OVERVIEW

LONG-TERM CARE

4/18/02

MEMORANDUM

April 10, 2002

To: Commissioner Jay Livey, Health and Social Services
CC: Deputy Commissioner Elmer Lindstrom, HSS
Director Sever Ashman, DOA, Division of Senior Services

From: Fred Dyson
State Representative

RE: Long Term Care Task Force and Assisted Living Reports

We are scheduling a House HESS Committee meeting at 3:00 on April 18 hoping to learn more about long term care and assisted living in Alaska.

First we would like to hear a summary of what was accomplished by the Long Term Care Task Force effort. What is in existence now that would not have been... what was left undone... what unintended consequences... We would also welcome a department written statement on what you would like to see if the Legislature authorizes future task forces.

Secondly, we would like a comprehensive picture of assisted living options in Alaska. I have attached a possible grid that could be filled out to paint this picture. The idea is to define the columns as all possible assisted living options and add whatever rows are necessary to distinguish easily between the options in the columns. Feel free of course to design the "picture" as you see fit, but please answer the questions this grid implies. Incidently, we have LCD projection on which we can show Excel files.

	Group # 1	Group # 2	Group # 4	group # 3	Group #4	Group # 5
Type of Housing	Studio Apartment	One BR Apartment	two or more BR	Pioneer home	Senior's Private Home?	Private Group Home?
Facility owner	private business	hud		State of AK	client	
Number of Beds						
Services Provided	none other than subsidized housing.				Housekeeping 2-3 Meals per day Laundry Transportation Intermittent Nursing Services	
Type of Client	elderly	dd		?		
Caregivers per facility	n/a					
Revenue source/s:						
State Subsidy		$				
Medicaid Subsidy		$				
Co-pay		$				
HUD		$				
Other						
Accountability:						
Case Managers						
Regular Audit						
Licensing Authority						
Inspections						
Billing Procedure						
Note: Please expand this and fill in the blanks...						

Jason,

Please Schedule a HESS meeting on "Long Term Care". We want two departments to tell us 1) What actions have been taken, 2) What actions will be taken, 3) How actions have changed services for the recipients 4) What is still "broken? Note: These are just draft leading questions... Please get refinement from Sheila Peterson in Wilken's office and perhaps Halcro--- and of course we will pump Fred ...

Fyi: The "requests" resulted from a long term care task force (LTCTF) that tried to resolve some of the snarls that exist partly because there are two Dept's involved. I do not remember who was on the LTCTF other than Senator Wilken. Probably Halcro was on it also or he would not have asked. Sheila will know and we could find it in HESS minutes in 1998. They produced a really nice report and proposed three or four pieces of legislation several of which passed. So, the goal of this meeting is to preserve the work that was done and keep the issued defined for us and those that might follow.

After this rush of bills we are collecting in HESS there will be a lull. Because HESS is often the first committee of referral, we are the first to feel the slack. Put this request in your queue file and watch for an opportunity to schedule it promptly after the rush. Just before scheduling it (not more than a day or two), contact DOA and HSS and put them on notice that we want a response to the questions.

Early April

Sheila (Wilken)
3709

9:36

ALASKA STATE LEGISLATURE

CHAIR
TRANSPORTATION

VICE-CHAIR
LABOR AND COMMERCE

MEMBER
COMMUNITY AND REGIONAL AFFAIRS

SPECIAL COMMITTEE
ECONOMIC DEVELOPMENT AND TOURISM

REPRESENTATIVE ANDREW HALCRO
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MEMORANDUM

TO: Representative Fred Dyson, Chair
House HESS Committee

FM: Representative Andrew Halcro AH

DATE: January 25, 2002

RE: Long-Term Care Task Force recommendations

After our conversation, I reviewed the fifteen recommendations made in the 1999 Report by Long-Term Care Task Force. Four of the fifteen required specific legislation, of which, three became law while the fourth failed due to an $800.0 fiscal note.

The remaining recommendations were directives for the administration to follow. I am interested in checking the progress of the nine recommendations not requiring legislative action. I have attached the LTCTF recommendations for your review. At your convenience, we can discuss this further.

WES
WHAT DO YOU THINK ABOUT HAVING THE ADMINISTRATION TELL A HESS HEARING WHAT THEY HAVE DONE to follow THE RECOMMENDATIONS of THE LONG-term CARE TASK FORCE?
Yes - but maybe ^we need to wait & combine something similar (maybe Assisted Living)
2/15/02 - I called Sheila Peterson & bounced idea off of her - she really likes the idea. I asked Jason to put it on schedule.

E-Mail: Representative_Andrew_Halcro@legis.state.ak.us

Long-Term Care Task Force
Time Table for Specific Requests

Request	Who	What	To Whom	When	Comment
No. 3 *		Introduce legislation relating to the disclosure of licensing reports and licensing of home health agencies.			
No. 6	Department of Administration	Consider the formal recommendations outlined in *The Alaska Guardianship Report* and recommend necessary statutory changes.	Senate President and House Speaker	March 31, 1999	
No. 7 *		Introduce legislation relating to the protection of a vulnerable adult from a guardian, attorney-in fact or surrogate decision-maker who may harm the vulnerable adult.			
No. 8	Alaska State Hospital and Nursing Home Association	Prepare a full report on the actions required to be taken as a result of the conclusion reached at the statewide *Work Force Development Summit* to be held April 9-10 , 1999	Senate President and House Speaker	No Date Specified	
No. 10	Alaska Commission on Aging	Implement a plan to increase the awareness of Alaskans to advance directives and prepare a report on the Commission's efforts to do so.	Senate and House HESS Committees	Beginning of the Second Session of the 21st Legislature	
No. 12	Department of Health and Social Services	Aggressively pursue the rebuttal of the federal Health Care Financing Administration's interpretation of the Social Security Act as it relates to the Indian Health Service.	Legislature	Semi-annually	

TIME TABLE FOR SPECIFIC REQUESTS

Request	Who	What	To Whom	When	Comment
No. 13 *		Introduce legislation relating to the establishment of a home and community-based services program for certain adults with long-term care needs.			
No. 14	Departments of Administration and Health and Social Services.	Review all options available to support the long-term care needs of patients whose sole diagnosis is Alzheimer's Disease and prepare a preliminary report outlining findings and recommendations	Senate President and House Speaker	April 30, 1999	
No. 18	Alaska Commission on Aging	Coordinate efforts to inform and educate all Alaskans on the various long-term care services available and provide updates on its efforts.	Senate and House HESS Committees	Semi-annually	
No. 19	Department of Administration	Establish a uniform and comprehensive screening and assessment tool and develop a pilot to assess its validity and reliability.	Not Specified	July 1, 2000	
No. 21 *		Introduce legislation relating to the adoption of the nursing home certificate of need recommendations developed by the *Legislative Working Group on Long-Term Care.*			
No. 24	Department of Health and Social Services	Identify necessary changes to assure the Medicare program funds health care services provided to dual eligible patients. Prepare a report on its efforts and make recommended changes.	Senate President and House Speaker	March 31, 1999	

TIME TABLE FOR SPECIFIC REQUESTS

Request	Who	What	To Whom	When	Comment
No. 29	Department of Commerce	Compile relevant information on the need for and availability of long-term care insurance in Alaska and disseminate the information to the general public.	All Alaskans	January 1, 2000	
No. 31 *	Senate and House HESS Committees, in consultation with legislative leadership	Consider the creation of a new task force to continue the review and monitoring of long-term care in Alaska.			
Letter to Commissioner Bob Poe	Department of Administration	Prepare a summary of a public hearing regarding the administrative practices of the Anchorage Pioneers' Home and corrective actions either taken or proposed to be taken, by the department.	Senate and House HESS Committees	February 28, 1999	

* Requires legislation

LTC TASK FORCE
Long-Term Care Task Force

FINAL REPORT
January 1999

Representative Con Bunde, Co-chairman
Senator Gary Wilken, Co-chairman

State Capitol Building
Juneau, Alaska 99801-1182

Long-Term Care Task Force Members

Representative Con Bunde - Co-chairman
Senator Gary Wilken - Co-chairman

Representative Al Kookesh
Representative Joe Ryan
Senator Lyman Hoffman
Senator Bert Sharp
Ms. Joyanna Geisler
Mr. John Hanchett
Mr. Dennis Murray

Ms. Alison Elgee
Ms. Karen Perdue
Ms. Deborah Sedwick

The Long-Term Care Task Force recorded its meetings. The tape recordings may be obtained from the Alaska Legislative Reference Library, Goldstein Building, Room 400, Juneau, AK 99801.

LTC TASK FORCE
Long-Term Care Task Force

FINAL REPORT
January 1999

Representative Con Bunde, Co-chairman
Senator Gary Wilken, Co-chairman

State Capitol Building
Juneau, Alaska 99801-1182

Alaska State Legislature

Official Business

State Capitol
Juneau, Alaska 99801-1182

Long-Term Care Task Force

January, 1999

To the reader;

The report you are now holding could not have been possible without the dedication and hard work of many people, in government and the private sector, who overcame significant limitations in time and resources to produce valuable recommendations on how Alaska can best provide long-term care for its citizens.

While we helped guide this process as co-chairs of the Long-Term Care Task Force, the credit for its achievement lies with them. We would therefore like to acknowledge our appreciation:

To the members of the Long-Term Care Task Force themselves, who absorbed vast amounts of data and produced creative approaches to one of our state's most pressing human concerns;

To the staffers at various state agencies, who generously shared their experience and expertise so that our recommended actions would have the best possible foundation in real-world experience;

And to the members of the public, who honored us with their time and attention, and whose personal testimony ever reminded us that all Alaskans have a personal stake in ensuring quality long-term care in the Last Frontier.

Thank you one and all.

Sincerely,

Representative Con Bunde
Co-Chair

Senator Gary Wilken
Co-Chair

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INTRODUCTION TO LONG-TERM CARE

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, improved technology and an aging baby boomer generation are contributing factors. Because of the advancements in technology and health care, elderly people and people with disabilities are living longer. Soon people 65 years old and older in this country will outnumber the young.

"Soon people 65 years old . . . 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.[1]

Alaska, too, is experiencing a rapid growth in our senior and disabled populations. Senator Bert Sharp, Fairbanks, and Senator Jim Duncan, Juneau, introduced Senate Concurrent Resolution 11 (SCR 11) in 1997 to address this critical issue and plan for the future. In his sponsor statement, Senator Sharp made the following comments regarding this resolution:

> As Alaska's senior community grows, it is necessary that we plan for the long-term care needs of these citizens. While it is the desirable goal of most families to provide home care for their elderly parents, the reality is that most will live in a long-term care facility. Either way, the costs of providing long-term care is becoming insurmountable to the state and to our private citizens.
>
> SCR 11 will create a long-term care task force. Their mission is to review the findings of the legislative working group and develop an equitable plan for providing actuarially sound and affordable long-term care options for all of the Alaska's senior citizens.[2]

"The Long-Term Care Task Force is created."

This resolution was adopted in 1998 and the 12-member Long-Term Care Task Force, composed of legislators, state officials and private citizens, was created.

The Task Force held meetings in Anchorage and many concerned Alaskans from around the state talked to the panel about the long-term care needs of seniors and adults with disabilities. Rural residents raised concerns about sparse services in rural Alaska. Many pointed to a shortage of workers to provide in-home personal care, the kind of help that can keep older people in their own homes. The exploding price tag associated with the cost of providing long-term care was frequently mentioned.

The task before this group was daunting, but all members of the task force were willing to devote their time and expertise to grapple with the challenge of accommodating and providing for adequate long-term care services for more and more Alaskans. The first step for the Task Force was to review the various reports and studies conducted over the past several years. These studies were invaluable in their work.

"Between the years of 1990-96, Alaska had a 42 percent increase in people age 65 years and older."

The *Legislative Working Group on Long-Term Care*, created in 1996, analyzed the state's population trends and noted that the number of Alaskans age 65 years and older is growing dramatically. The senior community is growing about 5 percent annually while the rest of the population is growing annually about 2 percent.

Alaska is second in the nation in the proportional growth of our senior population – with a 42 percent increase in people age 65 years and older in only six years (1990-96). Only Nevada had a greater rate (45 percent) in the same period of time.

Equally impressive is the anticipated long-term growth of Alaska's senior population. In 1980, there were 11,547 people over the age of 65 years. Using moderate growth projections, population experts agree this number may reach 80,927 by the year 2015. This is a 600 percent increase in only 35 years.[3]

The increased number of Alaskan seniors is the result of many factors, the three most mentioned being: 1) the state's more stable economy which makes it feasible for seniors to retire in Alaska; 2) successful public health care services; and 3) the many community-based programs which assist seniors to receive long-term care at home in their communities.

"Who should pay for long-term care?"

However, an increase in the number of elderly and adults with disabilities in Alaska means a dramatic increase in the number of people needing long-term care services. The *Legislative Working Group on Long-Term Care* noted that in FY96 the annual cost to provide long-term care services was $73 million, while in FY15 those same services would cost $372 million (assuming moderate population growth

and inflation). "The growth of the long-term care programs ... will be significant over time if costs or population grow at even a moderate rate."[4]

The question of who should pay for long-term care – the federal government, the state government, or private individuals themselves – was the focus of much discussion. 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.[5] In Alaska, Medicaid pays for the care of 80 percent of all nursing home residents. (The state pays 40 percent of all Medicaid costs.)

"The public is in denial about long-term care needs."

"The public is in denial about long-term care and routinely ignores the risk. Less than ten percent of seniors have purchased long-term care insurance and virtually none of the baby boomers have done so," stated Mr. Stephen Moses, Long-Term Care Center President, before a National Press Club Forum on November 19, 1998 in Washington, D.C. 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.[6]

Both at the state and federal level, policymakers are wrestling with this issue. *The Wall Street Journal* reported on December 7, 1998 that the Clinton administration was working on a proposal to provide tax credits to defray the cost of long-term care for the elderly and people with physical disabilities. Others are urging reform through the Social Security Act.

"The recommendations proposed by the Task Force will slow the growth of state expenditures."

The Task Force only scratched the surface in its discussion on how to adequately fund the increasing demand for long-term care for seniors and persons with disabilities living in Alaska. More in-depth and extensive research and analysis is necessary before a single funding plan, or a group of funding alternatives, can be structured. In the meantime, the recommendations proposed by the Task Force will slow the growth of state expenditures and begin the shift from public spending to private payers. ❖

QUALITY LONG-TERM CARE

As society has changed, so has the long-term care community. Long-term care now includes a broad spectrum of care including subacute medical care, ongoing skilled nursing care, care of the developmentally disabled and special populations, to adult day care, residential care, assisted living, and home and community-based care.[7]

A big change in home care for seniors and adults with disabilities was the development of the Medicaid waiver CHOICES program in December 1993. Indeed, a number of low-income seniors and adults with physical disabilities, who otherwise would need nursing home care, may now elect to receive long-term care services in their home or community. The plan of care is designed to meet the needs and preferences of each individual.

"The CHOICES alternataive is a popular option; the number of clients more than doubled between 1996 and 1998."

The CHOICES alternative is a popular option for qualifying Alaskans; the number of clients more than doubled between 1996 and 1998. Unfortunately not all seniors have this choice. The vast land area of our state, low population density, and our population distribution combine to create difficult hurdles to clear. But these unique problems can be solved, one step at a time.

The Task Force recognizes that long-term care is reinventing itself as providers strive to meet the diverse needs of Alaska's seniors and adults with physical disabilities. With each step, the quality of long-term care continues to improve. ❖

PERSONAL CARE ATTENDANT

RECOMMENDATION 1

The Task Force acknowledges and supports the effort of the Personal Care Attendant Design Team to redesign the personal care services delivery system and establish professional standards for personal care attendants.

Personal Care Attendant (PCA) services enable adults with physical and mental disabilities and elderly Alaskans to live in their own homes or communities. PCA services are typically provided in a consumer's home by trained health care para-

professionals and include assistance with activities of daily living such as eating, bathing, dressing, personal hygiene and medication needs. Ideally, these services are part of a continuous and coordinated system of social and medical support.[8]

In order to facilitate their integration with other home and community-based services, PCA services are administered through the Division of Senior Services, Department of Administration. Two models of personal care services are available in Alaska: the *independent model* and the *agency-based model.*

"Two models of personal care services are available in Alaska: the independent model and the agency-based model."

In the *independent model*, the consumer hires and manages the personal care attendant as an employee. In FY97, independent personal care attendants provided services to approximately 65 individuals. Independent care attendants who serve Medicaid clients contract directly with the Division of Medical Assistance for $12 per hour.

In the *agency-based model*, specific non-profit agencies provide personal care attendant services. In FY97, almost 950 individuals received personal care services through agency personal. The reimbursement rate for agencies to provide personal care services to Medicaid clients is $21 per hour. The attendant directly providing the services receives an average of $9-12 per hour, with or without benefits.

Personal care attendants are the cornerstone of home and community-based programs that allow Alaskans to receive health care support services in their home communities.

"Personal care attendants are the cornerstone of the waiver programs."

On November 14, 1998 a "Personal Care Attendant Services Summit" was held in Anchorage to develop clear objectives for improving Alaska's delivery of PCA services. The summit was directed by a steering committee composed of the key individuals and organizations, both public and private, actively involved in providing or directing long-term care services in the state.

Approximately 85 participants attended the statewide "Personal Care Attendant Services Summit." This conference was an instrumental step toward refining the way thousands of Alaskans with disabilities and seniors will receive long-term care in their homes and communities and continue to live independently in the future. To accomplish their goal, summit attendees 1) adopted guiding principles for a delivery system that provides service for all levels of care; 2) began the design of a PCA service program that fits Alaska; and 3) identified potential bar-

riers that must be addressed before a smooth transition to the new delivery system can occur.[9] (Please see Appendix G, page 79, for further detail.)

The Task Force recognizes that this summit represents a first step in a long, involved process that may include regulatory and statutory changes, as well as some possible change in funding sources. The Task Force applauds and encourages that beginning. As the Division of Senior Services and others continue and complete their work, the Task Force encourages the general public to get involved.

In addition to reviewing the options for a new delivery system for personal care attendant services, the Task Force recommends that the Division of Senior Services and others review the possibility of establishing professional standards for personal care attendants. The adoption of standards developed through a public process will provide a reasonable framework to assure quality care. ❖

"The Task Force recommends that the Division of Senior Services review the possibility of establishing professional standards for PCAs."

DELEGATION OF NURSING ACTIVITIES

The Task Force recognizes the efforts of the Alaska Board of Nursing to address the issue of "delegation of nursing activities" and challenges all interested parties to actively participate in the Alaska Board of Nursing public hearing process when this issue is addressed.

On September 21-23, 1998, approximately 100 community, agency and senior advocacy leaders from across Alaska met to identify and address opportunities and challenges affecting the growing number of older Alaskans. The focus of the conference, entitled *Alaskan Seniors: Finding the Common Ground*, was to unite the participants' efforts to better meet the needs and address the concerns of Alaskan seniors. (Please see Appendix H, page 81 for further detail.)

"Alaska is proud of its caregivers."

At this conference the participants stressed that the foundation of any long-term care service is the quality of the actual service provided through the public and private sector. A person who is elderly or experiences a disability must have assurance that the care provided is appropriate, provided in a timely manner, and performed by qualified personnel.

Likewise it is recognized that many long-term care recipients may wish to maximize their personal independence. To achieve this independence, they are willing to assume some personal risk.

The caregivers in Alaska are dedicated and well respected. "The degree of commitment to clients of those working in the Alaska long-term care systems seems higher than most states."[10] Alaska is proud of its caregivers.

"Delegation of some nursing activities is appropriate."

With the growth of Alaska's senior community and the expansion of the home and community-based programs and assisted living homes, the care of Alaskan seniors and people with disabilities may be provided by unlicensed assistive personnel. Unlicensed assistive personnel are individuals who are not authorized to perform nursing acts or tasks that are regulated by the Board of Nursing except pursuant to legal delegation by a nurse.[11]

Changes in the levels of health care provided in traditional and non-traditional settings have altered the scope of practice of nursing and its relationship to unlicensed assistive personnel. The unlicensed home care provider may now be involved in procedures such as assisting with medication, intermittent bladder catheterizations and gastrostomy feedings.[12]

Delegation of some nursing activities is appropriate and, in fact, a legally accepted part of the practice of nursing. However, at times, it can be difficult to define what is appropriate to delegate and in what circumstance. The Board of Nursing has the authority to regulate nursing practices, including the delegation of nursing tasks. In 1993 and 1995 the Board of Nursing wrote two position statements on how the practice of using unlicensed assistive personnel relates to the nursing practice.

"The Task Force applauds the continued effort of the Alaska Board of Nursing to establish guidelines."

Alaska is not alone in wrestling with this issue. At the national level, the issue of appropriate, safe nurse delegation is an ongoing topic among state boards of nursing and health care providers.

The question of delegation of responsibilities extends beyond the nursing staff. Other professionals such as pharmacists, social workers, physical therapists and occupational therapists provide input and directives regarding the care of clients. Unlicensed assistive personnel often carry out their directives.

The Task Force applauds the continued effort of the Alaska Board of Nursing to clarify the guidelines regarding the delegation of nursing tasks by nurses. In addition, the Task Force recognizes the importance of approaching this task with cre-

ativity and the active engagement of all interested individuals, agencies, long-term care providers and other professional boards. The Task Force challenges everyone to participate in the decision-making process. ❖

HOME HEALTH AGENCIES/LICENSING REPORTS

The Task Force recommends that legislation be drafted and introduced relating to the disclosure of licensing reports and licensing of home health agencies.

The Task Force was presented draft legislation that covered two specific areas of concern. The first subject dealt with the disclosure of licensing reports. Under current law, AS 18.20.090, the Department of Health and Social Services cannot make available to the public the annual inspection and investigation reports of the hospitals or nursing homes licensed by the department. As noted in testimony before the Task Force, full public disclosure of licensing reports would benefit the public and help individuals make appropriate decisions regarding their health care needs.

"Full public disclosure of licensing reports would benefit the public."

The proposed legislation under consideration will make the department's licensing reports available to the public within 14 calendar days after the information is made available to the health care facility being reviewed. Any information that identifies patients or clients remains confidential.

The second area of discussion centered on the actual licensing process for home health agencies. A home health agency, either public or private, is an entity that provides primarily skilled nursing care and therapeutic services to people in their own homes, an assisted living home, or another residential setting.

"A home health agency is an entity that provides primarily skilled nursing care."

The Department of Health and Social Services has, since the early 1980s, licensed home health agencies. Regulations (7AAC 12.500-12.590) were adopted under the department's broad regulatory authority. Only recently did the Department of Law question that authority. The draft legislation presented to the Task Force provides the Department of Health and Social Services with the necessary and specific statutory authority to license and regulate the quality of care provided by

these agencies. The continued oversight of home health agencies will assure the public that the quality of care being provided to clients meets minimum standards.

The Task Force acknowledges the importance of the concepts included in the proposed legislation and recommends the legislation be introduced for further consideration. (Please see Appendix B, page 69, for further detail.)

SMALL BUSINESS TRAINING

The Task Force supports an increased effort to train Assisted Living Home administrators in proven small business practices and urges collaboration between the Department of Administration and the University of Alaska to provide this education.

On January 14, 1994 Governor Wally Hickel introduced legislation that developed a system of long-term care "by encouraging the establishment of assisted living homes that provide a homelike environment for elderly persons and persons with a mental or physical disability who need assistance with the activities of daily living." (Chapter 130, SLA 1994) Assisted living homes promote and sustain the independence of Alaskans through a social model of community-based long-term care.[13]

"Eighty-five assisted living homes have been licensed by the Department of Administration."

Assisted living homes provide a home-like setting as well as certain health-related services or assistance with certain personal activities. Such services allow the elderly to age in place, rather than having to be transferred to a more institutionalized nursing-home setting, and allow adults with a physical or mental disability to become integrated into their community.[14] Eighty-five assisted living homes have been licensed by the Department of Administration to serve the elderly. In addition, the Department of Health and Social Services has licensed 134 assisted living homes to provide care primarily to individuals with a mental or developmental disability.

Assisted living homes have become a reality in many, but not all, areas of Alaska.[15] In some instances, it is difficult to establish an assisted living home and provide the necessary care. Interested care providers must first have an adequate, safe facility and then must obtain the required licensure, insurance coverage, and per-

sonnel before they can open their doors to clients. The start-up costs can be substantial and the risks great.

As was noted in the draft *Alaska Rate Study Report*, November 1998, many assisted living home owners/operators are not financially prepared or sufficiently trained in business operations to meet the needs of Alaska's aging population. The Division of Senior Services recognizes that more in-depth business education is necessary, and plans to expand its training options available to interested long-term care providers.

"The University ...is exploring the possibility of offering a three-credit college course in business practices for assisted living home administrators."

Currently assisted living home administrators and executive personnel are offered a one-day orientation seminar in which necessary fiscal practices are reviewed. The covered topics include general accounting practices, the state and federal reimbursement systems, availability of bank financing and various insurance requirements. In addition, the Division conducts a weeklong workshop and similar topics are reviewed in greater depth. At the completion of this course, the participants are recognized as "certified assisted living home administrators."

The Division of Senior Services and the University of Alaska are exploring the possibility of offering a three-credit college course in business practices for assisted living home administrators. The Task Force applauds this effort and encourages continued business training for owners and operators of assisted living homes. ❖

ASSISTED LIVING STANDARDS

The Task Force requests the Department of Administration review the current regulations governing assisted living homes and, through a public process, establish statewide standards for long-term care services provided in an assisted living home.

Recently the *Assisted Living Quality Coalition*, a coalition of six assisted living consumer and industry associations, issued a report that provides a framework for quality initiatives in assisted living facilities, as well as guidelines to help state policymakers set minimum quality standards.

The *Assisted Living Quality Coalition* consists of the American Health Care Association, the Alzheimer's Association, the American Association of Homes and Services for the Aging, the American Association of Retired Persons, the American Seniors Housing Association, and the Assisted Living Federation of America.[16]

"The guidelines will provide an excellent frame of reference to begin a discussion on statewide standards."

The issues addressed by this coalition are the same concerns regarding long-term care expressed by the Alaska Chapter Alzheimer's Association. It was noted in a letter to the Task Force that standardization of care in all facilities across the state is of utmost importance.[17] The quality initiative and the consensus guidelines as proposed by the *Assisted Living Quality Coalition* will provide an excellent frame of reference to begin a discussion on statewide standards for quality care in assisted living homes.

The Task Force requests the Department of Administration review the current regulations governing assisted living homes and, through a public process, establish statewide standards for long-term care services provided in an assisted living home. The standards may include a standard of care that takes into account each individual resident's needs and preferences, as well as whether the living arrangement is appropriate for a particular level of care.

In addition, the Task Force requests the Department of Administration determine if the current assisted living regulations are appropriate for any size facility. In certain instances, regulations that are appropriate for a small assisted living home may not be appropriate for a larger home. The Department is requested to promulgate the necessary changes, if needed. ❖

ALASKA GUARDIANSHIP SYSTEM

The Task Force urges the Department of Administration and the Division of Senior Services give serious consideration to the formal recommendations outlined in the report, *The Alaska Guardianship System*, and notify the Legislature of any statutory changes necessary.

Three guardianship systems exist in Alaska, each providing a different mix of services; public guardians, private professional guardians; and private unpaid (usually family) guardians. Under each system, the guardian is legally in charge of the affairs of a minor or incapacitated person.

In September 1998 the McDowell Group, Inc. reviewed and assessed the guardianship system in Alaska and issued a report entitled, *The Alaska Guardianship System.* This review was funded by the Mental Health Trust Authority and is the result of the Trustees' desire to look proactively at the future of guardianship services in Alaska. Most clients served within Alaska's guardianship system are Trust beneficiaries.

"The Alaska Guardianship System is reviewed."

The final product met two major objectives: 1) To describe and quantify the entire complex guardianship system; and 2) To identify and analyze major issues and provide clear recommendations for improving the quality of guardianship in Alaska.

This study included 70 in-depth interviews, a facilitated group discussion with the public guardian staff, and a sample telephone survey of 17 private guardians in Anchorage and Fairbanks. In addition, court data on open guardianship cases was analyzed and secondary research was conducted on other state's practices and standards.

The Alaska guardianship system was found to be complex, sophisticated, fragmented and confusing. Guardianship is a wide-ranging issue interconnecting Alaska courts, state agencies, the legislative branch, the legal profession, non-profit sector, many local, state and federal social service agencies, and private households.[18]

"The McDowell Group estimated that individuals suffering from Alzheimer's Disease account for approximately half of all guardianship cases."

As estimated by the McDowell Group, individuals suffering from Alzheimer's Disease and related dementia accounted for approximately half of all the guardianship cases and individuals experiencing developmental disabilities accounted for a quarter of all the cases. In other words, almost seventy-five percent of all clients receiving guidance and support from a guardian may also be receiving long-term care service.

The Task Force applauds the foresight of the Mental Health Trust Planning Board in initiating this review and urges serious consideration and discussion of the formal recommendations outlined in the report. In addition, the Task Force recommends that the President of the Senate and the Speaker of the House be notified by March 31, 1999 of any statutory changes necessary to implement the report's recommendations. ❖

LEGISLATION TO PROTECT VULNERABLE ADULTS

The Task Force recommends that legislation be drafted and introduced to protect a vulnerable adult from a guardian, attorney-in-fact or surrogate decision-maker who may harm the vulnerable adult.

AS 47.24.900 (16) defines a vulnerable adult as a person 18 years of age or older who, because of physical or mental impairment, is unable to meet his or her own needs or to seek help without assistance.

Under current law, if a person has reason to believe that a vulnerable adult suffers from abandonment, exploitation, abuse, neglect or self-neglect, the concerned individual must contact the Department of Administration which, in most instances, initiates an investigation. After the department conducts an investigation, a written report is prepared of the department's findings, recommendations, and determination of whether supportive or protective services are necessary.

"After the department conducts an investigation, a written report is prepared."

The department must immediately terminate an investigation upon the request of the vulnerable adult who is the subject of the report. Unfortunately, in some instances, the adult's guardian, attorney-in-fact, or surrogate decision-maker, who is the alleged perpetrator of the abuse and the subject under investigation, may make the request. Currently AS 47.24.015 (c) does not allow the Department of Administration any option in such a case but to terminate the investigation. A change to this statute is necessary to adequately protect the vulnerable adult.

The investigation findings and the reports of the abandonment, exploitation, abuse, neglect or self-neglect of a vulnerable adult filed with the department are considered confidential. However, the reports are disclosed if the vulnerable adult who is the subject of the report consents in writing. A problem arises when the vulnerable adult's guardian, attorney-in-fact or surrogate decision-maker is suspected of abuse and is under investigation. The disclosure of the complaint, in this case, would severely restrict the department's ability to effectively continue with its inquiry.

"A problem arises when the vulnerable adult's guardian is under investigation."

The Task Force recognizes that a situation may arise where a guardian, attorney-in-fact or surrogate decision-maker will abuse or harm a vulnerable adult and the statutes should reflect this possibility. The proposed legislation addresses this like-

lihood and gives the Department of Administration the needed leeway to conduct a thorough investigation in order to protect the vulnerable adult. (Appendix B)

Federal and state law provides for long-term care ombudsman services for vulnerable adults who are 60 years and older and reside in a nursing home or an assisted living facility. The Task Force recognizes that vulnerable persons under the age of 60 who reside in nursing homes or assisted living facilities also have a need for protective services. The Disability Law Center, the State Independent Living Council and its regional centers, the Division of Senior Services, and the Division of Mental Health and Developmental Disabilities offer protective and advocacy services to these individuals. Greater access and collaboration between these organizations will help strengthen their ability to meet the needs of these vulnerable persons under the age of 60 who are living in an institutional setting.

"The Task Force recognizes that vulnerable persons under the age of 60 who reside in nursing homes or assisted living facilities also have a need for protective services."

The Task Force recommends that these entities coordinate efforts: 1) to increase residents' awareness of the protection and advocacy services available within the state; 2) to facilitate the system's response to complaints and requests for assistance. ❖

WORK FORCE DEVELOPMENT SUMMIT

The Task Force endorses the efforts of the Alaska State Hospital and Nursing Home Association, in conjunction with the other training councils, to hold a statewide Work Force Development Summit.

On September 17, 1998 the Alaska Human Resource Investment Council (AHRIC) and the University of Alaska Statewide Vocational/Technical Education Advisory Council (UASVTEAC) held a joint meeting in Seward to discuss issues surrounding the demand and capacity of Alaska's health care industry.

"Low pay, lack of adequate training and frequent job turnover (are) problems."

The concerns expressed at this joint meeting parallel the testimony received by the Long-Term Care Task Force. Many long-term health caregivers testified in great detail about how fragile the job situation is for people who provide day-to-day health care for seniors and adults with disabilities. Low pay, lack of adequate training and frequent job turnover were some of the reoccurring problems mentioned.

"Alaska faces a crisis in meeting the demand for qualified workers within the health care industry."

Alaska faces a crisis in meeting the demand for qualified workers within the health care industry. The quality, affordability and availability of health care impacts every community and citizen in Alaska. The inability to meet the workforce demand translates into higher customer costs, limited service in the community, lower quality of service and added stress on the existing limited health care workers.[19]

The Alaska State Hospital and Nursing Home Association (ASHNHA) plans to hold a statewide conference, in cooperation with AHRIC and UASVTEAC, on April 9 - 10, 1999 to address the five major areas of concern identified on September 17, 1998. The goal of the conference is to find ways to: 1) increase training opportunities for health-related occupations: 2) create career ladders for personal care attendants, certified nurse aides, licensed practical nurses, and individuals with an associate's degree in nursing; 3) design worker retention strategies for employers and existing workers; 4) recommend new workplace policies; and 5) increase the number of Alaska residents acquiring new jobs in the industry.[20]

The Task Force further recommends that a full report on the actions required to be taken as a result of the statewide summit be submitted to the President of the Senate and Speaker of the House for additional review and action. ❖

CAREER LADDER FOR HEALTH CARE PROVIDERS

The Task Force encourages the University of Alaska to explore further the development and expansion of its curriculum to facilitate a career ladder for health care providers.

On September 17, 1998 more than 70 people attended a statewide conference sponsored by the Alaska Human Resource Investment Council and the University of Alaska Statewide Vocational/Technical Education Advisory Council, focusing on *Alaska's Health Care Industry: Workforce Demand and Capacity*. The Department of Labor outlined the workforce demand and occupational forecasts for the health-care industry. In addition, several industry representatives offered a unique view of the current workforce demand in health care and the corresponding training capacity.

During the facilitated roundtable discussions, the group was challenged to envision a more responsive workforce development system that produces a quality, skilled Alaska health care workforce. A common theme throughout the discussion was the lack of a formal, education career ladder that encourages an individual health caregiver to advance and grow within the health care field. As it was envisioned, a person could enter the health care profession at the entry level (personal care attendant) and through training and college education advance in the field. Through training, education and experience the caregiver could obtain certification at each level of expertise. This career ladder would enhance the training, education opportunities, and earnings for health care providers.

"It is projected that more than 1,500 new jobs in the health care profession will be created over the next five years."

As noted at the conference, it is projected that more than 1,500 new jobs in the health care profession will be created over the next five years. One half of these new jobs will require two-year associate's degrees, four-year baccalaureate degrees or master's degrees. An integrated training program that includes both vocational and college education will be necessary to meet this new job demand.

The Task Force is excited about the new job possibilities and expansion of the health care industry, but also recognizes the challenge before the University of Alaska and other training institutions. A well-qualified, trained workforce must be available. The Task Force applauds the University of Alaska's active involvement in addressing the needs of the health care industry and encourages the University to explore further the development and expansion of its curriculum to facilitate a career ladder for health care providers. ❖

ADVANCE DIRECTIVES

RECOMMENDATION 10

The Task Force encourages the Alaska Health Fair, Alaska Commission on Aging, AARP, and other related organizations to provide educational information on the importance of advance directives and encourage the use of advance directives in the provision of health care.

"Advance directives help all individuals maintain control over their health care decisions."

Advance directives are legal documents, prepared in advance of any incapacitating condition, stating the author's preference for health care. Advance directives help all individuals maintain control over their health care decisions even after the loss of decision-making capability. The Task Force heard testimony in support of

the concept of planning medical decisionmaking through the use of living wills and durable powers of attorney for health care.

In a *living will*, the applicant describes a specific preference for medical treatment if terminally ill or near death. With this document, even if the patient cannot communicate, he/she ensures that his/her desires have been conveyed to the doctors and family members. Alaska's living will has a checklist that helps describe the type of care desired.

"A person does not give up any control with an advance directive."

A *durable power of attorney* for health care is a legal document that expresses an individual's wishes about health care treatment and appoints someone to speak for the patient if the person becomes seriously ill or injured and cannot speak. Once signed and witnessed, this document becomes part of the individual's medical record.

A person does not give up any control with an advance directive. As long as the individual is able to make decisions, he/she is the decisionmaker. An advance directive only applies when one cannot speak or otherwise provide instruction to caregivers. The document can be changed or revoked at any time, as many times as wished.[21]

"AARP has established an education network to inform its membership on many issues facing us as we age."

The Alaska Health Fair plans and stages over 120 health fairs annually throughout Alaska, reaching approximately 40,000 people in both urban and rural settings. This outreach venue provides an excellent opportunity to inform many citizens on the various advance directives honored in Alaska.

In addition, the American Association of Retired Persons has established an education network to inform its membership on many issues. The Alaska Commission on Aging also regularly circulates information on resources available to all Alaskans as we age. Together their added voices will increase the education effort on the advance directives available.

The Task Force encourages the Alaska Health Fair, Alaska Commission on Aging, AARP, and other related organizations to provide educational and informational forums, as appropriate, on the importance of advance directives and encourage the use of advance directives in the provision of health care. In addition, the task force requests the Alaska Commission on Aging to coordinate these efforts, develop an implementation plan by December 31, 1999, and report to the Senate and House HESS Committees at the beginning of the Second Session of the 21st Legislature regarding the Commission's activities. ❖

ACCESS TO LONG-TERM CARE

One way, and possibly the best way, to ensure that Alaskan seniors and adults with disabilities remain as independent as possible for as long as possible is through a continuum of care. Under a continuum of care, individuals have available to them a broad spectrum of services that range from home and community-based services and preventive services at one end to 24-hour skilled nursing home care, notes the Alaska State Hospital and Nursing Home Association.

The Alaska long-term care system has many services available. However, it is not always the case that seniors are able to have a choice as to the type of service or the location of these services. This is especially true for services in the rural communities, as many Native elders need to leave their home communities and travel great distances to obtain services in unfamiliar urban settings.

"It is not always the case that seniors are able to have a choice."

The *Legislative Working Group on Long-Term Care* noted, "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 to a full range of services."

The Task Force recognizes that in some areas of the state access to appropriate health care services is a problem and recommends several changes to improve the availability of long-term care. ❖

AFN RESOLUTION

The Task Force recognizes and supports Resolution 98-59, *In Support of Elder Care Facilities in Rural Alaska*, as adopted at the Alaska Federation of Natives 1998 Annual Convention.

"The resolution supports elder care facilities."

At the recent Alaska Federation of Natives 1998 Annual Convention, Resolution No. 98-59, *In Support of Elder Care Facilities in Rural Alaska*, was submitted by the St. Mary's Native Corporation and formally approved by the whole convention. This resolution recognizes Alaskan elders as a respected group of people within the family unit and acknowledges the lack of proper facilities in rural areas that provide care for elders.

The resolution resolves that "(T)he Alaska Federation of Natives politically supports the efforts of rural organizations in seeking, acquiring, and administering the required funding, facilities, personnel, and technical and professional support for elder care facilities." The Task Force supports this effort to expand long-term care services in rural Alaska.

In FY99, the Division of Senior Services received funding to implement a rural long-term care development proposal that will focus on increasing home and community-based services in the rural regions of Alaska. The Alaska Mental Health Trust Authority is funding this two-year effort.

"By the end of FY00, more assisted living homes will be available in these five communities."

Five interested communities will receive assistance on ways to expand an existing home and community-based program or means to implement a new program. Local government, tribal authorities and federal and state agencies will be included in the planning and implementation process.

By the end of FY00, more assisted living homes will be available in these five communities. An appropriate workforce will also be created to meet the long-term care needs in those settings. ❖

INDIAN HEALTH SERVICE

RECOMMENDATION 12

The Task Force supports the Indian Health Service's role in providing long-term care services and encourages the Department of Health and Social Services to aggressively pursue its rebuttal of the Health Care Financing Administration's interpretation of the Social Security Act.

The Indian Health Service plays a pivotal role in the delivery of health care in rural areas of Alaska. "Designing a health care delivery system in rural Alaska, mostly populated by Alaskan Natives residing in communities of a few dozen to a couple thousand people, has been totally dependent upon the system developed by the Indian Health Service."[25]

"The Indian Health Service plays a pivotal role in the delivery of health care in rural areas of Alaska."

The Indian Self-determination and Education Assistance Act (PL 93-638) enabled Alaska Native people to become more actively involved in determining their destinies in health and educational affairs by allowing tribes to take over the operation of Indian Health Service programs and facilities. The Alaska Area Native Health Service encompasses nine service units distinguished by their cultural similarities and transportation patterns. Each service unit's field hospital or clinic serves as that service unit's headquarters and hub from which services radiate. In addition, personnel work at 22 health centers, and 167 village-built clinics.[26]

It has required ingenuity and determination to deliver community-based care to the dozens of villages scattered over thousands of square miles that each tribe serves without benefit of a road system.[27] The principal provider of health services at the village level is the community health aide, chosen by the village council. Planning for long-term care involves determining the level of patient care needed and providing home health services when possible. To date, with the exception of a nursing home wing in Nome, there are no nursing facilities in Alaskan villages and only two developing home health agencies. The establishment of home and community-based long-term care services has been difficult and has achieved limited success.

"The principal provider of health services at the village level is the community health aide."

New federal policy released during FY97 expanded 100 percent federal funding for Medicaid services to Alaska Natives to include tribal facilities and contract health services. Unfortunately the Health Care Financing Administration (HCFA) has determined that the actual health care must be provided "in" an Indian Health Service or tribal owned or leased facility in order to qualify for the 100 percent

federal funding. This ruling effectively eliminates any home and community-based care services from receiving the full federal reimbursement.

"The DHSS took exception to this ruling."

The Department of Health and Social Services took exception to this ruling and on June 9, 1997 wrote a position paper in support of an expansion of HCFA's interpretation to include community-based care. This letter states, "(It) is clear that the intent in adopting the 100 percent Medicaid Reimbursement Formula was to remedy the problem of access to Medicare and Medicaid supported services, and assure that states did not receive an unfair and inequitable burden of costs that normally would have been born by the Indian Health Service."[28]

The paper continued, "Home care services are under the control of the Indian Health Service or tribal health program, authorized under the Indian Health Care Determination Act, and covered as State Plan services under Medicaid, and should not be restricted from enhanced federal funding."[29]

The Indian Health Service is the prime provider of long-term care health service in rural Alaska. If the Health Care Financing Administration were to alter its opinion and recognize community-based services as being eligible for 100 percent federal reimbursement, the potential additional funding would have a definite beneficial impact on the level of services provided in rural Alaska.

"The Task Force recognizes and supports the Indian Health Service's role in providing long-term care."

The Task Force recognizes and supports the Indian Health Service's role in providing long-term care services. In addition, the Task Force encourages the Department of Health and Social Services to aggressively pursue its rebuttal of the Health Care Financing Administration's interpretation of 1905 (b) of the Social Security Act and provide the Legislature with semi-annual updates on the process of the Department's inquiry. ❖

HOME AND COMMUNITY-BASED LEGISLATION

RECOMMENDATION 13

The Task Force recommends that legislation be drafted and introduced to establish a home and community-based services program for certain adults with long-term care needs.

In 1995 Governor Knowles appointed a Long-Term Care Steering Committee, chaired by Department of Administration Commissioner Mark Boyer and Department of Health and Social Services Commissioner Karen Perdue, to develop and implement an interdepartmental Long-Term Care Strategic Plan. The Steering Committee developed legislation to create a comprehensive home and community-based services program that would not be limited to just Medicaid-eligible persons.

"Many seniors and adults with disabilities cannot fully pay for all the long-term care services they need."

Many seniors and adults with disabilities cannot fully pay for all the long-term care services they need, but still cannot qualify to receive Medicaid benefits. When these moderate income seniors or adults with disabilities do not receive the necessary health care services, they can ultimately require more intensive services than would have been needed had they received earlier support to stabilize their situation.

The legislation proposed by the Steering Committee authorizes the Department of Administration to establish and administer a program of home and community-based support services for adults with long-term care needs. Under this proposed legislation, adults receiving services are expected to contribute through co-payments for services on a sliding scale and are required to apply for payment from other sources if available.

"The Task Force acknowledges the value of home and community-based long-term care services."

The long-term care home and community-based program offered under Medicaid is meeting great acceptance. When given an option, people often elect to receive the long-term health care they need in their home and community rather than an institution. Almost twice as many Alaskans elected this Medicaid waiver in FY97 as in FY96.

Passage of the proposed legislation will allow all Alaskans with demonstrated needs the opportunity to request services through the Department of Administration's home and community-based care program, not just those eli-

gible for Medicaid. The Task Force acknowledges the value of home and community-based long-term care services and recommends this legislation be introduced for further consideration. (Please see Appendix B, page 69, for further detail.) ❖

MEDICAID COVERAGE FOR ALZHEIMER'S PATIENTS

The Task Force requests the Departments of Administration and Health and Social Services review all options available to the state, including Medicaid, to support the long-term care needs of patients whose sole diagnosis is Alzheimer's Disease and Related Disorders.

Alzheimer's Disease and Related Disorders (ADRD) refers to cognitive impairments that are progressive and degenerative in nature. As a result of these impairments, effected adults require supervision and cueing from other individuals in order to adequately and routinely perform activities of daily living and instrumental activities of daily living.[30] People whose sole diagnosis is Alzheimer's Disease and Related Disorders do not typically require daily supervision by medical professionals.

"To be eligible for Alaska's Medicaid long-term care waiver programs, applicants must require skilled nursing services."

To be eligible for nursing home care and home and community-based services from Alaska's Medicaid program, applicants must be low-income and require skilled nursing or intermediate care. Persons whose sole diagnosis is ADRD typically do not meet the criteria for skilled nursing or intermediate care and consequently, the Alaska Medicaid program will not pay for nursing home placement or home and community-based services.

Alaska is only one of two states whose Medicaid eligibility standards for nursing home and home and community-based services require that the patient needs "professional-level medical supervision."[31] This requirement, as determined by the Department of Health and Social Services, effectively eliminates eligible Medicaid ADRD-only patients from the state's major long-term care services.

Persons with ADRD may have great difficulty living without assistance.[32] Currently for many people who suffer from ADRD, respite service for their families is the only long-term care service available.[33] The Task Force recognizes the desire for additional assistance for this particular group of Alaskans and understands that

the temporary relief provided to the family caregivers is not enough to adequately address the pressing long-term care needs of an ADRD individual.

However, modifying the Medicaid eligibility requirement for ADRD-only patients may have budget implications for the state.[34] Approximately 40 percent of the cost for qualified Medicaid patients is paid from the state's General Fund. Some states have reduced the budget impacts by requiring that all long-term care patients receive universal care plan counseling. (Please see recommendation 20) The effect of this requirement has been to place residents in the least restrictive long-term care setting, which often is also the lowest-cost setting. The effect has been to prolong the time that residents can pay for their own care, and therefore, reduce the potential cost to the Medicaid program.[35]

"Persons with ADRD may have great difficulty living without assistance."

In addition to the budget concerns, the Division of Senior Services may not have the capacity to serve the additional clientele who may apply for home and community-based waiver services if ADRD is included as an eligible diagnosis.

Even though changing the Medicaid eligibility requirement to include ADRD-only patients raises serious concerns, 48 other states offer Medicaid programs to patients suffering from only Alzheimer's Disease. Alaska should too.

The Task Force requests the Department of Administration and the Department of Health and Social Services review all options available to the state, including Medicaid, to support the long-term care needs of patients whose sole diagnosis is Alzheimer's Disease and Related Disorders. Also, the Task Force requests that a preliminary report outlining the departments' findings be submitted to the President of the Senate and Speaker of the House by April 30, 1999. ❖

INCREASE MEDICARE ACCESS

RECOMMENDATION 15

The Task Force requests the Department of Health and Social Services conduct a review of Medicare patients' access to medical services within the state and, if warranted, explore options to increase their access to health care.

The Task Force heard testimony regarding individuals covered by Medicare who were having difficulty accessing health care services. General concerns were ex-

pressed that some medical providers may refuse to accept new clients covered by Medicare, may drop patients as they approach age 65, or may elect not to become Medicare certified.

"Lack of access to adequate care under Medicare may have adverse consequences for the health of elderly Alaskans."

Lack of access to adequate care under Medicare may have adverse consequences for the health of elderly Alaskans and, as such, impact the long-term care needs of that population. If our seniors cannot get adequate primary care, their health may deteriorate. Because Medicare does not pay for most long-term care services, the lack of access to primary care has the effect of shifting the cost of care from Medicare to Medicaid, out-of-pocket expenses, and other local resources.

The Task Force is concerned about the possible limited access to Medicare services. The Task Force requests the Department of Health and Social Services conduct a review of Medicare-eligible Alaskans' access to medical services within the state and, if warranted, explore options to increase their access to health care. The Task Force recommends that a comparison be made of allowable Medicare rate reimbursements to the actual cost of providing the service and a summary of the findings be included in the review. ❖

INCREASE RATE FOR GENERAL RELIEF PATIENT CARE

The Task Force supports an increase in the rate paid to assisted living home providers under the general relief assistance program and requests the recommendations of the *Alaska Rate Study Report* be considered in determining the new rate structure.

The Department of Administration has the responsibility to provide a vulnerable adult with protective services when necessary. (AS 47.24.017) Often, the needed protective service includes placement of the vulnerable adult in an assisted living home at the state's expense.

"The rate...for the typical general relief client was established in 1983 at $34.50 per day."

The general relief payment made by the state is the amount needed to make up the difference between what the clients can pay, and the predetermined cost of provided services. The rate of payment for assisted living services for the typical general relief client in Alaska was established in 1983 at approximately $34.50 per day. The Division of Senior Services noted on a 1998 fiscal note accompanying legislation under consideration, "(T)he current base rate is not adequate to meet rising costs of providing assisted living care. A rate increase is overdue."[36]

It was also noted in a recent study that over 95 percent of the residents living in smaller assisted living homes (15 beds or less) are being provided help with activities of daily living. While the vast majority of these residents are private pay, the general relief residents were being provided most of these services as part of the base rate. "It should be noted that these services are much more difficult to provide in the smaller homes without the appropriate staff-to-resident ratio."[37] Without adequate reimbursement for general relief clients, it is difficult to maintain the appropriate staff-to-resident ratio.

"The lack of cost-of-care adjustments to the Assisted Living Home fee structure jeopardizes the future of Assisted Living Homes," wrote the Division of Mental Health and Developmental Disabilities, February 25, 1998.[38] Subsequently, the Assisted Living Training Institute, LLC, was hired as a consultant by the Department of Administration to review the current rate structure for general relief clients, and recommend a new rate plan that fairly represents the cost to provide the needed long-term care services.

"The lack of adjustments to the fee structure jeopardizes the future of Assisted Living Homes."

The Institute stated, "(M)inimal support of Activities of Daily Living (ADL) should and must be provided within any rate agreed upon. All facilities surveyed indicated that ADL services are now being provided without compensation."[39]

The Task Force recognizes that the current daily rate for general relief patients is unacceptable and supports an increase to the basic rate. The *Alaska Rate Study Report* should be considered in determining the final rate structure increase. ❖

SENIOR HOUSING OFFICE

RECOMMENDATION 17

The Task Force urges continued support for Alaska Housing Finance Corporation's Senior Housing Office and its state planning grant program.

In 1990 the Legislature established the Senior Housing Office (SHO) to " . . . promote a comprehensive response to the needs of senior citizens for adequate, accessible, secure, and affordable housing in the state." (AS 18.56.700) Initially the Senior Housing Office was operated within the Department of Community and Regional Affairs. On July 1, 1992 the SHO, other DCRA housing activities

and the Alaska State Housing Authority were merged with the Alaska Housing Finance Corporation.

Before the creation of the Senior Housing Office, senior housing development was almost nonexistent. Since its inception, AHFC programs have helped to create 25 new senior housing facilities with total development costs approaching $85 million. According to testimony presented to the Task Force, all senior housing has been designed with the "aging in place" concept, which helps facilitate both the current and future needs of older Alaskans.

"AHFC programs have helped to create 25 new senior housing facilities with total develoopments costs approaching $85 million."

Recently the Senior Housing Office has been expanding its efforts to encourage the construction of assisted living facilities. Within the past couple of years, the SHO has helped in the development of approximately 135 new units of assisted living, thereby providing increased capacity to seniors who need long-term care services.

In addition to the loan program available under AHFC, the Senior Citizen's Housing Development Fund (AS 18.56.800) provides grants to qualified recipients to develop and plan various types of senior housing facilities. Funds from this program cover professional expertise (preliminary architectural drawings, construction and operating estimates, legal fees, and other services) necessary to develop and plan a senior housing unit. Testimony indicated that this program is vital to the future growth of senior housing in Alaska.

The Task Force recognizes the past efforts of AHFC's Senior Housing Office and applauds its success in assisting in the construction of 25 senior housing facilities. The Task Force urges continued support of the Senior Housing Office and its vital state planning grant program. ❖

LONG-TERM CARE DELIVERY SYSTEM

The *Legislative Working Group on Long-Term Care* stated its goal was to "advocate for long-term care that is responsive to the individual circumstances of Alaska's senior citizens and those with physical disabilities."[40] The *Working Group* recommended making the fullest use of the state's long-term care funding through expanding health care choices that are cost-effective and provide the long-term care as close to home as feasible.

"The Working Group recommended making fullest use of the state's long-term care funding through expanding health care choices."

The system of delivering long-term care has changed over the past few years. The current and projected population growth have encouraged new and creative long-term care programs. Alaskans are now able to receive the care they need in their homes or as close to their homes as is possible.

As the delivery system continues to evolve, issues that are of mutual interest to long-term care consumers and their families and private and public long-term care providers will be identified and resolved. It is a never-ending evolution of ideas and solutions. ❖

LONG-TERM CARE SERVICES AVAILABLE

RECOMMENDATION 18

The Task Force requests the Alaska Commission on Aging coordinate and strengthen efforts to inform and educate all Alaskans on long-term care services available in Alaska.

Alaska's home and community-based long-term care services enable a limited number of Alaskans to receive long-term care in their homes and communities, rather than in institutions. Under this program, Alaska offers a wide variety of services to seniors and adults with physical disabilities.

Home and community-based care services are partially funded through Alaska Commission on Aging grants to non-profit corporations across Alaska. In most instances, the state grants cover from 45 percent to 60 percent of the actual cost of services. The non-profit corporations generate a mix of local funding to cover the actual costs of services. Clients pay for services on a sliding scale according to their income. The services provided are as follows:

"The care coordinator identifies appropriate services based on (an) assessment."

- *Care Coordination* is a service through which a trained professional assesses a frail consumer's needs. The care coordinator identifies and arranges appropriate services based on this assessment and in consultation with the consumer's family. Care coordination incorporates outreach, intake screening, initial assessment, care planning, service arrangement, ongoing monitoring and formalized assessment.

- *Adult Day Centers* provide supervised group care and therapeutic activity in a social setting for seniors needing assistance with daily living tasks. Care is provided at a central site during the weekdays. Recently some centers have begun providing limited weekend care as well.

- *Respite Care* is provided by trained caregivers who provide periodic care in a senior's home. This means family caregivers can take a break from their work as full-time caregivers. While this care is usually provided in the elder's own home, respite care can also be provided in facilities such as assisting living homes, nursing homes, and adult day centers.

- *Hot nutritious meals* are prepared and served in group settings to seniors at central locations or delivered to homebound seniors.

"Medicaid provides funds for two long-term care home and community-based waiver programs, through the CHOICES program."

- *Escorted transportation services* are available in many communities and allow consumers access to community services.

Medicaid provides funds for two long-term care home and community-based waiver programs, through the CHOICES program. These programs, administered by the Division of Senior Services, Department of Administration, cover the costs of care necessary for individuals to continue living within their home or community. The cost of these waiver services must not exceed the cost of nursing home services the person would otherwise receive.

In addition to care coordination, adult day services, and respite care, the CHOICES program may cover the following, as necessary:

- *At-Home Skilled Nursing Care* provides skilled nursing care by licensed professionals.

- *Assisted Living Care* services, other than room and board, are provided for seniors or adults with physical disabilities who need assistance with activities of daily living.

- *Personal Care* 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. (A person does not need to elect a waiver program to receive personal care services.)

"Over the last several years, home and community-based alternatives have increased dramatically."

Over the last several years, home and community-based alternatives to institutional long-term care in Alaska have increased dramatically, in part because of the expansion of Medicaid coverage of these services.[41] However, it still is difficult for the consumer to negotiate the confusing array of long-term care service alternatives.[42] Concise, relevant information on services available to seniors and individuals with disabilities must be readily and easily accessible to all.

The Task Force requests the Alaska Commission on Aging coordinate and strengthen efforts to inform and educate all Alaskans on the various long-term care services available. In addition, the Task Force requests the Alaska Commission on Aging to provide semi-annual updates on its efforts to the members of the Senate and House Health, Education and Social Services Committee. ❖

SCREENING AND ASSESSMENT TOOL

The Task Force requests the Department of Administration establish a uniform and comprehensive screening and assessment tool to be used by all program administrators when an individual enters a nursing home or selects a Medicaid waiver program.

In April 1996 the United States General Accounting Office examined the assessment instruments utilized in long-term care planning for all 50 states. Their findings indicated that very few states use a comprehensive assessment tool. Questions were raised as to whether sufficient information was being collected in the

less comprehensive assessments to develop an appropriate plan of care across settings.

Alaska is no exception. Alaska does not utilize an assessment process that supports a smooth transition between places of care.[43] At this time, several divisions within the Department of Health and Social Services and the Department of Administration administer programs for seniors and adults with disabilities. These agencies not only bring different perspectives to long-term care assessment, but also use different assessment tools for a variety of different purposes. This fragmented assessment process makes it difficult for a patient to move along the long-term care continuum of services.

"An accurate assessment is a valuable cornerstone to any program that provides for the long-term needs of Alaskans."

An accurate assessment is a valuable cornerstone to any program that provides for the long-term needs of Alaskans. Such assessment is especially relevant in Alaska, where there are multi-service long-term care programs offered. A uniform screening and assessment tool will assist patients to receive the right level of care, at the right time, and in the most cost-effective manner possible.

A comprehensive assessment tool will assist extended care providers in Alaska in planning for a person's health care needs at the first point of service along the continuum of care. This information will 1) ensure that the patient receives the right level of care, at the right time, and in the most cost-effective manner; 2) provide a centralized data base for the efficient and effective planning for extended care services in Alaska; and 3) contribute to developing a seamless planning process as the patient moves between settings along the continuum of care.[44]

"The use of consistent definitions...will provide health caregivers a common understanding of long-term needs in Alaska."

The Task Force recognizes that a genuine effort has been made to reach the goal of having a uniform, comprehensive screening and assessment tool, but unfortunately this goal has not yet been met. The Division of Senior Services is poised to tackle this challenge and plans to involve all the key health care industry stakeholders to help design the assessment tool, as well as determine the necessary health care definitions. The use of consistent definitions that are recognized and understood statewide will provide health caregivers a common understanding of long-term care needs in Alaska.

The Task Force requests the Department of Administration establish a uniform and comprehensive screening and assessment tool to be used when an individual enters a nursing home or selects a Medicaid waiver program and develop a pilot program to assess its validity and reliability by July 1, 2000. ❖

UNIVERSAL CARE PLAN COUNSELING

The Task Force requests the Department of Administration evaluate a phased-in universal care plan counseling requirement for all Alaskans entering the long-term care system, regardless of their ability to pay.

The purpose of universal long-term care plan counseling (or pre-admission assessment) is to educate consumers about their long-term care options. Long-term care counseling helps individuals find an appropriate long-term setting of their choice. Currently long-term care counseling is not available to all Alaskans entering the long-term care system.

"The purpose of universal long-term care plan counseling is to educate consumers about their long-term options."

Medicaid eligible patients are now more likely to receive information about their long-term options than are non-Medicaid eligible individuals. "(N)on-Medicaid eligible Alaskans who are being discharged from hospitals are not receiving adequate and consistent information, and as a result, some have been placed in nursing homes without understanding their choices. Others are not necessarily receiving the services of their choice, or in the location of their choice."[45]

Under a pilot project in Anchorage, long-term care planning is available in hospitals and long-term care facilities. Professional staff from the Division of Senior Services, Department of Administration, work directly with long-term care providers to identify Medicaid-eligible Alaskans for whom the waiver program might be appropriate. A care coordinator is assigned to the patient and the patient's needs are screened and assessed. The seniors and the adults with physical disabilities are active participants in the planning process and determine the best health care plan for them. Based on the information provided to them, many adults opted for the waiver services.

"Medicaid eligible patients are now more likely to receive information about their long-term options than are non-Medicaid eligible individuals."

Both Medicaid-eligible and non-Medicaid-eligible individuals will benefit from long-term care planning. The Task Force recognizes how important appropriate and timely long-term care planning and care coordination is for the long-term health of both seniors and adults with disabilities. Therefore, the Task Force requests the Department of Administration evaluate a phased-in universal care plan counseling requirement for all Alaskans entering the long-term care system, regardless of their ability to pay. ❖

CERTIFICATE OF NEED

RECOMMENDATION 21

The Task Force recommends that legislation be drafted and introduced to adopt the nursing home certificate of need recommendations developed by the *Legislative Working Group on Long-Term Care* (1997).

Under AS 18.07, the Department of Health and Social Services administers the Certificate of Need Program. This program was created as a tool to control health care costs and prevent unnecessary or duplicative facilities or services. A certificate of need is required of any health facility planning to spend one million or more for construction, expansion or remodeling.

"The certificate of need review process is required of any health facility planning to spend a million dollars or more for construction."

The certificate of need review is initiated when a health care facility submits a letter of intent to the Department of Health and Social Services. This letter of intent provides the project description, estimated cost, and starting and completion dates for the project. Based on the letter of intent, the department determines whether a detailed certificate of need application is needed. Once the application is received and declared complete, department staff analyzes the request and makes a recommendation to the Commissioner of Health and Social Services, who decides to approve or deny the application. The decision to grant or deny a certificate of need may be appealed.

In June 1996, HB 528 was signed into law (Chapter 84, SLA 96). This placed a two-year moratorium 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 until the moratorium expired. This two-year moratorium expired May 1, 1998. The law was passed due to concerns over the potential rapid growth of nursing home beds that became imminent as the result of the planned addition of 147 new nursing beds costing $11 million annually. The moratorium allowed time to develop alternatives to nursing home beds and assess what could be done to promote cost containment.[46]

The six-member working group established under HB 528 thoroughly analyzed the current procedure to grant certificates of need to long-term care health facilities and determined several weakness in existing law. As currently written, 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." In other words, the Department must grant a certificate of need for new construction, expansion or remodeling of a nursing home facility if the service is not available or sufficiently accessible, and the applicant can demonstrate that the proposed service will be provided in a quality manner.

"The Legislative Working Group states that the certificate of need program requires more explicit statutory definition."

In its report the *Legislative Working Group* stated the following:

> 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 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.[47]

Currently there is a potential in Alaska for many new nursing beds to be built and, if built, these beds will cost the state a great deal. Using a medium growth projection, it is estimated that the senior population in Alaska will grow from 31,398 in 1997 to 80,927 by 2015.[48] In FY97, the Alaska Medicaid program spent $43.8 million for 720 licensed nursing home beds. If the need for beds remains constant in the future, the number of beds could grow to 1,861 by 2015, a 250 percent growth at the annual cost to Medicaid of an additional $109.5 million. "Proposed projects need to be compared against feasible alternatives to determine if the proposal is the most cost effective way of achieving comparable results."[49]

"Under the legislation, new nursing home projects will need to demonstrate cost effectiveness."

Under the legislation proposed by the *Legislative Working Group on Long-Term Care*, new nursing home projects will need to demonstrate the cost-effectiveness of each request. Proposed projects will be compared against feasible alternatives to determine if the proposal is the most effective way to achieve comparable results. The Task Force recognizes that this issue needs more discussion and recommends that legislation be introduced for further consideration. (Please see Appendix B, page 69, for further detail. ❖

CONSOLIDATION OF SERVICES

The Task Force requests the Departments of Health and Social Services and Administration monitor the success of long-term care programs offered by states which have consolidated their efforts and determine if consolidation would benefit the people of Alaska in the future.

In 1995, the Division of Senior Services, Department of Administration, contracted with Ladd & Associates to review the long-term care system in Alaska, compare it with other state systems, and evaluate its effectiveness.

In its analysis of Alaska's long-term care system, Ladd & Associates said, "The state organizational structure that administers long-term care is one of the most fragmented in the nation. Each of these units of state government has different missions and different methods of conducting business. Many of these agencies serve other populations besides those requiring long-term care, and they also administer other health and social programs. It is difficult to make long-term care a priority in this current state structure."[50]

"It makes little sense, from a management point of view, to have this program separated from the other components of long-term care."

Based on its findings, Ladd & Associates recommended that the Division of Senior Services, Department of Administration, be transferred intact to the Department of Health and Social Services. "It makes little sense, from a management point of view, to have this program separated from the other components of long-term care, and the other supportive health and social services that seniors require."[51]

The Alaska State Hospital and Nursing Home Association (ASHNHA) also echoed ideas expressed by Ladd & Associates. In August 1996 ASHNHA hired Health Dimensions, a consulting firm specializing in health care issues, to identify common themes regarding long-term care services in Alaska and propose solutions to the identified problem areas. As the result of this review, ASHNHA recommended the reorganization of the Pioneer Homes under the authority of the Department of Health and Social Services. "The Pioneer Homes and the community nursing homes are under separate administrative offices yet they are a significant financial component to providing long-term care services to seniors."[52]

"Keeping these homes under separate funding sources supports the continuation of a fragmented continuum of care."[53] Under their proposal, the Department of

Health and Social Services would become a central point for identifying and monitoring statewide efforts to provide increased services to the increasing senior population with limited state dollars.[54]

"Other states in general have found that through consolidation, they reduce the time and energy spent managing these programs and concentrate their resources on the people that the programs serve."[55]

"A major organizational restructure occurred with the creation of the Division of Senior Services."

The Task Force wrestled with these recommendations from two respected, yet distinctly different, consultants. The Task Force noted the fact that both long-term care advisors arrived at the same conclusion. However, it also recognized that in 1993, a major organizational restructure occurred with the creation of the Division of Senior Services within the Department of Administration. As noted in Administrative Order No. 139, the purpose of the reogranization was to provide better access to services and promote dignity and independence for seniors. In addition to this major reorganization, in 1996 and 1997, several other programs were transferred from the Department of Health and Social Services to the Department of Administration.

The Task Force recognizes that the various programs responsible for the delivery of long-term care services have undergone significant management restructuring over the past few years and, possibly, the time is not right to consider yet another move: a move towards consolidating all long-term care programs within one department.

"At some point, the time may be right for Alaska to consider the value of consolidation of services."

However, at some point the time may be right for Alaska to consider the value of consolidation of services. The Task Force recommends the Department of Health and Social Services, Department of Administration, and the Legislature monitor the success of the various long-term care programs offered by states that have consolidated their efforts into one agency and determine if consolidation would benefit the people of Alaska in the future.

In addition, the Task Force received testimony that the Office of the Long-Term Care Ombudsman may be more effective if placed in a department or agency that is independent of the administrative functions that administer long-term care services, funding or licensing. The Task Force requests the Department of Administration survey other states to determine whether the Office of the Long-Term Care Ombudsman is located in a neutral agency and recommend any necessary changes.

GOVERNMENT FUNDING FOR LONG-TERM CARE

States beware – Medicaid long-term expenditures for the elderly could double in inflation-adjusted dollars between 1993 and 2018. That was the opening message of Dr. Joshua M. Wiener, principal research associate at the Urban Institute, who addressed participants from 46 states during the April 2, 1998, *Health Policy Monitor Teleconference.*

Wiener also added that the "current long-term care for the elderly accounts for 14 percent of state and local health expenditures and 25 percent of all Medicaid expenditures. Medicaid long-term care takes on a broader function than it does for the population as a whole and thus, states will face unprecedented pressures in the years ahead. Considering these facts and the onset of an aging population, long-term care for the elderly is clearly an important issue for states."[56]

"Because of the high cost of nursing home care, Medicaid serves as a safety net for both the middle class and the poor."

Medicaid expenditures in Alaska mirror what is happening elsewhere. Because of the high cost of nursing home care, Medicaid serves as a safety net for both the middle class and the poor. The percentage of long-term care Medicaid payments far exceeds the percentage of eligible beneficiaries. The elderly and individuals with disabilities compose only 16 percent of the people eligible for Medicaid, while their Medicaid expenditures total 52 percent.

The Task Force recognized this looming problem, but a quick fix was elusive and not available. Alaska, like all other states, must continue to confront these issues and make small, incremental improvements until a national solution is implemented. ❖

COORDINATION BETWEEN MEDICAID AND MEDICARE

RECOMMENDATION 23

The Task Force requests the Department of Health and Social Services seek out new opportunities for improved program coordination between Medicare and Medicaid and consider this relationship when developing state Medicaid policy.

Medicare, administered by the federal government, is a major source of health care coverage for people over age 65 and for many younger people with substantial disabilities. While Medicare provides coverage for most primary and acute care services, it covers very little long-term care services.

"Medicaid is the primary payer of long-term care services in Alaska."

On the other hand, Medicaid, administered by state government, is the primary third-party payer of long-term care services in Alaska. Yet the management of long-term care cannot truly be separated from primary and acute care. Good primary care can reduce long-term care needs by keeping people healthy and more active longer. Good long-term care support services can reduce the need for acute care services by keeping people from the medical crises associated with inadequate long-term care.

Coordination of these two programs is important to the management and delivery of effective long-term care. In 1997, Congress established the Program for All-inclusive Care for the Elderly (PACE), a cooperative arrangement between Medicare and Medicaid. Under the PACE model, people who are 55 years of age and older and need a nursing-home level of care can receive their care from a PACE provider. This provider is responsible for providing all Medicaid and Medicare services for the PACE recipient.

"Less comprehensive means of coordinating the Medicaid program with Medicare may be available."

PACE offers a way to make integrated health policy decisions and to capture the cost savings associated with better care management; however, the decision to pursue this option cannot be made lightly. A substantial, multi-year planning effort would be necessary to assure the success of the program in Alaska.

In the meantime, less comprehensive means of coordinating the Medicaid program with Medicare may be available to the Department of Health and Social Services. The Task Force requests the Department of Health and Social Services seek out new opportunities (including PACE, if practical) for improved program

coordination and consider the relationship of these two programs when developing state Medicaid policy. ❖

MEDICAID AND MEDICARE ELIGIBLE

The Task Force requests the Department of Health and Social Services identify the necessary changes, either in regulation or in statute, to assure the Medicare program funds health care services provided to dual eligible patients.

Medicare is the federal health insurance program for Americans age 65 or older and certain Americans with disabilities. Eligible Americans are automatically covered by Medicare Part A (hospital insurance) if they receive Social Security benefits. If the individual is not eligible for Social Security, a premium may be required.

Medicare is completely funded by federal dollars; no state money is necessary. Unfortunately Medicare doesn't pay for all of the medical expenses for the people it is meant to serve. In fact, Medicare now pays for less than half of the total health care bill of older people.[57] But for those services that Medicare will reimburse, it is to Alaska's advantage to bill the federal government for payment.

"If nursing homes billed Medicare for services...an estimated General Fund savings to the Medicaid program could be as high as $400,000."

Currently the Alaska Medicaid program pays Medicare premiums, deductibles, and coinsurance on behalf of Medicaid recipients eligible for Medicare benefits. However, not all Alaska nursing homes bill Medicare when appropriate, but, instead rely on Medicaid to reimburse the facilities for the health care costs incurred. (Medicaid is a federal and state health care program; 40 percent of the cost is paid from the state's General Fund.) If nursing homes billed Medicare for Medicare services provided to patients eligible for both Medicaid and Medicare, the Department of Health and Social Services estimates that the annual General Fund savings to the Medicaid program could be as high as $400,000.[58]

In recent years, the Department of Health and Social Services has encouraged nursing facilities to bill Medicare for services provided to patients who qualify for both Medicare and Medicaid (dual eligible). This urging has achieved limited results.[59] In some instances, nursing homes bill Medicare for inpatient hospital care (Medicare Part A), but do not request payment from Medicare for ancillary

services covered under Medicare Part B (physician services, laboratory tests, occupational therapy and physical therapy).

"DHSS has several options on how to build a plan that will assure Alaska receives the maximum benefit from the federal government."

The Department has several options on how to build a plan that will assure Alaska receives the maximum benefit from the federal government for dual eligible patients. One alternative under consideration is to remove Medicare-eligible services from the Medicaid payment rates structure.[60] This action would force nursing facilities to either bill Medicare for the services, or discontinue the service, or absorb the cost of service.

As the state is currently paying Medicare premiums for Medicaid patients so that those clients will be eligible for Medicare health benefits, it is important that the federal government pay for all health services covered under Medicare. But it is equally important that health care providers and the Department of Health and Social Services cooperatively decide on the solution to recover federal dollars under Medicare.

The Task Force requests the Department of Health and Social Services identify the necessary changes, either in regulation or statute, to assure the Medicare program funds health care services provided to dual eligible patients. In addition, the Task Force requests that the department report to the President of the Senate and the Speaker of the House by March 31, 1999 on its efforts to comply with this recommendation.

MILLER TRUST

RECOMMENDATION 25

The Task Force requests the Department of Health and Social Services review the regulations that govern the Miller Trust program and propose recommended changes, if necessary.

In determining eligibility for Medicaid assistance for long term care services, Alaska is considered an "income-cap" state. The financial eligibility criteria for Medicaid assistance for nursing home or home and community-based services per individual is a monthly income limit of $1,482 with a resource limit of $2,000.[61] As a result of this income level cap, many individuals are disqualified due to excess income,

even though they still do not have enough income or resources available to cover their long-term medical needs.[62]

The "Miller Income Trust" authorized by the Omnibus Budget Reconciliation Act of 1993 lifted the lid on income caps altogether for most people.[63] Under federal law, an individual may establish an irrevocable trust, known as a "Miller Trust." The trust is a mechanism that allows people who do not qualify for Medicaid coverage, based solely on income, to qualify by assigning their income to a trust. Approximately 70 Alaskans established Miller Trusts in 1997 thereby qualifying for long-term care services through Medicaid. Although all medical needs are covered under Medicaid, people who establish a Miller Trust will permanently lose all their disposable income. "It is a big step, and should not be entered into lightly."[64]

"Many individuals are disqualified even though they still do not have enough income to cover their long-term medical needs."

The Miller Trust allows individuals who need long-term care services and earn slightly more than the established allowable monthly maximum to qualify for Medicaid. "However, one difficulty that we (Alaska Legal Services Corporation) have observed is that trustee fees are not among the items for which the Trust must pay. For needy Alaskans with disabilities or the elderly who have no friends or family to serve as trustees, this can create an extreme hardship."[65] In response to this recognized concern, Ms. Marcia Rom, director of the Senior Law Project, and private attorney Ms. Una Gandbhir conducted a policy study on how Miller Trusts were administered nationwide. This study was supported by a grant from the Alaska Mental Health Trust Authority.

Upon completion of the nationwide review, it was concluded that two options were available to help relieve this financial burden assumed by some individuals who establish a Miller Trust. Two possible solutions are: 1) that the cost of administering the trust be considered an allowed expense covered by the Miller Trust; or 2) that an independent funding source be identified and established to pay a fixed fee for trust administration. The Task Force agrees that this issue should be explored further and requests the Department of Health and Social Services revisit the regulations governing the Miller Trust in response to this recent study.

"The Task Force agrees that this issue should be explored further."

SecureCare Congressional Proposal

RECOMMENDATION 26

The Task Force acknowledges and supports the four guiding principles of the American Health Care Association's *SecureCare* congressional proposal.

"The elderly and Americans with disabilities deserve quality long-term care."

The American Health Care Association (AHCA), formed in 1949, is a federation of 50 affiliated health care associations, together representing more than 11,000 non-profit and for-profit assisted living, nursing facility, and subacute care providers. AHCA is concerned about the "graying" of America and the looming health care crisis. "Our nation is not prepared to care for its aging population. We must replace the existing long-term care system with a new system that is designed to meet the long-term care needs of our grandparents, our parents and ourselves before the current system collapses. The elderly and Americans with disabilities deserve quality long-term care. It is what each of us wants for our loved ones and ourselves. If we are to ensure that quality long-term care is available to all that need it, the nation must work together for change. *SecureCare* is that change."[73]

SecureCare, a proposal before Congress, is built on four principles designed to solve the nation's long-term care crisis while preserving the safety net for America's poor elderly and persons with disabilities. The guiding principles are to: 1) transform long-term care from welfare to health care; 2) coordinate long-term care private resources with Medicare and Social Security; 3) encourage personal and family responsibility for long-term care; and 4) maximize quality and control costs through market competition and consumer choice.

The Task Force recognizes that the long-term crisis is not limited to Alaska, but is a problem facing the entire nation.

- Across the nation, Medicare does not address the long-term care and nursing home needs of our nation's elderly. Medicare covers only those nursing facility services provided to help a resident recover from an acute illness or injury. In most cases, Medicare provides for, at a maximum, the first 100 days of care and only if certain conditions are met.[66]

- Nationwide, two out of every three nursing home residents rely on Medicaid to pay for their care.[67] (However, in Alaska four out of every five nursing home residents are Medicaid patients.)

- Every eight seconds in America, a baby boomer turns 50.[68]

"Every eight seconds in America, a baby boomer turns fifty."

- Americans aged 85 and older are the fastest-growing segment of population and the heaviest users of long-term health care services. From 1960-1994, the 85 and older age group increased by more than 274 percent. Longevity is expected to rise for all ages.[69]

- Two out of five Americans will need long-term care at some point in their lives.[70]

- In 1996, the nationwide average cost of a stay in a nursing facility was $41,000 per year. Only one in four Americans can afford private nursing home care for one year – yet the average length of stay in 1995 for a nursing facility resident was 2.3 years.[71] (In Alaska, the current average cost of a stay in a nursing home facility is $98,000 per year for a Medicaid patient and $117,500 per year for a private pay patient.)

"In Alaska, the current average cost of a stay in a nursing facility home is $98,000 per year for a Medicaid patient and $117,500 per year for a private pay patient."

- Three out of four nursing facility residents are women.[72]

These statistics are daunting and the problem, overwhelming. The creative minds of all Americans will be required to find a solution. One option under consideration is the American Health Care Association's proposal *SecureCare*. AHCA's goal is "to work together with other organizations and legislative bodies to develop solutions. For us, *SecureCare* is not an end product but rather the beginning of a process to stimulate discussion."[74]

The four guiding principles of *SecureCare* set the framework for this discussion and will lead toward a workable resolution of the long-term care uncertainty. The Task Force acknowledges and supports these four guiding principles. ❖

ALASKA MENTAL HEALTH TRUST AUTHORITY

RECOMMENDATION 27

The Task Force supports the continued partnership with the Alaska Mental Health Trust Authority to help meet the long-term care needs of Alaskans.

In 1994, the Alaska Mental Health Trust Authority was created to ensure an integrated, comprehensive mental health program (AS 47.30.011). The Authority administers the Mental Health Trust, reconstituted by the Legislature in 1994, and preserves and protects the trust assets.

"Through a collaborative partnership...the lives of many have significantly improved."

Through a collaborative partnership between the Trust Authority, the Governor, and the Legislature, the lives of many Trust beneficiaries, who are heavy users of Alaska's long-term care system, have significantly improved. The Trust's beneficiary groups include Alaskans experiencing mental illness, developmental disabilities, Alzheimer's Disease and Related Dementia, and chronic alcoholism with psychosis.

Beginning in FY97, the Trust allocated between $6.6 – $11.5 million each year for three years to provide direct services or home and community-based services for people needing long-term care. Trust income, increases in General Fund/mental health dollars and other receipts have funded new projects for community living support services, treatment and emergency services, and planned closing or size reduction of institutions to return residents to community-based settings where appropriate. The projects and proposals funded through the Trust created new efficiencies and innovative ways to deliver long-term care services.

"The Trust allocated between $6.6 million to $11.5 million each year for three years..for people needing long-term care."

The FY00 Trust funding recommendations include critical funding for increased rates for general relief clients residing in assisted living homes. In addition, the Trustees have expressed support for the "one-stop shop" concept for long-term care services, recommended using savings from the Alaska Longevity Bonus program to increase services to senior Alaskans, and explored ways to improve the guardianship system in Alaska.

The current partnership between the Trust Authority, the Governor, and the Legislature, is necessary to assure these improvements continue. The Task Force recognizes the partnership formed with the Alaska Mental Health Trust Authority and supports the continued working relationship. ❖

PRIVATE FUNDING FOR LONG-TERM CARE

In a recent interview, U.S. Sen. Charles Grassley, Chairman of the Senate Special Committee on Aging, stated the following:

"The role of private long-term care insurance is critical."

> Longer and healthier lives are a blessing and a testament to the progress and advances made by our society. However, all Americans must be alert and prepared for long-term care needs. The role of private long-term care insurance is critical in meeting this challenge. Because increasing numbers of Americans are likely to need long-term care services, it is especially important to encourage planning today.
>
> Earlier this year, the Special Committee on Aging, which I chair, held a hearing to explore the challenges of providing long-term care for the baby boomer generation. A key message from that hearing was that policy makers need to encourage personal responsibility for financing long-term care. Most families are not financially prepared when a loved one needs long-term care.
>
> So, with the impending retirement of the baby boomers, it is imperative that Congress takes steps now to encourage all Americans to plan ahead for potential long-term care needs. The bill I introduced, S.2492, The *Long-Term Care and Retirement Security Act*, will do this. It will allow Americans who do not currently have access to employer subsidized long-term care plans to deduct the amount of such a plan from their taxable income. This bill will encourage planning and personal responsibility while helping to make long-term care insurance more affordable for middle class taxpayers and encourage Americans to be pro-active and prepare for their own long-term care needs by making insurance more widely available and affordable.

"The Task Force applauds the fact that members of Congress recognize the severity of the long-term care financing problem."

The Task Force applauds the fact that members of Congress recognize the severity of the long-term care financing problem facing America, as well as Alaska, and that possible solutions are being proposed and discussed. ❖

ALASKA'S LONG-TERM CARE PLAN FOR RETIREES

The Task Force recognizes and applauds the Public Employees' Retirement Board and the Teachers' Retirement Board effort to update the State of Alaska's Long-Term Care Plan and encourages consideration to expand the LTC Plan to include active employees.

"Alaska was the first state government employer to offer long-term care coverage."

In 1987 Alaska was the first state government employer to offer long-term care coverage to retiring state employees.[75] Employees covered under the Public Employees' Retirement System or the Teachers' Retirement System may select a voluntary Long-Term Care (LTC) Plan for themselves and their spouses upon retirement. This LTC Plan provides a range of health and social services for people who, because of a chronic condition, might need help with the basic activities of daily living.[76] The plan's premiums are paid entirely by the retirees.

Since the first Long-Term Care Plan was offered to retiring employees, it has been a popular option. Currently, approximately 45 percent of retirees select the LTC Plan. Of the 18,839 state retirees covered by medical insurance as of June 1998, 8,309 had signed up for LTC insurance. Almost half of those, or 3,479, had also enrolled their spouses.[77] The premium is based on the individual's age on the date of enrollment: a person under the age of 50 years pays a monthly premium of $16.10, while an employee retiring at the age of 65 years will pay $80.45 per month.

"The employees of the State of Alaska are very fortunate that this Long-Term Care Plan is available to them."

The employees of the State of Alaska are very fortunate that this Long-Term Care Plan is available to them. According to the 1994 Employee Benefits Survey by the Bureau of Labor Statistics, only 4 percent of state and local government employees in the United States were eligible for long term-care insurance.[78]

In order to assure the best plan possible is offered, the Public Employees' Retirement Board and the Teachers' Retirement Board met in a joint meeting, October 27, 1998 and considered a presentation by Deloitte & Touche LLP on the existing Long-Term Care Plan and several options for improvement. Deloitte & Touche LLP discussed possible plan modifications to allow flexibility in choosing the Daily Maximum Benefit, as well as a Lifetime Maximum. The presentation discussed the potential expansion of the "benefit triggers" to include cognitive impairment, e.g. Alzheimer's Disease and Related Diseases, and explained the possible components covered under home and community-based services. Both re-

tirement boards expressed interest in adjusting its current Long-Term Care Plan and asked Deloitte & Touche LLP to refine the various options presented to the boards and report back in another joint meeting on March 23, 1999.

Deloitte & Touche LLP brought to the two boards' attention the possibility of including active state employees under the Long-Term Care Plan. According to Deloitte & Touche LLP, Alaska is unique in limiting eligibility for long-term care insurance to retirees only.[79] Any proposal that increases the number of individuals covered under a private long-term care insurance plan will decrease the potential future burden to the Medicaid program and ultimately reduce the state's General Fund obligation. The "true promise" of long-term care insurance is in the employer-sponsored market, where people can buy policies when they are young enough to ensure affordability.[80]

"Any proposal that increases the number of individuals covered under a private long-term care insurance plan will decrease the potential future burden to the Medicaid program."

The Task Force applauds the Alaska Retirements Boards' foresight in exploring ways to expand the Long Term Care Plan to include active employees and encourages serious consideration of this proposal. ❖

INFORMATION ON PRIVATE LONG-TERM CARE INSURANCE

The Task Force requests the Division of Insurance compile relevant information on the need for and availability of long-term care insurance in Alaska and disseminate the information to the general public.

On March 9, 1998 Mr. Paul Willging, Ph.D., executive vice-president of the American Health Care Association, testified before the U.S. Senate Special Committee on Aging. "Most Americans (76 percent) do not believe they will ever need long-term care, but the facts are that two out of five will at some point in their lives, and that one in five over the age of 50 is at risk of needing long-term care within 12 months. None-the-less, few take any steps to plan for the possibility, believing Medicare will provide for their needs. Medicare, of course, will not. It only provides limited long-term care, so government help for most Americans comes only when they have exhausted their personal savings and are forced onto welfare."[81]

"Most Americans (76%) do not believe they will ever need long-term care, but the facts are that two out of five will at some point in their lives."

Private long-term care insurance coverage, must be considered as another option. Although the market is still small – the American Association of Retired Persons

estimates 6 percent of older people have private polices – interest is growing. The Health Insurance Association of America (HIAA) data revealed that in 1986, fewer then 125,000 policies were in effect. Eleven years later, roughly 5 million policies had been written.[82]

"In Alaska in 1997, approximately 80 percent of nursing home costs were paid by the Medicaid program."

Private long-term care insurance usually pays for skilled, intermediate, or custodial care in a nursing home. It can also cover a variety of home and community-based care services. Typically, long-term care polices pay up to a specific dollar amount for covered services per day, reimbursing policy owners for expenses they incur. Annual premiums for long-term care insurance policies can range from $250 to over $2,500 depending on age, waiting periods, and the duration and amount of benefits.[83]

According to the Health Care Financing Administration, approximately 80 percent of nursing home costs were paid by the Medicaid program in Alaska in 1997, while only 10 percent were paid by either private long-term care insurance or out-of pocket. This federal-state welfare system cannot continue to exist unless a change is made. The private sector must begin to shoulder a greater portion of the financial burden. As shown, private long-term care insurance is affordable if purchased early in life. Unfortunately, many people believe that long-term care insurance is unnecessary and display a basic unwillingness to face up to their own future frailty.[84]

"Alaskans should be encouraged to examine the options available through private long-term care insurance."

However, this does not mean that the issue should be dropped. Indeed, Alaskans should be encouraged to examine the options available through private long-term care insurance and ultimately, if appropriate, purchase policies that meet their individual needs. Accurate, concise, and unbiased information about long-term care insurance and the alternatives available is invaluable in this decision-making process. State government, especially through its annual publications, mailings, and mass media campaigns, has the ability to inform all residents about this issue.

The Task Force requests the Division of Insurance compile relevant information on the need for and availability of long-term care insurance in Alaska and disseminate the information to the general public by January 1, 2000. ❖

CENTER FOR LONG-TERM CARE FINANCING

RECOMMENDATION 30

The Task Force recognizes the value of the information compiled and distributed by the Center for Long-Term Care Financing and encourages the continued association with the Center.

Mr. Stephen Moses and Mr. David Rosenfeld established The Center for Long-Term Care Financing in April 1998. The Center's mission is to promote universal access to top-quality long-term care by encouraging private financing and discouraging welfare financing of long-term care for most Americans.

The Center for Long-Term Care Financing advocates public policy that targets scarce public resources to the neediest, while encouraging people who are young, healthy and affluent enough, to take responsibility for themselves. The Center publishes, free of charge, a periodic on-line news service called "LTC Bullets" which covers the latest information and trends in long-term care financing.

"The Center for Long-Term Care Financing's mission is to promote universal access to top-quality long-term care by encouraging private financing and discouraging welfare financing."

Mr. Stephen Moses was formerly Director of Research for LTC, Incorporated and a senior analyst for the Health Care Financing Administration and the Office of Inspector General of the U.S. Department of Health and Human Resources. On November 19, 1998 Mr. Moses addressed a National Press Club Forum in Washington, D.C. on the topic of long-term care financing reform.

The Task Force reviewed the Center's first policy paper, *LTC Choice - A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle*, and found the material very informative and practical. As the issue of long-term care financing is discussed at the national level, as well as in Alaska, the current and accurate information available through this organization will be invaluable. The Task Force recognizes the value of the information compiled and distributed by the Center for Long-Term Care Financing and encourages the continued association with the Center. ❖

CONCLUSIONS

The major driving force in the Alaska long-term care system for the next few decades will be the extremely high growth rate of the elderly population. At the current high growth rate the 65 to 74 age population will double every 14 years, the 75 to 84 age population will double every 12 years, and the 85 and over population will double every 10 years. These growth rates will have lasting consequences in Alaska. [85]

These high growth rates are coupled with the high cost of providing long-term care in Alaska. Medicaid nursing home costs per day are the highest in the nation, $223.61.[86] For a private pay patient the average cost of a stay in a nursing home facility is $117,500 per year.[87] Long-term health care in Alaska is expensive.

We must remember that neither private health insurance nor Medicare covers long-term care to any significant extent, and few older adults have private long-term care insurance. Because of the high cost of long-term care, Medicaid coverage for long-term care provides a safety net for the middle class as well as the poor. In Alaska, 80 percent of nursing home residents were dependent on Medicaid to finance at least some of their care. Medicaid long-term care expenditures for the elderly are projected to more than double in inflation-adjusted dollars between 1993 and 2018.[88] If this projection is tied to Alaska's high growth rate of the elderly population, the potential financial burden facing our state is tremendous.

"The ideas are a beginning; this problem will be solved one step at a time."

The recommendations presented by the Long-Term Care Task Force are certainly not the total answer to this huge problem. But the ideas are a beginning; this problem will be solved one step at a time. With the steps set forth in this report, the quality of long-term care will improve, the access to long-term care will expand, and the delivery of long-term care will be enhanced. These steps will slow the growth of state expenditures and begin the shift from public spending to private responsibility.

The Task Force recommended creative approaches to one of our state's most pressing health concerns. Our recommendations are grounded in real-work experience and the realization that all Alaskans have a personal stake in ensuring quality long-term care is available for all residents. The Task Force trusts the 21st Legislature will give serious consideration to these recommendations. ❖

CREATION OF A NEW TASK FORCE

RECOMMENDATION 31

The Task Force requests the Senate and House Health, Education and Social Services Committees, in consultation with the legislative leadership, strongly consider the creation of a new task force to continue the review and monitoring of long-term care in Alaska.

Senate Concurrent Resolution 11 created the Long-Term Care Task Force, but also terminated the task force upon the convening of the First Regular Session of the Twenty-First Alaska State Legislature, January 19, 1999.

As acknowledged throughout this report, the study and review conducted by this Task Force is only the first step in meeting its ultimate goal in developing a suitable and equitable plan for providing access to long-term care for all Alaskans. Additional work needs to be done; current long-term care options must be further analyzed and new options explored.

"Oversight by a group of legislators, state officials, and the public interested in long-term health care is important."

The Task Force recognizes that oversight by a group of legislators, state officials, and the public interested in long-term health care is important. Such a commission, if appointed, would be in a position to monitor the state's long-term care programs as they evolve to meet the needs of all Alaskans. This group would provide the necessary leadership and guidance to ensure success of the Task Force's suggestions and recommendations.

The representatives of the public may include people who are receiving long-term care, have relatives who are receiving long-term care, are from an organization that represents the interests of people in need of long-term care, are health care providers whose services include long-term care, or have had experience with an Alaska Native organization that delivers long-term care services in a rural area of the state.

The Task Force requests the Senate and House Health, Education and Social Services Committees, in consultation with the legislative leadership, strongly consider the creation of a new task force to continue the review and monitoring of long-term care in Alaska.

GLOSSARY OF COMMONLY USED TERMS

ADRD - Alzheimer's Disease and Related Disorders.

Activities of Daily Living - This term includes activities such as: eating, bathing, dressing, using the toilet, communication, and moving from one place to another.

Assisted Living Homes - Formerly called adult foster homes, assisted living homes are facilities that provide a homelike environment for seniors and people who have a disability and need assistance with everyday living activities.

Care Coordination or Case Management -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.

Certificate of Need (CON) - A certificate issued by the State of Alaska to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment, modify a health facility, or offer a new or different health service. CON is intended to control expansion of facilities and services by preventing excessive or duplicative development of facilities and services.

CHOICES - The CHOICES Program provides home and community-based services for seniors 65 or older and adults with physical disabilities who require a nursing facility level of care and who are eligible for Medicaid. With the assistance of a care coordinator, each senior or adult with physical disabilities who qualifies and elects home care instead of care in a nursing facility will have services described in a plan of care paid for from state Medicaid funds.

Chronic Care - Care and treatment provided to individuals whose health problems are long-term and continuing in nature.

Health Care Financing Administration (HCFA) - The federal government agency within the U.S. Department of Health and Human Services which directs the Medicare and Medicaid programs and conducts research to support those programs.

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.

Long-Term Care - A combination of health care, personal care, and social services required by people who have some degree of diminished capacity on a long-term basis.

Medicaid - A federally-aided, state-operated and administered program that provides medical benefits for certain indigent or low-income persons in need of health and medical care. Authorized under Title XIX of the Social Security Act, it requires people to meet specified eligibility criteria. Subject to broad federal guidelines, states determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.

Medicare - A U.S. health insurance program for people aged 65 and over, for individuals eligible for Social Security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis. Monies from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B).

Personal Care Attendant - A trained health care paraprofessional who has received 75 hours of classroom training and who provides services under the clinical supervision of a nurse. Personal care attendants provide hands-on assistance to help clients perform activities of daily living.

Skilled Nursing Facility - A nursing facility participating in the Medicaid and Medicare programs which meets specified requirements for services, staffing, and safety.

Spend-Down - The amount of expenditure for health care services, relative to income, that qualifies an individual for Medicaid in states that cover categorically eligible, medically indigent individuals. Eligibility is determined on a case-by-case basis.

Underinsured - People with public or private insurance policies that do not cover all necessary medical services, resulting in out-of-pocket expenses in excess of their ability to pay.

Wellness - A dynamic state of physical, mental, and social well-being; a way of life which equips the individual to realize the full potential of his or her capabilities and to overcome and compensate for weaknesses; a life-style which recognizes the importance of nutrition, physical fitness, stress reduction, and self responsibility.

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The following sources were used extensively by the Task Force:

Legislative Working Group on Long-Term Care Report to Governor Tony Knowles – A copy may be obtained from Mr. David Pearce, Division of Administrative Services, Department of Health and Social Services.

Long-Term Care in Alaska: Recommendations for Reform – A copy may be obtained from Ms. Kay Burrows, Director of the Division of Senior Services, Department of Administration.

Moving Toward the Development of a Balanced Long-Term Care Delivery System in Alaska – A copy may be obtained from the Alaska State Hospital and Nursing Home Association.

APPENDIX A

SCR 11

CS FOR SENATE CONCURRENT RESOLUTION NO. 11(FIN)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE SENATE FINANCE COMMITTEE

Offered: 3/19/98
Referred: Rules

Sponsor(s): SENATORS SHARP, Duncan, Ward, Adams, Ellis, Hoffman, Kelly, Taylor, Wilken, Torgerson, Mackie, Green

REPRESENTATIVES Hudson, Brice, Croft

A RESOLUTION

Creating the Long-Term Care Task Force.

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

WHEREAS the establishment of a system to meet the long-term care needs of aging Alaskans is an important issue not only for elderly persons but also for young and middle-aged Alaskans as they attempt to meet the needs of their parents at the same time that they are facing their own and their children's needs; and

WHEREAS the cost of long-term care, whether in a home setting or in an institution, often exceeds an individual's ability to pay for the care either immediately or after a short period of time, causing extreme economic and social stress and hardship for many people who have worked hard for many years and still do not have sufficient assets or income to bear the costs of their care; and

WHEREAS residents in a Pioneers' Home have been asked to pay the full cost of their long-term care within seven years, resulting in as much as a 30 percent increase this year in some rates for care in the system; and

WHEREAS 80 percent of the cost of care for persons now receiving long-term care in privately operated long-term care facilities is paid through state and federal funds under the Medicaid program; and

WHEREAS current federal and state long-term care policies of the state have resulted in large subsidies from the state's general fund that will increase in the future, competing with funding for other state programs; and

WHEREAS the legislature established a working group in 1996 to analyze issues regarding long-term care services in the state, including projected costs to the state of various alternative methods of providing long-term care;

BE IT RESOLVED that the Alaska State Legislature establishes the Long-Term Care Task Force to develop an equitable plan for providing long-term care for all Alaskans; and be it

FURTHER RESOLVED that the task force shall consist of the following nine voting members:

(1) three members of the House of Representatives appointed by the Speaker of the House of Representatives; at least one member shall be a member of the majority and at least one a member of the minority;

(2) three members of the Senate appointed by the President of the Senate; at least one member shall be a member of the majority and at least one a member of the minority;

(3) three members of the public, one each chosen by the Governor, the Speaker of the House of Representatives, and the President of the Senate, from among people who are receiving long-term care, have relatives who are receiving long-term care, are from an organization that represents the interests of people in need of long-term care, are health care providers whose services include long-term care, or have had experience with an Alaska Native organization that delivers long-term care services in a rural area of the state; and be it

FURTHER RESOLVED that the following persons may serve on the task force as nonvoting members:

(1) the commissioner of health and social services or the commissioner's designee;

(2) the commissioner of commerce and economic development or the commissioner's designee; and

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

be it

FURTHER RESOLVED that the public members of the task force shall serve without compensation but are entitled to per diem and travel expenses authorized for boards and commissions under AS 39.20.180; and be it

FURTHER RESOLVED that the task force shall select a chair and vice-chair from among its voting members, shall meet as frequently as the task force determines necessary to perform its work, may meet during the interim, and may meet and vote by teleconference; and be it

FURTHER RESOLVED that the task force shall

(1) review the work done and the recommendations made by the long-term care working group established under sec. 3, ch. 84, SLA 1996, if available;

(2) review existing elder care services in Alaska, including rural Alaska, including the current types of delivered care and the projected future care demands;

(3) review the existing Pioneers' Home system, its current types of delivered care, and its projected future care demands, and craft a mission statement for the Pioneers' Home system to set goals to meet long-term senior care needs;

(4) prepare a plan, including drafts of legislation that might be necessary to implement the plan, for establishment of an actuarially sound system of long-term care and propose funding options, including options that would allow prepayments by persons desiring coverage for long-term care and require reasonable copayments by the recipients of the care;

(5) hold public hearings on the plan, legislation, and funding proposals developed under (4) of this clause;

(6) redraft the plan, legislation, and funding proposals based on the comments received at the public hearings and other information that becomes available to the task force; the final plan, with proposed legislation and funding options, shall be available for public review at least 30 days before the convening of the First Regular Session of the Twenty-First Alaska State Legislature; and

(7) submit the plan, proposed legislation, and funding options to the Governor and the legislature by the convening of the First Regular Session of the Twenty-First Alaska State Legislature; and be it

FURTHER RESOLVED that the task force may begin work immediately upon the

appointment of its full voting membership and is terminated upon the convening of the First Regular Session of the Twenty-First Alaska State Legislature.

APPENDIX B

PROPOSED LEGISLATION

1-LS0139\A
Lauterbach
11/6/98

_____ BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - FIRST SESSION

BY

Introduced:
Referred:

A BILL

FOR AN ACT ENTITLED

"An Act allowing the disclosure of reports with regard to inspection and investigations of certain health care facilities; authorizing the Department of Health and Social Services to license home health agencies; and providing for an effective date."

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

* **Section 1.** AS 18.20.090 is repealed and reenacted to read:

Sec. 18.20.090. Disclosure of information. (a) The department shall make reports concerning annual inspections and investigations of the facilities or entities it licenses in this chapter, including statements of deficiencies and approved plans of correction, available to the public within 14 calendar days after the information is made available to the facility or entity being reviewed.

(b) The department may not publicly disclose information that identifies patients or clients of the facility or entity under review.

* **Sec. 2.** AS 18.28 is amended by adding new sections to read:

Article 2. Home Health Agencies.

Sec. 18.28.110. Purpose; applicability. (a) The purpose of AS 18.28.110 - 18.28.190 is to promote safe and adequate home health services for individuals by setting standards for home health agencies that will ensure quality of care, safeguard patient's rights, and otherwise protect public health, safety, and welfare.

(b) AS 18.28.110 - 18.28.190 and the regulations adopted under those sections apply to agencies for which licensure is required under AS 18.28.130.

Sec. 18.28.120. Powers of department. The department may

(1) license and supervise home health agencies;

(2) inspect applicants and licensees, including subunits and branches of the licensee, and persons that the department reasonably believes are operating an agency without a license in violation of this chapter;

(3) consistent with the purposes identified in AS 18.28.110, adopt regulations to implement AS 18.28.110 - 18.28.190, including regulations establishing licensure and renewal procedures, inspection procedures, standards, fees, and requirements for operation of home health agencies;

(4) accept accreditation by the Joint Commission on the Accreditation of Health Organizations or another national accreditation organization recognized by the department in lieu of an inspection of a home health agency by the department for the year in which the accreditation was granted if the accreditation standards are substantially similar to the inspection standards of the department.

Sec. 18.28.130. License required. (a) An entity that establishes, conducts, or represents itself to the public as a home health agency or an organization that provides coordinated home health services for compensation must have a license from the department authorizing it to be a home health agency under AS 18.28.110 - 18.28.190.

(b) A parent agency or subunit of a home health agency must be located in the state. Each subunit must independently meet the requirements of this section and be issued a separate license. A branch office of the parent agency or of one of its subunits is not required to independently meet the requirements for licensure.

Sec. 18.28.140. Application for license. Application for a license to operate

a home health agency shall be made to the department on a form provided by the department and shall be accompanied by applicable fees established by the department under AS 18.28.120.

Sec. 18.28.150. Issuance and renewal of license. (a) Upon receipt of an application for license and the license fee, the department shall issue a license if the applicant meets the requirements established under AS 18.28.110 - 18.28.190. If the applicant does not meet the requirements established under AS 18.28.110 - 18.28.190 but makes continued efforts to comply with them, the department may grant a temporary or provisional license for a limited period of time.

(b) Each license issued is for the person, agency, corporation, partnership, association, or other form of organization named on the application and is not transferable or assignable except with the written approval of the department.

(c) The department shall establish the standards for license renewal and determine the renewal period by regulation.

(d) A license is not renewable if it has been suspended or revoked under AS 18.28.160.

Sec. 18.28.160. Denial, suspension, or revocation of license. (a) The department may deny, change to a provisional license, or revoke a home health agency application or license if the department finds that the agency

(1) has endangered or would endanger the health, safety, or welfare of a patient;

(2) has a history of deficiencies in quality of care;

(3) has had a license to operate a home health agency revoked in any licensing jurisdiction;

(4) has been convicted of operating a home health agency without a license in any licensing jurisdiction;

(5) lacks a sufficient number of personnel who have the training, experience, or judgment to provide adequate patient care;

(6) has committed fraud, deceit, misrepresentation, or dishonesty associated with the application for or operation of a home health agency in any licensing jurisdiction; or

(7) has violated regulations adopted under AS 18.28.110 - 18.28.190.

(b) The department may, without a hearing, summarily suspend a home health agency license if it finds that the actions or deficiencies of the agency cause an immediate and serious threat to the public health, safety, or welfare. A summary suspension remains in effect until the department finds that the actions or deficiencies are corrected or the license is revoked.

(c) The department may, without a hearing, change a home health agency license to a provisional license for a period of time established by the department if the department finds that an agency is temporarily unable to comply with AS 18.28.110 - 18.28.190 or is in the Medicare decertification process, but is taking the appropriate steps necessary to bring the agency into compliance. An agency holding a provisional license may not accept new patients. If the agency fails to correct its deficiencies within the provisional license period, the department shall revoke that agency's license.

(d) Application denial and revocation actions by the department shall be conducted under AS 44.62 (Administrative Procedure Act).

Sec. 18.28.190. Definitions. In AS 18.28.110 - 18.28.190,

(1) "branch" means an office location from which a home health agency provides service within a portion of the total geographic area served by the parent home health agency and that is sufficiently close in geographic proximity to the parent home health agency that it shares administration, supervision, and services on a daily basis;

(2) "department" means the Department of Health and Social Services;

(3) "geographic area" means the location, site, or address of the clients served by the parent home health agency or its parents or subunits;

(4) "home health agency" is a public agency or private organization, or a subdivision of such an agency or organization, that primarily engages in providing skilled nursing services in combination with medical social services, occupational therapy, speech therapy, and other home health aide services to individuals in the individual's home, an assisted living home, or another residential setting;

(5) "parent home health agency" means a licensed home health agency,

which may have branches or subunits;

(6) "subdivision" means a component of a multi-function home health agency, such as the home care division of a hospital or the nursing division of a health agency, that independently meets the requirements for a licensure as a home health agency;

(7) "subunit" means a home health agency that provides services beyond the geographic area served by the parent home health agency and is unable to share administration, supervision, and services on a daily basis with the parent home health agency.

* **Sec. 3.** TRANSITION. A department affected by this Act may proceed to adopt regulations necessary to implement this Act. Regulations to implement a provision of this Act take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of sec. 2 of this Act.

* **Sec. 4.** REVISOR'S INSTRUCTION. In AS 18.28.040, 18.28.050, and 18.28.100, the revisor shall substitute "AS 18.28.010 - 18.28.100" for "this chapter."

* **Sec. 5.** Section 3 of this Act takes effect immediately under AS 01.10.070(c).

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

TONY KNOWLES, GOVERNOR

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MEMORANDUM

DATE: January 11, 1999

TO: Sheila Peterson
Staff Assistant
Long-Term Care Task Force

FROM: Elmer A. Lindstrom
Special Assistant to the Commissioner

SUBJ: Licensing Home Health Agencies and Disclosure of Licensing Reports Bill

The Department of Health and Social Services and Department of Administration have reviewed the above named bill under consideration by the Long-Term Care Task Force. We support this bill, both for the Disclosure of Licensing Reports and Licensing Home Health Agencies sections. We have included an analysis of each section and recommendations we feel are essential to the bill.

Section 1
Disclosure of Licensing Reports
Analysis:
The disclosure of licensing reports would affect all health facilities licensed by the Department under AS18.20. This would include hospitals, nursing homes, ambulatory surgical centers and free standing birth centers. We believe it is in the interest of the public to have access to licensure reports to assist in making decisions about their health care needs.

Recommendations:
If this language is included only in AS18.20, it would not allow for the disclosure of licensure reports for hospice organizations licensed under AS18.18 or for disclosure of reports of home health agencies licensed under statute proposed in this bill. It is recommended the bill include similar language in AS18.18 and in the home health licensure section to allow for disclosure of reports in these facilities/agencies as well. Recommended language would be:

- ***Section _. AS 18.18. is amended by adding a new section to read:**
  Sec. 18.18.350. Disclosure of information. (a) The department shall make reports concerning inspections and investigations of the hospice programs it licenses in this chapter, including statements of deficiencies and approved plans of correction, available to the public within 14 calendar days after the information is made available to the hospice organization or entity being reviewed.

(b) The department may not publicly disclose information that identifies patients or clients of the organization or entity under review.

- Similar language is included in recommendations for home health agencies below.

Note: There is no FY2000 fiscal impact to this section of the bill.

Section 2
Home Health Agencies
Analysis:
The Department has, since the early 80s, licensed home health agencies. It was only recently that the Department of Law questioned the authority to do so. Currently the department has regulations (7 AAC 12.500-12.590) under the broad statutory authority of AS 18.05. for regulating home health agencies. This bill would provide unquestionable, clear and specific statutory authority to license and regulate the quality of care provided by these agencies. It is felt this bill is justified in order for the Department to have statutory authority for oversight of home health agencies to assure minimum standards in quality of care are being provided to clients.

Recommendations:

- I am not sure why the bill suggests putting this statute under AS 18.28. Chapter 28 relates to "State Assistance for Community Health Aide Programs." Home health agencies have no relationship to the Community Health Aid Programs. I would suggest the bill place the statute in a separate chapter the same as the hospice program licensure was (AS 18.18), such as AS 18.17 or AS 18.19.

- **Section 18.28.120(1) should be revised to read:**
  Sec. 18.28.120. Powers of department. The department may
  (1) license[AND SUPERVISE] home health agencies;

Note: The words "and supervise" should be removed because it is not a function of the licensing agency to supervise a home health agency. As a regulator, we enforce regulation and statute and provide oversight to ensure compliance. This would be different than supervision

- Section 18.28.130(a) should be revised to read:
  Sec. 18.28.130. License required. (a) An entity that establishes, conducts, or represents itself to the public as a home health agency, or otherwise meets the definition found at AS 18.28.190(4) [OR AN ORGANIZATION THAT PROVIDES COORDINATED HOME HEALTH SERVICES FOR COMPENSATION] must have a license from the department authorizing it to be a home health agency under AS 18.110 - 18.28.190.

  Note: The language "or an organization that provides coordinated home health services for compensation" should be stricken because there are other types of services provided in the

  home by other types of organizations that should not be considered home health agencies under this proposed statute. These include but are not limited to: entities providing in home respiratory care; and in home intravenous therapies provided by pharmacies. Entities such as these may coordinate care in the home and not meet the definition of a home health agency.

The current language is too broad and would lead to confusion and challenge. Rationale for requiring licensing of entities that meet the home health agency definition is to ensure compliance with minimum standards for entities effectively operating as home health agencies, but may not be calling themselves such.

- **Section 18.28.190(4) should be revised to read:**
  Sec. 18.28.190. Definitions

. . .

(4) "Home health agency" is a public agency or private organization, or a subdivision of such an agency, or organization, that primarily engages in providing skilled nursing services in combination with [MEDICAL SOCIAL SERVICES,] physical therapy, occupational therapy, speech therapy, or [AND OTHER] home health aide services to individuals in the individual's home, an assisted living home, or another residential setting;

Note: A home health agency is only required to provide at a minimum skilled nursing service in combination with one other therapy of those listed above. Acceptable therapies are physical therapy, occupational therapy, speech therapy or home health aide services. Medical social services MUST NOT be included as a qualifying service. This is consistent with the federal standards for Medicare certification. Additionally, the current language would require home health agencies provide all the above therapies, which would create undue hardship on most home health agencies and would result in many to go out of business. Therefore, it is highly recommended that "medical social services" be deleted, "physical therapy" be inserted, "or" be inserted, and "and other" be deleted as shown above. Again, physical therapy qualifies as one of the therapies that may be used along with skilled nursing, and must be included, while medical social services does not qualify as one of the required therapies that may be used. Medical social services may be provided by a home health agency, however the agency must also have skilled
nursing service and one of the other qualifying therapies as well.

- Disclosure of licensure reports for home health agencies licensed under the statute proposed in this bill is recommended. Recommended language to be inserted would be:

Sec. 18.28.170. Disclosure of information. (a) The department shall make reports concerning inspections and investigations of the home health agency it licenses in this chapter, including statements of deficiencies and approved plans of correction, available to the public within 14 calendar days after the information is made available to the home health organization or entity being reviewed.

(b) The department may not publicly disclose information that identifies patients or clients of the organization or entity under review.

Note: Because the Department is currently surveying home health agencies, there would be no increased funding necessary for this bill anticipated for FY2000.

Sec. 3 TRANSITION
Sec. 4 REVISOR'S INSTRUCTION
Sec. 5

No concerns or comments.

cc: Pat Pourchot, Legislative Director
Office of the Governor
Karen Perdue, Commissioner
Department of Health and Social Services
Alison Elgee, Deputy Commissioner
Department of Administration

1-LS0135\A
Lauterbach
11/5/98

_____ BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - FIRST SESSION

BY

Introduced:
Referred:

A BILL

FOR AN ACT ENTITLED

"An Act relating to vulnerable adults; and providing for an effective date."

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

*** Section 1.** AS 47.24.015(c) is amended to read:

(c) The department, or its designee, shall immediately terminate an investigation under this section upon the request of the vulnerable adult who is the subject of the report made under AS 47.24.010 **unless** [. HOWEVER, IF] the investigation to that point has resulted in reasonable cause to believe that the vulnerable adult is in need of protective services**, the request is made personally by the vulnerable adult and the vulnerable adult is not competent to make the request on the adult's own behalf, or the request is made by the vulnerable adult's guardian, attorney-in-fact, or surrogate decision maker and that person is the alleged perpetrator of abuse and is being investigated under this chapter. If the department has reasonable cause to believe that the vulnerable adult is in need of protective services.**

(1) the department may petition the court as set out in AS 47.24.019;

or

(2) the department or its designee may refer the report made to the department under AS 47.24.010 to a police officer for criminal investigation.

*** Sec. 2.** AS 47.24.019(a) is amended to read:

(a) If, after investigation under AS 47.24.015, the department has reasonable cause to believe that a vulnerable adult is in need of protective services and is an incapacitated person, the department may petition the court under AS 13.26 for appointment of a guardian or temporary guardian**, or for a change of guardian,** for the vulnerable adult for the purpose of deciding whether to consent to the receipt of protective services for the vulnerable adult.

*** Sec. 3.** AS 47.24.019(c) is amended to read:

(c) If a vulnerable adult who has consented to receive protective services, or on whose behalf consent to receive protective services has been given, is prevented by a caregiver**, guardian, attorney-in-fact, or surrogate decision maker** from receiving those services, the department may [ASSIST THE VULNERABLE ADULT OR THE PERSON WHO CONSENTED TO THE VULNERABLE ADULT'S RECEIPT OF THE SERVICES TO] petition the superior court for an injunction restraining the caregiver**, guardian, attorney-in-fact, or surrogate decision maker** from interfering with the provision of protective services to the vulnerable adult.

*** Sec. 4.** AS 47.24.050(b) is amended to read:

(b) The department shall disclose a report of the abandonment, exploitation, abuse, neglect, or self-neglect of a vulnerable adult if the vulnerable adult who is the subject of the report **or the vulnerable adult's guardian, attorney-in-fact, or surrogate decision maker** consents in writing. **The department may not disclose a report of the abandonment, exploitation, abuse, neglect, or self-neglect of a vulnerable adult to the vulnerable adult's guardian, attorney-in-fact, or surrogate decision maker if that person is an alleged perpetrator of abuse and is being investigated under this chapter.** The department shall, upon request, disclose the number of verified reports of abandonment, exploitation, abuse, neglect, or self-neglect of a vulnerable adult that occurred at an institution that provides care for vulnerable adults or that were the result of actions or inactions of a public home care provider.

* Sec. 5. TRANSITION. A department affected by this Act may proceed to adopt regulations necessary to implement this Act. Regulations to implement a provision of this Act take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of sec. 1 of this Act.

* **Sec. 6.** Section 5 of this Act takes effect immediately under AS 01.10.070(c).

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

TONY KNOWLES, GOVERNOR

P.O. BOX 110601
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MEMORANDUM

DATE: January 11, 1999

TO: Sheila Peterson
Staff Assistant
Long-Term Care Task Force

FROM: Elmer A. Lindstrom
Special Assistant to the Commissioner

SUBJECT: Draft legislation relating to vulnerable adults

The Department of Health and Social Services and Department of Administration have revised the draft legislation relating to vulnerable adults and support it's introduction as drafted.

This bill will increase the State's ability to provide protective services to a vulnerable adult in circumstances when the vulnerable adult's guardian, attorney in fact, or surrogate decision-makers the alleged perpetrator of abuse.

We appreciate the Task Force's endorsement of these changes.

cc: Pat Pourchot, Legislative Director
Office of the Governor
Karen Perdue, Commissioner
Department of Health and Social Services
Alison Elgee, Deputy Director
Department of Administration

1-LS0138\A
Lauterbach
11/6/98

_____ BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - FIRST SESSION

BY

Introduced:
Referred:

A BILL

FOR AN ACT ENTITLED

"An Act establishing an in-home and community-based services program for certain adults with long-term care needs; and providing for an effective date."

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

*** Section 1.** FINDINGS AND POLICY RELATED TO SECTION 2. (a) Regarding sec. 2 of this Act, the legislature finds that

(1) many elderly, chronically ill, or other physically or cognitively impaired adults in Alaska have long-term care needs and would benefit from the availability of a wider range of in-home and community-based services;

(2) currently the long-term care needs often go unmet or require the adult to seek services in an institutional setting when in-home or community-based services could provide a more appropriate and less costly level of care;

(3) expanding the availability of in-home or community-based services would allow adults to maintain their independence longer, maximize the adult's or family's resources to provide essential care and perhaps avoid or reduce state expenditures for care, and avoid

potential emotional and social problems that can result from an adult having to relocate to an institution hundreds of miles away from family or friends;

(4) currently, in-home and community-based services are not readily available in many parts of Alaska and, where they do exist, the adults and families who would benefit from the services are unaware of their availability or lack resources to procure them without some state assistance;

(5) Alaskans would benefit by having a system of long-term care assessment and care coordination to improve access to and understanding of appropriate in-home and community-based services.

(b) Regarding sec. 2 of this Act, the legislature declares that it is the policy of the state to

(1) increase the availability of in-home and community-based services for elderly, chronically ill, or physically or cognitively impaired adults with long-term care needs;

(2) give priority for in-home and community-based services to those adults described in (1) of this subsection who are at the greatest risk of being, or who already have been, placed in a care setting that may be more restrictive than the adult wishes or requires; and

(3) encourage a variety of agencies, facilities, and individuals to provide in-home and community-based services in the state.

* **Sec. 2.** AS 47.24 is amended by adding new sections to read:

Article 2. In-Home and Community-Based Services Program for Medically, Physically, or Cognitively Impaired Adults.

Sec. 47.24.200. In-home and community-based services program for medically, physically, or cognitively impaired adults. (a) There is created in the department a program to administer, coordinate, and deliver or to award grants or contracts for the delivery of in-home and community-based services for adults eligible for services under AS 47.24.200 - 47.24.290.

(b) The program may serve only the adults who are eligible for the program. The program may not replace or augment state-administered programs for in-home and community-based services for adults described in AS 47.24.205(b). The expenditures of this program may not exceed the appropriations available for it.

(c) The department may adopt regulations necessary to implement, interpret, or otherwise carry out the purposes of AS 47.24.200 - 47.24.290. Notwithstanding the provisions of AS 47.24.200 - 47.24.290, the regulations adopted may further define, limit, or assign priorities to adults eligible for the services and define, limit, or assign priorities to services to be provided as necessary to fulfill program objectives or as necessary to ensure that program expenditures will not exceed appropriations available for the program.

Sec. 47.24.205. Adults to be served. (a) An adult is eligible for services under AS 47.24.200 - 47.24.290 if the department determines that

(1) the adult is not described in (b) of this section;

(2) the adult has a long-term care need;

(3) the adult's need for services is because of medical, physical, or cognitively functional impairment;

(4) the adult's limitations restrict the ability to carry out the normal activities of daily living and to live independently; and

(5) the adult meets the requirements of AS 47.24.200 - 47.24.290 and the regulations adopted under those provisions.

(b) The department may not consider an adult with any of the following illnesses, impairments, or disorders as eligible for the program even if the adult also has other illnesses, impairments, or disorders that would otherwise make the adult eligible for the program:

(1) a developmental disability as described in the definition of "person with a developmental disability" under AS 47.80.900;

(2) a mental illness as defined in AS 47.30.915;

(3) a disorder associated with chronic alcoholism as described in AS 47.30.056(f);

(4) incapacitation as the result of alcoholism or drug abuse as described in the definition of "incapacitated by alcohol or drugs" in AS 47.37.270.

Sec. 47.24.210. Eligibility for services. An adult who meets the requirements of AS 47.24.205 is eligible for services under AS 47.24.200 - 47.24.290 if the adult

(1) is at risk of being or already has been placed in a setting providing

services more restrictive than is necessary to meet the adult's needs or more restrictive than the adult would choose;

(2) has long-term care needs that can be met through in-home and community-based services;

(3) has insufficient personal income and assets to pay for services needed; and

(4) has needs that cannot be met from other available support, including family members, neighbors, or public service agencies.

Sec. 47.24.215. Eligible services and places of delivery. (a) The department may pay for or provide only in-home and community-based services and care coordination that enable an eligible adult to remain at home or in a less restrictive care setting than that provided in an institutional setting. The department shall, by regulation, specify the types of care, care coordination, and health, social, and other assistance that are eligible services under this section.

(b) The department may not authorize payment for services that are intermediate or skilled care provided by a nursing facility or hospital licensed under AS 18.20 or provided in the Alaska Pioneers' Home under AS 47.55. The department may adopt regulations to grant waivers from the provisions of this subsection if the department finds that these services are necessary on a short-term basis to allow the adult to remain at home or in a less restrictive care setting than that described in this subsection.

Sec. 47.24.220. Delivery of services. (a) The department may use its own staff or enter into agreements, grants, or contracts to administer the program or to provide eligible services.

(b) The department shall solicit proposals from providers to provide services under AS 47.24.205 - 47.24.240. An interested provider shall submit its proposal in a form and manner as required by the department. An entity, an agency, a facility, a local government, or an individual intending to offer services under AS 47.24.200 - 47.24.290 is eligible to submit a proposal to the department to provide eligible services. The department may enter into an agreement or award a contract or grant if the proposal meets the requirement of AS 47.24.200 - 47.24.290 and furthers the

purposes of the program.

(c) In areas not served by a provider selected by the department, the department may provide services through individual agreements, grants, or contracts to meet the needs of eligible adults.

(d) The department may use demonstration projects to test new approaches to in-home and community-based services in limited areas in the state.

Sec. 47.24.225. Responsibilities. (a) An adult receiving services under the program shall contribute a copayment towards the cost of care and apply for, cooperate with, and seek payment from other sources as required by the department for which the adult is eligible for the same services.

(b) The department shall establish in regulation a schedule for copayments under this section. The schedule must vary on a sliding scale based on

(1) the adult's net income and readily available assets;

(2) the other uncovered expenses needed to meet the adult's medical and social needs; and

(3) the costs to the department of the services.

(c) The department may waive a requirement of this section if the department determines that it is not cost effective to require conformance or if the waiver is in the public interest.

Sec. 47.24.230. Collection from third-party payors. (a) If the department pays for or provides services or assistance under the program to an adult eligible for third-party payments for those services or assistance, the department may seek and recover the payments on behalf of the adult to offset program expenditures. An adult receiving services or assistance under the program is considered to have assigned to the state, through the department, all rights to accrued and continuing payment obligations that the adult may have from the third-party payors.

(b) If the department determines that it is feasible, the department may require that a provider seek and recover payment from insurance or other third-party payor before seeking payment from the department for the services under the program.

Sec. 47.24.235. Comprehensive data system. The department shall develop and implement a comprehensive data system that tracks in-home and community-based

services, expenditures, services, consumer profiles, and consumer preferences. The department shall seek to coordinate and to share data with other state and local agencies or organizations.

Sec. 47.24.240. Assessment and care coordination services. The department may implement a system of long-term care assessment and care coordination to minimize administrative costs, improve access to appropriate services, and minimize obstacles to the delivery of in-home and community-based services to adults eligible for services under the program.

Sec. 47.24.245. Confidentiality and access to records. Medical, social, and other client records received or developed under AS 47.24.200 - 47.24.290 are confidential and are not open to public inspection or copying except as provided in regulations of the department to further the purposes of the program or to better coordinate care and services. Nothing in this section prohibits the department from releasing nonidentifying information in aggregate form for research or other purposes.

Sec. 47.24.290. Definitions. In AS 47.24.200 - 47.24.290,

(1) "program" means the in-home and community-based services program for medically, physically, or cognitively impaired adults under AS 47.24.200 - 47.24.290;

(2) "provider" means an entity, an agency, a facility, or an individual providing services under AS 47.24.200 - 47.24.290;

(3) "services" means in-home and community support services provided under AS 47.24.200 - 47.24.290.

*** Sec. 3.** AS 08.63.200(b) is amended to read:

(b) Notwithstanding (a) of this section, a person licensed under this chapter shall report incidents of

(1) child abuse or neglect as required by AS 47.17;

(2) harm or assaults suffered by an elderly person or disabled adult as required by **AS 47.24.010** [AS 47.24].

*** Sec. 4.** AS 47.05.017(b) is amended to read:

(b) The department shall adopt regulations identifying actions that it will take, in addition to those otherwise required under AS 47.17 and **AS 47.24.010 - 47.24.130**

[AS 47.24], when a report of harm is made under AS 47.17 or **AS 47.24.010** [AS 47.24] that might relate to harm caused by actions or inactions of a public home care provider. The regulations must

(1) address circumstances under which the department will, or will require a contractor or grantee to, reassign, suspend, or terminate a person alleged to have perpetrated harm;

(2) include appropriate procedural safeguards to protect the due process rights of public home care providers who may be reassigned, suspended, or terminated under the circumstances described in (1) of this subsection; and

(3) if the home care provider is a certified nurse aide, include procedures under which the department shall notify the Board of Nursing if the nurse aide is suspected of abuse, neglect, or misappropriation of property.

* **Sec. 5.** AS 47.24.011 is amended to read:

Sec. 47.24.011. Duties of the department regarding services and protection for vulnerable adults. In order to facilitate the provision of supportive and protective services for vulnerable adults, the department shall

(1) compile information on available supportive and protective services for vulnerable adults in the state;

(2) establish, publicize, and maintain a central information and referral service for vulnerable adults;

(3) develop and coordinate a statewide system to serve vulnerable adults who are in need of protective services;

(4) establish criteria and procedures for the authorization and supervision of other state agencies or community-based service providers to serve as designees of the department under **AS 47.24.010 - 47.24.130** [THIS CHAPTER];

(5) in accordance with **AS 47.24.010 - 47.24.130** [THIS CHAPTER], designate other state agencies or community-based service providers to deliver supportive and protective services to vulnerable adults who are in need of protective services;

(6) develop within the central information and referral service for vulnerable adults a central registry for reports of vulnerable adults in need of protective

services;

(7) maintain confidentiality of records as provided for in AS 47.24.050; and

(8) adopt regulations to carry out the purposes of **AS 47.24.010 - 47.24.130** [THIS CHAPTER].

*** Sec. 6.** AS 47.24.050(a) is amended to read:

(a) Investigation reports and reports of the abandonment, exploitation, abuse, neglect, or self-neglect of a vulnerable adult filed under **AS 47.24.010 - 47.24.130** [THIS CHAPTER] are confidential and are not subject to public inspection and copying under AS 09.25.110 - 09.25.125. However, in accordance with **AS 47.24.010 - 47.24.130** [THIS CHAPTER] and regulations adopted under **AS 47.24.010 - 47.24.130** [THIS CHAPTER], investigation reports may be used by appropriate agencies or individuals inside and outside the state, in connection with investigations or judicial proceedings involving the abandonment, exploitation, abuse, neglect, or self-neglect of a vulnerable adult.

*** Sec. 7.** AS 47.24.070 is amended to read:

Sec. 47.24.070. Required review of proposed regulations. Before adoption by the department, regulations to implement **AS 47.24.010 - 47.24.130** [THIS CHAPTER] shall be provided to the Alaska Commission on Aging established under AS 44.21.200 for review.

*** Sec. 8.** AS 47.24.130 is amended to read:

Sec. 47.24.130. Treatment through spiritual means. **Nothing in AS 47.24.010 - 47.24.130** [THIS CHAPTER] may [NOT] be construed to mean that a person is abused, neglected, self-neglected, vulnerable, unable to consent, abandoned, exploited, or in need of emergency or protective services for the sole reason that the person relies on or is being furnished treatment by spiritual means through prayer alone in accordance with the tenets and practices of a church or religious denomination of which the person is a member or adherent, provided that the person consents to the treatment through spiritual means only and the treatment is administered by an accredited practitioner of the church or religious denomination. In this section, "church or religious denomination" has the meaning given to "religious organization" in

AS 05.15.210.

* **Sec. 9.** This Act takes effect immediately under AS 01.10.070(c).

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

TONY KNOWLES, GOVERNOR

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MEMORANDUM

DATE: January 8, 1999

TO: Sheila Peterson
Staff Assistant
Long-Term Care Task Force

FROM: Elmer A. Lindstrom
Special Assistant to the Commissioner

SUBJ: Proposed Amendments to draft legislation establishing an in-home and community-based services program for certain adults with long-term care needs

Funding for home-based services under the ne program established under the bill was never intended to supplant other funding available to clients through existing state programs. The original draft of the bill addressed this potential issue by deeming certain classes of persons, e.g., the developmentally disabled, ineligible for the new program since developmentally disabled persons are already eligible for home-based services through existing programs.

The proposed amendments attempt to accomplish the same objective by making it clear that the Department of Administration may not authorize payment for services under the new program if the applicant is eligible for these services through another state program. We believe this is a cleaner approach to resolving the issue than making persons with specific illnesses, impairments, or disorders categorically ineligible for the program.

Based on this analysis, the Department of Health and Social Services and Department of Administration recommend the following amendments:

AS 47.24.200 (b)

Line 30 - Strike "described in AS 47.24.205(b)"

AS 47.24.205 (a)

Line 10 - Strike (1), and renumber.
Lines 18-28 - Strike all of (b)

AS 47.24.215 (b) is amended to read:

The department may not authorize payment for the following services:

(1) intermediate or skilled care provided by a nursing facility or hospital licensed under AS 18.20;

(2) services provided in the Alaska Pioneers' Home under AS 47.55;

(3) home and community based services normally provided through another state program.

The department may adopt regulations to grant waivers from the provisions of this subsection if the department finds that these services are necessary on a short-term basis to allow the adult to remain at home or in a less restrictive care setting than that described in (1) or (2) of this subsection.

Please feel free to contact my office if you or Legislative Legal Services have any questions about the proposed amendment.

cc: Pat Pourchot, Legislative Director
Office of the Governor
Karen Perdue, Commissioner
Department of Health and Social Services
Alison Elgee, Deputy Commissioner
Department of Administration

1-LS0137\A
Lauterbach
11/9/98

_____ BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - FIRST SESSION

BY

Introduced:
Referred:

A BILL

FOR AN ACT ENTITLED

"An Act relating to the certificate of need program for nursing care facilities and other facilities; 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) ch. 84, SLA 1996, placed a two-year moratorium on the issuance or modification of certificates of need under AS 18.07 for nursing beds and created a working group to analyze issues relating to long-term care and the certificate of need program;

(2) it is anticipated that the long-term care system in Alaska will face a crisis in its ability to provide services to a growing and increasingly aging population by the twenty-first century unless the system can provide services in a more efficient and appropriate manner;

(3) in 1996, the state spent $120,000,000 in long-term care services for approximately 5,000 Alaskans; approximately two-thirds of these expenditures, $80,000,000, were made from the state general fund;

(4) moderate assumptions about population and inflation would project that more than $545,000,000 will be needed to pay for long-term care services in Alaska by the year 2015;

(5) a shift from the current significant reliance on costly institutional care to a more balanced continuum of home-based and community-based services is needed;

(6) a two-year moratorium on the issuance or modification of a certificate of need for the addition of nursing home beds was enacted in law in 1996 to

(A) encourage the development of home-based and community-based services;

(B) direct the state's resources toward the services that can best meet the needs of the clients; and

(C) facilitate actions to provide a more balanced system of care and more appropriate placement of clients, enlarge client choice, and avoid unnecessary new long-term care costs;

(7) appropriate planning is necessary to ensure that a certificate of need for new or replacement nursing home beds is not approved without a

(A) demonstrated long-term need for those beds on a regional basis;

(B) demonstration that the project is financially feasible and fosters the least reliance on the state general fund for provision of the most appropriate service;

(C) demonstration of public participation in the planning process and support by affected groups; and

(D) showing that the approval or modification of the certificate of need is consistent with existing state plans for delivery of care in Alaska; and

(8) this Act provides a minimum framework to ensure that the approval of new or replacement nursing home beds enhances access to the appropriate level of care to meet the needs of Alaskans and does not foster reliance on the state general fund to finance the operating and capital costs.

*** Sec. 2.** AS 18.07.021 is amended to read:

Sec. 18.07.021. <u>Administration</u> **[OFFICE OF PLANNING AND RESEARCH].** The [OFFICE OF PLANNING AND RESEARCH IN THE] department shall administer the certificate of need program under this chapter and

perform other functions prescribed in this chapter.

* **Sec. 3.** AS 18.07.031 is amended to read:

Sec. 18.07.031. Certificate of need required. (a) A person may not make an expenditure of $1,000,000 or more for any of the following unless authorized under the terms of a certificate of need issued by the **department** [OFFICE]:

(1) construction of a health care facility;

(2) alteration of the bed capacity of a health care facility; or

(3) addition [OR ELIMINATION] of a category of health services provided by a health care facility.

(b) Notwithstanding the expenditure threshold in (a) of this section, a person may not convert a building or part of a building [THAT IS LICENSED AS AN ASSISTED LIVING FACILITY UNDER AS 47.33] to a nursing home that requires licensure under AS 18.20.020 unless authorized under the terms of a certificate of need issued by the **department** [OFFICE].

* **Sec. 4.** AS 18.07.041 is amended to read:

Sec. 18.07.041. Standard of review for applications for certificates of need relating to non-nursing home beds. The **department** [OFFICE] shall grant a sponsor a certificate of need or modify a certificate of need **that authorizes beds other than nursing home beds or that is for a health care facility other than a nursing home** 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 required to maintain the good health of citizens of this state.

* **Sec. 5.** AS 18.07 is amended by adding a new section to read:

Sec. 18.07.043. Standard of review for applications for certificates of need relating to nursing homes and nursing home beds. (a) The department shall develop criteria and standards for reviewing an application for a certificate of need, or for a modification of a certificate of need, issued under this chapter for a health care facility that is a nursing home or has nursing home beds.

(b) In developing the criteria and standards under (a) of this section, the department shall consider

(1) whether the sponsor recognized statewide, regional, and community

needs in planning for the project;

(2) whether the sponsor has included a public process in planning and designing for the nursing home or nursing home beds;

(3) whether the sponsor has designed the proposed project to provide the services in the most efficient and cost-effective manner;

(4) whether there are adequate home-based and community-based services in the community or region of the state where the nursing home or nursing home beds are proposed to be located;

(5) whether an additional nursing home is or additional nursing home beds are an effective way of providing appropriate services for consumers in the community or the region of the state where the nursing home or nursing home beds are proposed to be located;

(6) whether there is a demonstrated need for a nursing home or nursing home beds in the community or region of the state where the nursing home or nursing home beds are proposed to be located;

(7) whether the addition of the nursing home or nursing home beds will result in increased costs to the state;

(8) whether the sponsor has access to the resources necessary to sustain the financial viability of the proposed services or nursing home on a long-term basis without increasing dependency on the state treasury;

(9) whether the proposed services are to be provided in a manner that maintains quality of care and professional competence of staff; and

(10) other factors that the department determines are necessary to evaluate the application for the certificate of need or modification of a certificate of need according to the standards set out in this chapter.

(c) The department shall grant a sponsor a certificate of need or modify a certificate of need that authorizes nursing home beds or that is for a health care facility that is a nursing home if the department finds that the sponsor meets the criteria established in or under this chapter.

* **Sec. 6.** AS 18.07.061 is amended to read:

Sec. 18.07.061. Modification and termination of activities. The certificate

holder shall apply to the **department** [OFFICE] for a modification of the certificate before terminating part of the activities authorized by the terms of issuance, but the certificate holder is not required to obtain the acquiescence of the **department** [OFFICE] before terminating all the activities authorized by the certificate. If a certificate holder terminates all of the activities authorized by a certificate, the certificate holder is required to notify the **department** [OFFICE] 60 days before termination and to surrender the certificate to the **department** [OFFICE] within 30 days of termination.

*** Sec. 7.** AS 18.07.071 is amended to read:

Sec. 18.07.071. Temporary and emergency certificates. (a) The **department** [OFFICE] shall grant a sponsor an emergency certificate for the construction of a health care facility for which a certificate is required under AS 18.07.031 if the sponsor shows, by affidavit or formal hearing, that the act of construction consists of effecting emergency repairs.

(b) The **department** [OFFICE] may grant a sponsor a temporary certificate for the temporary operation of a category of health service [,] if the sponsor shows by affidavit or formal hearing

(1) the necessity for early, immediate, or temporary relief; [,] and

(2) adverse effect to the public interest by reason of delay occasioned by compliance with the requirements of AS 18.07.041**, 18.07.043,** and application procedures prescribed by regulations under this chapter.

(c) A temporary certificate granted under (b) of this section does not confer vested rights on behalf of the applicant. The **department** [OFFICE] shall impose those special limitations and restrictions concerning duration and right of extension that the **department** [OFFICE] considers appropriate. A temporary certificate may not be granted for a period longer than necessary for the sponsor to obtain review of the action certified by the temporary certificate under AS 18.07.051. Application for a certificate of need under AS 18.07.041 **or 18.07.043** must commence within 60 days of the date of issuance of the temporary certificate.

*** Sec. 8.** AS 18.07.081(a) is amended to read:

(a) The **department** [OFFICE], a member of the public who is substantially

affected by activities authorized by the certificate, or another applicant for a certificate of need may initiate a hearing to obtain modification, suspension, or revocation of an existing certificate of need by filing an accusation with the commissioner as prescribed under AS 44.62.360. A revocation, modification, or suspension of an outstanding certificate may not be undertaken unless it is in accordance with AS 44.62.330 - 44.62.630.

*** Sec. 9.** AS 18.07.081(c) is amended to read:

(c) A certificate of need shall be suspended if an accusation is filed before the commencement of activities authorized under AS 18.07.041 **or 18.07.043** that charges that factors upon which the certificate of need was issued have changed [,] or new factors have been discovered that significantly alter the need for the activity authorized. A suspension of a certificate may not exceed 60 days. At the end of this period or sooner, the **department** [OFFICE] shall revoke or reinstate the certificate.

*** Sec. 10.** AS 18.07.081(d) is amended to read:

(d) A certificate of need may be revoked if

(1) the sponsor has not shown continuing progress toward commencement of the activities authorized under AS 18.07.041 **or 18.07.043** after six months of issuance;

(2) the applicant fails, without good cause, to complete activities authorized by the certificate;

(3) the sponsor fails to comply with the provisions of this chapter or regulations adopted under this chapter;

(4) the sponsor knowingly misrepresents a material fact in obtaining the certificate;

(5) the facts charged in an accusation filed under (c) of this section are established; or

(6) the sponsor fails to provide services authorized by the terms of the certificate.

*** Sec. 11.** AS 18.07.101 is amended to read:

Sec. 18.07.101. Regulations. The commissioner shall adopt, in accordance with AS 44.62 (Administrative Procedure Act), regulations that establish procedures

under which sponsors may make application for certificates of need required by this chapter and that govern the review of those applications by the **department** [OFFICE], establish requirements for a uniform statewide system of reporting financial and other operating data, and otherwise carry out the purposes of this chapter.

*** Sec. 12.** AS 18.07.111(2) is amended to read:

(2) "certificate" means a certificate of need issued by the **department** [OFFICE] under AS 18.07.041**, 18.07.043,** or **18.07.071** [AS 18.07.071];

*** Sec. 13.** AS 18.07.111 is amended by adding a new paragraph to read:

(13) "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 a day to individuals admitted to the health care facility because of illness, disease, or physical infirmity.

*** Sec. 14.** AS 18.07.111(11) is repealed.

*** Sec. 15.** TRANSITION. (a) A matter described in former AS 18.07.031 that is authorized under a certificate of need issued before the effective date of this Act shall be reviewed and completed in accordance with the applicable statutes and regulations as they existed on the day before the effective date of this Act.

(b) Except as provided in (a) of this section, pending applications and any other matters described in former AS 18.07.031 or in AS 18.07.031, as amended by this Act, shall be reviewed and completed in accordance with the provisions of this Act.

*** Sec. 16.** This Act takes effect immediately under AS 01.10.070(c).

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

TONY KNOWLES, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

MEMORANDUM

DATE: January 11, 1999

TO: Sheila Peterson
Staff Assistant
Long-Term Care Task Force

FROM: Elmer A. Lindstrom
Special Assistant to the Commissioner

SUBJECT: Proposed amendments to Certificate of Need draft legislation

The Department of Health and Social Services and Department of Administration have reviewed and support the proposed certificate of need draft legislation because it will provide an additional tool to control rising nursing home bed costs. Following is an analysis of each section of the bill along with several suggested amendments:

Sec. 18.07.031: Certificate of Need Required: Currently the Department of Health and Social Services reviews all nursing bed projects that cost over $1 million. LS 137 adds the requirement that all conversions of acute care or other beds to nursing beds must have a CON review. The department supports this change. It should be noted that a loophole remains for a facility to add new nursing beds if they can be built for under $1 million.

Sec. 18.07.043: Standard of Need for non-nursing beds: This section allows the standard of need to remain the same for non-nursing beds and other services. Non-nursing beds are primarily acute care beds, but also includes other services such as ambulatory surgery and kidney dialysis. **Recommendation:** The title on this section should be changed to read "Standard of Need for non-nursing home services."

Sec. 18.07.043: Standard of Need for applications: This is a new section that allows broader review analysis for nursing homes and nursing home beds. Decisions are currently limited to accessibility and quality. This new section allows decisions to be made based on additional standards such as need, financial feasibility, and availability of alternatives.

The list of criteria and standards to be developed in AS 18.07.043 (b), need to be changed to be more specific and better reflect the recommendations of the Legislative Working Group on Long-Term Care. Standard number (10) may be worded too broadly to be passed into law because it allows "any other factor" that the department determines "is necessary" in the analysis of a CON application. Also, (7) is insignificant because all new nursing beds will cost the state additional money. Following is a revised list of standards proposed by the department:
* Sec. 5. AS 18.07 is amended by adding a new section to read:

Sec. 18.07.043. **Standard of review for applications for certificates of need relating to nursing homes and nursing home beds.** (a) The department shall develop review standards for an application for a certificate of need or for an application to modify a certificate of need, issued under this chapter for a health care facility that is a nursing home or has nursing home beds.

(b) In developing review standards under (a) of this section, the department shall consider

(l) whether a public process and existing appropriate statewide, regional and local plans were included in planning and designing the project;

(2) whether the project meets minimum required utilization rates for new nursing beds and the impact on utilization rates for existing nursing home beds;

(4) whether the project demonstrates consideration of community, regional and statewide the needs for new nursing home beds;

(5) whether the project meets the minimum number of new nursing beds that should be required in a facility to ensure efficiency and economies of scale;

(6) whether the project demonstrates the proposed service will provide a quality of care equivalent to existing community, regional or statewide services .

(7) whether the project demonstrates financial feasibility, including long-term viability, and what the financial impact will be on consumers and the state; and

(8) whether the sponsor has demonstrated cost effectiveness through considering the availability of appropriate, less costly alternatives of providing the services planned.

(c) The department shall grant a sponsor a certificate of need or modify a certificate of need that authorizes nursing home beds or that is for a health care facility that is a nursing home if the department finds that the sponsor meets the criteria and standards under (a) and (b) of this chapter.

Other Changes: All other changes included in LS 137 are cosmetic and are meant to clean up the law. Examples include changing the reference to the program from the "State Health Planning and Development Agency" to the "Department."

cc: Pat Pourchot, Legislative Director
Office of the Governor
Karen Perdue, Commissioner
Department of Health and Social Services
Alison Elgee, Deputy Commissioner
Department of Administration

APPENDIX C

LETTER ON THE ANCHORAGE PIONEERS' HOME

Alaska State Legislature

State Capitol
Juneau AK
99801-1182

Official Business

Long-Term Care Task Force

January 15, 1999

Mr. Bob Poe, Commissioner
Department of Administration
PO Box 110200
Juneau, AK 99811-0200

Dear Commissioner Poe,

As you know, the Long-Term Care Task Force was created last year with the passage of SCR 11 to develop a suitable and equitable plan for providing access to long-term care for all Alaskans. We have served as co-chairmen of this 12-member task force composed of legislators, state officials, and private citizens. On January 6, 1999 the task force conducted its last public meeting in Anchorage. Approximately 100 individuals participated in the hearing either in Anchorage or other communities via teleconference. Public comment was offered on the draft report of the findings and recommendations of the Long-Term Care Task Force as well as other issues impacting long-term care available in Alaska.

The level of long-term care offered in the Anchorage Pioneers' Home and the current administrative practices at the Home were topics of significant discussion by those appearing before the committee. Relatives of individuals residing in the Home recounted personal observations that put into question the safety and care of some residents. Their narratives highlighted the problems caused by insufficient staffing levels, the injuries that resulted from the lack of safety precautions, and the negative impact that limited social activities has on residents. Unfortunately this is not the first time these problems have been voiced. The family members expressed frustration that their concerns and experiences are not taken seriously and there is no apparent avenue available to them to affect positive change.

Deputy Commissioner Alison Elgee announced a public hearing in Anchorage to review these various complaints and concerns before the end of January. The Task Force is sensitive to the issues raised regarding the Anchorage Pioneers' Home and would like to

be informed of the time and location of this public meeting. In addition, the Task Force requests that the co-chairmen of the Senate and House Health, Education and Social Services Committees receive a summary of this public hearing and any corrective actions taken by the Department of Administration to address the identified issues by February 28, 1999.

Thank you for your assistance in this very serious matter. The quality of long-term care given to our Pioneers' Home residents must be beyond reproach.

Sincerely,

Representative Con Bunde
Co-chairman

Senator Gary Wilken
Co-chairman

Cc: Long-Term Care Task Force Members
Deputy Commissioner Alison Elgee
Mr. Jim Kohn

APPENDIX D

TIME TABLE FOR SPECIFIC REQUESTS

Long-Term Care Task Force
Time Table for Specific Requests

Request	Who	What	To Whom	When	Comment
No. 3 *		Introduce legislation relating to the disclosure of licensing reports and licensing of home health agencies.			
No. 6	Department of Administration	Consider the formal recommendations outlined in *The Alaska Guardianship Report* and recommend necessary statutory changes.	Senate President and House Speaker	March 31, 1999	
No. 7 *		Introduce legislation relating to the protection of a vulnerable adult from a guardian, attorney-in fact or surrogate decision-maker who may harm the vulnerable adult.			
No. 8	Alaska State Hospital and Nursing Home Association	Prepare a full report on the actions required to be taken as a result of the conclusion reached at the statewide *Work Force Development Summit* to be held April 9-10 , 1999	Senate President and House Speaker	No Date Specified	
No. 10	Alaska Commission on Aging	Implement a plan to increase the awareness of Alaskans to advance directives and prepare a report on the Commission's efforts to do so.	Senate and House HESS Committees	Beginning of the Second Session of the 21st Legislature	
No. 12	Department of Health and Social Services	Aggressively pursue the rebuttal of the federal Health Care Financing Administration's interpretation of the Social Security Act as it relates to the Indian Health Service.	Legislature	Semi-annually	

TIME TABLE FOR SPECIFIC REQUESTS

Request	Who	What	To Whom	When	Comment
No. 13 *		Introduce legislation relating to the establishment of a home and community-based services program for certain adults with long-term care needs.			
No. 14	Departments of Administration and Health and Social Services.	Review all options available to support the long-term care needs of patients whose sole diagnosis is Alzheimer's Disease and prepare a preliminary report outlining findings and recommendations	Senate President and House Speaker	April 30, 1999	
No. 18	Alaska Commission on Aging	Coordinate efforts to inform and educate all Alaskans on the various long-term care services available and provide updates on its efforts.	Senate and House HESS Committees	Semi-annually	
No. 19	Department of Administration	Establish a uniform and comprehensive screening and assessment tool and develop a pilot to assess its validity and reliability.	Not Specified	July 1, 2000	
No. 21 *		Introduce legislation relating to the adoption of the nursing home certificate of need recommendations developed by the *Legislative Working Group on Long-Term Care.*			
No. 24	Department of Health and Social Services	Identify necessary changes to assure the Medicare program funds health care services provided to dual eligible patients. Prepare a report on its efforts and make recommended changes.	Senate President and House Speaker	March 31, 1999	

TIME TABLE FOR SPECIFIC REQUESTS

Request	Who	What	To Whom	When	Comment
No. 29	Department of Commerce	Compile relevant information on the need for and availability of long-term care insurance in Alaska and disseminate the information to the general public.	All Alaskans	January 1, 2000	
No. 31 *	Senate and House HESS Committees, in consultation with legislative leadership	Consider the creation of a new task force to continue the review and monitoring of long-term care in Alaska.			
Letter to Commissioner Bob Poe	Department of Administration	Prepare a summary of a public hearing regarding the administrative practices of the Anchorage Pioneers' Home and corrective actions either taken or proposed to be taken, by the department.	Senate and House HESS Committees	February 28, 1999	

* Requires legislation

APPENDIX E

AFN RESOLUTION

ALASKA FEDERATION OF NATIVES, INC.

1998 ANNUAL CONVENTION

RESOLUTION NO. 98-59

TITLE: IN SUPPORT OF ELDER CARE FACILITIES IN RURAL ALASKA

WHEREAS: The elders are a much respected group of people within the family unit and community for the Yup'ik people and all Alaskan Natives alike; and,

WHEREAS: Most villages in rural Alaska do not have the proper facilities for the care of elders; and,

WHEREAS: The only elder care facility for many regions is in the city of Anchorage, which is too far away from the family unit and communities; and,

WHEREAS: Being away from familiar surroundings, culture, foods, and activities, would be detrimental to the health and welfare of the elders; and,

WHEREAS: There is a growing and significant need for proper elder facilities throughout rural Alaska;

NOW THEREFORE BE IT RESOLVED by the Delegates to the 1998 Annual Convention of the Alaska Federation of Natives, Inc., that AFN politically supports the efforts of rural organizations in seeking, acquiring, and administering the required funding, facilities, personnel, and technical and professional support for elder care facilities.

SUBMITTED BY: St. Mary's Native Corporation

COMMITTEE RECOMMENDATION: DO PASS

CONVENTION ACTION:

Passed

APPENDIX F

MISSIONS AND MEASURES

Alaska State Legislature

Official Business

State Capitol
Juneau AK
99801-1182

Long-Term Care Task Force

MEMORANDUM

To: Representative Eldon Mulder, Co-chairman
Representative Gene Therriault, Co-chairman
House Finance Committee

Senator Sean Parnell, Co-chairman
Senator John Torgerson, Co-chairman
Senate Finance Committee

From: Representative Con Bunde, Co-chairman
Senator Gary Wilken, Co-chairman
Long-Term Care Task Force

Date: January 15, 1999

Re: Mission and Measures for Long-Term Care programs

As you know, the Long-Term Care Task Force was created last year with the passage of SCR 11 to develop a suitable and equitable plan for providing access to long-term care for all Alaskans. We have served as co-chairmen of this 12-member task force composed of legislators, state officials, and private citizens.

As part of the Task Force's review, legislative staff and directors of the divisions of Alaska Longevity Programs and Senior Services met and prepared draft mission statements and performance measures for these two divisions. The draft mission and measures are attached for your review.

The Task Force recommends that these documents be critiqued and refined during the next legislative budget cycle with input from both the legislature and administration. The divisions' mission and measures statements will help direct long-term programs offered in the state.

Missions & Measures

Draft as of January 6, 1999

Program: Senior Services – Commission on Aging

Statutory reference: § 47.65

Mission.

Assist and advocate for older Alaskans to lead dignified, independent and useful lives through partnering with state, local and private agencies.

Measures.

- At least 5 communities will have coordinated transportation systems by 6/30/03. (current systems: Anchorage, Ketchikan, Kodiak and Juneau)
- Percentage of annual change in number of persons served with home based meals.
- Percentage of annual change in number of persons served with community based meals.
- Number of public requests for information.
- Number of presentations made by Commission staff.
- Percentage of total resources spent on targeted seniors in ___% of communities. (Targeted seniors = over 75 years, low income, minority and/or rural)

Missions & Measures

Draft as of January 6, 1999

Program: Pioneers Homes

Statutory reference: A.S. 47.55 and A.S. 44.21

Mission.

Provide senior Alaskans, especially those with needs associated with Alzheimer's Disease and Related Disorders, a safe, home-like environment that meets their dietary, recreation and therapeutic requirements at an affordable cost.

Performance measures.

- 100% criteria met in each resident's contract (as required for Assisted Living License)
- Percentage change in reported incidents related to resident injury.
- Percentage increases in overhead will not exceed the Consumer Price Index.
- 6 (100%) Pioneers Homes will be registered as Eden Alternatives Homes by 12/31/98.
- 6 (100%) Pioneers Homes will be certified as Eden Alternatives Homes by 6/30/2000.

Missions & Measures

Draft as of January 6, 1999

Program: Senior Services – Residential Choices

Statutory reference: § 47.65

Mission.

Provide quality residential alternatives for vulnerable Alaskans in their home communities.

Measures.

- Number of Assisted Living units statewide.
- % change of rural Assisted Living units available by region (regions measured individually).
- % of Assisted Living Home licenses renewed annually without violations.
- % of suspended Assisted Living Home licenses cleared within 90 days.
- % of Assisted Living Home licenses renewed with adequate business management practices as defined by Division policy.
- % of waiver days (out of total of waiver and nursing home days) in Medicaid.
- % of waiver decisions made within __ days.
- % change of independent Personal Care Attendants enrolled as Medicaid providers.
- Number of communities with enrolled Personal Care Attendants.

Missions & Measures

Draft as of January 6, 1999

Program: Senior Services

Statutory reference: § 47.65

Mission.

Maximize the independence of vulnerable and elder Alaskans by providing choices and access to prevention, wellness and quality long term care services.

Missions & Measures

Draft as of January 6, 1999

Program: **Senior Services**
Project: **Data Integration Project**

Authority:

Mission

Capture and track client information in an integrated data system to expedite coordinated services to Alaska's seniors.

Performance measures.

- Complete the business process mapping for the data integration project by 6/30/99.
- Implement data integration by 6/30/01.

Missions & Measures

Draft as of January 6, 1999

Program: **Senior Services**
Project: **Grant Management System**

Authority:

Mission

Standardize a process and procedure for grant administration and evaluation to provide community and home based services to Alaska's seniors.

Performance measures.

Develop evaluation criteria for grant management that promotes

- Collaboration with public and private partners,
- Access to quality services,
- Prevention and wellness education, and
- Self-determination.

Implement evaluation criteria by 6/30/01.

APPENDIX G

PCA RECOMMENDATIONS

(The attached proposed recommendations were presented to the Task Force, but were neither discussed nor adopted by the Task Force.)

RECOMMENDATIONS

PERSONAL CARE ATTENDANT PROGRAM IN ALASKA

December 15, 1998

A steering committee, called the PCA Design Team composed of 14 people including consumers, providers, advocates, and state staff from 7 agencies, contemplated the strengths and weaknesses of delivery of Personal Care Attendant Services in Alaska, including Medicaid-reimbursed services. The PCA Design Team then presented their thoughts at a larger meeting called the PCA Summit held on November 14, 1998. Approximately 75 people from all over the state, including providers, consumers, advocates and state agency staff, attended to discuss the issues and develop clear objectives for improving the delivery of PCA services in Alaska. As a result of that process, the PCA Design Team makes the following recommendations:

1. Remove the Medicaid rates of reimbursement from regulation, and instead set rates by a mechanism that is responsive to and reflective of market factors that influence cost of service.

2. Equalize the rates of Medicaid reimbursement for agency and independent PCA providers for comparable services.

3. Revise the "scope of services", "excluded services", and definition of "skilled nursing care" under 7 AAC 43.750, 43.755 and 43.795(2) to expand the types of Medicaid-reimbursable services PCAs may perform. [This may also require clarification or revision of statutes and regulations governing the practice of registered nursing or practical nursing.]

4. Allow recipients the choice to have nursing supervision of their service plan, or not.

5. Rename the "time for task" form to "service plan". Eliminate the time allotments from the recipient's service plan; and provide reasonable time allotments as guidelines in a new booklet entitled, "PCA Service Plan Guidebook."

6. Perform service plan assessments by third party (independent of the PCA agency providers and the State), with a preference for assessment by local personnel familiar with the recipient's community and available resources. Mandate regular visits in the recipient's home by the assessing entity to ensure that assessments and re-assessments are based on personal knowledge of the recipient's needs. Entities proposed to do such assessments: (1) Public Health nurses; (2) First Health or similar utilization review contractor; (3) independent RNs.

7. Add PCA services as a waiver service to all waiver programs - do this as a compliment to the regular Medicaid PCA services and not in place of regular Medicaid PCA services.

8. Establish a referral service of PCA providers, with a statewide toll-free number, to allow recipients to locate available PCA providers and back-up or on call personal care attendants.

9. Establish a formal recipient-driven grievance process statewide.

10. Use the PCA grant program to provide PCA services to eligible recipients on a co-pay basis.

11. Open the agency provider pool to include any provider that meets the enrollment requirements.

12. Establish professional standards for personal care attendants and develop a certification program for PCAs.

13. Conduct a study on actuarial claims data to compare home and community based services, including PCA services, and institutional services.

Guiding Principles for Personal Care Attendant Services

Personal Assistance Services are a variety of services that provide assistance to persons who are elderly and/or may experience a disability. These services may include, but are not limited to: personal care attendant services, chore services, respite services and health related services. The following principles apply to personal care attendant services.

1. Recipients must have control in selecting, managing and controlling their personal care services.
2. Personal care services must be community based and culturally relevant to the recipient.
3. Eligibility for personal care services must be based upon functional need.
4. Personal care services must be available at home and in other locations of each person's choice. People must not need to be "home bound" in order to receive these services.
5. Personal care services must be available 24 hours a day, seven days a week.
6. Backup and emergency personal care services must be available at all times.
7. Personal care services will be available to all Alaskans with a variety of payment models, including co-payment.
8. Training in the management and supervision of personal care attendants will be available to interested recipients.
9. Personal care attendants will be adequately compensated.
10. Personal care services will be written in an agreed upon individualized service plan.
11. Health related tasks can be delegated to and done by personal care attendants.
12. Recipients must be able to receive the same quality and level of services in the setting of their choice throughout the state.
13. There will be a variety of models of service delivery available to all Alaskans.
14. Personal care services will be provided with a high standard of quality of care.
15. Personal care services will have periodic evaluations using consistent state wide standards.
16. All recipients of personal care services must have access to a consumer driven and fair grievance process.
17. All communities will be given authority to develop services based on their unique needs and service delivery options.

Presented to the Long-Term Care Task Force by the Personal Care Attendant Design Team

APPENDIX H

ALASKA COMMISSION ON AGING

(The attached preliminary findings were presented to the Task Force, but were neither discussed nor adopted by the Task Force.)

Alaskan Seniors

FINDING THE COMMON GROUND

from the Alaska Commission on Aging

Preliminary findings from:

Alaskan Seniors: Finding the Common Ground

A Statewide Conference sponsored by
The Alaska Commission on Aging

September 21 - 23, 1998: Regal Alaskan Hotel, Anchorage

From September 21 - 23, one hundred community, agency, and senior advocacy leaders from across Alaska met to identify and address opportunities and challenges affecting the growing numbers of older Alaskans. Together they defined the "common ground" uniting their organizations and businesses, and developed strategies to act on those shared challenges and opportunities. The Conference Steering Committee will present the conference findings and recommendations in a November report.

The fundamental message from participants: ***Increase collaboration*** -- between seniors, their families, senior advocacy organizations, local agencies and governments, private business, the medical community, and state & federal government agencies. In this way, we will share responsibility to create a focus on:

- ***Increased access***
  - *to information on current services available to seniors,*
  - *to the actual services.*
- ***Education and information*** ***- in relation to***
  - *the exploding statewide senior community and the opportunities and challenges this represents*
  - *building the geriatric expertise of the entire 'circle of caring' involved in assisting frail older Alaskans: families, community agency caregivers, assisted living providers, the home health and medical communities.*
- ***Assurance of quality*** ***in relation to***
  - *actual services provided through the public and private sector*
  - *streamlining access to services.*
- ***Seniors exercising increased self-determination*** ***to***
  - *pursue the Legislative Long Term Care Task Force concept of reinvesting Longevity Bonus phase-out funds. Why? To assist in supporting services to assist frail and ill seniors to live independently as long as possible*
  - *reach out to the medical community to identify and address unmet geriatric medical needs*
  - *secure increased consumer protection within our State.*
- ***Applying prevention to increase wellness*** ***- we know that***
  - *healthy lifestyles significantly contribute to older Alaskans abilities to live independently. This is most fulfilling and relatively speaking, "Health doesn't cost; illness does!"*
  - *achieving healthy lifestyles occurs through lifelong education and promotion of*
    - *healthy nutrition and regular exercise*
    - *tobacco and alcohol/drug free lifestyles*
    - *social involvement and helping others.*