$183.66	$283,837,114
2013	373,408	$ 195,680,459	$524.04	214,237	$68,798,219	$321.13	926,330	$25,987,322	$28.05	654,212	$20,014,784	$ 30.59	1,513,975	$290,466,000	$191.86	$310,480,784
2014	393,692	$ 216,625,313	$550.24	214,237	$72,238,130	$337.19	976,648	$28,768,901	$29.46	689,749	$22,157,086	$ 32.12	1,584,577	$317,632,344	$200.45	$339,789,430
2015	415,077	$ 239,812,020	$577.75	214,237	$75,850,036	$354.05	1,029,700	$31,848,210	$30.93	727,216	$24,528,692	$ 33.73	1,659,014	$347,510,266	$209.47	$372,038,957

8% Cost Increase and 6.5% Population Growth (High Range Projection)

Year	Nursing Homes Covered Days	Cost	Cost Per Covered Day	Pioneers' Homes Covered Days	Cost	Cost Per Covered Day	Home Based Cost per day Covered Days	Cost	Cost Per Covered Day	Home Based cost per hour Covered Hours	Cost	Cost Per Covered Hour	Total Covered Days	Cost	Cost Per Covered Day	Total Cost
1996	151,933	$34,737,440	$228.64	214,237	$30,016,400	$140.11	376,907	$4,613,302	$12.24	266,187	$3,553,049	$ 13.35	743,077	$69,367,142	$93.35	$72,920,191
1997	161,809	$39,400,073	$243.50	214,237	$31,967,503	$149.22	401,406	$5,306,220	$13.22	283,489	$4,086,717	$ 14.42	777,452	$76,349,905	$98.21	$80,436,622
1998	172,326	$44,688,548	$259.33	214,237	$34,045,391	$158.91	427,497	$6,103,214	$14.28	301,916	$4,700,542	$ 15.57	814,061	$84,114,854	$103.33	$88,815,397
1999	183,527	$50,686,868	$276.18	214,237	$36,258,341	$169.24	455,285	$7,019,917	$15.42	321,540	$5,406,564	$ 16.81	853,049	$92,756,599	$108.74	$98,163,163
2000	195,457	$57,490,313	$294.13	214,237	$38,615,134	$180.24	484,878	$8,074,309	$16.65	342,441	$6,218,630	$ 18.16	894,572	$102,381,748	$114.45	$108,600,378
2001	208,161	$65,206,950	$313.25	214,237	$41,125,117	$191.96	516,395	$9,287,070	$17.98	364,699	$7,152,668	$ 19.61	938,794	$113,110,474	$120.48	$120,263,142
2002	221,692	$73,959,353	$333.61	214,237	$43,798,250	$204.44	549,961	$ 10,681,987	$19.42	388,405	$8,226,999	$ 21.18	985,890	$125,078,282	$126.87	$133,305,281
2003	236,102	$83,886,547	$355.30	214,237	$46,645,136	$217.73	585,708	$ 12,286,422	$20.98	413,651	$9,462,694	$ 22.88	1,036,047	$138,438,018	$133.62	$147,900,712
2004	251,448	$95,146,219	$378.39	214,237	$49,677,070	$231.88	623,779	$ 14,131,843	$22.66	440,538	$10,883,991	$ 24.71	1,089,465	$153,362,131	$140.77	$164,246,122
2005	267,793	$107,917,220	$402.99	214,237	$52,906,080	$246.95	664,325	$ 16,254,445	$24.47	469,173	$12,518,766	$ 26.68	1,146,355	$170,045,250	$148.34	$182,564,016
2006	285,199	$122,402,409	$429.18	214,237	$56,344,975	$263.00	707,506	$ 18,695,863	$26.43	499,670	$14,399,085	$ 28.82	1,206,942	$188,707,091	$156.35	$203,106,176
2007	303,737	$138,831,872	$457.08	214,237	$60,007,398	$280.10	753,494	$ 21,503,982	$28.54	532,148	$16,561,827	$ 31.12	1,271,468	$209,595,755	$164.85	$226,157,582
2008	323,480	$157,466,580	$486.79	214,237	$63,907,879	$298.30	802,471	$ 24,733,880	$30.82	566,738	$19,049,413	$ 33.61	1,340,188	$232,991,464	$173.85	$252,040,878
2009	344,506	$178,602,532	$518.43	214,237	$68,061,891	$317.69	854,632	$ 28,448,908	$33.29	603,576	$21,910,635	$ 36.30	1,413,375	$259,210,789	$183.40	$281,121,425
2010	366,899	$202,575,457	$552.13	214,237	$72,485,914	$338.34	910,183	$ 32,721,935	$35.95	642,808	$25,201,613	$ 39.21	1,491,319	$288,611,448	$193.53	$313,813,061
2011	390,748	$229,766,148	$588.02	214,237	$77,197,498	$360.34	969,345	$ 37,636,769	$38.83	684,591	$28,986,895	$ 42.34	1,574,329	$321,597,730	$204.28	$350,584,625
2012	416,146	$260,606,509	$626.24	214,237	$82,215,336	$383.76	1,032,352	$ 43,289,812	$41.93	729,089	$33,340,727	$ 45.73	1,662,735	$358,626,657	$215.68	$391,967,384
2013	443,196	$295,586,418	$666.94	214,237	$87,559,333	$408.70	1,099,455	$ 49,791,942	$45.29	776,480	$38,348,504	$ 49.39	1,756,888	$400,214,949	$227.80	$438,563,453
2014	472,003	$335,261,504	$710.29	214,237	$93,250,689	$435.27	1,170,920	$ 57,270,691	$48.91	826,951	$44,108,449	$ 53.34	1,857,160	$446,946,930	$240.66	$491,055,379
2015	502,684	$380,261,980	$756.46	214,237	$99,311,984	$463.56	1,247,030	$ 65,872,749	$52.82	880,703	$50,733,538	$ 57.61	1,963,950	$499,483,480	$254.33	$550,217,019

APPENDIX - III
Inventory of Alaska's Long-Term Care Services

Regions of Alaska	1995 65+ population	Services funded through ACOA grants	Personal Care Attendant Services	Assisted Living	Pioneers' Homes	Nursing Homes
STATEWIDE	28,096					
ANCHORAGE REGION-NTS Serving Eagle River and Chugiak	10,684	ADRD Education & Caregiver Support, In-home Respite Care 19,352 hours to 135 consumers -12hrs/mo Nutrition, Transportation, Support Services (NTS) Care Coordination 4,301 hours to 356 consumers-1hr/mo	Personal Care Services 26,223 hours to 130 consumers-16.8 hrs/mo			
Anchorage		Adult Day Services 51,769 hours to 78 consumers-55hrs/mo		28 homes 193 beds	224 beds	3 facilities 329 beds
Chugiak		Adult Day Services 23,756 hours to 32 consumers-62hrs/mo		1 home, 22 beds		
Eagle River				3 homes, 21 beds		
NORTHWEST REGION - NTS Serving Kotzebue, Barrow, Wainwright, Regional program serving 4 villages outside of Nome	1,071	ADRD Education & Caregiver Support, In-home Respite Care 2,765 hours to 18 consumers-12.6 hrs/mo Nutrition, Transportation, Support Services (NTS)	Personal Care Services 5,159 hours to 35 consumers 12.3 hrs/mo			
Nome		Adult Day Srvcs 11,068 hours to 15 consumers-61.5 hrs/mo		1 home, 5 beds		15 beds
Barrow						
Kotzebue				1 home, 20 beds		
SOUTHEAST REGION-NTS Serving communities through city, tribal and regional programs	4,806	ADRD Education & Caregiver Support, In-home Respite Care 9,762 hours to 60 consumers -13.5 hrs/mo, Nutrition, Transportation, Support Services (NTS)	Personal Care Services 31,264 hours to 108 consumers 24 hrs/mo			
Juneau		Adult Day Services 17,898 hours to 24 consumers-62 hrs/mo Care Coordination 449 hours to 48 consumer-1hr/mo		2 homes, 10 beds	48 beds	44 beds
Ketchikan		Adult Day Services 15,498 hours to 34 consumer-38 hrs/mo Care Coordination 1,773 hours to 90 consumer-1.6 hrs/mo		1 home 5 beds	49 beds	46 beds
Sitka					102 beds	5 beds + 4 swing
Wrangell				1 home, 3 beds		14 beds + 4 swing
Petersburg						14 beds + 4 swing
SOUTHWEST REGION-NTS Serving 45 communities through 6 regional & city programs	1,613	ADRD Education & Caregiver Support, In-home Respite Care 9,762 hours to 60 consumer 13.6 hrs/mo Nutrition, Transportation, Support Services (NTS)	Personal Care Services 14,056 hours to 189 consumer-6.2 hrs/mo			
Bethel		Adult day Center 8,197 hours to 9 consumer-76 hrs/mo				

Inventory of Alaska's Long-Term Care Services - Continued

Regions of Alaska	1995 65+ population	Services funded through ACOA grants	Personal Care Attendant Services	Assisted Living	Pioneers' Homes	Nursing Homes
INTERIOR REGION-NTS Serving Fairbanks, Ft. Yukon, Minto, Nenana, Tanana and regional services from Tok)	3,789	ADRD Education & Caregiver Support, In-home Respite Care 10,535 hours to 65 consumers-13.5 hrs/mo Nutrition, Transportation, Support Services (NTS)	Personal Care Services, 34,667 hours to 155 consumers -16.3 hrs/mo			
Fairbanks		Adult Day Cent. 21, 179 hours to 40 consumers-44 hrs/mo Care Coordination 2,446 hrs to 113 consumers-1.8 hrs/mo		11 homes 51 beds	101 beds	90 beds
North Pole				5 homes 18 beds		
Tanana				1 home 9 beds		
SOUTHCENTRAL REGION	6,060	ADRD Education & Caregiver Support, In-home Respite Care 6,144 hours to 43 consumers-12hrs/mo Nutrition, Transportation, Support Services (NTS)	Personal Care Services 17,469 hours to 65 consumers 22.4 hrs/mo			
Mat-Su Valley - (NTS) Serving Houston, Palmer and Wasilla)	2,612	Care Coordination 4,042 hours to 120 consumers-2.8 hrs/mo				
Palmer/Wasilla		Adult Day Srvcs 21,255 hrs to 45 consumers 39.4 hrs/mo				
Kenai Peninsula- NTS Serving Homer, Kenai, Ninilchik, Seldovia, Soldotna	3,448	Nutrition, Transportation & Support Services (NTS)	Personal Care Services 49,040 hours to 110 consumers -37 hrs/mo			
Homer		Adult Day Cent. 2,234 hrs to 26 consumers -39.2 hrs/mo		3 homes 51 beds		20 beds + 4 swing
Kenai		Adult Day Cent. 11,766 hrs to 31 consumers -39.6 hrs/mo				
Kasilof				2 homes 14 beds		
Soldotna						45 beds + 4 swing
Cordova						10 beds + 4 swing
Seward				1 home 5 beds		66 beds + 2 swing
Valdez						16 beds + 6 swing
Kodiak		Adult Day Cent. 11,489 hrs. to 18 consumers 53.2 hrs/mo				19 beds + 4 swing

APPENDIX - IV

Numbers of Seniors , Seniors with Severe Impairment Levels and Services Available, Projected to 2015

Region	(1) 1995 65 + pop	(2) Est. # Srs. with severe impairment 1995	(3) #. Srs. Recv Adult Day Srvcs FY96	(4) #. Srs Recv Care Coord. FY96	(5) # Srs Recv Respite Care FY96	(6) # Srs. Recv. PCA Svcs FY97	(7) # Assisted Living Home Beds	(8) # Pioneers' Home Asstd. Living Beds	(9) # Nursing Home Beds	(10) Est. # seniors age 65+ 2000	(11) Est. # Srs. w/severe impairment 2000	(12) Est. # seniors age 65+ 2005	(13) Est. # Srs. w/severe impairment 2005	(14) Est. # seniors age 65+ 2010	(15) Est. # Srs. w/severe impairment 2010	(16) Est. # seniors age 65+ 2015	(17) Est. # Srs. w/severe impairment 2015
ANCHORAGE: Municipality																	
Total MoA	10,687	1,389	102	238	123	130	236	224	329	13,922	1,810	18,136	2,358	23,626	3,071	30,778	4,001
INTERIOR: Fairbanks No Star Boro, Yukon Koyukuk, .& SE Fairbanks																	
Total Interior	3,789	530	38	113	65	155	78	101	90	4,936	691	6,430	900	8,377	1,173	10,912	1,528
NORTHWEST North Slope Borough, NW Arctic Boro, Nome																	
Total Northwest	1,071	214	15	0	23	35	25	0	15	1,395	279	1,818	364	2,368	474	3,084	617
SO. CENTRAL Mat-Su Boro Kenai Pen. Boro, Kodiak Is. Boro., Valdez-Cordova																	
Total So. Central	6,130	736	162	120	51	175	75	82	176	7,986	958	10,403	1,248	13,552	1,626	17,654	2,119
SOUTHEAST: Skag-Yakutat-Angoon , Haines Borough, C&B Juneau, C&B Sitka, Wrangell-Petersburg, POW-Outer Ktkn, Ketch Gateway Boro																	
Total Southeast	4,806	721	59	144	60	108	18	199	329	6,262	939	8,159	1,224	10,631	1,595	13,851	2,078
SOUTHWEST: Wade Hampton, Lake & Peninsula Boro., Bethel, Dillingham, Bristol Bay Boro, Aleutian Is. East, Aleutian Is. West,																	
Total Southwest	1,613	306	15	0	19	189	0	0	90	2,101	399	2,737	520	3,566	678	4,646	883
TOTAL STATE	28,096	3,933	391	615	341	792	432	606	1,029	36,602	5,124	47,684	6,676	62,120	8,697	80,927	11,330

NOTES: 1) A high degree of duplication exists when counting the numbers of seniors who received long-term care services in a year (adult day care, care coordination, respite and PCA services) in columns 3 thru 6.This is because many seniors receive these services either concurrently or within the same year.

2) Data used to estimate the "#s of seniors with impairments" in columns 2,11,13,15 and 17 is taken from the 1991 OAC report Home is Where the Heart Is. The percentages of seniors in this category vary slightly among the regions with the NW and SW regions having the highest rates of both moderate and severe impairment in the state. Both regions cover vast geographic areas and contain few resources. For purposes of this report, only the "severe impairment" level is used, meaning these seniors need assistance with 3 or more ADL's (the very frail and old who are one "slip and fall" away from a nursing home but who may not yet need 24-hr. nursing care.

3) The 1995 base year population (28,096) used in this chart is taken from the "1995 Alaska Population Overview", Table 1.22. This base year population estimate was used to project growth through 2015 by using the medium growth projection of 5.432% per year shown in Ch. 2, Fig. 1 "Alaska's Senior Population Growth, Projected to 2015" contained in this report: Legislative Working Group on LTC, Feb. 1997.

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Long-Term Care for the Elderly: 1993 and Beyond. Older Alaskans Commission, September 1993.

Long-Term Care in Alaska: Recommendations for Reform. Ladd and Associates, Austin Texas; March 1996.

Human Faces: Young Alaskans Living in Nursing Homes. Governor's Council on Disabilities and Special Education and the Alaska State Independent Living Council, April 1996

Moving Toward the Development of a Balanced Long-Term Care Delivery System In Alaska, Alaska State Hospital and Nursing Home Association, Prepared by Health Dimensions Minneapolis, Minnesota, December 1996

Glossary

ACTIVITIES OF DAILY LIVING (ADLs) : An index or scale which measures a person's degree of independence in bathing, dressing, using the toilet, eating and moving from one place to another.

ASSISTED LIVING: Formerly called adult foster homes, assisted living homes are facilities that provide a home-like environment for seniors and people who have a disability and need assistance with everyday living activities.

CARE COORDINATION: The assessment of needs, coordination and monitoring of services required by an individual experiencing a short-term medical crisis or long-term chronic care. These services, offered by trained providers, will ensure that long-term care resources are used strategically.

CASE MANAGEMENT: Same as care coordination

CHOICE: CHOICE for the elderly provides community-based services for seniors age 65 and older who require a nursing facility level of care ***and*** who are eligible for Medicaid. With the assistance of a care coordinator, each senior who qualifies and elects home care instead of care in a nursing facility will receive services described in a plan of care paid for from state Medicaid funds.

HOME AND COMMUNITY-BASED CARE: Long-term care services delivered outside of a nursing home. These services include transportation, home delivered meals, home care, home alterations and maintenance, personal care, adult day services, assisted living facilities, respite care, and care coordination.

- **IMPAIRMENT LEVEL**: A categorization of the level of difficulty with daily living activities (ADLs) experienced by an older person. Three impairment levels for seniors are used:

Well/No Impairment **no ADL or IADL impairments**

Moderately Impaired **1 or more impairments in IADL, but less than 3 in ADL**

Severely Impaired **3 or more ADL impairments**

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL): Capabilities that are not absolutely essential to basic functioning, but which enable a person to reside in the community. Examples of IADLs are: preparing food, obtaining appointments, using the telephone, managing money, doing laundry, using public transportation.

LONG-TERM CARE: Personal care and assistance related to health and social services, given over a sustained time, to assist people of all ages and their families to achieve the highest level of functioning possible, regardless of the setting in which care is given. Long-term care consists of a range of services and informal supports. Long-term care services may be needed to assist with routine, chronic, and periodic needs, and may include service management, general medical services, in-home assistance, information and referral, community-based services (adult day, respite, and care coordination), and many other types of services.

MEDICAID: A federally aided, state operated and administered entitlement program that provides medical services for low-income people. The State of Alaska and the Federal government each pay 50% of the total cost to operate Alaska's Medicaid program, for which the Alaska Department of Health and Social Services is the lead State agency. Authorized under Title XIX of the Social Security Act, people must meet specified eligibility criteria to qualify for the program which is geared to the elderly, blind, disabled, pregnant women, families with dependent children, and other groups with special needs.

MEDICARE: The national health insurance program for people age 65+; those who are eligible for social security disability payments for two years or more; and for certain workers and their dependents needing kidney transplants and dialysis. Individuals contribute to Medicare through payment of payroll taxes and premiums; these are deposited in special trust funds used to fund expenses experienced by the insured. Medicare has two coordinated separate parts: hospital insurance (Part A), and supplementary medical insurance (Part B).

- **Nursing home care:** Medicare covers limited care in a skilled nursing home after a recipient has been in the hospital for at least three days, and is certified as needing skilled nursing or rehabilitation services. Medicare pays 100% of cost for the first 20 days' care in a nursing facility. From day 21 - 100, the recipient contributes a daily payment at a set amount ($89.50 in 1995), with Medicare paying the balance.
- **Home health care:** To qualify for this Medicare benefit, a recipient must be housebound, under a physician's care, and in needing of physical or occupational therapy or skilled nursing care. Services include part-time or intermittent skilled nursing care and home health aide services; physical, occupational or speech therapy; and certain kinds of medical equipment.

JACKI ORTELLI

HUMAN FACES:

YOUNG ALASKANS LIVING IN NURSING HOMES

A Report on Facility-based versus Community-based Long Term Care

A joint project sponsored by the

Governor's Council on Disabilities and Special Education

and the

Alaska State Independent Living Council

April 12, 1996

Forward

The members of this task force wanted to educate ourselves, legislators, policy makers and the public on the issues that affect public policy as it relates to persons with disabilities living in nursing homes and those living independently in the community. We interviewed 16 Alaskans with disabilities under the age of 65 who live in nursing care facilities in Anchorage, Juneau, Seward, and Fairbanks. These stories are real, and the people who took the time to tell them to us are all too often forgotten. Our request to the reader of this report is that you remember these people and their stories.

Task Force Members

The following task force members contributed significant time, effort and resources to the development of this report:

Arthur Walters, Chair	Governor's Council on Disabilities and Special Ed.	Seward
Vicky Chapman	Independent living specialist	Anchorage
Joy Davis	Former nursing home resident	Anchorage
Ken Dean	Southeast Alaska Independent Living Center	Juneau
Joyanna Geisler	Kenai Peninsula Independent Living Services	Homer
David Jacobson	Access Alaska	Fairbanks
Jerry Kainulainen	Southeast Alaska Independent Living Center	Juneau
Candy Norman	Parent of nursing home resident	Seward
Patrick Reinhart	Executive Dir. State Independent Living Council	Anchorage
Marie Simmons	Governor's Council on Disabilities and Special Ed.	Fairbanks
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Thanks also go to the following people whose contribution made the information gathering effort possible: Jim Pinneo, Social Worker and Providence Extended Care; Cindy Berger, Staff Attorney at the Disability Law Center; Derrill Johnson, Program Manager Department of Mental Health and Developmental Disabilities; David Levy, Executive Director Access Alaska; Jay Livey, Deputy Commissioner Department of Health and Social Services; and David Maltman, Executive Director Governor's Council on Disabilities and Special Education. Mary Elizabeth Rider, former Health Planner for the Governor's Council, supervised this project.

We want to thank the following nursing homes and their staff for providing us with information and assistance to conduct this research: Denali Center, Fairbanks; Ketchikan General Hospital, Ketchikan; Providence Extended Care, Anchorage; Sitka Community Center, Sitka; Sourdough Place, Valdez; St. Ann's Care Center Juneau; and Wesley Rehabilitation Center, Seward.

Executive Summary

Background

The Governor's Council on Disabilities and Special Education (Governor's Council) and the State Independent Living Council (SILC) are both concerned with services to Alaskans with significant disabilities. The two Councils are working together to inform themselves, policy makers and the public on the needs of Alaskans with disabilities under age 65 who use long term care services.

The Long Term Care Task Force

A Long Term Care Task Force convened in October 1995 as a joint project of the Governor's Council and the SILC. Members include Governor's Council members, SILC members, independent living providers, persons who experience significant disabilities, and parents of persons with disabilities who have lived in nursing homes. The task force was staffed by an University of Alaska Anchorage Social Work Intern at the Governor's Council. The task force was represented by members in Anchorage, Fairbanks, Juneau, Sitka, Seward, Soldotna and Homer.

Project Description

Task force members field-tested interview questions with three sample interviews of individuals who had lived in nursing homes. They conducted interviews to determine consumers' wishes, needs and abilities for services and living needs. They interviewed 16 nursing home residents from Anchorage, Fairbanks, Juneau, Seward, and other areas of the state in the winter of 1995-96. After identifying the community-based services required to serve these individuals in the community, Task force members estimated the costs for these services and provided a cost comparison for each person.

Conclusion

Fifteen of the sixteen persons interviewed expressed a strong desire to leave nursing facilities and live in community settings. Task force members believe that most individuals with disabilities under the age 65 who currently reside in nursing homes do not need 24-hour nursing care and would be able to live in a community setting if adequate support services were available to them. Analysis of the costs to move these individuals into the community showed an average annual saving of approximately $55,000.00 per person.

It became evident that many persons with disabilities currently residing in nursing homes can be served more satisfactorily and at less cost in community settings instead of in nursing care facilities. The total savings for the State of Alaska could exceed $7.5 million a year; savings that could be used to provide community based services.

Recommendations

To balance Alaska's long term care system, the legislature should:

1. Adopt a moratorium on long-term care beds. A moratorium will contain Medicaid costs, and allow time for Alaska to balance its long-term care system.

2. Fully fund Alaska's Medicaid Waiver programs. Waiver programs allow for individuals to receive medical services at home instead of being institutionalized at a much higher cost to the state.

3. Appropriate more funds in community-based services. By assuring access to community-based services, legislators can contain the costs of long-term facility-based care.

Table of Contents

Forward and Acknowledgments i
Executive Summary ii
Table of Contents iv
Introduction 1
Individual Stories
- Phyllis Halgron 2
- Evelyn Emry 3
- Al Wilson 4
- Teisha Simmons 5
- Bruce Hinke 6
- Roy Clayton 7
- Rodney Katzeek 8
- Carla Norman 9

Recommendations 10
Appendix I: Alaska Nursing Home Census
Appendix II: HB 528

JACKI ORTELLI

Partnership Provides Resident-Centered Living

The changes that come with age are normal and a part of living. The residents of Denali Center receive services designed to meet the residents' emotional, spiritual, and physical needs—all equally important to the continuum of care provided by Denali Center/Fairbanks Memorial Hospital.

At Denali Center, the driving philosophy is called "Choices." Residents have control over their lives, make decisions for themselves, and have the chance to influence how Denali Center provides care and operates.

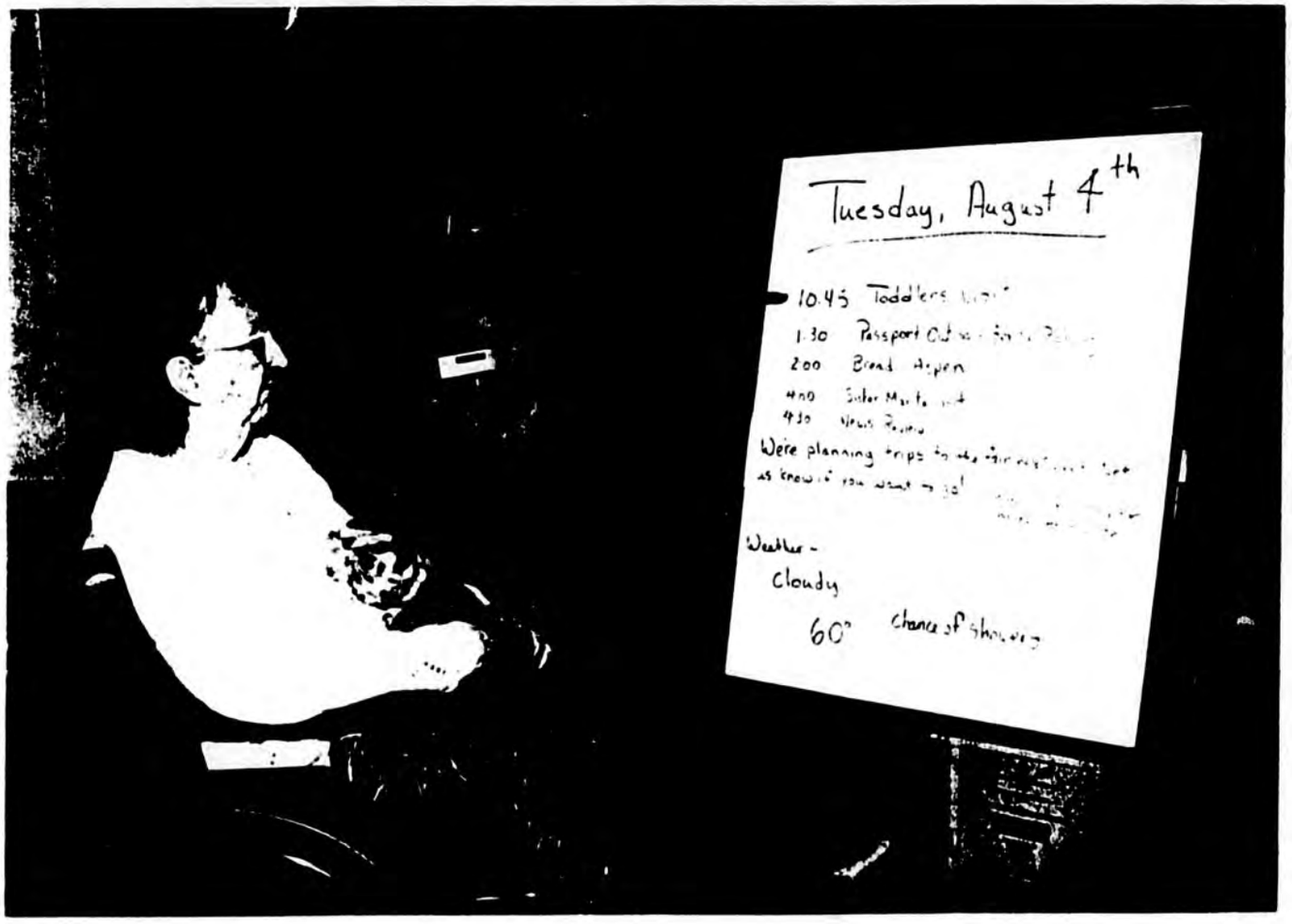
"Denali Center provides restorative care and care coordination, but our facility is considered a center for living," says Jackie Ortelli, Assistant Administrator, Continuum of Care. "We are committed to providing the quality of life services that contribute to the psychological well being of our residents." One way residents, family members, and staff can direct service is by participating in councils.

The Family Council meets quarterly and addresses education and activities. Case managers facilitate the meetings. Family members who don't live in the area can participate in the meeting by telephone. The August family potluck/barbecue is an example of an activity generated by the Family Council.

The Resident Council meets monthly. The council members are residents who make recommendations, address concerns, and express preferences regarding quality of life services. Facilitated by the Activities Manager, Council meetings are a forum for ideas for improved services. An electric door for easier access resulted from the Resident Council's recommendations.

The Resident Care Council is made up of staff members and facilitated by the Quality Management coordinator. The focus of the meetings is to improve processes based on reports and concerns expressed by residents, family, and staff members. This council has been instrumental in developing support to improve the system for addressing falls, including the use of alarms and early detection methods.

The opportunity to advise staff, make decisions for themselves, and influence how care is provided is a vital component of living as a resident of Denali Center. The partnership of residents, family members, and staff is a reflection of Denali Center's commitment to be a customer-driven "center for living."



Introduction

As of February 1996, approximately 140 Alaskans under age 65 who experience disabilities reside in nursing homes in the state.[1] Most of these individuals are Medicaid recipients. The average annual nursing home cost exceeds $92,000.00 per person. The total average cost to the State of Alaska is almost $13 million a year.[2]

Do all these people with disabilities require the intensive medical care of nursing home facilities at high state costs? Can we better serve these individual Alaskans through a variety of home and community-based services which allow the greatest degree of self-determination for the individual? Is the array of services for our citizens with the most severe disabilities slanted towards institutionalization? If so, at what cost to the public, and at what costs to the individuals whose very lives are affected by these policies? These are just some of the questions this report attempts to answer.

This project evolved out of growing concern and belief that individuals in nursing facilities: (1) do not want to live in institutions, (2) have enforceable legal rights under the Constitution and the Americans with Disabilities Act (ADA) to choose where they receive care[3], and (3) would cost the state significantly less if served in community-based settings.

The Governor's Council on Disabilities and Special Education (Governor's Council) and the State Independent Living Council (SILC) are both concerned with services to Alaskans with significant disabilities. The two Councils decided to inform themselves, policy makers and the public on the needs of Alaskans who use long term care services, and to put a human face on the statistics about Alaskans with disabilities under age 65 living in nursing homes.

Task force members field-tested interview questions with sample interviews with three individuals who had lived in nursing homes. They conducted interviews to determine consumers' wishes, needs and abilities regarding provision of services and their living environment. Sixteen persons living in nursing homes located in Anchorage, Fairbanks, Juneau, Seward, and other areas of the state were interviewed in the winter of 1995-96. Task force members listened to people's personal experiences of living with a disability and about their needs and wants. Based on the interviews, statements of relatives, assessments of nursing home social workers, case managers, and/or independent living providers, task force members determined specific services each person interviewed may require to be served in the community. A cost comparison analyzing residential versus community-based services was developed for each person. This information, combined with an analysis of Alaska's current long-term care system and its cost to the state, provided the basis for the recommendations of this report.

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1 The scope of this project was limited to people under the age of 65 because the Alaska Commission on Aging regularly assists people over the age of 65 to acquire community-based services.

2 Alaska Nursing Homes Census (2/29/96). State of Alaska, Department of Health and Social Services, Division of Medical Assistance, Health Facilities Licensing & Certification

3 In Helen L. V. DiDario, 6 NDLR, ¶ 92 (3d Cir. 1994), the Third Circuit held it was a violation of the ADA to keep a persons with a disability "unnecessarily segregated" in a nursing home rather than provide services in the community. The State was willing to provide the plaintiff with personal care attendant services only if she continued to reside in a nursing facility even though the plaintiff would not need to reside in a nursing home if she received the personal care services in the community. This landmark decision clearly enunciates a new standard under which people with disabilities can petition for release from an institution and into community based care.

Phyllis Hallgron, age 49

"I am in a nursing home because I don't have the money to rent an apartment. "

Phyllis has been suffering from degenerative disk disease, congenital deformities, chronic pain syndrome, and chronic bursitis since she was 21 years old. Nevertheless, she raised two children and gathered the strength to leave her abusive husband in 1985 to move to Soldotna, Alaska. When her condition worsened, she had to give her children back to their father. She stayed in Soldotna without any family members. Since 1988, Phyllis has used a wheelchair, but by no means has she been helpless. She managed to find herself an apartment, and arranged to get personal assistance services from Peninsula Home Health Care.

In 1994 Phyllis fell sick with intestinal cramps that would not allow her to absorb any type of food. As a consequence she lost 130 pounds and became incapacitated. She was transported to Providence Hospital in Anchorage, where she stayed for seven weeks and finally recovered completely. During her stay in the hospital she lost her apartment, mainly due to her landlady's concern regarding Phyllis' medical condition. Phyllis was admitted to Providence Extended Care until she could arrange another living situation. That was over one year ago.

While Phyllis certainly needs some assistance to live independently, she is able of take care of herself. She can transfer herself from the bed to the wheelchair, she can dress herself, and warm up her food. She is able to arrange for transportation from the Municipality; she communicates her needs and desires clearly, and she is capable of making choices and decisions. Phyllis is aware that she would need a personal care attendant for a few hours a day, would benefit from services like "meals on wheels," and needs an apartment that is wheelchair-accessible.

Currently Phyllis pays about $720 a month towards the expenses of her stay in Providence Extended Care, which leaves her $130 a month for personal expenses. She pays $80 for the storage of her furniture. She has not been able to save enough money to pay the security deposit for an apartment and consequently continues to stay at Providence at the state's cost of over $200 per day.

Cost Comparison

Annual cost of Providence Extended Care (Anchorage)[4]	**$74,609.65**
Estimated annual cost of a wheelchair accessible apartment in Anchorage @ $700.00 per month[5]	$8,400.00
Estimated annual cost for personal assistance services at $18.00/hr, 3hrs/day[6]	$19,710.00
Annual cost for care coordinator @ $200.00/month[7]	$2,400.00
Total annual cost of independent living	**$30,510.00**

[4] Alaska Nursing Homes Census (2/29/96). State of Alaska, Department of Health and Social Services, Division of Medical Assistance, Health Facilities Licensing & Certification.

[5] Access Alaska, Anchorage, estimate 2/22/96.

[6] Access Alaska, Anchorage, estimate 2/22/96.

[7] Easter Seal Society of Alaska, Inc., Anchorage, estimate 4/11/96.

Evelyn Emry, age 43

"All I need is a wheelchair accessible apartment."

Evelyn Emry is a forty-three year old Athabaskan woman from Northway. She is a mother of three. Her two girls are young adults who live on their own. Her boy, however, is eight years old and currently lives with his aunt in Northway. Evelyn misses her son tremendously.

Evelyn has been experiencing rheumatoid arthritis since her thirties and has been institutionalized six times in the last ten years. She recently had a hip replacement from which she is recovering. She has been living in the Denali Center in Fairbanks for over one year. Evelyn wants to leave the Denali Center as soon as possible. Her fiancé and other family members will provide the help she needs to keep the household and to run errands. Evelyn requires help with transfers in and out of bed, bathing, and dressing. She transports herself in the wheelchair. She will also require care with personal hygiene. This, too, will be supported by family members.

Evelyn dreams of once again living in her village, Northway. She would love to live near her family that remains in Northway - people she is close to and with whom she has much in common. She misses Native foods and activities and would probably get more visitors if she were living in her village. However, she knows she will be unable to do so because existing village structures are not barrier free. She would require indoor plumbing, flat floor surfaces, and ramping for stairs.

Nevertheless, Evelyn is determined to live independently in the community. She needs wheelchair accessible housing in Fairbanks, and she can use para-transit as she has in the past. Evelyn wants to be involved in a support group with other people who experience disabilities. She also has indicated an understanding of accessing in-home support if she requires help of people outside her family.

Evelyn can live successfully in the community and requires little support to do so. She looks forward to the time when she can get accessible housing in Fairbanks and when her family can be reunited.

Cost Comparison

Annual cost of care at Denali Center[8]	**$96,666.60**
Estimated annual cost of a wheelchair accessible apartment in Fairbanks @ $600.00 per month[9]	$7,200.00
Estimated annual cost of para-transit services @$2.00 per ride, 30 rides per month[10]	$720.00
Annual cost of care coordinator @ $200.00/month[11]	$2,400.00
Total annual cost of independent living	**$10,320.00**

[8] Alaska Nursing Homes Census (2/29/96). State of Alaska, Department of Health and Social Services, Division of Medical Assistance, Health Facilities Licensing & Certification.

[9] Access Alaska, Fairbanks, estimate 2/29/96.

[10] Access Alaska, Fairbanks, estimate 2/29/96.

[11] Easter Seal Society of Alaska, Inc., Anchorage, estimate 4/11/96.

Al Wilson, age 49

"If Al had a personal assistant for a few hours per day, he could leave the nursing home."

"Sourdough Al", as he is known to many, deeply desires to be independent again. Al traveled around the state as a storyteller until last summer when he experienced a freak accident which resulted in major lifestyle changes for him. He now has quadriplegia and uses a wheelchair. Al is 49 years old and has always been fiercely independent.

Last June, when Al was thrown from his bicycle and his spinal cord was severed, he spent several months in rehabilitation at a VA hospital outside the state. Al's independent spirit was tested on a daily basis as he was told how he must do things. One time his physical therapy and occupational therapy services were suspended when he refused to have his bowel movement the way they wanted. Al feels he is the true expert when it comes to such a personal function!

Life at Denali Center in Fairbanks overall has been good according to Al but he and the head nurses occasionally have differences of opinion. For example, there have been times Al likes to get out of bed at 6 a.m. but has been told he can't because Denali doesn't have the staff at that time to assist him. Also, he doesn't want male providers working with him. This is something he feels strongly about and feels that his wishes are not being respected.

Al claims that the staff hasn't talked to him about a discharge plan or explored goals beyond his present life at the institution. He believes the philosophy at Denali Center is "once you're in; you don't get out." Al desires to get back in the community as soon as possible. He will need assistance with are self-care and mobility. Al identified basic areas in which he needs help: to obtain low-cost housing, reliable transportation, whirlpool baths, and to work in the schools as he once did. Al would like to remain in Alaska.

Cost Comparison

Annual cost of care at Denali Center[12]	**$96,666.60**
Estimated annual cost of a wheelchair accessible apartment in Fairbanks @ $600.00 per month[13]	$7,200.00
Estimated annual cost of para-transit services @ $2.00 per ride, 30 rides per month[14]	$720.00
Annual cost of personal assistant @ $18.00/hr, 3hrs/day[15]	$19,710.00
Annual cost of care coordinator for 6 mos. @ $200.00/month[16]	$1,200.00
Annual cost of independent living	**$28,830.00**

[12] Alaska Nursing Homes Census (2/29/96). State of Alaska, Department of Health and Social Services, Division of Medical Assistance, Health Facilities Licensing & Certification.

[13] Access Alaska, Fairbanks, estimate 2/29/96.

[14] Access Alaska, Fairbanks, estimate 2/29/96.

[15] Access Alaska, Fairbanks, estimate 2/29/96.

[16] Easter Seal Society of Alaska, Inc., Anchorage, estimate 4/11/96.

Teisha Simmons, age 18

"Thanks to the Personal Assistance Program, I have a life and a future."

Teisha will turn 19 years old on March 31, 1996. She grew up with her four elder siblings in the village of Galena. Teisha is graduating from high school with honors in May, 1996 and is planning to enroll at the University of Alaska, Fairbanks. Her long term goal is to become a psychologist and work with young people.

Teisha was injured in a car accident three years ago and is now paralyzed from her shoulders down. She depends on a ventilator to help her breathe. After her accident she stayed temporarily in a nursing home. Teisha shudders when she remembers the experience, which seems like a nightmare to her now. The nurses put her in her wheelchair every morning and took her to the TV room where they left her until lunch time. After lunch they would take her outside and leave her alone for hours without any way for her to call for help if she needed it. She observed other patients who sat in the TV room most of their time, drooling on themselves or talking to themselves, not being able to control their body functions, and being totally forgotten. The nurses frequently became agitated when Teisha requested their assistance. Teisha says her experience with the nursing home was degrading and humiliating; she does not wish it for anyone.

During the month of June, Teisha will go to the Craig Institute of Rehabilitation to receive intensive rehabilitation to get off the ventilator, breathe on her own, and lead a more independent life.

Currently Teisha lives with her mother in Fairbanks. She is also in the process of getting her own apartment with a live-in personal care attendant. After being in the nursing home, it is vitally important to Teisha that she live in the community with a live-in personal care attendant, to be as independent as possible and live a quality life. Teisha needs an attendant to live with her to help her dress, prepare meals, settle in for the night, and to handle other personal needs. She also needs assistance in her classes which the university will provide.

Teisha is very grateful for the services she receives through the Personal Care Attendant Program. She would hate to be in a nursing home. Independence and living in a community of her choice are very important for Teisha.

Cost Comparison

Annual cost of care at Denali Center[17]	**$96,666.60**
Estimated annual cost of a wheelchair accessible apartment in Fairbanks @ $600.00 per month[18]	$7,200.00
Estimated annual cost for live-in personal assistant[19]	$37,400.00
Total annual cost of independent living	**$44,600.00**

[17] Alaska Nursing Homes Census (2/29/96). State of Alaska, Department of Health and Social Services, Division of Medical Assistance, Health Facilities Licensing & Certification.

[18] Access Alaska, Fairbanks, estimate 2/29/96.

[19] Fairbanks Resource Agency, Fairbanks, estimate 4/12/96.

Bruce Hinke, age 51

"With the right equipment I could leave the nursing home and get back to work."

Bruce, 51, lived in Juneau and Douglas until 1994. He has experienced multiple sclerosis since his late twenties. Two years ago complications in his condition and the lack of assistance forced him to move into St. Ann's Care Center.

He desperately wants to live on his own and is convinced that he can live independently with the part time help of a personal care attendant. He can feed and clean himself, and operate augmented computers. He would like to live in Juneau's Mendenhall Valley or Douglas to be close to his family. His mother or brother are willing to assist him if a Personal Care Attendant can be found for part of the time.

Bruce believes he can get back into professional data processing provided he can access certain accommodations and assistive technologies. He would need a programmed speaker phone or TTD, speech enhancing communication device, a power wheelchair, and accessible transportation.

Bruce says that he wants to leave St. Ann's as soon as possible. He says being around people that are just waiting to die is affecting his mental state.

Cost Comparison

Annual cost of care at St. Ann's Care Center[20]	**$87,529.00**
Estimated cost of a programmed speakerphone and a speech enhancer, one time[21]	$3,000.00
Estimated cost of a power wheelchair (E&J Lancer), one time[22]	$8,000.00
Estimated cost of lift-equipped van, one time[23]	$10,000.00
Annual cost of personal assistant @ $18.00/hr, 3hrs/day[24]	$19,710.00
Annual cost of care coordinator @ $200.00/month for 6 months[25]	$2,400.00
Total annual cost of independent living for the first year -	**$43,110.00**
Total annual cost thereafter	**$22,110.00**

[20] Alaska Nursing Homes Census (2/29/96). State of Alaska, Department of Health and Social Services, Division of Medical Assistance, Health Facilities Licensing & Certification.

[21] SAIL, Juneau, estimate 2/22/96.

[22] SAIL, Juneau, estimate 2/22/96.

[23] SAIL, Juneau, estimate 2/22/96.

[24] SAIL, Juneau, estimate 2/22/96.

[25] Center for Community, Juneau, estimate 3/4/96.

Roy Clayton, Jr., age 38

"My wife would take care of me at home if she could get the Personal Care Attendant Training."

Roy used to live in Anchorage and was a laborer on highway projects. He has a spouse, two boys and one girl. Roy suffered a stroke in August 1994. In September 1995, he was admitted into St. Ann's Nursing Home in Juneau.

Roy wants to live with his wife and family. He is sure he could live independently if he had some wheelchair mobility training, a personal care attendant for a few hours a day and independent living skills training. His wife is willing to be trained as his personal care attendant. Roy also believes he could be economically self sufficient if he could learn one hand typing skills and some enhanced computer skills.

He and his wife would like to move to Anchorage. He is unaware of independent living community services and does not have any information about the State Independent Living Council or the Division of Vocational Rehabilitation. However, he thinks he would be able to locate accessible transportation in Anchorage.

Cost Comparison

Annual cost of care at St. Ann's Care Center[26]	**$87,529.00**
Estimated annual cost of a wheelchair accessible apartment in Anchorage @ 700.00 per month[27]	$8,400.00
Cost of PCA training for Roy's wife, one time[28]	$250.00
Cost of computer skill training, one time[29]	$260.00
Estimated cost of mobility training, one time[30]	$3,000.00
Estimated cost of independent living skill training, one time[31]	$3,000.00
Annual cost of care coordinator @ $200.00/month[32]	$2,400.00
Total annual cost of independent living for the first year	**$17,310.00**
Total annual costs thereafter	**$10,800.00**

26 Alaska Nursing Homes Census (2/29/96). State of Alaska, Department of Health and Social Services, Division of Medical Assistance, Health Facilities Licensing & Certification.

27 Access Alaska, Anchorage, estimate 2/22/96.

28 Hospice Home Health, Juneau, estimate 4/12/96.

29 Ability Design Associates, Anchorage, estimate 4/12/96.

30 SAIL, Juneau, estimate 2/22/96.

31 SAIL, Juneau, estimate 2/22/96.

32 Center for Community, Juneau, estimate 3/4/96.

Rodney J. Katzeek, 38

"With just a little help, I could live at home."

Rodney is from Klukwan and that is where he would like to live. His two girls live there. He feels he could be independent if he could receive some daily living skills training, some interpersonal communication skills training and had the help of a personal care attendant for a few hours daily.

Rodney had a stroke when he was 37. He was admitted to St. Ann's one day before his 38th birthday, just after Christmas of 1994. Nobody informed him of any community services. He had not heard of the State Independent Living Council or of the Division of Vocational Rehabilitation. His only experience with Southeast Alaska Independent Living (SAIL) was when SAIL provided portable ramps for his mother's house so Rodney could visit her one time.

Rodney could stay with his mother if a ramp and housing modification would be provided. He truly desires to live in the community. He says he is too young to live in a nursing home.

Cost Comparison

Annual cost of care at St. Ann's Care Center[33]	**$87,529.00**
Estimated cost of mobility training, one time[34]	$3,000.00
Estimated cost of independent living skill training, one time[35]	$3,000.00
House modifications, one time[36]	$3,000.00
Estimated cost of communication skill training, one time[37]	$2,000.00
Annual cost of care coordinator @ $200.00/month[38]	$2,400.00
Annual cost of personal assistant @ $18.00/hr, 3hrs/day[39]	$19,710.00
Total annual cost of independent living for the first year	**$33,110.00**
Total annual costs thereafter	**$21,110.00**

[33] Alaska Nursing Homes Census (2/29/96). State of Alaska, Department of Health and Social Services, Division of Medical Assistance, Health Facilities Licensing & Certification.

[34] SAIL, Juneau, estimate 2/22/96.

[35] SAIL, Juneau, estimate 2/22/96.

[36] SAIL, Juneau, estimate 2/22/96.

[37] SAIL, Juneau, estimate 2/22/96.

[38] Center for Community, Juneau, estimate 3/4/96.

[39] SAIL, Juneau, estimate 2/22/96.

Carla Norman, 29

"For five years I have been fighting to get out of the nursing home into an assistive living residence."

Carla was born and raised in Seward, Alaska. Her parents and her younger brother live in Seward and her ten-year-old daughter lives with her father in Washington. Her daughter visits Carla in the summer and during Christmas.

In 1988 Carla left Seward for Washington. She lived in Washington for only a few months before she was involved in a car accident and sustained a closed head injury. She was in a coma for six months. One month after the accident, she moved back to Alaska to be closer to her family. There were no rehabilitative services for her at Wesley Rehabilitation Care Center at that time, so family and friends provided range of motion and other exercises three to four times a day for about one year. The family was told that Medicaid would not approve outside rehabilitation services because it was not a "life and death situation." Therefore, Carla did not receive the intensive physical and speech/language rehabilitation services she needed to improve. Carla uses a wheel chair and an augmentative communication device. Both pieces of equipment are outdated and do not allow for the independence of which Carla is capable.

Until a year ago Carla and her family were not aware of community based services and knew very little about other independent living options. She currently receives case management services from Hope Cottages and advocacy services from the Kenai Peninsula Independent Living Center.

Because Carla has been institutionalized since her injury eight years ago and because of the lack of immediate rehabilitation services, she will initially need 24-hour care when she moves into a community living situation. Currently, Carla needs assistance with all her daily living needs. However, in a more independent living situation she would be able to practice, learn and regain some strengths and skills which have been lost by living in a nursing home facility. Therefore, the initial costs for community-based living will be high. These costs will decrease as she is able to participate in her own care.

Cost Comparison

Annual cost of care at Wesley Rehabilitation Care Center[40]	**$74,146.10**
Estimated first year cost of Medicaid Waiver services including all living, medical and equipment needs, and care coordination[41]	**$78,000.00**
Estimated annual cost thereafter including care coordination and live-in care provider[42]	**$55,000.00**

[40] Alaska Nursing Homes Census (2/29/96). State of Alaska, Department of Health and Social Services, Division of Medical Assistance, Health Facilities Licensing & Certification.

[41] Hope Cottages, Anchorage, estimate 10/95.

[42] Hope Cottages, Anchorage, estimate 10/95.

Recommendations

The Alaska long-term care system has a variety of services available for people with long-term care needs. These services, for the most part, meet those needs; however, people are not always able to be served by the long-term care service of their choice, nor in the location of their choice. Waiting lists, lack of service providers, and limited funding for home and community based services force many people to either wait to receive services, or to opt for services like nursing homes that they do not prefer. The costs of these services are very high; the services are often not located near those who need them, and more often than not they restrict individuals' independence unnecessarily.

Alaska's long-term care system is unbalanced. A high percentage of the long-term care dollars go to nursing homes, and nursing homes provide a high level of care at great cost. Many people in need of long-term care can be safely cared for in alternative, less expensive settings. It is also true that most people who receive facility-based, long-term care prefer these alternative settings.

The task force recommends the following to balance Alaska's long-term care system, provide services consumers require and value, reduce provision of unnecessary and unwanted services, and to stabilize and eventually reduce health care cost to the state.

Balance Alaska s Long-Term Care System

A construction moratorium on long-term care beds will allow time for Alaska to move towards a more balanced long-term care system.

Representative Mark Hanley recently proposed House Bill 528 which establishes a moratorium on long term care beds. This bill will assist the state to contain Medicaid costs, develop home and community-based services, serve persons in need of long-term care more effectively and cost efficiently.

Several areas of Alaska have empty nursing home beds. The Alaska long-term care system is highly dependent on nursing homes, and needs to diversify to a greater degree. At an average cost of $220.84 per day, the cost of Alaska nursing homes is about triple the average nursing home rate in the United States of $71.03 per day.[43]

The current bed level in nursing homes should be held for several years. Individuals who could be served in community-based settings should be moved out, and savings should be directed towards community-based services.

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[43] Ladd & Associates. (1995). Long-Term Care in Alaska: Recommendations for Reform (Draft), Austin, Texas.

Medicaid Waivers

The State of Alaska should fully fund all waiver programs to reduce the overall long-term care costs.

Alaska has home health services and personal care services offered through the Medicaid program, and a variety of other services through community based care waiver programs. These services are more cost efficient that nursing home care. In order to reduce Alaska's long term care costs it is important to fully fund the Medicaid Waiver programs.

Funding

The State of Alaska should appropriate more funds in community-based services.

Community based services are more desirable to the consumer and less expensive for the State.

Development of a Continuum of Long-Term Care Services

A continuum of services will ensure that individuals with disabilities can obtain services based on their needs instead of receiving unwanted, more restrictive and more expensive services.

Alaska should have an array of long-term care services. It should consist of a broad spectrum of services such as home care, adult day care, adult foster homes, assisted living facilities, nursing homes, and other care settings.

Alaska already has an innovative and viable home and community based care system for both older Alaskans and Alaskans with disabilities. This system is under-funded and has not been allowed to reach its full potential. Too many of our public resources go toward nursing home care.

ALASKA NURSING HOMES CENSUS

AS OF: February 29, 1996

FACILITY	MEDICAID PER DIEM RATE	CERTIFIED CAPACITY NF BEDS	CERTIFIED CAPACITY SWING BEDS	MEDICAID PLACEMENTS ICF	MEDICAID PLACEMENTS SNF	NON-DMA PLACEMENTS MEDICARE	NON-DMA PLACEMENTS * OTHER	TOTAL CENSUS	VACANT BEDS	% OCCUPANCY OF TOTAL BEDS OVERALL	% OCCUPANCY OF TOTAL BEDS MEDICAID
CORDOVA COMMUNITY MEDICAL CENTER LTC	$414.28	10	4	8	0	0	0	8	6	57%	57%
DENALI CENTER (Fairbanks)	264.84	90	0	52	16	6	9	83	7	92%	76%
HERITAGE PLACE (Soldotna)	172.49	45	0	38	1	1	3	43	2	96%	87%
KETCHIKAN GENERAL HOSPITAL LTC	299.37	46	0	12	1	5	1	19	27	41%	28%
KODIAK ISLAND HOSPITAL CARE CENTER	312.48	19	4	13	0	0	0	13	10	57%	57%
MARY CONRAD CENTER (Anchorage)	223.29	89	0	72	11	4	1	88	1	99%	93%
PROVIDENCE EXTENDED CARE CENTER (Anchorage)	204.41	224	0	102	82	18	15	217	7	97%	82%
PETERSBURG MEDICAL CENTER LTC	272.11	14	4	11	0	2	1	14	4	78%	61%
QUYAANA CARE CENTER (Nome)	439.69	15	0	14	1	0	0	15	0	100%	100%
SITKA COMMUNITY HOSPITAL LTC	230.31	6	4	4	0	0	2	6	3	67%	44%
SOURDOUGH PLACE (Valdez)	309.70	16	0	15	0	0	1	16	0	100%	94%
SOUTH PENINSULA HOSP. LTC (Homer)	375.66	20	4	16	3	2	0	20	4	83%	75%
ST. ANN'S CARE CENTER (Juneau)	239.26	45	0	21	13	0	3	37	8	82%	76%
WESLEY REHABILITATION CARE CENTER (Seward)	203.14	66	0	41	1	1	3	46	20	70%	64%
WRANGELL GENERAL HOSPITAL LTC	286.02	14	4	9	0	3	2	14	4	78%	50%
SWING BEDS (Acute to LTC):											
CENTRAL PEN. HOSPITAL (Soldotna)	234.64	0	4	0	0	0	1	1	3	25%	0%
SEWARD GENERAL HOSPITAL	234.64	0	2	0	0	0	0	0	2	0%	0%
VALDEZ COMMUNITY HOSPITAL	234.64	0	6	0	0	1	0	1	5	17%	0%
VALLEY HOSPITAL (Palmer)	234.64	0	4	0	0	0	0	0	4	0%	0%
YUKON-KUSKOWIM REGIONAL HOSPITAL (Bethel)	234.64	0	3	0	0	0	0	0	3	0%	0%
	TOTAL	761		427	129	43	42	641	120	84%	73%

* Includes VA, private pay, insurance, and other.

3/12/96

SHELBERT LARSEN, ACTING ADMINISTRATOR
DIVISION OF MEDICAL ASSISTANCE (907) 561-8081
HEALTH FACILITIES LICENSING & CERTIFICATION

DATE

ICF/MR AND IMH CENSUS

AS OF: February 29, 1996

PSYCHIATRIC BEDS	PER DIEM RATE	CERTIFIED BEDS	CURRENT OCCUPANCY			TOTAL CENSUS	VACANT BEDS
			MEDICAID UNDER 22	MEDICAID OVER 65	NON-MEDICAID		
ALASKA PSYCHIATRIC INSTITUTE Anchorage	$507.82	130	13	2	45	60	70
CHARTER NORTH HOSPITAL Anchorage	N/A	46	15	0	15	30	16
NORTH STAR HOSPITAL Anchorage	N/A	34	11	0	8	19	15

ICF/MR BEDS	PER DIEM RATE	CERTIFIED BEDS	CURRENT OCCUPANCY		TOTAL CENSUS	VACANT BEDS
			MEDICAID	NON-MEDICAID		
HARBORVIEW DEVELOPMENTAL CENTER Valdez	425.56	64	23	1	24	40
HOPE COTTAGES Anchorage	360.84	41	41	0	41	0

3/12/96

SHELBERT LARSEN, ACTING ADMINISTRATOR — DATE

DIVISION OF MEDICAL ASSISTANCE (907) 561-8081

HEALTH FACILITIES LICENSING & CERTIFICATION

CS FOR HOUSE BILL NO. 528(FIN)

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - SECOND SESSION

BY THE HOUSE FINANCE COMMITTEE

Offered: 4/15/96
Referred: Rules

Sponsor(s): HOUSE FINANCE COMMITTEE

A BILL

FOR AN ACT ENTITLED

"An Act relating to applications for certificates of need and licensing of nursing homes; establishing a moratorium with respect to acceptance of new applications for a certificate of need or for a license for additional nursing home capacity in the state until May 1, 1998; establishing a working group to study and issue a report about long-term care; and providing for an effective date."

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

* **Section 1.** FINDINGS. The legislature finds that

(1) many nursing home residents would benefit from care that is less intensive and less costly than nursing home care through assisted living facilities or through home care agencies;

(2) this state has only recently begun to develop a system for providing long-term care for seniors needing care through home care or assisted living facilities so that the long-term care system is not in balance at the present time;

(3) with the unnecessary focus on nursing homes, the long-term care system will remain out of balance until community-based services can be developed;

(4) a moratorium on the addition of nursing home beds will encourage the development of home and community-based services, and direct the state's resources toward the services that can best meet the needs of the recipients; and

(5) a moratorium on the addition of nursing home beds will facilitate actions to provide a more balanced system of care, more appropriate placement of seniors, and additional client choice, and to avoid new long-term care costs.

* Sec. 2. MORATORIUM FOR CERTIFICATE OF NEED. (a) Notwithstanding AS 18.07, the Department of Health and Social Services may not accept an application for a certificate of need under AS 18.07, and the department may not grant a certificate of need based on an application filed before the effective date of this Act, except as provided in (b) of this section, for

(1) construction of a health care facility that includes nursing home beds requiring licensure under AS 18.20.020; or

(2) conversion of a building or part of a building to include nursing home beds.

(b) The Department of Health and Social Services shall consider the findings in sec. 1 of this Act when reviewing an application under AS 18.07 that was pending on the effective date of this Act for the addition of nursing home beds or the conversion of existing beds to nursing home beds. The department may grant a pending application only when granting it would be consistent with the policy underlying the findings in sec. 1 of this Act.

(c) Notwithstanding AS 18.20, the department may not issue a license for

(1) construction of a health care facility that includes new nursing home beds; or

(2) additional new nursing home beds in a health care facility.

(d) In this section, "nursing home bed" means a bed not used for acute care in which nursing care and related medical services are provided over a period of 24 hours each day to individuals admitted because of illness, disease, or physical infirmity; the term "nursing home bed" does not include acute care beds converted to skilled nursing home beds used for transitional short-term care needs.

* Sec. 3. WORKING GROUP; REPORT. (a) There is established a six-member working

group to analyze issues regarding long-term care services in the state. The members of the group are

(1) two individuals appointed by the governor who are involved in providing long-term care services, one of whom is a licensed nursing home administrator who operates a community nursing home in this state;

(2) two individuals appointed by the governor who are receiving long-term care services, at least one of whom must be at least 60 years of age;

(3) the commissioner of administration, or the commissioner's designee; and

(4) the commissioner of health and social services, or the commissioner's designee.

(b) The working group established under this section may select a presiding officer from among its members.

(c) After gathering information through methods considered appropriate by the group, the working group established under this section shall prepare a report that includes the following:

(1) a description of the current status and costs of the state's system for long-term care services;

(2) the projected number of state residents who will be needing long-term care services through the year 2000, the year 2005, the year 2010, and the year 2015;

(3) the projected costs to the state, based on the projection of needs under (2) of this subsection, if no changes are made to the state's present system of long-term care services;

(4) an estimated number of state residents who are currently receiving care in nursing facilities that could more appropriately be receiving home- and community-based care outside of nursing facilities;

(5) a description of the alternative methods available to provide nursing care for state residents and the relative cost to the state for these methods; and

(6) recommendations for principles that should be used to guide the development of the state's long-term care system, including principles that should guide the certificate-of-need process under AS 18.07.

(d) The working group shall deliver its report to the governor by the first day of the

First Regular Session of the Twentieth Alaska State Legislature and notify the legislature that the report is available.

* Sec. 4. Section 3 of this Act is repealed on the first day of the First Regular Session of the Twentieth Alaska State Legislature.

* Sec. 5. Sections 1 and 2 of this Act are repealed May 1, 1998.

* Sec. 6. This Act takes effect immediately under AS 01.10.070(c).

JIM KOHN

THE MISSION OF THE ALASKA PIONEERS' HOMES

"The Alaska Pioneers' Homes are dedicated to serving Alaskans by providing residential services that are designed to maximize independence and quality of life by addressing the physical, psychosocial and spiritual needs of residents. These needs are addressed in a continuum of services within an assisted living philosophy, with special capacities for residents with Alzheimer's Disease and Related Disorders. Services are provided by caring, experienced, and qualified staff who recognize that strong community support and interaction are vital to our mission."

****

Since the Pioneers' Home system began in 1913, the mission of the Alaska Pioneers' Homes has continued to evolve in order to best serve the needs of the growing senior population. Currently, seniors who require assistance are choosing to utilize home and community-based services now available in the state, and those who enter the Pioneers' Homes do so later in their lives. The average age of residents in the Pioneers' Homes is now 85. With the more advanced age of the population, the needs of the residents have changed. Some of the residents have few needs for assistance, while others' needs are quite extensive. A primary need of current applicants and residents is for care related to Alzheimer's Disease, a degenerative brain disease. The number of persons entering the Pioneers' Homes with Alzheimer's Disease or Related Disorders (ADRD) is far greater than ever before because diseases of this type tend to strike with greatest frequency those most advanced in age. The physical and behavioral problems which result from this disease often make it impossible for family members to provide necessary care on a 24-hour basis.

Pioneers' Home FY 99 Initiatives

✧ **Provide a homelike model of care for residents having ADRD which meets their needs for care in an assisted living environment:**

- As the population of Pioneers' Home residents with ADRD continues to increase continue to improve and develop ADRD programs at all Pioneers' Homes.

- Develop and implement Alzheimer Care training programs specific to the needs of Pioneers' Home staff members and ADRD caregivers surrounding communities.

- Establish day and respite services for those on the active branch of the Pioneers' Homes waiting list.

✧ **Increase the Pioneers' Homes rates to the full cost of care by FY 2003.**

✧ **Cost containment:**

- **Increase efficiencies by reducing costs of overhead expenses such as worker's compensation, revenue collection, supply purchase, pharmaceutical purchase, staff scheduling, and facility energy consumption.**

DIVISION OF ALASKA LONGEVITY PROGRAMS

State Of Alaska
Department of Administration
Division of Alaska Longevity Programs
Pioneers' Home Occupancy Report
As of May 31, 1998

	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Coordinated Services							
Total	26	25	11	80	3	3	148
Unavailable	0	0	0	0	0	0	0
Occupied	20	25	11	72	3	3	134
Assigned	1	0	0	0	0	0	1
Available	5	0	0	8	0	0	13
Basic Assisted Living							
Total	23	21	25	44	16	17	146
Unavailable	0	0	0	0	0	0	0
Occupied	18	21	24	39	15	17	134
Assigned	2	0	0	0	0	0	2
Available	3	0	1	5	1	0	10
Enhanced Assisted Living							
Total	25	24	11	25	13	14	112
Unavailable	0	0	0	0	0	0	0
Occupied	25	23	11	23	12	13	107
Assigned	0	0	0	1	0	1	2
Available	0	1	0	1	1	0	3
ADRD Unit							
Total	24	18	21	42	12	9	126
Unavailable	13	0	0	0	2	0	15
Occupied	11	18	21	40	9	8	107
Assigned	0	0	0	0	0	1	1
Available	0	0	0	2	1	0	3
Comprehensive Services							
Total	4	12	14	36	4	5	75
Unavailable	0	0	0	0	0	0	0
Occupied	3	12	14	36	4	5	74
Assigned	0	0	0	0	0	0	0
Available	1	0	0	0	0	0	1
Total Spaces							
Total	102	100	82	227	48	48	607
Unavailable	13	0	0	0	2	0	15
Occupied	77	99	81	210	43	46	556
Assigned	3	0	0	1	0	2	6
Available	9	1	1	16	3	0	30
Infirmary Beds							
Total	6	2	2	4	1	0	15
Available Beds Occupied & Assigned	89.9%	99.0%	98.8%	93.0%	93.5%	100.0%	94.9%

Waiting List							
Active List	15	24	22	16	23	49	149
Inactive List	625	727	926	1,383	418	637	4,716
Number of applicants choosing more than one home on both lists							2,329
Total Number of Actual Applicants on Active Waiting List							111
Total Number of Actual Applicants on Inactive Waiting List							2,425
Total Applicants on Waiting Lists							2,536

Status Changes For May 1998

	Sitka	Fairbanks	Palmer	Anchorage	Ketchikan	Juneau	Total
Admission							
Coordinated Services	0	0	0	0	0	0	0
Basic Assisted Living	0	0	0	2	0	1	3
Enhanced Assisted Living	1	2	0	1	0	0	4
ADRD Unit	0	0	2	0	0	1	3
Comprehensive Services	0	0	0	0	0	0	0
Deaths							
Coordinated Services	0	0	0	0	0	0	0
Basic Assisted Living	0	0	0	0	1	0	1
Enhanced Assisted Living	0	1	0	1	0	0	2
ADRD Unit	0	0	0	0	0	2	2
Comprehensive Services	0	0	0	2	0	0	2
Discharges							
Coordinated Services	0	1	0	0	0	0	1
Basic Assisted Living	0	0	0	2	0	0	2
Enhanced Assisted Living	1	0	0	0	0	0	1
ADRD Unit	0	0	0	0	0	0	0
Comprehensive Services	0	0	0	0	0	0	0

* Unusual Occurances

Ketchikan - 2 beds unavailable due to construction

Sitka - 13 beds unavailable due to ADRD unit being developed with MHTA capital funds; unit [illegible] July 1998

James L. Kohn

James L. Kohn, Director

May1998.xls 6/16/98

Alaska Pioneers' Homes
Rate History

MONTHLY

Effective Date	Residential	Assisted Living	Skilled Nursing
1954	$150		$195
July 1966	$180		$225
July 1976	$225		$275
October 1983	$425		$525
December 1989	$525	$630	$800
February 1993	$600	$700	$880
February 1994	$665	$780	$975
February 1995	$735	$860	$1,100

Effective Date	Coordinated Services	Basic Assisted Living	Enhanced Assisted Living	Alzheimer's & Dementia Related Disorders	Comprehensive Services
July 1996	$934	$1,289	$1,553	$1,579	$1,864
July 1997	$1,140	$1,720	$2,140	$2,200	$2,630
July 1998	$1,340	$2,150	$2,730	$2,815	$3,395

Note:

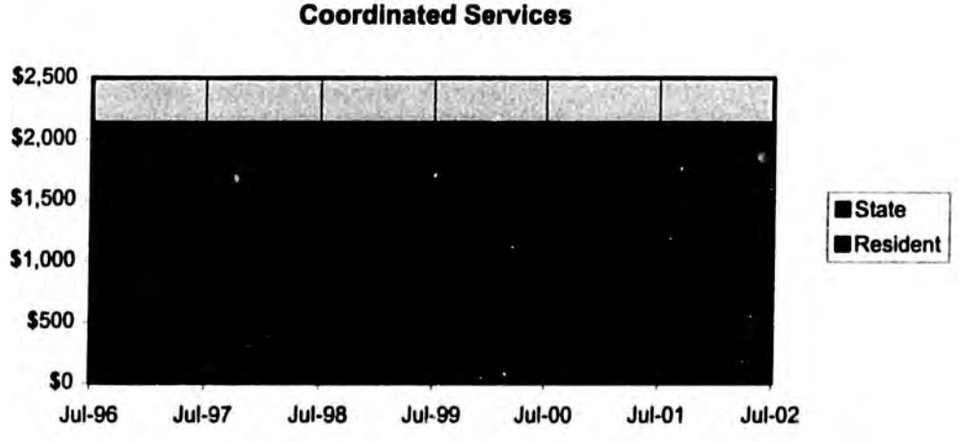
(1) July 1996 was the first increase in the pioneers' Home Advisory Board's seven year plan to move to charging the full cost of care.

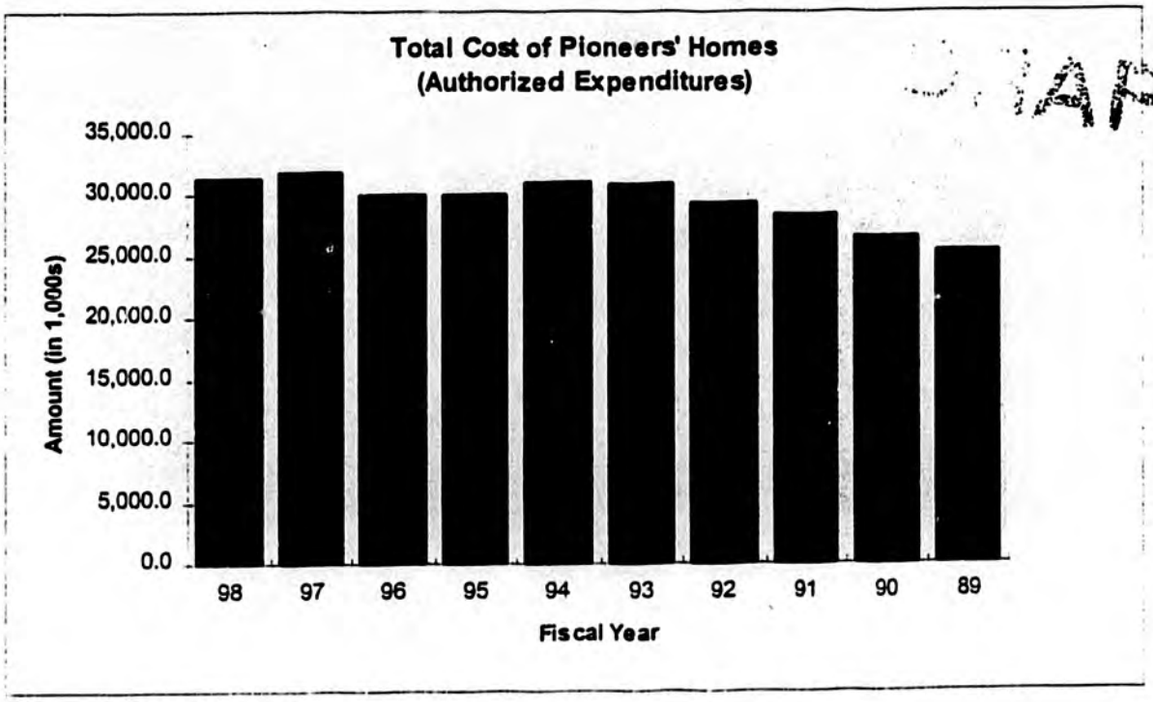
(2) A payment assistance program is available for residents who cannot afford the monthly rate.

Alaska Pioneers' Homes
Full Cost of Care Increases
(Actual Rates through July 1998, Proposed Rates through July 2002)

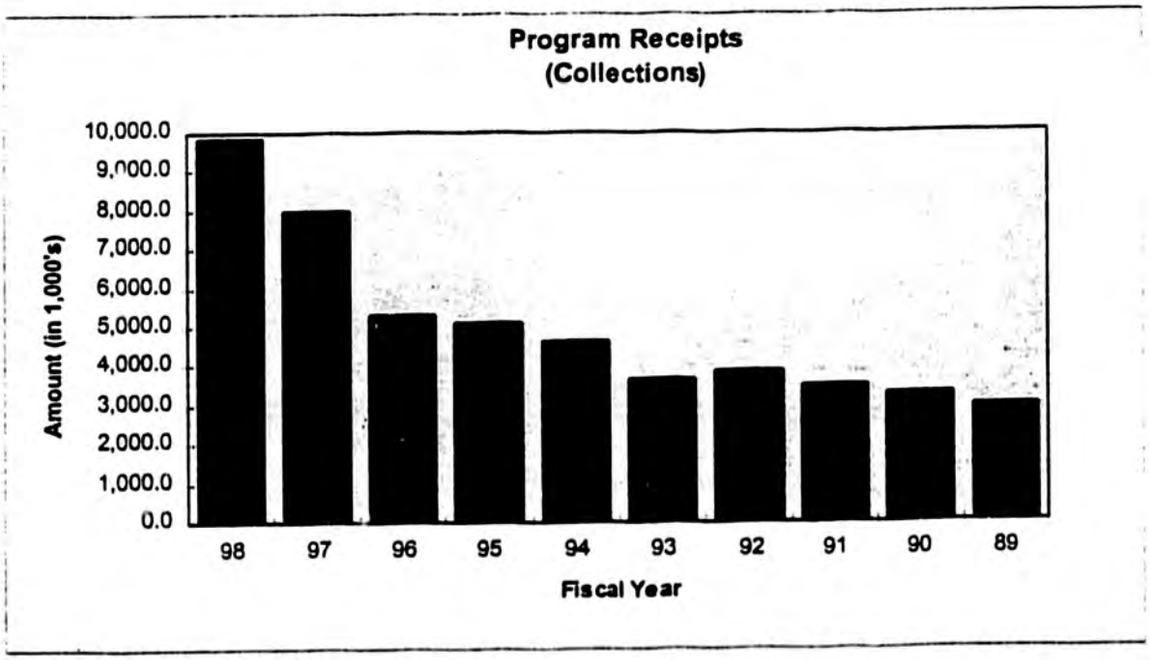
Resident	01-Jul-96	01-Jul-97	01-Jul-98	01-Jul-99	01-Jul-00	01-Jul-01	01-Jul-02
Coordinated Services	$934	$1,140	$1,340	$1,531	$1,730	$1,929	$2,129
Basic Assisted Living	$1,289	$1,720	$2,150	$2,576	$3,005	$3,434	$3,862
Enhanced Assisted Living	$1,553	$2,140	$2,730	$3,317	$3,905	$4,493	$5,079
ADRD Services	$1,579	$2,200	$2,815	$3,421	$4,035	$4,649	$5,262
Comprehensive Services	$1,864	$2,630	$3,395	$4,156	$4,920	$5,684	$6,448

State	01-Jul-96	01-Jul-97	01-Jul-98	01-Jul-99	01-Jul-00	01-Jul-01	01-Jul-02
Coordinated Services	$1,195	$989	$789	$598	$399	$200	$0
Basic Assisted Living	$2,573	$2,142	$1,712	$1,286	$857	$428	$0
Enhanced Assisted Living	$3,526	$2,939	$2,349	$1,762	$1,174	$586	$0
ADRD Services	$3,683	$3,062	$2,447	$1,841	$1,227	$613	$0
Comprehensive Services	$4,584	$3,818	$3,053	$2,292	$1,528	$764	$0



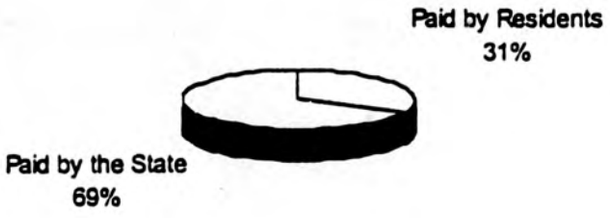


Note: The FY 1995 and FY 1996 budget amounts identified above exclude the Pioneers' Homes Central Office. In FY 1995 and FY 1996 the Pioneers' Homes Central Office budget was combined with the overall Division of Senior Services Administration budget so the amount specifically attributable to Central Office cannot be identified.

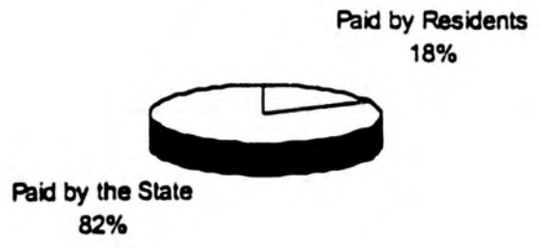


Cost of Pioneers' Homes

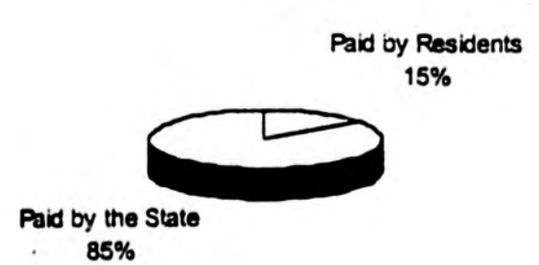
FY 1998



FY 1996



FY 1994



Pioneers' Homes Funding Summary

	FY 1999 (Requested)	FY 1998	FY 1997	FY 1996	FY 1995	FY 1994
General Fund \ Program Receipts (Rents)						
Sitka	1,636.8	1,636.8	1,230.9	751.6	690.3	62[illegible]
Fairbanks	1,783.8	1,783.8	1,381.6	890.1	795.1	717.5
Palmer	1,395.6	1,395.6	1,047.7	945.9	782.2	705.7
Anchorage	3,474.6	3,474.6	3,095.5	1,949.9	1,987.0	1,793.5
Ketchikan	745.3	745.3	576.1	401.2	409.2	369.2
Juneau	812.4	812.4	654.6	393.8	459.7	414.8
Subtotal	9,848.5	9,848.5	7,986.4	5,332.5	5,123.5	4,623.5
Mental Health Trust Funds	6,613.6	513.6	482.7	414.0	414.0	210.0
General Funds	14,910.3	21,006.8	23,375.1	24,304.8	24,600.8	26,270.1
CIP Receipts	53.0	53.0	53.6			
Total	**31,425.4**	**31,421.9**	**31,897.8**	**30,051.3**	**30,138.3**	**31,103.6**

Note:

(1) The Pioneers' Home Central Office was integrated into the Division of Senior Services in FY 1995.

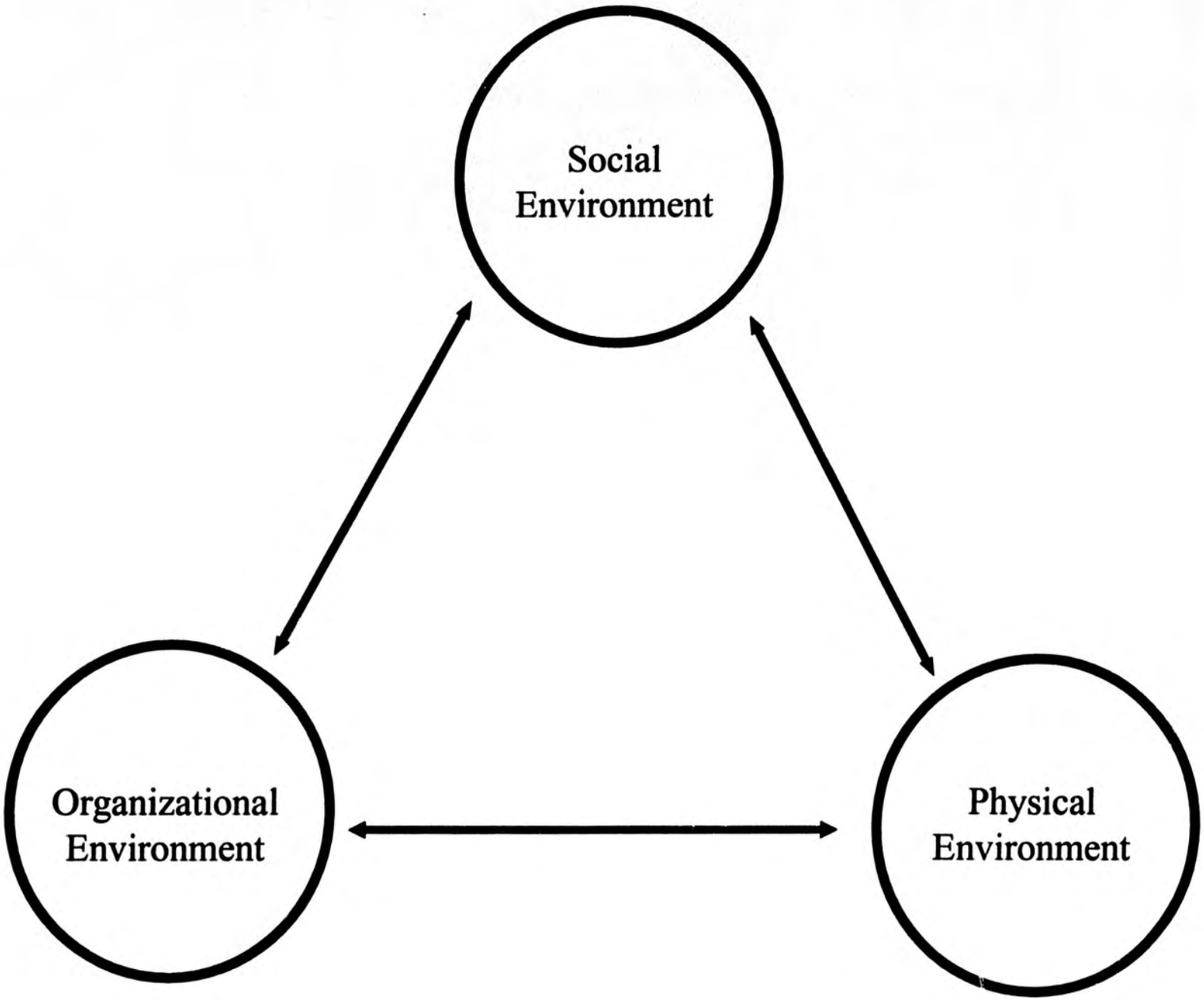
(2) The FY 1995 and FY 1996 Pioneers' Home Central Office amounts are excluded from the above information. Unable to specifically identify the Central Office budget from the overall Division of Senior Services Administration budget.

(3) Pioneers' Home Central Office transferred to the newly established Division of Alaska Longevity Programs in FY 1997.

(4) In FY 1997 and FY 1998, the costs of administering the Longevity Bonus program were included in the Pioneers' Home Central Office budget. These costs are excluded from the amounts listed above.

(5) The Pioneers' Home Pharmacy was established during FY 1998. It will be budgeted as a separate project beginning FY 1999.

FACILITY DEVELOPMENT PROCESS



THE FACILITY DEVELOPMENT PROCESS

	Preparation	Planning	Functional Programming	Architectural Programming	Design	Evaluation
Organizational Environment	Review Alternative Philosophies and Models of Care Review Mission of Organization	Define Philosophy of Care Determine Center Size and Staffing Needs & Patterns	Develop Care Plan, Admission and Discharge Criteria Develop Staff Training Program			Assess staff job satisfaction, absenteeism, and turnover
Social Environment	Review Common Human Needs	Define Desired Social Milieu & Patterns of Social Behavior	Develop Daily Program			Assess patterns of space usage. Identify locations of high & low social interaction
Older Persons with Physical &/or Cognitive Impairments	Review Demographics of Aging & Age Related Deficits	Identify Target Population to be Served	Develop Profile of Population to be served (Functional, Social & Cultural Characteristics)			Assess residents' cognitive & functional abilities over time
Environment as Experienced	Identify and Visit Comparable Facilities	**Define Desired Therapeutic Goals**	**Principles for Design (Develop Desired Attributes of Environmental Experience)**			**Does Facility Provide Desired Attributes of Environmental Experience?**
Physical Environment	Define Site Criteria & Identify Potential Locations Review Relevant Research Literature Review Relevant Codes & Standards Review Plans and Costs of Similar Projects	Develop Budget Review and Select Architect and Consultant Team Members Identify Potential Contractors and/or Developers		Articulate Desired Relationships Between Spaces Specify Sensory & Spatial Properties for Individual Spaces Specify Furniture, Equipment & Finishes for Individual Spaces	Develop & Review: • Schematics • Final Design • Construction Documents & Specifications	Does Facility Provide Desired Sensory & Spatial Attributes? Does Facility Provide Desired Furniture, Finishes, and Equipment?

November 1996

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School of Architecture & Urban Planning
University of Wisconsin-Milwaukee
Milwaukee, WI 53211-0413

JIM KOHN

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[Feature Home, July '98]
[Feature Home, June '98]

August 1998
Eden Feature Home of the Month

Why should Juneau Pioneers' Home be Eden's feature home of the month? Here are some of the reasons the staff, family members, residents and volunteers of the Juneau Pioneers' Home have:

Arsenia Sales (CNA) - Juneau Pioneers' Home is different than other nursing homes--because of the animals, residents like living here. There are more activities when residents want to attend, staff and residents have a flexible schedule that they can work and live in and the environment is one that is really like a home.

Denice McPherson (Physical Therapist) - Staff has leaned a lot over the years to provide a wonderful home environment that anyone would want to live in.

Bea Buchanan (Resident) - The beauty of the outside grounds - it is so beautiful outside. I love it. Lots of room to walk.

Trudy Gruber (Activity aide - CNA) - I like the animals and the plants. Staff and residents are very warm and loving. The environment is like a home, not a institution. When I retire - I hope that I can move into the JPH.

Marjorie Quimpo (CNA) - Staff helps each other - they work as a team and family.

Evelyn Cabalhin (CNA) - It is a home for everyone. We try to work together to have the residents feel like they are at home and happy.

Flor Batac (Maintenance) - Staff are good to work with. They all do their job well. Housekeeping staff does a great job of keeping the home clean. The Administrator is understanding to the needs of the home. I like how the maintenance department gets to help and assist the residents.

Tessie Punongbayan (Ward clerk) - Lots of animals that the residents can love and enjoy.

Diana Reed (Family member) - JPH is a home environment. Families are very welcome here. Volunteers are greatly appreciated. They spend one on one with residents and in groups. Volunteers are also welcome at any age.

Maxine Henrichs (Resident) - Because it is the BEST, of course!

Doug Holt (Administrator) - Things have really evolved far enough that I can indeed be the "coach," 'cheerleader," and facilitator. It is a lot more productive role than being a "traditional administrator" - sure a heck of a lot more fun!

Tom Barnett (Food Service Director) - Because of how the home is set up, the staff meets challenges and needs as they occur and not necessary by what department they work in, such as today I assisted a resident that needed help and then helped unplug a sink. Staff helps out where and when it is needed throughout the whole home.

June Baker (Volunteer) - JPH has a home feeling. The care of the residents receive is good. I get a lot of enjoyment and get to see the residents smile. To see improvement in residents is also a great joy.

Lillian Lim (RN) - We care for the residents in a home environment. We have been creative in bring "a home" into JPH—from the plants, animals, and family involvement to the attitude and vision that the staff shares.

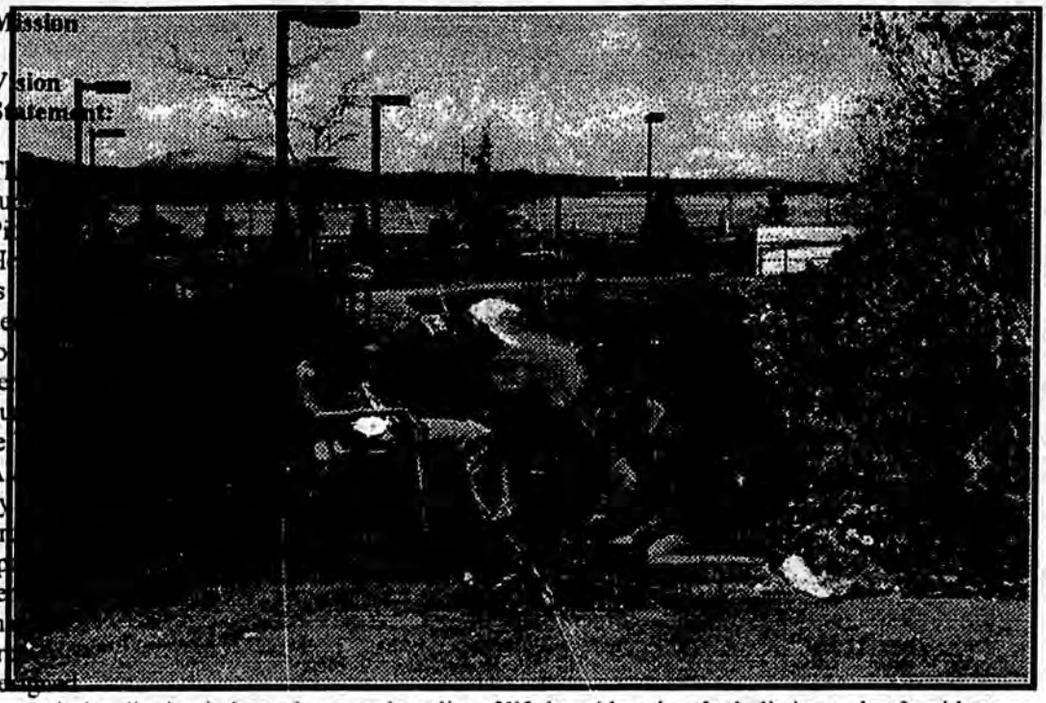
Vangie LaBoca (CNA) - JPH offers training that helps with my job, such as working with people that have dementia.

JPH continues on the journey of creating a home that anyone would be proud to call home. JPH is reaching their goal of becoming a wonderful "home" for seniors by using education and implementation of the Eden Alternative. Changes do not come easy but no one seems afraid to try new ideas and to be creative. Walls are printed a warm green color, shelves on walls display plants and photos, pet birds can be spotted on someone's shoulder, bedrooms are printed a salmon color that makes the room feel warm and safe and a cat can be found curled up on a bed. Team members meet often to discuss programs, schedules and ways to make their areas better. They work closely to provide a safe, secure home for people with dementia. The community plays a huge part in the home, from holding fundraisers to help finance the changes, to volunteering. It is a place where everyone can feel welcome as they walk though the door.

Contact Information:

Organization:	Juneau Pioneer's Home
Address:	4675 Glacier Hwy. Juneau, AK 99801 USA
Phone:	907.780.6422
Fax:	907.780.4765
Location Type:	Rural
Facility Size:	48
Facility Type:	

M ission / V sion S tatem t:



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to maximize dignity, independence and quality of life by addressing the holistic needs of residents, be they physical, psychosocial, or spiritual in nature. Our expressed primary mission is to provide optimal care for those affected with Alzheimer's Disease and Related Disorders.

Our therapeutic care is based on the Social Model of intervention which is the basis of our Assisted Living program. We choose to provide our service by coming together in a therapeutic community that facilitates optimal performance for residents and staff alike.

Our community is all inclusive: Residents, families, friends, staff, volunteers, and all who would add their energies and goodwill.

Our community strives for and honors in its' daily work: Trust, mutual respect, mutual support, sound communication, the constant improvement of, and constant transmission of knowledge, skills and positive attitude.

Our community is committed to sharing the knowledge and experience we are gaining through our work with individuals with ADRD. We welcome all who would walk this path of learning and teaching with us.

Our community believes that working as a team is the most effective way to fulfill our missions and we strive for the comradeship and the synergy that being part of a good team can provide. Our team is dedicated to crossing boundaries and borders that hinder learning and knowing. We have come to understand that stories are an important source of knowledge and insight and a basis for innovation. (Added in 1997) We have found a "kindred spirit" in the "Eden Alternative" vision of revolutionizing the long term care environment. We see it as an additional powerful tool to combat the plagues of boredom,loneliness and helplessness found in traditional long term care environments. We are committed to the concept of creating a habitat for the residents and ourselves in our mutual environment.that empowers and enriches the lives of all who enter our community.

Eden Vision:

We apparently have been walking down the same path for the last several years. The Eden Vision is offering us an opportunity for renewal of our mission and adding the dimension of the human habitat concept. There is strength and opportunity in sharing-as well as a greater opportunity to share with others.

Eden Progress:

We have come to believe that relationships-staff to resident-staff to staff-resident to resident and the commitment to the Human Habitat will allow all in this community to blossom once again. We have given up our nursing license in this pursuit and have taken the license of an assisted living facility in order to gain the freedom to allow us to allow others to thrive.==We have empowered all employees through dismantling traditional work environments and supervisory modes and all work now in self directed work teams that "own" their units,set their own work schedules,---The CNA now have the offices on the unit to coordinate activities and all other staff,i.e.nurses, administrator,social services,PT,activities,etc.,are in support of their mission. The administrator is mostly a coach,cheerleader, sometimes teacher and facilitator.I raise the money for Eden and they spend it!==We have sent Carol Ende to Eden conferences/educational sessions with you in New York and she is now certified and our Eden "guru"-an associate is being trained.==We have definitely entered the "fur and feather"arena during the last two years with many birds,scores of plants and an ever increasing number of children-I think Carol is sending you a video to show you our place.===Obviously, the leadership at the top is awesome!!===As I said earlier,we have been going down this"non-traditional" path now for almost five years-the Eden Vision is helping us to consolidate the gains and pushing us on to even bigger and better things.

Last updated: August 10, 1998.

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- *Telephone:* 607-674-5232
  Fax: 607-674-6723
  Post: The Eden Alternative 742 Turnpike Road Sherburne, NY 13460

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JIM KOHN

1998 Best Practice Awards

ANCHORAGE HOME BOOSTS STAFF MORALE, SAVES MONEY

By SUSAN DIANNE RICE

Imagine running a nursing facility for mentally impaired elders. Would you think it possible to save hundreds of thousands of dollars, get more work accomplished with the same number of employees and improve staff morale at the same time? The Alaska-based Anchorage Pioneers' Home (APH) garnered a 1998 Best Practices Award from the American Society on Aging and the Brookdale Center on Aging of Hunter College for accomplishing exactly that.

APH's award, bestowed on innovative human resources programs in conjunction with the American Society on Aging's 44th Annual Meeting in San Francisco, is one of three conferred on organizations having developed creative solutions to workforce dilemmas in the areas of recruitment, training, management and retention. Also receiving awards were the Career Nurse Assistants Programs Inc. and Stonerock and Associates, publishers of *Home Health Aide Digest* (see separate article on this page).

Photos: Robert Montague

The Parkview Team, one of four caregiving groups at the Anchorage Pioneer Home, includes, from left, Peggy Fache, Becky Cameron, Anna Mellott and Natalia Ballard.

ALZHEIMER'S CARE

Three years ago, APH found itself at a critical juncture, switching from a skilled nursing facility to a 226-bed long-term care home for elders suffering from end-stage Alzheimer's disease and related dementia—the first such facility, public or private, in Alaska. The change required APH to provide more services at the same time that its budget was shrinking.

"Alaska's economy is driven by oil prices," APH assistant administrator Leslie C. Brundige explained in a recent interview. "The oil-producing nations have increased their output. With oil prices going down, that means less state revenue." In addition to the budget crunch, APH faced a demoralized and divided staff suspicious of the changes under way.

APH administrators realized that many of their problems were traceable to a rigid hierarchical structure that strait-jacketed progress, frustrated communication and left workers on the bottom feeling unappreciated. For example, if a certified nurse aide (NA) discovered a leaky faucet in a resident's room, she notified a nurse, who notified his or her supervisor, who notified his or her supervisor on up the chain to a very senior nurse who informed the maintenance superintendent who would dispatch a maintenance worker.

Brundige recalled that one female resident had been prescribed milk with every meal as a nutritional supplement, but the dietitian was unaware she disliked it. Every day, the milk was thrown out. Under the new team structure, an NA who worked regularly with the resident noticed that the milk was being discarded and informed the dietitian. "We learned that the woman loves cherry yogurt," Brundige said. "Now she eats her cherry yogurt every day and gets the nutrition she needs."

Frontline workers now have a voice in organizational issues and evaluate themselves and each other. They also receive ongoing education and training to improve both skills and self-esteem. Nurses and managers function as coaches and mentors rather than authoritarian figures.

tions with co-workers; after the change, that figure jumped to nearly 100%. In 1995, about 5% of staff agreed with the statement, "My colleagues and I readily share information." That number soared to 80% two years later.

The new spirit of cooperation has yielded quantifiable benefits as well. Annual employee injury costs declined from $650,000 to $99,000. Use of sick leave plummeted 46%; coupled with a decrease in overtime, that saved $90,000 in personnel costs in 1997.

NURSE ASSISTANTS

Nationwide, however, there are still plenty of eldercare workers who feel unappreciated.

"There are a lot of fallacies out there about nurse assistants," says Genevieve Gipson, director of the Career Nurse Assistants' Programs Inc. (CNAP) of Norton, Ohio. "One is that nurse assistants are responsible for everything that's wrong with nursing homes," she said, citing lurid television exposés about nurse assistants who steal from and abuse nursing home residents. "The good nurse assistants don't like those [assistants] either," she said.

CNAP, another 1998 Best Practice Award winner, has worked for two decades to promote these nursing paraprofessionals by sponsoring programs to

Leslie C. Brundige explained in a recent

HOME AIDE AWARD

Home Health Aide Digest, a publication of Stonerock and Associates, Kalamazoo, Mich., is a bimonthly newsletter aimed at "nurturing the occupational and personal growth of home health aides and increasing the recognition and prestige of their profession."

The *Digest*, which has 6,000 paid subscribers, is the only publication dedicated to home health aides (HHAs). It received a 1998 Best Practice Award from the American Society on Aging and the Brookdale Center on Aging at New York's Hunter College. Articles in the magazine, written or reviewed by registered nurses, have covered such topics as elder abuse, cardiovascular care and incontinence.

According to the *Digest*, there are 500,000 HHAs in the United States, and 500,000 more will be needed by the year 2005. Job dissatisfaction among HHAs—often expressed as a feeling that their services are undervalued by agencies, clients, the community and other health professionals—has yielded a turnover rate as high as 75% in some parts of the country, a situation which the publication hopes to help remedy. ◆

[illegible] supervisor, who notified his or her supervisor on up the chain to a very senior nurse who informed the maintenance superintendent who would dispatch a maintenance worker.

The organization responded by reconfiguring work teams to promote cooperation rather than competition, increasing the autonomy of lower-level employees and broadening the scope of information dissemination. The hierarchical pyramid was replaced with cross-functional teams, each consisting of NAs, an activity person, one to three housekeepers, dietary personnel, a physical therapist and a maintenance worker. Teams were organized on a 24-hour basis and rotating assignments were eliminated so that employees work with the same residents and colleagues every day, facilitating the formation of close relationships.

This was crucial because, as Brundige noted, the average age of APH residents is 87.1 years. "A lot of them have outlived their families," she said. "Their only families now are the caregivers."

APH accomplished the change by replacing a three-shift schedule with a four-shift schedule, using the same number of employees. Shifts were set to overlap during meal times, so that added staff were on hand when they were most needed. Residents who formerly had to wait as long as 32 minutes with an empty tray in front of them were now served quickly.

THE FIRST TO KNOW

The new structure also recognized that the frontline worker is often the first—and sometimes only—one to know if there is a problem with one of the residents. [illegible] ongoing education and training to improve both skills and self-esteem. Nurses and managers function as coaches and mentors rather than authoritarian figures.

In instigating the changes, APH defined its mission as creating a caring, teamlike environment for the 180-member staff—a facility that would be homey rather than institutional, that would encourage interrelationships among residents and staff, and where information would flow freely and employees would enjoy more independence and could grow in their jobs.

A September 1995 survey revealed deep employee dissatisfaction, expressed in terms of lack of trust in co-workers, confusion regarding goals, poor communication in all directions, inadequate supervision and abuse of sick leave. "No one asks for my opinion" was a familiar complaint.

Nurses and department managers were the only personnel with access to company e-mail. Low-level workers were left out of the information loop. Decisions about resident room changes and care plans often were made by clinicians who had never even met the patient. There were both turf wars and task avoidance. "It's not my job" became a mantra for some workers. Assignments were rotated so that nurses' aides routinely worked with different supervisors and different residents, frustrating any effort to develop a bond of friendship.

Employees were surveyed again in 1997, after the changes were made. Their responses differed dramatically. Before the restructuring, only about 10% of employees said they enjoyed their interac-

Certified nurse aide Becky Cameron assists an elder at the Anchorage Pioneer Home.

recognize the excellent services they provide, by conducting research and developing practices to improve care, by sharing information with other service providers through vehicles such as the quarterly *Network News*, by providing a voice for the direct care worker nationwide, and by facilitating networking among related groups.

According to the group, which was profiled in the March/April 1997 issue of **Aging Today**, there are more than 1 million NAs in the United States; an additional 425,000 will be needed by the year 2000 to serve the burgeoning elder population. NAs provide up to 90% of care received in nursing homes and other long-term care settings. Most are women, often single parents, and minorities working at minimum wage. ◆

Contact Leslie C. Brundige, Anchorage Pioneers' Home, 923 West Eleventh Ave., Anchorage, AK 99501; (907) 343-7206; fax (907) 343-7272. Contact Genevieve Gipson, Career Nurse Assistants' Programs Inc., 3577 Easton Rd., Norton, Ohio 44203-5661; (330) 825-9342; fax (330) 825-9378.

JOHN SHERWOOD

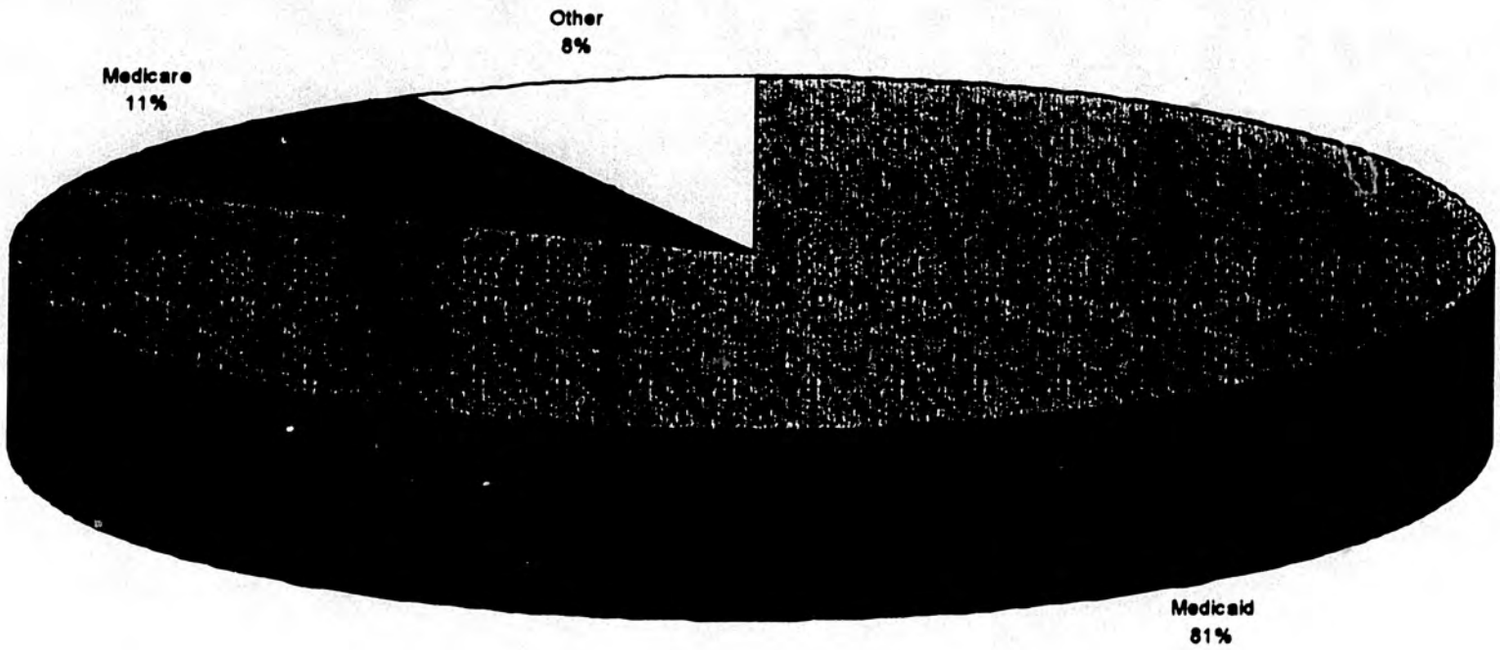
MEDICAID FINANCING OF LONG TERM CARE

A Presentation to the Long-Term Care Task Force

Jon Sherwood
Division of Medical Assistance
August 18, 1998

JOHN SHERWOOD

Sources of Payment for Nursing Home Beds
6/98



*Does not include Swing Beds

Long Term Care: What Does Medicaid Pay For?

- Nursing Homes
- Personal Care Attendant Services
- Home and Community-Based Waivers
  - Care Coordination
  - Respite Care
  - Assisted Living Services (not room and board)
  - Environmental Modifications
  - Chore Services
  - Other HCB Services

Who's Who in Medicaid Long Term Care

Division of
Public Assistance
General & Financial
Eligibility Determination

Division of
Medical Assistance
Administration of
Medicaid

Division of
Senior Services
HCB Waivers/CHOICE
Nursing Home Authorization
Personal Care Services

Medicaid Rate
Advisory Commission
Facility Rate Setting

Division of
Mental Health and
Developmental Disabilities
HCB Waivers
ICF/MR Authorization

First Health
Claims Payment

Special Medicaid Eligibility for Long Term Care

- Higher income limits for nursing home residents
- A special resource allowance for the community spouse of a nursing home resident
- HCB waiver recipients treated as if they lived in nursing homes
- Children living at home who meet an institutional level of care are treated as if they live in nursing homes (TEFRA option)
- People who need expensive long term care can qualify for Medicaid using special trusts to voluntarily impoverish themselves

Financial Eligibility Criteria for Medicaid

	Monthly Income Limit	Resource Limit
Adult Public Assistance (Selected)		
Individual	$917	$2,000
Couple - Both Eligible	$1,359	$3,000
Institutional/HCB Waiver		
Individual	$1,482	$2,000
Community Spouse Resoure Allowance		$80,760

1998 standards

Number of Medicaid Clients
In Long Term Care Status
June 93 vs. June 98

Status	Jun-93	Jun-98
Nursing Home	517	485
Older Alaskans Waiver		396
Adults with Physical Disabilities Waiver		106
Intermediate Care Facility for Mental Retardation	85	0
People with Mental Retardation Waiver		410
Children with Complex Medical Conditions Waiver		65
TEFRA Option for Children Under Age 19		291
Total Medicaid Long Term Care Caseload	**602**	**1,753**

Source:Alaska Nursing Home Census, Division of Medical Assistance and Preliminary MMIS data for FY 98.

Medicaid Expenditures for Long Term Care
Services Requiring an Institutional Level of Care
($ in thousands)

	FY 93	FY 98
Institution		
Nursing Homes	$39,902.2	$44,533.0
ICF/MR	$7,671.7	$932.9
Total Long Term Care Instititutions	**$47,573.9**	**$45,465.9**
Waiver		
Older Alaskans Waiver		**$6,730.8**
Adults with Physical Disabilities Waiver		**$1,476.9**
People with Mental Retardation Waiver		**$19,369.7**
Children with Complex Medical Conditions Waiver		**$1,905.3**
Total HCB Waivers	$0.0	$29,482.7
Total Instititutional Level of Care Service Expenditures	**$47,573.9**	**$74,948.6**

Source: Division of Medical Assistance Annual Report for FY 93;
MMIS Report MR O-91.

People in Care & Medicaid Expenditures
Adults Meeting Nursing Home Level of Care
FY 93 vs. FY 98

People Receiving Care	Jun-93	Jun-98
Nursing Home	517	485
Older Alaskans Waiver		396
Adults with Physical Disabilities Waiver		106
Total Medicaid Nursing Home Level Caseload	**517**	**987**

Expenditures ($ in Thousands)	FY 93	FY 98
Nursing Homes	$39,902.2	$44,533.0
Older Alaskans Waiver ~~(413 Individuals in 97)~~		$6,730.8
Adults with Physical Disabilities Waiver ~~(91 Individuals in 97)~~		$1,476.9
Adult Nursing Home Facility and Waiver Service Expenditures	**$39,902.2**	**$52,740.7**

Note: Nursing Home data may include a small number of children.

Source: Division of Medical Assistance Annual Report for FY 93;
Alaska Nursing Home Census, DMA; MMIS Report MR O-91.

JOHN SHERWOOD

CHRONIC CARE

THE BALANCED BUDGET ACT of 1997 is already reaping results.

The home care subsidiary of Columbia/HCA Healthcare Corp. posted a $20 million loss in this year's first quarter. Apria Healthcare Group Inc., already a sea of red ink, said its first quarter loss grew to $6.6 million. At American Homepatient, net revenue and pre-tax income fell by $6.1 million, though the fast-growing Brentwood, Tenn.-based company still reported a first quarter profit.

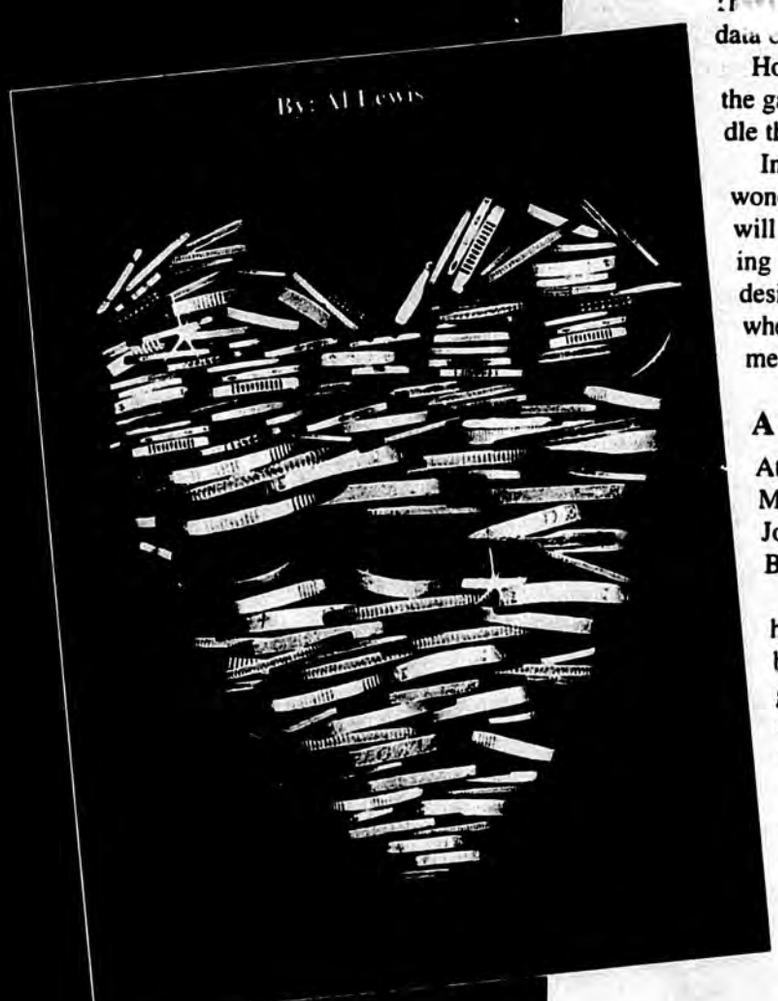
All three companies attributed these dramatic declines, in part, to reduced reimbursements under the Balanced Budget Act.

"I think it's fair to say that home health is in a firestorm right now," said Elizabeth Hogue, a Washington D.C.-based health care industry attorney. "My guess is that it will end in about another year or so. But in the meantime it's going to be very difficult."

Under an interim payment system put in place between now and fall 1999, many home care agencies can not even calculate what they will be paid for basic services during this period. There are new per patient caps imposed, but not all the data on how to calculate the caps have been released.

Hogue said her home care clients' reactions run the gamut: "Some are saying, 'we think we can handle this,' others are sort of suicidal."

In the midst of this uncertainty, many observers wonder about the plight of the chronically ill. How will they fit into a system that is constantly squeezing providers? And how will providers continue to design disease management programs and the like when it appears Medicare and Medicaid reimbursement won't pay for them?



A POSITIVE OUTLOOK

At Amcare Medical Services Inc. in Newton, Mass., Vice President of Business Development Joseph Martini, does not worry about the Balanced Budget Act.

"A lot of that is with the nursing side and that hasn't really affected us," he said. "There have been reductions in reimbursement rates for oxygen therapy and that's affected us. But we are taking the lead in bringing disease management into the home."

For the past four years, Amcare has been developing and operating disease management programs for asthma, chronic obstructive pulmonary disease and obstructive sleep apnea, achieving impressive results.

Amcare's asthma program at one large managed care organization resulted in an 87

percent decrease in hospitalizations and a 66 percent decrease in emergency room visits over two years.

"As people were increasingly watching the dollars, we have been quietly building up evidence that our interventions save money in the long run," Martini said. "With the government, there's no one to really talk to about that. But with managed care organizations, you find a much more receptive audience."

The staffers Amcare sends to homes are trained in respiratory therapy, home care and education. When they go into a home, they not only teach patients how to manage their ailments, but identify factors in their homes that may be exacerbating their conditions, and involve family members in the treatment process.

"We do a complete assessment of the environment," Martini said. "And we help both the patient and the family understand the disease and what they need to do to help manage the disease themselves."

Does Medicare and Medicaid pay for this?

No, says Martini. Amcare works exclusively with managed care providers such as United Healthcare of New England, Harvard Pilgrim Health Care, Blue Cross and Blue Shield of Rhode Island and Neighborhood Health Plan of Rhode Island.

But won't these managed care organizations be forced to abandon home care-based disease management programs under the constraints of the Balanced Budget Act? No, says Martini again.

"If you don't give the chronic patient ongoing care, they're going to wind up in the hospital," he explained. "At managed care organizations, people are looking at patient populations holistically. If you can demonstrate an overall savings and a higher quality of care to the patient, they generally will work with you."

Martin concedes it will be more difficult for home care and disease management companies to work directly with government payors under the Balanced Budget Act, but he believes the act may force more Medicare and Medicaid patients into managed care programs. And that, in turn, expands the pool of prospective patients for his own brand of disease management in the home.

Consequently, in a round about way, he believes the Balanced Budget Act will benefit disease management programs.

"Now, people are going to be much more receptive to what we've been saying for a long time," he said. "We have some ways to help the patient and the family manage the disease process and we can reduce overall costs."

Optimism Not Pervasive

Though Martini and many other players in the emerging disease management arena speak confidently in the face of great unknowns, not everyone is as certain.

"I don' see how this will force Medicare beneficiaries into managed care," said Hogue. "Besides, managed care plans generally pay even less than Medicare does."

As the government puts the squeeze on health care providers, it is clear only those disease management programs that can actually demonstrate a cost savings will survive. In the grand scheme, those programs are rare.

"We certainly see lots of positive results that show the ability to impact disease," said Mark Zitter, president of The Zitter Group, an outcomes research education and publishing company in San Francisco. "But we see fewer studies that show net cost savings. It's a lot easier to say somebody got better than it is to say how much was saved. That analysis is a bit trickier."

Many say disease management has a long ways to go. Some programs are nothing more than the glorified marketing schemes of pharmaceutical manufacturers. Others show great promise, at least anecdotally, but don't have reliable numbers to back their claims.

Like home care itself, disease management is a phenomenon that is developing regionally. In areas where it is already strong, observers say it is more likely to take hold. But the Balanced Budget Act may have an adverse affect in areas where such programs have not been fully developed.

A National Focus On Chronic Disease

"How we service people with chronic conditions across settings and overtime has a profound effect on our ability to contain healthcare costs," said Richard Bringewatt, president and chief executive officer of the National Chronic Care Consortium. "Simply slashing payments under current structures will not contain costs and ensure quality over the long term.

"It's kind of a mixed blessing," he said of the Balanced Budget Act. "There are some things in it that are good, like a national focus on chronic disease and like a focus on outcomes. But the Act hasn't given enough of a focus on the problem."

Bringewatt's group is part of a national coalition working to make chronic care the focus of Medicare and Medicaid reform.

The group's members include the American Association of Homes and Services for the Aging, the American College of Physicians, the American Hospital Association, the Catholic Health Association of the United States, the National Chronic Care Consortium, the National PACE Association and the Social HMO Demonstration. While members of the coalition have differing views and pursue independent legislative agendas, they are committed to collaboration among purchasers, payors, providers and consumers in finding person-centered, systems-oriented solution to issues of chronic disease and disability.

To the coalition, the equation is simple: People with chronic diseases and disabilities represent the most expensive and fastest-growing group of patients in health care.

According to the groups literature:

- ♥ Almost 100 million Americans have one or more chronic condition.
- ♥ In the next 25 years, the number of people with chronic conditions will grow by 35 million.
- ♥ Nearly 70 percent of the nation's personal healthcare expenditures is for people with chronic conditions.
- ♥ 90 percent of all morbidity and 80 percent of all deaths are related to a chronic condition.
- ♥ More than one-third of all Americans are at risk of having their chronic condition limit their daily activities.
- ♥ Direct medical costs for people with chronic conditions will nearly double by the year 2050.
- ♥ Medicare and Medicaid cover more than 60 percent of long-term care costs.

To the coalition, the focus of all health care reforms should be reducing incidence rates of chronic disease.

"The national debate is on the wrong stuff," said Bringewatt. "We are caught up with policy fights around places where care is provided as opposed to how people are being served. Instead of focusing on the problem, we're having fights about how much money should go to home health and how much should go to hospitals.

Circle 102 on Reader Service Card

"We're locked into short-term, cost-containment rather than looking at costs as they evolve over time," Bringewatt said. "If you take managed care at its simplest level, one would think that dollars would move to home and community-based services and other kinds of methods that we know to be most cost-effective over time. Yet we seem to be organized in a way that locks in outmoded institutions and then ratchets down their costs. Under this system, dollars won't always float to do what's cost-effective."

The Chronic Care Coloration aims to establish a National Chronic Care Act. "Our intent is to get Congress to shift its focus from ratcheting down costs piece by piece to looking at problems of chronic disease and disability," Bringewatt said.

The coalition also has set several short-term policy objectives:

- ♥ Establish problems of chronic disease and disability as a national priority.
- ♥ Better respond to consumer needs.
- ♥ Integrate Medicare and Medicaid managed care programs for the chronically ill.
- ♥ Simplify and standardize Medicare, Medicare and other public programs.
- ♥ Provide a broader range of managed care options and establish other integrated payment methods.
- ♥ Offer incentives for all providers to establish new methods consistent within this policy framework.

Fog In The Forest

At the think-tank level it is perhaps easier to see the forest from the trees. At the provider level, many agencies find themselves lost in the woods. Hogue relays a story of a home care provider in Worthington, Texas, that was told that it would only receive $13.10 per skilled nursing visit under the interim payment system now in place.

"You can't even get someone to look at your house for termites for $13.10," she exclaims.

Meanwhile, most other agencies do not yet know what their rates will be under the interim payment system. The caps are being set by the Health Care Finance Administration under extremely complicated formulas.

"Can you imagine saying to a business person, we want your services and you are going to provide them for months at a time, but we're just really not quite sure what we're going to pay you for them?" asks Hogue. "If somebody called and said that to me, I'd say you better find yourself another lawyer." How is it exactly that providers are supposed to be in business for all these many months when they do not know what they are being paid?"

Such questions leave many to wonder about the fate of people with the long-term illnesses, especially in a system that not only puts caps on services, but on patients as well.

(more on page 8)

"When you have a per-beneficiary cap, it puts a lot of pressure on agencies to have fewer long-term, high-intensity chronically ill patients," said Hogue.

To make the system work, Hogue said home care providers will favor patients with short-term ailments. How else will they be able to balance out their books to meet the per beneficiary cap?

"Under the old system of reimbursement, all you had was a cost cap and your cost cap was to some extent dependent upon your volume of visits," she said. "It was sort of like a big tent theory. But now with the imposition with this additional per beneficiary cost cap, agencies are saying whoa, we can only take so many of these patients.

"The Balanced Budget Act really means that agencies are likely to be reluctant to take in long-term chronic care patients the way that they used to."

Corrective Environment

Hogue sees the current payment system, as it applies to home care agencies, as punitive or at least corrective.

"Right now, I think the government is generally convinced there is fraud, abuse and waste in the home care industry and that needs to be fixed," she said. "Also, I think we've always got to account for the fact that home care is a relatively new model of care. We don't really know whether national home care will work from a business perspective or a quality of care perspective. And we cannot answer with verifiable data many of the key questions about home care. It's still an emerging industry and I think that's part of what we're all wrestling with right now.

"What will home care look like in the future? What HCFA is telling us is that it better not look like it's looked like in the past." In the end, Hogue believes the home care industry will prevail over the trials and tribulations of the day.

"It is so consistent with all of the policy objectives we have set for ourselves in this country – keeping people out of institutions and lowering costs. I think it's got a very bright future but for now, I think there are a number of adjustments that home care providers are going to be making."

Though in some ways government-distorted economics are working against chronic care in the short-term, health care providers clearly need to focus on the problems of the chronically ill for the longer haul.

"Just be tenacious about it," Bringewatt said. "Take some risks and do the best you can to prove outcomes and cost reductions, because providers with effective management of chronic diseases and disabilities are going to be the players of the future."

"As we enter the 21st century, that's only going to get more pronounced," he said. "When you consider the aging of Americans and new care interventions that allow us to do things on an inpatient basis, it's going to be those who can solve the problems of chronic disease and disability who will prevail." **RR**

The national debate is on the wrong stuff," said Bringewatt. "We are caught up with policy fights around places where care is provided as opposed to how people are being served.

JOHN SHERWOOD

Medicaid in Alaska
Fiscal Year 1997

State of Alaska

Dept. of Health & Social Services

Division of Medical Assistance

A special thanks to Lisa Simono of the Dept. of Health and Social Services for her contribution of photos used in this report.

A Message From the Director

Dear Reader,

Welcome to the FY97 Annual Report of the Division of Medical Assistance.

This year's report is dramatically different from previous years. It has been streamlined and is presented in an easy-to-read format, allowing quick access to needed data. You will notice that the sometimes lengthy text describing our programs is absent. We have decided to include this information in another of our publications, "Introduction to Medical Assistance in Alaska," which will be produced every other year.

Since our division deals with issues on a very personal level, our annual report must focus more on the human side of medical assistance. Because of that, we are profiling a person who has used the Medicaid system for health coverage and a person who provides services. We feel these two people exemplify the idea behind medical assistance in Alaska: to provide the best possible health care services for those that fit the eligibility criteria.

We hope you find this year's report informative and interesting to read.

Sincerely,

Bob Labbe

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Table of Contents

Defining Medical Assistance 4

Overview of Medical Assistance 4

Highlights & Initiatives 7

FMAP Change 7
Managed Care Pilot Programs 7
Long Term Care 8
Mental Health Coverage 9
MMIS Reprocurement 10
Provider Fee Schedule 11
Rural Hospital Regulations 11
Facility Cost Containment Regulations 12
Increasing 100% Federal Reimbursement for Natives 12
Instituting Claims with the Indian Health Service 12

Our Beneficiaries 13

Medicaid Eligibles and Recipients 13
Profile: Kristy Hinkle 14
Profile: Dr. William Larson 15

Financial Summary 17

State Only Programs 23
Alternatives to Institutional Care 24

Home and Community-Based Care 24
TEFRA 24
Personal Care Attendant Services 25

Keeping Children Healthy 25

Medicaid Healthy Baby Program 25
Medicaid Healthy Kids Program 25

Mental Health Services 26
Indian Health Service & Tribal Facilities 28
Providers Billing Medicaid 29

Charts, Graphs, and Tables

5	Program Overviews
6	Medicaid Statistics FY94 - FY97
6	FY97 Medicaid Expenditures
6	FY97 Medicaid Eligibles
13	Medicaid Eligibles and Recipients
16	Alaska Medicaid Eligibility by Qualifying Need Standard
17	FY97 Medicaid Expenditures by Categories of Service
18	FY97 Medicaid Expenditure Distribution by Eligibles
19	FY97 Medicaid Eligibles, Recipients & Expenditures by Categories of Assistance
19	Average Yearly Cost Per Medicaid Eligible
20	FY97 Medicaid Expenditures by Categories of Assistance
21	FY97 Medicaid Eligibles, Recipients & Expenditures by Race
21	FY97 Medicaid Eligibles, Recipients & Expenditures by Sex
22	FY97 Medicaid Eligibles, Recipients & Expenditures by Age Group
23	FY97 State Funded Medical Assistance Programs Expenditure Distribution by Eligible
24	Home and Community-Based Care Program FY97 Utilization and Expenditures
25	Total Births in Alaska/Healthy Baby Program/AFDC Births
26	FY97 Community Mental Health Services for Children (under 21 years)
27	FY97 Community Mental Health Services for Adults (age 21 and over)
28	Summary of FY97 IHS Billings by Facility
29	Claim Documents Processed (FY88-FY96)
30	Expenditures and Patient Days Utilized: Long Term Care Facilities
31	Expenditures and Patient Days Utilized: Inpatient Facilities
32	FY97 Total Expenditures Summary with Collocation Code

A Note to Readers Regarding Data Used in This Report

The Medicaid Management Information System (MMIS) is used to process claims for medical services provided to Medicaid recipients and tracks the eligibility of providers and Medicaid beneficiaries. Data extracts from the MMIS claims processing are the basis for the majority of the tables and graphs pertaining to Medicaid program participation and financial activity in the annual report. Readers should be aware that limitations exist in reporting Medicaid data.

The Medicaid program is a dynamic environment. For that reason reports that summarize annual Medicaid program expenditures and provider and beneficiary participation are based on data at a point in time, e.g., a data "snapshot" of Medicaid taken at June 30, 1997. Program activity is related to claims paid in the period July 1, 1996 through June 30, 1997. A point in time is used because Medicaid eligibility policy allows for eligibility determinations that can be applied retroactively and because persons who were denied eligibility may appeal, which results in a lag time between when a person is determined to be eligible and the period for which that eligibility applies. Similarly, if an expenditure report were based on the dates a person received services instead of when a particular claim was paid, the values would be markedly different from the report based on date of payment.

Medical Assistance

The Division of Medical Assistance, within Alaska's Department of Health and Social Services (DHSS), administers programs that are designed to help residents meet their medical needs: Medicaid and General Relief Medical (GRM). The Permanent Fund Dividend Hold Harmless (PFDHH) and the Alaska Longevity Bonus Hold Harmless (ALBHH) programs are also available to help Medicaid recipients maintain Medicaid eligibility. While the GRM, PFDHH and ALBHH programs are vital to the health care of many Alaskans, this report will emphasize the Medicaid program as it serves more people and requires greater expenditures.

Overview of Medical Assistance

Medicaid is an "entitlement program" created by the federal government, but administered by the state, to provide payment for medical services for low-income citizens. People qualify for Medicaid by meeting federal income and asset standards and by fitting into a specified eligibility. Under federal rules, DHSS has authority to limit services as long as the services provided are adequate in "amount, duration, and scope" to satisfy the recipient's medical needs.

Medicaid began as a program to pay for health care for poor people who were unable to work. It covered the aged, the blind, the disabled, and single parent families. Over the years, Medicaid has expanded to cover more people. For instance, children and pregnant women may qualify under higher income limits and without asset limits. Families with unemployed parents may qualify, and families who lose regular Family Medicaid because a parent returns to work may continue to be covered for up to one year.

There have also been changes in the eligibility rules for people who need the level of care provided in an institution, such as a nursing home. Now, most Alaskans who need — but cannot afford — this expensive care may qualify for Medicaid. In addition, recent changes within the Alaska Medicaid program give some people who need an institutional level of care the opportunity to stay at home to receive that care.

General Relief Medical (GRM) is a 100% state-funded medical assistance program that pays for a very limited amount of health care services for very low income adults who do not qualify for Medicaid. Covered services include limited inpatient hospital stays and prescription drugs for individuals with certain chronic illnesses.

The Alaska Legislature created the ***Permanent Fund Dividend Hold Harmless*** program (PFDHH) to protect those Medicaid clients who would lose their eligibility as a result of receipt or retention of the Permanent Fund Dividend. Receipt of the PFD

How it works

Eligibility for Medicaid is determined by the Division of Public Assistance according to federal and state rules. The case worker will look at age, income, assets, disability status, and other factors to determine what eligibility category will work. Once determined eligible, the individual will be assigned a unique identification number and issued a Medicaid coupon, which contains information on removable labels. For the most part, recipients are able to choose their own health care provider, but before Medicaid will pay the medical bill, the provider must be enrolled with the Medicaid program. When services are provided, the enrolled provider removes one of the labels and sticks it on a special claim form. Some providers are also able to submit claims electronically. All prescription drug claims are submitted electronically. Before Medicaid reimburses the provider, a claim review is done to make sure the claim fits within acceptable medical and fiscal guidelines. Reimbursement rates for physicians and other private practice providers are established according to a methodology that assigns a relative value to the service provided. Hospital and nursing home rates are established by a special rate setting commission. Except for established recipient cost sharing amounts, providers must agree to accept the Medicaid rate as full reimbursement and not require the recipient to pay more.

may force client income over the qualifying income limit. Under the PFDHH program, the state maintains the client's eligibility for up to four months by using state funds to pay for medical services.

The ***Alaska Longevity Bonus Hold Harmless*** (ALBHH) program was created by the Alaska Legislature to protect Medicaid clients from losing their Medicaid eligibility as a result of receiving the bonus. Without the program, some recipients would be over the qualifying Medicaid income limit. Starting in October 1991, the ALBHH program underwent a significant reduction as the Division of Medical Assistance took advantage of a federal policy change allowing exemption of ALBHH income for most Medicaid recipients. Relatively small, the ALBHH program in FY97 cost the state $43,258 to provide services for 10 recipients.

The chart below provides a general overview of the three main programs supported through the Division of Medical Assistance (DMA): General Relief Medical (GRM), Permanent Fund Dividend Hold Harmless (PFDHH), and Medicaid. The distribution of eligible persons is shown according to major groupings of race, age, and location. Expenditures are shown according to major services categories.

	GRM		PFDHH		Medicaid	
FY97 Eligibles	856		764		87,977	
Race Distribution	White	79%	White	47%	White	45%
	Black	9%	Alaska Native	42%	Alaska Native	37%
	Hispanic	3%	Black	4%	Black	6%
	Asian	3%	Asian	2%	Hispanic	4%
	Unknown	2%	Hispanic	2%	Asian	3%
	Alaska Native	2%	American Indian	1%	Unknown	2%
	Pacific Islander	2%	Unknown	1%	Pacific Islander	2%
	American Indian	1%			American Indian	1%
Age	21-44	61%	21-44	75%	21-44	27%
	45-64	36%	45-64	13%	6-14	24%
	15-20	2%	65+	5%	1-5	19%
			15-20	3%	15-20	10%
			6-14	2%	0	7%
			1-5	1%	65+	6%
					45-64	6%
Eligibles by location	Anchorage	46%	Anchorage	25%	Anchorage	34%
	Fairbanks	11%	Fairbanks	7%	Fairbanks	7%
	Wasilla	8%	Wasilla	6%	Wasilla	5%
	Juneau	4%	Palmer	5%	Juneau	3%
	Palmer	4%	Emmonak	2%	Palmer	3%
	North Pole	3%	Kodiak	2%	Ketchikan	2%
	Soldotna	3%	Kipnuk	2%	Kenai	2%
	Ketchikan	2%	Togiak	2%	Soldotna	2%
	Sitka	2%	Nunapitchuk	2%	North Pole	2%
	Homer & Eagle River	1%	Delta Junction	2%	Kodiak	2%
	Kodiak & Big Lake	1%	Soldotna	2%	Homer	1%
Expenditure by Category of Service	Physician	41%	Nursing Home	65%	Hospital	34%
	Hospital	34%	Hospital	13%	Physician	17%
	Pharmacy	15%	Physician	9%	Nursing Home	12%
	Other	6%	Pharmacy	5%	Physician	17%
	Transportation	3%	Mental Health Clinics	3%	Mental Health Clinics	10%
	Nursing Home	1%	Other	3%	Other	8%
			Transportation	2%	Pharmacy	7%
					Waivers	5%
					EPSDT	4%
					Transportation	3%
Expenditures	$3,412,864.51		$453,441.69		$349,170,283.57	

The following table compares changes in the Medicaid program from FY94 to FY97. During FY97, the total number of eligibles grew 0.9% from FY96. The number of recipients grew by 1,571, or 2.3%, compared to a decrease in recipients in FY96 of 131. The increase in recipients could be attributed to several factors, including an increase in the number of people receiving waivered services.

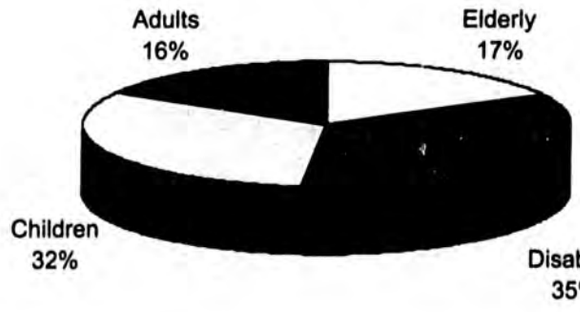
Medicaid Statistics FY94 - FY97

	FY94	% Chg. (94-95)	FY95	% Chg. (95-96)	FY96	% Chg. (96-97)	FY97
Eligibles	83,920	3.0%	86,445	0.8%	87,159	0.9%	87,977
Recipients	69,631	0.2%	69,739	-0.2%	69,608	2.3%	71,179
Pct. of Eligibles Participating	83.0%	-2.8%	80.7%	-1.0%	79.9%	1.3%	80.9%
Cost Per Recipient	$3,491.42	5.6%	$3,686.20	9.0%	$4,016.19	1.5%	$4,077.75
Cost per Eligible	$2,896.94	2.7%	$2,973.82	7.9%	$3,207.46	2.9%	$3,299.16
Providers Participating	2,819	2.4%	2,887	8.0%	3,119	7.0%	3,337
Payment Per Participating Provider	$86,240	3.3%	$89,045	0.7%	$89,631	-3.0%	$86,979
Total Reimb. for Claims Paid**	$243,111,100	5.7%	$257,071,900	8.7%	$279,559,000	3.8%	$290,250,300
Claim Lines Processed*	2,053,070	0.7%	2,067,963	10.7%	2,289,193	8.3%	2,478,250
Paid Claim Lines	1,847,046	-2.2%	1,807,108	6.1%	1,917,994	8.9%	2,088,176
Processed Claim Lines Paid	90.0%	-2.9%	87.4%	-4.1%	83.8%	0.6%	84.3%
Payment Per Paid Claim	$131.62	8.1%	$142.26	2.5%	$145.76	-4.6%	$139.00
Paid Claims Per Recipient	26.5	-2.3%	25.9	6.3%	27.6	6.5%	29.3
Pd. Claims Per Participating Provider	655.2	-4.5%	625.9	-1.8%	614.9	1.8%	625.8

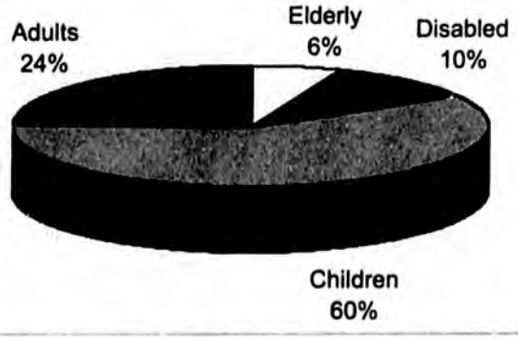
*Value slightly underreported; represents processed lines identifiable as Medicaid. Excludes claims denied which lack an eligibility determination.
**Excludes DMHDD general fund dollars for NF & ICF/MR ($9 million) as well as payments to the Indian Health Service and Medicaid state programs.

The chart below on the right shows the percentage of Medicaid eligible beneficiaries according to typical groupings. The chart on the left shows the percentage of expenditures for direct services provided to persons in the typical groups. Children (less than 21 years of age) account for the majority of the eligible population (60%), but they only cost an average of $1,773 for services. Adults (ages 21 through 64) cost an average of $2,227 in FY97. The elderly (age 65 and over) cost $9,161 per eligible and account for 17% of the eligible population. The most costly eligible group was adults and children with disabilities at $11,202 per person. Medicaid expenditures derive from the sum of amounts paid for Medicaid facility, non-facility, Indian Health Services, and waivered services only.

FY97 Medicaid Expenditures



FY97 Medicaid Eligibles



Highlights & Initiatives

Alaska's Medicaid program realized many changes during fiscal year 1997, including an increase in the Federal Medical Assistance Percentage (FMAP), changes in the federal reimbursement for services delivered to Alaskan Natives, and the initiation of two managed care pilot programs, among others. These changes have helped the state's Medicaid program become more efficient and, to some degree, have increased the availability and number of services provided.

FMAP Change

Since the early 1990s, Alaska has been attempting to change the Federal Medical Assistance Percentage (FMAP) rate for Medicaid. The Federal Poverty Level (FPL), used to determine financial eligibility for assistance programs, has always been adjusted for Alaska to take into account the higher cost of living in the state. However, the formula for determining the federal match rate (which uses a state's per capita income) has never been similarly adjusted. This year, in the Balanced Budget Act of 1997, the federal match rate for Alaska was changed for a three year period from 50% to 59.8%, resulting in an annualized savings of $29.7 million (the amount for FY98 is less by $7.4 million because of the overlap of the state and federal fiscal years, resulting in one-quarter funded at the old federal match rate).

Managed Care Pilot Programs

During the 1996 legislative session, Rep. Norman Rokeberg introduced House Bill 393 instructing the Division of Medical Assistance to introduce two managed care pilot projects for the Medicaid beneficiary population. After considerable research, review and planning, the division developed and implemented two managed care pilot projects, Telephone Triage and Care Coordination.

The ***Telephone Triage*** pilot project began in May 1997 and is offered in three areas of the state: Fairbanks, the Mat-Su Valley, and the Kenai Peninsula Borough. DMA contracted with CareWise, a company with over 14 years of experience to staff the triage call center. The division's Care Management Teams oversee the quality of the service, the marketing of the program, consumer satisfaction, and evaluation of the program's effectiveness. The Telephone Triage pilot project provides 24-hour, 365 day a year access via a toll free number to a highly trained registered nurse. The service is currently available to over 25,000 Medicaid beneficiaries. The triage nurses provide callers with information and guidance on whether to seek medical care immediately, call their doctor, or consider self-care options. The nurses can also refer the caller to a primary care provider in their area if they do not have one.

Approximately 80% of all calls received by the Telephone Triage program are from women who have questions about either their baby's health or their own.

With permission from the caller, the nurse faxes a chart report to the doctor or receiving health care facility. The pilot project provides immediate access to medical advice so that beneficiaries can choose the appropriate level of care or get medical information. This program decreases inappropriate use of the emergency room and supports the callers in their decision making about seeking care and staying

healthy. This program has been very popular and early next spring the division will be evaluating its effectiveness in terms of reducing inappropriate emergency room usage, consumer satisfaction, and clinical outcomes.

The ***Care Coordination*** pilot project, initiated in June 1997, is designed to coordinate health care services to seriously ill, medically complex Medicaid beneficiaries in the Anchorage area who do not have access to coordination services through any other Medicaid program. PRO-West, the contractor for this project, has a Registered Nurse Care Coordinator in the Anchorage office who works telephonically and in person to collaborate with the patient, the family, and the care providers to assess, plan, implement, monitor and evaluate options and services to best meet the patient's health needs. The division's Care Management Team oversees the quality and effectiveness of this program in terms of patient outcomes, consumer satisfaction, and cost savings. The goal of this project is to assist the patient in getting immediate access to needed medical care minimizing red tape and the duplication of services, while ensuring that the patient has the necessary level of care to reduce the risk of rehospitalization and costly medical complications. The division will be evaluating this pilot project during spring 1998 to determine its effectiveness in terms of improved patient outcomes, consumer satisfaction, and cost savings.

The Division of Medical Assistance has been working with the Yukon-Kuskokwim Health Corporation (YKHC) in Bethel on a managed care pilot project for rural Alaska. While YKHC is developing the capacity to enter into a contractual relationship with Medicaid in the future, the division is focusing on a transportation brokerage waiver with the corporation. Several states have obtained waivers from HCFA for brokering transportation to a private vendor in order to save money and provide services more efficiently; the broker negotiates rates with transportation vendors and takes over the functions of authorizing medically necessary transportation. As half of the Medicaid transportation budget is used by recipients living in Bethel and the 52 villages in the YK Delta, the division believes that program savings can be addressed by a brokering system while increasing access.

Alaska's elderly Medicaid population now has the option of receiving home and community-based care instead of relying on nursing homes to provide for their needs. The process for being accepted onto the Older Alaskans waiver, which is handled by the Division of Senior Services, has been significantly streamlined.

Long Term Care

Over the last several years, home and community-based alternatives to institutional long term care in Alaska have increased dramatically, in part because of expansion of Medicaid coverage of these services. However, it was also becoming apparent that there were significant barriers to accessing this type of care. A number of state agencies were responsible for funding or providing long term care services for Alaskans. People who needed long term care, and people trying to provide it, often had to deal with a number of agencies, points of entry, program requirements, and funding mechanisms; the situation was especially difficult for people who were trying to receive care while remaining at home or in another residential setting. As home and community-based care is often less expensive than institutional care and preferred by the client, the result was a less efficient, less responsive long term care system.

Beginning in FY96, the Division of Medical Assistance began working with other state agencies and providers to streamline access to home and community-based care and to consolidate management of Medicaid long term care services with the state agencies

responsible for administering other programs for clients who need this care. In FY97, the major emphasis of this effort was to consolidate management of Medicaid home and community-based long term care services with the Division of Senior Services (the elderly and adults with physical disabilities) and the Division of Mental Health and Developmental Disabilities (people with developmental disabilities and for children with complex medical conditions). At the same time, management of home care service grants, previously with the Division of Public Health (DPH), were transferred to DSS. Positions responsible for managing long term care services were transferred from the Divisions of Medical Assistance and Public Health to DSS.

As a result, people can access long term care services, whether Medicaid funded or not, without having to go through the Division of Medical Assistance for approval. This streamlines the process of obtaining long term care services. The division will continue this process further by implementing preadmission care plan counseling, provided by DSS, for people seeking nursing home admission. This counseling will help ensure that clients have access to their choice of services, while avoiding expensive institutional placements unless it represents the client's choice. For information regarding long term care expenditures, please see page 30 of this report.

Mental Health Coverage

Regulations were promulgated by DMA in 1992 that defined Medicaid coverage of mental health clinic and rehabilitation services for adults and children. These regulations implemented legislation (House Bill 545) that added mental health and substance abuse rehabilitation services to the list of Medicaid covered services This provided a mechanism for reducing general fund expenditures for mental health services grants paid by the Division of Mental Health and Developmental Disabilities (DMHDD) by shifting funding of these expenditures to Medicaid where federal matching funds were available.

Since 1992, Medicaid expenditures for mental health services provided by DMHDD community mental health grantees have more than tripled. Mental health surveillance and utilization review (SURS) cases indicated a need for on-site reviews of CMHC patient records to verify that services paid for by Medicaid were provided in compliance with Medicaid regulations.

As DMHDD is the state agency responsible for the development and administration of programs that provide for the care and treatment of Alaskans who experience mental illness, a joint project between that division and DMA was indicated. The "Mental Health Quality Assurance/Utilization Review Project" was initiated with the general aim of providing the framework for continued federal financial participation for mental health rehabilitation services provided under the Alaska State Plan for Medical Assistance and the DMHDD Community Mental Health Program. The project is designed to result in a quality assurance/utilization review and assessment program for Medicaid mental health services ensuring that clinically appropriate, medically necessary mental health services are provided to Medicaid eligible children and adults in the least restrictive and most appropriate environment. The project prescribes certain functions and deliverables including data gathering, analyses, and reports, technical assistance and training to Medicaid enrolled CMHC grantees, periodic program reviews, and other functions administered by DMHDD.

DMHDD performed the first of these Quality Assurance Reviews (QAR) in February 1996. Based on DMA evaluations of the initial QAR reports, it was determined that further financial review of certain CMHCs was needed. During October 1996, DMA contracted with PRO/West, a professional review organization, to perform on-site reviews of twelve CMHCs. PRO/West performed detailed reviews of the clinical records of thirty recipients with the highest rates of service utilization from each of the twelve CMHCs, comparing these records to billings for Medicaid services. The DMHDD QA reviews and the PRO/West reviews found that overpayments were made to the CMHCs. DMA then requested that these providers repay $2,162,067 to the Medicaid program.

Several of the CMHCs have appealed these findings and their cases are currently in various stages of the appeal process. The final repayment figure will likely change with the resolution of these appeals.

MMIS Reprocurement

Since 1979, Alaska has moved from a manually intensive, state-operated claims payment system, to a semi-mechanized state/contractor operation, to the current fully mechanized fiscal agent-operated claims processing system known as the Alaska Medicaid Management Information System (MMIS) which is a federally certified MMIS. Operation costs of the system are eligible for enhanced federal financial participation (FFP) matching rate of 75%.

Federal regulations require that MMIS contracts be periodically competitively reprocured. The Division of Medical Assistance prepared and submitted to the federal Health Care Financing Administration (HCFA) an advance planning document requesting an enhanced (90%) FFP for the design development, modification and implementation of a new Medicaid Management Information System. This request would fund a more flexible, responsive, and automated claims processing and information retrieval system which would enhance the state's program management, claims processing, and reporting capabilities. This would be achieved by the new MMIS's incorporation of cost effective technological improvements.

During FY96 the division issued a Request For Proposal (RFP) to procure a new federally certified MMIS. The state received only one bid in response to the RFP. That bid represented a 40% increase in operating costs as well as a $22 million development effort. The proposer also offered some solutions which were still only in the vendor's conceptual stage. Following extensive negotiation with the vendor to reduce the proposed costs the division during FY97 elected not to award a new fiscal agent contract. The improvements offered in the proposed system were not adequate to justify the high cost and staff resources necessary to implement the system to Alaska's requirements.

Public Health Nurse Carol Histand attends to Kathlynn Payton, one of Kenai's newest residents. The Medicaid Services Unit, a section within the Division of Public Health, administers the Healthy Baby and Healthy Kids programs. For information regarding these programs, please see page 25 of this report, or you may contact the Medicaid Services Unit at (907)465-2845.

DMA has taken time to consider options and to allow the Congress to resolve issues of Welfare and Medicaid reform. The division believes the uncertainty surrounding these national and state programs discouraged potential vendors from participating in the procurement. Additionally, some states have begun to explore different strategies for promoting competition and quality systems. The division will proceed slowly by evaluating these efforts in other states before attempting another reprocurement. Consequently, the division has extended its current fiscal agent contract through December 30, 1999.

Provider Fee Schedule

On February 1, 1997, the division implemented a fee schedule for physicians and other private practitioners that was the culmination of nearly three years of effort. The division hired a contractor in 1994 to create a data base for RBRVS (Resource Based Relative Value Scale) projections and formed a Physician Advisory Committee with volunteer members of the American Medical Association to advise on RBRVS policy and other issues facing the Medicaid program. The division adopted the Medicare RBRVS, which creates a relative value for each medical procedure based on complexity and amount of time necessary to perform the required tasks, related overhead, and malpractice costs. Adoption of the RBRVS replaced the previous system of reimbursement that paid physicians based on historical billing practices, and other practitioners at 80 percent of charges. The fee schedule assures equity in reimbursement among physician specialty types, and adopts a national standard for valuing procedures that receives annual review by a physician committee advised by numerous subcommittees of specialty practitioners.

Rural Hospital Regulations

The utilization of local hospitals in Alaska has declined over the past several years and facilities in rural areas have been stressed by regulation and shrinking revenue. This situation has also contributed to a decline in the professional resources available to these hospitals. As a result, many of the rural hospitals are no longer able to provide the comprehensive level of services to the communities that has traditionally been seen in the past.

In 1996, state regulations required hospitals to be able to provide a wide and traditional spectrum of services. This was problematic for those hospitals unable to provide those services and maintain state licensure. In response to the increasing concerns, the Division of Medical Assistance met early in 1996 with administrators from some of the small rural hospitals and the Alaska State Hospital and Nursing Home Association (ASHNHA) to determine which, if any, state requirements might be altered or repealed to provide regulatory relief to rural hospitals.

Later that year the Department of Health and Social Services proposed to amend, repeal, and adopt regulations in Title 7 of the Alaska Administrative Code dealing with hospital licensure to create two types or levels of acute care hospitals: General Acute Care Hospitals and Rural Primary Care Hospitals. A rural primary care hospital would not be mandated to provide all the services required of a general acute care hospital.

With the approval and implementation of the regulations in May 1997, the first level of limited-service rural hospital was created, which allows for existing rural hospitals to downsize their operations by making some services optional, such as obstetrical, surgical and anesthesia. With this option, rural hospitals can choose to limit services, based on utilization and availability of resources without affecting federal Medicare/Medicaid certification and without the need for waivers to federal or state requirements.

Two hospitals, Providence Seward Medical Center & Cordova Community Medical Center, are currently licensed as Rural Primary Care Hospitals.

Facility Cost Containment Regulations

During the past two years, the Medicaid Rate Advisory Commission (MRAC), under the auspices of the Dept. of Health and Social Services, has been working on formulating and implementing regulations which improve the rate setting process used for hospitals and nursing homes while containing Medicaid program costs. The regulations were implemented in January 1997.

Provisions which improve the rate setting process included expanding and defining timelines for activities in the process; removing penalties to Medicaid payment rates for late filing of reports by facilities; removing unnecessary calculations and reporting forms; providing an opportunity for facilities to amend reports submitted to the department; and adjusting calculations to use more current cost information as the basis for establishing the prospective payment rates.

One provision in the regulations which focused on cost containment applied an occupancy standard in the calculation of nursing facility per diem payment rates. Application of this provision will reduce Medicaid payments to those nursing facilities which maintain surplus bed capacity, and discourage providers from building unneeded nursing facility beds.

Other changes which improved the rate setting process while containing costs for the Medicaid program include expanding by one year the time available to audit and work with facilities to complete the rate setting process; changing and simplifying the manner in which capital is calculated for purposes of Medicaid rate setting; clarifying that certain costs are not allowable for purposes of Medicaid rate setting and reimbursement; revising and clarifying the manner in which the year-end conformance calculation is performed; clarifying problematic definitions previously discovered in the rate setting regulations; and clarifying the calculation of payment rates for new facilities participating in the Medicaid program.

Increasing 100% Federal Reimbursement for Natives

New federal policy released during FY97 expanded 100% federal funding for Medicaid services to Alaskan Natives to include tribal facilities and contract health services. Most contract care funds for Alaskan Natives remain with the Alaska Native Medical Center in Anchorage, as that is the tertiary care center for the native health care delivery system, although some contract care funds are allocated to Fairbanks and Southeast tribal health programs. The division has entered into data agreements with the IHS, and has developed protocols for claiming federal funding for contract health services provided through the private sector in a manner that will maintain an audit trail.

Instituting Claims with the Indian Health Service

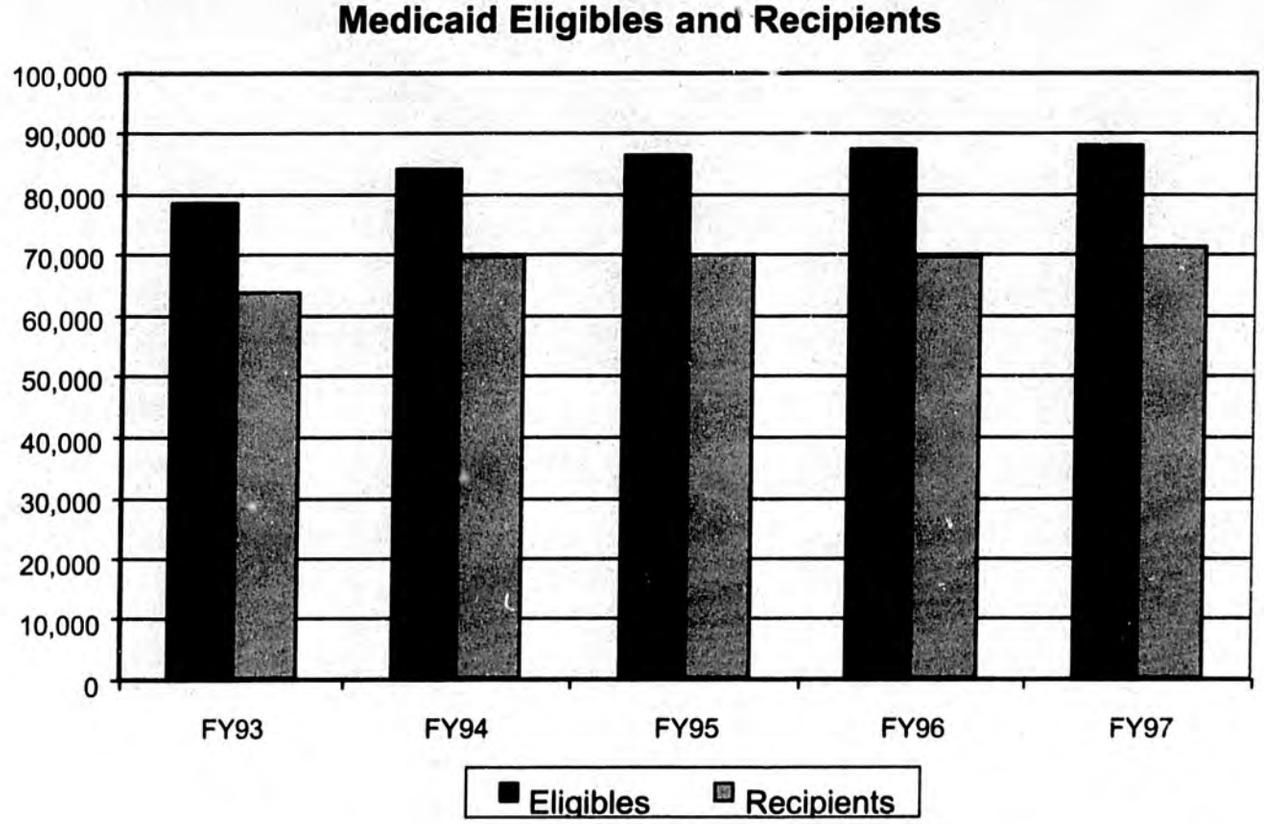
Because the IHS was incapable of producing detailed claims, their facilities have submitted claims to the division in summary form since the mid 1980s. Since fall 1996, the division has been working with the facilities to complete and submit claims for hospital and clinic services. The division's goal in accepting IHS claims is to gain data from these facilities on the services provided and the recipients receiving those services, and assure that the IHS facilities will be able to participate as primary care providers in future managed care plans. Some facilities began submitting claims in the summer of 1997, and the division plans to have all IHS facilities submitting claims during calendar year 1998.

Our Beneficiaries

Medicaid Eligibles and Recipients

The terms "eligibles" and "recipients" are common throughout this report. When a person becomes eligible for Medicaid, he/she may use the benefits available. Once those benefits are used, that person becomes a recipient. The table and graph below show the growth in eligibles and recipients Alaska's Medicaid program has experienced for the past five fiscal years.

Since FY93, the number of eligibles has increased 12.1% while the number of recipients has grown proportionately, by 11.8%. From FY96 to FY97, the number of eligibles grew by 0.9% and the number of recipients grew by 2%. The usage rate of Medicaid services by eligibles has hovered around 80% for the past several years.



	FY93	FY94	FY95	FY96	FY97
Eligibles	78,418	83,920	86,445	87,159	87,977
Recipients	63,663	69,631	69,739	69,608	71,179
% Usage	81%	83%	81%	80%	81%

Haines resident Becky Hinkle is ecstatic about Alaska's Medicaid program.

"If it weren't for them, Kristy would have dried up and withered away."

Kristy Hinkle was an active 11 year old girl who never thought about eating disorders. She liked Mom's home cooking and she wanted to eat, but she couldn't keep any of it down, and this made her scared.

"I thought I was really sick," Kristy said. "I thought I was going to die."

When both mother and child reached the point of knowing there was something seriously wrong, Becky took her daughter to the Haines Public Health Center for help. There, she found a nurse who also wanted to get to the bottom of what appeared to be a psychological eating disorder, an uncommon problem for an 11 year old.

"She vomited up every meal," said Naomi Kerwin, a Public Health nurse. "They're usually in their teens when they start thoughts of self image and induce vomiting. I've never heard of a kid that young with bulimia."

After seeing doctors and nurses in Haines, Kerwin suggested that Becky take her daughter to see a Juneau pediatrician. It was also suggested that if she could not afford expensive medical care, Becky should apply for Medicaid for her three kids. Since this problem appeared to be very serious, Naomi Kerwin would help expedite the application, along with some help from the Division of Public Health's Medicaid Services Unit.

"The Public Health nurse gave me the information I needed to apply for Medicaid," Becky said. "It took about a week to get on the program. Naomi really helped us out."

Once on Medicaid, the testing in Juneau began. Although Kristy's problem was still thought of as psychological, physical tests were ordered as well.

"She had to drink this stuff that would show what her swallowing was like," Becky said. "Instead of going through smoothly, it would spurt through. The valve near her esophagus just collapsed and closed down."

The magnetic resonance imaging (MRI) test that Kristy had taken left no doubt what the problem was: achalasia, a disorder where visceral openings fail to relax. Instead of needing mental health counseling, it was determined surgery at Children's Hospital in Seattle could correct the problem.

"I was ready for it... kinda scared, though," Kristy said. "I was in the hospital for a day or two after the surgery. I couldn't eat anything, only drink liquid."

Since Kristy's surgery, life has returned to normal for the Hinkles. Becky has taken a job where she can buy health insurance and she no longer needs Medicaid. "I think the last coupon came through in October," she said.

And now that Kristy is back to her old self and eating again: "Chicken and dumplings are my favorite. Mom makes the best."

Dr. William Larson, M MD Faap, has been seeing Medicaid patients in Alaska since 1970. The doctor is a tall quiet man whose eyes light up when you talk about his passion – children. After a brief three years at Elmendorf Air Force Base, Larson has spent more than twenty years in Anchorage as a general pediatrician with the last seven specializing in allergies and Attention Deficit Disorders (ADD).

During the late 1970s, in addition to his growing private practice, Dr. Larson served as the Medical Director at the Anchorage Neighborhood Health Center. Because of the clinic's downtown location and the fact that patients were charged on a sliding scale (based on what they could afford), the clinic served a large number of Medicaid eligible patients.

"I've been seeing Medicaid patients, mostly kids, for twenty seven years," Larson said. "I've never – so far as I know – turned one away in my whole life. I believe Medicaid is one of the better health insurance programs. Medicaid makes medical care available to the poor and the working poor. I worry though, about families caught in the middle, those who don't have health care insurance or Medicaid, who don't receive adequate health care."

"I've known Bill for 25 years. I am a consultant in pediatric gastroenterology, so he and I have shared the care of many children through the years. He is a man of tremendous energy and dedication."
Dr. Clinton B. Lillibridge

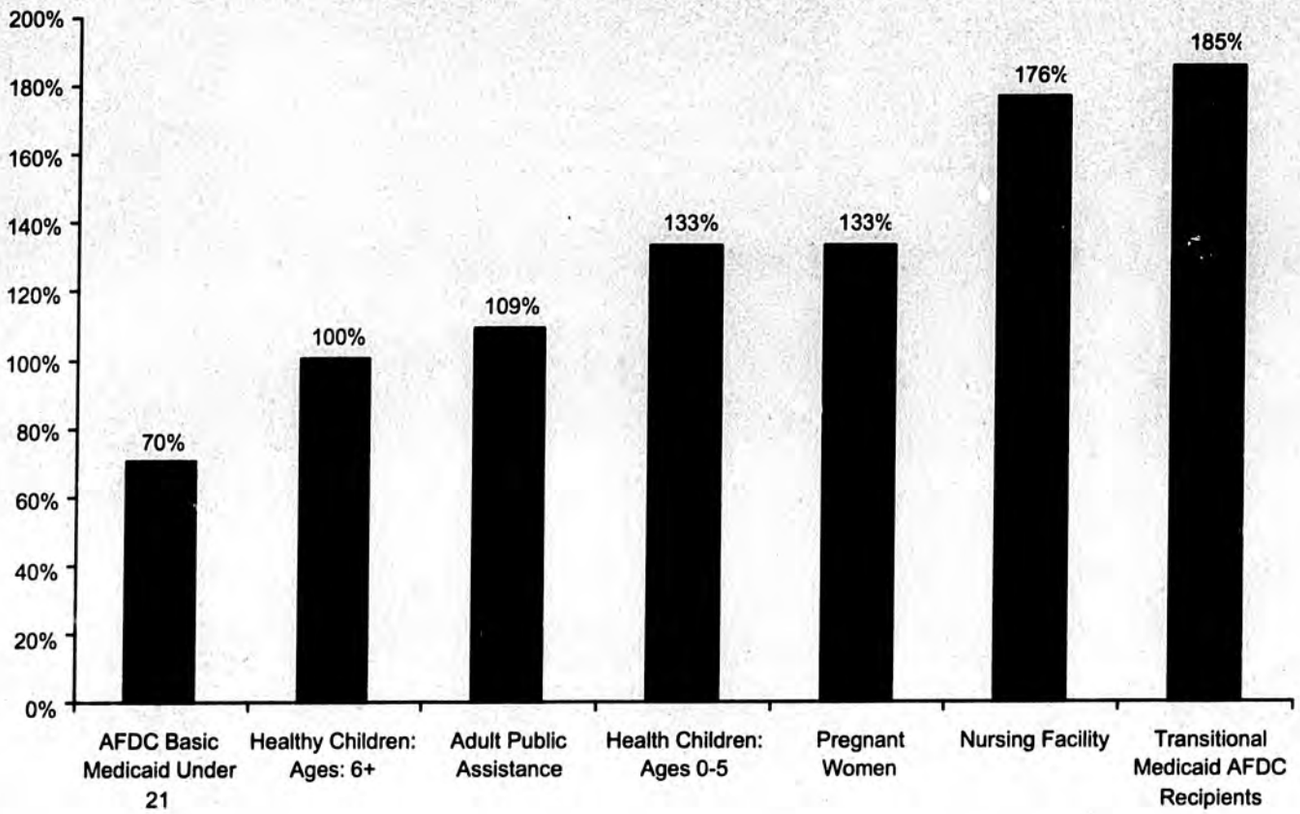
As his specialty is children diagnosed with ADD, Larson has strong views on needs for such patients.

"They need structure and stability at home and in school," he said. "They need an early diagnosis so that their teachers can respond appropriately to their scattered, hyperactive behavior; and they need medication so that they can stay on focus, complete one set of instructions, and move through the day without distractive behavior. They need the same thing adults with ADD need. There is increasing evidence that ADD (which tends to be genetic) doesn't go away."

Over the years, the doctor's young patients have grown up. Not every one of them have graduated with honors, but thanks to Larson's expertise in the field of pediatrics, persistence in character, and love for children, one vulnerable premature baby the doctor cradled in the palm of his hand 18 years ago is donning a cap and gown this spring.

People receive Medicaid by qualifying for certain cash assistance programs or by meeting Medicaid qualifying need standards. The federal poverty level and the Aid to Families with Dependent Children (AFDC) eligibility standards are updated at different times of the year. The graph and table below compare eligibility need standards and poverty levels in effect on January 1, 1997.

Alaska Medicaid Eligibility by Qualifying Need Standard



% of Poverty	Household Size	Annual Income	Hourly Equivalent
70%	4	$14,088	$6.77
100%	4	$20,070	$9.65
133%	4	$26,700	$12.84
185%	4	$37,140	$17.86

Medicaid Hotline

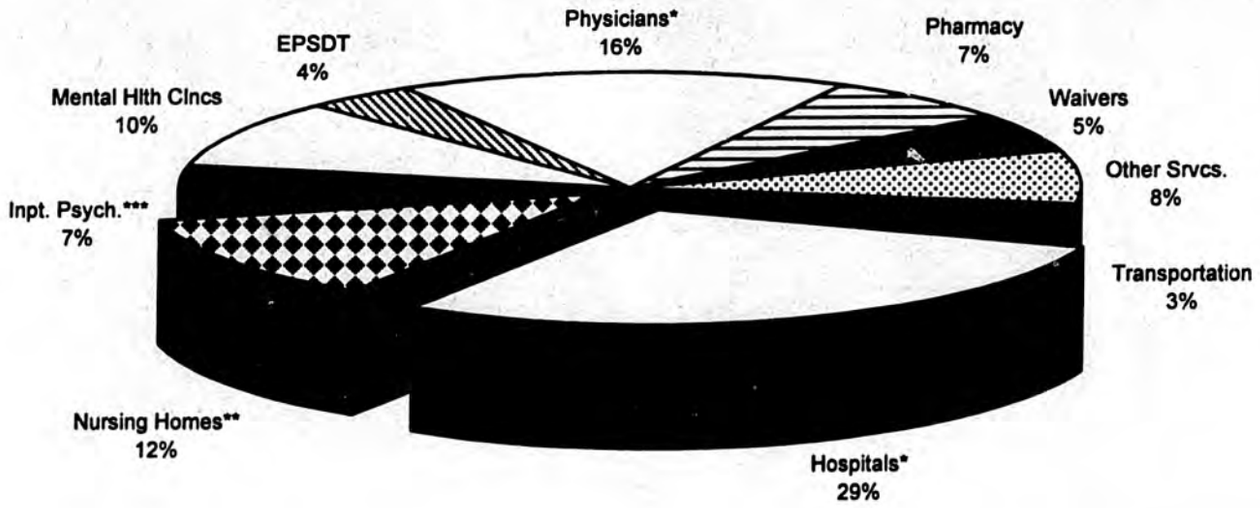
The Medicaid Hotline was initiated in July 1996 and is a service offered to recipients, family members, advocates, and others who call on behalf of recipients. The purpose of the Hotline is to provide consistency of information given to Medicaid customers, to provide accessibility of current information for Medicaid clients, and to serve to empower Medicaid clients regarding their own health care. During FY97, the Hotline recieved 6,574 calls, an average of 547 per month. The majority of the calls (54%) concerned billing issues and questions about covered services. Thirty-two percent of all callers had their problem resolved with the initial call. Problems requiring research of over 30 minutes accounted for 16% of all calls. The Hotline number is (907)561-2171 and the caller should ask for the Hotline. Collect calls are accepted. After business hours, callers may leave a message and their call will be returned the following business day.

Financial Summary

The pie chart below indicates the distribution of Medicaid funds according to the category of service provided. Hospitals, inpatient psychiatric hospitals, and nursing home facilities account for 48% of the total FY97 Medicaid costs. The chart reflects all Medicaid funds expended, including another $9.0 million in a general fund match from the Division of Mental Health and Developmental Disabilities.

An increase in waivered services from FY96 by 2% indicates that more recipients are moving from nursing home facilities into homecare. Nursing home expenditures fell by 4% compared to FY96.

FY97 Medicaid Expenditures by Categories of Service



	Expenditures *(in thousands)*	Expenditure Percent
Hospitals*	$102,592.4	29%
EPSDT	13,297.5	4%
Mental Hlth Clncs	34,639.6	10%
Nursing Homes**	43,775.3	12%
Inpt. Psych.***	24,417.8	7%
Physicians*	57,786.1	16%
Pharmacy	24,935.2	7%
Waivers	18,681.9	5%
Other Srvcs.	27,098.2	8%
Transportation	10,958.9	3%
Total	$358,183.0	100%

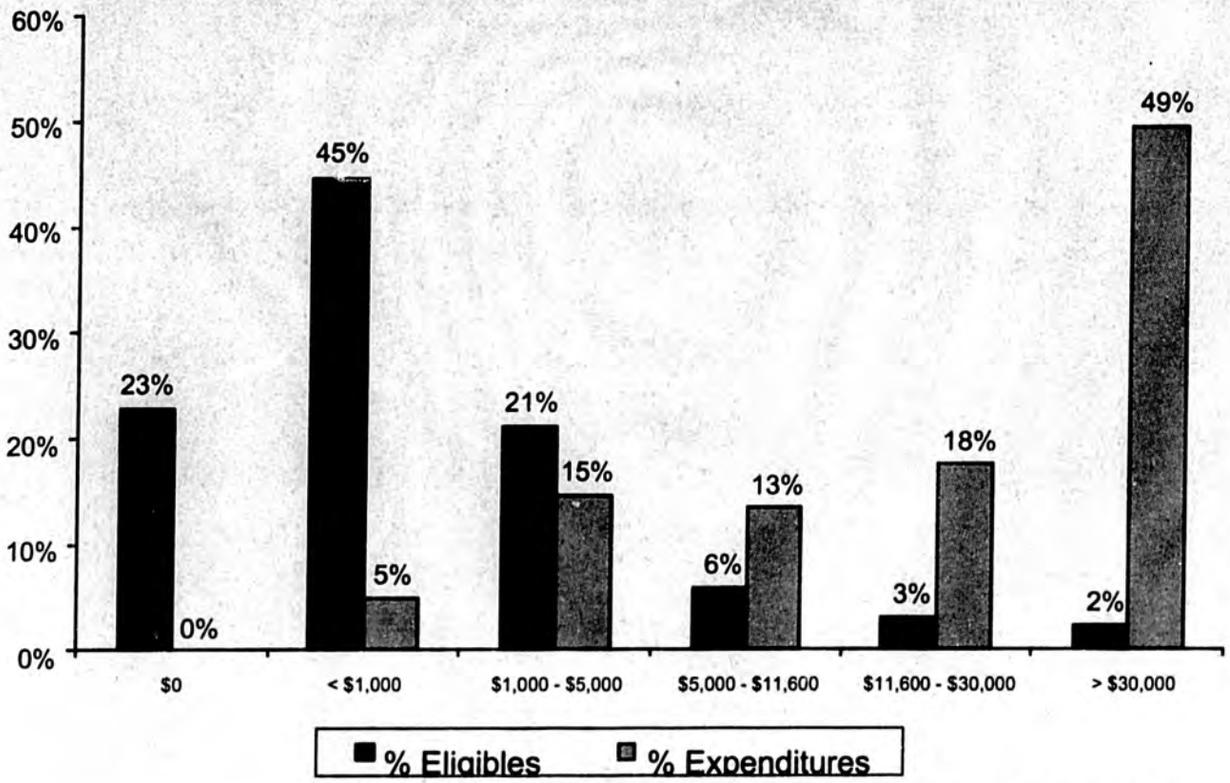
* IHS payments included.
** Includes $1.7 million GF match in DMHDD Budget not reflected in AKSAS report.
*** Includes $7.3 million GF match in DMHDD Budget not reflected in AKSAS report.

Bulk of the money

The pie chart above indicates that hospitals and long term care institutions make up almost half (48%) of the total FY97 Medicaid expenditures. The price of the services these facilities provide is set by the Medicaid Rate Advisory Commission.

Community mental health clinics were the fourth largest expenditure for the Medicaid program in FY97. The Alaska Legislature has directed the Division of Medical Assistance to maintain these services at FY97 levels during FY98.

FY97 Medicaid Expenditure Distribution by Eligibles

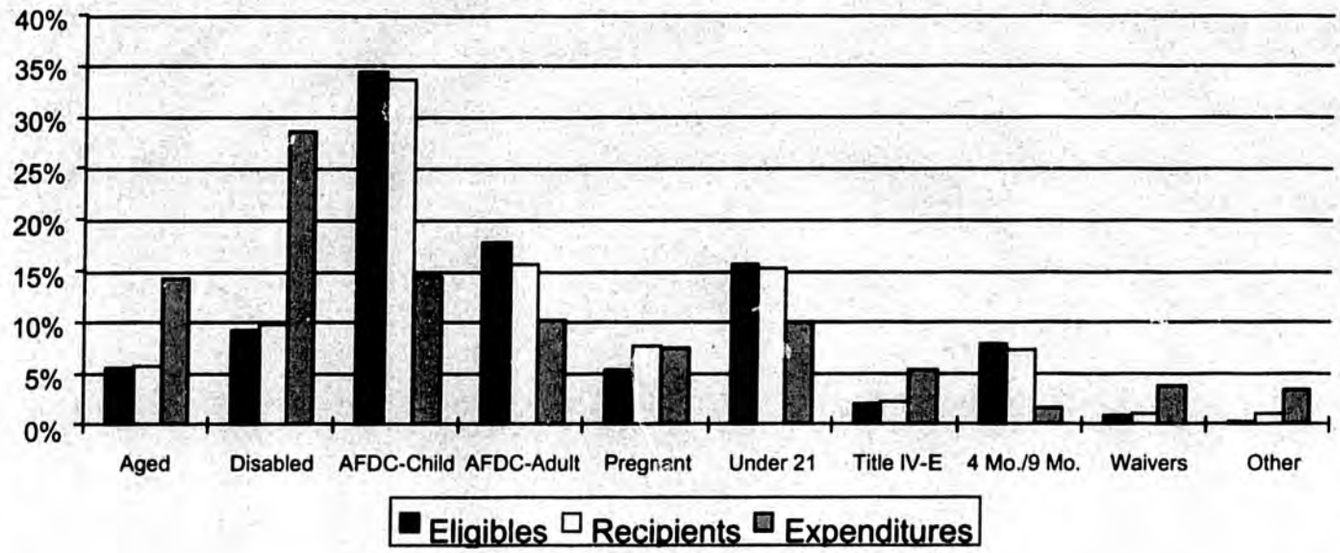


Expenditure Category	Eligibles*	Percent Eligibles	Percent Expenditures	Average Annual Expenditure Per Eligible
$0	18,391	21%	0%	$0
< $1,000	40,191	46%	5%	$365
$1,000 - $5,000	19,125	22%	15%	$2,282
$5,000 - $11,600	5,334	6%	13%	$7,480
$11,600 - $30,000	2,843	3%	18%	$18,311
> $30,000	2,093	2%	49%	$70,133
Total	87,977	100%	100%	$3,377

* Eligibles count based on last eligibility segment in SFY 1997.

The Early and Periodic, Screening, Diagnosis and Treatment program, commonly called Healthy Kids, had over 56,000 children enrolled last year. Of that number, 38% were six to 14 year olds. Babies from birth to one year old accounted for just over 11% of the enrolled children.

FY97 Medicaid Eligibles, Recipients & Expenditures by Categories of Assistance



The chart above shows the relationship among the number of Medicaid eligible people, recipients of services, and the cost of those services as defined within categories of assistance. In some cases, the level of recipients may be greater than eligibles. This is due to this chart being based on date of payment rather than date of service. A Medicaid eligible person may have received services in the prior fiscal year but those services may not have been billed to Medicaid until the current fiscal year. Thus, the recipient count could appear greater than the current eligible count.

As can be seen in the chart, the distribution of eligibles and recipients by categories of eligibility are often disproportionate to the expenditures distribution.

Average Yearly Cost Per Medicaid Eligible

The table on the right displays the average yearly cost per Medicaid eligible from FY87 through FY97. Since FY87, the average cost has increased $1,337, or 68%.

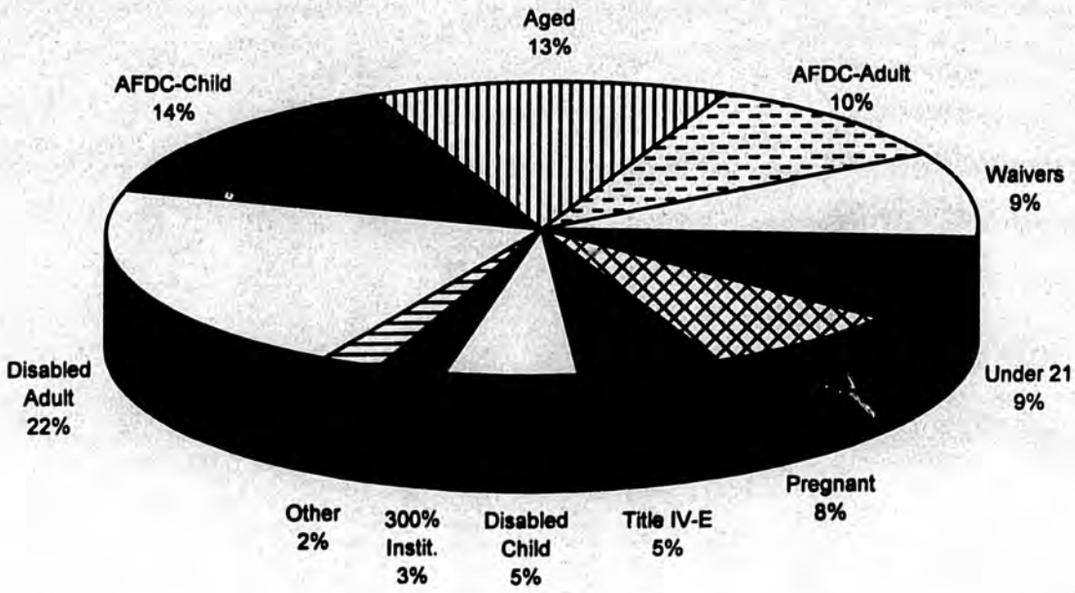
This table is being reported differently than in past fiscal year reports. It now shows "eligible" instead of "recipient" cost. Providing average eligible costs will better help gauge the potential expenditures of the Medicaid program. Also, this table now reflects all Medical assistance services except Indian Health Services and state program expenditures.

A major increase in the average yearly cost per eligible is not a reliable indicator for the cost of adding clients to the Medicaid program. The best cost indicators are the medical condition of new eligibles, the number of individuals within a new eligibility category, and the costs associated with the types of services they utilize.

Year	Ave. Cost*	Eligibles
1987	$1,962	39,843
1988	$2,109	43,318
1989	$2,419	44,625
1990	$2,728	47,793
1991	$2,790	57,251
1992	$2,677	69,286
1993	$2,602	78,418
1994	$2,897	83,920
1995	$2,974	86,445
1996	$3,207	87,159
1997	$3,299	87,977

*Rounded

FY97 Medicaid Expenditures by Categories of Assistance



Federally identified categories of medical assistance are broadly defined as: aged, disabled, AFDC children, and AFDC adults. Medicaid eligibility programs are further classified by basis of eligibility for medical care. The pie chart above shows the percentage of FY97 Medicaid expenditures for the various categories of assistance. A reduction in disabled adult expenditures by $5 million from FY96 most likely had an impact on the $17 million increase in waiver services from last fiscal year as more recipients are taking advantage of home and community-based care services.

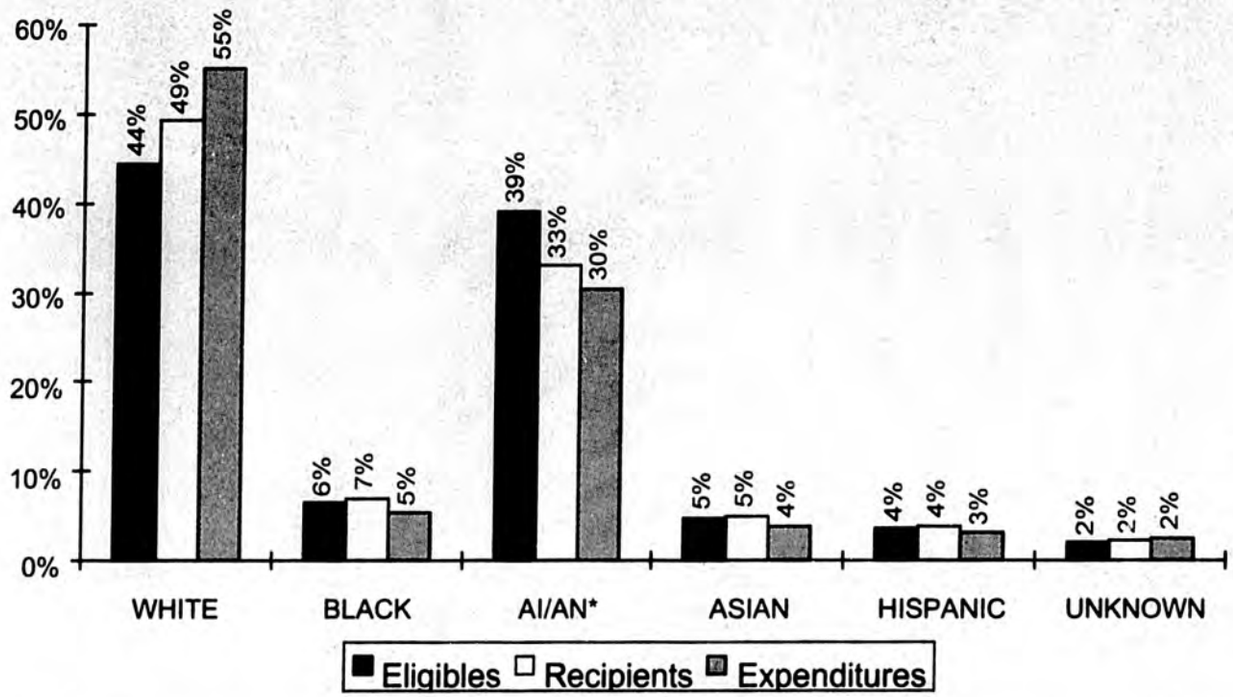
Category	Expenditures	Percent
Disabled Adult	$62,108,484	22%
AFDC-Child	$40,449,625	14%
Aged	$38,164,431	13%
AFDC-Adult	$29,551,708	10%
Waivers	$27,345,366	9%
Under 21	$27,291,932	9%
Pregnant	$21,999,932	8%
Title IV-E	$15,301,313	5%
Disabled Child	$14,042,507	5%
300% Institutional	$7,648,121	3%
Other	$6,346,836	2%
Total	$290,250,255	100%

Based on Medicaid claims processed through MMIS. Excludes IHS funds and Reimbursable Service Agreements (RSAs), TPL recovery contracts, and AKSAS adjustments not reflected on MMIS.

Dr. Bruce Chandler is a pediatrician at the Anchorage Neighborhood Health Center. During FY97, there were 3,337 providers participating in the Medicaid program, including doctors, dentists, hospitals, nursing homes, pharmacists, and a variety of other health care professionals and services. The average payment per participating provider in the Medicaid program for FY97 was $86,979.

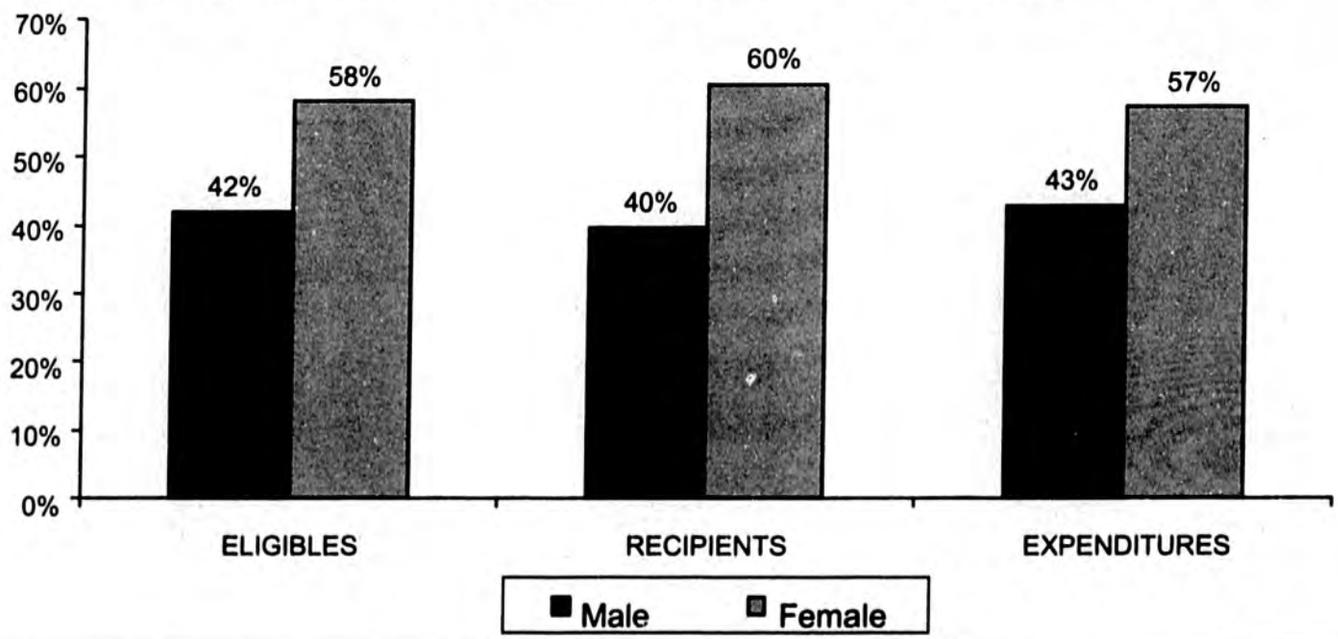
The chart below shows Medicaid eligibles, recipients and expenditures by race. The recipient counts for American Indian (AI) and Alaska Natives (AN) are low because the Indian Health Service (IHS) does not supply that information to the division for IHS claims. The number of eligible persons and the financial information for IHS claims has been otherwise included in the chart below, but the recipient count for the AI/AN category is probably significantly under represented.

FY97 Medicaid Eligibles, Recipients & Expenditures by Race



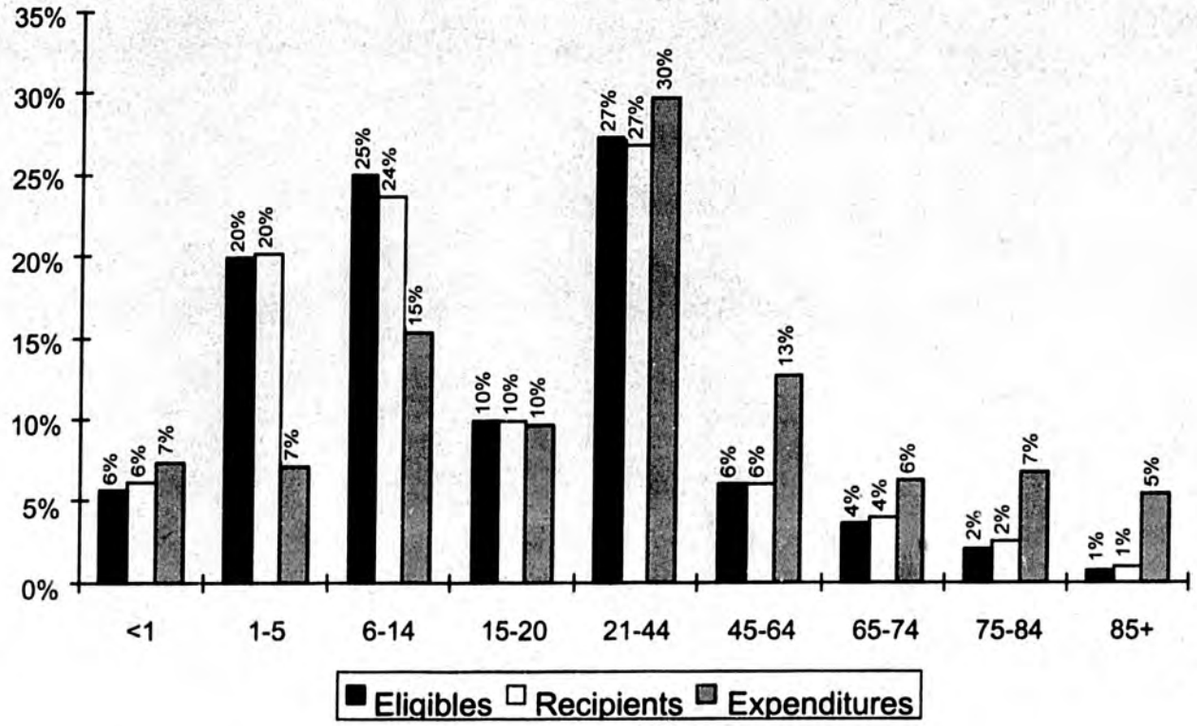
The Medicaid eligible population is approximately 42% male and 58% female, as shown below. Recipients are approximately 40% male and 60% female. Females account for 57% of Medicaid expenditures and males account for 43%. These percentages have changed little, if any, from FY96.

FY97 Medicaid Eligibles, Recipients & Expenditures by Sex



The following chart shows Medicaid eligibles, recipients and expenditures as related to age. Information regarding IHS facilities is not reported.

FY97 Medicaid Eligibles, Recipients & Expenditures by Age Group



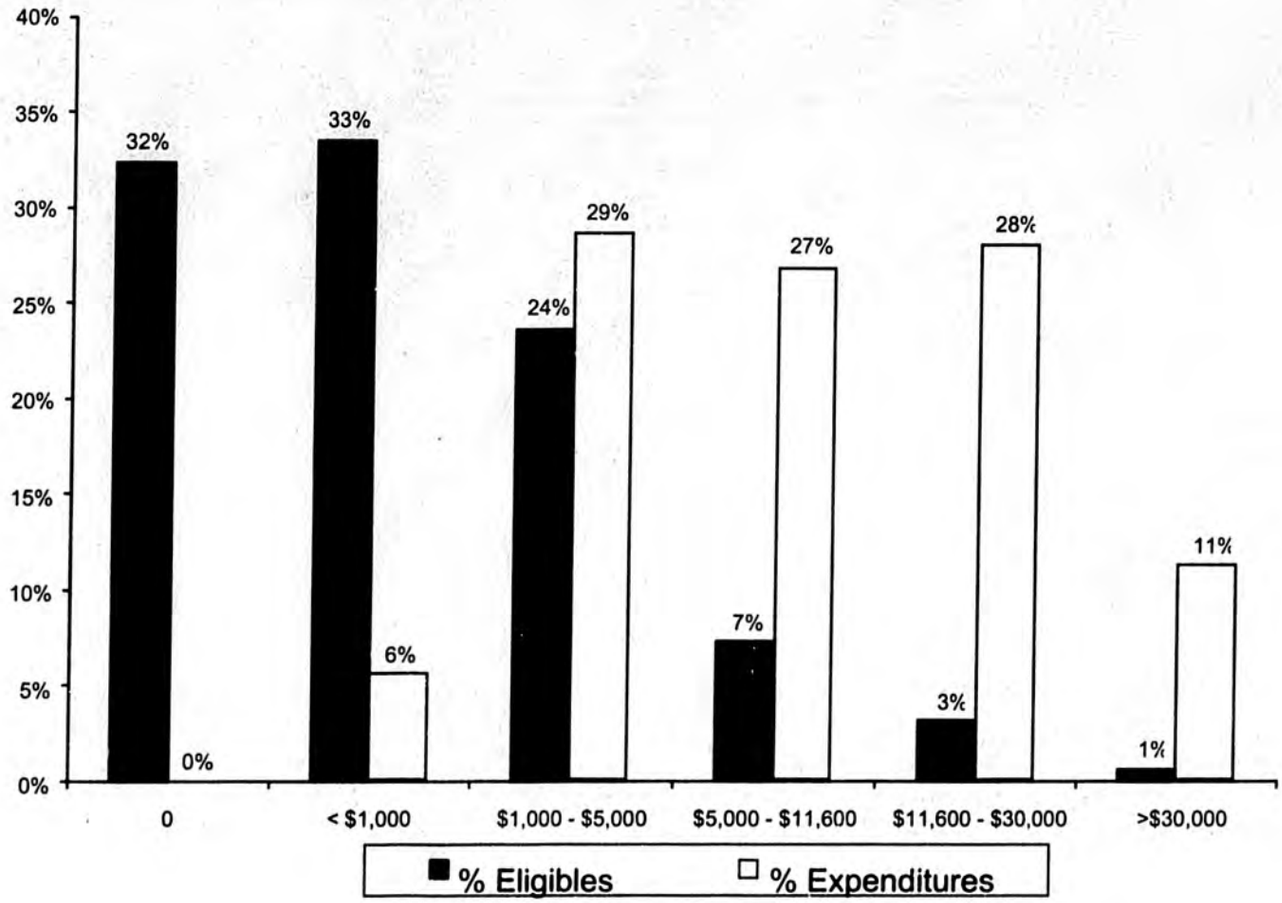
Age	Expenditures	Recipients	Cost Per Recipient	Eligibles	Cost Per Eligible
<1	21,380,206	4,385	$4,875	4,982	$4,291
1-5	20,535,914	14,329	$1,433	17,482	$1,175
6-14	44,288,377	16,836	$2,631	21,930	$2,020
15-20	27,798,684	7,010	$3,966	8,699	$3,196
21-44	86,291,398	19,088	$4,521	23,970	$3,600
45-64	36,840,960	4,289	$8,589	5,279	$6,979
65-74	18,039,022	2,807	$6,425	3,164	$5,702
75-84	19,586,460	1,749	$11,196	1,827	$10,722
85+	15,489,237	684	$22,630	644	$24,053
Total*	$290,250,257	71,179	$4,078	87,977	$3,299

*Excludes Medicaid expenditures for IHS, RSA's, TPL recovery contracts, & AKSAS accounting. Adjustments are not processed thru MMIS.

State Only Programs

The following graph and table illustrate the distribution of expenditures for the state funded General Relief Medical (GRM), Permanent Fund Dividend Hold Harmless (PFDHH), and Alaska Longevity Bonus Hold Harmless (ALBHH) programs. The data demonstrates that 65% of eligibles during FY97 required less than $1,000 in services to be paid. These expenditures were mostly for physician services and prescription drugs. The data also shows that 1% of the eligibles required $30,000 or more in expenditures. The majority of this cost can be attributed to inpatient hospital services.

FY97 State Funded Medical Assistance Programs
Expenditure Distribution by Eligible



Expenditure Category	Unduplicated Eligibles*	Percent Eligibles	Percent Expenditures	Average Annual Expenditure Per Eligible
0	522	32%	0%	$0
< $1,000	540	33%	6%	$332
$1,000 - $5,000	381	24%	29%	$2,421
$5,000 - $11,600	117	7%	27%	$7,373
$11,600 - $30,000	50	3%	28%	$18,045
>$30,000	9	1%	11%	$40,310
	1,619	100%	100%	$1,995

* Eligibles count based on having a GRM or Hold Harmless eligibility segment in SFY97.
Expenditure amounts are based on services rendered in SFY97 and paid for between 7/1/96 and 9/30/97.

Alternatives to Institutional Care

There are a number of services available for people who desire to receive an institutional level of care within their home. These options are outlined below, along with FY97 expenditure and utilization information. For complete information regarding these services, please contact the agencies responsible.

Home and Community-Based Care

The Medicaid Home and Community-Based Care (HCBC) program allows persons to receive the health care they need in their home rather than an institution. The cost of these waiver services must be no more than the cost of the institutional services which the person would have otherwise required. During FY97, 917 Alaskans chose waiver services, which is almost double the number from FY96. This increase could be attributed to a streamlined application procedure and management consolidation of services. The number of providers participating dropped from 662 in FY96 to 409 during FY97.

The HBCB program is a joint effort among DMA, DMHDD (Dept. of Health and Social Services) and the Division of Senior Services (Dept. of Administration). DSS is responsible for care coordination, client intake, assessment, and care plan development for Older Alaskans and Adults with Physical Disabilities. DMHDD is responsible for Children with Complex Medical Conditions and People with Developmental Disabilities.

Home and Community-Based Care Program
FY97 Utilization and Expenditures

Population Served	No. of Recipients	HCBC Expenditures*	Other Medicaid Expenditures	Total Medicaid Expenditures
Children with Complex Medical Conditions	70	$1,569,842	$1,663,453	$3,233,365
People with Developmental Disabilities	343	$14,797,065	$2,060,473	$16,857,881
Adults with Physical Disabilities	91	$1,542,793	$1,418,156	$2,961,040
Older Alaskans	413	$4,587,075	$1,982,193	$6,569,681
Totals	917	$22,496,775	$7,124,275	$29,621,967

*Expenditures reflect claims paid through MMIS during FY97

TEFRA

The Tax Equity and Fiscal Reconciliation Act of 1982 option provides another method for assuring Medicaid coverage for children with disabilities who would otherwise have to live in an institution. This optional eligibility group was added to the Medicaid statute in 1993 to allow children to qualify for Medicaid without counting the income of their parents. During FY97, the Division of Medical Assistance funded services to 245 children under TEFRA. The total expenditure for these services was $2,459,459.

For more information regarding the TEFRA option, contact the Division of Mental Health and Developmental Disabilities at (907)465-3370.

Personal Care Attendant Services

Personal Care Attendant (PCA) services are intended to enable a person with nontechnical medical care needs to remain at home rather than live in an institutional setting. Medicaid pays for these services when provided by personal care agencies or through independent PCAs enrolled as a provider in the Medicaid program. In FY97, PCA services were provided to 980 people at a cost of $4,575,022. Personal care agencies provided services to 940 Medicaid recipients; independent PCAs provided services to 65 recipients; and personal care nurses provided services to 26 recipients.

For more information regarding the PCA program, contact the Division of Senior Services at (907)563-5654.

Keeping Children Healthy

The Dept. of Health and Social Services offers two coordinated efforts among the Divisions of Public Health, Public Assistance, and Medical Assistance which are designed to provide services for pregnant women, children, and young adults under the age of 21.

Medicaid Healthy Baby Program

The purpose of the Medicaid Health Baby program is to ensure that pregnant women have timely access to adequate prenatal services in order to lower the rates of infant mortality and morbidity in Alaska. A pregnant woman who has income at or below 133% of the federal poverty level is eligible for the program. Following birth, if the child remains with the mother, the child receives medical care paid for by the program for his/her first year of life.

Total Births in Alaska/Medicaid Births

	1989	1990	1991	1992	1993	1994	1995	1996
Total Births	11,656	11,901	11,688	11,715	11,073	10,590	10,236	10,035
Medicaid Births	2,587	3,221	3,823	4,228	4,220	3,999	4,152	4,660
% of Births to Medicaid Recipients	22%	27%	33%	36%	38%	38%	41%	46%

Reporting period based on calendar year.

Medicaid Healthy Kids Program

Sometimes called Early and Periodic, Screening, Diagnosis and Treatment Program, or EPSDT, the Healthy Kids program helps to detect and treat health concerns early for low income children from birth to age 21. The program is also designed to improve the health status of needy children and to replace crisis-only health care with an orderly system of preventative care.

Healthy Kids Screening

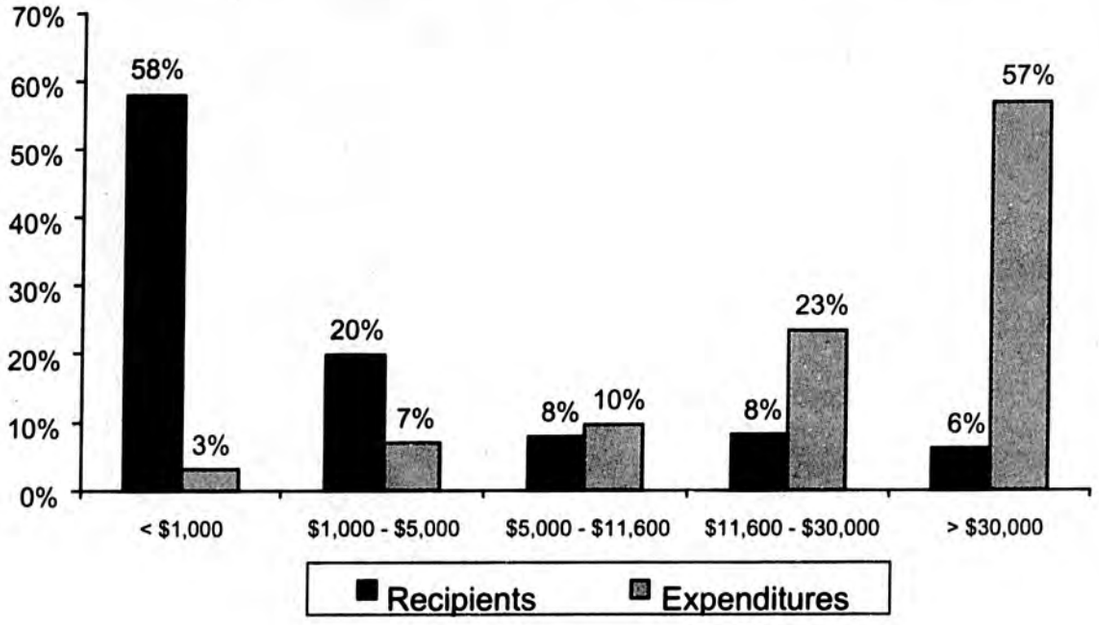
In 1991, the State of Alaska adopted the American Academy of Pediatrics Periodicity Schedule for well child care or "Healthy Kids Screening Schedule." This screening schedule increased the number of screens due for each child by 33%. This periodicity schedule includes six screenings in the first year of life, three in the second, annual screenings) to age six, and then every other year until age 20. For more information regarding the Health Baby or Health Kids programs, contact the Medicaid Services Unit at (907)465-2845.

Mental Health Services

The Division of Medical Assistance works with the Division of Mental Health and Developmental Disabilities (DMHDD) to provide coverage for mental health clinic and rehabilitation services through community mental health clinics. DMA focuses on processing of claims, and financial audit functions. DMHDD is responsible for client advocacy, quality assurance, and administration of non-Medicaid funding sources. Services provided include assessments, various therapies, and medication management. For more information regarding mental health services available through the Medicaid program, contact DMHDD at (907)465-3370.

The following chart shows the expenditure range for children recipients of mental health services. Less than $1,000 was spent on a majority (58%) of recipients while 6% of the population cost $30,000 or more for services. These expenditures include FY97 Medicaid payments for children served by DMHDD grants. There were a total of 3,419 unduplicated recipients under 21 that received services in FY97. Total cost of mental health services for this age group was $22,164,639.

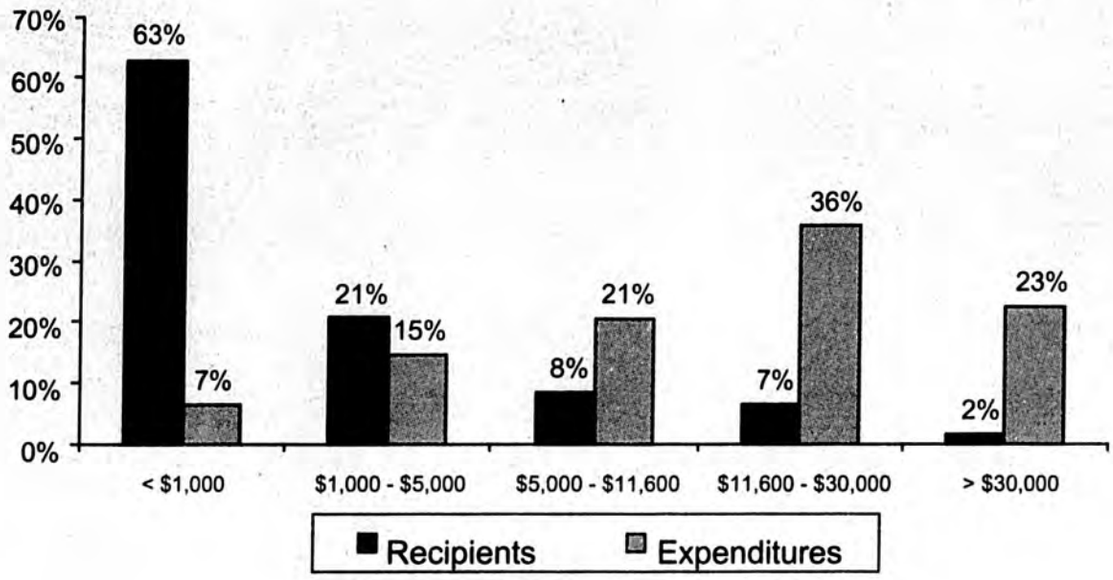
FY97 Community Mental Health Services for Children (under 21 years)



Expenditure Category	Unduplicated Recipients <21 Years	Percent	Expenditures	Percent
< $1,000	1,981	58%	$701,178	3%
$1,000 - $5,000	679	20%	$1,537,688	7%
$5,000 - $11,600	266	8%	$2,153,423	10%
$11,600 - $30,000	282	8%	$5,185,852	23%
> $30,000	211	6%	$12,586,498	57%
Total	3,419		$22,164,639	

The following chart shows the expenditure range for adult recipients of mental health services. Services received by the majority (63%) of recipients cost less than $1,000 while 2% of the recipients cost in excess of $30,000 apiece. A total of $11,540,834 was expended for services to 3,515 people.

FY97 Community Mental Health Services for Adults (age 21 and over)



Expenditure Category	Unduplicated Recipients >=21 Years	Percent	Expenditures	Percent
< $1,000	2,202	63%	$764,362	7%
$1,000 - $5,000	727	21%	$1,679,802	15%
$5,000 - $11,600	297	8%	$2,380,545	21%
$11,600 - $30,000	231	7%	$4,114,770	36%
> $30,000	58	2%	$2,601,354	23%
Total	3,515		$11,540,834	

Applying for Medicaid

Medicaid eligibility depends on a number of factors but generally a person must have a low income to qualify. People interested in applying for the Medicaid program may contact a Public Assistance Office or a village fee agent. To apply, a person must fill out an application form and have an interview. The application and interview are confidential. No one will give out information regarding health, income, or other private information regarding the applicant. After reviewing the application, the Public Assistance Office will send the applicant a notice saying whether or not the applicant is qualified. If the application is denied, the notice will indicate why; if the applicant does qualify, the notice will say what benefits are allowed and when they will begin. If a person does not qualify for Medicaid, he/she may always apply again if income, resources, or medical needs change. For more information regarding where a Public Assistance Office is located, persons interested may call toll free 1(888)804-6330.

Indian Health Service & Tribal Facilities

IHS and tribal contract facilities listed below are providers who directly bill DMA by monthly invoice for reimbursement of services rendered to Medicaid eligible patients. All data presented is collected by each facility and does not reflect any claims data in the MMIS. The following table summarizes FY97 IHS recipients, units of service and expenditures for these contract facilities.

Summary of FY97 IHS Billings by Facility

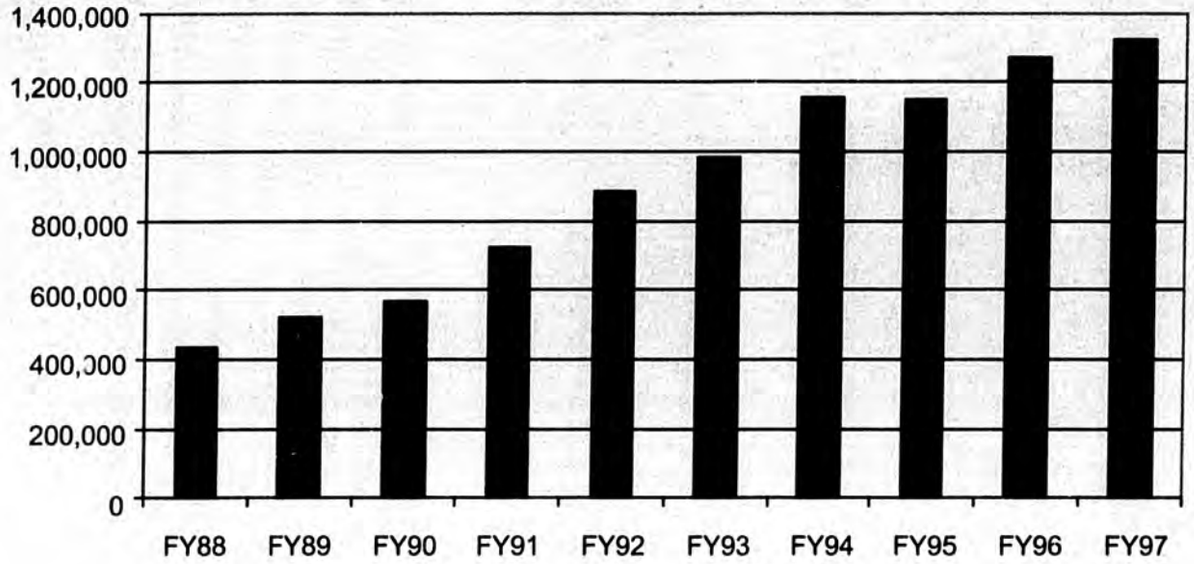
	INPATIENT			OUTPATIENT		
Facilities	**Recipients**	**Days**	**Amount**	**Recipients**	**Visits**	**Amount**
Anchorage	1,530	6,930	$6,815,576	18,450	35,303	$8,642,399
Barrow	17	30	$27,900	436	996	$239,734
YKHC/Bethel	1,025	2,348	$2,086,057	18,606	29,919	$6,647,392
Kanakanak	80	163	$152,448	2,829	4,219	$888,801
Kotzebue	268	294	$292,971	3,183	6,379	$1,481,239
Mt. Edgecumbe	107	274	$253,350	2,181	3,192	$745,813
Fairbanks	------	N/A	----------	10,446	15,787	$3,711,038
Juneau	------	N/A	----------	2,514	4,486	$901,515
Ketchikan	------	N/A	----------	2,266	3,715	$821,446
Metlakatla	------	N/A	----------	1,314	2,411	$549,922
Chuguimuit	------	N/A	----------	260	378	$97,744
Aleutian/Pribilof	------	N/A	----------	110	211	$49,547
Other Providers			$2,582,188			$3,428,119
Totals	3,027	10,039	$12,210,490	62,595	106,996	$28,204,709

Helen Carius, born at Boxer Bay on St. Lawrence Island, contracted polio when she was 11 years old. She has been self supporting all her life and only became a Medicaid recipient when she was 65 years old. Here she spends time with her daughter, Shirley, and granddaughters Amara and Reine. Helen's wheelchair was provided through the Medicaid program.

Providers Billing Medicaid

The term "claim" in the realm of medical assistance simply means that a provider is billing Medicaid for the services or procedures that he/she has performed for a recipient. The increase in the volume of claim documents processed from FY88 through FY97 is shown below. The total number of claim documents has increased tremendously during this time, which may be attributed in part by providers submitting claims electronically instead of by traditional paper claims. Electronic claims submissions have increased by over 60% from FY88.

Claim Documents Processed (FY88-FY97)



Electronic claims may be submitted by the provider by sending in a computer disk of information or by using a modem to telephonically transfer information. All claims are submitted to First Health Services Corporation, a professional company that the Division of Medical Assistance has contracted with to handle claims, payments, provider relations, and billing procedures. Once the claim is received by First Health, both the provider and recipient are checked for eligibility. If both are eligible, a number of other checks are performed, such as making sure the service or procedure provided is covered by Medicaid, and whether or not there is a third party insurance company involved. Once the claim has been deemed appropriate, First Health will then issue payment to the provider.

Fiscal Year	Average Per Month	Percent Change	Total Annual
88	36,384		436,608
89	43,382	19.2%	520,588
90	47,132	8.6%	565,589
91	60,467	28.3%	725,606
92	73,837	22.1%	886,044
93	81,704	10.7%	980,450
94	96,587	18.2%	1,159,044
95	95,835	-0.8%	1,150,018
96	105,849	10.4%	1,270,191
97	110,511	4.4%	1,326,126

When a recipient goes to a pharmacy and requests a prescription, the pharmacy performs what is called a "point-of-sale" transaction. At the time the prescription is picked up, the pharmacy will go "online" via computer and verify the recipient's eligibility – among other checks – and is essentially submitting a claim for the service being provided at that time.

Currently, 72% of claims received by First Health are electronically submitted. The average amount of time it takes from receipt of the claim to process it is 2.76 days.

Expenditures and Patient Days Utilized: Long Term Care Facilities

The following tables summarize, by facility, expenditures and patient days utilized for long term care institutions and inpatient hospitals. Amounts are based on date of service.

SNF and ICF Facilities: INSTITUTION	*Total Days FY95	Avg Daily Cost	**Total Paid FY95	*Total Daily FY96	Avg Paid Cost	**Total Paid FY96	*Total Days FY97	Avg Daily Cost	**Total Paid FY97
Providence Extended Care	68,210	$190	$12,992,075	68,376	$192	$13,139,000	61,548	$197	$12,098,810
Denali Center	22,794	232	5,293,611	24,071	263	6,339,772	22,078	291	6,432,795
Mary Conrad	30,176	202	6,104,233	30,751	200	6,156,705	29,587	206	6,102,185
Wesleyan Nursing Home	16,483	193	3,188,753	15,422	193	2,978,125	13,159	196	2,584,082
St. Ann's Nursing Home	12,026	216	2,600,518	12,001	222	2,659,913	10,830	225	2,433,899
Quyaana Care Center	4,762	419	1,995,946	5,052	448	2,261,137	5,104	475	2,426,128
Heritage Place	12,906	154	1,993,973	13,938	154	2,149,315	14,032	157	2,204,441
South Peninsula Hosp.	5,908	364	2,152,706	6,682	349	2,329,810	6,626	303	2,008,353
Kodiak Island Hosp.	4,486	273	1,223,253	4,296	292	1,255,397	4,250	381	1,618,045
Ketchikan Gen. Hospital	5,595	286	1,598,348	4,923	307	1,510,989	4,493	320	1,436,110
Cordova Comm. Hosp.	2,632	433	1,139,836	2,859	392	1,119,686	3,143	398	1,251,573
Harborview Dev. Center	4,564	250	1,143,275	5,384	298	1,603,892	3,689	320	1,181,048
Petersburg Gen. Hosp.	4,222	273	1,152,923	4,196	263	1,104,622	4,256	258	1,097,170
Wrangell Gen. Hosp.	3,378	276	932,647	$3,945	271	1,070,937	3,936	277	1,090,395
Sitka Community Hosp.	300	199	59,678	1,608	216	347,382	1,197	396	473,963
Kotzebue Sr. Center	0		0	0		0	0		0
Subtotal ICF & SNF	198,442	$220	$43,571,775	203,504	$226	$46,026,682	187,928	$236	$44,438,998
% Change	0%	2%	3%	3%	3%	6%	-8%	5%	-3%
ICF/MR Facilities:									
Harborview Dev. Center	10,393	$431	$4,478,004	8,302	$416	$3,453,031	4,746	$455	$2,159,478
Hope Cottages, Inc.	14,231	$352	$5,008,602	13,823	$357	$4,929,592	0	$0	$0
Subtotal ICF/MR	24,624	$385	$9,486,606	22,125	$379	$8,382,623	4,746	$455	$2,159,478
Totals	154,856	$343	$53,058,381	225,629	$241	$54,409,305	192,674	$242	$46,598,476
Change relative to prior year	-31%		-1%	46%		3%	-15%		-14%

(Admin. wait days not included, GRM days included above)
*Excludes EMC Medicare crossovers
**Excludes Medicare crossovers

FY95 Data Extracted from MR-O-14 run 10/14/97 for DOS 7/1/94-6/30/95.
FY96 Data Extracted from STARS
FY97 Data Extracted from STARS

Expenditures and Patient Days Utilized: Inpatient Facilities

INSTITUTION	*Total Days FY95	Ave Daily Cost	**Total Paid FY95	*Total Days FY96	Ave Daily Cost	**Total Paid FY96	*Total Days FY97	Ave Daily Cost	**Total Paid FY97
Providence	14,429	$1,433	$20,675,123	15,945	$1,492	$23,796,218	16.366	$1,672	$27,367,578
Alaska Regional	4,606	1,777	8,183,306	4,287	1,435	6,153,314	4,833	1,819	8,791,077
Fairbanks Memorial	4,897	1,359	6,656,647	4,828	962	4,643,119	5,073	1,123	5,697,197
Charter North	7,759	833	6,462,125	6,569	819	5,382,950	7,070	777	5,490,249
Valley	2,051	1,570	3,220,252	1,861	1,424	2,650,496	1,823	1,565	2,852,390
Bartlett Regional	1,403	1,131	1,586,378	1,707	1,049	1,790,317	1,607	1,166	1,874,050
Central Peninsula	1,477	1,190	1,757,380	1,496	1,212	1,813,011	1,430	1,200	1,715,844
Ketchikan General	931	1,226	1,141,693	895	1,283	1,147,968	987	1,269	1,252,504
South Peninsula	599	1,620	970,186	606	1,205	730,419	700	1,339	936,954
North Star	4,214	750	3,161,572	3,881	891	3,458,934	917	992	909,549
Kodiak Island	594	1,299	771,883	567	1,304	739,428	590	1,390	820,022
Norton Sound	390	1,484	578,611	292	1,501	438,208	213	1,855	395,117
Alaska Psychiatric	721	498	358,848	715	497	355,347	699	538	375,804
Sitka Community	254	1,422	361,261	218	1,324	288,531	200	1,233	246,555
Valdez Community	84	1,120	94,108	37	1,544	57,113	86	1,153	99,152
Wrangell General	54	1,238	66,876	45	1,489	66,990	55	1,552	85,363
Cordova Community	27	1,079	29,136	45	1,206	54,256	35	1,004	35,133
Petersburg General	20	1,415	28,308	48	1,217	58,433	19	1,357	25,791
Providence Seward	75	1,381	103,542	37	1,778	65,776	23	1,050	24,150
Alaska Children's Srvs.	14,675	252	3,696,059	14,493	254	3,687,020	11,855	254	3,007,486
Totals	59,260	$1,011	$59,903,294	58,572	$980	$57,377,849	54,581	$1,136	$62,001,966
Change relative to prior year	-5%		-3%	-1%		-4%	-7%		8%

*Excludes EMC crossover days
**Excludes crossover expenditures

Data extracted from MR-O-14 run 9/20/95 for DOS 7/1/94 thru 6/30/95.
Data extracted from STARS run 12/9/97 for DOS 7/1/95 thru 6/30/96.
Data extracted from STARS run 12/9/97 for DOS 7/1/96 thru 6/30/97.

FY97 Total Expenditures Summary with Collocation Code *(in thousands)*

Acct	Category of Service	FY96 Actuals	FY97 Actuals
MEDICAID NON-FACILITY			
	MEDICAID PHYSICIAN SERVICES		
200	Physician Services	45,267.0	45,098.5
205	Rural Health Clinics	47.7	1,244.6
210	Federally Qualified Health Center	0.0	0.0
	TOTAL MED PHYSICIAN SERVICES	**45,314.7**	**46,343.0**
	MEDICAID OTHER SERVICES		
221	Transportation	10,382.1	10,958.9
222	Laboratory & Xray	1,344.4	1,349.5
223	Pharmacy	21,675.2	24,935.2
224	Glasses Non-EPSDT	473.1	536.1
225	Pros. Devices-Medical Equip	5,499.3	5,438.2
226	Hearing Services/Equipments	108.0	111.0
227	TPL Recovery Other	(372.0)	(437.3)
240	Mental Health Clinics	28,751.2	34,639.6
241	Nutritionist Services	3.1	4.1
242	Home Health Care	871.0	1,125.8
243	Adult Dental	160.9	80.8
244	Personal Care	3,278.5	3,734.8
245	Chiropractic	65.0	65.0
246	Hospice	9.6	42.7
247	Drug Abuse Center	1,455.7	2,002.0
249	Disability/Blindness Exams	206.9	177.8
250	Waiver Determination	111.0	168.5
260	Family Planning	785.8	687.6
261	Hysterectomy	899.9	623.9
262	Abortion	0.0	0.0
263	Sterilization	657.1	525.6
280	Speech Language Therapy	382.0	611.9
281	Physical Therapy	824.9	1,064.6
282	Occupational Therapy	41.0	62.5
290	QMB Medicaid Services XIX	0.0	0.0
291	QMB Medicare Services XVIII	7.7	12.7
330	Part A Buy-In Premium	2,029.7	2,295.8
331	Part B Buy-In Premium	3,648.6	3,746.4
335	Private Health Ins. Premium	0.0	0.0
	TOTAL MED OTHER SERVICES	**83,299.7**	**94,563.6**
	MEDICAID EPSDT		
350	EPSDT Dental Care	5,725.0	5,985.1
351	EPSDT Physician Services	117.8	131.3
352	EPSDT Other Services	5.3	0.1
353	EPSDT Laboratory & Xray	1.0	0.1
354	EPSDT Glasses	1.0	
355	EPSDT Therapy	56.7	61.4
356	EPSDT Pros. Devices-Med Equip	5.7	0.5
357	EPSDT Transportation	157.9	152.7
	TOTAL MED EPSDT	**6,069.4**	**6,331.3**
399	TPL Recovery Contract	64.9	81.4
	TOTAL TPL RECOVERY CONTRACT	**64.9**	**81.4**

Acct	Category of Service	FY96 Actuals	FY97 Actuals
MEDICAID FACILITIES			
	MEDICAID HOSPITALS		
400	Inpatient Hospital	55,352.2	56,669.2
405	Inpatient Psych Hospital	9,412.5	6,722.3
410	Outpatient Hospital	13,884.9	14,123.5
415	Outpatient Surgical Centers	723.2	644.9
	TOTAL MED HOSPITALS	**79,372.8**	**78,160.0**
	MEDICAID NURSING HOMES		
420	Nursing Home Skilled	11,535.8	8,812.3
425	Nursing Home Intermediate	33,492.6	31,222.6
426	OBRA '87 REIMBURSEMENT	35.8	36.7
427	ACS Res Psy Treat	3,729.2	3,104.6
430	Nursing Home Hope ICF MR	5,013.0	161.3
440	Interim Payments	18.0	0.0
	TOTAL MED NURSING HOMES	**53,824.4**	**43,337.6**
449	TPL Recovery Contract	52.7	107.7
	TOTAL TPL RECOVERY	**52.7**	**107.7**
MEDICAID STATE PROGRAMS			
570	Inpatient Psych - API	214.9	168.3
571	API Dispr Share Adj Payment	7,384.3	7,127.1
575	DOE School Based Services	0.0	1,700.0
576	PH Compass RSA	0.0	540.1
577	CRA Compass RSA	0.0	76.2
578	DOL Tbcco LW Suit DF	0.0	35.0
580	Harborview ICF/MR	1,749.2	1,090.1
581	Harborview ICF	854.9	627.2
582	DADA RSA	70.9	119.9
583	DOE RSA	213.5	0.0
584	DOL-Legal Services RSA 100%	85.0	85.0
585	Public Advocacy RSA	41.3	67.8
587	DOL-Legal Services RSA 50%	154.1	190.0
588	DPS - Background Check	1.7	1.7
589	Disability Determination RSA	51.5	88.8
590	DFYS Identify Svc ND	0.0	14.0
591	DMHDD RSA XIX	919.0	1,146.8
594	OAC Waiver RSA	209.7	691.6
595	CON RSA XIX	65.8	66.7
596	DFYS RSA XIX	215.0	259.5
597	DFYS-MH	752.6	0.0
598	DPH RSA	6,093.4	6,884.8
	TOTAL MED STATE PROGRAMS	**19,076.8**	**20,980.8**
MEDICAID INDIAN HEALTH SERVICE			
600	IHS Clinic	7,130.6	9,428.2
610	IHS Inpatient	10,465.7	12,246.0
620	IHS Outpatient	13,024.2	18,908.7
	TOTAL MED IHS	**30,620.5**	**40,582.9**
MEDICAID WAIVERS			
	OLDER ALASKAN WAIVER		
650	Care Coordination		481.5
651	Residential Support Living		1,828.3

Acct	Category of Service	FY96 Actuals	FY97 Actuals
	OLDER ALASKAN WAIVER, *cont.*		
652	Chore, PDN, ADC, Respite		1,296.3
653	SME & Environmental Modification		213.9
654	Meal Service and Transportation		224.7
	TOTAL OLDER ALASKAN WAIVER	**1,926.0**	**4,044.6**
	ADULT DISABLED WAIVER		
660	Care Coordination		150.1
661	Residential Services		980.9
662	Day Services		125.0
663	SME & Environmental Modification		99.5
664	Chore Services & Respite		154.7
	TOTAL ADULT DISABLED WAIVER	**873.7**	**1,511.2**
	MENTALLY RETARD/DEVELOPMENTALLY DISABLED WAIVER		
670	Care Coordination		731.8
671	Residential Services		9,412.1
672	Day Services		1,220.1
673	SME & Environmental Modification		62.7
674	Chore Services & Respite		182.5
	TOTAL MR/DD WAIVER	**3,995.5**	**11,609.2**
	CHILDREN W/MEDICALLY COMPLEX CONDITION WAIVER		
680	Care Coordination		140.0
681	Residential Services		1,018.9
682	Day Services		1.0
683	SME & Environmental Modification		112.4
684	Chore Services & Respite		244.5
	TTL CMCC WAIVER	**1,096.7**	**1,516.9**
	TOTAL ALL MEDICAID SERVICES	**326,276.2**	**349,170.3**
GENERAL RELIEF MEDICAL			
	GRM HOSPITAL		
900	Inpatient Hospital	1,113.8	684.3
905	Outpatient Hospital	0.2	0.2
	TOTAL GRM HOSPITAL	**1,114.0**	**684.5**
930	GRM PHYSICIANS SERVICES	1,080.4	1,148.6
	TOTAL GRM PHYSICIANS SERVICES	**1,080.4**	**1,148.6**
	GRM OTHER SERVICES		
939	GRM Other Services	0.0	0.0
940	Pharmaceuticals XIX	0.0	0.0
941	Pharmaceuticals GRM	394.7	488.4
942	Transportation	91.7	118.7
943	Dental Care XIX	0.0	0.0
944	Dental Care GRM	3.5	3.6
947	Pros Device-Medical Equipment	19.2	20.8
950	Independent Labs	16.3	19.3
951	Nursing Home Care	(60.0)	13.3

Acct	Category of Service	FY96 Actuals	FY97 Actuals
	GRM OTHER SERVICES, *cont.*		
955	Family Planning	2.8	2.3
956	Abortion XIX	654.8	887.8
957	Sterilization (ALL OTHER)	23.2	18.2
958	Abortion GRM	4.8	4.4
	TOTAL GRM OTHER SERVICES	**1,151.0**	**1,576.8**
989	TPL Recovery Contract	16.3	2.9
	TOTAL TPL RECOVERY CONTRACT	**16.3**	**2.9**
	TOTAL ALL GRM SERVICES	**3,361.7**	**3,412.9**
	ALASKA LONGEVITY BONUS HOLD HARMLESS		
790	ALB Hold Harmless	29.4	43.3
	TOTAL ALB HOLD HARMLESS	**29.4**	**43.3**
	PERMANENT FUND DIVIDEND HOLD HARMLESS		
750	PFD Hold Harmless Non-Facility	122.8	139.4
760	PFD Hold Harmless Facilities	390.0	314.0
	TOTAL PFD HOLD HARMLESS	**512.8**	**453.4**
	TOTAL MEDICAL ASSISTANCE	**330,180.1**	**353,079.8**

FY97 Expenditures Summary

MEDICAID NON-FACILITY	**134,748.8**	**147,319.4**
Medicaid Physician Services	45,314.7	46,343.0
Medicaid Other	83,299.7	94,563.6
Medicaid EPSDT	6,069.4	6,331.3
Medicaid TPL Recovery	64.9	81.4
MEDICAID FACILITIES	**133,249.9**	**121,605.3**
Medicaid Hospitals	79,372.8	78,160.0
Medicaid Nursing Homes	53,824.4	43,337.6
Medicaid TPL Recovery	52.7	107.7
MEDICAID STATE PROGRAMS	**19,076.8**	**20,980.8**
MEDICAID INDIAN HEALTH SERVICE	**30,620.5**	**40,582.9**
MEDICAID WAIVERED SERVICES	**8,580.3**	**18,681.9**
TOTAL ALL MEDICAID SERVICES	**326,276.3**	**349,170.3**
GENERAL RELIEF MEDICAL		
GRM Hospital	1,114.0	684.5
GRM Physicians Services	1,080.4	1,148.6
GRM Other Services	1,151.0	1,576.8
GRM TPL Recovery	16.3	2.9
TOTAL ALL GRM SERVICES	**3,361.7**	**3,412.9**
ALASKA LONGEVITY BONUS H.H.	**29.4**	**43.3**
PERMANENT FUND DIVIDEND H.H.	**512.8**	**453.4**
TOTAL MEDICAL ASSISTANCE	**330,180.2**	**353,079.8**

Tony Knowles
Governor

Karen Perdue
Commissioner

February 1998

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"...to promote and protect the well-being of every Alaskan by investing in families and communities."

DULCE NOBRE

ALZHEIMER'S ASSOCIATION
ALASKA CHAPTER

Annual Report 1996 1997

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FROM OUR PRESIDENT AND OUR DIRECTOR

During the past year, the Alzheimer's Association Alaska Chapter considerably expanded its ability to serve individuals and families dealing with Alzheimer's disease and related disorders (ADRD). Thanks to consistent public and private support our revenue increased substantially, and our dedicated volunteers multiplied in numbers and in their level of commitment.

This growth enabled us to continue to provide outreach and support to families throughout the state, to increase our education programs for professional and lay caregivers, and to support national research efforts. During fiscal year 1997, we strengthened our Care Coordination and Respite Programs through increased staff training and further integration of program operations. Our In-home Respite Program alone delivered over 50,000 hours of care to families statewide, an increase of 67% over the previous year. We also renewed our fund development efforts by recruiting a development director.

As we continue hoping for effective new treatments and a cure, Alzheimer's disease continues taking its toll on Alaskans. By the year 2010, the number of people with Alzheimer's will double to more than 6,000. However, because we believe that the information and support that the Alzheimer's Association provides can ease the hardship of this devastating disease, we will continue working hard to enhance the care and support available to families. In a pro-active stance, in April of '97, our Board began a strategic planning process that will prepare us and guide us into the new century. The plan is optimistic, and filled with hopes about research breakthroughs, while realistic about the challenges that lie ahead.

As a private, non-profit organization we rely on individual and corporate support to meet the expanding needs of families. Therefore, we want to acknowledge all our members and supporters, public and private entities, who realize the importance of the work we do and support our efforts. We are also proud of the commitment of our Board, staff and volunteers as we move through the challenges, towards a world without Alzheimer's.

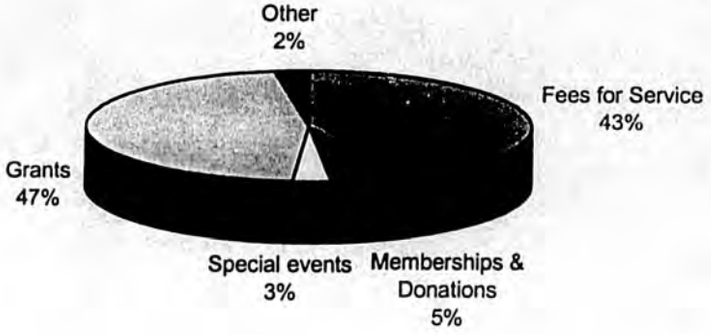
Jonell M. Snook-Holmes,
President of the Board of Directors.

Dulce Nobre
Executive Director

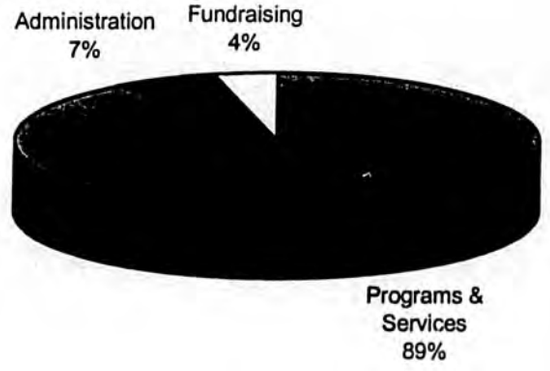
1996 - 1997 FINANCIAL REPORT

The Association ended its fiscal year 1997 with revenue of $1,680,095, from sources as shown. Overall expenses were $1,561,074 with almost 90% of expenses attributed to program costs.

FY 1997 REVENUE



FY 1997 EXPENSES



Audited Financial Statements for the year ending June 30, 1997 were

SUPPORT GROUPS

Our support groups meet monthly and bi-monthly throughout the state. Caregivers attend these to discuss problems, share concerns, exchange information and lend each other emotional support. In FY97, more than 340 caregivers attended our 65 support groups.

IN-HOME RESPITE

Our Respite Workers go into the homes and allow caregivers time off for rest, self-care or tasks. Statewide we:

- provided 50,839 hours of in-home respite care for 230 families affected by Alzheimer's Disease and related disorders;
- presented 18 hours of training and continuing education for our 80 respite workers.

CARE COORDINATION

We locate and access community services and resources for adults needing assistance. FY 97 was our second year of operation, and our Care Coordinators served 456 clients in the Anchorage area.

Under a one-time contract with the State Division of Senior Services, to determine needs and identify available resources, we conducted geriatric assessments for individuals living in assisted living homes or on the waitlist for the Pioneers' Homes.

ACTIVITIES TRAINING FOR ASSISTED LIVING FACILITIES

With a grant from the national Alzheimer's Association we developed an Activity Training Curriculum, purchased materials and established an "activities lending closet" which is available to the public. We provided training to 14 assisted living facilities at which we reached 68 care providers and residents.

MEMORY WALK 1996

Our largest event of the year was held for the 4th year in a row, in Anchorage, Fairbanks, Juneau and Homer. It raised $37,000 and attracted 300 walkers statewide. The top fundraiser in Alaska was Frances Vadla, from Big Lake.

ADVOCACY

We continue to advocate for the rights of individuals coping with ADRD, and for the development of appropriate services. In FY97 we:

- participated in the Public Policy Forum in Washington, D.C., along with 428 other advocates from all over the Nation. Our efforts yielded, among other successes, $335 million in the overall funding of the National Institute of Health, the largest supporter of Alzheimer's research;
- coordinated advocates' training workshops in Anchorage and Fairbanks.

ANNA FATH

Long Term Care Task Force Meeting
August 19, 1998

Tanana Chiefs Home Care serves the frail elders and the disabled of 43 Interior villages.. This geographic area is about the size of Texas and ranges from the Canadian Border West to Holy Cross; from the Brooks range to the Alaska range. There is an elderly population of about 650 in this area. Our clients are mostly Athabascan native elders but several are non-natives who live in the rural villages. Services are currently available in 23 of the villages. Services include Respite, Personal Care Services and Care Coordination. There are 60 clients receiving Personal Care or Respite services from any of 42 providers. There are 12 clients who are on the Home and Community Based Waiver. About 80 clients receive care coordination services. This is a duplicated number since this also includes the PCA and Choice Waiver clients.

Our program allows the client to age in place in his or her home community, close to those they love and with the faces, foods and routines comfortable and familiar to them. Family and friends are supported in caring for their loved ones and the risk of "burnout" is reduced. A year's worth of home care, even with the enhanced services offered by the Choice Waiver is cheaper than the cost of an extended care facility in an urban area. The price of separation from loved ones and land cannot be measured. This is congruent with our mission statement that says that *Home Care will provide compassionate services for the elderly and disabled to have the opportunity to live and die with dignity in their own homes or community*

This program offers more than just services to the elderly and disabled. It offers training and jobs to members of these rural communities. The personal care attendants are recruited from the villages and receive 3 weeks of training. They sit for the state examination and the majority meet the requirements for licensure as Certified Nurses Aides. Confidence, dedication and pride are just a few of the outcomes for the provider. This work is difficult. These individuals are advocates for their clients and most go "above and beyond" in what they do for the client and the family. They are role models for the practice of the art of nursing. The bonds between client and provider are visible. These individuals and the services they provide are often the fragile link between remaining at home or institutionalization.

There is a program director, Cyndi Nation-Cruikshank who is a social worker. Two program assistants who deal with payroll, timesheets, Medicaid billing and administrative details. Two RN's who provide the direct supervision and link with the providers in the field. The RN's visit the villages twice per year to perform the assessments and reassessments for the clients. At least once per year every person over the age of 60 is visited to review their health status, home safety, risk factors for illness. Many of the "young elders" are often the primary caretakers of their own frail "very old" parents. In more than one case we have situations where the services offered to a single 90-something client benefit the 70-something kids who have their own problems with arthritis, heart disease, diabetes, etc and are just squeaking by. If they succumb physically or to emotional burnout, that old elder will wind up in assisted living or Denali. I can cite more than one situation where we are getting 3 for the price of 1! The program is explained to them. We also survey what the elders of each community see as their primary needs. There are four resounding needs: more chore services, transportation, community senior housing or assisted living, and friendly visitors. I have seen elders try to sweep snow from the arctic entry or top step, lose their balance and fall; try to get to the post office to pick up mail and fall on the ice; empty a honey bucket; get wood from the pile, wrench a back making a bed or changing the linens or just plain "bummed" because they cannot maintain the standard of housekeeping they were used to when they were younger. The communities are not paved and even in beautiful summer weather the paths and roads are uneven. This confines the elders whose gait is less steady. The isolation is depressing. Just a van or some kind to get to the store or community center would make life easier. I have never met a client who has told me of the burning desire to live in Fairbanks or Anchorage. They all want to live at home. TCC's vision is *to establish PCA and Respite services in 50 villages by July, 1999 and initiate chore services in 10 villages by July, 1999.*

The services offered at this local level prevent injury, provide comfort, assure compliance with medical regimens. The elders are kept at home longer and healthier. They can end their days in dignity and surrounded by those they love. Ultimately this converts to dollars saved. How we treat the weakest members of our society is a measure of our degree of civilization and humanity. What we do in caring for them is an example for our young people. The example that we set and the infrastructure established for the frail and the old will set the stage for how we will be treated in our dotage or infirmity.

Anna M. Fath RN Coordinator, TCC Home Care

PATRICK REINHART

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

STATE INDEPENDENT LIVING COUNCIL

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July 17, 1998

Karen Perdue, Commissioner
Department of Health & Social Services
P.O.Box 110660
Juneau, AK 99811-0660

RE: Proposed PCA Regulations (AS 47.05.010 and 47.07.030)

Dear Commissioner Perdue:

I would like to offer my professional observations regarding the proposed regulation changes to the State's Personal Care Attendant Program (June 10, 1998): AS 47.05.010 and AS 47.07.030.

First, the proposed regulations include some needed changes, but they do not go far enough in making this personal care attendant program the best it can be for our citizens who need these services to live on a daily basis. ***This program should be about consumer choice and empowerment.*** It should be about giving people the tools they need to live free of institutional walls. ***We must take the steps necessary to move the program in that direction, and if it costs more money to do it right, it pales in comparison to the costs of doing it wrong.***

This program, more than any other Medicaid sponsored program, can do the greatest amount of good for our citizens with the severest disabilities and our frail elderly, while at the same time save money which might be spent on expensive institutional care. ***I encourage you, and the Division of Medical Assistance, to hire an independent, outside consultant to review the true costs and benefits (financial and otherwise) of providing a quality an innovative personal assistance services program, such as those in Kansas and Oregon.*** I say this because the fiscal note attached to the proposed regulations describe only the expenses of this program, and not the savings anticipated in other Medicaid funded services, such as avoidable hospitalization and unnecessary incarceration in nursing homes and assisted living homes.

At a conference in May of this year, myself and other Alaskans heard representatives of Kansas and Oregon talk about how their investment in their state's personal assistance service program a few years ago is now reaping much larger benefits for their disabled citizens, as well as decrease their state's Medicaid costs. Plus, we listened to officials from the Health Care Finance Administration talk about how they are encouraging states to look at this very issue and to

innovate. The message was clear: ***there are very few restrictions on what and how states provide personal care attendant services, and how much we spend on it, except for what we place upon ourselves right here at home.*** These regulations, therefore, are those restrictions that we place upon ourselves. (Based on what I heard at the one "unteleconferenced" public hearing on July 7, they are not the restrictions that the disability community wanted to hear).

Of general note, the disability community worked very hard to move this program and its services away from the "we'll take care of you" medical model of the past, hence HB 459's provisions to remove the physicians prescription and nurse supervision requirements of the program. We thought the message of these statutory changes was clear. Yet, the language of the proposed regulation continues to speak of "treatment plans", "medical conditions", etc. ***Also, there is not one sentence that speaks to the issue of "consumer directed" services, or "consumer managed care"***, a point we have been discussing with the Division of Senior Services for well over a year.

Overall, I believe the Department should move forward with these regulations, particularly concerning the issues of reimbursement rates, although I and many others I have spoken with have several reservations which are described in the attached. In my professional opinion, these regulations are only small Band-Aids to a program that should go back to the drawing board altogether. We need to step aside and say "what is the best personal assistance services program we can provide", and then outline the costs and advocate with the Governor and the Legislature to make the statutory changes and get the level of funding we need to do it right. (Kind of like what you all did with the "Smart Start" package for kids). Overall, to do this right, to support people with the severest disabilities and our elderly to stay in their homes, with quality personal assistance services, paid for mostly by the feds, and with the chance to save money in the long run, it should be an easy sell compared to "Smart Start". I know our council is going to work on this very issue as a legislative piece this year. I certainly hope you will join us and support us in this endeavor.

Attached are some specific points of concern regarding the proposed regulations.

Sincerely,

Patrick Reinhart
Executive Director

cc. Mark Boyer, Commissioner, Department of Administration
Bob Labbe, Director, Division of Medical Assistance
Kay Burrows, Acting Director, Division of Senior Services
David Maltman, Governor's Council on Disabilities and Special Education
Joyanna Geisler, Chair, SILC Personal Assistance Services Committee
Jane Demmert, Alaska Commission on Aging
Attachment

State Independent Living Council
1016 West 6th Avenue
Ste. 205
Anchorage, Alaska 99501
Patrick: (907) 269-3571
Karla: (907) 269-3576
Fax: (907) 269-3633

Memo

To: Jon Sherwood, Division of Medical Assistance

From: Patrick Reinhart, Executive Director, State Independent Living Council

CC: Karen Perdue, Mark Boyer, Bob Labbe, Kay Burrows, David Maltman, Joyanna Geisler

Date: 07/20/98

Re: Comments – AS 47-05.010 and AS 47.07.030, "State Personal Care Attendant Program"

Under 7 AAC 43.750(a).....

(a) Remove from line 6 the words "prescribed by a physician". I was under the impression HB 459 removed this requirement. It seems to be eliminated elsewhere but not here.

(b) Under section 3, remove the words "treatment plan" and replace with "consumer directed personal assistance service plan". We need to move away from "medical model" terminology. People who use these services may not be sick and may not need treatment, but they could use some help getting out of bed, eating, etc. This is not "treatment", it is assistance.

(d) See (b) above.

Under 7 AAC 43.760(f).....

(f) Remove from line 4, the following "....are appropriate for the care of the recipient", and simply say "the living conditions include adequate sanitary conditions for hand washing and waste disposal". Again, medical model terminology is unnecessary.

Also, why define "personal residence" further to include foster homes and assisted living homes? Isn't the first line which describes a personal residence as a place the recipient considers his/her home enough? I am concerned that listing assisted living homes as a specific place where services can be provided will only lead to more people being placed in homes for the purpose of getting these services, particularly if personal care attendant services performed at assisted living homes become a higher priority than those in personal residences in times of budget shortages.

Under 7 AAC 43.765 (c).....

See (b) above, i.e. replace "treatment plan" with "consumer directed personal assistance service plan".

Under 7 AAC 43.790 (b) and (d) – (h).....

(b) We have been talking with the Division of Senior Services for well over a year about getting away from the whole "time for task" method of calculating the hours of services an individual needs. All reference to "treatment plans" should be stricken and instead, it should read as follows:

"The division will base its reimbursement upon the needs of each individual recipient, as specified in the individual's consumer directed personal assistance service plan, developed jointly by the recipient and a representative of the division. Except as provided in (d) of this section, the division will not reimburse a provider for services not included in the consumer directed personal assistance service plan".

(d) The proposed plan to limit recipients of pca services to 4 hours/day or 28 hours per week (down from 8 hours and 56 per week), will result in inadequate assistancefor recipients. ***The result is likely to be increased hospitalizations of recipients, unnecessary and early entry into nursing homes and assisted living facilities, and a massive increase in the administrative burden of the Division of Senior Services.*** Under these proposed regulations, DSS (or its designee) would have to review and approve or deny all "treatment plans" that require more than 4 hours a day, based on the individual's "medical condition". Allowing flexibility in the hours of services will not break the bank, and if other state's experiences in doing this, such as in Kansas and Oregon, is an indication, then we will save money on the nursing home and assisted living side. Essentially, we should trust the individual recipient in describing their particular needs. The professionals at DSS and its designee's can spot abuses when they exist, and use, if necessary existing Medicaid fraud laws to pursue scofflaws. TRUST THE CONSUMER. Do not punish them up front. If the consumer believes this is their program, and they are the managers of it, they are not likely to abuse it. Instead, section d should read:

(d) "When a recipients consumer directed service plan requires personal care attendant services for more than 8 hours per day, or 56 hours per week, the consumer should submit a written justification to the division for approval. If the division approves a consumer directed personal assistance service plan that requires more than 8 hours per day or 56 hours per week, the division will reimburse the personal care agency or the independent personal care provider a t the hourly rate provided for in this section or $200 per day, whichever is less.

(e) No recommended changes.
(f) No recommended changes.

(g) Presently, there is a shortage statewide of independent pca's, and this is the reason why: WE DO NOT PAY THEM ENOUGH. Being a pca is a critically important job, one that is crucial to helping individuals maintain in less restrictive and higher quality living environments, and keep them out of more expensive nursing homes and assisted living settings. The proposed regulation change increases the wage from $9/hr to $12/hr. An independent pca must also then pay their own payroll taxes, cover their own medical, retirement, etc.

Recently, I checked with the Municipality of Anchorage, and their starting pay for "swampers", those people who handle our raw sewage, get paid either $14.17/hr (non-union temporary), or $12.85 hour (union, permanent). Garbage handlers, on average, make $15/hr or more. On top of this wage, their employer pays payroll taxes, workman's comp, etc, on their behalf, and they are eligible for medical benefits and retirement packages. What does this say about the State of Alaska if we are willing to pay people who handle our trash and sewage more than those who provide essential, life preserving work for our disabled citizenry.

What is being proposed, $12/hr, while welcome by independent pca's, is completely inadequate. Why not institute a tiered system be in place for independents. $12/hr for all new entries in the program, and $15/hr for all persons who are licensed and practicing (i.e. provided at least 500 hours of pca services, either in an agency or independent, the previous two years. For those who have at least three documented years of service, go to $18/hr. By doing this, we will actually encourage the number of independents, get people off the waiting list and out of institutions. The division keeps track of hours, so this should not be too difficult to institute.

(h) No proposed changes.

End of comments.

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PATRICK REINHART

THE ECONOMIC IMPACT OF LONG-TERM CARE ON INDIVIDUALS

Lisa Alecxih and David Kennell

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I. INTRODUCTION

The major public insurance program for the elderly, Medicare, does not provide long-term care benefits for chronic disabling conditions. Only about 12 percent of the elderly are enrolled in the Medicaid program, either in nursing homes or in the community, and only about five percent participate in any kind of private financing plan for long-term care. Thus, more than four out of five elderly persons lack adequate public or private insurance for long-term care and are vulnerable to the financial risks associated with long-term care use.

Users of formal long-term care services face important economic consequences. These consequences are primarily a function of: (1) the amount of care used; and (2) the user's financial resources. The economic impact of a short nursing home stay is not likely to be great for most people. Nor will the economic impact of long-term care use be significant for the wealthy, regardless of how much care they need. On the other hand, the economic impact on elderly people of moderate means who require extended care can be enormous.

An understanding of the economic impact of long-term care on individuals is a prerequisite for an informed policy debate. Before devising a new set of policies, it is important to understand what effects the current long-term care system has on the elderly, who is most severely affected, and under what circumstances. To this end, this chapter examines the following questions:

- What are the financial resources of the elderly, and how does the economic status of the elderly affect their ability to purchase long-term care services without public assistance?
- How does the use of long-term care affect the financial well-being of those who need care?
- Who can afford long-term care and which groups experience the greatest economic burden?
- What is the combined impact of acute and long-term care costs on elderly persons?
- How affordable are private financing mechanisms for long-term care? What percentage of elderly persons cannot afford to participate in private financing plans?

II. THE FINANCIAL RESOURCES OF THE ELDERLY

The ability of the elderly to buy long-term care services with private resources largely depends upon their personal income and assets. As among the non-elderly population, there is considerable economic diversity among the elderly. Some are very well off, others live in poverty.

Although users of long-term care are generally disabled (particularly the oldest old), it is important to examine the financial resources of both the entire elderly population and the disabled elderly because most users of long-term care have not always been disabled. For example, approximately one-half of all persons entering nursing homes over a two year period were not disabled up to 24 months prior to their

entry. [1]

II.A. Economic Characteristics of the Elderly

Most elderly persons (64 percent) live in families with modest incomes (150 to 299 percent of the poverty level) or moderate to high incomes (300 percent of the poverty level or above) as shown in Table 1. However, over one in three elderly persons lives in a poor or near-poor family (income less than 150 percent of the poverty level). [2] In 1990, the median annual income of these poor and near-poor elderly families was $6,834, or $570 per month.

The elderly's income is derived from four primary sources: (1) Social Security; (2) pension income; (3) employment earnings; and (4) income from assets (see Table 1). Elderly persons in low-income families live primarily on Social Security, while those with moderate to high incomes receive a much higher percentage of their total income from pensions, employment, and assets. Low income persons receive an average of 71 percent of their total income from Social Security. In contrast, persons with moderate to high incomes receive only 23 percent of their income from Social Security, even though they receive higher Social Security benefits. Twenty percent of their income comes from pensions, 29 percent from employment, and 23 percent from income on assets.

Many elderly persons have substantial asset holdings (both financial assets and home equity) due to the accumulation of wealth over their lifetimes. Indeed, the income and asset characteristics of elderly households are very different from those of non-elderly households. The elderly, in general, have lower incomes, but far greater assets. In 1988, the median net worth of elderly households was about twice that of non-elderly households.[3] For example, in 1988, while the median *income* of households under age 35 was about *twice* that of households over the age of 75 ($24,000 versus $11,724), the median *net worth* of households over age 75 was approximately ten times that of households under age 35 ($61,491 versus $6,078).[4]

In recent years, the average net worth of elderly households has increased, while the average net worth of non-elderly households has declined. Between 1984 and 1988, the median net worth of elderly households increased from $68,600 to $73,471 (in 1988 dollars), an increase of 7 percent.[5] Over the same time period, the median net worth of non-elderly households declined in real terms. For example, the median net worth of households between the ages of 35 and 44 declined by 18 percent over this four-year period.

The distribution of wealth among the elderly is highly skewed towards those with the highest incomes. As shown in Table 2, over 20 percent of poor and near-poor elderly persons have no financial assets whatsoever, whereas almost all elderly persons in the higher income groups have financial assets.[6] Of those with financial assets, the median amount of assets owned by the poor and poor-near elderly was approximately $5,510 in 1990. By comparison, the median amount of financial assets owned by elderly persons with modest incomes was about five and half times higher--$30,310. The median amount of financial assets owned by the highest income group was $84,920, more than 15 times higher than those in the low income group. The vast majority of the wealth owned by the elderly is owned by those with the highest incomes.

In comparison to financial assets, home equity assets are more evenly distributed across income groups. Although 40 percent of the elderly with low incomes do not have any home equity, those who do have fairly significant amounts.[7] The median amount of home equity owned by poor and near-poor elderly persons who owned their homes was about $30,500 in 1990. Although non-poor elderly persons had more home equity, the differential in home equity assets is nowhere near as great as the difference in financial assets (see Table 2). Home equity assets comprise the vast majority of the assets held by poor and near-poor elderly persons. Although elderly persons with higher incomes have more home equity than those with low incomes, it does not comprise a majority of their net worth.

Although the elderly have more wealth than the non-elderly, the percentage of elderly persons with both low income and low wealth is *higher* than the percentage of non-elderly persons with both low income and low wealth.[8] Low income elderly (those with income less than 150 percent of the poverty level)

constitute over one-third of the elderly population but hold less than five percent of financial assets. This demonstrates the skewed nature of wealth toward higher income elderly.

Older elderly persons are more likely to be poor or near-poor than the younger elderly. As shown in Table 3, 35 percent of elderly persons between the ages of 65 and 74 live in families with low incomes. In comparison, almost two-thirds of the elderly over age 85 live in poor or near-poor households.

The higher rate of poverty among the very old is partly due to their marital status. Many elderly women become poor as a result of their husbands' death, as evidenced by the many poor people over the age of 85 who are widows living alone with a primary source of income of Social Security survivor's benefits. A widow can become poor as a result of her husband's death for three main reasons: 1) a loss of pension income; 2) a decline in Social Security benefits; and 3) the expenses related to her husband's death. Overall, about two-thirds of elderly persons who are poor or near-poor are not married, and over half live alone. The elderly population with the highest rate of poverty are very old widows who live by themselves.

Older age groups among the elderly are at higher risk of needing long-term care. Table 4 takes a closer look at the economic circumstances of persons age 75 and older. As expected, fewer persons age 75 and over are in families in which someone is still working, and fewer have pension income. As a result, almost half of all persons over age 75 are in poor or near-poor families. Median family income for all persons over the age of 75 was under $1,000 per month in 1990.

II.B. Economic Characteristics of the Disabled Elderly

Of greater relevance to long-term care policy discussions is the economic circumstances of the disabled elderly who most often need to buy long-term care services. Unfortunately, this group is also the least able to afford long-term care services. As shown in Table 5, the disabled elderly are more likely to have low incomes than the non-disabled elderly.[9] Over half of all disabled elderly persons live in poor or near-poor families. In comparison, only about one-third of the non-disabled elderly have low incomes. Also, median financial assets of the elderly disabled are only about one-third that of the non-disabled.

The lower incomes and assets of the disabled elderly are not simply a function of their disability, but also of their age, marital status, and living arrangements. They are more likely to be old, unmarried, and living alone--other factors that are associated with being poor. In sum, elderly persons at the greatest risk of poverty are also those at the greatest risk of being disabled and needing long-term care.

III. ECONOMIC IMPACT OF LONG-TERM CARE USE

The financial circumstances of the elderly are highly diverse, although elderly persons at the highest risk of needing long-term care are more likely to be poor or near-poor. But what is the actual impact of long-term care use on the elderly? For many, the use of long-term care has minor financial impacts. For others, the impact of long-term care use can be catastrophic. It can cause the depletion of lifetime savings, dramatically reduce one's standard of living, or force someone to purchase less care than they need. Economic considerations also sometimes force people to enter a nursing home even though they would rather be home, just because it is easier to qualify for Medicaid coverage in a nursing home than at home.

III.A. Factors Which Determine the Economic Impact of Long-term Care Use

The financial effects of long-term care use differ according to:

- the *type* of services used;
- the *duration* of care; and

- the *level* of financial resources available to pay for care.

Depending on the interaction of these variables, an individual's long-term care use can have little or no impact, a limited impact, or catastrophic consequences.

Type of Services Used

Nursing home care has a far greater financial impact on the elderly than other types of long-term care. Indeed, nursing home care is the largest out-of-pocket health care cost for elderly consumers, accounting for 42 percent of all out-of-pocket health care payments. At an average price of around $80 per day in 1990, the cost of a private nursing home stay can build up very quickly.

Not all persons who enter nursing homes, however, suffer severe economic impacts. Many elderly people enter nursing homes for relatively short stays after being in the hospital for an acute illness, where Medicare will pay for the first 20 days of a nursing home stay if the stay meets Medicare skilled nursing facility (SNF) criteria. About 20 percent of all nursing home admissions are covered by Medicare for at least the first part of the stay.

Home care generally has less of a financial impact on the elderly. First, most elderly persons who receive care at home do not use formal (paid) care. At a point-in-time, only about 20-25 percent of the elderly with functional impairments receive formal services in their homes. Of these, according to data collected in the 1982 National Long-Term Care Survey, about half paid for their own care without help from third-party coverage or other sources.[10] In 1982, disabled elderly persons in the community who paid for home care services spent an average of $222 per month (in 1990 dollars); about half spent less than $54 per month, and ten percent paid more than $540 per month.

Data from the 1987 National Medical Expenditure Survey (NMES) provide information on the home health care use of disabled persons over the course of an entire year. These data indicate that nearly one-third of the disabled elderly (32 percent) use formal home care services. For users, the average number of annual visits was approximately 80. Nearly one half of spending for these services was paid out-of-pocket, while Medicare and Medicaid paid approximately 20 and 25 percent respectively.

Both the costs of private nursing home care and of home care vary significantly around the country, largely depending upon local labor costs. In areas with an excess supply of labor, it is possible to hire home care workers at close to the minimum wage, particularly if services are not purchased through a formal home care agency. Private nursing home prices also reflect local labor costs--as well as capital costs and state regulatory costs.

In the aggregate, the elderly spent about $19.0 billion for nursing home care out of their own pockets in 1989, and about $2.4 billion for home care. Thus, private payments for nursing home care outweigh spending for home care services by about eight to one.

Duration of Care

How long a person uses long-term care services has considerable influence on the financial impact of using long-term care. Although many elderly may be able to afford $7,500 for a three-month nursing home stay in 1990, few can afford the $90,000 required for a three-year stay.

Many elderly persons who use nursing home care experience little financial impact because they have short stays. For example, about 40 to 50 percent of persons turning age 65 in 1990 will enter a nursing home at some point during their remaining lifetime. Of these, one in three will use less than two months of care, in total, over their lifetime. Paying for a two month nursing home stay out-of-pocket in 1990 required a little less than $5,000 in financial resources, an amount many elderly can afford. And, as discussed above, many of these short stays are partly or fully paid for by Medicare.

On the other hand, about 20 percent of all persons turning age 65 in 1990 will spend a year or more in a nursing home before they die--about 45 percent of all nursing home users. Although many of these

persons will have Medicare and/or Medicaid coverage for all or part of their stays, many others will pay for most of their care privately. At $30,000 per year, a year or more of nursing home care not covered by Medicare or Medicaid is beyond the means of many elderly persons.

Level of Resources

Obviously, the economic impact of long-term care is also related to the amount of income and assets an elderly person has when they start needing care. Previously, we discussed the diverse financial resources of elderly persons, and the correlation between elderly persons at risk of being poor and near-poor and at risk of needing of long-term care. However, the ability to purchase long-term care services relates not only to one's absolute level of financial resources, but also to other circumstances. For example, even though single persons generally have fewer resources than couples, paying for nursing home care out-of-pocket can be less difficult for single persons who are likely to be permanent nursing home residents because they do not have to maintain a separate household for a non-institutionalized spouse.

In addition, a single person may have less of a need to preserve financial assets. A nursing home resident with a non-institutionalized spouse will want to preserve assets for the future financial security of the spouse. The depletion of assets, in and of itself, is not necessarily a drastic economic event for unmarried nursing home residents, as long as there are sufficient assets to pay for all the care that will be required. In general, the depletion of lifetime savings for a single person is probably less devastating than asset depletion for a couple.

Indeed, asset depletion during the later stages of life is a normal event in "precautionary" theories of savings accumulation and depletion. Just because someone is depleting assets to pay for nursing home care does not mean that they are necessarily suffering a severe economic event.[11] People accumulate assets during their lifetimes precisely because they know that they will have to draw upon those assets during their retirement years. The question is whether people have adequately saved for the possibility of needing nursing home care, and what effect the use of long-term care has on someone's use of their accumulated assets over the course of the remainder of their life.

It is often assumed that a person who qualifies for Medicaid coverage upon admission to a nursing home experiences little financial impact because they are "insured" by Medicaid. However, Medicaid nursing home insurance has a very high copayment requirement--all income except for $30 per month. Thus, persons on Medicaid with relatively high incomes but few assets can still experience significant financial impacts. All income must be applied to the cost of nursing home care, and little or no income is available to pay for "amenities" such as clothing, trips outside the home, hair appointments, birthday presents for relatives, or telephone calls.

Another consideration is that although nursing home care costs more than home care, payments for nursing home care include shelter and food, as well as services. Thus, although someone may have lower out-of-pocket costs for home care services, the economic impact on their standard of living can be much greater, if they have less income left for living expenses. They may use less heating fuel, take fewer baths, eat less well, or not use other medical services, such as taking prescription medicines. The economic impact of using home care services must be assessed both in the context of an individual's financial resources *and* their other living expenses.

In sum, the economic impacts of long-term care use on individuals depends upon the type of care they need, how long they need it, and how well they can afford it. Other factors must also be considered, such as whether a nursing home recipient has a non-institutionalized spouse, and what other living expenses a home care user has reduced in order to pay for formal services.

III.B. Long-Term Care Costs Affect Different Groups of Users

This section discusses how the use of long-term care affects different types of users. We begin by talking about types of long-term care use that have little or no financial impact. Other types of use have a moderate impact; they may significantly affect an individual's economic circumstances, but not to a devastating degree. Finally, there are some persons for whom the use of long-term care turns into a

financial catastrophe.

Little or No Financial Impact

- **Persons recovering from an acute care episode where longterm care services are covered by Medicare**. About 14 percent of all nursing home admissions consist of persons who are both admitted and discharged on Medicare.[12] The vast majority of these persons are discharged prior to using 21 days of care, and therefore they have no co-payment requirements for Medicare-covered days after the 20th day.

- **Persons who qualify for Medicaid in the community in States that have more generous long-term care coverage**. Persons who qualify for Medicaid in the community already have "long-term care insurance," although the degree to which States provide long-term care coverage for Medicaid beneficiaries varies substantially from State to State. Medicaid recipients in States with broad home care coverage may have relatively good access to Medicaid-financed home care services, while recipients in other States may have little or no access, in spite of being "insured." Approximately 2.4 million elderly were Medicaid enrollees in the community in 1990. (8 percent of the elderly population)

- **Persons with mild impairments who receive informal care only from a spouse, family, or friends**. About three out of four persons living in the community with IADL and/or ADL impairments receive no paid care at all. They receive all of their care from spouses, family or friends. It is important to note that not all of these persons experience little or no financial impact from using long-term care. If family members or friends have reduced or terminated employment in order to serve as caregivers, then substantial financial impacts may have occurred, if not directly on the recipient of care, then on the caregiver.

Moderate or Short-Term Financial Impacts

- **Private pay patients with short nursing home stays. Most nursing home stays are not long stays**. Even most persons who are not covered by Medicare or Medicaid when they enter a nursing home experience only moderate financial impacts. About half of all persons who enter nursing homes as private pay patients are discharged in three months or less.[13] With the average cost of a three-month nursing home stay somewhere between $7,000 and $8,000 in 1990, a short-term nursing home stay would have a moderate financial impact, but not a catastrophic impact on most elderly persons.

- **Elderly persons who qualify for Medicaid upon admission to a nursing home**. Research indicates that about half of all elderly persons who are eligible for Medicaid during the first month of their nursing home stay were *not* eligible for Medicaid prior to entering a nursing home.[14] These persons generally have low assets, but too much income to qualify for Medicaid outside a nursing home. Once they enter a nursing home, they must contribute all of their income to the cost of their care, except for a small personal needs allowance of $30 per month in most States. For these persons, the major financial impact is that they are left with virtually no discretionary income once they enter a nursing home--they have become entirely dependent on Medicaid and the nursing home to provide shelter, food and services.

- **Elderly persons with adequate financial resources**. About 25 percent of the elderly live in families with moderate to high incomes, and which have significant financial assets. The median annual family income of persons in this group in 1990 was about $34,000. In addition, median financial assets owned by persons in this group was about $85,000, and almost 90 percent owned additional equity in their homes. Single elderly persons in this income group will generally have sufficient income and assets to pay for several years of nursing home care. For married couples, there may be a more substantial financial impact on the standard of living of the non-institutionalized spouse, given the share of their combined incomes that must be used to pay for private nursing home care.[15]

Catastrophic Impacts

- **Elderly persons with moderate income and assets who require extended nursing home ca** About one in four persons who enter nursing homes as private pay clients stay for one year or more. Persons with modest incomes(between $12,000 and $25,000 annually) cannot afford the private cost of nursing home care from their current income and must also use their assets to m their monthly nursing home payments. Many persons of moderate means who require extended nursing home care end up depleting *all* of their financial assets and applying for Medicaid coverage. This process is referred to as "Medicaid spend down." Other persons may not ever spend down all the way to Medicaid eligibility levels, but still deplete the vast majority of their total financial wealth before death or discharge. Persons who are discharged alive after depleting most of their life's savings in a nursing home may not be able to be financially independent in the community and may subsequently become eligible for Medicaid or other forms of public assistance (e.g., SSI or food stamps).

- **Poor and near-poor disabled persons living in the community who do not qualify for Medicaid**. Many disabled elderly persons living in the community have income below or slightly above the poverty level, but do not qualify for Medicaid coverage. These persons cannot afford to buy formal home care services, because they have little or no discretionary income. They may also have other out-of-pocket health care costs, such as for prescription drugs and Medicare Part B co-payments for doctor's visits. Severely impaired elderly persons in this group, if they have families, can become heavy burdens on their informal caregivers. Others have long-term care needs which go unmet. Some enter nursing homes, even though they would rather stay at home, simply because they can qualify for Medicaid coverage more easily if they do so. Although many disabled elderly persons fall into this category, reliable estimates are lacking.

In sum, many users of long-term care do not experience severe financial impact as a result of needing long-term care. Either they receive all of their care from informal caregivers, or they only need care for a short period of time, or they have sufficient financial resources to purchase long-term care services even over an extended period of time.

Other people experience severe financial impact as a result of needing long-term care. A group that suffers particularly severe effects from long-term care is middle-class elderly persons who require extended nursing home care. They cannot afford to pay for their care from current income, and end up depleting a substantial amount of their accumulated life savings, or even all of their financial assets, in paying for nursing home care.

Another group which suffer a severe impact is poor and near-poor disabled persons living in the community who need home care services but who do not qualify for Medicaid coverage. Rather than experiencing severe financial hardship, this latter group is more likely to either have unmet, or undermet needs, or to become a burden on their spouses and families providing care. Some States have non-Medicaid programs which provide home care services to this population, but most do not.

IV. MEDICAID SPEND DOWN

People who enter nursing homes, deplete their financial assets, and then apply for Medicaid coverage, are commonly identified as a population which experiences severe financial impacts from using long-term care. This process is commonly referred to as "Medicaid spend down." A number of research studies have been conducted in recent years focusing on the Medicaid spend down phenomenon. This section provides a brief summary of the spend down literature.

Research on Medicaid spend down poses special methodological challenges. Ideally, a study of Medicaid spend down would follow a representative sample of nursing home admissions, and then track changes in nursing home payment sources for all sample members across all episodes of care, until virtually all members of the cohort have died. Existing studies obviously fall short of this ideal, and thus

must be interpreted in the context of specific limitations in data and methods.[16]

Two studies of the 1985 National Nursing Home Discharge Survey found that only about 10-11 percent of all persons who entered nursing homes as private pay patients spent down to Medicaid prior to discharge.[17,18] The major limitation of these studies is that they only examine spend down patterns over a single nursing home stay, and thus do not account for spend down episodes that may occur during prior or subsequent stays. Therefore, they tend to underestimate the rate of Medicaid spend down over all nursing home stays.

A recent study of the Institutional Population Component (IPC) of the 1987 National Medical Expenditures Survey found that 26.3 percent of all elderly persons who entered nursing homes as private pay patients had spend down to Medicaid at the time of the survey.[19] However, because this study looked at current residents, rather than discharges, it oversamples nursing home users with long lengths-of-stay, who are more likely to spend down than residents with shorter stays. This sampling approach is therefore likely to bias estimates of spend down upward.

Other studies have looked at spend down patterns in individual States. One study showed that 27 percent of all nursing home users in Michigan who were eligible for Medicaid at some point in 1984 had begun their stay as a private pay patient.[20] Several studies have been conducted of the Connecticut Nursing Home Patient Registry, a unique data set which has tracked all nursing home users in that State since 1977. A study of a discharge sample showed that 39 percent of all Medicaid discharges had begun their stay as a private pay client, and about 17 percent of all persons who had begun their stay as private pay client had spent down to Medicaid.[21] This study also documented the importance of looking at the experiences of nursing home users over multiple nursing home admissions, since 77 percent of all persons who had spent down had more than one nursing home stay.

Two other studies using the Connecticut Nursing Home Patient Registry have tracked nursing home admission cohorts. One study of a one-year admission cohort showed that 21 percent of all persons admitted as private pay had spent down after 7-8 years, and 39 percent of all persons who ever qualified for Medicaid had begun their stay as a private payer.[22] Another study which looked at successive admission cohorts over six years found roughly similar results: 22 percent of persons beginning their stay as private payers had spent down, and about 44 percent of all persons who received Medicaid at some point during their stay had begun their stay as private pay patients.[23]

One observation from the State-specific studies is that it appears that Medicaid spend down patterns differ significantly from State to State. For example, comparisons of the Connecticut nursing home population with the National Nursing Home Survey sample suggest that nursing home users in Connecticut are more likely to begin their stay as private payers, and are less likely to spend down, than the national average.[24] This may be due to the fact that the elderly in Connecticut are wealthier, on average, than the national elderly population.

These findings again underscore the observation that the financial impact of being a long-term care user can vary greatly depending upon where one lives. There is a less devastating impact in States where the elderly, on average, have more financial resources to pay for care (i.e. wealthier States) and where State Medicaid programs provide broader long-term care coverage.

Not all persons spend down to Medicaid as a result of an extended nursing home stay. In fact, the spend down research suggests that between 40 and 55 percent of persons who spend down do so within six months of nursing home admission.[25] Thus, many persons who spend down are persons of modest means who spend their available assets rapidly once they enter a nursing home, and qualify for Medicaid soon after admission.

A few efforts have been made to estimate the extent to which elderly persons spend down to Medicaid eligibility levels outside of a nursing home. One study estimated that although the likelihood of spending down to Medicaid increases dramatically once an individual enters a nursing home, that the actual *number* of disabled elderly persons who convert to Medicaid is higher in the community.[26] However, data on the extent to which out-of-pocket costs for long-term care and other health care services cause

elderly people to spend down to Medicaid eligibility levels in the community are lacking. Other research suggests that health care costs are not the major contributing factor.[27]

IV. THE AFFORDABILITY OF LONG-TERM CARE

Research on how people pay for nursing home care provides only part of the picture on the economic impact of long-term care use on individuals. For example, although we can conduct research on the extent to which people are able to pay privately for nursing home care without spending down to Medicaid, this does not give us information about the specific economic impact on these individuals. The spend down research looks at the economic impact of nursing home use on individuals through a relatively narrow lens. Even among people who never spend down to Medicaid, severe economic impact can occur. To what extent are people selling their homes in order to stay off Medicaid? Are children helping to pay for their parents' care? What level of financial resources did these individuals begin their nursing home stay with, and how much remained when they left?

In addition, data on the number, or percentage, of people who spend down to Medicaid over time do not convey the complete picture. To what extent are Medicaid spend downers people who may be qualifying for Medicaid prematurely because they have successfully protected their assets through "Medicaid estate planning" strategies? How many have been able to keep their homes and still qualify for Medicaid? How does Medicaid spend down affect community spouses? In sum, although some research has been conducted on the economic impact of long-term care costs on individuals, there is much that is still not known.

Another lens that can be used to look at the economic impact of long-term care on individuals is to estimate the "affordability" of long-term care for *potential* users of long-term care living in the community. In this approach, we estimate the ability of noninstitutionalized elderly persons to finance a potential nursing home stay out of their annual savings or discretionary income.

Development of these estimates requires assumptions about what constitutes "affordability." First, the resources an individual has "available" to pay for care must be determined. What changes in lifestyle and financial status should be expected of elderly persons when they require long-term care services? Also, what role does the depletion of financial assets play in defining "affordability"? In brief, out of an individual's or family's total income and assets, how does one define what is affordable and what is not?

With these caveats in mind, analyses of the ability of the elderly to "afford" long-term care were conducted using alternative measures of affordability. These measures were used to assess the percentage of persons over the age of 65 who could afford to purchase ***one year of privately-financed nursing home care***. The analyses focus on the affordability of nursing home care, as opposed to home care, because nursing home costs pose the greater financial risk to the elderly.

Different measures of affordability were developed for couples and individuals. Other factors being equal, nursing home care is more affordable to individuals because there is no need to preserve income and assets for the non-institutionalized spouse. However, as discussed in Section I, elderly couples generally have more financial resources than do individuals. Thus, estimates of the affordability of long-term care for couples and individuals are presented separately below.

Couples

For nursing home care to be affordable for an elderly couple, adequate income must be preserved for the community dwelling spouse for fixed expenses such as housing, and health and other types of insurance. These costs would not decline when one spouse is institutionalized. Other household expenses (food, transportation, clothing) would also continue, although at a reduced level. Three measures of "affordability" were developed for couples:

- The **"No Assets"** definition estimates the percentage of couples who could afford one year of nursing home care for one spouse entirely from combined total income, without depleting any

assets.[28] Further, the cost of nursing home care is defined as affordable only if the community spouse did not experience a decline in available income for current household expenditures. Thus, the couple's housing, health and personal insurance expenditures were assumed to be unavailable to pay for long-term care. All other expenditures were assumed to be protected for the community spouse at a level two-thirds of the couple's pre-institutionalized level, meaning one-third of these expenditures were considered available to pay for care.

- The **"50% of Assets Over 4 years"** definition estimates the percentage of couples who could afford one year of nursing home care if they used up 50 percent of their combined financial assets (excluding home equity) over a four-year period. Protected income for the community dwelling spouse is defined the same as above. This definition essentially indicates the percentage of couples who could afford to pay for up to four years of care before depleting 50 percent of their financial assets.

- The **"50% of Assets in 1 year"** definition estimates the percentage of couples who could afford one year of nursing home care if they used up to 50 percent of their financial assets in one year. Further, it also allows the community spouse to keep only 50 percent of all non-housing, health, and personal insurance expenditures. Finally, previous household expenditures for alcohol, tobacco, and charitable contributions are made available to pay for care.

Using these alternative definitions of affordability, we found that from 3 to 48 percent of elderly couples could afford to pay privately for a one year stay in a nursing home (see Table 6). Only three percent of couples could afford to pay for care without using any of their financial assets (at the defined protected income level for the community spouse). If couples use their financial assets at a rate that would deplete 50 percent of their assets over four years, about 16 percent could afford a one year nursing home stay (also a four-year stay). Only when half of all financial assets are assumed to be immediately spent down, and a lower protected income for the community spouse is assumed, does the proportion of families able to afford a year of care approach 50 percent.

We also examined available resources for couples aged 65 and older where at least one spouse was disabled. We defined disability to include persons who require assistance with personal needs such as eating, bathing, or dressing. These disabled individuals who reside in the community are at greatest risk of needing nursing home care in the near future and hence represent an alternative group to consider when estimating who could afford to pay privately for nursing home care. The results are quite similar to those for all couples.

Single Persons

Different measures of affordability were used for single persons, since there is no community-dwelling spouse who must still meet basic consumption needs. Because the institutionalized person's needs for food and other basic living expenses would be met by the nursing home, many current expenditures are foregone. Thus, fewer expenses need to be subtracted from total income in determining the amount of income available to pay for nursing home care.

Nonetheless, one consideration is whether someone who owns a home is allowed to keep the home in case the individual is able to return to the community. If so, expenses for maintaining the home in a nursing home user's absence must be deducted.

Another difference between couples and singles arises in the treatment of financial assets, because it is not necessary to assume that half of the financial assets need to be reserved for the community dwelling spouse. All assets are potentially available to pay for nursing home care.

Thus, for single persons, the following three definitions of affordability were used:

- **No Assets**. This definition estimated the percentage of single persons who could afford one year of nursing home care without depleting any financial assets. It was assumed that a homeowner would be allowed to maintain an owned home by excluding housing-related expenditures from

available income (aside from purchases on new household equipment or furnishings). The individual is also assumed to continue current spending on insurance, personal care needs, reading, apparel, and services and miscellaneous expenses.

- **All Assets over 4 Years**. This definition is the same as the "no assets" definition except that it assumes that all assets are used to pay for care over a four-year period. It essentially indicates the percentage of persons who could afford to pay privately for nursing home stays of up to four years.

- **All Assets in 1 Year**. This definition assumes all financial assets are spent over one year. The amount of income available to pay for care is the same definition used in the prior two definitions.

The findings indicate that somewhat smaller percentages of single persons could afford to pay for one year of nursing home care than elderly couples (see Table 7). This is somewhat surprising, given that the definitions employed allow a higher percentage of income and assets to be available to pay for care for single persons. However, as previously discussed, single elderly persons have lower average incomes and assets than elderly couples.

As also shown in Table 7, the most likely users of nursing home care, the disabled elderly living alone, have the least ability to meet their own needs. Almost none of these individuals could pay for care without using their financial assets, and even then, only about 17 percent could afford up to one year of care.

VI. IMPACT OF ACUTE CARE EXPENDITURES ON THE DISABLED ELDERLY

Elderly persons with chronic disabling conditions are likely to also have expenses for acute medical care in addition to their long-term care requirements. Even though most acute care expenditures are covered by public or private insurance, the costs of recurring prescriptions, doctor's visits, and hospital stays due to deductibles, copayments, and non-covered services can add up very quickly. Some data on the out-of-pocket expenses of the elderly and the use of acute care services by the disabled elderly are available, but there are limited data on the interaction and combined out-of-pocket burden of acute and longterm care needs.

VI.A. Out-of-Pocket Acute Care Expenses of the Elderly

Out-of-pocket medical expenditures for services other than long-term care can be a financial burden for many elderly persons. In 1987, the most recent year of available data, 94 percent of the non-institutionalized elderly had some type of health care expenditure. The average annual expenditure for these persons was approximately $4,560. Twenty-one percent of these expenditures, or nearly $1,000 were financed out-of-pocket, while Medicaid covered a little less than one-half, and private insurance covered 16 percent. The remaining 16 percent of average expenditures among the elderly were financed by Medicaid, other public programs (such as the Indian Health Service), Worker's Compensation, charity and other private sources.[29]

The elderly spend, on average, almost 12 percent of their income for out-of-pocket *acute* medical expenses. One-fifth of the elderly spend more than 15 percent, and one-tenth spend over 20 percent of their income.[30]

Out-of-pocket medical expenditures are a particular problem for low income elderly persons. Persons with income less than $10,000 in 1986 spent an average of 14 percent of their income on medical expenses, double the share of income spent by persons with income above $10,000. For the lower income group, one-third spent more than 15 percent of their income, compared to 6 percent for those with higher incomes. The out-of-pocket medical expenses causing the expenditure of these high percentages of income are not very large; two-thirds of the low income group spending over 15 percent

of their income had out-of-pocket expenses of less than $1,500.

VI.B. Acute Care Use of the Disabled Elderly

The disabled elderly are at greater risk of high out-of-pocket acute care medical expenses than the non-disabled population. Poor health and high levels of impairment for the disabled elderly population increase the use of medical care. In 1984, three-quarters of the severely impaired elderly population reported being in poor to fair health compared to one-quarter of the non-impaired population. Severely impaired elderly persons had over twice the number of physician contacts and three times the probability of a hospital stay in a year than the non-impaired population. The severely impaired elderly population was also more likely to rely on Medicare coverage alone than the non-impaired elderly population, resulting in a higher liability for Medicare copayments and non-Medicare covered services.

An analysis of the average out-of-pocket expenditures per month for disabled elderly persons found that 94 percent of this group had out-of-pocket health care expenditures, and the average per month for all elderly disabled persons was close to $130 in 1982. Out-of-pocket expenditures were distributed by type of service as follows: 42 percent for acute care services (hospital stays and physician care); 20 percent for prescription medicines; 14 percent for home and community-based services; and 25 percent for nursing home care.[31]

The level of out-of-pocket expenditures for health care services among the disabled elderly increases with income level. For example, average monthly expenditures for those with monthly income greater than $1,000 were approximately $167 while those with monthly income less than $500 spent approximately $96 per month out-of-pocket. (See Table 8) However, disabled elderly with lower income have a much higher likelihood of spending over 15 percent of income on out-of-pocket health expenses. Overall, 41 percent of the disabled elderly spent more than 15 percent of their income on out-of-pocket health expenses. Among those with monthly income greater than $1,000 per month, 18 percent spend more than 15 percent of income, while 53 percent of those with monthly income of $500 exceeded this level. Nursing home use was the biggest contributor to catastrophic expenses. The probability of nursing home users having out-of-pocket health care expenditures in excess of 15 percent of income was over two and one-half times that of non-nursing home users.

VII. THE POTENTIAL IMPACT OF PRIVATE LONG-TERM CARE INSURANCE

Private long-term care insurance, and other risk-pooling mechanisms, can mitigate the financial impacts of long-term care on individuals by spreading long-term care costs across users and non-users of services. However, a key issue in the policy debate is the affordability of private long-term care insurance. This section examines three important questions regarding the potential impact of private long-term care insurance for reducing out-of-pocket costs for long-term care:

- What impact can private long-term care insurance have on public and private expenditures for long-term care?
- How affordable is private long-term care insurance?
- Who is a good candidate for purchasing long-term care insurance?

The section focuses on the potential impacts of private long-term care insurance, as opposed to other private financing mechanisms, such as CCRCs and home equity conversions, because it is the most prevalent risk pooling mechanism, and likely to have the greatest impact on the future financing of long-term care. Other private financing mechanisms will also have impacts, but probably to a lesser extent.

VII.A. The Potential Impact of Long-Term Care Insurance on Public and Private

Expenditures for Long-term Care

Even though there has been dramatic growth in the private long-term care insurance market over the last seven years, private insurance is not likely to have a major impact on public and private expenditures for long-term care in the short run. First, only a small percentage of elderly persons currently have insurance, and even most of those who do are not likely to need long-term care (submit claims) for another ten to twenty years. Consequently, in examining the potential impact of long-term care insurance on public and private expenditures, one must project this impact into the relatively distant future.

According to estimates generated from the Brookings/ICF Long-Term Care Financing Model, between 10 and 30 percent of the elderly will have private long-term care insurance coverage by the year 2020, thirty years from now. This estimate assumes that there will be no major changes in public policy, or in the private sector, to make private insurance more affordable than it is today, for example, by changing the tax status of employer and employee contributions to private long-term care insurance premiums.

This increased market penetration of private insurance is projected to occur for the following reasons:

- Continued growth in real incomes among the elderly will make private insurance more affordable to a greater percentage of the elderly.
- Private insurance will be more widely available, and individuals will have more opportunities to purchase insurance at younger ages, further increasing its affordability.
- The value of the elderly's financial assets will also continue to grow, increasing the demand for the asset protection provided by insurance (i.e. the financial risks of long-term care use will increase).
- The elderly will become more aware of the need to protect themselves from the financial risks of long-term care, further increasing demand.
- The group market will continue to grow, increasing the availability of policies with lower premiums.

Under these market penetration assumptions, it is estimated that private long-term care insurance will finance approximately three to seven percent of all nursing home costs by the year 2020, depending on the price and coverage offered by the policies which are purchased.

This level of increased private insurance coverage would lower both out-of-pocket expenditures for purchasers and Medicaid expenditures. Table 9 shows projected public and private expenditures for nursing home care in 2018 under two alternative scenarios: (1) the long-term care insurance market does not develop and no one has insurance; and (2) long-term care insurance is purchased by 30 percent of the elderly.

Compared to a future in which no one has private insurance, it is estimated that 30 percent coverage would reduce aggregate out-of-pocket expenditures for nursing home care by approximately six percent. Increased private insurance would also reduce Medicaid spending by about three percent, since fewer elderly would be forced to spend down to Medicaid eligibility. The percentage of total long-term care expenditures financed by Medicaid would decline from 40.4 percent without insurance to 37.9 percent with insurance coverage.

For individual purchasers of insurance, reductions in out-of-pocket expenditures for long-term care would be substantial. In the long run, policyholders would pay about half as much out-of-pocket for nursing home care as they would have paid without insurance (44 percent of the total cost, instead of 88 percent). Long-term care insurance would cover approximately half of annual nursing home expenditures for purchasers in 2018. Medicaid expenditures for insurance purchasers would only be about one-third of what they would have been had insurance not been purchased.

VII.B. How Affordable is Private Insurance?

The affordability of private long-term care insurance is a subject of heated debate. It is an issue that is central to discussions concerning whether the majority of the elderly can afford to protect themselves from the high costs of long-term care, or whether public financing mechanisms are necessary to provide adequate protection.

The concept of "affordability" has a number of dimensions, and people differ greatly on whether or not they think they can "afford" to buy a certain product. The following factors should be considered:

- The affordability of private long-term care insurance will vary depending upon the breadth and depth of coverage which a policy offers. The price of long-term care insurance varies according to the specific coverage terms of the policy. For example, a policy with a long waiting period (deductible) costs less than a policy with a short waiting period, because most nursing home stays are short.

- The concept of affordability also rests on assumptions about the percentage of income which can be allocated to the purchase of insurance. Some researchers have defined insurance to be affordable if it costs less than 5 or 10 percent of family income. But this standard ignores family circumstances that dictate whether such a share of income is feasible. Many families may not have that much to spare, while, for others, a 10 percent share of income may not be too large a commitment. Also at issue is whether potential purchasers might use asset holdings to pay for long-term care insurance.[32]

- As previously discussed, the cost of private insurance goes up significantly with age. Thus, affordability also relates to when people first purchase insurance. In essence, private long-term care insurance involves saving for the future, and the younger someone starts saving, the more affordable insurance becomes.

- The current and future affordability of private insurance may differ, depending upon relative increases in the real cost of insurance and real family incomes.

The Brookings/ICF Long-term Care Financing Model was used to conduct a series of analyses on the affordability of private long-term care insurance, using different assumptions about the amount of "available resources" families have to purchase insurance. However, it is necessary to point out that not all individuals who could afford to purchase insurance under these assumptions will actually do so. Families may elect to use "available resources" for other types of needs, such as saving for a child's education or meeting projected retirement needs. Moreover, because long-term care insurance is often promoted as a means for protecting assets, a family devoting all of its savings to the purchase of insurance will have fewer assets to protect. Consequently, all of these definitions should be viewed as alternative estimates of who *could* afford to purchase insurance, not who *will* purchase insurance.

Three alternative definitions of "available resources" were used in the analysis:

- *50% of Annual Savings*. This definition assumes that half of all annual savings, after taxes and all household expenditures are subtracted, are available to purchase insurance. This means that the family's spending patterns would remain unchanged and that they would not use any of their assets to buy insurance.

- *100% of Annual Savings*. This definition assumes that all the family's annual savings available from income, after taxes and all household expenditures are subtracted, are used to purchase insurance. Like the first definition, the family's spending patterns would remain unchanged and no assets would be used to buy insurance.

- Annual Savings Plus Some Discretionary Income. This definition assumes that the family would forgo all of its annual savings plus some of its other expenditures in order to afford a long-term care insurance policy. The definition assumes that, if necessary, families would sacrifice on some

luxury items and forgo big ticket purchases to come up with a sufficient amount to pay the cost of premiums.[33]

It is important to note that *none* of the definitions require families to use any of their accumulated assets to buy insurance, and only the third definition assumes families will change their usual spending patterns.

We compared these estimates of available resources with the premium costs of two prototype long-term care insurance products. The costs of these prototype policies, by age of purchase, are presented in Table 10. Annual premium costs range from $285 for the lower-priced policy for purchasers in the youngest age group (45-49) to $4,073 for the higher-priced policy for persons in the oldest age group (age 75-79).[34]

The results indicate that:

- the percentage of persons able to afford a policy declines with age; this occurs primarily because premiums increase with the age of initial purchase;
- for single persons from age 55 to 74, about 20-44 percent of the elderly could afford a policy under the range of assumptions used (see Table 11);
- far fewer single persons over the age of 75 could afford to buy a policy, particularly a higher-priced policy that includes coverage of home care services;
- for couples headed by a person from age 55 to 74, 34-69 percent could afford a policy. Affordability is higher for couples because they have higher incomes (and more savings) and because they can buy one policy. (See Table 12.)

Additional analyses were conducted to assess the affordability of private insurance using both income and asset criteria, instead of just income criteria. Persons with fewer than $10,000 in financial assets were considered unable to afford a policy. These persons also have less incentive to buy insurance because they have fewer assets to protect.

Adding asset criteria reduces the percentage of persons able to afford insurance. For example, 37 percent of single adult households between the ages of 45 and 79 could afford the lower-priced policy if they used 100 percent of their annual savings. If we restrict consideration to only those who have at least $10,000 in financial assets, the percentage who could afford a policy drops to 20 percent.

The Health Insurance Association of America (HIAA) sponsored a survey of purchasers of long-term care insurance age 55 and older in 1990.[35] Although the data do not permit determination of the purchase rate of long-term care insurance (the number of purchasers over the total number of persons) because the data are not weighted to be a representative sample, it does offer information concerning the characteristics of purchasers compared to the general population.

Among persons age 55 and older, purchasers of individual longterm care insurance tend to be younger elderly persons with higher levels of income, assets and education than the general population. Purchasers are more likely to be between the ages of 65 and 74 than the general population (58 percent versus 34 percent). This confirms that in 1990 people tend to make purchase decisions as they get closer to an age of needing longterm care. The small proportion of the oldest old among purchasers also demonstrates the effect of underwriting and the fact that some companies did not offer policies to persons over age 80. In 1990, over 70 percent of purchasers have household income of $20,000 or more compared to 36 percent of the general population age 55 and older. Over 40 percent of purchasers have liquid assets greater than $100,000 compared to seven percent among the general population. Finally, over 60 percent of purchasers had some post-high school education while only 18 percent did among the general population. Unfortunately, the reported data do not permit an analysis of the reasonableness of assumptions using premiums as a percent of income as an affordability criteria.

VII.C. Who is a Good Candidate for Insurance?

In examining prospects for the future growth of the long-term care insurance market, another relevant question is: Even for those who can afford to buy insurance, is it an appropriate purchase? Long-term care insurance can serve a number of objectives. Its primary objective is to reduce out-of-pocket costs that might otherwise deplete, even exhaust, someone's accumulated net worth. It also reduces the risk and fear of spending down to Medicaid eligibility. Private insurance can also improve access to better quality care.

However, for private long-term care insurance to serve these objectives, individuals must not only have sufficient resources to pay premiums, but also the resources to cover copayments and deductibles after they become eligible for insurance benefits. Although it is difficult to establish appropriate income and asset standards for the purchase of private long-term care insurance, persons should be able to afford the premiums required, the deductibles (which routinely amount to several thousand dollars), and the copayments associated with long-term care products.

To address this issue, estimates of the deductible amounts and annual copayments required for someone who bought a policy in 1990, and then entered a nursing home 15 years later were made. We assumed that the policy paid $80 per day, with a deductible period of 90 days. We also assumed that the individual had purchased an unindexed policy, and that nursing home prices had increased by 5.5 percent per year over the 15 year period, leaving the insurance purchaser with a significant copayment for daily costs over the $80 benefit amount.

Under these assumptions, the deductible would cost $16,110 and the individual's first year's copayments would have been $27,225 in the year 2005 (see Table 13). In 1990 dollars, the deductible is equivalent to $8,900 and the copayments are equal to $15,100. This means that the individual who bought this policy would have approximately $24,000 in cost sharing for the first year in a nursing home, in 1990 dollars.

Policies which are partially or fully-indexed will have lower cost sharing requirements when claims against the policy are actually made. As shown in Table 13, if an individual purchased a fully indexed policy, the required cost sharing for the first year of nursing home use would only amount to $16,110 (or $8,900 in 1990 dollars). However, the premiums for this type of policy are l..gher. First year cost sharing requirements for someone who purchased a partially-indexed policy would lie in-between these two amounts: the purchaser would need $26,835 to pay first year costs above and beyond covered benefits ($14,900 in 1990 dollars).

Consequently, in assessing the "affordability" of long-term care insurance, one must take into account not only the actual premium cost of the policy, but also the depth of coverage which the policy will provide when benefits are paid down the road. While some individuals may be able to "afford" one of the lower-priced policies, such as those which do not include protection against inflation, these policies may actually provide very limited or no protection whatsoever, because cost sharing requirements will consume all of the policyholder's resources in deductibles and copayments prior to paying many benefits. In essence, people who would spend down to Medicaid eligibility levels relatively quickly (e.g. within six months of nursing home entry) are probably not good candidates for private insurance.

The purchase of long-term care insurance is primarily of value to persons with substantial incomes and assets to protect. For most couples, the primary motivation is to ensure that the income and assets of the non-institutionalized spouse will be protected if one of them enters a nursing home. For single individuals, the primary motivation is to protect their estates from being depleted, so that they may pass their estates on to their heirs. Nearly one-half of the purchasers of long-term care insurance in 1990 cited minimizing financial exposure and protecting family resources as the most important reason for purchase.[36] Preserving income and assets for one's own self is rarely a primary objective, because most persons with extended nursing home stays do not return home.

However, even people who have no spouse and no desire to protect their estates for their heirs may have an additional objective in purchasing private insurance--staying off Medicaid. Over 90 percent of purchasers in 1990 cited avoiding dependence on Medicaid as a very important or important reason for

purchasing long-term care insurance.[37] Some Medicaid recipients have reduced access to nursing homes. In particular, they may have limited access to better quality nursing homes.[38] Even individuals who enter higher quality homes as private pay clients are not guaranteed that they will stay in those homes once they spend down to Medicaid. They may have a hospitalization, and then find that no bed is available in their prior home upon hospital discharge. Thus, to the extent that insurance coverage enables an individual to sustain or to guarantee private pay status for a longer period, purchasers of private long-term care insurance may have preferred access to a wider range of nursing homes, including better quality homes.

In addition, policies covering home care may increase access to these services by making them more affordable to persons who cannot qualify for means-tested public benefits. This, in turn, can decrease dependence on informal care, giving the disabled elderly more control over how much functional assistance they receive as well as when, how, and by whom assistance is provided. With greater ability to pay for home care, the elderly disabled may worry less about being a burden on family and friends, and their families may worry less about whether they are receiving the care they need. In the HIAA survey of purchasers, 30 percent cited avoiding dependence as the most important reason for purchasing long-term care insurance.

In some cases, home care coverage may also help the disabled elderly sustain independent living; that is, it may help to avoid or postpone moving in with adult children, or at a minimum rely less on informal support systems. However, in order for home care to aid in independent living, elderly long-term care insurance beneficiaries may have to forgo asset protection and supplement their home care insurance benefits with sizable out-of-pocket payments. For this reason, stand-alone home care policies are also likely to be inappropriate for individuals with low incomes and assets even though these policies are oriented more toward increasing access to and affordability of services rather than asset protection.

Coverage for home care services can result in much higher premium costs. Premiums for policies that cover both nursing home and home care are often double the cost of policies that cover nursing home care only. Much of the variation in premiums for home care is the result of the uncertainty among insurers about the future use of home care benefits among policyholders. In addition, it is more difficult to define the "insured event" for home care services, since it does not entail a clearcut event such as a nursing home admission. Thus, it is unclear, at this point in time, whether current home care benefits offered in long-term care insurance policies are worth the additional cost because of the limited circumstances under which benefits will be paid and the lack of a well-developed service delivery system to provide the benefits.

VIII. CONCLUSIONS

The economic impact of long-term care on individuals depends primarily on the types of services they use, the duration of their care, and their available financial resources. Many elderly persons with long-term care needs experience little or no financial impact, others experience moderate economic impacts, and still others experience catastrophic impacts on their financial well-being. Understanding of the diverse economic impacts of long-term care use on individuals is key to informed debate about future directions in Federal and State long-term care policy. Although we have learned much in recent years about the economic impacts of long-term care, there is still much that is not well understood.

Economically, the elderly are a highly diverse population. Contrary to what many people believe, the incomes of individuals and families do not become more equal as they enter retirement. In fact, there is considerable evidence that there is greater economic diversity among the elderly population than among the non-elderly.[39] Wealth among the elderly is even more unevenly distributed than income. Those elderly with the highest incomes own the vast majority of all financial assets.

A significant percentage of the elderly are poor or near-poor, with few financial assets. About 36 percent of the non-institutionalized elderly live in families with incomes below 150 percent of the poverty level, which was $11,800 for an elderly couple and $9,300 for a single individual in 1990. Most of these

5. The increase in median net worth of elderly households was primarily attributable to increased net worth among the 65 to 74 year age cohort. Median net worth of elderly households over age 75 declined slightly, from $62,865 to $61,491 over this period (although the standard errors of these statistics exceeds the difference between them). Source: U.S. Bureau of the Census, ***Household Wealth and Asset Ownership: 1988***.

6. Financial assets include savings accounts, savings bonds, checking accounts, money market funds, equity in rental property, equity on stock holdings, equity in a business, mortgages held, IRAs, and Keoghs less any consumer debt.

7. Home equity is defined at the market value of the home minus mortgage or other debt associated with the house.

8. Radner, D. "New Worth and Financial Assets by Age Groups in 1984." ***Social Security Bulletin*** Vol.52(3):2-15, March 1989.

9. These data, drawn from the Survey of Income and Program Participation (SIPP) use a broad definition of disability. Disabled is defined as needing assistance moving around inside or outside the house, getting into our out of bed, or requiring personal care, such as eating, bathing, or dressing. The SIPP, unlike the National Long-Term Care Survey (NLTCS), does not include detailed measures of disability. The NLTCS, on the other hand, does not include detailed measures of income or wealth.

10. Liu, K., Manton, K. and Liu B. "Home Care Expenses for the Disabled Elderly." ***Health Care Financing Review*** Vol.7(2):51-58, Winter 1985.

11. Pauly, M. "The Rational Nonpurchase of Long-Term Care Insurance." ***Journal of Political Economy*** Vol.98(11):153-168, 1990.

12. Spence, D. and Wiener, J.: "Estimating the Extent of Medicaid Spend Down in Nursing homes." ***Journal of Health Politics, Policy and Law*** Vol.15(3):607-626, Fall 1990.

13. Based on single stays, not entire episodes of care.

14. Burwell, B., Adams, E., and Meiners, M.: "Spend-down of Assets Before Medicaid Eligibility Among Elderly Nursing-Home Recipients in Michigan." ***Medical Care*** Vol.28(4):349-362, April 1990.

15. The financial impact on non-institutionalized spouses of nursing home residents was ameliorated substantially by the spousal impoverishment provisions of the Medicare Catastrophic Coverage Act of 1988, one of the few provisions of the Act that was *not* subsequently repealed.

16. Adams, K., Meiners, M. and Burwell, B. ***Medicaid Spend-Down in Nursing Homes: A Synthesis of Recent Research***. Paper prepared for the Office of the Assistant Secretary for Planning and Evaluation, DHHS, under contract HHS-100-88-0041, November 1990.

17. Liu, K., Doty, P. and Manton, K.: "Medicaid Spend-down in Nursing Homes." ***The Gerontologist*** Vol.30(1):7-15, 1990.

18. Wiener, J. and Spence, D.: "Estimating the Extent of Medicaid Spend-Down in Nursing Homes." ***Journal of Health Politics, Policy and Law*** Vol.15(3):607-626, Fall 1990.

19. Short, P., Kemper, P., Cornelius, L. and Walden, D.: "Public and Private Responsibility for Financing Nursing Home Care: The Effect of Medicaid Spend-Down." Paper presented at the 1990 meetings of the American Public Health Association, October 1990.

20. Burwell, B. et al.: "Spend-Down of Assets Before Medicaid Eligibility Among Elderly Nursing

Home Recipients in Michigan."

21. Farbstein, K., Gruenberg, L. and Pattee, C.: "When Nursing Home Spend-Down Occurs: An Analysis of Multiple Episodes of Nursing Home Use From a Discharge Cohort." Study conducted for the Connecticut Partnership for Long Term Care Research Institute, September, 1989.

22. Gruenberg, L, Farbstein, K., Hughes-Cromwick, P., Pattee, C., and Mahoney, K.: "An Analysis of the Spend-Down Patterns of Individuals Admitted to Nursing Homes in the State of Connecticut." Study conducted for the Connecticut Partnership for Long Term Care Research Institute, September. 1989.

23. Bice, T. and Pattee, C.: "Nursing Home Stays and Spend-Down in the State of Connecticut: 1978-1983 Admission Cohorts." Study conducted or Planning and Evaluation, Department of Health and Human Services, October 1990.

24. Farbstein, K. et al: "When Nursing Home Spend-Down Occurs."

25. Adams, K. et al: "Medicaid Spend-Down in Nursing Homes: A Synthesis of Recent Research."

26. Liu, K. et al: "Medicaid Spend-Down in Nursing Homes."

27. Adams, K.: "Enrollment in Medicaid by the Elderly: Which Catastrophe?" Paper prepared for the Office of Research, Health Care Financing Administration under contract no. HCFA-500-86-0016, 1990 (Draft).

28. Essentially, this estimates the percentage of elderly couples who could afford to pay for private care indefinitely for one member, since no assets are needed to pay for care.

29. Hahn, B. and Lefkowitz, D. (November 1992). "Annual Expenses and Sources of Payment for Health Care Services". (AHCPR Pub.No.9300007). National Medical Expenditure Survey Research, Findings 14.

30. Feder, J., Moon, M. and Scanlon, W. (1987) "Medicare Reform: Nibbling at Catastrophic Costs", ***Health Affairs*** 6, 6-19.

31. Liu, K. Perozek, M. and Manton, K. "Catastrophic Acute and Long-Term Care Costs: Risks Faced by Disabled Elderly Persons".

32. A survey of long term care insurance purchasers indicates that approximately 60 percent of purchasers use liquid assets to help finance insurance premiums.

33. Specifically, one-half of what the family now spends on tobacco, alcohol, and cash contributions to others and the full amount of spending on vehicles, educations, and household equipment and furnishings was subtracted. In addition to the fact that these last three groups of expenditures are discretionary, they also appear in these data in lump sum and thus exaggerate the spending patterns of many families. That is, many families extend their care payments over three or four years but the data on consumer expenditures show the full amount of the cost of the car on the date of purchase regardless of how it is financed.

34. The lower priced policy is a nursing home only policy that covers four years of care after a 100 day waiting period. The higher priced four year policy includes a home care benefit. Both would pay $80 per day currently and would be adjusted over time for inflation.

35. HIAA, "Who Buys Long-Term Care Insurance?" submitted by LifePlans, 1992.

36. HIAA, 1990.

persons also have few financial assets. What wealth they do have is usually tied up in their homes. Although they are poor or near-poor, most have incomes or assets above Medicaid eligibility levels. Only about eight percent of the elderly living outside of nursing homes are enrolled in Medicaid.

The elderly most at risk of needing long-term care have fewer financial resources than the non-disabled elderly. Poverty among the elderly is strongly associated with (1) being single; (2) living alone; and (3) being very old. This is also the group that is at the highest risk of needing paid long-term care services, since they have high rates of disability and fewer family and friends to provide informal care.

Persons not eligible for Medicaid who have extended nursing home stays are at the greatest risk for experiencing catastrophic financial impacts from long-term care use. The average annual cost of a nursing home stay in 1990 was about $30,000. About 20 percent of all elderly persons turning age 65 in 1990 will spend a year or more in a nursing home before they die. Although many of these persons will have Medicare and/or Medicaid coverage for all or part of their nursing home stays, many others will be required to pay for most of their nursing home care with private resources. Recent studies indicate that somewhere between 10 and 25 percent of all persons who enter nursing homes spend down to Medicaid eligibility prior to their final discharge.

Although "affordability" is difficult to measure, analyses indicate that very few of the elderly can afford a one-year stay in a nursing home. Almost no elderly couples or individuals can afford to pay for nursing home care without using their accumulated financial assets. Only forty to fifty percent of the elderly could afford to pay for one year of nursing home care without depleting available financial assets. Only ten to twenty percent could afford up to pay for up to four years of nursing home care.

Poor and near-poor elderly persons living in the community, who are not eligible for Medicaid, experience a different type of economic impact--they cannot afford home care. Poor elderly who are eligible for Medicaid can receive publicly-financed home care services at no cost to themselves, although the availability of these services varies significantly from State to State. Poor and near-poor persons not eligible for Medicaid are generally not eligible for publicly-financed services, but cannot afford to buy them privately. These persons have a high likelihood of having unmet needs and/or imposing a heavy care burden on their family members. In these cases, the *economic* impacts can fall on families, rather than the recipients themselves.

Private long-term care insurance provides an opportunity to ameliorate the economic impacts of long-term care use, but not everyone can afford it. Because long-term care insurance spreads the costs of long-term care across users and non-users, more people can afford to buy insurance than can afford to buy long-term care services without insurance. Good candidates for private insurance are persons who have adequate income to pay premiums and adequate financial resources to pay deductibles and co-payments. Higher-priced policies which have inflation protection mechanisms and shorter waiting periods have higher premium costs, but can significantly reduce cost sharing requirements if and when policyholders need care.

Persons who purchase long-term care insurance will have reduced out-of-pocket costs, diminished risk and fear of spending down to Medicaid eligibility, and increased access to quality care. For persons between the ages of 45 and 79, long-term care insurance premiums are generally affordable for 37 percent of single persons and 59 percent of families with more than one adult if they choose to use all their annual savings to pay the premiums. The younger someone begins buying insurance, the more affordable it becomes. In brief, the sooner we start saving for future long-term care needs, the less financial risk we face later on.

Even if the market for private long-term care insurance continues to expand, and achieves significant market penetration, public and private expenditures for long-term care will not be markedly affected over the short term. If 30 percent of the elderly have long-term care insurance coverage in thirty years, Medicaid expenditures for nursing home care would be approximately $1 billion (in 1989 dollars) less and out-of-pocket payments would be about $3 billion less than if there were no insurance coverage. However, for those who purchase long-term care insurance, the amount they would otherwise have to pay out-of-pocket for nursing home care would be cut in half.

The risk of incurring catastrophic economic impacts from long-term care use is directly related to delayed planning for future needs. The longer people wait before they begin to plan for their future long-term care needs, the less "affordable" financial protection from high long-term care costs becomes. Currently, people fall into three distinct groups, in terms of their ability to plan for future needs:

- **Persons over age 80**. Persons in this age group face the greatest risks of needing long-term care and incurring severe economic impacts from long-term care use. They are also, in general, the group with the fewest financial resources. For this group, the ability to purchase long-term care insurance is limited, because of age/underwriting restrictions or the cost of insurance. A small percentage can buy some protection by investing significant assets in CCRCs. However, most CCRCs still do not provide financial protection from extended nursing home stays.

- **Persons age 65-79**. Individuals in this age group are less likely to be disabled and, in general, have greater financial resources. They still have opportunities to save for future long-term care needs. Analyses indicate that up to 30-50 percent of this group could afford to purchase long-term care insurance that offered significant financial protection. Persons in this group with low income and assets are less able to purchase insurance and have less incentive to buy insurance, since they have fewer assets to protect. Many will end up on Medicaid if they require extended nursing home care.

- **Persons under age 65**. The vast majority of persons in this age group are not disabled and could afford to buy long-term care insurance at significantly reduced premium costs. Most people in this group do not recognize the need to plan for future long-term care needs, and will not do so without substantial public and private sector initiatives.

The elderly of tomorrow are expected to be financially even better-off than the elderly of today. More will be able to afford to purchase their own long-term care services, although it is also possible that the use of long-term care will also increase, with increasing longevity. The more rapidly individuals start participating in risk pools, and the earlier they start, the more affordable long-term care will be to a greater percentage of the elderly. Medicaid and other public programs will remain the principal payer for most elderly persons with low incomes and assets, because they are not good candidates for private insurance. Moderate and upper-income elderly, who do not purchase financial protection, will continue to risk the possibility of experiencing catastrophic economic consequences if they require extended nursing home care.

IX. NOTES

1. Hanley, et al. "Predicting Elderly Nursing Home Admissions: Results from the 1982-84 National Long Term Care Survey," ***Research on Aging***. Sage Publications, Vol.12, No.2, June 1990.

2. For a single elderly persons, 150 percent of the poverty level in 1990 is approximately $9,300. For an elderly couple, it is approximately $11,800. Elderly poverty levels are approximately 8 percent lower than the levels for non-elderly persons. Estimates in this section are based on family income, which means that sources of income and amounts for family members under the age of 65 are included for elderly persons living with others. Approximately 31 percent of the elderly live alone, 44 percent live with their spouse only, and the remaining 25 percent live with relatives or others.

3. The new worth concepts used here does not account for human capital, vested pension assets, social security wealth or in kind transfers, such as Medicare.

4. U.S. Bureau of the Census, Current Population Reports Series P-70, No.22, ***Household Wealth and Asset Ownership: 1988***, U.S. Government Printing Office, Washington, D.C. 1990.

37. HIAA, 1990.

38. General Accounting Office, "Nursing Homes Admission Problems for Medicaid Recipients and Attempts to Solve Them," HRD-90-135, September 1990.

39. Crystal, S. and Shea, D.: "Cumulative Advantage, Cumulative Disadvantage, and Inequality Among Elderly People." ***The Gerontologist*** Vol.30(4):437-443, August 1990.

TABLE 1: SOURCES OF [illegible] INCOME OF THE ELDERLY BY [illegible] (in 1990 dollars)

Family Income Source	Family Income Level			
	Low	Modest	Moderate to High	Total
Percent of Persons	36%	40%	24%	100%
Social Security				
• Percent with Income	94%	98%	93%	95%
• Median Amount a	$5,234	$8,413	$9,216	$6,943
• Average % of Total Income b	71%	47%	23%	51%
Pension				
• Percent with Income	28%	66%	68%	52%
• Median Amount a	$1,253	$3,574	$8,550	$3,737
• Average % of Total Income b	6%	18%	20%	14%
Employment				
• Percent with Income	14%	35%	54%	32%
• Median Amount a	$2,081	$6,941	$18,139	$7,837
• Average % of Total Income b	5%	16%	23%	13%
Asset				
• Percent with Income	62%	92%	97%	82%
• Median Amount a	$467	$1,769	$6,161	$1,677
• Average % of Total Income b	7%	15%	23%	13%
Otherc				
• Average % of Total Income b	11%	4%	5%	8%
Total Median Income	$6,834	$16,442	$34,208	$14,846

a. Median amount for persons with income from this source.

b. Average percent of family income for all persons.

c. Other income includes SSI, rental income, and business income.

NOTE: Low income is defines as less than 150 percent of the poverty level; modest income is defined

NOTE: Low income is defines as less than 150 percent of the poverty level; modest income is defined as between 150 and 299 percent of the poverty level and moderate to high income is defines as 300 percent of the poverty level or greater. Family income is based on income from all persons in the family.

SOURCE: Lewin/ICF estimates based on data from the 1984 Survey on Income and Program Participation (SIPP).

TABLE 2: ASSETS OF THE ELDERLY BY LEVEL OF INCOME
(in 1990 dollars)

Family Income Source	Family Income Level			
	Low	Modest	Moderate to High	Total
Percent of Persons	36%	40%	24%	100%
Financial[a]				
• Percent of Persons with Assets	78%	96%	99%	90%
• Median Amount [b]	$5,509	$30,309	$84,921	$26,704
Home Equity				
• Percent of Persons with Equity	60%	81%	88%	75%
• Median Amount [b]	$30,538	$44,821	$64,830	$45,021

a. Financial assets include: savings accounts, savings bonds, checking accounts, money market funds, equity in rental property, equity in stock holdings, equity in a business, mortgages held, IRAs, and Keoughs less consumer debt.

b. Median amount for persons with assets.

NOTE: Low income is defined as less than 150 percent of the poverty level; modest income is defined as between 150 and 299 percent of the poverty level; and moderate to high income is defined as 300 percent of the poverty level or greater as high. Family income is based on income from all persons living in the family.

SOURCE: Lewin/ICF estimates based on data from the 1984 Survey on Income and Program Participation (SIPP).

Family Income Status				
Percent of Persons	48%	34%	18%	100%
Social Security				
• Percent with Income	95%	98%	96%	96%
• Median Amount a	$5,183	$7,504	$8,871	$6,214
• Average % of Total Income b	74%	47%	24%	56%
Pension				
• Percent with Income	26%	62%	66%	46%
• Median Amount a	$1,136	$3,400	$8,174	$3,202
• Average % of Total Income b	6%	17%	17%	11%
Employment				
• Percent with Income	6%	25%	51%	21%
• Median Amount a	$2,312	$9,865	$17,941	$10,087
• Average % of Total Income b	2%	12%	25%	9%
Asset				
• Percent with Income	68%	94%	97%	82%
• Median Amount a	$528	$2,506	$7,713	$1,663
• Average % of Total Income b	9%	19%	28%	16%
Otherc				
• Average % of Total Income b	9%	5%	6%	8%
Total Median Income	$6,560	$15,778	$33,814	$11,588

a. Median amount for persons with income from this source.

b. Average percent of family income for all persons.

c. Other income includes SSI, rental income, and business income.

NOTE: Low income is defines as less than 150 percent of the poverty level; modest income is defined as between 150 and 299 percent of the poverty level and moderate to high income is defines as 300 percent of the poverty level or greater. Family income is based on income from all persons in the family.

SOURCE: Lewin/ICF estimates based on data from the 1984 Survey on Income and Program Participation (SIPP).

TABLE 5: DISTRIBUTION OF ALTERNATIVE GROUPS OF ELDERLY PERSONS BY FAMILY INCOME LEVEL

(in 1990 dollars)

	Family Income Level			
	Low	Modest	Moderate to High	Total
Non-Disabled Elderly	33%	42%	25%	100%
Elderly Age 75 and Over	48%	34%	18%	100%
Disabled Elderly	52%	31%	16%	100%
Disabled Elderly Age 75 and Over	55%	30%	15%	100%
All Elderly	36%	40%	24%	100%

NOTE: Low income is defines as less than 150 percent of the poverty level; modest income is defined as between 150 and 299 percent of the poverty level and moderate to high income is defines as 300 percent of the poverty level or greater. Family income is based on income from all persons in the family.

SOURCE: Lewin/ICF estimates based on data from the 1984 Survey on Income and Program Participation (SIPP).

TABLE 6: PERCENT OF ELDERLY COUPLES ABLE TO PRIVATELY PAY FOR ONE YEAR OF LONG TERM CARE

(in 1990 dollars)

	Available Resources		
	No Assets	50% of Assets Over 4 Years	50% of Assets Over 1 Year
All Elderly Couples	3.2%	16.1%	48.0%
Disabled Couples	3.4%	18.8%	38.1%

No Assets--Housing, health and personal insurance expenditures are assumed to remain as is. Other expenditures are protected for the community spouse up to two-thirds of the preinstitutionalization level. Assets and asset income are left intact.

50% of Assets over 4 Years--Assumes the expenditures projections listed above, allowing the community spouse all housing, health and personal insurance expenses and 2/3 of everything else. It also effectively requires that the couple devote up to half of its financial assets to the cost of the institutionalization over a four year period.

50% of Assets over 1 Year--An upper bound on the contribution that could be expected form a couple would be to protect housing, health and personal insurance but no expenditures for alcohol, tobacco and ash contribution and only 1/2 of all other expenditures, and to require that the couple use of half of its financial assets in one year.

NOTE: Disability is defined as requiring assistance with personal needs such as eating, bathing, or dressing.

SOURCE: Lewin/ICF and Urban Institute estimates based on a statistically matched data base of 1984 Consumer Expenditures Survey data and 1984 Survey of Income and Program Participation data.

TABLE 7: PERCENT OF ELDERLY COUPLES ABLE TO PRIVATELY PAY FOR ONE YEAR OF LONG TERM CARE

(in 1990 dollars)

	Available Resources		
	No Assets	All Assets Over 4 Years	All Assets In 1 Year
All Single Persons	0.5%	12.3%	39.5%
Disabled Single Persons	0.0%	7.5%	17.0%

No Assets--Housing, health and personal insurance expenditures are assumed to remain as is. Other expenditures are protected for the community spouse up to two-thirds of the preinstitutionalization level. Assets and asset income are left intact.

50% of Assets over 4 Years--Assumes the expenditures projections listed above, allowing the community spouse all housing, health and personal insurance expenses and 2/3 of everything else. It also effectively requires that the couple devote up to half of its financial assets to the cost of the institutionalization over a four year period.

50% of Assets over 1 Year--An upper bound on the contribution that could be expected form a couple would be to protect housing, health and personal insurance but no expenditures for alcohol, tobacco and ash contribution and only 1/2 of all other expenditures, and to require that the couple use of half of its financial assets in one year.

NOTE: Disability is defined as requiring assistance with personal needs such as eating, bathing, or dressing.

SOURCE: Lewin/ICF and Urban Institute estimates based on a statistically matched data base of 1984 Consumer Expenditures Survey data and 1984 Survey of Income and Program Participation data.

TABLE 8: AVERAGE OUT-OF-POCKET EXPENDITURES PER MONTH AND THE PERCENTAGE OF DISABLED ELDERLY PERSONS WITH PRIVATE EXPENSES EXCEEDING 15% AND 20% OF INCOME, 1982

	Income Per Month			
	All Persons	<500	$500-$1,000	>$1,000
Out-of-Pocket				
Average Expenditures Per Month	$130	$96	$148	$167
Out-of-Pocket Expenditures Exceeding Percentage of Income				
>15%	41%	53%	40%	18%
• Nursing Home Users	87%	90%	89%	72%
• Non Nursing Home Users	35%	47%	33%	12%
>20%	30%	42%	27%	11%
• Nursing Home Users	81%	87%	81%	63%
• Non Nursing Home Users	23%	35%	20%	6%

SOURCE: Liu, K., Perozek, M. and Manton, K. "Catastrophic Acute and Long-Term Care Costs: Risks Faced by Disabled Elderly Persons."

TABLE 9: PROJECTED NURSING HOME CARE EXPENDITURES FOR THE [illegible] 2019 (billions of [illegible] dollars)			
	No Long Term Care Insurance Purchase	[illegible] Long Term Care Insurance Purchase	Percent [illegible]
Medicare	$2.9	$3.0	3.5%
Medicaid	41.0	39.6	-3.4%
Public	$43.9	$42.6	-3.0%
Long Term Care Insurance	0.0	7.5	NA
Out-of-Pocket	57.7	54.3	-5.9%
Private	$57.7	$61.8	7.1%
Total	$101.5	$104.4	2.9%

NOTE: The long term care insurance policy modeled primarily covers nursing home care and the results assume 30 percent of the elderly purchase long term care insurance.

SOURCE: Brookings/ICF Long Term Care Financing Model.

TABLE 10: LONG-TERM CARE INSURANCE POLICY PREMIUMS		
Age of Purchaser	**Lower Priced Policy**	**Higher Priced Policy**
45-49	$285	$1,025
50-54	377	1,142
55-59	499	1,269
60-64	660	1,559
65-69	933	1,902
70-74	1,355	2,586
75-79	2,008	4,073

NOTE: Both policies are marketed to individuals, not through a group market. The lower priced policy primarily covers nursing home services for four years at $80 per day, after meeting a 100 day deductible period. The higher priced policy also covers home care benefits at $40 per visit. Benefit amounts are indexed at five percent the original benefit amount annually.

SOURCE: AMEX, 1990.

TABLE [illegible]			
Age			
	50% of Savings	100% of Savings	100% of Savings Plus Some Discretionary Income
45-54	34-43%	40-46%	52-58%
55-59	26-36%	35-40%	42-50%
60-64	23-32%	31-36%	38-47%
65-74	17-26%	26-33%	31-41%
75-79	6-15%	15-31%	18-35%
Total (55-74)	20-29%	29-35%	35-44%
Total (45-79)	21-30%	29-37%	36-46%

50% of Annual Savings--One-half of the savings available from income after taxes and all current expenditures are subtracted.

100% of Annual Savings--Savings available from income after taxes and all current expenditures are subtracted.

Annual Savings Plus Some Discretionary Income--Savings available from income after taxes less all basic expenditures, one half of what the family now spends on tobacco, alcohol, and cash contributions to others and the full amount of spending on vehicles, education, and household equipment and furnishings are subtracted.

NOTE: The lower percentage is for those who can afford the more expensive policy and the higher percentage under each definition is for those who can afford the lower priced policy.

SOURCE: Lewin/ICF and Urban Institute estimates based on a statistically matched data base of 1984 Consumer Expenditures Survey data and 1984 Survey of Income and Program Participation data.

TABLE 12: PERCENT OF FAMILIES WHO COULD AFFORD MORE ADULTS ABLE TO AFFORD LONG-TERM CARE INSURANCE						
Age of Head of Household	50% of Savings		100% of Savings		Savings Plus Some Discretionary Income	
	One Policy	Two Policies	One Policy	Two Policies	One Policy	Two Policies
45-54	56-61%	49-60%	60-62%	56-61%	77-79%	74-78%
55-59	57-61%	47-59%	60-62%	57-61%	72-74%	69-73%
60-64	47-52%	37-49%	51-54%	47-52%	64-66%	59-65%
65-74	41-51%	23-41%	51-55%	41-51%	62-67%	53-62%
75-79	34-51%	13-35%	49-59%	34-51%	62-70%	46-63%
Total (55-74)	47-55%	34-49%	54-57%	47-55%	66-69%	60-66%
Total (45-79)	50-57%	38-52%	56-59%	50-57%	70-73%	64-71%

50% of Annual Savings--One-half of the savings available from income after taxes and all current expenditures are subtracted.

100% of Annual Savings--Savings available from income after taxes and all current expenditures are subtracted.

Annual Savings Plus Some Discretionary Income--Savings available from income after taxes less all basic expenditures, one half of what the family now spends on tobacco, alcohol, and cash contributions to others and the full amount of spending on vehicles, education, and household equipment and furnishings are subtracted.

NOTE: The lower percentage is for those who can afford the more expensive policy and the higher percentage under each definition is for those who can afford the lower priced policy.

SOURCE: Lewin/ICF and Urban Institute estimates based on a statistically matched data base of 1984 Consumer Expenditures Survey data and 1984 Survey of Income and Program Participation data.

TABLE 13: EXPECTED DEDUCTIBLES AND COPAYMENTS UNDER LONG-TERM CARE INSURANCE

(in normal dollars)

Long-term Care Insurance Policy [a]	Expected Deductible in 2005	Expected Copayment in First Year	Total
Unindexed	$16,110	$27,225	$43,335
Partially Indexed [b]	$16,110	$10,725	$26,835
Fully Indexed [c]	$16,110	$0	$16,110

a. Policies are assumed to have a 90 day deductible and pay $80/day in 1990. Nursing home costs are assumed to be $179/day in 2005 (5.5 percent annual inflation). Policies are assumed to be purchased in 1990.

b. Benefits increase at 5 percent of the original benefit.

c. Benefits increase 5.5 percent annually.

SOURCE: Lewin/ICF estimates.

MARGUERITE STETSON

Good morning Mr. Chairman, members of the Long Term Care Task Force. Thank you for the opportunity to speak with you today regarding a very important topic, long term care.

My name is Marguerite Stetson. I have lived in Alaska since 1966 and retired from the University of Alaska Fairbanks in 1987. Currently, I am State President of AARP with a state membership of over 50,000 members; and a national membership exceeding 30 million. Membership is for those persons retired, or working, who are 50 years of age or older.

Since its inception, AARP has been strongly committed to the establishment of a long term care system that provides a continuum of services for all ages including disabled persons. We hear regularly from our members about the challenges they face when requiring long term care, whether it be in their own homes, from a local adult day care health program or from a nursing home. We also know that our national members prefer staying in their own homes as long as feasible. I am quite sure that each of you on this Task Force and others in this room share this same preference. We all want to stay in our homes until we die. The question is: what will it take to make that preference become a reality?

The points I would like to cover today, in the time allotted are the following:

1. a short description of what long term care is;

2. where it is provided;

3. who pays for LTC;

4. issues, concerns and future directions

Long Term Care is a broad range of services needed by persons of all ages with physical or mental impairments, who have lost or never acquired the ability to function independently. It includes personal care, nursing and home health care, rehabilitation, adult day care, case management, social services, and assisting technology. These services are provided in a variety of settings from homes to residential housing to nursing facilities.

You may think of a continuum of care ranging from in-home care as the least restrictive setting to the nursing home which is the most restrictive. LTC services may be needed on a regular or respite basis over a period of several month, several years or a lifetime.

It is true that most people who need LTC live in their own homes. Most LTC is informal, unpaid help which is provided by family and friends. We know that of the 10.6 million Americans who need LTC, 84% live in their own homes and 70-80 percent of the care is provided by family members and friends. Family members are the unsung heroes of our LTC

system. In Alaska there could be a lack of family members causing an increased financial burden on the state.

AARP commends the wisdom of the legislature for supporting the Alaska PROJECT CHOICE which allows Alaskans to stay in their homes as long as possible with community based services. We need more of such program which keep people out of costly institutional settings. We need a range of community programs which include nutrition, social or health care services and a range of alternative housing that make it possible for the person to remain at home or in the community and maintain their independence.

You know that only about 5.1% of the population over 65 is currently in a nursing home. However, the *State Government News* (August 1998) reports that 40% of all Americans will need nursing home care at some time in their lives; therefore, planning for this use is imperative. About 40% of those will stay less than 3 months. This usually occurs when an individual is in a nursing home for rehabilitation following a stroke or fall.

Nursing home care is for those who are chronically ill or recovering from an acute illness and need extended care, but not hospitalization. Persons with a long stay in nursing homes tend to be individuals with chronic or debilitating disease, such as Alzheimer's disease. It is estimated

that 50% of all nursing home residents have a diagnosis of Alzheimers or a related dementia.

As you know, the Pioneer Homes are moving toward specializing in Alzheimers care with residents paying the full cost of care within seven years, resulting in a 30 percent increase in cost of care to residents. The State with pick up costs for those who cannot afford this increase. Current costs for nursing home care in some areas of Alaska exceed $100,000 per year; this is more than double the average cost of one year in a nursing home in the U.S. According to the August 1998 *State Government News*, it is estimated than in less than 30 years the cost will be closer to $140,000 for the U.S. Using this estimated increase for the U.S., could Alaska's cost be close to $350,000 in 30 years?

Alaska still has a smaller percentage of people over 65 living in this state than other states. However, this percentage seems to be growing as the state provides incentives for older people to remain in Alaska. It is estimated that this population could increase 316 percent by 2025; from around 32,000 in 1996 to over 100,000 in 2025.

While there are costs to the state when older persons remain here, there are many more benefits, including the impact on the economy as these persons receive pensions and social security and purchase goods and

services within the state; and the benefit of having these persons volunteer and participate in decisions within their local communities. It is vital to the health of any community to have their "elders" with them.

According to AARP statistics, and probably as a result of budget tightening, there has been a 1.3 percent drop in nursing home residents between 1995 and 1996. There are some licensed adult day care centers in Alaska but probably not a sufficient number of high-quality centers. This may need to increase to provide assistance for those individuals not in nursing homes but needing care. Alaska's occupancy rates in nursing homes, in 1996, was 81 versus 89.9 for the U.S; ranking Alaska as 44. Only Oklahoma and Texas had lower occupancy rates in 1996; four states were not reported. It would appear that Alaska should restrict expansion in this area for the near future. I believe that the legislature has take action on this issue.

The membership of AARP is very concerned about long term care. This care is important for all ages including the disabled in Alaska. The cost of long term care in the home versus an institution is causing economic and social stress as well as a financial hardship on the state and the individual. AARP applauds Alaska's efforts to develop a long range plan for long term care.

Who funds LTC? As you know, states bear substantial responsibility for long term care. You administer federal and state funds, and are responsible for regulating nursing homes and home health agencies to assure that quality services are provided to the citizens of Alaska. You know that spending for LTC has placed a great demand on our state budget.

Eighty percent of the cost for long term care in long term care facilities is paid by Medicaid—for those persons who qualify. The large subsidies for long term care from the state's general fund will increase in the future competing with funding for other state programs.

Good quality in-home care needs to be provided to help people remain in the least restrictive setting. There will need to be affordable assisted living homes to keep more Alaskans out of nursing homes. Medical transportation needs to be improved, again to assist those individuals that wish to remain independent but can no longer drive themselves.

Perhaps our new AARP Information Center in Anchorage, along with the United Way supported AK Info Data Base, could assist in being a center for information about long term care in Alaska.

Thank you again, for allowing me to present AARP's position on long term care. AARP welcomes the opportunity to work with you in shaping a

Long Term Care plan and to provide you with any further information you may require.

AARP PRINCIPLES

The following long-term care principles are designed to guide the Association's efforts to bring about comprehensive reform and establish a public long-term care program. These principles do not address every specific issue relating to long-term care, but they do provide criteria for evaluating and comparing reform proposals. They also serve to guide the Association in its participation in the public debate about long-term care reform at both the federal and state level.

UNIVERSAL COVERAGE. Long-term care services should be available to all people who need them, regardless of age or income. The long-term care program should base eligibility for services on a person's physical and cognitive or other mental functioning, including limitations in performing activities of daily living (e.g., eating, bathing, and dressing) and a person's need for supervision. Uniform national assessments should determine whether a person meets the eligibility criteria for the program and what type and level of care a person needs.

COMPREHENSIVE COVERAGE. A national public long-term care program should provide a comprehensive range of services. These services should include (1) in-home assistance; (2) community services; (3) long-term care services in a full range of supportive housing options; (4) institutional care; (5) rehabilitative services; and (6) long-term care related transportation services. Long-term care should be provided in the least restrictive setting possible.

SUPPORT FOR INFORMAL CARE. The new public program should assist, not replace, current informal caregivers. Families and friends need access to supportive services so that they are not unreasonably burdened and can continue to provide care. The services should include respite care, adult day care, and other types of assistance, such as an expanded dependent care tax credit.

PHASED-IN IMPLEMENTATION. Implementation of the public program must be phased in to ensure orderly development of the new system. Expansion of services should be accompanied by development of a long-term care infrastructure, including health care personnel, that will permit the delivery of a comprehensive range of home, community, and institutional services. The program should not be phased in on the basis of income or assets.

SHARED RISK. The principles of social insurance (e.g., Social Security or Medicare) and shared risk must be extended to long-term care. Under social insurance programs, individuals pay into the system and are then entitled to benefits when they are needed. By spreading the cost across the entire population, universal protection can be achieved in an affordable, equitable manner for everyone.

ADEQUATE PUBLIC FINANCING. The new long-term care program should be financed primarily through taxes earmarked to a trust fund. Revenue sources could include payroll taxes, increased estate and gift taxes, income taxes, and modest premiums. The new public program must be financed through taxes and premiums so that it does not increase the federal deficit.

PRIVATE SECTOR INVOLVEMENT. The new public program must provide a solid foundation for protection which the private sector can build. The private sector could supplement the public program with insurance products similar to Medigap policies that would cover the program's copayments and deductibles as well as services that the public program does not provide. Any private-sector approach (e.g., long-term care insurance) should be subject to strong standards to protect consumers from inadequate products.

ADEQUATE REIMBURSEMENT. Payment to providers of long-term care services must be reasonable and provide appropriate incentives to deliver quality care. Reimbursement systems for home, community, and institutional care must respond to clients' needs, promote delivery of quality care, and recognize the outcomes of care provided to clients.

COST CONTAINMENT. Cost containment mechanisms must be built into the new long-term care system. Use of services could be controlled by providing a defined set of services to beneficiaries. Modest deductibles and copayments also could be included. However, people with low incomes should be protected.

QUALITY ASSURANCE. The federal and state governments should assure delivery of quality care under the new long-term care program. Quality assurance systems for nursing homes and home health agencies should be swiftly and vigorously enforced. In addition, new methods of assuring the quality of other home and community services must be found.

MARGUERITE STETSON

STATE GOVERNMENT NEWS....AUGUST, 1998

health

The aging of America

With the prospect of 54 million Americans being over the age of 65 within two decades, the need for long-term health care is increasing rapidly.

BY ANNE C. LAYZELL

Nobody likes to be told they are getting old. But in the case of the U.S. population, it's true.

Once thought of as a nation of young people, the United States quickly is becoming elderly. Declining fertility rates, longer life spans, better health care and an aging baby boomer generation are contributing factors. Soon persons 65 years old and older in this country will outnumber the young.

In 1900, there were 3.1 million people age 65 or older in the United States. By 2020, this population is expected to reach 54 million, representing about one out of every six Americans. In addition, a large portion will be over the age of 85 — a group that is most likely to need assistance with everyday activities.

Public burdens

This trend is proving to be problematic for policy-makers. More elderly in the population means more need for long-term care. And the increased demand for these services is making states nervous about how to pay for them. The average cost of one year in a nursing home is more than $40,000. U.S. Care, a chronic care management company, predicts that in less than 30 years the cost will be closer to $140,000 per year. Considering the current median net worth of retired households is about $74,000, it would take less than two years at today's nursing home care cost level to wipe out a life savings.

Since Medicare and most private health insurance policies generally do not pay for long-term care, many people look to public financing to fund their nursing home or home health care needs. Last year, according to the American Health Care Association, Medicaid paid for the care of 68 percent of all nursing home residents. Consequently, Medicaid accounts for more than 65 percent of all public dol-

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lars spent on long-term care.

In recent years, Medicaid has consumed 20 percent or more of total state expenditures, according to the General Accounting Office. Most experts agree that this level of Medicaid spending cannot continue without drastic cutbacks in state budgets. Because of this, many state lawmakers are seeking to reform the long-term care system as a way to end the heavy reliance on Medicaid dollars.

States can use a number of strategies to control spending on long-term care services. Joshua Wiener of the Urban Institute's Health Policy Center says most strategies fall into three broad categories: increase private resources to offset state expenditures on Medicaid; reform the delivery system for these services to provide care in a more cost-effective manner; or reduce Medicaid eligibility, reimbursement and service coverage.

State attempts to bring more private resources into the long-term care system focus on encouraging the purchase of long-term care insurance, discouraging the transfer of assets and expanding attempts to recover the cost of Medicaid from the estates of beneficiaries. Long-term care insurance reduces Medicaid spending by providing a safety net for low- and middle income families. It also provides financial benefits to consumers who purchase a plan by allowing them to retain many of their assets.

Efforts to encourage people to buy long-term care insurance have been relatively unsuccessful. Currently, less than 5 percent of Americans have this type of coverage. The problem is that most of the available policies are too expensive for those who need them. An average policy can cost more than $2,000 a year for a healthy 65-year-old, and the cost increases with age.

Many states are providing tax incentives to encourage people to purchase insurance policies before the premiums become too expensive. Last year, the Minnesota Legislature adopted a law that provides an income tax credit for long-term care insurance premiums. The statute allows residents to take a credit for 25 percent of premiums, not to exceed $100, that were not deducted for federal income tax purposes.

For those facing long-term care expenses, however, the prospect of paying for services is not as daunting as the possibility of not having any assets to leave to their families. Current federal law requires a person to spend down their nonhousing assets to $2,000 before applying for Medicaid assistance to pay for long-term care. Because of this, many decide to transfer their assets so they look poor on paper yet still leave an inheritance.

To avoid this situation, some states have created public/private partnerships between the state and the long-term care insurance industry. These partnerships allow people to buy state-approved policies that protect some of their assets while they remain eligible for Medicaid.

A partnership created in 1993 al-

One out of three of us will need long-term care at some point in our lives. However, fewer than one in 20 Americans have purchased insurance to pay for it, forcing Medicaid to pick up the tab instead. To control Medicaid spending, states are looking for new ways to finance long-term care services for the elderly.

lows New Yorkers to purchase a policy to help pay for the first three years of nursing home care or the first six years of home health care. Once the policy expires, the individual automatically is eligible for Medicaid. The policy protects existing assets but the policy holder must spend down income in accordance with Medicaid rules once Medicaid takes effect.

Postponing expensive care

Wisconsin may serve as a model among states controlling spending through reform of their delivery system. In the 1981-83 biennial budget, the state created what some have called a pioneering program to reduce the costs of long-term care delivery.

The Community Options Program encourages home health and community care to keep people out of more expensive care until absolutely necessary. The program is based on the assumption that if there are services available at the county or community level, people will remain independent and in their homes longer. Critics argue, however, that the system has evolved into a bureaucratic nightmare as Wisconsin residents seeking long-term care assistance must weed through more than 40 state and county programs to determine their eligibility.

In his 1998 State of the State address, Wisconsin Gov. Tommy Thompson pledged to overhaul the system again by pumping more than $10 million into long-term care. His new plan, called Family Care, is projected to be in place by 2000. Pilot programs in several counties have begun. Based on the popular "one-stop shopping" model, the Family Care plan will allow seniors to go to a single source in the county for information about long-term care options. The information will allow them to plan ahead to avoid exhausting their assets.

Arguing that the state can't afford to continue paying for the current system of long-term care, Thompson said the program will curb costs by consolidating services and focusing on home health care. However, the Wisconsin Legislative Fiscal Bureau suggests that the new plan could raise costs by encouraging more residents to enter the program if it means they will not have to live in a nursing home.

Fast facts:

- The first baby boomers will become elderly on Jan. 1, 2011 — followed by the 75 million others in that generation.
- Forty percent of all Americans will need nursing home care at some time in their lives.
- Sixty percent of those over 65 will be unable to care for themselves at some point.
- The average cost of one year in a nursing home is about $40,000.
- Long-term care costs in the U.S. will grow to $225 billion by 2000.
- Only 4 percent of Americans have purchased long-term care coverage.
- Currently, the government pays about 65 percent of all long-term care costs.

Sources: The U.S. Bureau of the Census; U.S. Care

Curbing costs

Conventional strategies for controlling state spending on long-term care include reducing nursing home reimbursement rates and limiting the supply of available beds. Until recently, federal regulations governed state reimbursement practices, requiring "reasonable and adequate rates" to allow for quality care. Opponents argued that this centralized control mechanism forced many states to spend more than necessary on nursing homes because it assumed that rates were uniform throughout the country. The recent repeal of the regulation allows states to set their nursing home rates based on average state cost.

Another option states have is to reduce or freeze the number of nursing home beds. This strategy assumes that by limiting the supply, seniors — especially those on Medicaid — will find cheaper alternatives such as home health care. Twenty states have instituted a moratorium on the expansion of nursing home beds, including North Dakota, South Dakota, Texas, Louisiana and Maine. These states either have stopped construction of new facilities or capped the number of beds available in existing facilities. In addition, most other states require nursing homes to receive a certificate of need before constructing new facilities or adding new beds.

With baby boomers fast approaching retirement, states have major interests in long-term care for the elderly. Solutions listed here might not work in every state. Therefore, each state will have to determine the best course of action for its residents and its budget.

CSG resources

Read more about our aging population in *Firstline Midwest*, April 1998, available from CSG's Midwestern office, *State Trends*, Summer 1998, available from CSG's publication sales department, (800) 800-1910, and *The Second Half of Life*, from CSG-*WEST*.

MARGUERITE STETSON

PUBLIC POLICY INSTITUTE

MEDICAID AND LONG-TERM CARE FOR OLDER PEOPLE

Introduction

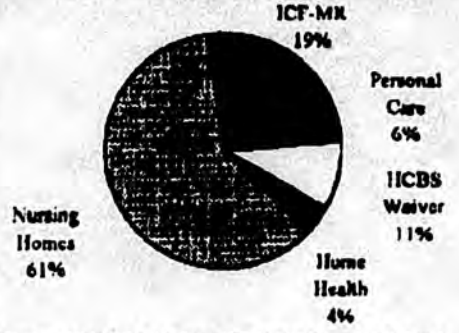
The Medicaid program was designed to provide coverage for health care and nursing home services to the poor. Today, one-third of all Medicaid spending pays for long-term care, making Medicaid our nation's largest source of payment for long-term care services. Medicaid funding is shared between federal and state governments and, consistent with federal law, each state has flexibility in designing and administering its Medicaid program.

Medicaid's role in providing coverage for long-term care is critically important to older people with disabilities, since Medicare -- the nearly universal source of acute health care coverage for people age 65 and older -- covers few long-term care services.

Services

Each state's Medicaid program *must* pay for nursing home care for eligible persons age 21 and older. Medicaid is also required to pay for home health services for individuals who would qualify for nursing facility coverage. Home health services include skilled nursing and, at state option, a number of therapies. State Medicaid programs have the *option* of covering other long-term care services that can include personal care (help with daily activities such as bathing and dressing and related household help), Intermediate Care Facilities for the Mentally Retarded (ICF/MR), and home and community-based services (HCBS) under a "waiver" of federal Medicaid rules. Using the Medicaid waiver option, states provide a range of home care services, which may include personal care, transportation, respite care, homemaker, chore, and other related services.

Figure 1
Medicaid Expenditures for LTC Services, 1996*
(Total Expenditures = $51.3 billion)



Source: HCFA-64 Medicaid Statistics Report, FY 1996.
* Percentages do not add to 100 percent due to rounding.

Eligibility

In general, individuals must meet strict income and asset rules to be eligible for Medicaid. In most states, aged or disabled adults who are eligible for Supplemental Security Income (SSI) are also eligible for Medicaid. In 1998, the federal SSI limits for individuals are $494 per month in countable income and no more than $2,000 in countable assets.

Special *income* eligibility rules pertain to persons who receive Medicaid long-term care services in a nursing home or through a waiver program. Individuals whose income is not adequate to cover their health and long-term care costs can usually qualify for these long-term care services, even if their income exceeds the SSI standard. To qualify, however, individuals must contribute nearly all their income to pay for their care.

In addition to meeting financial eligibility criteria, such individuals must meet the state's *functional* eligibility criteria to receive Medicaid-covered long-term care services. These criteria vary across the states, but generally include both health status and physical and cognitive functioning.

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Preventing Spousal Impoverishment

Special income eligibility rules pertain to nursing home residents whose spouses reside in the community. To prevent the high cost of long-term care from impoverishing the spouses of nursing home residents, Congress enacted special laws that *require* states to protect the income and assets of community-dwelling spouses. In 1998, each state must allow a spouse to retain $1,326 per month (this amount will increase to $1,357 in July 1998), and states *may* allow a spouse to protect as much as $2,019 per month. In addition, states must allow the spouse to retain the *greater* of $16,152 in assets or half the couple's joint assets up to $80,760. States are allowed to apply these rules to the spouses of individuals who receive home and community-based services under a "waiver," but not all states exercise this option.

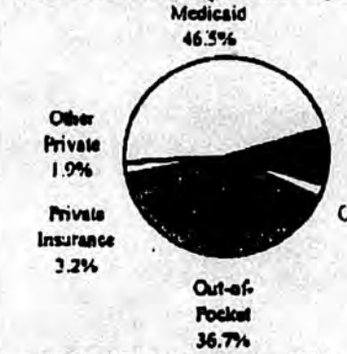
Medicaid Spending

In 1996, the Medicaid program spent $51.3 billion paying for long-term care. Of this amount, $40.8 billion (80 percent) paid for institutional care and $10.5 billion (20 percent) paid for home and community-based care. **Figure 1** illustrates Medicaid long-term care expenditures, by type of service.

These expenditures make Medicaid the single largest payer of long-term care services in the U.S., paying for nearly half (46.5 percent) of nursing home costs in 1995. **Figure 2** illustrates the sources of payment for *nursing home care* in the U.S.

Because the average cost of care in a nursing home was about $46,000 per year in 1995, most people who need extended nursing home care rely on Medicaid for at least a portion of the cost of their care. About one-third of people who enter a nursing home are eligible for Medicaid upon admission, while another third deplete their assets paying for care and then turn to Medicaid to pay for the portion of care that exceeds their income.

Figure 2
Sources of Nursing Home Payments, 1995



Source: HCFA, Office of the Actuary, 1996.
*Percentages do not add to 100 percent due to rounding.

Issues and Concerns

Although the majority of people who need long-term care prefer to remain at home, Medicaid spending for long-term care remains heavily weighted toward institutional care. States have been working to provide more services in home and community-based settings; however, progress has been slow. Medicaid provided nursing home services to 1.7 million persons in 1995, while home and community-based waiver programs served approximately 500,000 individuals.

Secondly, because Medicaid was designed as a program for the poor, its eligibility criteria are quite restrictive. Many individuals must deplete their life savings before they can qualify for Medicaid to cover the cost of the care they continue to need.

Finally, some policymakers are concerned that individuals attempt to "game the system" by sheltering or giving away their assets to qualify for Medicaid. Recent laws have attempted to eliminate this practice.

Written by Enid Kassner and Natalie Graves Tucker.
AARP Public Policy Institute
February 1998
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Senate District Q

Senate

SB 321

"An Act relating to assisted living homes."

Assisted living homes, formerly called adult foster care homes, and facilities that provide a home-like environment for seniors and people who have a disability and need assistance with everyday living activities. The program is under the Department of Administration, Division of Senior Services.

This program is regulated by the old general assistance regulations that need to be revisited and updated to be in line with the standard of care that is practiced by the other Assisted Living Programs. The cost of care is grossly outdated and has not been adjusted to the current care standards or to reflect the cost of providing a level of care.

The purpose of this legislation is to increase the daily rate paid to Assisted Living Homes by the State for vulnerable adults that are unable to provide safely for their own medical, emotional and personal care needs.

Currently the rate paid by the State is $34.50 per day. SB 321 would increase the daily rate to a minimum of $70 per day based on individual care. There has not been a rate increase since 1983.

I respectfully request your consideration in passing SB 321.

0-LS1041\F
Lauterbach
3/9/98

CS FOR SENATE BILL NO. 321( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR MILLER

A BILL

FOR AN ACT ENTITLED

"An Act relating to assisted living homes; and providing for an effective date."

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

*** Section 1.** AS 47.07.070 is amended by adding a new subsection to read:

(h) This section does not apply to the minimum daily reimbursement rate specified by law under AS 47.24.017 or AS 47.25.195(f) for assisted living homes.

*** Sec. 2.** AS 47.24.017 is amended by adding a new subsection to read:

(d) If the protective services under this section include the placement of a vulnerable adult in an assisted living home at the state's expense, the minimum daily reimbursement rate to the assisted living home for the vulnerable adult is $70. The department may, under its regulations, provide for a daily rate higher than $70 if the additional care provided to the vulnerable adult in the assisted living home justifies the additional reimbursement. In this subsection, "assisted living home" means an assisted living home licensed under AS 47.33.

*** Sec. 3.** AS 47.25.195(b) is amended to read:

(b) <u>Except as provided in (f) of this section, a</u> [A] health facility receiving

a payment under this chapter is subject to the requirements of AS 47.07.070 - 47.07.075.

* **Sec. 4.** AS 47.25.195(c) is amended to read:

(c) **Except as provided in (f) of this section, if** [IF] insufficient money is appropriated to fund medical assistance under AS 47.25.120 - 47.25.300 when taking into consideration projected use and the health facility payment rates established in accordance with (b) of this section, the department may, by regulation, establish at any time in the fiscal year a prospective pro rata reduction of the facilities' established payment rates that will be paid by the department for services provided by facilities under AS 47.25.120 - 47.25.300.

* **Sec. 5.** AS 47.25.195(d) is amended to read:

(d) Notwithstanding (a) - (c) of this section, the department may enter into agreements with a facility to provide services at a payment rate lower than the rate established in accordance with (b) of this section, **except that the department may not enter into an agreement with an assisted living home to provide services at a daily reimbursement rate lower than $70**.

* **Sec. 6.** AS 47.25.195(e) is amended to read:

(e) For purposes of this section,

(1) "assisted living home" means an assisted living home licensed under AS 47.33;

(2) "health facility" includes a hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic.

* **Sec. 7.** AS 47.25.195 is amended by adding a new subsection to read:

(f) Notwithstanding other provisions of this section and the provisions of AS 47.07, if the assistance provided to a needy person under AS 47.25.120 - 47.25.300 includes the initiation or continuation of placement of the person in an assisted living home at the state's expense, the department's minimum daily reimbursement rate to the assisted living home for the person is $70. This minimum rate is not subject to reduction under (c) of this section. The department may, under its regulations and

under the procedures of AS 47.07.070 - 47.07.075, provide for a daily rate higher than $70 if the care provided to the needy person in the assisted living home justifies the higher reimbursement. A daily rate higher than $70 for assisted living homes may be reduced under (c) of this section, but not below $70.

* **Sec. 8.** APPLICABILITY. The minimum daily reimbursement rate set under AS 47.24.017(d), enacted by sec. 2 of this Act, and AS 47.25.195(f), enacted by sec. 7 of this Act, applies to services provided on or after July 1, 1998, and is not dependent on the adoption of regulations of the Department of Health and Social Services.

* **Sec. 9.** This Act takes effect July 1, 1998.

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. SB 321

Revision Date:
Title: * An act related to assisted living homes...*

Sponsor: Senator Mike Miller
Requestor: (S) HES

Department Affected: Administration
BRU: Senior Services
Component: Protection, Community Services, Administration

COMPONENT SERIAL NO. 2083

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING EXPENDITURES	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	1,819.0	1,819.0	1,819.0	1,819.0	1,819.0	1,819.0
MISCELLANEOUS						
TOTAL OPERATING	1,819.0	1,819.0	1,819.0	1,819.0	1,819.0	1,819.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	1,819.0	1,819.0	1,819.0	1,819.0	1,819.0	1,819.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
OTHER						
TOTAL	1,819.0	1,819.0	1,819.0	1,819.0	1,819.0	1,819.0

Estimate of any current year (FY 98) cost: $ none

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

This bill would require the Department of Administration to increase the rate paid to assisted living homes under the existing general relief assistance program to a base rate of $70 a day. The current payment system administered by the Division of Senior Services is based on three levels of client need and related services provision by assisted living homes. An assisted living home rate schedule is attached which describes the rates which this bill would require the state to pay for assisted living services in the six regions of the state at each of the three levels of care starting with a base rate of $70 a day in Anchorage. The six regions are paid according to geographical cost of living differentials. Taking into account geographical cost differentials and a system of three levels of care beginning with a base rate of $70 a day, a budget of $1,819.0 is needed annually to fund this bill.

Recommendation: This bill is consistent with the existing adult protective services program objective to provide financial assistance to eligible vulnerable adults who are in need of assisted living resources for both protection and supportive services under AS47.24. The current base rate of $30 a day is not adequate to meet rising costs of providing assisted living care. A rate increase is overdue. This bill would require substantial funding which has not been approved by OMB. This bill would allow for improving the current system of general relief payment by increasing rates to an adequate amount based on levels of care statewide. The bill needs to be amended to include the Department of Administration. The supporting statute is AS47.24 Protection of Vulnerable Adults.

Prepared by: Dwight Becker
Division: Senior Services

Phone: 269-3674
Date: 2/23/98

Approved by Commissioner: Mark Boyer
Agency: Department of Administration

Date: 2/25/98

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ANALYSIS: (continued)

Calculation of General Relief Payment by State

The general relief payment made by the state is the amount needed to supplement the client's contribution to meet the rate indicated in the specific geographic region and according to the level of services provided. The average contribution of the clients is the adult public assistance payment standard of $856 per month or $28.14 per day. Normally client's are not able to contribute during the first month of placement, as they have no money and have normally not qualified for benefits. They must apply for benefits. Therefore, about 20% of the total of 29,200 days paid by the state are paid at the full rate without any contribution by clients.

Services provided by General Relief Program

80 clients per month x 365 days = 29,200 days of service per year

Days of Service by Region

Anchorage	65% of 29,200 days =	18,980 days
Palmer/Wasilla	5% =	1,460
Southeast	5% =	1,460
Northern	15% =	4,380
Western	5% =	1,460
N/Western	5% =	1,460
		29,200 days

Cost per Region which includes both State and Client Payments

Anchorage	$80.00 per day average	x	18,980	=1,518,400
Palmer/Wasilla	83.23	x	1,460	= 121,515
Southeast	80.00	x	1,460	= 116,800
Northern	92.02	x	4,380	= 403,048
Western	106.42	x	1,460	= 155,373
N. Western	110.42	x	1,460	= 161,213
Total				$ 2,476,349

Client Contribution Towards Payment for Assisted Living

$856 payment standard per mo. x 12 mo. / 365 days = $28.14 per day

(20% of the days are not contributed towards due to emergency situations and due to the time period needed for client to become eligible for benefits)

80% of 29,200 days x $28.14 per day = $657,350

The General Relief Assistance payment by the State as required by this bill.

$2,476,349 minus $657,350 = $1,818,999

Proposed Assisted living Daily Rate Payment Schedule

Region	Level I	Level 2	Level 3
Anchorage	70.00	80.00	90.00
Palmer/Wasilla	72.80	83.23	93.58
Southeast	70.00	80.00	90.00
Northern	80.50	92.02	103.48
Western	93.08	106.42	119.66
N.Western	96.58	110.42	124.16

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSIO..

BIL' ..C SB 321

evision Date:
Title: An act relating to Assisted Living Homes

Sponsor: Miller
Requestor: Senate (HES)

Dept. Affected: Health and Social Services
BRU: Community Mental Health Grants
Component: Services for the Chronically Mentally Ill
COMPONENT SERIAL NO. 800
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	1,661.7	1,711.6	1,762.9	1,815.8	1,870.3	1,926.4
MISCELLANEOUS						
TOTAL OPERATING	**1,661.7**	**1,711.6**	**1,762.9**	**1,815.8**	**1,870.3**	**1,926.4**
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health	1,661.7	1,711.6	1,762.9	1,815.8	1,870.3	1,926.4
Other (please specify)						
TOTAL	**1,661.7**	**1,711.6**	**1,762.9**	**1,815.8**	**1,870.3**	**1,926.4**

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

The Department of Health and Social Services, Division of Mental Health and Developmental Disabilities serves approximately 138 individuals in Assisted Living Home environments with a FY98 budget of $622.2. The number of individuals receiving support for Assisted Living Home services authorized by the Adult Residential Care regulations varies each year. 7AAC 47.450 -470 governs the fee structure for Adult Residential Care and has not been revised since 1982. Adult Residential Care is now referred to as Assisted Living Home services. The lack of cost of care adjustments to the Adult Residential Care fee structure jeopardizes the future of Assist Living Homes. Assisted Living options is a cost-effective alternative to institutional care for individuals choosing to remain in their home communities. Development of the Assisted Living Home industry is very important for our Long-Term Care Plan for the State of Alaska. Also, it is a residential care approach that all disability groups support. This fiscal note is based on a zero population growth. It will fix the system as it now exists. Growth in community based services for Mental Health consumers is addressed in the "API Community Implementation Plan" dated October 31, 1997, published by J.L. Mitson & Associates. This growth is not included in this fiscal note. Growth for the developmentally disabled consumer is provided in the Community Developmental Disabilities Grants Component FY99 budget.

Prepared by: Derrill L. Johnson — Phone: 465-4827 or 465-3370
Division: Mental Health and Developmental Disabilitie — Date: 02/25/98

Approved by Commissioner: Karen Perdue, Commissioner — Date: 3/25/98
Agency: Department of Health & Social Services

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ANALYSIS (cont.):

Page 2
SB-321
Fiscal Note

The following rationale was used to develop the needed General Fund increase to implement SB-321 as written and remains the same for the amendment proposed by the Department noted on the bill analysis:

Current Practice

DMH&DD augments the cost of care by an avg. daily rate:		$12.35 /day *
Consumer contributes entitlements avg. monthly $850		
Less Personal allowance	$ -75	
	$775 = avg. daily rate:	$25.48/day**
Average paid for total care in an Assisted Living Home		$37.83/day

* FY98 Budget of $622,200 divided 138 served = $4509 divided 365 days=$12.35/day
**Consumer Entitlements (SSI/SSA/AD) = $850 avg. - $75 personal allowance = $775/month divided 356 days = $25.48/day

Proposed in SB-321 with Recommendations

Currently DMH&DD augments the cost of care by an avg. daily rate:		$12.35/day
Consumer contributes entitlements avg. monthly $850		
Less increase Personal allowance	-$100	
	$750 = avg. daily rate:	$24.66/day ***
Average now available after the increased personal allowance:		$37.01/day
Needed increased augmentation by DMH&DD to equal $70/day avg.		$32.99/day ****
Total to be received by the Assisted Living Home		$70.00/day

*** Consumer Entitlements (SSI/SSA/AD) = $850 avg.-$100 personal allowance = $750/month divided 365days= $24.66/day
**** Additional daily rate funding with zero growth in the population to fix the Assisted Living Homes system as it pertains to the Department of Health and Social Services.

The Department of Health and Social Services, Division of Mental Health and Developmental Disabilities will need an increase in General Funds of $1,661,707 ($32.99/day x 365days = $12,041.35 x 138 served = $1,661,706 for FY99. These funds will utilize to bring the existing Assisted Living Home placements to a level of care that will meet their health and safety needs. The average cost of care should remain around $70/day. Some individuals will require supports costing less that $70/day, while others may need additional supports exceeding $70/day. The Department believes that with funds requested and the needed regulatory changes, the Assisted Living Home industry can become a viable option. Additionally, and of equal importance, these changes will ensure the health and safety of all served. Subsequent fiscal year's calculations have been planned with zero population growth for this bill. The Department did add a three- percent inflation factor for each fiscal carried forward.

The Alaska Mental Health Trust Authority has shown interest in the idea of a multi-year system change approach to address the funding needed to fix the Assisted Living Homes service system. They have indicated interest in receiving a jointly backed proposal from the Departments and planning boards impacted by the need to maintain the existing Assisted Living Home service system.

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. CS SB 321 (HES)

Revision Date:
Title: Relating to assisted living homes
Sponsor: Miller
Requestor: Senate (HES)

Dept. Affected: Health and Social Services
BRU: Medical Assistance Admin
Component: Health Purchasing Group
COMPONENT SERIAL NO. 243
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

Under Section 7 of Committee Substitute for Senate Bill 321 would allow, but not require, the Department to pay assisted living facility rates above $70 per day if established under the procedures of AS 47.07.070-47.07.075, which establishes a cost-based rate setting process under the Medicaid Rate Advisory Commission for Medicaid-enrolled health facilities.

The Department does not anticipate a cost of this provision, as the Department does not anticipate using the Medicaid Rate Advisory Commission to establish assisted living facility rates.

3/18/98

Prepared by: Jon Sherwood
Division: Medical Assistance
Phone: 465-3355
Date: 03/18/98

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 3/18/98

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FRANCES PURDY

State of Alaska
Office of the Long-Term Care Ombudsman

3601 C Street, Suite 260
Anchorage, Alaska 99503-5209
Telephone (907) 563-6393
1-800-730-6393 Fax (907) 561-3862

The Office of the Long Term Care Ombudsman is a program under 42 USC 3058(g) and AS 44.21.231 for the benefit of persons 60 years of age or older. The Long Term Care Ombudsman has authority to:

- **Investigate and resolve complaints of abuse, neglect and financial exploitation made by or on behalf of residents' of nursing homes and assisted living homes.**

- **Investigate and resolve complaints related to health, welfare, safety or rights in long term care, senior housing or other residential circumstances or associated with long term care services.**

- **Pursue administrative, legal or other appropriate remedies on behalf of an older Alaskan who resides in a long term care facility.**

- **Provide information and referral regarding long term care services for seniors and administrative and technical assistance on long term care services for seniors.**

- **Monitor the development and implementation of federal, state, and local long term care laws and policies;**

- **Promote the development of citizens' organizations and train volunteers.**

FRANCES PURDY

Office of the Long-Term Care Ombudsman

The Office of the Long-Term Care Ombudsman (OLTCO) is mandated by Public Law 102-375 and Alaska Statute 44.21.231. The OLTCO has jurisdiction to investigate and resolve complaints made by or on behalf of Alaskans age 60 and over when the issue centers around a decision, action, or failure to act by a long-term care provider or their representative, or when issues adversely affect Alaskan senior's health, safety, welfare, or rights. The OLTCO also advocates for the needs of the seniors when their situation involves problems with public housing, public assistance or benefits, government agencies or grant programs, public utilities, health care facilities, and health care providers. To resolve complaints, the OLTCO may subpoena and compel the attendance of witnesses, require that evidence be produced, administer oaths, and examine individuals under oath in relation to complaints. In addition the OLTCO is mandated to pursue administrative, legal and other appropriate remedies on behalf of older Alaskans in long-term care. Under certain circumstances, a report of the investigation may be distributed and available to the public upon removal of confidential information or consent by the complainant.

Long-Term Care Ombudsman FY 97 Statistics

516 Total Complaints Received

181 Total Requests for Consultation and Assistance

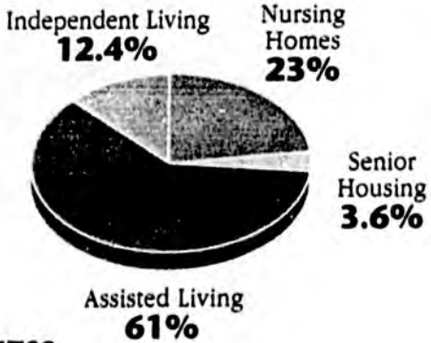
The OLTCO serves the state with two staff persons and nine trained and active Volunteer Long-Term Care Ombudsman.

The size, distribution, and makeup of Alaskan facilities vary:

Skilled Nursing facilities: 16 nursing homes in 14 different communities with a total of 797[1] beds. Skilled nursing facilities range in size from 5-224 beds.

Assisted Living Homes: The Division of Senior Services has 69 licensed homes with a total of 1,063 beds. The Division of Mental Health and Developmental Disabilities has 136 licensed homes with 826 beds.

Senior Housing: There are 2,000+ senior housing apartments throughout the state.



OLTCO Complaint Sources

In FY 97 the OLTCO opened 261 cases which included 418 complaints; an additional 98 complaints were referred to other agencies for enforcement and resolution, for a total of 516 complaints.

[1] With the phaseout of Harborview Development Center/Sourdough Place in Valdez, the total number of nursing home beds in Alaska will drop by 80 beds. There were only 16 residents in the facility in its final year. The last resident was moved to a community placement November 15, 1997. The building is now closed while the Department of Corrections makes plans for future use.

Examples of complaints resolved with assistance from the Office of the Long-Term Care Ombudsman (OLTCO):

A resident living in senior housing was having difficulty taking care of herself (cooking, bathing, shopping, cleaning the apartment, taking medication on time) without assistance. Neighbors called Adult Protective Services to intervene and assist the senior to gain access to social and health services. Even though somewhat confused, the senior feared if she agreed to assistance she would be placed in a nursing home against her will. The OLTCO assisted the senior and her family in reaching agreement on a durable power of attorney which would allow her son to coordinate the services to be brought into her home, but limited his ability to place her in a nursing home. The senior agreed to personal care and medical services through CHOICE and is able to remain in her own home.

The OTLCO received word that a resident in an assisted living home was being neglected. Upon investigating the complaint, the reviewer found that the resident's care plan did not address the rehabilitation needs of the resident, who had recently been discharged from the hospital following a massive stroke. Through intervention by the OTLCO, the assisted living home staff were given training on proper transfer techniques. The resident's personal dignity concerns were addressed in such a way that staff understood to not show the resident's bare body or underclothing when lifting her out of a chair. The family was assisted in negotiating a realistic plan of care for their mother, which included physical rehabilitation, mental health, recreation, social activities, daily care, and personal preferences.

A 77-year-old woman contacted the OLTCO because she was living in a hotel with her dog after being evicted from an apartment complex. The OLTCO connected her with legal services and a private-sector care coordinator to find housing and support services. She moved into an assisted living home that was unable to meet her needs. The senior moved out and was not heard from for a few months. She recontacted the OLTCO from a homeless shelter. The OLTCO and a local senior center advocate coordinated to rebuild the senior's willingness to try a match with another care coordinator. She now lives in senior housing with her dog and is accepting home-based services. She maintains periodic contact with the OLTCO office to report her happiness with the present arrangement.

Free statewide telephone number to reach the Long-Term Care Ombudsman:

1-800-730-6393

OLTCO
Disposition of Complaints

MONTA FAYE LANE

ALASKA CAREGIVERS ASSOCIATION

109 E. 5th Avenue, North Pole, AK 99705 (907)-488-9159

August 19, 1998

Rep. Con Bunde, Chairman
Long-Term Care Task Force
716 W. 4th Avenue
Anchorage, AK 99501

Representative Bunde and Members of the Task Force:

I want to thank you for allowing me to speak on behalf of all the assisted living homes in Alaska. In recognition of the importance of the service assisted living homes provide, Senator Mike Miller introduced SB 321. All of you need to sign on in support of this legislation next session.

I have spoke many times about the need to have an increase in the General Relief pay rate for indigent, frail, and elderly who are alcoholics, mentally ill and demented. These people make up the majority of the population in assisted living homes. We in assisted living homes provide a service Alaska can not do without, in that we save you money. We take people in an emergency situation when Denali Center and the pioneers home do not.

I hear state agencies talk about improving qualifications of people delivering assisted living services. If you want to improve these services, you must be willing to pay for these services. Our association has members who have completed a national training funded by the Division of Senior Services. We are national certified administrators. About 14 in Fairbanks and 20 to 30 in Anchorage. We in assisted living under the present general relief are paid $1.44 an hour or $34.50 a day. These people live with us 24 hours a day. We don't go home at the end of the day. We don't work 9 to 5. We work at least from 6 a.m. to 12 midnight and can expect to be waked up during the night.

The pioneer's home gets reimbursed at a rate up to $9,000 a month. CNA's get $12.00 an hour. There is a lot of disparity between $12.00 an hour $1.44 an hour.

Able bodied people are currently reimbursing the state at a $90.00 for being incarcerated in state corrections facilities, but the state expects assisted living facilities to provide intensive care for disabled adults for $34.50 a day.

As for the money, you all must find it. I can no longer go to members of my organization and tell them there is no money. I believe that federal funds designated for alcoholism programs and state funds from the mental health trust can be and should be used to provide assisted living services to products of alcohol and drug abuse, as well as, the mentally ill.

We take people after they no longer can live in their own home. We are not asking for the same compensation per occupant as the pioneer home or Denali Center receives, but we are required to operate under the same regulations as them.

Without increased funding, we can no longer accept general relief clients. We will only be able to accept private pay clients. This will force the State to find money to build more state operated nursing homes.

We also need to have the pay to assisted living be in a more timely manner. We do some very hard work. I would ask that each of you take one of these seniors or indigent people one week at $34.50 a day or $1.44 per hour and then tell me that we are getting paid an appropriate fee for all that we do.

With the decrease at API and Haborview, you can find some of the clients at assisted living homes at $34.50 a day, especially in Anchorage.

I know that the elder home in Fairbanks has refused Alaskan Native general relief clients because of the $34.50 a day. I know because two of my clients are Alaska Natives refused services at the Elder Home. The native associations get all kinds of grants from state and federal sources. Why then don't they accept Alaska Natives on general relief at "Forget Me Not?" Now they are constructing a new facility with public and native funds. I have a problem with that. I built my home out of my pocket, not state or federal funds. We can not compete with their methods of getting money, yet we are taking clients they consider excess baggage.

Just be fair with us, is what I want you to do. Treat us with respect and help us to remain in business. You have no idea what is coming down the pike with frail elders. We have the 50 to 60 year-old-generation who abused their health so badly, that you will appreciate the frail elderly we now are taking care of. When you meet the "Boomers" just hide and watch and you will go crazy looking for money then.

Thank you for your time and consideration.

Sincerely,

Monta Faye Lane

Monta Faye Lane

AUG-19-98 WED 11:38 AM FAIRBANKS LIO FAX NO. 907 456 3348 P. 02

MONTA FAYE LANE

ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the Rep. Con-Bunde
Committee Name

Committee on Long Term Care Task Force Dated 8-19-98
Bill / Subject

WE must have Senate Bill 321 Be Passed this Next Session.

MayBe There could be a Fund set up For Some of the Replacement Cost of the Assisted Living Homes.

with out this increase Some Homes will close, Some New Home's may never open.

WE must Be Reviewed more often than 15 years, or Completly Fail our Seniors

Increase's Should Be As State Employees Recieve Increase's in wage's or Stipends.

The money From the State Needs to Be in a more Timely manner. Not 45 to 60 Days Behind. our work is up Front So Should they Pay Be.

You can't Pay $15.00 Per hr For CNA's when you only get $34.50 a day I don't have employee's Because I can't Afford the wages, the Benefits, the vacations, I can't do this if I didn't have the Lane Company Burner Service For the Last 10 years. I Support this home From this Business also. Please come visit us. Thank you.

About Pharmacy I cant have time to run to all town for meds. It is more likly I would support a closere pharmacy. Not Just.

SIGNED: Monta Faye Lane
Testifier

Alaska Caregiver Assoc. / Arctic Heath Assisted Living
Representing

109 E 5th ave. North Pole, AK. 99705
Address / Phone Number

1-907-488-9159 Fax 907-488-7979.

ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the REP CON BUNDLE
Committee Name

Committee on _____ Dated _____
Bill / Subject

PAGE 2.

I WOULD LIKE to iNVite ALL OF YOU ON this BOARD to PLEASE if you ARE iN my AREA to PLEASE COME to VISIT my ASSisted LiVing home to SEE What it is LiKE. How it is operated! How WE LiVE With ALL OUR PEOPLE. COME TAKE SUPPER With US IM AN EXCELLENT COOK. COME SEE US.

Morita Lane

5 OR 6 of the people
Testifying were Alaska Caregiver assoc members:
Pat Edmonds, Anna Stalls, Sue Sammit, Leslee Arebaugh,
Candice Drayton + one more I didn't get the name. -
In Fbks Morita Faye, Les westling Merimon Griffin,

SIGNED: Morita Faye Lane
Testifier

Representing

Address / Phone Number

RYNNIEVA MOSS

ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the Long Term Care task Force
Committee Name

Committee on SB 321 Dated 8/19/98
Bill / Subject

I have seen and talked to Monto Faye's clients. She is very devoted to her clients and they have told me she treats them like family. I am here to say that there is a definite need to increase payments for assisted living.

Most assisted living clients are people with Alzheimers or with medical or mental problems related to alcohol and drug abuse.

In FY'97 the legislature authorized $17.3 million in alcohol & drug grants and $24.8 in mental health funding. That's a total of $42.1 million spent for alcohol, drug & mental health spending. The fiscal notes on SB 321 total $3.7 million. I believe federal funds earmarked for alcohol and drug program and mental health funds should be used to increase assisted living payments.

SIGNED: Rynnieva W. Moss Rynnieva Moss
Testifier

Rep Vezey's Constituents
Representing

119 N. Cushman, Rm 211, Fairbanks, AK 99701
Address / Phone Number
907-456-5081