SCOMM 110:6

TONY KNOWLES, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

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March 28, 1997

Honorable Gail Phillips, Speaker
Alaska State House of Representatives
State Capitol, Rm. 107
Juneau, AK 99801-1182

Dear Representative Phillips:

The Legislative Working Group on Long-Term Care that was established by Ch 84, SLA 96 has completed its work. A copy of the report has been delivered to the Governor's office as required.

Enclosed, please find additional copies for your use and review.

I hope you find this report useful and if we can be of any further assistance, please do not hesitate to contact me.

Sincerely,

Jay Livey
Deputy Commissioner

JL\bi

Enclosure
cc: Alaska State Representatives

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STATE OF ALASKA

LEGISLATIVE WORKING GROUP
ON
LONG-TERM CARE

REPORT TO GOVERNOR TONY KNOWLES

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Executive Summary

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

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

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

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

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

CHAPTER ONE: INTRODUCTION

Background

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

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

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

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

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

Composition Of The Working Group

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

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

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

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

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

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

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

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

Thea Zumwalt, Soldotna
Long-Term Care Recipient

Duties Of The Working Group

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

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

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

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

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

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

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

List Of Meeting Dates

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

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

CHAPTER 2: STATEMENT OF LONG-TERM CARE PRINCIPLES

Primary Guiding Principle:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Individual Profiles

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

Early Intervention to Delay the Need for Long-Term Care

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

Home & Community Based Services for Alaskans with Moderate Impairments

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

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

Home & Community Based Services for Alaskans with Severe Impairments

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

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

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

Institutional Long-Term Care Services for Alaskans with Severe Impairments

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

Major Issues:

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

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

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

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

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

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

Long-Term Care for Alaskans with Developmental Disabilities

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

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

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

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

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

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

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

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

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

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

These services are available to both children and adults:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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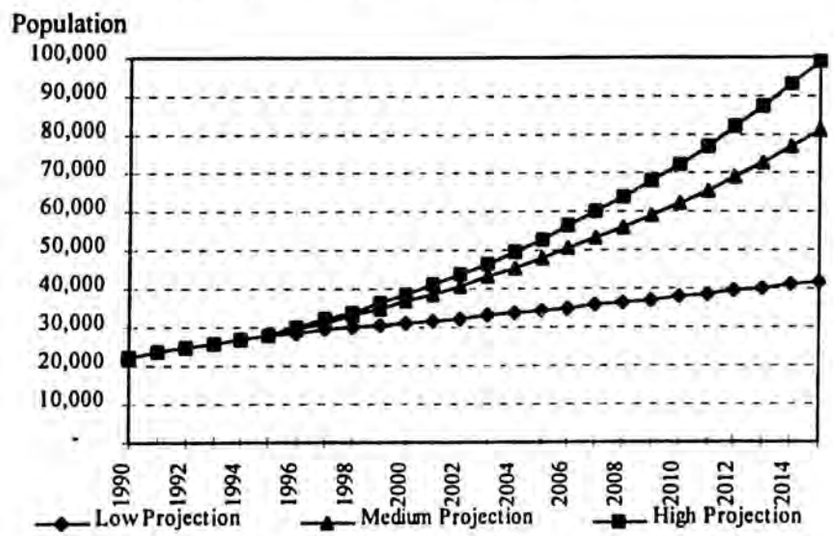
CHAPTER 4 - LONG-TERM CARE PROGRAM USAGE IN ALASKA TO 2015

Assumptions

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

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



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

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

Analysis

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

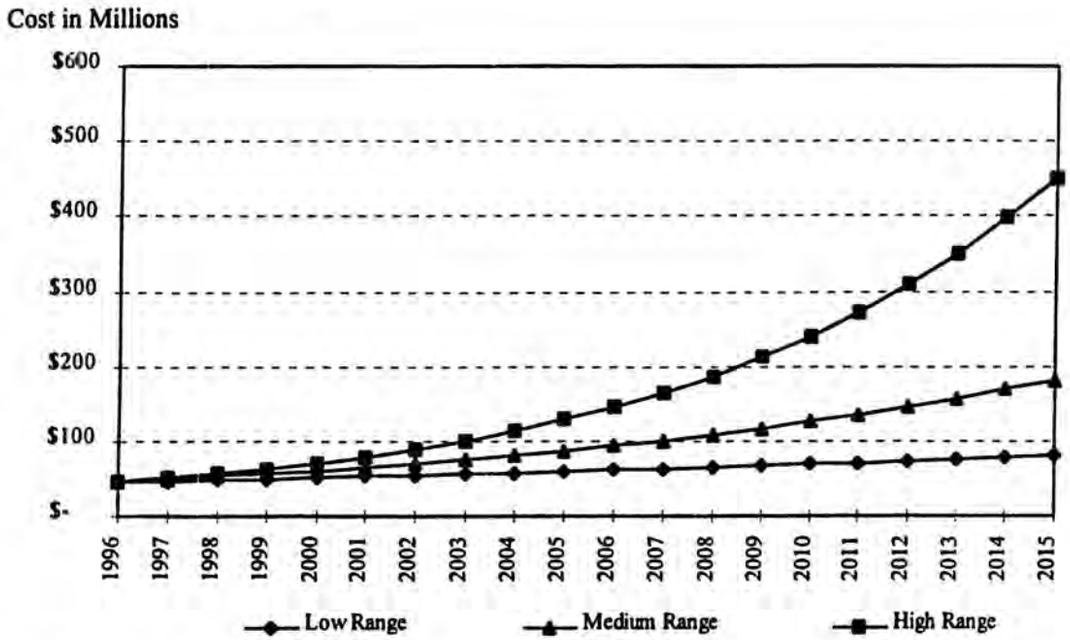
Tables 3 and 4, (pages 25 and 27), show projections of low, medium, and high growth rates for the services and costs of the long-term care system in Alaska to 2015. The population growth and inflation rates used to make these projections are described in the text. It should be noted that ICF/MR institutions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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

For more detailed expenditure projection see Appendix II

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

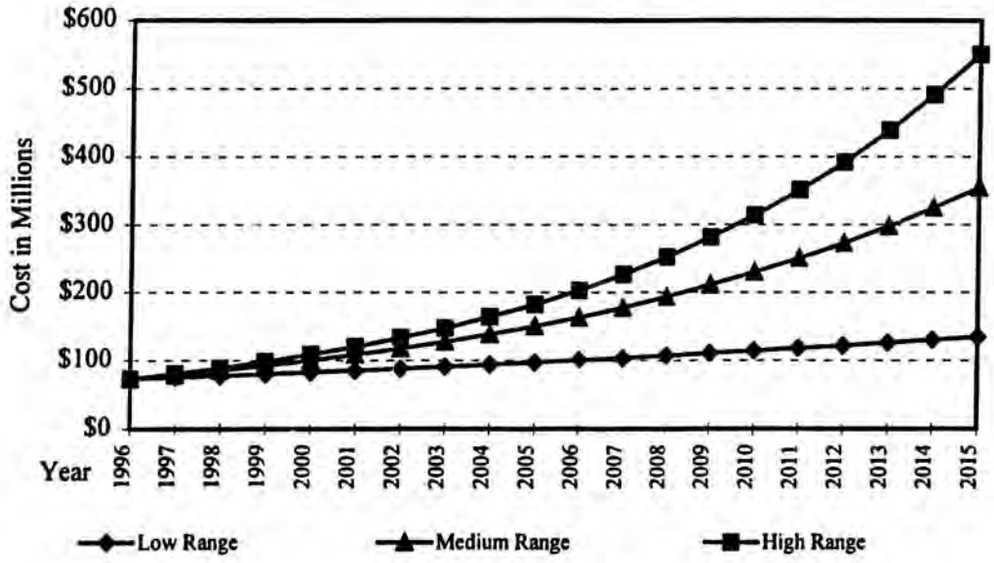


Figure 3 shows that for the population aged 65 and over the costs of long-term care services will continue to increase greatly in the future. The most optimistic projection scenario for low cost and population growth presented in Table 4, on the previous page, projects nearly a doubling in costs over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

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

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

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

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

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

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

For more detailed expenditure projections see Appendix II

CHAPTER 5: ALTERNATIVES TO THE PRESENT SYSTEM

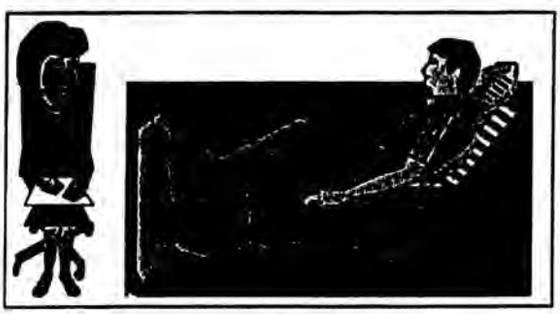
Senior Alaskans And Alaskans With Physical Disabilities. By 2015, Alaska's population of senior citizens age 65+ will increase by a projected 180% from the 1995 figure of 28,096 to 80,927, based on the medium growth projection data in this report. This will in turn propel growth in long-term health care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

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

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

Desired Entry Into The Long-Term Care System

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



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

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

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

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

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

Alaskans With Developmental Disabilities.

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

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

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

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

CHAPTER 6: CERTIFICATE OF NEED PROGRAM

How The Program Works

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

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

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

Current Standard Of Review

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

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

L[illegible]tations Of Current Standard Of Review

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

Recommendations For Principles To Guide The Certificate Of Need Process

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDED GUIDING PRINCIPLES/CRITERIA FOR CERTIFICATE OF NEED

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

CURRENT LAW

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

Availability
- **Services not available**

Accessibility
- **Services not sufficiently accessible**

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

PROPOSED ADDITIONS

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

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

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

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

STATE HEALTH POLICY PLAN

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

APPENDICES

APPENDIX - I

APPENDIX - II

APPENDIX - III

APPENDIX - IV

APPENDIX - I

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

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

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

Table 2: DD Service Provider Overview

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

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

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

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

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

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

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

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

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

Table 4: Percent of DD Persons Receiving Services by Age

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

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

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

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

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

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

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

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

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

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

Table 7: Number of DD Persons Waiting for Services

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

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

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

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

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

Table 9: Number of Persons Waiting for Specific DD Services

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

Table 10: Average Time on DD Wait List

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

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

* May include 1 or more of the other 9 services

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

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

APPENDIX - II
TABLE 1

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

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

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

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

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

TABLE 2

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

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

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

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

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

2% Cost Increase and 1% Population increase

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

5% Increase in Costs and 2.5% Increase in Population

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

8% Increase in Costs and 5% increase in Population

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

TABLE 4. Alaska Long-Term Care Programs Ages 65 and over - Cost increases of 2%, 5% & 8% Population Growth rates of 2%, 5.43% and 6.5%

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

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

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

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

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

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

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

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

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

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

APPENDIX - IV

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

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

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

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

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

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Glossary

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

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

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

CASE MANAGEMENT: Same as care coordination

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

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

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

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

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

Severely Impaired **3 or more ADL impairments**

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

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

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

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

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