

SCOMM

110:3

LONG-TERM CARE TASK FORCE
October 21, 1998
9:08 a.m.

COMMITTEE CALENDAR

Worksession

TAPE(S)

98-9, SIDES A & B
98-10, SIDES A & B
98-11, SIDES A & B
98-12, SIDES A & B

NOTE:

The meeting was recorded and handwritten log notes were taken. A copy of the tape(s) and log notes may be obtained by contacting the House Records Office at 130 Seward Street, Suite 211, Juneau, Alaska 99801-1182, (907) 465-2214, and after adjournment of the second session of the Twentieth Alaska State Legislature, in the Legislative Reference Library.

LONG TERM CARE TASK FORCE

MANCHESTER, LI

CB:

DS, JH, AE, JR, CB, GW, DM, JG

000

Bill Brown - NYLP

Carson Hayes eno

Frank Krule cns

Elyan AMCH

Bill

Paul Haley FHX MCH

Carl King

Ray Murrey DIV MH

K Brown

030

GW - were got lots work to do
we'll deal up 14 to 20, & then go on for 12-14 weeks
- we'll deal up right track that help P most

051

we'll stay on schedule

053

CB I hope LTCF will come up w/ rough draft legislation
by end of tomorrow (Thurs) & then can say yes and LEG

068

we need fairly clear request for legislation

070

JG Quality of LT Care

will talk re personal care services
Refer to JG document 'Personal Care Services'

083 PCS are for disabled persons
are basis & backbone for LTC
- help w/ feeding, cleaning,

- eval through Medicaid, and waiver recipients (higher
2 delivery models

A) INDYS - P contract w/ independent PCAs

- paid 65 p m FY 97

- paid $\approx$ \$12/hr, & must pay own taxes, workers comp, insurance
most don't have in

B) Agency based

- get subsidy thru DR SR SUCS
- FY 97 940 p

140

KB

144

GW

145

JG In FY 97 total cost for 980 p \$4.5 m \$13/dy/p
- very cost effective

PROBLEMS - PCs aren't available everywhere, esp in Bush
towns per high
little choice of providers - often just 1 provider
most services avail only in home - not for church, shopping, etc

~170

1/A
172 ^{Prominent} ^{can}
long waiting list for providers

SOLUTIONS

178 ~~GW~~

179 JR - what do PCAs do - sometimes CNAs do RN's work
are PCAs doing work that requires extra training

193 PCA can only do non medical, non invasive care
problem - many patients need catheters, insulin shots

202 KB CNAs are supervised by RN periodically not constantly
- some need more, some less

219 JG CNAs sometimes act as PCA, @ PCA pay - they're
overtrained & underpaid

225 KB there's debate over training needs
CNA is trained more
PCA is entry level

237 DM - medications is a big issue/problem
what is def into "assisting" w/ medication, and actually "administering"

265 DM some require LSN to dispense
drugs & training

if all comes down to cost - what you want P to do &
what level of skill & responsibility

1/A

280

JR - repl newspaper story
wld be prudent to draw lines of liability

290

GW on PCA ~~to~~ home-based
what's education

295

KB

requir. HS diploma

75 hrs - approved curriculum by DIV. SERVICES

CPR training

immunizations

1st and 2nd

- finding training is a problem (though letter in search is offing
and some @ VA -

318

GW HS + 2 wks

if we raise training required, must we raise pay

KB - were denied

328

16 - developing career ladder

333

rebel story, & benefits

338 KB

≈ 100+ only PCA, - but we don't know
2-300 total

1/A
343 JH -

359 Catherine Hayes^{CH} CNS PCA (+LANT)
shows lots of PCAs in private pay, - but private
employers want more training

369 KB - true, but some I will have neighbor
- true - does no standard for private caregivers

372 DM - a

CB as requirements go up, so does cost

384 JR - my wife is RN & only 49

388 Catherine Hayes -

CNSs will follow \$, unless they're loyal to client
she described case in which client needed care of a nurse,
but lacked authority to ad

940 PM KP MR

425 CB -

is it fair to say LTCF pay, at home/care case is
equal w/ support as the highest

1/A
438

[general consensus]
56 - no argument

CB - in spite of difficulties, we'd like to make
CMA PMA more available

451 - DM, but we must know costs/benefits, & how that
drives different behavior

CB - concerns noted - not all are best served by CMA PMA

464 Delly Sennet DS

this is new topic for me

what are CMA requirements

is it poss to have - would it help to set entry level

496 CB -

498

NB choose services & reports service providers are
not entry level jobs, & have no training

its market driven by region, & by regulation

CB we now have \$12/m ^{INDY} PMA by regulation

524 NB

agency PMA

?

- CMA gets more

1/A
530 CB -

KB - CNAs do have internships

DM - 140 hrs required training (up from 105 hrs)

CB - includes OOT?

DM - about 70-80 split classroom/practicum

540 JS PGAs have supervising nurse

560 CB - they

565 DH - where is nurse supervising in independent PCA/CNA school

JS same

577 KH when this problem

KB only PCA is required to have

588 DS - could DM last rate diff

594 DM AGENCY monitor requires RN ~~for~~ does everything who is also the supervisor

- (we call em PCAs, but they are CNAs)

C
CB - anyone need help w/ acronyms?

DM A
B

1B 000 DM described how RN supervises CMT in agency-based PCA model
 - we try to avoid taking ~~some~~ action outside our

PKY - PCA \$9.38/hr + benefits
 we pay

049 \$119,000/yr in workers comp for PCA & NH new

ongoing education

057 KP endue - this is maj. job growth area - is a career job
 - choices are blurring lines
 - how to make overnight & appropriate care is the issue
 - this kind of effort bears fruits

072 - CB - endless prob, few solutions

074 JG SOL

(A) dev. multiprovider system to allow choice in service providers

(B) pilot project some different models

let agency not an employment agency but let patients control w/ provider times work as

(C) link pay w/ training and longevity in career

1/B

(D) -

(E) dev recruitment strategies (similar issues w/
DD direct care - SWs counsel MROD DMS MROD)

108

steering comm of MROD, Andy Jerry Council, OPIRS, ILG, Pughlets
☆ Pughlets - SW - develop guiding ^{PRINCIPLES} ~~principles~~ for personnel on
to put DD, elderly etc communities on same wavelength
- ^{SWRS} ~~SWRS~~ needs 11/18, preparatory to 11/14 summit

138 -

it's a huge issue/problem - hope you don't

147

- CB rather than have turf battle, maybe we can
focus on elder care, & let that SWRS comm.

156

KB Summit will be very imp. - stakeholders
can't separate LTC from different population - ELDERLY,
DD, A

168 CB

our resolution dealt w/ elderly & its expanded to
the LTC

174 JR

- what happens when

are we getting qualified, responsible employees for what
we pay, or do we need to pay more \$ for what we want

1/B

186 JS often we get better qual care than we pay for
- to gain interest in career field (nur, wellness work,
- we must ext a framework

201 CB - we need to encourage greater supply of pers/cons
also educate consumers as to their benefits
- [refd to draft legislation on pers - he asked
valuable advice

226 KB - LBAH just ord 97,000 of MHT unit Coughlin ✓
to test the "agency as employment agency" model - basically
to draw up a ~~new~~ manual TO DIV SR SR

OW

242 DM - "supervising" nurse isn't - it's more of a backup
~~in private provider~~

KB

- in agency model, we do supervise weekly, including
making sure instructions are carried out

261 CB - independent

273 DM - as agency provider he must do assessment... some interesting dilemmas

1/B

289

DM concerned about how we can monitor the quality & quantity of service provided under independent model (is paid for by govt)

298 CB

VULNERABLE ADULTS

do we need more legislation to deal w/ vulnerable adults

310 AB

proposed leg in packet reflects Adult Protection Services - how gov allowed to do more than help info or sue to surround but what if guardian is abuser
this leg allows way to get other courts for solution to

332 Frances Purdy. LTC ^{on BIRMINGHAM} APS Adult Protection Services
guardian holds ~~then~~ legal rights

CB

357 FP ^{EXISTING} statute omits financial exploitation (misuse of funds and etc)

368 JR - is yr trying to get swift court action, but full hearing etc

FP No it's not like a restraining order - it just makes changes
④ in APS - allowing state to offer protection
⑤ allows prosecution through courts system

1/B
430 CB

Are gonna leave for ~~now~~ a while

2 questions - Should we address vulnerable adults

② is FIV EXPLOITATION part of LTCPP jurisdiction

460 KP - ~~YES~~ YES

this is one of more important things we can do
we should also look @ guardianship and trusteeship statutes
more & more services are in-home, & we lack enforcement
& oversight

491 ON - so you agree it's part of our job

492 JH - you, as LTC ombudsman, - are ~~the~~ seeing lots of
exploitation

501 FP - yes -

511 JH - robots magnitude

FP - LTC ombudsman checks stuff for in-homes, but in last
yr were ~~the~~ had 10-14 cases, many of em referred by cops
but, because the standard is 'knowing' not 'negligent'

536 JR

559 FP

1/B

FP

2 different groups
there are 2 different issues
VULN ADULTS
CONSERVATIVE

591 JG

593 FP

598 SW

601 FP

- why guardians issue needs its own task force

624 AE

I'm unfamiliar w/ the issue

TAPE 98-10, SIDE A

000 AE

001 FP

002 KP

very interesting
safest place to live is NH, but few P live there

019 JH

AE - we just got report on divorce, MHT & re-guardianship
in NH - it includes lots of info of interest

035 KB

- court system response

036 JH

if we need to wrap up by DEC, we may need
subcommittee

HAM TO RESET

000 DM

problem is durable power of atty -

2/A

024 SW

lets use guardianship as start for deliberation?
should LTCIT make recommendations or ~~approximate~~ sell
it early

038 DM

all power of atty

FP

guardians

045 SW

Will recommend that the issue of guardianship
be evaluated

our deadline is 12/17/98

053 KP

We'll leave that issue

064 JR

SW

Chen can delay, or appt a subcommittee
I think we

068 FP

AK KSN of Conservator & Guardianship Is

072 KB

report just came to us - - - there is a group making
recommendations

080 SW

We'll leave that open for more words, & take it
up @ next mtg

or let's recommend

? 2/A

087 JH let's offer our support to — prices

or re: PCA

— much like we should increase choices, increase
home based - IS THIS OUR RBT

OR 101 - would it be right to ask MC RD of WORKING for
help on certificates/beam

AE 109 - let's watch what comes out of Summary report

for these 2 days

A) watch what comes of summit

KB 118 -

Recommendations
125 SW ① we need to inc # of PCAs
② get input from summit
③

132 JH - what's this draft law for FOR

137 AB it exts way state can supplement poor P in getting
home based services

2/A
AE its financing

150 SW

151 DR

157 AE the leg sets up grant fund to bridge funding gap

162 DR any Medicaid waivers

163 AE NO -

KP

SW

the PCA changes were already passed

170 AE

JH

175 AE

178 JH

188 SW

JH

KP

193 DK

PCA/CNA standards - no consensus

I recommend we set standard for care given

211 JH

I'm not comfortable making a rec. until we hear from summit

222 SW

it could be a rec. that summit look at the issue

2/A

JR

230 AE ~~do~~

245 KB - we haven't addressed that in summit

274 OW - REER

① me

②

③

④

OW other thoughts on JG

290 DS it's hard for me to know what we must deal w/

298 OW we've got to move on Army.

303 AE - address ^{inc} # of REER.

we should make recs on training & salary standards

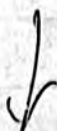
313 FP one possibility is to use areas of summit

323 SHARON CLARK in Iowa

ACCESS TO LTC

staff to SEN MILLER

353



2/A

363

SHARON CLARK

ACCESS TO LTC

MARGARET SAMUEL - NENTMA - DIR _____ CTR

JAMES DEMMEYER EX DIR COMMUNITY IN AGING

453

KEN JOHNS pres Cap Riv Native Assn

474

- CRNA funded by IHS for health care, & BIA

inc SR, MH

- home visits to help keep up homes, carry water to homes, wood, but
only for the Native elders

~~all~~
~~Wish to see~~

- hope to find ways to keep elders close to home, where
life has meaning & context - assisted care in rural areas
- eldercare is nothing new to Native now profit health corps,
for they've only been doing it for Am Natives

2/A

TAPE 98-10, SIDE B

035

were focussing on prevention of problems of elders in LTC (youth
alcohol prevention)

056

① there for Local LTC

② support 9859

060 06

③ suggest we work w/ Native corps & IHS as we develop local
LTC in rural areas

2/B

OGG JR

- we need bills left up to turn over some health care prog to

072

BH BILL HERMAN planner of MH Mental Health Trust
BH some of our courtel groups have interest in LTC

1130 AM CB RET.

1/3 of our projects this year relate to LTC

SB MOR

100

- we're funding projects through community agency - \$1 million
we fund 2 adult day care ctrs for Alzheimer
w/ of DHEC to improve Pioneer Home to help Alzheimer patients

projections show we will have more seniors
we have less infrastructure for SRS

we need more benefits for LTC services to poor people

135

we have to try to increase basic rate
we'd like better data collection & dissemination of info

150

MH Trust income goes to fund innovative approaches to problems
we'll need additional SF

161 JR

2/B
171

~~188 JEFF JESSE~~

190 STEVE ASHMAN SA AHFC hair combed straight back
we don't differentiate between Rural & Urban
but we do give 20 pts for rural (?)

204 Bethel Assisted Living Facility - many orgs cooperated to
get it built & operating
- hope to build one in Pillingham, Nebraska

FINANCING -

- Fed Home Loan

- fed low income housing tax credit

- local govt property tax exemptions

Comm Dev Block Grant \$

185 VET -

Couch

288

PERSONAL RECOMMENDATIONS

- leg should provide more seed \$ to

- "capital funds for building assisted living PRO-

- educate assisted living ops on better business practices

- raise rate state pays for housing subsidy

321 DR - is arbitrage fund source of some of yr funds for -

2/B

326

no, but

332 DM

- you talked mostly about building new facilities
- have you studied how converting existing structure
or housing projects into assisted living (some

355 ~~Am~~ SA

anything we finance now needs to meet new fire
codes for assisted living

373 DM -

395 GW lots stay on track

400

MARGARET SANDER - MENANA
DIRECTOR

453

Longevity Bonus \$ should go to Senior Services

476

KB a Assisted Living Rate Study
prelim thoughts

~~you are not~~

social security indexing would mean daily rate would be \$68/ds
instead of \$362/ds ^{from 83 →}

2/B

523

11/15 second phase
- out for comment

reld Rural Health Project - MHT unit & grant for
long-term development

557

mission & measuring 1st draft

567 AE - could KB address efforts @ 1 stop shopping

573 KB - we agree w/ need for 1 stop, cuz so complex
- 'care plan counseling' - 1 assessment

593 - it's gotta be different solution for different communities

2/A

TAPE 98-11, SIDE A

01/15

CB

000 J. Demmet

5 recommendations - [SEE HANDBOOK]

~~one more~~

065

066 DM in recent yr, decline or increase in grants to
local chs

068 JD decline, then rise

3/A

DM 000 back forth

079 SW - we need to get to Pioneer Home
12:18pm LUNCH

2:10pm RESUME

080 DON BITTLE FOX

130 SW. lets agree/disagree on

ACCESS TO LTC RECOMMENDATIONS

- 1) thru for local LTC
- 2) support Resolution 98-52
- 3) recognizing IHS assistance
- 4) Legislature should delegate rural LTC to Naha
 - 1) stop shopping
 - 2) measure effectiveness
 - 3) redirect Long. Care to senior services
 - 4) raise assisted living rate
 - continue grants for Sr Housing
 - increase education of assisted living

156 KP - aggressively doing that and welfare

3/A

170 CB \$ from Longevity Bonus is just not earned & available - its delusional

175 JR - do Leg phase just Long Bonus cuz too rapid growth its off \$ & over later co

184 DS lets keep it on list and discuss more

188 CB maybe discuss more DMH

200 AB

RECS on ACCESS TO LTC
consider leg to allow LTC for moderate income indiv

220 SHARON CLARK
did we address MHT unit & availability, & list MHT

224 CB our goal is to continue MHT & involvement

232 BILL HORMAN - yes

233 SC

241 KP long process - requires consensus to move from list
BH

3/A

256 CB DELIVERY OF LTC

267 JG ~~has~~ a menu of services sub Medics

~~the program~~ waiver prog pays more, & more

PCS

WHAVER ¹⁰

- home health, chrs, adult day care, & care coord, and living, etc

311 [JG any questions]

322 JG. POSS SACTIONS

- implement LAB report
- elim CON process or strengthen it
- app for Medicaid ^{1915B} waivers

361 JOHN SHERWOOD - Div of Finance??
1915Bs allow state to...

393 AE - great high range reimbursement attached to rural hospitals

402 CB \$10 asprin

407 KP - if we designed HC system for 600,000 should be 1 by loc
facility - having local facilities is not efficient

3/A

420 CB efficiency of state ~~to~~ efficiency

CB - were not gonna build NH facilities in village

437 JS 1915 B. person we don't have facilities now
that can take advantage

441 CB - too small, not now necessary

453 JS - is ———— gravelable now in AK?

455 JS - to very limited extent

468 CB might be good segue into...

474 KP

499 CB

KP

KP

there gonna be big demand for new NH beds

were done good job of implementing LAMP report
Pine

554 CB

is pressure for new beds from builders, or consumers?

555 KP

- from community

CB

want to make

580 DM - CONAF - Certificate of Need (CON)

just cutting # of NH beds doesn't necessarily cut costs.
- how do you provide more services in village before going to next step

TAPE 3A

TAPE 98-11, SIDE B

000 DM, continued

- 021 CB we don't want to force consumer choice - some P don't want to pay NH prices for longer services
- we're not gonna build another 'Huberman' in small community
- 036 KP - we won't see B15 NH in village, but will see some expansion of existing
- 038 CB how many local funds will off-road communities vote to pay to build?
- KP no one urban or rural, pay for NH by itself - (Medicare pays for much of it)
- 055 CB this has been fun conversation
- 060 AE Problems w/ not having
- we're now doing study of rates for acute living.
- rates not increased in 10 yrs - Sen. Miller's 1998 bill would double it
- 110 AE
- 115 KP
- 116 AE
- 117 CB Medicaid reimbursement
- 123 KP - Medicaid gives lots of \$ - 60% of it state split
- it est. mandate to provide SVCS to all comers

3/B

138 JS medical rates are diff for small bus...

147 KB were trying to streamline Medicaid payors

160 CB of consumer wants 1 stop shopping

161 KB

171 CB

179 AB

all pieces are intertwined - NH demand ~ lack of alternatives

193 CB

RECOMMENDATIONS

199 JS

Oregon has been working since 8/1

210 AB

① I recommend TF recommend extending cov more
lets delay that discussion until broader discussion of

CB

- its delayed ②

216 JS

② pre admission screen before admittance to NH

227 DM

part of reason for _____ is different services/names
we lack standard language, so need standard definitions

250 KB

MB

you've got a position paper
lets number _____

3/B

256 CB

SW

KP

We want someone to give us a lot
gatekeepers must decide — tell grandma she's
going into

268 CB

274 KP

285 KB

289 KP

JG

CB

293 KB

Care coordinators — state and contracted
were got flexible system

308 CB

how do you know cory relation between care coordinators
and gatekeepers

310 KB

318 ~~CB~~ SW — has Oregon

JG

322 KB

DM

CB

JG

CB

you
Indiana is leading state for pre-admission screening in LTC
rec; ~~pre~~ extend pre-admission screening to all LTC
and gatekeeping

3/B

336 AE

there's a prob - lack of info on LTB options
we need to inform med profs. as to home care alternatives

CB REC: improved communication as to options in care

353 KP sometimes going to NH is easiest option

355 CB were creating new options

362 SW Q
CB

369 KP - ~~don't~~ timing:

1) education ~~to~~ may need to be done

2) what when patient requests the gatekeeper's option

388 CB invited KB to sit @ table

396 JH if we contract out to care coordinators as gatekeepers...

429 CB if communication works, discharged P will know of options

434 KB pilot prog showed that
↓

465 KP

467 KB - if P have choice, they'll give least restrictive, expensive

476 JG. I'd like to move some lower level med NH residents
back into home community w/ other services

3/B

488 CB

- seems obvious to me

490 DG

CB

508 FP

there been effort on AK to pull part of NH care
we have rel high need for NH care, relative to L48, any
not many candidates (or options/alternatives like home care) for
home based care

531 DM

- FP is right - typical AK NH patient is different

575 CB

AK will prob choose from other states

582 AE

- Home & Care based system is designed for low-income
or soon to be poor people
- we must expand HCS resources

3/B

TAPE 98-12, SIDE A

607 CB

009 GW

told story on Pioneer Home budget

Why is PH in Dept of ADMIN

in 81 PH was pulled out of HSS cuz of dissatisfaction

I hope we can continue effort to consolidate PH into HSS
its to run services, not to try to save \$

4/A
034 CB

leading by example - 1 stop shopping
- it seems logical to co-locate

Today was simple - tomorrow we do funding

- ① Ireland -
- ② co pay - state/ireland
- ③ state = ind pays second-hand

[CB DEP 3.45 PM]

050

JACKI ORTELLI admin @ Penali Ctr

Free, looking @ how we could realign services to meet people's needs

105

108 AE

Understand desire to consolidate svcs
DIV. SR SVCS has expanded to provide $\approx$ 1 stop shopping for many svcs formerly under HSP

in Pbx

2
① not byre - why fix it?

② HSP has focus on children, & may ignore SR SVCS

4/A

131 KP

We have joint work plan
① state gives ADMIN SR & CS planning authority

Joint work plan entire ADMIN/HSR

176

we need program budget for this area

② Leg confers many activities all in 1 dept w/ having a program budget
consolidation of program

③ TF already has full plate

170 DM - state move to community based w/ brought growth of
SR & CS area
- Issue prob in how programs are managed differently for different
mar groups

consolidation should address consistent treatment
of different groups

200 ON - let's establish record of why/why not consolidate

207 KP - we go through this kind of thing
if we leave issues unresolved it'll prompt to gear up
to defend against consolidation - leads to them vs us,
it takes lots of energy & attention

4/A

228

2 callers on consolidation didn't help clarify

232 AB

HSS is big, multi-mission dept. - to all srsvcs, might need to cut other things out

246

J.O. - srsvcs is 1/2 of HMMIN, a big dept - you won't get automatic efficiency by consolidating

there are likely to be ways to improve srsvcs

263 JH

what problem prompted need/demand to consolidate

av - no prob - just question by TF - why do we provide LTC from two different departments

284 FP

~ Quality Assurance & M&E

"

licensing - maybe consolidate licensing, ^{GA} std of all dpts

296 DS

324 JR

big fish eat little fish - persistent consolidation consolidation would save admin costs

333 BW

Apologize in advance for stinky article last & thank you general

4/A

341 GW

REVIEW COST OF N^{EW} Program

360 RE

385 ME

looking @ CON ... we must look at cost, demand, balance
part of community plan is cost sensitivity
GW yes?

413 EUMER LIMSTRUM

CON program is simply stated a P63 15-21 in draft CON Bill
its not a tough test to meet

468 GW

whats FN?

470 EL

not sure what you have

482 KP

final impact expect

487 JR

- One had put up CON. preamble

market forces may lead to monopoly - loosening CON might
allow more competition

533 KP

583 JR

- computer market monopoly

KP

HC is not any elastic commodity

611 EUMER

community hospitals have NOT lost control



Alaska State Legislature

Long-Term Care Task Force

October 21 - 22, 1998 Meeting

NAME	MAILING ADDRESS (Please give full mailing address)			PHONE #	FAX #
	Street Address	City	Zip		
KATHERINE HAYES	16826 RIDDELL ST	Eagle River	AK 99577	696-1444	
MELISSA MITCHELL	ALZHEIMER'S ASSOC. 240 E TADUS #110		99503	561-3313	
Gary Mantzich	Dun Hdd Anch.			269-3611	
BILL HERMAN	AK Mental Health Trust 558 W 7th #1820	Anch	99501	269-7960	269-7966
Ken Johns	Box H Copper Center	AK	99573	822-5241	822-5247
Rick Solie	FMH/DC 1650 Cowles St. Fbks.	AK	99701	458-5300	458-5324
DEBRA L.W. JORDAN	PO Box 196604	Anch, AK	99519	Dept: UR/LM 562-2211 Ext 4069	261-4889
JEFF JESSEE	THE TRUST 550 W 7th Ave S. #1820		99501	269-7960	269-7966
Sue H Samet	Providence Horizon House 4041 Folger	Ala	99511	261-4140	261-4160
Pat Dooley	Many Conrad Center 9100 Centennial Drive	Ala	99504	269-3223	338-6789
Patrick Reinhart	SILC, 1016 W 6th Ave Suite 205	Anch AK	99501	269-3571	269-3633
Fran Purdy	OLTCO 3601 C #260	Anchorage	AK 99503	563-6393	561-3862
Valtjeunert	Alaska Commission on Aging			465-2200	465-4716
Ton Sherwood	DMA, Innman			465-5820	465-2200
Lisa Demer	Anchorage Daily News			257-4390	258-2157
Shue Ashman	Senior Housing Office			330-8460	
Sila Craig	1416 Birchwood	Anchorage	AK 99518	279-7878	258-3627
Katherine Alexander	ALSC, 1016 W 6th Ave Suite 205		99501	272-9431	
Rodman Wilson	361 Egavik Dr	Anch	99503	563-7010	563-7015

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

October 21 - 22, 1998 Meeting

LONG-TERM CARE TASK FORCE
October 22, 1998
9:12 a.m.

COMMITTEE CALENDAR

Continuation of October 21, 1998 worksession.

TAPE(S)

98-12, SIDE B
98-13, SIDES A & B
98-14, SIDES A & B
98-15, SIDES A & B
98-16, SIDE A

NOTE:

The meeting was recorded and handwritten log notes were taken. A copy of the tape(s) and log notes may be obtained by contacting the House Records Office at 130 Seward Street, Suite 211, Juneau, Alaska 99801-1182, (907) 465-2214, and after adjournment of the second session of the Twentieth Alaska State Legislature, in the Legislative Reference Library.

LONG TERM CARE TASK FORCE

10/21/98

TAPE 98-12, SIDE B

001 SW

004 JS Q support including is

005 DM clarification

012 JR

what does it cost to build NH

015 DM

there are RFD "Potential NH Bed Search 1998" in packet under

030 JR

035 KP

it'd be hard to build a new NH for \$1 mil

041 SW

JR

so do you want to eliminate Caf N. is well, not necessarily

048 JH

057 KP

there is no financial risk to build NH, any eventually

065 SW

KP

069 AE

well leave rec. to include 528 report recs.

080 KP

one leg binding another

4/B

087 JO

091 SW anything else on Cd Med - No
we'll have our recs. typed up for tomorrow

117 SW AND @ 4:36 pm

[REDACTED]

120 CB - recovered @ 9:12 am

139 KP we can't x for Medicaid payments
145 JR [too faint to hear]

159

163 CB

lets introduce rebar

JG rep goes apt

DM apt h Key Thelby

KP

SW

CB

JR

NE dep com 10 min

JH apt h Jan Miller - my apt s MZ Assn

DS comm. Commore s Ben Per

CB

4/B

180 JH

186 CB

JH

if we need to est. uniform screening definition.

195 CB

198 DM

- may uniform & common

200 CB

202 GW

so it works.,

CB

205 AE

CB

we tried it in past & couldn't get everyone to use it
est & encourage use of common definition

222 BL

Bill Bolton -

Rev Wicker HQ

Liz Tinsley AA by mgr

J Deane AK Commissioner on Agony

Steve Newman AHP

Pat Pooley - den nursing May Carmichael - geriatric

JS Sir Mark Gumbrell

Bill Herman AK MHT anchor

241 CB

on Funder

lets be creative

recognize \$500 mil budget gap

by asked to cut state spending

- we must find broad based support from public, or risk rejection from public

4/B

263 CB

for ex - Longevity Bonus \$ is not dedicated & avail for services
- how? individual buy-in
lets brainstorm

275 CB

DM

is it a given that we need more \$
[shares held NO]

CB

we spend $\approx$ \$70mm/yr on LTC in AK - projected
raise to \$200-300mm

300 JR

Want Economics 101

327

most prudent thing is to invest & use proceeds to pay
- some companies offer currency -
it doesn't seem practical to finance this

I don't cost of LTC will not rise
I agree w/ CB it should be paid

taxing & using PF are politically impossible in AK

- still require

349 KP

- as administrators: over last 4 yrs we've put lid on unit cost of serv
ex: Medicaid spendings been held flat, while about 8% inc in # of
eligible (old & disabled)
- NH been held flat
- community HC services is growing

we must consider resumption of medical inflation after a
period of flat growth

AKHC MICHM CPI 8%

4/B

397

We have saved what we can save

Medicaid now covers 9,000 MNT, & biggest HC LNS in AK
we have to find other revenues, private revenues

BUT - P don't want to buy LTC

398 CB

u

399 KP

New revenues — we are obligated to pay for the 8%
new people

— but maybe state should fund smaller services to
short of going to Medicare well

423 CB

AK's secret — we get more fed \$ than we pay

424 BN

— HC cost increases @ 3x fed, natural rate of payment

— it helps to compartmentalize service recipients

birth → many 30 yrs window

marriage → retirement 70

retirement → death 10

458 CB

our resolution SJR — mentioned annuity

we must have some kind of ownership

I hope it comes out that LTC is a personal responsibility

488 ME

referral to package tab: 'ALL FUNDING SARCOT' 901
Emergency Bonus Forecast report

531 ME

last page in tab 10/19 KB memo

4/B

~~is resident~~

TAPE 98-13, SIDE A

AE

- 003 JS - its just for Pover 65y
005 KP Shula may have
007 CB - What's SoAKs per capita cost for SRs vs
ME - SRs are 5% of AK pop - \$175 MIL of \$3.5 BIL
proportionate to

- 017 CB Old head ~\$6000/SR
ME 30,000 SR of \$175 pop
- must consider whether /capita SR benefits include SR
prop tax exemptions

- 026 CB - public will look @ overall benefits to SRs
028 DM - last 30 days of life are usually Medicare paid
CB - we need accurate picture of what we're spending

041 GW

042 AE

SSI - fed
food stamps - fed
60% Medicaid

051 GW

053 AE

DM

\$10 mm in PH dispo
of PHA \$30 mm \$20 mm in SF, \$10 mm in resident fee

5/A

057 CB

AE

CB

- we have to show we're using state funds fairly
almost \$70m of \$125m in SR over 10 Long bones
- must acknowledge.

073 CB

return to SOR 17 establishing LTCF

maybe we want to ~~just~~ limit our work to elderly LTC

084 DM

only one I remember as

085 CB

we could reach resolution to be as broad or narrow,
we want, the not just for PH

095 KB

- 'Seniors' will all soon be there, if not already
I suggest that LTC encompasses disabled as well as SR

107 JD

What is 'SR'?

117 DM

re SOR 17 dilemma - by segmenting into age groups, we set
up competition for \$ & resources.

- you can't segment services in small villages - doesn't
work on smaller scales, & sets up inappropriate barriers &
classifications

142 CB

is there value of dividing into age cohorts?

5/A

147 JH

maybe we could est ~~as~~ common facilities, even if the funding that follows patients comes from different sources

159

I make choices, and such choices carry ^{responsibilities} ~~consequences~~ - a village just can't justify full services

173 CB

resources

we can't have full services in every community, tho we may have really good 1st aid bit.

183 JH

maybe we can have a care ctr, if not a NH

190 KP

every community has a level, and a construct showing what's an appropriate level of SR res
- we don't have a prob w/ a NH in 200 pop village

200 CB

there'll always be political component to an
we've got a big challenge/loss

210 DM

There is a point @ which we can't force services any P
- we can provide NH-type care in-home, at more cost than
there'd be in an actual NH

224 CB

Choice brings need to choose

229 DM

- we're trying to be all things, so the cost #s won't go down

5/A

240 NE

if you require P to move to get svs, you may be forcing them to most costly facility, & why not ~~try~~ expand Pct

249 CB

NE

- only if the patient will accept the lower level of svs

CB

- 24 hr trained nursing care doesn't come cheap

258 DM

I'm not just advocating for NH (I used to work svs)
Homes NH 49 bed ct is 60% full & struggling, any 65% limit

282 SH

MPF - we have ability to drop age limit to 55%

290 CB

fed dur...

300 DG

Part of prob is we have no plan
if we can help P develop their own community plan for
services, they'll be more willing to buy into it & pay
for it

323 CB

- but I want huge variety of services

We don't know what 'it' is, but we've gotta find
a way to pay for it

- how do we account for growth

- do we force statewide participation

if we don't enforce any penalties, we're toothless

5/A

366 KP

2 times - individuals' responsibilities
community " "

we need to talk about applying portable benefits
if we can't talk about financing of our Medicare, which
applies to everyone over 65%

388 CB

we may be in gestation period

[CB DEP 10:20]

390 GW

introd TCF NEW ORLEANS trio AFCA

TB

TOM BURRIS: dir PR for Assoc	media interest
TOM SMITH dir leg policy/analysis	LTC ins
ROSE LESTER? SR Cong affairs director	leg issues

GW - gave me parameters of yr talk

430 TB

445 DM

GW

455 TOLD SMITH^T dir leg policy & analysis for Am H.C. Assn.
464 crisis is simple

1/20/80

494

Medicaid pays when you're broke

5/A

500

Medicare meets only MINIMUM LTC needs
critic - expanding needs -2030

530

Solutions?

motivate private sources to pay for LTC
wed like to enc personal responsibility by those w/ means to pay
how?

- incentives for P to buy LTC ins

(young 40-50 could pay couple 100\$/yr & take care of selves, but cost
rises fast as you age)

596

TAPE 98-13, SIDE B

000 Port ESTIMUL (RE) SECURE CARE

1 - pers responsibility, & return Medicaid to safety net

019

skilled nursing care is caring for P who have been in hospital
15 yrs or more

- but reimbursement rate doesn't cover cost

- there no incentives for either hospitals or NH to care for
those w/ high needs

036

- Congress \$1,500 cap (?)

049

Personal Resp

- Congress has passed laws to encourage it - tax incentives
allowing P to shelter assets & qualify for Medicaid

in 1986 Congress criminalized asset sheltering 'Granny Goes to Jail'
the P advising asset sheltering was liable to prosecution

5/B

068

Congress nullified
allowed states to take assets sheltered @ death
- in sum - Congress is trying, but
STATE LEVEL

- Alaska's efforts are encouraging - state LTC return enrollment
is high

- state, fed, private ^{WAS MEAN TO EDUCATE P}
40% of P think Medicaid will pay for LTC (AARP survey)

94

a) P need choices along a continuum of care
b) we need pers responsibility

098 SN

099

DM

Will Secure Care _____

102 TS

110 DM

117 TS

Secure Care - legislative reform (OASD)

4 Principles of Secure Care

1) move LTC from Medicaid to fed level & coord w/ Medicare

2) coord public & private financing (tax \$)

3) ^{ENCOURAGE} ~~discourage~~ more pers. responsibility & attention to LTC

4) move LTC into competitive marketplace

150 TS

also doing net

5/B

160 RE

- most controversial of scenarios is #1 - federalizing LTC - the impoverishment / Medicaid is cruel and inefficient

187 SW

pls turn down

189

Tan Bunde

I deal w/ media / public about "Looming Crisis"
P thinks Medicare will cover LTC

will head back of
medicaid system

- if we return Medicare to orig. intent, we won't head back

210

P's effort is to encourage financial planning

232

when you rely on Medicaid, you lose a lot of choice, dignity, health care options

SW

- Questions?

243 JR

concerned about momentum

247 TS?

we working on federalizing LTC (state → local)
effort in 1981 by Rand Stockman & Rich Gelbach

279 JR

SW

at dinner w/ devel, we long-handled you
What states are doing better

287 RE

- NY, CT - once P's LTC you report & they want 4 MEDICARE
still allowed some asset protection IN CA
HWA some states encourage private LTC INS

5/B

326 ON

do either of you know of Ctr for LTC Fin

TB

yes, led by Steve _____

348 TB

has reported by media

350 KP

- ^{in addition to Medicaid} AK has state-funded LTC program → PH - GFA.
pays for 1/2 of costs

- PH is blaming mm a source of misunderstanding

372

we don't get a good share from Medicaid; reimbursement
home care & Medicare? is better suited to big cities

385

* How do you deal w/ outlying areas like AK?

395 TB

AHCA is a 50 member association - were aware of variations
struggling to

411 RE

Dispute AK's small-state concerns
- we may see that federalizing isn't the answer, but
we wanted to start dialogue

- we started 1997, so our final plan may be different

462 KP

- the use of
→

5/B

States are just as exposed to "Hanny Gov to fail" as others

- we need to have alternate to helping/forcing people to improve
or to protect assets

488 TS enforcement

504 RE we don't intend to criticize states for going after Hanny
- have now number 1 for spending down a
- we'd rather convert to incentives & away from hammer

534 JR look to successful models - fed govt. is not successful

[11:15, KP DEP]

565 GW

566

578 DM in leg TF - will AHCA come up to AK to make presentation
if/when we take on legislation

599

5/B

TAPE 98-14, SIDE A

004 EN

006 DM

they talk confirm why we're here
I recommend...

030 JR it costs \$30 to act & \$15 check

6/A

034 DM

[denied] ~~or~~ not as expensive, under ~~the~~ result of Medicare now
reem

045 JH

What control does state have for changing Medicare? reg
its mov

050 DM

058 KB

maybe we need to be more specific about what kind of investment
personal investment I need to make

068 JH

- could we educate ARNs more about the costs of LTC
get out to them (such as that Medicare does NOT cover LTC)

112 SW

so, you ~~are~~ REC we inform them a cost, need & availability of
LTC

114 JH

126 DS

Disagree w/ JH
what are other states doing
I think doesn't fit all - ARNs have varied needs
we need to look @ real long-term

153

He is growth industry - maybe exp for BUSY
possible financing source is Federal Commission

168

SW

lets get back to schedule - don

179 DM

refl 'Medicare Present/Future' TAB

states share of Medicaid \$240,476,342 in 40% (~1962)

G/A

215 AB

a good chunk of Medicaid ^{out of the \$240 mn} is 100% ~~reimbursed~~ ^{not paid}

226 JS

230 DM

236 DM

2nd page is Medicare payments by area

SW

242 DM

- rec- coordinate benefits, & better integrate Medicare Medicaid

250 AE

- SRs' concern - willingness of doctors to provide Medicare services

263 DM

- leg could require _____

SW

DM penultimate 3 recs: ⁹ Medicare/Medicaid Coordination of Benefits

276 DM

1,2,3

SW

302 DM

310 JH

we could endorse parts of Secure Care we agree on
(exclude federalizing)

324 AE

- I agree - Oppose federalization, any HK would lose out if not based on
of MH beds

DM

- it'll(?) be notationally normal
lets act federalized, & approve other 3 principles

6/A

350 JH

354 JS

356 DM -

359 SW -

360 DM -

366 AE

369 SW

Wed be better off
do we rework graf - Janis
subject to #1 of w/m Col benefits

BA

What PACE?

381 DM

It's simplistic to say....

402 SW

Do we want to embody #1

AE

415 SW

- DM will type up a new page/graf

417 JH

Another avenue for... Community CTRs

434 DM

- you could require P to report # of P who see video
MHTA is possible funding source

451 AE

failure of advanced directives comes from provider's failure to
see if there are in effect

It's nice to encourage ADs

468 SW

before we get too formula ADs

6/A

473 AB

SW
115

Ans are great, but problems not w/ preparation

480 JH

How about the use of AOs

504 SW

offered modifications

514 ~~SW~~

SW

like w/ will, you ~~can't~~ ^{can} record AOs

→ AB OKP would like to talk about #10

we need to end @ 4:15 pm

RESUME @ 120

550

back @ 115

570

[1:34 pm RESUME]

SW refd PM rate survey

620 AB

6/A

TAPE 98-14, SIDE B

115

Mechanism for Alzheimer's is pot. fairly same

007 US

recovery more is focusing ~~RA~~ ALZHEIMER AZ

6B

013 JS

options on how to offer Medicaid coverage for --

057 JS

it would have the advantage of,

076 KP

have we done position paper... staff analyses

082 SW

is rec. formalized on P63

JS

Yes

SW

087 HE

were get need to see if it's good or bad idea

089 JG

was 1 of 2 states w/ strict definition

JS

only 2 states now allow --

095 JG

if we used functional definition it would

SW

should we start see on P67 of the "Federal LTC Funding"

100 JG

I would agree.

KP

before we do, I want input on cost..

103 KB

I bel it's a small number

120 JS

must assess impact on Pioneer Home

KP

staff analyses include

126 KB

that's why this needs to... soon task list

SW

comments?

137 DM

6B

- 141 JS when you offer waiver, offer chance to enter MS
- 148 DM to me they go hand in hand
- 147 JS all I asked for was clarification
- DM interest is given in HCB
- 150 JS takes us back to agreed-upon assessment tool
- 157 DM more inquiry & study on this would be a good 1st step
- 166 JD
- 173 JR I'm getting confused. We've got def. of MH care. We've been down fuzzy path of HCB. - less known, defined. True, we've ~~not~~ not defined it. 3-5 activities of daily living
- 182 JS Medicaid is now an all-or-nothing standard for LTC. Maybe we should broaden the range of qualifications
- 210 JR
- OR
- 214 KB I agree we're not defined...
- 219 GW REC - eliminate per
- 225 KP ① I don't know what timeline is. This will mean several million \$
- ② 10 source of funds - 10% whether analysis will include existing or
- 238 JH Is Karen saying...
- KP It'll cost more \$ to provide more services

6B

245 SW

Let's do Miller's Trust

254 JR

MILLER'S TRUST

this allows you to retain an interest, and get income, & can pass it along

AK recently passed laws allowing you to retain an "interest" but not a "right"

285 JS

It's essentially voluntary impoverishment

317 JR

Am not an atty -

330 SW

shall this group see, make recs. on Miller's Trust

JR

no

333

DM

it's only income based, not assets (?)

349 KP

the Legal Services memo on Miller's Trust,

376 JR

--- corpus

379 KP

whose reg are these

JS

ours

385

386

MARCIA ROY (Faint)

6/B

420 EN

well ship second ⁸page of blue agenda: State
Funding for Long

430 JR

NY Life proposed LTC ins program to Nevada, & asked
to give presentation on it

EN

RETD MEXICAN

453 KP

480 EN

KP

Is there...

[CB RET ~~11~~ 2:14 pm]

491 EN

JR

10 KP recs 'Molecular Present & Future'

BS 2 REC for
LCTF REC

498 DM

515 JR

519 DM

Ident think that's possible

529 JS -

KP

EN -

It also includes certification

DOVE

note FAX, RET MMT SV LIO on TCP

6/B

562

CYNTHIA HOWARD

MY LIFE LADY

611

I'm amazed by AK's innovation in est Pioneer Homes

TAPE 98-15, SIDE A

001

005 CB

006 CH

022 JH

asked CH to explain mao about LTC ins

~~023~~

030 CH

Kennedy / Hassebaum

041 CH

there's pending legislation
there's impetus to shift LTC responsibility to individuals - VIA INCENTIVES
in fed govt.
- problem is under 65 P who need LTC

084 JR

Did you see core of state employees as basis of coverage

CH

yes

083 JR

I'm old enough to need care soon (maybe) - Has NYC evaluated
state of this ins at how

7/A

002 CH

you could offer better service policy
- it was good for its time - but not high
enough coverage

105 CB

you're suggesting we host state any benefit of higher coverage

CH

No, ~~that's~~ what another state wants to do

121 CB

where can we get info on what it would cost.
premiums/p/nd

134 CH

w/ a state census, we could crunch #'s & tell you
but underwriting doesn't factor in geographic/location factors

\$350/yr active employees
\$1,300/yr retirees

146 AE

an Retirement Board is plans to renew LTC ins
any policy law
reimbursement

Deloitte & Touche actuaries
- I don't think LTC will become STD benefit, but maybe we
could offer it as part of Cafeteria plan (pre-tax payment
by employee)

167 CB

I was thinking...

7/A

172 AE

I suggest asking our benefit consultants what cost of LTC ins

-any ins plan anti-selection... - it'd cost more for those who choose LTC ins would pay more than if it was forced on everyone

185 CB

- I know.

or shall it be REC - enhance SBS to include LTC ins

196 - AE

if it's being investigated

KP

a pool

200 AE

now just looking @ state employees/retirees(?)

205 DM

209 CH

231 CB

Novak is considering mandatory ^{LTC} ins, ~~only~~ or Parent buying by choice we get caught in spiral

234 CH

ins. agents are trying to sell it to P who we don't buy it til we need it

242 DM

How contract re. What's industry put on using Medicare \$, m

7/A

255 CH

258 DM

Where will the \$ come from
we all pay it thru payroll deduction

266 JR

AK used to not require auto ins, only proof of
financial resps - we could use sim. plan a LTC INS

282 JH

- would MYLIFE be int. in offering LTC INS to all of AK
not just state workers

294 CH

Yes - cuz we've gotta look at all kinds of options

301 AE

- ~~we~~ public can go buy our LTC policy,

306 JH

- or for attractive

AE

- unless you make LTC ins mandatory, what would the
difference be?

JR

318 CB

not quite same

what kind of coercion do you use to market/encourage
purchase of LTC INS

- an annuity would have to be mandatory

360 JR

- any slides for encouragement

362 KP

- /

372 CH

CA is in "partnership" - 4 ins cos - whatever coverage you
buy in LTC is protected from spend-down for Medicaid coverage

7/A

406 KP

411 AE

AK would have to give PH
that part of resolution came from PH policy board
any they like LTC ins

422 CB

Tax benefits - state or fed?

423 CH

FBI -

I hope more P will buy LTC ins

CB

498 JR

CH

what's impact of AK's small population

507 JR

519

522 JR

will ask for industry projection of cost of LTC ins for AK

538 JH

AE

JH

554 CB

do we have demographics

yes

ANNUITY program
is available privately

557 CH

on conference call... book by Haley Gordon of MASS. on LTC

7/A
594 KP

something in my mind... So of AK does provide annuity
in form of Low Bow or Pioneer Home

how can we link personal responsibility to this benefit
\$30 mn LTC benefit

TAPE 98-15, SIDE B

CB But no one's paying into PH
.... poor farm or old folks home

006 DM

029 KP ~~the~~ In concern I will tell them it's ~~lose~~ leave AK
in 20 yrs we may not have as many seniors in AK
"Jobs here, good life here, dollars here"

040 CB Kennedy/Kanebaum
CH it must be portable

045 CB

051 CH Partnership...
054 CB it's have to be lifetime benefit (total)
CH what you Medicaid immediately
CB what incentive to protect yr legacy...

067 CB Can't
stick

086 CH It becomes educational mine

7/B

092 CB

185

anything you do to reduce cost to pool benefits whole pool

CB

103 CH

what if P move to Arkansas for cheaper treatment
ins policy pays costs

111 CH

112 JH

CB

DM

117 KP

was talking about P leaving

It would be bad for community
but not nec good for community

121 KP

if we could make annuity a program based benefit for
state residents (is not a portable benefit) how do we
make P trust that there'll be good PH care avail in future

133 EV

can you make that a recommendation

KP

not yet

136 DM

179 CH

EV

185 DM

tells of Frances Purdy

did hear rec to maintain PH @ competitive or

some will announce to compete w/ faculty running @
less than market cost

7/B

195 EN

AE

205 KP

why not say TF supports increasing PH fees to match cost of care
PH were created to have govt give home to reward those
who helped build AK

- I'd like a vision of how to help PH
do we want PH to be annuity for public, so we want
PH to be part of our LTC

230 CB

PH were created for old miners/trappers w/ no assets
so we've done great @ attracting & retaining elderly P

EW

244 JH

passed around sample of Traveler LTC INS
- buying LTC INS from comes great cost advantage over life
2002 PH

284 EW

- are you voicing support for public education

295 AE

Mandatory vs voluntary LTC INS - but - we are woefully
unprepared for retirement even as far as saving
- you've got to MANDATE

310 CH

P think of paying LTC INS out of income - better
try to find

320 EN

AE

can you put it in recommendation
- to me, the PFD is most ready way to pay
for LTC INS

330 JS

- mandatory LTC INS is the ~~best~~ ^{best} ~~way~~ ^{way}
cannot ~~put~~ ^{put} in the \$100 mm in state SP over and

7/B

343 CB

Agree w/ AE - ins should be mandatory, & require personal contribution

- may use state & in PF Earnings Reserve Act for state match

367 CB

Participation in LTC ins be mandatory
it includes the \$70 million

" " personal contribution

any add'l need comes from excess earnings of PF

380 JR

we must require P or PH to provide some proof of financial responsibility

EN

- put in a recommendation?

402 AE

- you can't require pers contrib under Medicaid rules

408 KP

Remember how important Medicaid is to others - we can't pull out of Medicaid program

JR

could require personal ins policy for admission to PH

AE

we require resident pay a PH to cover 1/2 of PH cost

438 KP

Why should people think/believe they had to pay for LTC ins when ~~PH is not paying~~ PH is sliding scale fee

JR

- P don't want to do what supposed to do unless there's a sanction

465 CB

we have to make it beneficial for P to

7/B

495 CH

496 CB

509 JH

532 Shannon McCoomy for (DS)

539 CB we should have rec. that there be a phase in
2 meetings are not enough

JH Jager

575 ON This mtg shows ~~need~~ difficulty of our task
staff will collect recommendations, write up draft
then mark it up for a ~~final~~ draft ^{prelim}

CB

ON Lets pull our calendars out
NOV. 18 9-5 Anch L10
maybe by TCF

- 027 JH - any final thoughts
 - AK has 1-800 # for retirees to get info on LTC that may be a bit disparaging on LTC
 - if P could learn more about this issue & want more info on LTC, maybe they could look to Aetna Life Underwriters Assn - to help educate public on how affordable LTC ins can be
- 060 AE - we never did get RFS on funding
 - we have to recognize that LTC costs will rise - & this must be part of the preface to any plan
- 071 CB
- 073 JR we have to run every 2 yrs (sorry for my absences)
 this prob may be overwhelming in 10-20 yrs
 I don't want to see level of acceptable medical practice degrade by moving toward HCB
 - P must be taught that P must pay for selves LTC
 - the Leg must pursue it, not just write report & put it on shelf

8/A

096 JS nother

099 DM - refd OCT 6 98 "Dean Parham" ltr by Alice J. Brown
in our final recs. ltr include educational track
- more named LTC providers in AR, the less we have
to pay for em

125 Certificate of Need

140 CB [CB DEP 407]

144 GW thanked commissioners
staff

AMJ @ 408m



Alaska State Legislature

Long-Term Care Task Force

October 21 - 22, 1998 Meeting

NAME	MAILING ADDRESS (Please give full mailing address)			PHONE #	FAX #
	Street Address	City	Zip		
Elizabeth Talbot	Alzheimer's Assn. 240 E Tudor Rd #110	Anchorage	AK 99503	521-3313	561-3315
STEVE ANMAN	Senior Housing Office			330-8460	
Gary Mandjich	DMHDP			269-3611	
Pat Dooley	May Convalescent Center 9100 Centennial Dr. Anch	AK	99502	269-3223	338-6789
Bill Ballou	600 3rd Street STE 197 FIDIS, AK		99501	452-7777	452-5828
Rodman Wilson	361 Egavik Dr anch		99503	563-7010	563-7015
BILL HERMAN	AK Mental Health Trust 550 W 7th #1820, Anch		99501	269-7962	269-7966
Kay Burrows	3600 C St Suite 310			269-3666	
EIA CRAIG	1416 Birchwood Anch		99508	279-2878	258-3627
Katherine Allevedese	ALSC, 1016 W 6th Ave, Ste 200		99501	272-9431	
Williamment	Alaska Commission on Aging			465-3200	465-4716
Lilo Berry	Circle of Care 3200 Prov. Drive		99576	261-4848	
Thelma P. Langdon	2363 Capt. Cook Dr Anch		99517		
DEBRA L.W. JORDAN	PROV AK MED CNT PO 196604 Anch		99519	563-3211 Ext 4069	261-4889

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

Long-Term Care Task Force Meeting
October 21-22, 1998

Personal Care Attendant Structure



INDEPENDENT LIVING CENTER

P.O. Box 2474 • Homer, Alaska 99603

Long Term Care Task Force Outline

HOMER

SELDOVIA

PORT GRAHAM

NANWALEK

ANCHOR POINT

NINILCHIK

CLAM GULCH

KASILOF

SOLDOTNA

KENAI

NIKISKI

STERLING

COOPER
LANDING

MOOSE PASS

SEWARD

HOPE

KODIAK
ISLAND

ALEUTIAN
CHAIN

Toll Free
1 (800) 770-7911
(V/TT)

Main Office
(907) 235-7911
(V/TT)
(907) 235-6236
(FAX)

Satellite Office
(907) 262-6333
(V/TT/FAX)

Assignment: Review the Personal Care Attendant and Home and Community Based Structure

Responsibility: Joyanna Geisler

I. Review and summarize existing relevant information

- A. Ladd Report
- B. LTC Plan Recommendations
- C. Info presented at first meeting
- D. MiCASA-HR 2020

II. Describe State of the State

A. Describe current status of Personal Care Services

- 1. Description
- 2. Populations who may use (e.g. elderly, children with disabilities, etc.)
- 3. Usual funding source and cost
- 4. Problem areas

B. Describe current status of Home and Community Based Services

- 1. Description of each
- 2. Populations who may use (e.g. elderly, etc.)
- 3. Usual funding source and cost
- 4. Problem areas

III. Possible Solutions

A. Research other states solutions (including sample legislation, additional funding sources, restructuring of systems)

**Faxed to: Representative Bunde's Office
Senator Wilken's Office**

Please distribute accordingly.

Post-it Fax Note	7671	Date	9/14/98	# of pages	2
To	Sheila	From	Joyanna		
Co./Dept		Co.			
Phone #		Phone #	235-7911		
Fax #	465-4714	Fax #	235-6236		

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION DIVISION OF SENIOR SERVICES

Adult Protective Services
Information & Referral
Assisted Living Licensing

Alaska Commission on Aging
CHOICE for the Elderly Home Care
Personal Care Attendant Program

Tony Knowles, Governor

CHOICES

3601 C Street, Suite 310
Anchorage, AK 99503-5984
Phone (907) 269-3666
1 (800) 478-9996
FAX (907) 269-3689

ANNOUNCEMENT

PCA Regulation Changes Effective October 21, 1998

The changes to the medicaid personal care program regulations (Article 16. Personal Care Services 7 AAC43.750 -795) have been approved and will become effective this month on October 21, 1998!

Enclosed is a copy of the current personal care attendant program regulations and a separate copy of the specific changes to those regulations that will become effective on October 21, 1998. The following is a summary of the changes that have been made to the personal care regulations:

- Increase the personal care service reimbursement rate for independent PCAs from the current \$9/hour to \$12/hour
- Increase the personal care service reimbursement rate for agencies from the current \$18/hour to \$21/hour
- Increase the maximum daily reimbursement rate for personal care services from the current \$150/day to \$200/day
- Eliminate the requirement for personal care services to be prescribed by a physician
- Allow personal care services to be provided by a qualified family member, except a spouse or parent of a minor child
- Allow personal care services to be provided in an assisted living home or a foster home regardless of size, unless the service is a duplication of the services being provided by the assisted living home or the foster home
- Prohibit a PCA from providing care to a client living in a foster home or an assisted living home if the PCA has a business or familial relationship with the owner or administrator of the foster home or the assisted living home
- Clarify that the Division of Medical Assistance can delegate authority to another entity (ie: DSS)
- Clarify that a member of the client's extended family may not develop a treatment plan or an assessment for the client
- Increase in the reimbursement rates for the independent registered nurse visits

If you have any questions about these changes in the personal care service regulations, please contact Susan Cook or Rik Stavale at the Division of Senior Services at 269-3666.

Register _____ 1991 HEALTH AND SOCIAL SERVICES

(Words underlined indicate language being added. Words [CAPITALIZED AND BRACKETED] indicate language being removed.)

ARTICLE 16. PERSONAL CARE SERVICES.

7 AAC 43.750(a), (b), (d), and (e) are amended to read:

7 AAC 43.750. PURPOSE AND SCOPE OF PERSONAL CARE ATTENDANT SERVICES. (a) The purpose of personal care attendant services is to enable an individual whose [MEDICAL] needs would otherwise require placement in an acute or long term care facility to remain safely in that individual's own home. A personal care attendant performs tasks [OF A NON-TECHNICAL MEDICAL NATURE] that assist an individual in following a plan of health [MEDICAL] care [PRESCRIBED BY A PHYSICIAN] and designed to improve or delay deterioration of an individual's physical health while enabling that individual to remain safely at home.

(b) Personal care attendant services that are provided to a recipient of Medicaid must be

(1) authorized by the division or the division's designee before service is provided in those cases that the division or the division's designee determines prior authorization is necessary;

(2) determined to be appropriate for the recipient, based on the assessment of the recipient's needs made under 7 AAC 43.765(a) or a later reassessment made under 7 AAC 43.780(a); and [PRESCRIBED BY A RECIPIENT'S PHYSICIAN AS MEDICALLY NECESSARY;]

(3) provided in accordance with the recipient's treatment plan by a person who is not a recipient's family member and who is a

These regs become effective 10/21/98.

Register _____ 1998 HEALTH AND SOCIAL SERVICES

(A) qualified personal care attendant who is independently enrolled under

7 AAC 43.772(d) [7 AAC 43.722];

(B) personal care attendant employed by a personal care agency enrolled

under 7 AAC 43.787; or

(C) person who is otherwise qualified under 7 AAC 43.771(c).

[7 AAC 43.790(c); AND

(4) PROVIDED UNDER CONDITIONS THAT ASSURE THAT ANY NEED
THE RECIPIENT MAY HAVE FOR SKILLED NURSING CARE IS PROVIDED BY
LICENSED MEDICAL PERSONNEL.]

....

(d) The division will, in its discretion, reimburse a personal care agency or an
independent personal care attendant for [THE FOLLOWING] services provided to a recipient in
accordance with the recipient's treatment plan, including [:]

.... (paragraphs (1) - (14) remain unchanged)

(e) In addition to the services described [IDENTIFIED] in (d) of this section, the division
or its designee will, in its discretion, reimburse for other services if those services are

(1) repealed / / [PRESCRIBED BY A PHYSICIAN];

(2) found by the supervising nurse to be beyond the capability of the recipient to
perform without assistance;

(3) within the capability of a qualified personal care attendant; and

Register _____ 199 _____ HEALTH AND SOCIAL SERVICE

(4) are not excluded under 7 AAC 43.755 or otherwise prohibited by state or federal law or applicable medical standards. (Eff. 11/6/86, Register 100; am 6/27/92, Register 122; readopt 8/7/96, Register 139; am ____/____/____, Register ____)

Authority: AS 47.05.010

AS 47.07.030

7 AAC 43.755(4) is amended to read:

(4) a task that the personal care agency, supervising nurse, or division determines

(A) could reasonably be performed by the recipient;

(B) is within the scope of service provided to the recipient as part of the residential services contract between the recipient and an assisted living home operator required under AS 47.33.210; or is the kind of task routinely provided to other residents of the assisted living home; or

(C) is within the scope of service provided to the recipient as part of a residential agreement between the division of family and youth services and a foster home operator under AS 47.14.100;

(Eff. 11/6/86, Register 100; am 6/27/92, Register 122; am ____/____/____, Register ____)

Authority: AS 47.05.010

AS 47.07.030

7 AAC 43.760(b)(4) is repealed:

(4) repealed ____/____/____.

Register _____ 199 HEALTH AND SOCIAL SERVICES

(Eff. 11/6/86, Register 100; am 6/27/92, Register 122; am 7/1/95, Register 134; readopt 8/7/96,

Register 139; am 3/1/98, Register 145; am ____/____/____, Register ____)

Authority: AS 47.05.010

AS 47.07.030

7 AAC 43.760(f) is amended to read:

(f) In this section, "personal residence" means the dwelling the recipient considers his or her established or principal home and to which, if absent, the recipient intends to return. A "personal residence" can be real or personal property, fixed or mobile, and located on land or water, provided that the living conditions are appropriate for the care of the recipient [PRESCRIBED BY THE PHYSICIAN], including adequate sanitary conditions for hand washing and waste disposal. "Personal residence" includes a foster home licensed under 7 AAC 50 and an assisted living home licensed under 7 AAC 75.

(Eff. 11/6/86, Register 100; am 6/27/92, Register 122; am 7/1/95, Register 134; readopt 8/7/96,

Register 139; am 3/1/98, Register 145; am ____/____/____, Register ____)

Authority: AS 47.05.010

AS 47.07.030

7 AAC 43.765(c) is amended to read:

(c) The supervising registered nurse or the employee of a personal care agency who develops the treatment plan or who performs the assessment under (b) of this section, may not be

(1) [(A)] a personal care attendant; or

Register _____ 1991 HEALTH AND SOCIAL SERVICES

(2) [(B)] a member of the recipient's extended family [RELATED TO THE RECIPIENT BY BLOOD OR MARRIAGE].

(Eff. 11/6/86, Register 100; am 6/27/92, Register 122; readopt 8/7/96, Register 139; am

____/____/____, Register _____)

Authority: AS 47.05.010

AS 47.07.030

7 AAC 43.770 is amended by adding a new subsection to read:

(b) In addition to meeting the requirements of (a) of this section, a personal care attendant who provides services to a recipient residing in a foster home licensed under 7 AAC 50 or an assisted living home licensed under 7 AAC 75 may not be in a contractual, business, or family relationship with the owner or administrator of the foster home or assisted living home.

(Eff. 11/6/86, Register 100; am 6/27/92, Register 122; readopt 8/7/96, Register 139; am

____/____/____, Register _____)

Authority: AS 47.05.010

AS 47.07.030

7 AAC 43.790(d) - (h) are amended to read:

....

(d) When a recipient's medical condition calls for a treatment plan that requires personal care attendant services for more than 8 hours per day or 56 hours per week, the treatment plan must be submitted to the division or its designee for approval. If the division approves a

09/16/98 WED 08:50 FAX

Register _____ 1991 HEALTH AND SOCIAL SERVICES

treatment plan that requires more than 8 hours per day or 56 hours per week, the division will reimburse the personal care agency or the independent personal care provider at the hourly rate provided for in this section or \$200 [\$150] per day, whichever is less.

(e) Reimbursement for an enrolled personal care agency's provision of personal care services may not exceed \$21 [\$18] per hour. This rate includes reimbursement for all nursing, personal care attendant, and administrative services rendered, including travel and telephone expenses. At least 50 percent of the annual total reimbursement made to an agency for personal care attendant services must be spent on compensation for personal care attendants.

(f) Reimbursement for an enrolled personal care agency's completion of an assessment and a treatment plan for a recipient, who has chosen to use the services of an independent personal care attendant, may not exceed \$250 [\$50] for both the assessment and the treatment plan.

(g) Reimbursement for the services of an enrolled independent personal care attendant may not exceed \$12 [\$9] per hour. This rate includes compensation for all costs the independent personal care attendant incurs as a self-employed contractor, including federal and state taxes and contributions, social security, unemployment insurance, and worker's compensation.

(h) Reimbursement for the services provided by an independently-enrolled registered nurse who supervises the treatment plan of a recipient who uses an independent personal care attendant may not exceed \$50 [\$25] for each visit to a recipient's personal residence, if that residence is in the nurse's home community. If the residence is outside of the nurse's home community, reimbursement will be determined by applying an hourly rate of \$50 to the actual time required for travel and the client visit or \$200, whichever is less (MAY NOT EXCEED

09/16/98 WED 08:50 FAX

Register _____ 1998 HEALTH AND SOCIAL SERVICES.

\$35]. The division will not reimburse for more than one visit in any 60-day period. For the purposes of this subsection, a supervising registered nurse shall declare at the time of enrollment the location of that nurse's "home community."

....

(Eff. 11/6/86, Register 100; am 6/27/92, Register 122; am 7/1/95, Register 134; readopt 8/7/96,

Register 139; am 3/1/98, Register 145; am ____/____/____, Register ____)

Authority: AS 47.05.010

AS 47.07.030

7 AAC 43.795(3) is amended and a new paragraph (4) is added to read:

(3) "recipient's extended family" ["RECIPIENT'S FAMILY"] means the parent, spouse, child, grandparent, or grandchild of the recipient; [.]

(4) "recipient's family member" means a legally responsible relative, including a recipient's spouse, a minor recipient's parent, or a relative with a duty to support the recipient under Alaska law. (Eff. 6/27/92, Register 122; readopt 8/7/96, Register 139; am ____/____/____, Register ____)

Authority: AS 47.05.010

AS 47.07.030

_____ BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - FIRST SESSION

BY THE _____ RULES COMMITTEE BY REQUEST OF THE GOVERNOR

Introduced:

Referred:

A BILL

FOR AN ACT ENTITLED

1 "An Act establishing an in-home and community-based services program for certain
2 adults with long-term care needs; relating to personal care services under AS 47.07;
3 and providing for an effective date."

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

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

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

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

13 (3) expanding the availability of in-home or community support services would
14 allow these adults to maintain their independence longer, maximize the adult's or family's

1 resources to provide essential care and perhaps avoid or reduce state expenditures for care, and
2 avoid potential emotional and social problems that sometimes result from an adult having to
3 relocate to an institution many hundreds of miles away from family or friends;

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

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

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

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

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

18 (3) encourage a variety of agencies, facilities, and individuals to provide in-home
19 and community support services in this state.

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

21 **Article 2. In-Home and Community-Based Services Program for Elderly and**
22 **Physically or Cognitively Impaired Adults.**

23 **Sec. 47.24.200. In-home and community-based services program for elderly**
24 **and physically or cognitively impaired adults.** (a) There is created in the department
25 a program to administer and coordinate, deliver services, and award grants or contracts
26 for in-home and community services for adults eligible for services under AS 47.24.200 -
27 47.24.290.

28 (b) The program may serve only the adults eligible for the program. The program
29 may not replace or augment state-administered programs for in-home and community
30 support services for adults described in AS 47.24.205(b). The expenditures of this
31 program may not exceed the appropriations available for its purposes.

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

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

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

(2) the adult's need for services is because of a physical, medical, or cognitive functional impairment;

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

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

(b) The department may not consider an adult with any of the following illnesses, impairments, or disorders as eligible for the program:

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

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

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

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

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

(1) is at risk of being or already has been placed in a setting providing services that is more restrictive than is necessary to meet the adult's needs or more restrictive than the adult needs or would choose;

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

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

(4) has no insurance or third-party payor resource available to pay for the

care; and

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

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

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

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

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

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

(d) The department may use demonstration projects to test new approaches to in-

1 home and community support services in limited areas in the state.

2 **Sec. 47.24.225. Responsibilities.** (a) An adult receiving services under the
3 program has a responsibility to contribute a co-payment towards the cost of care and to
4 apply for, to cooperate with, and to seek payment from other sources required by the
5 department for which the adult is eligible for the same services.

6 (b) The department shall establish in regulation a schedule for co-payments under
7 this section. The schedule must vary on a sliding scale based on

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

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

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

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

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

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

25 **Sec. 47.24.235. Comprehensive data system.** The department shall develop and
26 implement a comprehensive data system that tracks in-home and community services,
27 expenditures, services, consumer profiles, and consumer preferences. The department
28 shall seek to coordinate and to share data with other state and local agencies or
29 organizations.

30 **Sec. 47.24.240. Assessment and care coordination services.** The department
31 may implement a system of long-term care assessment and care coordination to minimize

administrative costs, improve access to appropriate services, and minimize obstacles to the delivery of in-home and community-based care services to adults eligible for services under the program.

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

Sec. 47.24.290. Definitions. In AS 47.24.200 - 47.24.290, unless the context otherwise requires,

(1) "department" means the Department of Administration;

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

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

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

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

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

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

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

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

(b) The department shall adopt regulations identifying actions that it will take, in addition to those otherwise required under AS 47.17 and AS 47.24.010 - 47.24.130 [AS 47.24], when a report of harm is made under AS 47.17 or AS 47.24.010 [AS 47.24] that might relate to harm caused by actions or inactions of a public home care provider. The regulations must

(1) address circumstances under which the department will, or will require

1 a contractor or grantee to, reassign, suspend, or terminate a person alleged to have
2 perpetrated harm; and

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

6 * Sec. 5. AS 47.07.900(15) is amended to read:

7 (15) "personal care services in a recipient's home" means services
8 authorized under a service plan in accordance with applicable federal and state law
9 [PRESCRIBED BY A PHYSICIAN IN ACCORDANCE WITH THE RECIPIENT'S
10 PLAN OF TREATMENT AND PROVIDED BY AN INDIVIDUAL WHO IS

11 (A) QUALIFIED TO PROVIDE THE SERVICES;

12 (B) SUPERVISED BY A REGISTERED NURSE; AND

13 (C) NOT A MEMBER OF THE RECIPIENT'S FAMILY];

14 * Sec. 6. AS 47.24.011 is amended to read:

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

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

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

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

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

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

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

1 services;

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

3 and

4 (8) adopt regulations to carry out the purposes of AS 47.24.010 -
5 47.24.130 [THIS CHAPTER].

6 * Sec. 7. AS 47.24.050(a) is amended to read:

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

16 * Sec. 8. AS 47.24.070 is amended to read:

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

21 * Sec. 9. AS 47.24.130 is amended to read:

22 **Sec. 47.24.130. Treatment through spiritual means.** Nothing in
23 AS 47.24.010 - 47.24.130 [THIS CHAPTER] may [NOT] be construed to mean that a
24 person is abused, neglected, self-neglected, vulnerable, unable to consent, abandoned,
25 exploited, or in need of emergency or protective services for the sole reason that the
26 person relies on or is being furnished treatment by spiritual means through prayer alone
27 in accordance with the tenets and practices of a church or religious denomination of which
28 the person is a member or adherent, provided that the person consents to the treatment
29 through spiritual means only and the treatment is administered by an accredited
30 practitioner of the church or religious denomination. In this section, "church or religious
31 denomination" has the meaning given to "religious organization" in AS 05.15.210.

DRAFT

DRAFT - DEPARTMENT OF LAW

DRAFT

1

* Sec. 10. This Act takes effect immediately under AS 01.10.070(c).

Vulnerable Adults

Possible legislation relating to
vulnerable adults —

15 * Sec. 3. AS 47.24.015(c) is amended to read:

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

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

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

31 * Sec. 4. AS 47.24.019(a) is amended to read:

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

7 * Sec. 5. AS 47.24.019(c) is amended to read:

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

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

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

29 * Sec. 7. TRANSITION. The departments affected by this Act may proceed to adopt
30 regulations necessary to implement this Act. Regulations to implement a provision of this Act
31 take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date

1 of sec. 2 of this Act.

2 * Sec. 8. Section 7 of this Act takes effect immediately under AS 01.10.070(c).

Urban & Rural LTC Services

ALASKA FEDERATION OF NATIVES, INC.

1998 ANNUAL CONVENTION

RESOLUTION NO. 98-59

TITLE: IN SUPPORT OF ELDER CARE FACILITIES IN RURAL ALASKA

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

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

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

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

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

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

SUBMITTED BY: St. Mary's Native Corporation

COMMITTEE RECOMMENDATION: DO PASS

CONVENTION ACTION:

Passed

Issue Brief: Universal (Long-Term) Care Plan Counseling

Definition: Care plan counseling is the service of informing people who are entering or considering entering the long-term care system of their care options, including information on available financial resources. The objective of care plan counseling is to help individuals find an appropriate long-term care setting of their choice and to find ways for people to live in their homes and stay in their communities longer.

Findings:

Care plan counseling is not currently available to all Alaskans who are entering the long-term care system. Since the inception of the Medicaid waiver programs, eligible Alaskans have begun receiving more uniform information about their options.

However, non-Medicaid eligible Alaskans who are being discharged from hospitals are not receiving the adequate and consistent information, and as a result, some have been placed in nursing homes without understanding their choices. Others are not necessarily receiving the services of their choice, or in the location of their choice.

A significant part of the problem is that the range of long-term care alternatives found in the lower 48 are not available in most Alaskan communities.

Considering the experience of other states, care plan counseling for all Alaskans, including non-Medicaid eligible Alaskans, will in the long-run save the state money. Care plan counseling will keep Alaskans from prematurely entering nursing homes thereby prolonging the time in which they spend down their own resources and become Medicaid eligible.

Alaska's home and community based services system for the elderly is so new that many still do not know what services are available.

Alternatives/Impacts and Costs:

Two states, Indiana and Oregon, are leaders in care plan counseling (which they refer to preadmission screening) because as a result of state laws, nearly all individuals entering the long-term care system are informed of their care alternatives.

In Indiana, state law requires that before an individual can be placed in a nursing facility, they must first be screened to determine if they meet the state's criteria for nursing facility placement. A part of the state's preadmission screening process, which is required for both Medicaid-eligible and private pay patients, is to ascertain whether alternative services are available in the community that would be more appropriate than care in a nursing facility (and not more expensive than the cost of a nursing facility). A part of the comprehensive, individualized plan of care is a cost comparison between the alternatives services. Individuals who are not prescreened lose their eligibility for Medicaid reimbursement for nursing facility care for up to one year.

In Indiana, the Area Agencies on Aging (AAA) act as the designated preadmission screening agenciesⁱ. The Medicaid agency pays for all of the preadmission screenings, reimbursing the AAAs \$15 for a Level I screeningⁱⁱ, \$140 for a Level II screeningⁱⁱⁱ, and \$132 for the state-required Medicaid preadmission screening^{iv}. These agencies have worked diligently with hospital discharge planners in their state to make the process work.

Indiana enacted its preadmission screening law in 1983. Both the hospitals and nursing homes fought its enactment, however, with more than 97 percent of individuals that enter nursing homes becoming eligible for Medicaid within one year, the law was essential to controlling Medicaid expenditures.

Oregon requires a preadmission assessment (their form of care plan counseling) to insure that non-Medicaid eligible individuals applying for or considering admission to a Medicaid certified facility receive information regarding appropriate services and placement alternatives.

The persuasive arguments used to get the Oregon law enacted were twofold, to control Medicaid expenditures and to provide residents with an important customer service. Preadmission assessments in Oregon are conducted by an array of private entities under the supervision of the Area Agencies on Aging and are paid approximately \$170 for each assessment^v.

Recommendation:

The purpose of universal care plan counseling is to educate Alaskans about their long-term care options. Alaska should evaluate a phased-in universal care plan counseling requirement for (all) Alaskans entering the long-term care system, regardless of their ability to pay.

A first step is to estimate the potential demand for care plan counseling and the cost of providing this service. A second step is to estimate the capacity requirements for long-term care services resulting from a universal care plan counseling requirement, and to work with existing agencies in developing a plan for meeting the demand. The evaluation should include a comparison of the cost of providing universal care plan counseling with long-term cost avoidance, particularly for the Medicaid program.

Implementation will necessitate streamlining the current set of required assessments as well as improving the standards for and training of care plan coordinators.

^v The Community Mental Health Centers and Bureau of Developmental Disability Services office also serve as designated preadmission screening agencies.

ⁱⁱ Level I screenings are done on all nursing facility patients regardless of the method of payment (that is, both Medicaid and non-Medicaid individuals). HCFA requires all states to complete Level I screenings, referred to as the Preadmission Screening and Annual Resident Review (PASARR).

ⁱⁱⁱ Level II screenings are required for those applicants identified through the level I screen as possibly mentally ill (MI) or mentally retarded (MR). This screen applies to all MI/MR individuals, regardless of whether or not the individuals are on Medicaid. HCFA requires all states to complete Level II screenings, referred to as the Preadmission Screening and Annual Resident Review (PASARR).

^{iv} Medicaid preadmission screenings are completed on all non-Medicaid (except MI/MR patients, see Level II) and Medicaid recipients applying for admission to nursing facilities or Medicaid home and community based waiver services.

* Preadmission assessment workers are required to pay a certification fee based on the volume of assessments completed. One exception to this payment is when a patient is being discharged from a hospital. In these cases, no payment for the preadmission assessment is made.

Governor's Council on Disabilities and Special Education
Creating change that improves the lives of people with disabilities.

**A Study of the Impact of
Deinstitutionalization
on the Former Residents of
Harborview Developmental Center
*August, 1998***



Department of Health and Social Services
Karen Perdue, Commissioner

Governor's Council on Disabilities and Special Education
Kris Johnston, Chair

Executive Summary

Since its formation in the late 1970's, the Governor's Council on Disabilities and Special Education advocated for the transfer of people living at Harborview Developmental Center to community programs. The Council and other advocates maintained that community services cost less than institutional care, the quality of life of people is better in the community, and the community based services system had the resources to provide support to Harborview residents. Now that Harborview has closed, the Council is conducting a study to determine whether the closure was in the best interest of the people who were living there.

The Harborview Study included interviews with former residents, a survey of family members and guardians, interviews with key informants, and an analysis of the economic impact of the transfer of Harborview Developmental Center residents to community programs. Major findings were:

- Between 1961, when Harborview opened, and 1997 when it closed, 344 people were admitted to the facility. The population at Harborview reached its peak in 1972 when 130 people lived there.
- Former residents, families/guardians and community service providers felt that the Division of Mental Health and Developmental Disabilities provided adequate support during the transition of Harborview residents to community programs. Former residents reported (77.8%) that they felt that their needs and wants were considered during the transition from HDC. All of the family members and guardians (100%) responding to the survey said that their views were considered during the transition process.
- While many family members or guardians were initially skeptical, most are now pleased with their family member's new lifestyle and the positive changes they have seen.
- Former residents and their guardians rated the former residents' quality of life highly in most areas. Areas that are problematic are employment and integration into the community.
- Former residents and guardians reported that community based services are meeting their wants and needs. Employment services are the greatest need. Most of former residents (77.8%) do not have jobs.
- The cost of care in the community (\$94,878, including Adult Public Assistance and Food Stamps) is significantly less than the costs at Harborview (\$164,000). The net saving equals \$69,122 per person.

The study also identified a number of system's issues:

- Most (77.3%) of the former HDC residents do not have jobs. Many others in community programs are also waiting for supported employment services. Without additional resources for employment services, this will continue to be an issue.
- There is still work to be done in providing consumers with real choices and integrating them into their communities. These are values that are widely held by community programs. They are also the values that are most difficult attain. While it is clear that programs are getting former residents out into the community, the challenge will be to support consumers in establishing individual relationships.
- Staff turnover negatively impacts family and guardian confidence in community services. Low wages and lack of benefits cause high turnover and a perceived lack of consistent and professional care.

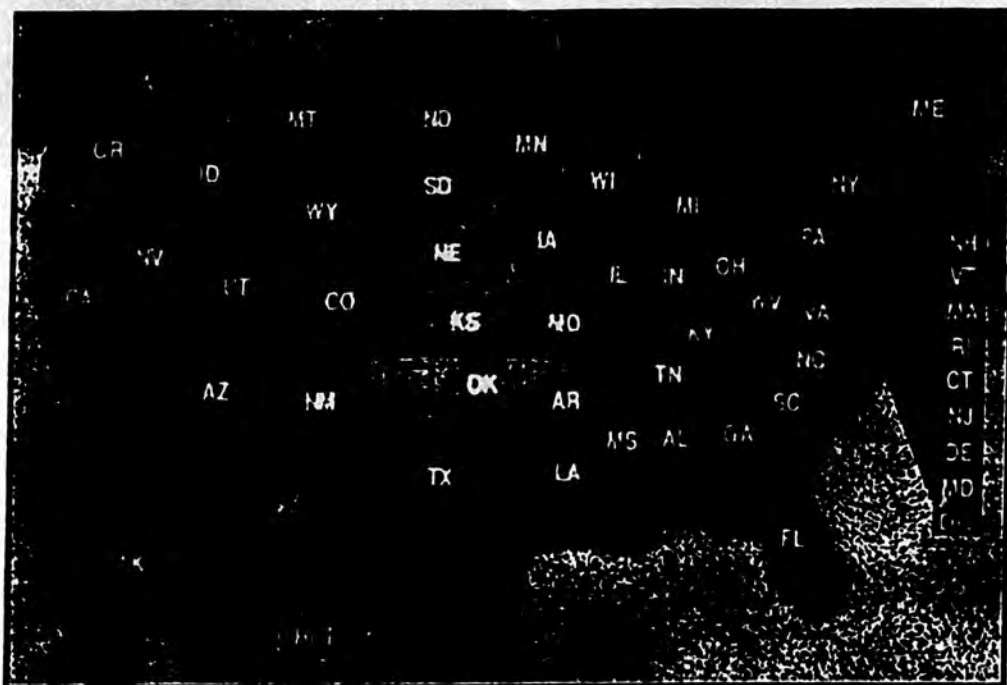
Administration On Aging



State LTC Profiles Report

In 1995 AoA sponsored the development of a report titled "State LTC Profiles Report." Drawn mainly from public data sources, this report contains brief descriptions of each State's progress in developing their systems of home and community based services for the elderly within their long term care systems.

Please click on any state to view a profile.



The report was written by Richard C. Ladd, Robert L. Kane, Rosalie A. Kane, and Wendy J. Nielsen, under the auspices of the National LTC Mentoring Program at the Institute for Health Services Research, School of Public Health, University of Minnesota. The State profiles are based on the following 25 data tables:

Provided by Rep. Ryan

Table 1: Age 85+ Growth Rate	Table 2: Pct. of Pop 85+
Table 3: 65+ Living Alone	Table 4: 65+ Minority Pct.
Table 5: 65+ Disabled Pct.	Table 6: 65+ in Poverty
Table 7: 65+ Receiving Medicaid	Table 8: 18-64 Disabled Per 1000
Table 9: Nursing Home Beds	Table 10: Nursing Home Occupancy
Table 11: NH Residents by 65+ Pop.	Table 12: Nursing Home Use 1980-90
Table 13: Nursing Home Acuity Rates	Table 14: Medicaid Cost per Day
Table 15: NH Expenditures 1980-90	Table 16: NH Expenditures per 65+
Table 17: HCBS Expenditures per 65+	Table 18: HCBS Percent of Total LTC
Table 19: Demand for Long Term Care	Table 20: Demand for Public LTC
Table 21: State Control of NH Use	Table 22: State Control of NH Cost
Table 23: Commitment to HCB Services	Table 24: Progress Toward HCBS System
Table 25: State Summaries	

To order a copy of the "State LTC Profiles Report," please send a check made payable to the University of Minnesota in the amount of \$25.00 to:

National LTC Mentoring Program
University of Minnesota
School of Public Health
Box 197 Mayo
420 Delaware Street SE
Minneapolis, MN 55455

 [Back to AoA Home Page](#)

HTML conversions by Dave Bunoski, AoA

Administration On Aging



Alaska

MEASURE	RATE	OBSERVATIONS
Potential Demand on the Total LTC System	LOW	Rated lowest in the country for percentage of total population age 85+; however, the growth rate for this age group is the 2nd highest. Percentage of elderly who live alone is very low, while the percentage who are minorities is very high. Prevalence of severe disabilities among the elderly is very low.
Potential Demand on the Public LTC System	LOW	Rated 3rd lowest for percentage of elderly with incomes below poverty level; however, a high percentage of elderly receive Medicaid. Prevalence of severe disabilities among persons age 18-64 is low.
Control of Nursing Home Utilization	ABOVE AVERAGE	Nursing home bed supply (per 1000 age 85+) is highest in the nation. Nursing home occupancy is 2nd lowest in the nation, while resident acuity levels are very high. Very low percentage of elderly reside in nursing homes. Growth rate for nursing home utilization during the 1980s was low.
Control of Nursing Home Expenditures	WELL BELOW AVERAGE	Medicaid nursing home costs per day are the highest in the nation. Amount spent on nursing home care per person age 65+ is 2nd highest in the nation. Growth rate for nursing home expenditures during the 1980s was low.
Commitment to HCBS	HIGH	Amount spent on HCBS per person age 65+ is very high. HCBS expenditures constitute a high percentage of total LTC expenditures.
Progress Toward an HCBS System	AVERAGE	Ranked 26th highest overall.

COMMENTS

Overall, Alaska has a rating of "average" for its progress toward an HCBS system. Alaska is probably unlike any other state in the nation. It has relatively few elderly and a low demand on LTC services. However, the vast areas of the state make delivery of LTC services difficult. The state appears to be moving in the right direction by shifting persons away from nursing home care and toward home and community-based care. With the second highest growth rate of persons age 85+ in the country, Alaska needs to plan carefully for LTC.



Population Growth: Age 85+

TABLE 1. 1983-1993 Age 85+ Growth Rate

STATE	% GROWTH	SCORE	RATING	RANK
NEVADA	111.30%	3.67	VERY HIGH	1
ALASKA	104.5	3.33	VERY HIGH	2
ARIZONA	85.2	2.36	VERY HIGH	3
FLORIDA	71	1.65	VERY HIGH	4
HAWAII	71	1.65	VERY HIGH	4
NEW MEXICO	60.9	1.15	VERY HIGH	6
UTAH	57.8	0.99	VERY HIGH	7
NORTH CAROLINA	51.4	0.67	HIGH	8
SOUTH CAROLINA	49.1	0.56	HIGH	9
TEXAS	46.1	0.41	HIGH	10
GEORGIA	44.9	0.35	HIGH	11
IDAHO	42.9	0.25	AVERAGE	12
ALABAMA	41.9	0.2	AVERAGE	13
NORTH DAKOTA	40.9	0.15	AVERAGE	14
TENNESSEE	40.3	0.12	AVERAGE	15
VIRGINIA	39.3	0.07	AVERAGE	16
MARYLAND	36.3	-0.08	AVERAGE	17
NEW HAMPSHIRE	36	-0.1	AVERAGE	18
COLORADO	35.3	-0.13	AVERAGE	19
LOUISIANA	35.1	-0.14	AVERAGE	20
OREGON	34.7	-0.16	AVERAGE	21
WASHINGTON	34.5	-0.17	AVERAGE	22
DELAWARE	34.4	-0.18	AVERAGE	23
ARKANSAS	34.3	-0.18	AVERAGE	24
MISSISSIPPI	33.5	-0.22	AVERAGE	25
KENTUCKY	32.7	-0.26	LOW	26
OKLAHOMA	32.4	-0.28	LOW	27
MISSOURI	32.1	-0.29	LOW	28
CALIFORNIA	32.1	-0.29	LOW	28
INDIANA	29.6	-0.42	LOW	30

PENNSYLVANIA	29.1	-0.44	LOW	31
MICHIGAN	28.4	-0.48	LOW	32
WISCONSIN	28.1	-0.49	LOW	33
WEST VIRGINIA	28	-0.5	LOW	34
WYOMING	27.9	-0.5	LOW	35
CONNECTICUT	27.5	-0.52	LOW	36
MONTANA	27.3	-0.53	LOW	37
OHIO	26.2	-0.59	LOW	38
NEW JERSEY	26	-0.6	LOW	39
ILLINOIS	25.5	-0.62	LOW	40
KANSAS	25.2	-0.64	LOW	41
VERMONT	24	-0.7	LOW	42
RHODE ISLAND	23.2	-0.74	LOW	43
MINNESOTA	23.1	-0.74	LOW	44
MAINE	21.7	-0.81	LOW	45
SOUTH DAKOTA	20.7	-0.86	VERY LOW	46
NEBRASKA	20	-0.9	VERY LOW	47
NEW YORK	20	-0.9	VERY LOW	47
MASSACHUSETTS	18.6	-0.97	VERY LOW	49
IOWA	17.2	-1.04	VERY LOW	50
DIST. OF COLUMBIA	14.5	-1.17	VERY LOW	51
TOTAL U.S.	33.80%			

Source: American Association of Retired Persons, State Data and Ranking, 1994.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

Go to Table 2 **Return to U.S. Map**



Percentage of Population Age 85 or Older

TABLE 2. 1992 Age 85+ Population as a Percentage of the Total Population

STATE	% OF POP.	SCORE	RATING	RANK
IOWA	2.03%	2.15	VERY HIGH	1
SOUTH DAKOTA	1.97	1.97	VERY HIGH	2
NORTH DAKOTA	1.89	1.73	VERY HIGH	3
NEBRASKA	1.87	1.68	VERY HIGH	4
KANSAS	1.74	1.29	VERY HIGH	5
FLORIDA	1.72	1.24	VERY HIGH	6
MISSOURI	1.66	1.06	VERY HIGH	7
RHODE ISLAND	1.59	0.85	VERY HIGH	8
MASSACHUSETTS	1.58	0.82	HIGH	9
MINNESOTA	1.58	0.82	HIGH	9
WISCONSIN	1.56	0.77	HIGH	11
MAINE	1.54	0.71	HIGH	12
ARKANSAS	1.54	0.71	HIGH	12
PENNSYLVANIA	1.51	0.62	HIGH	14
CONNECTICUT	1.49	0.56	HIGH	15
OKLAHOMA	1.49	0.56	HIGH	15
WEST VIRGINIA	1.49	0.56	HIGH	15
OREGON	1.41	0.33	HIGH	18
VERMONT	1.4	0.3	HIGH	19
NEW YORK	1.39	0.27	HIGH	20
DIST. OF COLUMBIA	1.36	0.18	AVERAGE	21
MONTANA	1.33	0.09	AVERAGE	22
KENTUCKY	1.33	0.09	AVERAGE	22
OHIO	1.33	0.09	AVERAGE	22
ILLINOIS	1.32	0.06	AVERAGE	25
INDIANA	1.32	0.06	AVERAGE	25
MISSISSIPPI	1.3	0	AVERAGE	27
NEW JERSEY	1.27	-0.09	AVERAGE	28
NEW HAMPSHIRE	1.26	-0.12	AVERAGE	29
ALABAMA	1.26	-0.12	AVERAGE	29

TENNESSEE	1.25	-0.14	AVERAGE	31
IDAHO	1.22	-0.23	AVERAGE	32
MICHIGAN	1.2	-0.29	LOW	33
WASHINGTON	1.17	-0.38	LOW	34
DELAWARE	1.16	-0.41	LOW	35
ARIZONA	1.12	-0.53	LOW	36
NORTH CAROLINA	1.11	-0.56	LOW	37
WYOMING	1.07	-0.67	LOW	38
LOUISIANA	1.05	-0.73	LOW	39
CALIFORNIA	1.01	-0.85	VERY LOW	40
COLORADO	1.01	-0.85	VERY LOW	40
NEW MEXICO	1.01	-0.85	VERY LOW	40
TEXAS	1.01	-0.85	VERY LOW	40
VIRGINIA	1	-0.88	VERY LOW	44
HAWAII	0.95	-1.03	VERY LOW	45
SOUTH CAROLINA	0.94	-1.05	VERY LOW	46
GEORGIA	0.92	-1.11	VERY LOW	47
MARYLAND	0.85	-1.32	VERY LOW	48
UTAH	0.83	-1.38	VERY LOW	49
NEVADA	0.68	-1.82	VERY LOW	50
ALASKA	0.25	-3.08	VERY LOW	51
UNITED STATES	1.28			

Source: Derived from the population estimates in Infrastructure of Home and Community Based Services for the Functionally Impaired Elderly. State Source Book. U.S. Administration on Aging, 1995.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

☐ [Go to Table 3](#)
☐ [Return to U.S. Map](#)

Administration On Aging



Percentage of Elderly Living Alone

TABLE 3. 1992 Percentage of Age 65+ Population Living Alone

STATE	AGE 65+ %			
	LIV. ALONE	SCORE	RATING	RANK
DIST. OF COLUMBIA	35.00%	2.48	VERY HIGH	1
WEST VIRGINIA	31.4	1.1	VERY HIGH	2
NEBRASKA	31.2	1.02	VERY HIGH	3
MISSOURI	30.9	0.9	VERY HIGH	4
OKLAHOMA	30.9	0.9	VERY HIGH	4
NORTH DAKOTA	30.8	0.86	VERY HIGH	6
SOUTH DAKOTA	30.8	0.86	VERY HIGH	6
IOWA	30.7	0.83	HIGH	8
WYOMING	30.6	0.79	HIGH	9
MISSISSIPPI	30.6	0.79	HIGH	9
MINNESOTA	30.5	0.75	HIGH	11
KANSAS	30.4	0.71	HIGH	12
KENTUCKY	30.4	0.71	HIGH	12
MONTANA	30.2	0.63	HIGH	14
INDIANA	29.9	0.52	HIGH	15
MASSACHUSETTS	29.7	0.44	HIGH	16
VERMONT	29.7	0.44	HIGH	16
RHODE ISLAND	29.6	0.4	HIGH	18
OHIO	29.6	0.4	HIGH	18
NEW YORK	29.6	0.4	HIGH	28
ARKANSAS	29.5	0.36	HIGH	21
WISCONSIN	29.5	0.36	HIGH	21
ALABAMA	29.5	0.36	HIGH	21
ILLINOIS	29.5	0.36	HIGH	21
MAINE	29.5	0.36	HIGH	21
LOUISIANA	29.3	0.29	HIGH	26
COLORADO	29.1	0.21	AVERAGE	27
TENNESSEE	28.8	0.09	AVERAGE	28
PENNSYLVANIA	28.8	0.09	AVERAGE	28

MICHIGAN	28.7	0.05	AVERAGE	30
WASHINGTON	28.3	-0.1	AVERAGE	31
GEORGIA	28.3	-0.1	AVERAGE	31
NORTH CAROLINA	28.1	-0.18	AVERAGE	33
OREGON	27.7	-0.33	LOW	34
NEW HAMPSHIRE	27.6	-0.37	LOW	35
SOUTH CAROLINA	27.5	-0.41	LOW	36
TEXAS	27.5	-0.41	LOW	36
CONNECTICUT	27.3	-0.49	LOW	38
IDAHO	27.2	-0.52	LOW	39
VIRGINIA	26.9	-0.64	LOW	40
DELAWARE	26.7	-0.72	LOW	41
NEW JERSEY	26.5	-0.79	LOW	42
NEW MEXICO	26.3	-0.87	VERY LOW	43
CALIFORNIA	26.1	-0.95	VERY LOW	44
MARYLAND	26.1	-0.95	VERY LOW	44
NEVADA	26	-0.99	VERY LOW	46
UTAH	25.6	-1.14	VERY LOW	47
ALASKA	25.6	-1.14	VERY LOW	47
FLORIDA	25	-1.37	VERY LOW	49
ARIZONA	24.9	-1.41	VERY LOW	50
HAWAII	16.7	-4.57	VERY LOW	51
UNITED STATES	28.20%			

Source: Infrastructure of Home and Community Based Services for the Functionally Impaired Elderly. State Source Book. U. S. Administration on Aging, 1995.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

[Go to Table 4](#)
[Return to U.S. Map](#)

Administration On Aging



Percentage of Elderly Minority

Table 4: 1992 Percentage of Age 65+ Population Who Are Minorities

STATE	AGE 65+ %			
	MINORITY	SCORE	RATING	RANK
MAINE	0.60%	-0.86	VERY LOW	1
VERMONT	0.7	-0.85	VERY LOW	2
NEW HAMPSHIRE	0.8	-0.84	VERY LOW	3
IOWA	1.4	-0.8	LOW	4
NORTH DAKOTA	1.4	-0.8	LOW	4
MINNESOTA	1.8	-0.77	LOW	6
OREGON	2.4	-0.73	LOW	7
IDAHO	2.5	-0.73	LOW	8
WISCONSIN	2.7	-0.71	LOW	9
SOUTH DAKOTA	2.7	-0.71	LOW	9
NEBRASKA	2.9	-0.7	LOW	11
MONTANA	2.9	-0.7	LOW	11
RHODE ISLAND	3.3	-0.67	LOW	13
WEST VIRGINIA	3.7	-0.64	LOW	14
UTAH	4.3	-0.6	LOW	15
MASSACHUSETTS	4.4	-0.6	LOW	16
WYOMING	4.6	-0.58	LOW	17
KANSAS	5.1	-0.55	LOW	18
WASHINGTON	5.4	-0.53	LOW	19
CONNECTICUT	6.2	-0.47	LOW	20
KENTUCKY	6.3	-0.47	LOW	21
INDIANA	6.4	-0.46	LOW	22
PENNSYLVANIA	7.2	-0.4	LOW	23
MISSOURI	7.9	-0.36	LOW	24
OHIO	8.5	-0.31	LOW	25
NEVADA	9.6	-0.24	AVERAGE	26
OKLAHOMA	10.7	-0.16	AVERAGE	27
COLORADO	10.9	-0.15	AVERAGE	28
ARIZONA	11.5	-0.11	AVERAGE	29

MICHIGAN	11.6	-0.1	AVERAGE	30
DELAWARE	12.2	-0.06	AVERAGE	31
NEW JERSEY	12.4	-0.05	AVERAGE	32
TENNESSEE	12.5	-0.04	AVERAGE	33
ILLINOIS	12.7	-0.03	AVERAGE	34
ARKANSAS	12.8	-0.02	AVERAGE	35
FLORIDA	13.2	0.01	AVERAGE	36
NEW YORK	16.8	0.25	HIGH	37
MARYLAND	17.9	0.33	HIGH	38
VIRGINIA	18	0.34	HIGH	39
NORTH CAROLINA	18.4	0.36	HIGH	40
ALABAMA	21.5	0.57	HIGH	41
GEORGIA	21.6	0.58	HIGH	42
CALIFORNIA	22	0.61	HIGH	43
TEXAS	23.5	0.71	HIGH	44
SOUTH CAROLINA	24.2	0.76	HIGH	45
ALASKA	25.7	0.86	VERY HIGH	46
LOUISIANA	26	0.88	VERY HIGH	47
MISSISSIPPI	29	1.09	VERY HIGH	48
NEW MEXICO	31.9	1.29	VERY HIGH	49
DIST. OF COLUMBIA	70.4	3.92	VERY HIGH	50
HAWAII	75.1	4.24	VERY HIGH	51
UNITED STATES	13.60%			

Source: Infrastructure of Home and Community Based Services for the Functionally Impaired Elderly. State Source Book. U. S. Administration on Aging, 1995.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

[Go to Table 5](#) [Return to U.S. Map](#)



Elderly Percentage with Disabilities

Table 5: 1992 Age 65+ Severely Disabled Persons Per 1000

STATE	SEV. DIS.			
	PER 1000	SCORE	RATING	RANK
MISSISSIPPI	94.8	2.86	VERY HIGH	1
LOUISIANA	86.2	1.8	VERY HIGH	2
ALABAMA	85.6	1.72	VERY HIGH	3
ARKANSAS	84.8	1.63	VERY HIGH	4
KENTUCKY	82.3	1.32	VERY HIGH	5
GEORGIA	81.5	1.22	VERY HIGH	6
SOUTH CAROLINA	81.2	1.18	VERY HIGH	7
NORTH CAROLINA	81.1	1.17	VERY HIGH	8
TENNESSEE	80.8	1.13	VERY HIGH	9
DIST. OF COLUMBIA	79.8	1.01	VERY HIGH	10
TEXAS	78.9	0.9	VERY HIGH	11
SOUTH DAKOTA	78.9	0.9	VERY HIGH	11
WEST VIRGINIA	77.5	0.73	HIGH	13
MISSOURI	76.9	0.65	HIGH	14
NEW YORK	75.4	0.47	HIGH	15
OKLAHOMA	75	0.42	HIGH	16
MAINE	74	0.3	HIGH	17
NORTH DAKOTA	73.7	0.26	HIGH	18
NEW MEXICO	73	0.17	AVERAGE	19
HAWAII	72.9	0.16	AVERAGE	20
MINNESOTA	72.1	0.06	AVERAGE	21
NEW HAMPSHIRE	72	0.05	AVERAGE	22
VIRGINIA	71.6	0	AVERAGE	23
IDAHO	71.6	0	AVERAGE	23
VERMONT	70.8	-0.1	AVERAGE	25
IOWA	70.5	-0.14	AVERAGE	26
MASSACHUSETTS	70.3	-0.16	AVERAGE	27
INDIANA	69.4	-0.27	LOW	28
WISCONSIN	69.2	-0.3	LOW	29

FLORIDA	68.9	-0.33	LOW	30
ILLINOIS	68.8	-0.34	LOW	31
PENNSYLVANIA	68.8	-0.34	LOW	31
NEW JERSEY	68.5	-0.38	LOW	33
KANSAS	68.3	-0.41	LOW	34
MONTANA	67.6	-0.49	LOW	35
RHODE ISLAND	67.3	-0.53	LOW	36
NEBRASKA	67.2	-0.54	LOW	37
MICHIGAN	66.9	-0.58	LOW	38
OHIO	66.8	-0.59	LOW	39
DELAWARE	66.3	-0.65	LOW	40
COLORADO	65.2	-0.79	LOW	41
UTAH	65	-0.81	LOW	42
ARIZONA	64.6	-0.86	VERY LOW	43
WYOMING	64.1	-0.92	VERY LOW	44
OREGON	63.5	-1	VERY LOW	45
MARYLAND	63.4	-1.01	VERY LOW	46
NEVADA	60	-1.43	VERY LOW	47
ALASKA	58.5	-1.61	VERY LOW	48
WASHINGTON	57.7	-1.71	VERY LOW	49
CONNECTICUT	57.4	-1.75	VERY LOW	50
CALIFORNIA	55	-2.04	VERY LOW	51
UNITED STATES	71.4			

Source: Infrastructure of Home and Community Based Services for the Functionally Impaired Elderly. State Source Book. U. S. Administration on Aging, 1995.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

Go to Table 6 **Return to U.S. Map**

Administration On Aging



Percent of Elderly in Poverty

Table 6: 1991 Percentage Age 65+ of the Population with Incomes Below the Poverty Level

STATE	AGE 65+ %			
	<POVERTY	SCORE	RATING	RANK
MISSISSIPPI	29.40%	3.16	VERY HIGH	1
LOUISIANA	24.1	2.1	VERY HIGH	2
ALABAMA	24	2.08	VERY HIGH	3
ARKANSAS	22.9	1.86	VERY HIGH	4
TENNESSEE	20.9	1.47	VERY HIGH	5
KENTUCKY	20.6	1.41	VERY HIGH	6
SOUTH CAROLINA	20.5	1.39	VERY HIGH	7
GEORGIA	20.4	1.37	VERY HIGH	8
NORTH CAROLINA	19.5	1.19	VERY HIGH	9
TEXAS	18.4	0.97	VERY HIGH	10
OKLAHOMA	17.9	0.87	VERY HIGH	11
DIST. OF COLUMBIA	17.2	0.73	HIGH	12
WEST VIRGINIA	16.7	0.63	HIGH	13
NEW MEXICO	16.5	0.59	HIGH	14
SOUTH DAKOTA	15.5	0.39	HIGH	15
MISSOURI	14.8	0.25	AVERAGE	16
NORTH DAKOTA	14.6	0.21	AVERAGE	17
VIRGINIA	14.1	0.11	AVERAGE	18
MAINE	14	0.09	AVERAGE	19
MONTANA	12.5	-0.21	AVERAGE	20
VERMONT	12.4	-0.23	AVERAGE	21
NEBRASKA	12.2	-0.27	LOW	22
MINNESOTA	12.1	-0.29	LOW	23
KANSAS	12	-0.31	LOW	24
NEW YORK	11.9	-0.33	LOW	25
RHODE ISLAND	11.6	-0.39	LOW	26
IDAHO	11.5	-0.41	LOW	27
IOWA	11.2	-0.47	LOW	28
COLORADO	11	-0.51	LOW	29

ARIZONA	10.8	-0.55	LOW	30
FLORIDA	10.8	-0.55	LOW	30
MICHIGAN	10.8	-0.55	LOW	30
INDIANA	10.8	-0.55	LOW	30
WYOMING	10.7	-0.57	LOW	34
OHIO	10.7	-0.57	LOW	34
ILLINOIS	10.7	-0.57	LOW	34
PENNSYLVANIA	10.6	-0.59	LOW	37
MARYLAND	10.5	-0.61	LOW	38
NEW HAMPSHIRE	10.2	-0.67	LOW	39
DELAWARE	10.1	-0.69	LOW	40
OREGON	10.1	-0.69	LOW	40
NEVADA	9.6	-0.79	LOW	42
MASSACHUSETTS	9.4	-0.83	LOW	43
WISCONSIN	9.1	-0.89	VERY LOW	44
WASHINGTON	9.1	-0.89	VERY LOW	44
UTAH	8.8	-0.95	VERY LOW	46
NEW JERSEY	8.5	-1.01	VERY LOW	47
HAWAII	8	-1.11	VERY LOW	48
ALASKA	7.6	-1.19	VERY LOW	49
CALIFORNIA	7.6	-1.19	VERY LOW	49
CONNECTICUT	7.2	-1.27	VERY LOW	51
UNITED STATES	12.80%			

Source: A Profile of Older Americans. American Association of Retired Persons and the U.S. Administration on Aging, 1992.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

[Go to Table 7](#)
[Return to U.S. Map](#)

Administration On Aging



Percentage of Elderly Receiving Medicaid

Table 7: 1992 Percentage of Age 65+ Population Receiving Medicaid

STATE	AGE 65+ %			
	ON MEDICAID	SCORE	RATING	RANK
RHODE ISLAND	25.90%	3.43	VERY HIGH	1
MISSISSIPPI	20.2	2.12	VERY HIGH	2
LOUISIANA	20	2.08	VERY HIGH	3
SOUTH CAROLINA	17.3	1.45	VERY HIGH	4
VERMONT	15.7	1.09	VERY HIGH	5
CALIFORNIA	15.1	0.95	VERY HIGH	6
DIST. OF COLUMBIA	15	0.92	VERY HIGH	7
TEXAS	14.8	0.88	VERY HIGH	8
TENNESSEE	14.6	0.83	HIGH	9
GEORGIA	14.6	0.83	HIGH	9
ARKANSAS	14.4	0.79	HIGH	11
NEW YORK	14.3	0.76	HIGH	12
NORTH CAROLINA	14.3	0.76	HIGH	12
ALASKA	13.6	0.6	HIGH	14
MAINE	13.3	0.53	HIGH	15
ALABAMA	13	0.46	HIGH	16
OKLAHOMA	12.9	0.44	HIGH	17
KENTUCKY	12.8	0.42	HIGH	18
MASSACHUSETTS	12.6	0.37	HIGH	19
CONNECTICUT	12.1	0.26	HIGH	20
WEST VIRGINIA	11.5	0.12	AVERAGE	21
NORTH DAKOTA	11.5	0.12	AVERAGE	21
VIRGINIA	11.2	0.05	AVERAGE	23
MISSOURI	10.8	-0.04	AVERAGE	24
NEW HAMPSHIRE	10.6	-0.09	AVERAGE	25
OHIO	10.4	-0.14	AVERAGE	26
HAWAII	10.4	-0.14	AVERAGE	26
MINNESOTA	10.3	-0.16	AVERAGE	28
WISCONSIN	10	-0.23	AVERAGE	29

SOUTH DAKOTA	9.3	-0.39	LOW	30
MARYLAND	9.2	-0.41	LOW	31
IOWA	8.9	-0.48	LOW	32
NEBRASKA	8.8	-0.5	LOW	33
WASHINGTON	8.4	-0.6	LOW	34
NEW MEXICO	8.2	-0.64	LOW	35
PENNSYLVANIA	7.6	-0.78	LOW	36
FLORIDA	7.5	-0.8	LOW	37
NEW JERSEY	7.4	-0.83	LOW	38
MICHIGAN	7.4	-0.83	LOW	38
MONTANA	7.3	-0.85	VERY LOW	40
INDIANA	7.3	-0.85	VERY LOW	40
ILLINOIS	7.2	-0.87	VERY LOW	42
KANSAS	7.2	-0.87	VERY LOW	42
OREGON	7.1	-0.9	VERY LOW	44
IDAHO	6.9	-0.94	VERY LOW	45
DELAWARE	6.3	-1.08	VERY LOW	46
NEVADA	6.2	-1.1	VERY LOW	47
WYOMING	6.2	-1.1	VERY LOW	47
UTAH	5.5	-1.26	VERY LOW	49
ARIZONA	4.5	-1.49	VERY LOW	50
COLORADO	2.8	-1.89	VERY LOW	51
UNITED STATES	11.20%			

Source: Infrastructure of Home and Community Based Services for the Functionally Impaired Elderly. State Source Book. U. S. Administration on Aging, 1995.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

[Go to Table 8](#)
[Return to U.S. Map](#)

Administration On Aging



Adults with Disabilities Per 1000

Table 8: 1993 Age 18-64 Severely Disabled Persons Per 1000

STATE	SEV. DIS.			
	PER 1000	SCORE	RATING	RANK
MISSISSIPPI	7.5	2.6	VERY HIGH	1
WEST VIRGINIA	7.1	2.06	VERY HIGH	2
LOUISIANA	6.9	1.79	VERY HIGH	3
TENNESSEE	6.8	1.66	VERY HIGH	4
ALABAMA	6.8	1.66	VERY HIGH	4
NEW MEXICO	6.7	1.52	VERY HIGH	6
ARKANSAS	6.7	1.52	VERY HIGH	6
KENTUCKY	6.6	1.39	VERY HIGH	8
SOUTH CAROLINA	6.3	0.99	VERY HIGH	9
DIST. OF COLUMBIA	6.3	0.99	VERY HIGH	9
OKLAHOMA	6.1	0.72	HIGH	11
GEORGIA	6	0.59	HIGH	12
SOUTH DAKOTA	6	0.59	HIGH	12
TEXAS	6	0.59	HIGH	12
FLORIDA	5.9	0.45	HIGH	15
MONTANA	5.9	0.45	HIGH	15
NEW YORK	5.8	0.32	HIGH	17
NORTH CAROLINA	5.8	0.32	HIGH	17
NORTH DAKOTA	5.8	0.32	HIGH	17
MICHIGAN	5.6	0.05	AVERAGE	20
MISSOURI	5.6	0.05	AVERAGE	20
OHIO	5.6	0.05	AVERAGE	20
PENNSYLVANIA	5.5	-0.08	AVERAGE	23
IDAHO	5.5	-0.08	AVERAGE	23
ILLINOIS	5.5	-0.08	AVERAGE	23
ARIZONA	5.5	-0.08	AVERAGE	23
CALIFORNIA	5.4	-0.22	AVERAGE	27
VIRGINIA	5.4	-0.22	AVERAGE	27
HAWAII	5.3	-0.35	LOW	29

INDIANA	5.3	-0.35	LOW	29
IOWA	5.3	-0.35	LOW	29
MAINE	5.2	-0.49	LOW	32
WYOMING	5.2	-0.49	LOW	32
VERMONT	5.1	-0.62	LOW	34
ALASKA	5.1	-0.62	LOW	34
NEBRASKA	5.1	-0.62	LOW	34
DELAWARE	5	-0.75	LOW	37
NEW JERSEY	5	-0.75	LOW	37
OREGON	5	-0.75	LOW	37
COLORADO	4.9	-0.89	VERY LOW	40
KANSAS	4.9	-0.89	VERY LOW	40
NEVADA	4.9	-0.89	VERY LOW	40
RHODE ISLAND	4.9	-0.89	VERY LOW	40
MARYLAND	4.8	-1.02	VERY LOW	44
MASSACHUSETTS	4.8	-1.02	VERY LOW	44
MINNESOTA	4.7	-1.16	VERY LOW	46
UTAH	4.7	-1.16	VERY LOW	46
WASHINGTON	4.7	-1.16	VERY LOW	46
WISCONSIN	4.6	-1.29	VERY LOW	49
CONNECTICUT	4.3	-1.69	VERY LOW	50
NEW HAMPSHIRE	4.3	-1.69	VERY LOW	50
UNITED STATES	5.6			

Source: Infrastructure of Home and Community Based Services for the Functionally Impaired Elderly.
State Source Book. U. S. Administration on Aging, 1995.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

[Go to Table 2](#)
[Return to U.S. Map](#)

Administration On Aging



Nursing Home Occupancy Rate

Table 10: 1992 Nursing Home Occupancy Rate

STATE	OCCUPANCY			
	RATE	SCORE	RATING	RANK
TEXAS	77.30%	-2.26	VERY LOW	1
→ ALASKA	77.5	-2.22	VERY LOW	2
MISSOURI	78	-2.12	VERY LOW	3
DELAWARE	79.2	-1.89	VERY LOW	4
UTAH	79.5	-1.83	VERY LOW	5
OKLAHOMA	80.7	-1.6	VERY LOW	6
ARIZONA	82.7	-1.22	VERY LOW	7
ILLINOIS	82.9	-1.18	VERY LOW	8
WYOMING	84	-0.96	VERY LOW	9
COLORADO	84	-0.96	VERY LOW	9
LOUISIANA	84.1	-0.95	VERY LOW	11
IDAHO	85.9	-0.6	LOW	12
INDIANA	85.9	-0.6	LOW	12
OREGON	86.2	-0.54	LOW	14
ARKANSAS	86.4	-0.5	LOW	15
OHIO	86.5	-0.48	LOW	16
CALIFORNIA	86.8	-0.42	LOW	17
KANSAS	87.7	-0.25	AVERAGE	18
IOWA	88.6	-0.08	AVERAGE	19
FLORIDA	89	0	AVERAGE	20
MARYLAND	89.2	0.04	AVERAGE	21
MONTANA	89.2	0.04	AVERAGE	21
SOUTH CAROLINA	89.6	0.12	AVERAGE	23
NEBRASKA	89.6	0.12	AVERAGE	23
NORTH CAROLINA	90	0.19	AVERAGE	25
NEW MEXICO	90	0.19	AVERAGE	25
NEVADA	90.3	0.25	AVERAGE	27
NEW HAMPSHIRE	90.4	0.27	HIGH	28
WASHINGTON	90.4	0.27	HIGH	28

KENTUCKY	90.6	0.31	HIGH	30
MICHIGAN	90.6	0.31	HIGH	30
PENNSYLVANIA	91	0.39	HIGH	32
WISCONSIN	91.7	0.52	HIGH	33
DIST. OF COLUMBIA	91.8	0.54	HIGH	34
NEW JERSEY	92	0.58	HIGH	35
TENNESSEE	92.3	0.64	HIGH	36
HAWAII	92.5	0.67	HIGH	37
CONNECTICUT	92.6	0.69	HIGH	38
WEST VIRGINIA	93.1	0.79	HIGH	39
MASSACHUSETTS	93.3	0.83	HIGH	40
VIRGINIA	93.5	0.87	VERY HIGH	41
MINNESOTA	94.3	1.02	VERY HIGH	42
GEORGIA	94.6	1.08	VERY HIGH	43
ALABAMA	94.7	1.1	VERY HIGH	44
MAINE	94.9	1.14	VERY HIGH	45
RHODE ISLAND	95.1	1.18	VERY HIGH	46
VERMONT	95.2	1.2	VERY HIGH	47
SOUTH DAKOTA	95.3	1.21	VERY HIGH	48
NORTH DAKOTA	95.9	1.33	VERY HIGH	49
NEW YORK	95.9	1.33	VERY HIGH	50
MISSISSIPPI	96.6	1.47	VERY HIGH	51

Source: Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1991-1993. Charlene Harrington, et al. University of California, January, 1995.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

[Go to Table 11](#)
[Return to U.S. Map](#)

Administration On Aging



Percentage of Elderly in Nursing Homes

Table 11: 1992 Nursing Home Residents as a Percentage of the Age 65+ Population

STATE	% AGE 65+			
	IN NH	SCORE	RATING	RANK
NEVADA	2.03%	-1.83	VERY LOW	1
ARIZONA	2.13	-1.76	VERY LOW	2
HAWAII	2.32	-1.63	VERY LOW	3
ALASKA	2.4	-1.58	VERY LOW	4
FLORIDA	2.47	-1.53	VERY LOW	5
OREGON	2.86	-1.26	VERY LOW	6
DIST. OF COLUMBIA	3.02	-1.15	VERY LOW	7
CALIFORNIA	3.08	-1.11	VERY LOW	8
NEW MEXICO	3.27	-0.98	VERY LOW	9
WEST VIRGINIA	3.28	-0.97	VERY LOW	10
SOUTH CAROLINA	3.34	-0.93	VERY LOW	11
UTAH	3.52	-0.81	LOW	12
MICHIGAN	3.66	-0.71	LOW	13
IDAHO	3.68	-0.7	LOW	14
NORTH CAROLINA	3.79	-0.62	LOW	15
ALABAMA	3.9	-0.55	LOW	16
NEW JERSEY	3.91	-0.54	LOW	17
VIRGINIA	3.92	-0.53	LOW	18
NEW YORK	4.05	-0.44	LOW	19
DELAWARE	4.07	-0.43	LOW	20
WASHINGTON	4.08	-0.42	LOW	21
KENTUCKY	4.27	-0.29	LOW	22
PENNSYLVANIA	4.29	-0.28	LOW	23
MARYLAND	4.39	-0.21	AVERAGE	24
MISSISSIPPI	4.53	-0.11	AVERAGE	25
TEXAS	4.67	-0.02	AVERAGE	26
COLORADO	4.69	0	AVERAGE	27
VERMONT	4.98	0.2	AVERAGE	28
GEORGIA	5.06	0.25	AVERAGE	29

TENNESSEE	5.08	0.26	HIGH	30
WYOMING	5.09	0.27	HIGH	31
MISSOURI	5.12	0.29	HIGH	32
NEW HAMPSHIRE	5.21	0.35	HIGH	33
OHIO	5.43	0.51	HIGH	34
ILLINOIS	5.44	0.51	HIGH	35
MAINE	5.57	0.6	HIGH	36
ARKANSAS	5.57	0.6	HIGH	36
MASSACHUSETTS	5.62	0.64	HIGH	38
MONTANA	5.68	0.68	HIGH	39
INDIANA	5.76	0.73	HIGH	40
CONNECTICUT	6.03	0.92	VERY HIGH	41
OKLAHOMA	6.07	0.95	VERY HIGH	42
RHODE ISLAND	6.08	0.95	VERY HIGH	43
LOUISIANA	6.5	1.24	VERY HIGH	44
WISCONSIN	6.54	1.27	VERY HIGH	45
IOWA	6.84	1.47	VERY HIGH	46
NEBRASKA	6.9	1.52	VERY HIGH	47
NORTH DAKOTA	7.15	1.69	VERY HIGH	48
KANSAS	7.19	1.72	VERY HIGH	49
SOUTH DAKOTA	7.34	1.82	VERY HIGH	50
MINNESOTA	7.59	1.99	VERY HIGH	51
TOTAL U.S.	4.41	0.7		

Source Health Data Associates 1994. Oregon Senior and Disabled Services Division 1995.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

[Go to Table 12](#)
[Return to U.S. Map](#)



Change in Nursing Home Use

Table 12: 1980-81 to 1990-91 Percentage Change in Nursing Home Utilization

STATE	NURSING HOME			
	DAYS OF CARE	SCORE	RATING	RANK
COLORADO	-17.70%	-1.06	VERY LOW	1
MINNESOTA	-13.1	-0.97	VERY LOW	2
WISCONSIN	-12.3	-0.95	VERY LOW	3
SOUTH DAKOTA	-11	-0.92	VERY LOW	4
MICHIGAN	-6.9	-0.84	LOW	5
TEXAS	-6.3	-0.83	LOW	6
OREGON	-6.2	-0.82	LOW	7
IOWA	-1.2	-0.72	LOW	8
ALABAMA	1.9	-0.65	LOW	9
OKLAHOMA	4	-0.61	LOW	10
VERMONT	5	-0.59	LOW	11
NORTH DAKOTA	5.1	-0.59	LOW	12
MONTANA	5.3	-0.58	LOW	13
MASSACHUSETTS	5.6	-0.58	LOW	14
KANSAS	5.7	-0.58	LOW	15
ARKANSAS	5.9	-0.57	LOW	16
NEBRASKA	6.2	-0.56	LOW	17
CALIFORNIA	6.9	-0.55	LOW	18
GEORGIA	7.2	-0.54	LOW	19
WASHINGTON	9.1	-0.5	LOW	20
NEW YORK	10.4	-0.48	LOW	21
MAINE	11	-0.46	LOW	22
ILLINOIS	13.6	-0.41	LOW	23
NEW HAMPSHIRE	15.1	-0.38	LOW	24
SOUTH CAROLINA	19.3	-0.29	LOW	25
ALASKA	19.4	-0.29	LOW	26
RHODE ISLAND	19.8	-0.28	LOW	27
MISSISSIPPI	21.5	-0.25	AVERAGE	28
VIRGINIA	23.8	-0.2	AVERAGE	29

CONNECTICUT	24.1	-0.19	AVERAGE	30
IDAHO	24.3	-0.19	AVERAGE	31
UTAH	24.6	-0.18	AVERAGE	32
LOUISIANA	28	-0.11	AVERAGE	33
NEW JERSEY	28.6	-0.1	AVERAGE	34
NEVADA	30.1	-0.07	AVERAGE	35
TENNESSEE	33.6	0.01	AVERAGE	36
HAWAII	39.3	0.13	AVERAGE	37
MARYLAND	40.6	0.15	AVERAGE	38
OHIO	45.8	0.26	HIGH	39
NORTH CAROLINA	52.6	0.4	HIGH	40
PENNSYLVANIA	54.5	0.44	HIGH	41
MISSOURI	62.4	0.61	HIGH	42
DELAWARE	66.8	0.7	HIGH	43
ARIZONA	71.8	0.8	HIGH	44
WEST VIRGINIA	86.3	1.11	VERY HIGH	45
KENTUCKY	89.2	1.17	VERY HIGH	46
NEW MEXICO	108.9	1.58	VERY HIGH	47
WYOMING	122.6	1.86	VERY HIGH	48
FLORIDA	124.7	1.91	VERY HIGH	49
DIST. OF COLUMBIA	144.5	2.32	VERY HIGH	50
INDIANA	246.7	4.45	VERY HIGH	51
US AVERAGE	32.60%			

Source: Wisconsin Bureau of Long-Term Care, Using the HCFA 2082, 1994. Arizona, New York, District of Columbia, and Utah are from 1980-1990 in Infrastructure of Home and Community Based Services for the Functionally Impaired Elderly. State Source Book. U. S. Administration on Aging, 1995.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

[Go to Table 13](#)
[Return to U.S. Map](#)



Propac Acuity Index - Severity of Impairment

Table 13: Propac Acuity Index -- Average Facility Scores by State (higher scores indicate nursing home residents have greater impairments)

STATE	PROPAC			
	INDEX	SCORE	RATING	RANK
HAWAII	149.2	3.84	VERY HIGH	1
NEW YORK	122.9	1.9	VERY HIGH	2
SOUTH CAROLINA	122.1	1.84	VERY HIGH	3
VIRGINIA	118.6	1.59	VERY HIGH	4
NORTH CAROLINA	116.6	1.44	VERY HIGH	5
ALASKA	115.6	1.36	VERY HIGH	6
KENTUCKY	114.3	1.27	VERY HIGH	7
OREGON	107.7	0.78	HIGH	8
PENNSYLVANIA	106.4	0.69	HIGH	9
ALABAMA	106.3	0.68	HIGH	10
DIST. OF COLUMBIA	106.2	0.67	HIGH	11
CALIFORNIA	106.1	0.67	HIGH	12
MARYLAND	104.8	0.57	HIGH	13
TENNESSEE	102.8	0.42	HIGH	14
GEORGIA	100.8	0.28	HIGH	15
MAINE	99.1	0.15	AVERAGE	16
WEST VIRGINIA	99	0.14	AVERAGE	17
MISSISSIPPI	98.8	0.13	AVERAGE	18
CONNECTICUT	98.8	0.13	AVERAGE	18
MICHIGAN	98	0.07	AVERAGE	20
NEVADA	97.6	0.04	AVERAGE	21
FLORIDA	97	0	AVERAGE	22
ARKANSAS	96.8	-0.02	AVERAGE	23
ARIZONA	96.8	-0.02	AVERAGE	23
NEW JERSEY	96.2	-0.06	AVERAGE	25
OHIO	96.2	-0.06	AVERAGE	25
TEXAS	95.5	-0.11	AVERAGE	27
MINNESOTA	93.7	-0.25	AVERAGE	28
MASSACHUSETTS	93.1	-0.29	LOW	29

NEW MEXICO	92.6	-0.33	LOW	30
MISSOURI	92.6	-0.33	LOW	30
IDAHO	92.2	-0.36	LOW	32
INDIANA	92.2	-0.36	LOW	32
WISCONSIN	90.8	-0.46	LOW	34
DELAWARE	90.8	-0.46	LOW	34
VERMONT	90.7	-0.47	LOW	36
WASHINGTON	90.5	-0.48	LOW	37
RHODE ISLAND	87.7	-0.69	LOW	38
OKLAHOMA	87.4	-0.71	LOW	39
COLORADO	87.4	-0.71	LOW	39
MONTANA	86.7	-0.76	LOW	41
ILLINOIS	86.1	-0.8	LOW	42
UTAH	84.5	-0.92	VERY LOW	43
SOUTH DAKOTA	84.4	-0.93	VERY LOW	44
NEW HAMPSHIRE	82.7	-1.05	VERY LOW	45
NORTH DAKOTA	82.2	-1.09	VERY LOW	46
NEBRASKA	80.8	-1.19	VERY LOW	47
KANSAS	79.9	-1.26	VERY LOW	48
LOUISIANA	79.6	-1.28	VERY LOW	49
WYOMING	76.9	-1.48	VERY LOW	50
IOWA	73.3	-1.75	VERY LOW	51

Source: Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1991-1993. Charlene Harrington, et al. University of California, January 1995.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

[Go to Table 14](#)
[Return to U.S. Map](#)

Administration On Aging



Medicaid Average Daily Nursing Home Costs

Table 14. Medicaid Average Cost Per Day in a Nursing Home

STATE	COST			
	PER DAY	SCORE	RATING	RANK
OKLAHOMA	36.44	-1.08	VERY LOW	1
IOWA	40.24	-0.97	VERY LOW	2
WYOMING	41.13	-0.94	VERY LOW	3
ARKANSAS	43.35	-0.88	VERY LOW	4
KANSAS	43.46	-0.87	VERY LOW	5
TEXAS	44.69	-0.83	LOW	6
MISSOURI	45.8	0.8	LOW	7
MISSISSIPPI	45.99	-0.8	LOW	8
SOUTH DAKOTA	48.77	-0.71	LOW	9
GEORGIA	49.86	-0.68	LOW	10
VIRGINIA	51.96	0.62	LOW	11
UTAH	52.77	-0.59	LOW	12
SOUTH CAROLINA	54.06	-0.55	LOW	13
LOUISIANA	54.38	0.54	LOW	14
TENNESSEE	56.11	-0.49	LOW	15
KENTUCKY	56.76	-0.47	LOW	16
NEBRASKA	57.36	-0.45	LOW	17
ILLINOIS	57.65	-0.44	LOW	18
ALABAMA	57.79	-0.44	LOW	19
COLORADO	58.32	-0.42	LOW	20
WISCONSIN	58.52	-0.42	LOW	21
OREGON	59.23	-0.4	LOW	22
IDAHO	63.53	-0.27	LOW	23
NORTH CAROLINA	63.74	-0.26	LOW	24
MONTANA	63.75	-0.26	LOW	25
NORTH DAKOTA	64.73	-0.23	AVERAGE	26
ARIZONA	64.76	-0.23	AVERAGE	27
NEW MEXICO	65.76	-0.2	AVERAGE	28
MARYLAND	67.48	-0.15	AVERAGE	29

INDIANA	68.94	-0.1	AVERAGE	30
FLORIDA	69.9	-0.08	AVERAGE	31
OHIO	72.43	0	AVERAGE	32
MINNESOTA	73.01	0.02	AVERAGE	33
WASHINGTON	74.1	0.05	AVERAGE	34
CALIFORNIA	76.09	0.11	AVERAGE	35
VERMONT	76.65	0.13	AVERAGE	36
RHODE ISLAND	78.47	0.18	AVERAGE	37
NEW HAMPSHIRE	78.53	0.18	AVERAGE	38
PENNSYLVANIA	79.23	0.21	AVERAGE	39
DELAWARE	81.71	0.28	HIGH	40
MAINE	81.75	0.28	HIGH	41
WEST VIRGINIA	83.04	0.32	HIGH	42
MASSACHUSETTS	83.32	0.33	HIGH	43
MICHIGAN	86.08	0.41	HIGH	44
NEW JERSEY	90.65	0.55	HIGH	45
NEVADA	101.92	0.89	VERY HIGH	46
CONNECTICUT	103	0.92	VERY HIGH	47
HAWAII	119.51	1.42	VERY HIGH	48
NEW YORK	145.19	2.19	VERY HIGH	49
DIST. OF COLUMBIA	177.83	3.17	VERY HIGH	50
ALASKA	223.61	4.55	VERY HIGH	51
TOTAL U.S.	71.03			

Source: Derived using 1993 Medicaid Nursing Home Expenditures and 1992 data from Health Data Associates, 1994.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

☐ [Go to Table 15](#)
☐ [Return to U.S. Map](#)



Change in Nursing Home Expenditures

Table 15: 1980-80 to 1990-91 Percentage Change in Nursing Home Expenditures

NURSING HOME				
STATE	% GROWTH	SCORE	RATING	RANK
WISCONSIN	-8.30%	-1.41	VERY LOW	1
MICHIGAN	1.7	-1.2	VERY LOW	2
MINNESOTA	6.4	-1.1	VERY LOW	3
MONTANA	15.6	-0.91	VERY LOW	4
COLORADO	19.1	-0.84	LOW	5
OKLAHOMA	21.1	-0.8	LOW	6
SOUTH DAKOTA	22	-0.78	LOW	7
TEXAS	22.5	-0.77	LOW	8
WASHINGTON	22.5	-0.77	LOW	8
ARKANSAS	25.5	-0.71	LOW	10
ALABAMA	26	-0.7	LOW	11
RHODE ISLAND	30.4	-0.61	LOW	12
ALASKA	33	-0.55	LOW	13
HAWAII	33.2	-0.55	LOW	14
VERMONT	34.1	-0.53	LOW	15
IOWA	34.2	-0.53	LOW	16
VIRGINIA	35	-0.51	LOW	17
OREGON	35.4	-0.5	LOW	18
TENNESSEE	37.1	-0.47	LOW	19
KANSAS	37.7	-0.45	LOW	20
LOUISIANA	40.8	-0.39	LOW	21
NEBRASKA	41.6	-0.37	LOW	22
SOUTH CAROLINA	42.4	-0.36	LOW	23
NEVADA	47.1	-0.26	LOW	24
MISSISSIPPI	49.8	-0.2	AVERAGE	25
WYOMING	53.5	-0.13	AVERAGE	26
MASSACHUSETTS	56.8	-0.06	AVERAGE	27
GEORGIA	56.9	-0.06	AVERAGE	28
KENTUCKY	59.9	0.01	AVERAGE	28

PENNSYLVANIA	60.3	0.02	AVERAGE	30
NEW HAMPSHIRE	60.5	0.02	AVERAGE	31
MAINE	62.2	0.06	AVERAGE	32
IDAHO	62.4	0.06	AVERAGE	33
MISSOURI	71.6	0.25	AVERAGE	34
CALIFORNIA	74.4	0.31	HIGH	35
ILLINOIS	75.4	0.33	HIGH	36
INDIANA	86	0.55	HIGH	37
NEW JERSEY	90.1	0.63	HIGH	38
NORTH CAROLINA	96.1	0.76	HIGH	39
DELAWARE	98.8	0.82	HIGH	40
MARYLAND	105.6	0.96	VERY HIGH	41
WEST VIRGINIA	127.4	1.41	VERY HIGH	42
NORTH DAKOTA	128.7	1.44	VERY HIGH	43
NEW MEXICO	145.7	1.79	VERY HIGH	44
OHIO	148.6	1.85	VERY HIGH	45
CONNECTICUT	159.1	2.07	VERY HIGH	46
FLORIDA	212.8	3.18	VERY HIGH	47
DIST. OF COLUMBIA	N/A			
ARIZONA	N/A			
UTAH	N/A			
NEW YORK	N/A			

Source: Wisconsin Bureau of Long-Term Care, using HCFA 2082 data, 1994.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

[Go to Table 16](#)

[Return to U.S. Map](#)



Nursing Home Expenditures Per Person 65+

Table 16: 1992 Nursing Home Expenditures Per Person Age 65+

STATE	PER AGE 65+			
	NH EXPEND.	SCORE	RATING	RANK
ARIZONA	314.02	-1.34	VERY LOW	1
FLORIDA	346.92	-1.24	VERY LOW	2
OREGON	363.39	-1.19	VERY LOW	3
NEVADA	377.58	-1.15	VERY LOW	4
UTAH	387.09	-1.12	VERY LOW	5
IOWA	481.57	-0.83	LOW	6
VIRGINIA	486.56	-0.82	LOW	7
SOUTH CAROLINA	487.87	-0.81	LOW	8
IDAHO	504.2	-0.77	LOW	9
MISSOURI	507.92	-0.75	LOW	10
OKLAHOMA	522.91	-0.71	LOW	11
MICHIGAN	529.74	-0.69	LOW	12
NEW MEXICO	540.29	-0.66	LOW	13
WEST VIRGINIA	542.46	-0.65	LOW	14
KANSAS	542.95	-0.65	LOW	15
TEXAS	544.67	-0.64	LOW	16
CALIFORNIA	559.23	-0.6	LOW	17
NORTH CAROLINA	571.21	-0.56	LOW	18
ALABAMA	586.86	-0.52	LOW	19
COLORADO	608.84	-0.45	LOW	20
MISSISSIPPI	630.13	-0.39	LOW	21
KENTUCKY	633.31	-0.38	LOW	22
MONTANA	636.41	-0.37	LOW	23
WYOMING	652.12	-0.32	LOW	24
WASHINGTON	655.08	-0.31	LOW	25
ARKANSAS	655.63	-0.31	LOW	26
TENNESSEE	662.56	-0.29	LOW	27
PENNSYLVANIA	665.87	-0.28	LOW	28
DELAWARE	675.16	-0.25	AVERAGE	29

SOUTH DAKOTA	679.59	-0.24	AVERAGE	30
MARYLAND	700.05	-0.18	AVERAGE	31
NEBRASKA	705.63	-0.16	AVERAGE	32
HAWAII	721.38	-0.11	AVERAGE	33
GEORGIA	743.48	-0.04	AVERAGE	34
ILLINOIS	756.2	-0.01	AVERAGE	35
NEW JERSEY	817.98	0.18	AVERAGE	36
INDIANA	848.7	0.27	HIGH	37
LOUISIANA	857.7	0.3	HIGH	38
VERMONT	868.91	0.33	HIGH	39
NORTH DAKOTA	926.17	0.51	HIGH	40
WISCONSIN	930.63	0.52	HIGH	41
OHIO	946.16	0.57	HIGH	42
NEW HAMPSHIRE	1,168.69	1.24	VERY HIGH	43
RHODE ISLAND	1,207.46	1.35	VERY HIGH	44
MINNESOTA	1,247.51	1.47	VERY HIGH	45
MAINE	1,309.52	1.66	VERY HIGH	46
MASSACHUSETTS	1,342.19	1.76	VERY HIGH	47
CONNECTICUT	1,497.94	2.23	VERY HIGH	48
NEW YORK	1,540.22	2.36	VERY HIGH	49
ALASKA	1,555.44	2.4	VERY HIGH	50
DIST. OF COLUMBIA	1,623.44	2.61	VERY HIGH	51
UNITED STATES	735.83			

Source: Derived using the 1992 Age 65+ Population Estimates in Table 2 and Infrastructure of Home and Community Based Services for the Functionally Impaired Elderly. State Source Book. U. S. Administration on Aging, 1995.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

[Go to Table 17](#)
[Return to U.S. Map](#)

Total Home & Community Based Long Term Care Expenditures

Table 17: 1992 Total Home and Community Based Long Term Care Expenditures Per Person Age 65+

STATE	HCBS PER	SCORE	RATING	RANK
	PERSON 65+			
NEW YORK	1179.62	6.41	VERY HIGH	1
OREGON	369.49	1.42	VERY HIGH	2
ALASKA	311.52	1.07	VERY HIGH	3
CALIFORNIA	239.56	0.62	HIGH	4
DELAWARE	225.44	0.54	HIGH	5
WASHINGTON	211.62	0.45	HIGH	6
MASSACHUSETTS	194.93	0.35	HIGH	7
NORTH CAROLINA	189.89	0.32	HIGH	8
MAINE	189.07	0.31	HIGH	9
WISCONSIN	184.15	0.28	HIGH	10
WEST VIRGINIA	157.84	0.12	AVERAGE	11
MINNESOTA	154.45	0.1	AVERAGE	12
CONNECTICUT	152.66	0.09	AVERAGE	13
MARYLAND	150.65	0.08	AVERAGE	14
TEXAS	143.87	0.03	AVERAGE	15
ARKANSAS	142.99	0.03	AVERAGE	16
INDIANA	137.7	0	AVERAGE	17
IDAHO	134.54	-0.02	AVERAGE	18
DIST. OF COLUMBIA	132.57	-0.04	AVERAGE	19
NEW JERSEY	125.06	-0.08	AVERAGE	20
NEW HAMPSHIRE	120.4	-0.11	AVERAGE	21
NEW MEXICO	117.14	-0.13	AVERAGE	22
OKLAHOMA	114.72	-0.15	AVERAGE	23
ILLINOIS	105.61	-0.2	AVERAGE	24
KENTUCKY	101.55	-0.23	AVERAGE	25
HAWAII	99.92	-0.24	AVERAGE	26
MONTANA	97.46	-0.25	LOW	27
GEORGIA	97.11	-0.25	LOW	28

VIRGINIA	90.23	-0.3	LOW	29
WYOMING	84.22	-0.33	LOW	30
VERMONT	82.93	-0.34	LOW	31
ALABAMA	80.28	-0.36	LOW	32
RHODE ISLAND	79.68	-0.36	LOW	33
NEBRASKA	77.85	-0.37	LOW	34
LOUISIANA	73.16	-0.4	LOW	35
SOUTH CAROLINA	72.21	-0.41	LOW	36
OHIO	71.82	-0.41	LOW	37
FLORIDA	71.7	-0.41	LOW	38
UTAH	71.47	-0.41	LOW	39
MISSOURI	69.7	-0.42	LOW	40
MICHIGAN	68.84	-0.43	LOW	41
ARIZONA	65.62	-0.45	LOW	42
COLORADO	65.56	-0.45	LOW	43
IOWA	57	-0.5	LOW	44
NORTH DAKOTA	53.66	-0.52	LOW	45
KANSAS	48.13	-0.56	LOW	46
NEVADA	46.65	-0.57	LOW	47
SOUTH DAKOTA	45.6	-0.57	LOW	48
PENNSYLVANIA	37.82	-0.62	LOW	49
TENNESSEE	36.23	-0.63	LOW	50
MISSISSIPPI	29.27	-0.67	LOW	51
UNITED STATES	\$199.23			

Source: Derived using the Age 65+ Population Estimates in Table 2 and Table 33, using Infrastructure of Home and Community Based Services for the Functionally Impaired Elderly. State Source Book. U. S. Administration on Aging, 1995.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

 [Go to Table 18](#)  [Return to U.S. Map](#)

Home & Community Based Care Expenditures

Table 18: 1992 Total Home and Community Based Care Care Expenditures as a Percentage of Total Long Term Care Expenditures

STATE	HCBS EXP. AS			
	% LTC EXP.	SCORE	RATING	RANK
OREGON	50.40%	4.2	VERY HIGH	1
NEW YORK	43.4	3.38	VERY HIGH	2
CALIFORNIA	30	1.81	VERY HIGH	3
DELAWARE	25	1.22	VERY HIGH	4
WASHINGTON	24.4	1.15	VERY HIGH	5
WEST VIRGINIA	22.5	0.93	VERY HIGH	6
IDAHO	21.1	0.76	HIGH	7
TEXAS	20.9	0.74	HIGH	8
ARKANSAS	18.6	0.47	HIGH	9
OKLAHOMA	18	0.4	HIGH	10
NEW MEXICO	17.8	0.38	HIGH	11
MARYLAND	17.7	0.36	HIGH	12
ARIZONA	17.3	0.32	HIGH	13
FLORIDA	17.1	0.3	HIGH	14
NORTH CAROLINA	17	0.28	HIGH	15
ALASKA	16.7	0.25	HIGH	16
WISCONSIN	16.5	0.22	AVERAGE	17
VIRGINIA	15.6	0.12	AVERAGE	18
UTAH	15.6	0.12	AVERAGE	18
INDIANA	14	-0.07	AVERAGE	20
KENTUCKY	13.8	-0.09	AVERAGE	21
MONTANA	13.3	-0.15	AVERAGE	22
NEW JERSEY	13.3	-0.15	AVERAGE	22
SOUTH CAROLINA	12.9	-0.2	AVERAGE	24
MASSACHUSETTS	12.7	-0.22	AVERAGE	25
MAINE	12.6	-0.23	AVERAGE	26
ILLINOIS	12.3	-0.27	LOW	27
HAWAII	12.2	-0.28	LOW	28
MISSOURI	12.1	-0.29	LOW	29
ALABAMA	12	-0.3	LOW	30
GEORGIA	11.6	-0.35	LOW	31
MICHIGAN	11.5	-0.36	LOW	32

WYOMING	11.4	-0.37	LOW	33
NEVADA	11	-0.42	LOW	34
MINNESOTA	10.9	-0.43	LOW	35
IOWA	10.6	-0.47	LOW	36
NEBRASKA	9.9	-0.55	LOW	37
COLORADO	9.7	-0.57	LOW	38
NEW HAMPSHIRE	9.3	-0.62	LOW	39
CONNECTICUT	9.2	-0.63	LOW	40
VERMONT	8.7	-0.69	LOW	41
KANSAS	8.1	-0.76	LOW	42
LOUISIANA	7.9	-0.78	LOW	43
DIST. OF COLUMBIA	7.5	-0.83	LOW	44
OHIO	7.1	-0.88	VERYLOW	45
SOUTH DAKOTA	6.3	-0.97	VERYLOW	46
RHODE ISLAND	6.2	-0.98	VERYLOW	47
NORTH DAKOTA	5.5	-1.07	VERYLOW	48
PENNSYLVANIA	5.4	-1.08	VERYLOW	49
TENNESSEE	5.2	-1.1	VERYLOW	50
MISSISSIPPI	4.4	-1.19	VERYLOW	51

Source: Health Data Associates 1994. Oregon Senior and Disabled Services Division 1995.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

 [Go to Table 19](#)
 [Return to U.S. Map](#)



Potential Demand for Long Term Care

TABLE 19. Potential Demand on the Total Long-Term Care System (High Total Average Score Indicates High Relative Potential Demand on Long-Term Care Services)

STATE	ONE	TWO	THREE	FOUR	FIVE	AVG	RATED
NORTH DAKOTA	0.15	1.73	0.86	0.8	0.26	0.76	HIGH
SOUTH DAKOTA	-0.86	1.97	0.86	0.71	0.9	0.72	HIGH
MISSOURI	-0.29	1.06	0.9	0.36	0.65	0.54	HIGH
IOWA	-1.04	2.15	0.83	0.8	-0.14	0.52	HIGH
ARKANSAS	-0.18	0.71	0.36	0.02	1.63	0.51	HIGH
WEST VIRGINIA	-0.5	0.56	1.1	0.64	0.73	0.51	HIGH
MISSISSIPPI	-0.22	0	0.79	-1.09	2.86	0.47	HIGH
KENTUCKY	-0.26	0.09	0.71	0.47	1.32	0.46	HIGH
NEBRASKA	-0.9	1.68	1.02	0.7	-0.54	0.39	HIGH
OKLAHOMA	-0.28	0.56	0.9	0.16	0.42	0.35	HIGH
MINNESOTA	-0.74	0.82	0.75	0.77	0.06	0.33	HIGH
ALABAMA	0.2	-0.12	0.36	-0.57	1.72	0.32	HIGH
KANSAS	-0.64	1.29	0.71	0.55	-0.41	0.3	HIGH
MAINE	-0.81	0.71	0.36	0.86	0.3	0.28	HIGH
TENNESSEE	0.12	-0.14	0.09	0.04	1.13	0.25	HIGH
FLORIDA	1.65	1.24	-1.37	-0.01	-0.33	0.24	HIGH
WISCONSIN	-0.49	0.77	0.36	0.71	-0.3	0.21	AVERAGE
VERMONT	-0.7	0.3	0.44	0.85	-0.1	0.16	AVERAGE
NORTH CAROLINA	0.67	-0.56	-0.18	-0.36	1.17	0.15	AVERAGE
MASSACHUSETTS	-0.97	0.82	0.44	0.6	-0.16	0.15	AVERAGE
RHODE ISLAND	-0.74	0.85	0.4	0.67	-0.53	0.13	AVERAGE
MONTANA	-0.53	0.09	0.63	0.7	-0.49	0.08	AVERAGE
INDIANA	-0.42	0.06	0.52	0.46	-0.27	0.07	AVERAGE
PENNSYLVANIA	-0.44	0.62	0.09	0.4	-0.34	0.07	AVERAGE
LOUISIANA	-0.14	-0.73	0.29	-0.88	1.8	0.07	AVERAGE
NEW HAMPSHIRE	-0.1	-0.12	-0.37	0.84	0.05	0.06	AVERAGE
IDAHO	0.25	-0.23	-0.52	0.73	0	0.04	AVERAGE
NEW YORK	-0.9	0.27	0.4	-0.25	0.47	0	AVERAGE
GEORGIA	0.35	-1.11	-0.1	-0.58	1.22	-0.05	AVERAGE
NEVADA	3.67	-1.82	-0.99	0.24	-1.43	-0.06	AVERAGE

ARIZONA	2.36	-0.53	-1.41	0.11	-0.86	-0.07	AVERAGE
OHIO	-0.59	0.09	0.4	0.31	-0.59	-0.07	AVERAGE
OREGON	-0.16	0.33	-0.33	0.73	-1	-0.09	AVERAGE
SOUTH CAROLINA	0.56	-1.05	-0.41	-0.76	1.18	-0.1	AVERAGE
ILLINOIS	-0.62	0.06	0.36	0.03	-0.34	-0.1	AVERAGE
TEXAS	0.41	-0.85	-0.41	-0.71	0.9	-0.13	AVERAGE
WYOMING	-0.5	-0.67	0.79	0.58	-0.92	-0.15	AVERAGE
MICHIGAN	-0.48	-0.29	0.05	0.1	-0.58	-0.24	AVERAGE
COLORADO	-0.13	-0.85	0.21	0.15	-0.79	-0.28	LOW
DIST. OF COLUMBIA	-1.17	0.18	2.48	-3.92	1.01	-0.28	LOW
NEW MEXICO	1.15	-0.85	-0.87	-1.29	0.17	-0.34	LOW
CONNECTICUT	-0.52	0.56	-0.49	0.47	-1.75	-0.34	LOW
UTAH	0.99	-1.38	-1.14	0.6	-0.81	-0.35	LOW
VIRGINIA	0.07	-0.88	-0.64	-0.34	0	-0.36	LOW
NEW JERSEY	-0.6	-0.09	-0.79	0.05	-0.38	-0.36	LOW
WASHINGTON	-0.17	-0.38	-0.1	0.53	-1.71	-0.37	LOW
DELAWARE	-0.18	-0.41	-0.72	0.06	-0.65	-0.38	LOW
ALASKA	3.33	-3.08	-1.14	-0.86	-1.61	-0.67	LOW
MARYLAND	-0.08	-1.32	-0.95	-0.33	-1.01	-0.74	LOW
CALIFORNIA	-0.29	-0.85	-0.95	-0.61	-2.04	-0.95	VERY LOW
HAWAII	1.65	-1.03	-4.57	-4.24	0.16	-1.61	VERY LOW

CRITERION 1: 1983-1993 Age 85+ Growth Rate (Table 1)

CRITERION 2: 1992 Age 85+ Population as Percentage of the Total Population (Table 2)

CRITERION 3: 1992 Percentage of Age 65+ Population Living Alone (Table 3)

CRITERION 4: 1992 Percentage of Age 65+ Population Who Are Minorities (Table 4, reversed)

CRITERION 5: 1992 Age 65+ Severely Disabled Persons per 1000 (Table 5)

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

☐ [Go to Table 20](#)
☐ [Return to U.S. Map](#)



IDAHO	0.04	-0.41	-0.94	-0.08	-0.47	LOW	31
CALIFORNIA	-0.95	-1.19	0.95	-0.22	-0.47	LOW	31
MICHIGAN	-0.24	-0.55	-0.83	0.05	-0.52	LOW	33
ILLINOIS	-0.1	-0.57	-0.87	-0.08	-0.54	LOW	34
INDIANA	0.07	-0.55	-0.85	-0.35	-0.56	LOW	35
KANSAS	0.3	-0.31	-0.87	-0.89	-0.59	LOW	36
ALASKA	-0.67	-1.19	0.6	-0.62	-0.63	LOW	37
ARIZONA	-0.07	-0.55	-1.49	-0.08	-0.73	LOW	38
WISCONSIN	0.21	-0.89	-0.23	-1.29	-0.73	LOW	38
WYOMING	-0.15	-0.57	-1.1	-0.49	-0.77	LOW	40
NEW HAMPSHIRE	0.06	-0.67	-0.09	-1.69	-0.8	LOW	41
OREGON	-0.09	-0.69	-0.9	-0.75	-0.81	LOW	42
MARYLAND	-0.74	-0.61	-0.41	-1.02	-0.93	VERY LOW	43
NEVADA	-0.06	-0.79	-1.1	-0.89	-0.95	VERY LOW	44
DELAWARE	-0.38	-0.69	-1.08	-0.75	-0.97	VERY LOW	45
NEW JERSEY	-0.36	-1.01	-0.83	-0.75	-0.99	VERY LOW	46
WASHINGTON	-0.37	-0.89	-0.6	-1.16	-1	VERY LOW	47
CONNECTICUT	-0.34	-1.27	0.26	-1.69	-1.02	VERY LOW	48
HAWAII	-1.61	-1.11	-0.14	-0.35	-1.07	VERY LOW	49
COLORADO	-0.28	-0.51	-1.89	-0.89	-1.19	VERY LOW	50
UTAH	-0.35	-0.95	-1.26	-1.13	-1.24	VERY LOW	51

CRITERION 1: Overall Average Scores (Table 19)

CRITERION 2: 1991 Percentage Age 65+ Population with Incomes Below the Poverty Level (Table 6)

CRITERION 3: 1992 Percentage Age 65+ Population Receiving Medicaid (Table 7)

CRITERION 4: 1993 Age 18-64 Severely Disabled Persons Per 1,000 (Table 8)

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

 [Go to Table 21](#)  [Return to U.S. Map](#)

TENNESSEE	0.1	0.64	0.26	0.01	-0.42	0.12	AVERAGE	31
VERMONT	-0.68	1.2	0.2	-0.59	0.47	0.12	AVERAGE	31
OKLAHOMA	1.24	-1.6	0.95	-0.61	0.71	0.14	AVERAGE	33
OHIO	0.57	-0.48	0.51	0.26	0.06	0.18	AVERAGE	34
NEW HAMPSH.	-0.37	0.27	0.35	-0.38	1.05	0.18	AVERAGE	34
MAINE	-0.08	1.14	0.6	-0.46	-0.15	0.21	AVERAGE	36
MONTANA	0.3	0.04	0.68	-0.58	0.76	0.24	AVERAGE	37
GEORGIA	0.68	1.08	0.25	-0.54	-0.28	0.24	AVERAGE	37
MASSACHUS.	0.05	0.83	0.64	-0.58	0.29	0.24	AVERAGE	37
CONNECTICUT	0.47	0.69	0.92	-0.19	-0.13	0.35	BELOW AVERAGE	40
WISCONSIN	0.64	0.52	1.27	-0.95	0.46	0.39	BELOW AVERAGE	41
KANSAS	0.57	-0.25	1.72	-0.58	1.26	0.54	BELOW AVERAGE	42
MINNESOTA	0.62	1.02	1.99	-0.97	0.25	0.58	BELOW AVERAGE	43
IOWA	0.52	-0.08	1.47	-0.72	1.75	0.59	BELOW AVERAGE	44
NEBRASKA	0.73	0.12	1.52	-0.56	1.19	0.6	BELOW AVERAGE	45
RHODE ISLAND	0.65	1.18	0.95	-0.28	0.69	0.64	BELOW AVERAGE	46
SOUTH DAKOTA	0.29	1.21	1.82	-0.92	0.93	0.67	BELOW AVERAGE	47
LOUISIANA	2.06	-0.95	1.24	-0.11	1.28	0.71	BELOW AVERAGE	48
NORTH DAKOTA	0.3	1.33	1.69	-0.59	1.09	0.76	BELOW AVERAGE	49
WYOMING	1.17	-0.96	0.27	1.86	1.48	0.76	BELOW AVERAGE	49
INDIANA	1.72	-0.6	0.73	4.45	0.36	1.33	WELL BELOW AVG	51

CRITERION 1: 1992 Nursing Home Beds Per 1000 Age 85+ (Table 9)

CRITERION 2: 1992 Nursing Home Occupancy Rate (Table 10)

CRITERION 3: 1992 Nursing Home Residents as a Percentage of the 65+ Population (Table 11)

CRITERION 4: 1980-81 to 1990-91 Percentage Change in Nursing Home Utilization (Table 12)

CRITERION 5: 1992 Propac Acuity Index. Average Facility Scores by State (Table 13, reversed)

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

[Go to Table 22](#)
[Return to U.S. Map](#)



State Control of Nursing Home Expenditures

TABLE 22. Control of Nursing Home Expenditures (Low Total Average Score Indicates the State Has Done Relatively Well in Controlling Nursing Home Expenditures)

STATE	ONE	TWO	THREE	AVG	RATING	RANK
OKLAHOMA	-1.08	-0.8	-0.71	-0.86	WELL ABOVE AVG	1
UTAH	-0.59	0	-1.12	-0.85	ABOVE AVERAGE	2
ARIZONA	-0.23	0	-1.34	-0.78	ABOVE AVERAGE	3
IOWA	-0.97	-0.53	-0.83	-0.78	ABOVE AVERAGE	4
TEXAS	-0.83	-0.77	-0.64	-0.75	ABOVE AVERAGE	5
OREGON	-0.4	-0.5	-1.19	-0.7	ABOVE AVERAGE	6
KANSAS	-0.87	-0.45	-0.65	-0.66	ABOVE AVERAGE	7
VIRGINIA	-0.62	-0.51	-0.82	-0.65	ABOVE AVERAGE	8
ARKANSAS	-0.88	-0.71	-0.31	-0.63	ABOVE AVERAGE	9
SOUTH DAKOTA	-0.71	-0.78	-0.24	-0.58	ABOVE AVERAGE	10
SOUTH CAROLINA	-0.55	-0.36	-0.81	-0.57	ABOVE AVERAGE	11
COLORADO	-0.42	-0.84	-0.45	-0.57	ABOVE AVERAGE	11
ALABAMA	-0.44	-0.7	-0.52	-0.55	ABOVE AVERAGE	13
MONTANA	-0.26	-0.91	-0.37	-0.51	ABOVE AVERAGE	14
MICHIGAN	0.41	-1.2	-0.69	-0.49	ABOVE AVERAGE	15
WYOMING	-0.94	-0.13	-0.32	-0.46	ABOVE AVERAGE	16
MISSISSIPPI	-0.8	-0.2	-0.39	-0.46	ABOVE AVERAGE	16
WISCONSIN	-0.42	-1.41	0.52	-0.44	ABOVE AVERAGE	18
MISSOURI	-0.8	0.25	-0.75	-0.44	ABOVE AVERAGE	18
TENNESSEE	-0.49	-0.47	-0.29	-0.42	ABOVE AVERAGE	20
WASHINGTON	0.05	-0.77	-0.31	-0.34	ABOVE AVERAGE	21
NEBRASKA	-0.45	-0.37	-0.16	-0.33	ABOVE AVERAGE	22
IDAHO	-0.27	0.06	-0.77	-0.32	ABOVE AVERAGE	23
KENTUCKY	-0.47	0.01	-0.38	-0.28	ABOVE AVERAGE	24
GEORGIA	-0.68	-0.06	-0.04	-0.26	ABOVE AVERAGE	25
LOUISIANA	-0.54	-0.39	0.3	-0.21	AVERAGE	26
NEVADA	0.89	-0.26	-1.15	-0.17	AVERAGE	27
CALIFORNIA	0.11	0.31	-0.6	-0.06	AVERAGE	28
ILLINOIS	-0.44	0.33	-0.01	-0.04	AVERAGE	29
VERMONT	0.13	-0.53	0.33	-0.02	AVERAGE	30

NORTH CAROLINA	-0.26	0.76	-0.56	-0.02	AVERAGE	30
PENNSYLVANIA	0.21	0.02	-0.28	-0.02	AVERAGE	30
MINNESOTA	0.02	-1.1	1.47	0.13	AVERAGE	33
MARYLAND	-0.15	0.96	-0.17	0.21	AVERAGE	34
INDIANA	-0.1	0.55	0.27	0.24	AVERAGE	35
HAWAII	1.42	-0.55	-0.11	0.25	BELOW AVERAGE	36
DELAWARE	0.28	0.82	-0.25	0.28	BELOW AVERAGE	37
RHODE ISLAND	0.18	-0.61	1.35	0.31	BELOW AVERAGE	38
NEW MEXICO	-0.2	1.79	-0.66	0.31	BELOW AVERAGE	38
WEST VIRGINIA	0.32	1.41	-0.65	0.36	BELOW AVERAGE	40
NEW JERSEY	0.55	0.63	0.18	0.45	BELOW AVERAGE	41
NEW HAMPSHIRE	0.18	0.02	1.24	0.48	BELOW AVERAGE	42
NORTH DAKOTA	-0.23	1.44	0.51	0.57	BELOW AVERAGE	43
FLORIDA	-0.08	3.18	-1.24	0.62	BELOW AVERAGE	44
MAINE	0.28	0.06	1.66	0.67	BELOW AVERAGE	45
MASSACHUSETTS	0.33	-0.06	1.76	0.68	BELOW AVERAGE	46
OHIO	0	1.85	0.57	0.81	BELOW AVERAGE	47
CONNECTICUT	0.92	2.07	2.23	1.74	WELL BELOW AVG	48
ALASKA	4.55	-0.55	2.4	2.13	WELL BELOW AVG	49
NEW YORK	2.19	0	2.36	2.27	WELL BELOW AVG	50
DIST. OF COLUMBIA	3.17	0	2.61	2.89	WELL BELOW AVG	51

CRITERION 1: 1993 Medicaid Average Costs Per Day in a Nursing Home (Table 14)

CRITERION 2: 1980-81 to 1990-91 Percentage Change in Nursing Home Expenditures (Table 15)

CRITERION 3: 1992 Nursing Home Expenditures Per Person Age 65+ (Table 16)

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

[Go to Table 23](#) [Return to U.S. Map](#)

Administration On Aging



Commitment to Home and Community Based Services

TABLE 23. Commitment to Home and Community Based Service (High Total Average Score Indicates High Commitment to Home and Community-Based Care Services)

STATE	ONE	TWO	AVG	RATING	RANK
NEW YORK	6.41	3.38	4.9	VERY HIGH	1
OREGON	1.42	4.2	2.81	VERY HIGH	2
CALIFORNIA	0.62	1.81	1.21	VERY HIGH	3
DELAWARE	0.54	1.22	0.88	VERY HIGH	4
WASHINGTON	0.45	1.15	0.8	HIGH	5
ALASKA	1.07	0.25	0.66	HIGH	6
WEST VIRGINIA	0.12	0.93	0.53	HIGH	7
TEXAS	0.03	0.74	0.39	HIGH	8
IDAHO	-0.02	0.76	0.37	HIGH	9
NORTH CAROLINA	0.32	0.28	0.3	HIGH	10
WISCONSIN	0.28	0.22	0.25	HIGH	11
ARKANSAS	0.03	0.47	0.25	HIGH	11
MARYLAND	0.08	0.36	0.22	AVERAGE	13
OKLAHOMA	-0.15	0.4	0.13	AVERAGE	14
NEW MEXICO	-0.13	0.38	0.12	AVERAGE	15
MASSACHUSETTS	0.35	-0.22	0.06	AVERAGE	16
MAINE	0.31	-0.23	0.04	AVERAGE	17
INDIANA	0	-0.07	-0.04	AVERAGE	18
FLORIDA	-0.41	0.29	-0.06	AVERAGE	19
ARIZONA	-0.45	0.31	-0.07	AVERAGE	20
VIRGINIA	-0.3	0.12	-0.09	AVERAGE	21
NEW JERSEY	-0.08	-0.15	-0.12	AVERAGE	22
UTAH	-0.41	0.12	-0.15	AVERAGE	23
KENTUCKY	-0.23	-0.09	-0.16	AVERAGE	24
MINNESOTA	0.1	-0.43	-0.17	AVERAGE	25
MONTANA	-0.25	-0.15	-0.2	AVERAGE	26
ILLINOIS	-0.2	-0.27	-0.24	AVERAGE	27
HAWAII	-0.24	-0.28	-0.26	LOW	28

CONNECTICUT	0.09	-0.63	-0.27	LOW	29
GEORGIA	-0.25	-0.35	-0.3	LOW	30
SOUTH CAROLINA	-0.41	-0.3	-0.3	LOW	30
ALABAMA	-0.36	-0.3	-0.33	LOW	32
WYOMING	-0.33	-0.37	-0.35	LOW	33
MISSOURI	-0.42	-0.29	-0.36	LOW	34
NEW HAMPSHIRE	-0.11	-0.62	-0.37	LOW	35
MICHIGAN	-0.43	-0.36	-0.4	LOW	36
DIST. OF COLUMBIA	-0.03	-0.83	-0.43	LOW	37
NEBRASKA	-0.37	-0.55	-0.46	LOW	38
IOWA	-0.5	-0.46	-0.48	LOW	39
NEVADA	-0.56	-0.42	-0.49	LOW	40
COLORADO	-0.45	-0.57	-0.51	LOW	41
VERMONT	-0.34	-0.69	-0.51	LOW	41
LOUISIANA	-0.4	-0.78	-0.59	LOW	43
OHIO	-0.41	-0.88	-0.64	LOW	44
KANSAS	-0.56	-0.76	-0.66	LOW	45
RHODE ISLAND	-0.36	-0.98	-0.67	LOW	46
SOUTH DAKOTA	-0.57	-0.97	-0.77	LOW	47
NORTH DAKOTA	-0.52	-1.07	-0.79	LOW	48
PENNSYLVANIA	-0.62	-1.08	-0.85	VERY LOW	49
TENNESSEE	-0.63	-1.1	-0.87	VERY LOW	50
MISSISSIPPI	-0.67	-1.19	-0.93	VERY LOW	51

CRITERION 1: 1992 Total Home & Community-Based Care Expenditures Per Person Age 65+ (Table 17)

CRITERION 2: 1992 Total Home & Community-Based Care Expenditures as a Percentage of Total Long-Term Care Expenditures (Table 18)

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

[Go to Table 24](#)
[Return to U.S. Map](#)

Administration On Aging



Progress Toward Home and Community Based Care

TABLE 24. Progress Toward an HCBS System (High Total Average Score Indicates the State Has Made Progress Toward a Home and Community-Based System)

STATE	ONE	TWO	THREEa	THREEb	AVG	RATING	RANK
NEW YORK	0.48	-2.27	4.9	4.9	2	WELL ABOVE AVG	1
OREGON	0.97	0.7	2.81	2.81	1.82	WELL ABOVE AVG	2
CALIFORNIA	0.74	0.06	1.21	1.21	0.81	ABOVE AVERAGE	3
WASHINGTON	0.13	0.34	0.8	0.8	0.52	ABOVE AVERAGE	4
TEXAS	0.41	0.75	0.39	0.39	0.48	ABOVE AVERAGE	5
DELAWARE	0.15	-0.28	0.88	0.88	0.41	ABOVE AVERAGE	6
IDAHO	0.37	0.32	0.37	0.37	0.36	ABOVE AVERAGE	7
ARIZONA	0.66	0.78	-0.07	-0.07	0.33	ABOVE AVERAGE	8
ARKANSAS	-0.05	0.63	0.25	0.25	0.27	ABOVE AVERAGE	9
N. CAROLINA	0.42	0.02	0.3	0.3	0.26	ABOVE AVERAGE	10
OKLAHOMA	-0.14	0.86	0.13	0.13	0.25	AVERAGE	11
UTAH	0.4	0.85	-0.15	-0.15	0.24	AVERAGE	12
VIRGINIA	0.42	0.65	-0.09	-0.09	0.22	AVERAGE	13
W. VIRGINIA	0.09	-0.36	0.52	0.52	0.19	AVERAGE	14
S. CAROLINA	0.7	0.57	-0.3	-0.3	0.17	AVERAGE	15
WISCONSIN	-0.39	0.44	0.25	0.25	0.14	AVERAGE	16
HAWAII	1.28	-0.25	-0.26	-0.26	0.13	AVERAGE	17
MARYLAND	0.11	-0.21	0.22	0.22	0.09	AVERAGE	18
ALABAMA	0.31	0.55	-0.33	-0.33	0.05	AVERAGE	19
MICHIGAN	0.41	0.49	-0.4	-0.4	0.03	AVERAGE	20
KENTUCKY	0.14	0.28	-0.16	-0.16	0.03	AVERAGE	20
NEW MEXICO	-0.04	-0.31	0.12	0.12	-0.03	AVERAGE	22
MONTANA	-0.24	0.51	-0.2	-0.2	-0.03	AVERAGE	22
COLORADO	0.23	0.57	-0.51	-0.51	-0.06	AVERAGE	24
NEVADA	0.56	0.17	-0.49	-0.49	-0.06	AVERAGE	24
ALASKA	0.54	-2.13	0.66	0.66	-0.07	AVERAGE	26
MISSOURI	-0.07	0.44	-0.36	-0.36	-0.09	AVERAGE	27
FLORIDA	0.28	-0.62	-0.06	-0.06	-0.12	AVERAGE	28

ILLINOIS	-0.1	0.04	-0.24	-0.24	-0.13	AVERAGE	29
NEW JERSEY	0.15	-0.45	-0.12	-0.12	-0.14	AVERAGE	30
GEORGIA	-0.24	0.26	-0.3	-0.3	-0.15	AVERAGE	31
IOWA	-0.59	0.78	-0.48	-0.48	-0.2	AVERAGE	32
MASSACHUSETTS	-0.24	-0.68	0.06	0.06	-0.2	AVERAGE	32
MAINE	-0.21	-0.67	0.04	0.04	-0.2	AVERAGE	32
WYOMING	-0.76	0.46	-0.35	-0.35	-0.25	AVERAGE	35
MINNESOTA	-0.58	-0.13	-0.17	-0.17	-0.26	BELOW AVERAGE	36
VERMONT	-0.12	0.02	-0.52	-0.52	-0.28	BELOW AVERAGE	37
NEBRASKA	-0.6	0.33	-0.46	-0.46	-0.3	BELOW AVERAGE	38
KANSAS	-0.54	0.66	-0.66	-0.66	-0.3	BELOW AVERAGE	38
NEW HAMPSHIRE	-0.18	-0.48	-0.37	-0.37	-0.35	BELOW AVERAGE	40
TENNESSEE	-0.12	0.42	-0.87	-0.87	-0.36	BELOW AVERAGE	41
MISSISSIPPI	-0.08	0.46	-0.93	-0.93	-0.37	BELOW AVERAGE	42
PENNSYLVANIA	0.1	0.02	-0.85	-0.85	-0.39	BELOW AVERAGE	43
S. DAKOTA	-0.67	0.58	-0.77	-0.77	-0.41	BELOW AVERAGE	44
INDIANA	-1.33	-0.24	-0.04	-0.04	-0.41	BELOW AVERAGE	44
LOUISIANA	-0.71	0.21	-0.59	-0.59	-0.42	BELOW AVERAGE	46
OHIO	-0.18	-0.81	-0.64	-0.64	-0.57	BELOW AVERAGE	47
RHODE ISLAND	-0.64	-0.31	-0.67	-0.67	-0.57	BELOW AVERAGE	47
CONNECTICUT	-0.35	-1.74	-0.27	-0.27	-0.66	BELOW AVERAGE	49
N. DAKOTA	-0.76	-0.57	-0.79	-0.79	-0.73	BELOW AVERAGE	50
DIST. COLUMBIA	-0.11	-2.89	-0.43	-0.43	-0.97	WELL BELOW AVG	51

CRITERION 1: Total Average Scores (Table 21)

CRITERION 2: Total Average Scores (Table 22)

CRITERION 3: Total Average Scores (Table 23) weighted by a factor of 2, shown as two columns above.

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

[Go to Table 25](#)
[Return to U.S. Map](#)

Administration On Aging



Home and Community Based Care Summary

TABLE 25. Summary Table Showing State Conditions and Efforts Along the 5 Measured Categories
(Ranked in the Order Found in Table 24)

STATE	RATING 1	RATING 2	RATING 3	RATING 4	RATING 5	RATING 6
NEW YORK	AVERAGE	AVERAGE	ABOVE AVERAGE	WELL BELOW AVG	VERY HIGH	WELL ABOVE AVG
OREGON	AVERAGE	LOW	WELL ABOVE AVG	ABOVE AVERAGE	VERY HIGH	WELL ABOVE AVG
CALIFORNIA	VERY LOW	LOW	ABOVE AVERAGE	AVERAGE	VERY HIGH	ABOVE AVERAGE
WASHINGTON	LOW	VERY LOW	AVERAGE	ABOVE AVERAGE	HIGH	ABOVE AVERAGE
TEXAS	AVERAGE	HIGH	ABOVE AVERAGE	ABOVE AVERAGE	HIGH	ABOVE AVERAGE
DELAWARE	LOW	VERY LOW	AVERAGE	BELOW AVERAGE	VERY HIGH	ABOVE AVERAGE
IDAHO	AVERAGE	LOW	ABOVE AVERAGE	ABOVE AVERAGE	HIGH	ABOVE AVERAGE
ARIZONA	AVERAGE	LOW	ABOVE AVERAGE	ABOVE AVERAGE	AVERAGE	ABOVE AVERAGE
ARKANSAS	HIGH	VERY HIGH	AVERAGE	ABOVE AVERAGE	HIGH	ABOVE AVERAGE
N. CAROLINA	AVERAGE	HIGH	ABOVE AVERAGE	AVERAGE	HIGH	ABOVE AVERAGE
OKLAHOMA	HIGH	HIGH	AVERAGE	WELL ABOVE AVG	AVERAGE	AVERAGE
UTAH	LOW	VERY LOW	ABOVE AVERAGE	ABOVE AVERAGE	AVERAGE	AVERAGE
VIRGINIA	LOW	AVERAGE	ABOVE AVERAGE	ABOVE AVERAGE	AVERAGE	AVERAGE
W. VIRGINIA	HIGH	VERY HIGH	AVERAGE	BELOW AVERAGE	HIGH	AVERAGE
S. CAROLINA	AVERAGE	VERY HIGH	ABOVE AVERAGE	ABOVE AVERAGE	LOW	AVERAGE
WISCONSIN	AVERAGE	LOW	BELOW AVERAGE	ABOVE AVERAGE	HIGH	AVERAGE

HAWAII	VERY LOW	VERY LOW	WELL ABOVE AVG	BELOW AVERAGE	LOW	AVERAGE
MARYLAND	LOW	VERY LOW	AVERAGE	AVERAGE	AVERAGE	AVERAGE
ALABAMA	HIGH	VERY HIGH	ABOVE AVERAGE	ABOVE AVERAGE	LOW	AVERAGE
MICHIGAN	AVERAGE	LOW	ABOVE AVERAGE	ABOVE AVERAGE	LOW	AVERAGE
KENTUCKY	HIGH	VERY HIGH	AVERAGE	ABOVE AVERAGE	AVERAGE	AVERAGE
NEW MEXICO	LOW	HIGH	AVERAGE	BELOW AVERAGE	AVERAGE	AVERAGE
MONTANA	AVERAGE	AVERAGE	AVERAGE	ABOVE AVERAGE	AVERAGE	AVERAGE
COLORADO	LOW	VERY LOW	AVERAGE	ABOVE AVERAGE	LOW	AVERAGE
NEVADA	AVERAGE	VERY LOW	WELL ABOVE AVG	AVERAGE	LOW	AVERAGE
ALASKA	LOW	LOW	ABOVE AVERAGE	WELL BELOW AVG	HIGH	AVERAGE
MISSOURI	HIGH	HIGH	AVERAGE	ABOVE AVERAGE	LOW	AVERAGE
FLORIDA	AVERAGE	AVERAGE	ABOVE AVERAGE	BELOW AVERAGE	AVERAGE	AVERAGE
ILLINOIS	AVERAGE	LOW	AVERAGE	AVERAGE	AVERAGE	AVERAGE
NEW JERSEY	LOW	VERY LOW	AVERAGE	BELOW AVERAGE	AVERAGE	AVERAGE
GEORGIA	AVERAGE	VERY HIGH	AVERAGE	ABOVE AVERAGE	LOW	AVERAGE
IOWA	HIGH	LOW	BELOW AVERAGE	ABOVE AVERAGE	LOW	AVERAGE
MASSACHUS.	AVERAGE	LOW	AVERAGE	BELOW AVERAGE	AVERAGE	AVERAGE
MAINE	HIGH	AVERAGE	AVERAGE	BELOW AVERAGE	AVERAGE	AVERAGE
WYOMING	AVERAGE	LOW	BELOW AVERAGE	ABOVE AVERAGE	LOW	AVERAGE
MINNESOTA	HIGH	LOW	BELOW AVERAGE	AVERAGE	AVERAGE	BELOW AVERAGE
VERMONT	AVERAGE	AVERAGE	AVERAGE	AVERAGE	LOW	BELOW AVERAGE
			BELOW	ABOVE		BELOW

NEBRASKA	HIGH	LOW	AVERAGE	AVERAGE	LOW	AVERAGE
KANSAS	HIGH	LOW	BELOW AVERAGE	ABOVE AVERAGE	LOW	BELOW AVERAGE
NEW HAMPSH.	AVERAGE	LOW	AVERAGE	BELOW AVERAGE	LOW	BELOW AVERAGE
TENNESSEE	AVERAGE	VERY HIGH	AVERAGE	ABOVE AVERAGE	VERY LOW	BELOW AVERAGE
MISSISSIPPI	HIGH	VERY HIGH	AVERAGE	ABOVE AVERAGE	VERY LOW	BELOW AVERAGE
PENNSYLVAN.	AVERAGE	LOW	AVERAGE	AVERAGE	VERY LOW	BELOW AVERAGE
S. DAKOTA	HIGH	HIGH	BELOW AVERAGE	ABOVE AVERAGE	LOW	BELOW AVERAGE
INDIANA	AVERAGE	LOW	WELL BELOW AVG	AVERAGE	AVERAGE	BELOW AVERAGE
LOUISIANA	AVERAGE	VERY HIGH	BELOW AVERAGE	AVERAGE	LOW	BELOW AVERAGE
OHIO	AVERAGE	AVERAGE	AVERAGE	BELOW AVERAGE	LOW	BELOW AVERAGE
RHODE ISLAND	AVERAGE	HIGH	BELOW AVERAGE	BELOW AVERAGE	LOW	BELOW AVERAGE
CONNECTICUT	LOW	VERY LOW	BELOW AVERAGE	WELL BELOW AVG	LOW	BELOW AVERAGE
N. DAKOTA	HIGH	HIGH	BELOW AVERAGE	BELOW AVERAGE	LOW	BELOW AVERAGE
DIST. COLUM.	LOW	HIGH	AVERAGE	WELL BELOW AVG	LOW	WELL BELOW AVG

CATEGORY 1: Potential Demand on Total LTC System (Total Average Score, Table 19)

CATEGORY 2: Potential Demand on Public LTC System (Total Average Score, Table 20)

CATEGORY 3: Control of Nursing Home Utilization (Total Average Score, Table 21)

CATEGORY 4: Control of Nursing Home Expenditures (Total Average Score, Table 22)

CATEGORY 5: Commitment to Home and Community-Based Services (Total Average Score, Table 23)

CATEGORY 6: Progress Toward an HCBS System (Total Average Score, Table 24)

The ratings and conclusions contained in this report are those of the authors and do not necessarily reflect the views of the Administration on Aging.

BACKGROUND

ahca

American Health Care Association

Fact Sheet on Long Term Health Care

General Information

- Medicare does not address the long term care and nursing home needs of our nation's elderly. Medicare covers only those nursing facility services rendered to help a resident recover from an acute illness or injury. In most cases, Medicare at a maximum provides for the first 100 days of care and only if certain conditions are met. (Health Care Financing Administration, 1996)
- Two out of every three nursing home residents rely on Medicaid to pay for their care. (Ibid.)
- In order to qualify for Medicaid, seniors are forced to "spend down" their assets to less than \$2,000 in most states to get the long term care they need. (Ibid.)
- More than eight of every ten Americans believe it is wrong for seniors to impoverish themselves to go on a government program for nursing home care. (1995 Luntz Research)

The Demographic Dilemma

- Every eight seconds in America, a baby boomer turns fifty. (U.S. Census Bureau, 1996)
- Americans aged 85 and older are the fastest growing segment of population and the heaviest users of long term health care services. From 1960-1994, the 85 and older age group increased by more than 274 percent. Longevity is expected to rise for all ages. (Ibid.)

Provided by ASHNNHA

- Two out of five Americans will need long term care at some point in their lives. (Health Care Financing Administration, 1996)
- In 1996, the average cost of stay in a nursing facility was \$41,000/year. Only one in four Americans can afford private nursing home care for one year, yet the average length of stay in 1995 for a nursing facility resident was 2.3 years. (Ibid.)

Long Term Care Affects Women And Families

- Family members are often the primary care-givers of long term health care. Increasingly, women -- the traditional family care-giver -- are working outside the home. A national study found that 80 percent of working caregivers reported emotional strain, 50 percent reported financial strain, while 40 percent missed work on a regular basis due to the health needs of an elderly loved one. (American Association of Retired Persons, 1997)
- Three out of four nursing facility residents are women. (U.S. Census Bureau, 1996)

####

BACKGROUND

ahca

American Health Care Association

Profile: Nursing Facility Resident

General

- Approximately 1.5 million people live in the nation's 17,000 nursing care facilities (American Health Care Association, *Facts and Trends*).
- More than 90 percent of nursing facility residents are over age 65. Five percent are age 55-64 (Health Care Financing Administration).
- Seventy-five percent of all nursing home residents are women (HCFA).

Residents

The typical nursing home resident is a woman in her 80s displaying a mild form of memory loss and dementia. Although physically healthy for a woman her age, she needs help with approximately 4 of 5 activities of daily living (eating, transferring, toileting, dressing, and bathing).

A typical resident has managed to set aside a total of only \$20,000 for her retirement. With the average annual cost of nursing home care running approximately \$41,000, she is unable to afford the care she needs beyond the first six months. The typical resident, however, will spend more than three years in a nursing facility due to her cognitive and physical disabilities. Her health insurance is limited to Medicare only with a modest Social Security check for income.

Financially incapable of meeting the costs of her care, the female resident must rely on Medicaid to pay for her 24-hour care and supervision. In order to qualify, she must impoverish herself to no more than \$2,000 in total assets.

####

BACKGROUND

ahca

American Health Care Association

Profile: Assisted Living Resident

General

- Assisted living provides relatively independent seniors with supervision, assistance, and limited health care services in a home-like atmosphere.
- Assisted living services include 24-hour protective oversight, food, shelter, and a range of services that promote the quality of life of the individual.
- Assisted living is licensed by state governments and is known by a large variety of names including: residential care, board and care, congregate care, and personal care. (National Center for Assisted Living/American Health Care Association Survey, June 1997)
- According to various estimates, there are approximately 25,000 assisted living facilities in the United States. (American Health Care Association, 1997 Facts & Trends; National Center for Assisted Living, The Assisted Living Sourcebook)

Residents

The "typical" assisted living resident is an 82-year old woman who is mobile, but needs assistance with one or two personal activities. Although most elderly assisted living residents are female, due to women's longer life expectancies, 29 percent are male. The "average" age of elderly residents, women and men combined, is 82 years, according to NCAL/AHCA survey findings.

The survey also found that while nearly one-third (31 percent) of all residents needed no help in taking care of their own personal activities, others did in varying degrees. Assisted living residents needed help with on average 1.6 common personal activities, which include activities such as bathing, dressing, transferring, toileting, and eating. (NCAL/AHCA)

Residents of assisted living facilities stay an average of 3.3 years, and leave the facility when a higher level of medical care is needed. (NCAL/AHCA)

Costs for assisted living residences vary greatly and depend on the size of the units, services provided, and location. In one study, monthly assisted living rates ranged from \$1,000 to \$3,000, depending on variables such as building design and amenities. (NCAL/AHCA, Survey of Assisted Living Facilities, 1996)

About 90 percent of assisted living services are paid for with private funds, making this market highly sensitive to economic forces. The Supplementary Security Income, Older Americans Act, and Social Services Block Grant programs pay for some assisted living services, while about 22 states allow the federal Medicaid program to pay for some service components. Funding patterns are likely to change as more and more states apply for Medicaid waivers and as managed care gets more involved in assisted living. (AHCA)

###

BACKGROUND



American Health Care Association

LONG TERM CARE INSURANCE: DEBUNKING THE MYTHS

Anyone, no matter what age or state of health, may need long term care (LTC) services at some point in his or her life. Yet 72 percent of Americans say they are unable to pay for LTC without outside help.¹ For most, that help will come only after they have exhausted their personal assets and are forced onto welfare.

Today, our nation's long term care financing system steers people toward impoverishment and reliance on Medicaid, a government assistance program. In the next century, Medicaid will not withstand the demographic tidal wave of aging baby boomers. Proposed cuts in Medicaid will present tremendous problems for the nation unless there is a fundamental shift to a system that relies more heavily on private long term care insurance. LTC insurance is a sensible and compassionate way to meet the nation's long term care needs. It can help protect Americans from financial ruin as they grow older and ease the fiscal burden on state and federal governments.

When asked, most Americans agree. According to a recent survey conducted by Luntz Research Companies for the American Health Care Association (AHCA), 76 percent of Americans said they want the government to shift from the current Medicaid financing program to one rooted in private LTC insurance.²

However, that survey also found that few Americans understand what LTC options exist and, as a result, few are taking adequate steps to prepare for the LTC needs they may face in the future. That's understandable among today's younger population, but it creates a serious problem for older Americans. The Luntz survey found that only one in three are financially prepared for the possibility that they may need LTC.

Myth #1: I Will Never Need Long Term Care.

A poll by The Gallup Organization shows that 76 percent of Americans believe they will never have the need for a nursing home, an assisted living program, home and community-based care, or any other type of LTC service.³ But the fact is two out of five Americans will need nursing home care at some point in their lives.⁴

According the U.S. Census Bureau, the over-85 population is the fastest growing segment of the U.S. population, and one out of four people in that age group lives in a nursing home. Approximately 75 percent of nursing home residents are women. AHCA projects that the number of elderly living in nursing homes will increase 58 percent by 2020.

Most who do need nursing home care will require an extended stay. A full 55 percent of those who enter nursing homes will stay at least one year; 21 percent will remain five years or longer.⁵

LTC services are a bargain compared to hospital care, where consumers paid an estimated average of about \$900 for a one-day stay in 1993.⁶ But sustained use of LTC can take a financial toll. It costs, for example, an average of \$41,000 a year (or \$112 a day) to live in a nursing home.⁷ An extended stay can run into the hundreds of thousands of dollars.

Failure to prepare for the cost of a nursing facility stay or other LTC is the primary cause of impoverishment among the elderly. The average American man can expect to spend \$56,895 on LTC. The average woman will spend \$124,370. Private health insurance policies offer limited, if any, coverage for LTC services. As a result, it can take only months – or mere weeks – from the time a person needs LTC until they are forced onto Medicaid by the depletion of personal resources.⁸

Expected Lifetime LTC Costs by Age and Gender, 1995

AGE	MALES	FEMALES
55 to 64	\$66,849	\$157,039
65 to 69	\$56,895	\$124,370
70 to 74	\$52,421	\$107,555
75 to 79	\$49,594	\$96,044
80+	\$48,145	\$86,645
Average (Age 67)	\$56,895	\$124,370

Source: LifePlans Inc. Long Term Care Utilization Model

In 1994, approximately 7.3 million elderly Americans needed LTC services. Experts predict this number will jump to nearly 9 million by the turn of the century. With the baby boom generation aging, estimates are that the number of people needing LTC services will increase to between 10 and 14 million by 2020, and 14 to 24 million in 2060.⁹

Myth #2: If I Do Need Long Term Care, Medicare or My Health Insurance Will Pay For It.

Studies show that most American fail to prepare for the costs of LTC because they believe Medicare or their own health insurance plans will pay for the bills, but the facts show otherwise.¹⁰ According to Health Care Financing Administration data, two out of three nursing home residents – about one million people – now rely on the Medicaid program to pay for their care.

Medicare covers post-hospital skilled nursing and rehabilitation care for a maximum of 100 days with each illness. For the first 20 days, Medicare pays the full cost of a patient's care, but for the next 80 days patients must assume a substantial co-insurance payment. In 1996, for example, the patient's co-insurance payment totaled \$92 per day. For a 100-day stay, the patient's out-of-pocket co-insurance costs alone would total \$7,360.

Unfortunately, most people do not realize they must finance their LTC out of savings or assets until they are actually faced with the need for LTC. Because most people aren't financially prepared for the expense of LTC, they must turn to Medicaid for help. But Medicaid covers LTC only after a person is impoverished. Medicaid is welfare and welfare limits the number of choices people can make about their care. Despite popular belief, general health insurance plans and Medigap plans do not cover LTC.

For 1994, the Health Care Financing Administration reports that the nation spent \$74.2 billion on nursing home care. Medicaid financed 51.6 percent, Medicare paid for 10.6 percent, out-of-pocket payments comprised 31.5 percent and 3.8 percent came from other sources. Taxpayers are shouldering a heavy burden. Accounting for only 2.4 percent of nursing home costs in 1994, private insurance is clearly under-utilized as a payment source.¹¹

Given efforts by Congress and the Administration to reduce Medicaid expenditures, it is doubtful that Medicaid will be able to sustain the level of support in paying for LTC, especially since our nation's elderly population is rapidly aging. However, research finds that Medicaid expenditures would be reduced by \$7,945 to \$15,519 for every nursing home entrant who had a LTC insurance policy.¹²

Myth #3: I Cannot Afford Long Term Care Insurance.

As more and more elderly Americans understand the risks associated with the need for and the cost of LTC, they are choosing to protect themselves with LTC insurance.

Some interest groups – vocal advocates for total government funding of the LTC system – claim that most Americans cannot afford LTC insurance. However, the data show that a substantial number of recent purchasers of LTC insurance fall squarely into the middle class.

A study released by the Health Insurance Association of American (HIAA) in 1995 found a majority of LTC insurance purchasers (61 percent) have annual incomes of less than \$35,000, and about one-third have assets valued at less than \$30,000.¹³

The authors of the study conclude: "Thus, this insurance does represent a viable financing option for a growing number of retiring middle-class elders."¹⁴

Certainly, LTC insurance is affordable when balanced against the astronomical costs incurred by a person who has no financial protection and needs care.

The HIAA reports that the typical policy purchased by people age 65:¹⁵

- pays an average \$86 daily nursing home benefit
- pays an average \$80 daily home care benefit
- covers 5.1 years of nursing home care
- costs an average of \$93 per month

That same study reports that purchasing LTC insurance at age 50 or younger can cut a monthly premium by half or more.

A study published in Health Affairs found that many elderly, middle-class Americans are willing to spend an average \$70 monthly on Medigap insurance.¹⁶

If most middle-class Americans can afford Medigap insurance, then they can afford LTC insurance at an average cost of \$93 per month. LTC insurance is a better bargain than Medigap insurance, particularly when purchased at age 50 or younger.

The need for LTC is a risk worth insuring against:

- The risk of catastrophic expenditures is not inconsequential – 45 percent of those needing LTC can expect expenditures greater than \$10,000.¹⁷
- The risk is largely unpredictable early on because the kinds of conditions that frequently lead to a need for LTC often are unforeseeable in youth (e.g., the onset of dementia or stroke).
- Those who need LTC rarely can afford to pay for it out of current income and assets. For example, in 1991, elderly women living alone had a median income of \$9,740 – about one-third the average annual cost of nursing home care at that time.

In addition, if the risks and costs of LTC are spread across a wider population, the costs for any one “unlucky” individual are far more affordable.¹⁸

Myth #4: Long Term Care Insurance Is Not A Good Value.

Advocates of government funding for LTC claim that LTC insurance policies are not worth the cost of their premiums. This argument begs the following questions:

- Is the cost of a LTC insurance policy worth freedom of choice in regard to care?
- Is the cost worth the freedom from personal debt?
- Is the cost worth knowing that my family will not be saddled with the cost of my care?

LTC insurance purchasers list a wide variety of reasons for purchasing LTC insurance. The HIAA survey showed that the top reason was “to avoid depending on others for care and to preserve my independence.”¹⁹

The HIAA survey makes it clear. A majority of Americans (59 percent) believe LTC insurance is worth the alternative: reliance on government.

The "worth" of LTC insurance can be measured on more than an individual level. More and more employers are beginning to realize the value of offering LTC insurance plans to their employees with an option for relatives to join. The "sandwich generation" – adults caring for both young children and elderly parents – often is stretched to the limit. Such pressure can affect performance in the workplace, resulting in lost productivity.

An article in Business & Health magazine notes the benefits employers receive when they offer LTC insurance to workers:

"For employers, the incentives for offering LTC insurance are employee satisfaction and productivity. Connecticut Community Care Inc., a state-licensed, private non-profit care management agency based in Bristol, estimates that corporations lost an average of \$220,000 a year per 500 employees as a result of their employees' care giving responsibilities. This excludes the costs of personal use of company telephones, increased payouts of health care benefits due to caregivers' stress, and productivity losses."²⁰

LTC insurance is regulated to ensure the integrity of the products offered. According to a recent HIAA survey analysis, 50 states have adopted laws and regulations affecting LTC insurance.

Additional Facts About LTC Insurance²¹

- By the end of 1994, more than 3.8 million people had purchased LTC insurance policies, compared to 815,000 by December 1987. From 1987 to 1994, LTC insurance sales grew at an annual average rate of 25 percent.
- In 1994, 121 companies sold long term care insurance.
- By the end of 1994, 1,028 employers were offering LTC insurance plans to their employees. The number of small firms (1 to 500 employees) providing long term care insurance increased from 58 in 1990 to 567 in 1994.
- Of the 1,028 employer-sponsored plans, at least 432 employers paid all or part of the employee premium.

Policies sold offered a wide range of benefit options and policy design flexibility at stable and affordable premiums. An in-depth analysis by HIAA of the 12 top sellers (responsible for 80 percent of all individual and group association policies in 1994) found:

1. All offered nursing home, home health care, and adult day care. Eleven plans also offered alternate care and respite care benefits. Hospice care was covered by 10 insurers.
2. None of the top sellers used a "medical necessity only" benefit trigger.
3. All plans are guaranteed renewable, have a 30-day free-look period, have a pre-existing condition limitation of less than six months, cover Alzheimer's disease, sell to persons over 80, and offer an unlimited lifetime nursing home maximum.
4. All plans conform to the National Association of Insurance Commissioners' Model Act and Regulation inflation protection.
5. All plans offer an optional non-forfeiture benefit to policyholders.

Conclusions

The current LTC financing system is bankrupting families and burdening taxpayers. Congress and the Administration are debating reduced government funding for Medicare and Medicaid. As the baby boom generation ages and the number of elderly Americans doubles, it is important to examine whether taxpayers can afford the tab for LTC. The cost of LTC is straining public budgets today. The pressure will increase as we enter the 21st century.

The LTC financing system can be reformed through a public policy that promotes the notion that people who *can* pay their own care *should* pay for their own care. The 1995 Luntz survey found that most Americans support the concept. A full 86 percent said it made sense to develop a policy that encourages people to buy LTC insurance and a full 87 percent agreed that government assistance should be provided for those who are "genuinely destitute."²²

A sound reform plan would encourage private insurance to absorb a much greater share -- about 25 percent -- of our nation's LTC bill. Older Americans who have worked and paid taxes all their lives should not be forced onto welfare simply for needing LTC.

People who prepare for the cost of LTC can be secure in the knowledge that they have greater freedom to choose their care and that their assets (and the assets of spouses/families) are more secure.

April 1997

SOURCES

- ¹ American Opinions on Reforming Medicaid: A national public opinion survey conducted by Luntz Research Companies. Nationwide survey conducted August 1-6, 1993; 3
- ² American Opinions on Reforming Medicaid.
- ³ Public Attitudes on Long Term Care: "The EBRI Poll": A National Public Opinion Survey Conducted by The Gallup Organization, Inc. Released August 1993; 15.
- ⁴ Kemper, Peter, and Christopher M. Murtaugh, "Lifetime Use of Nursing Home Care." New England Journal of Medicine 1991; 324 (9): 595.
- ⁵ New England Journal of Medicine 1991; 324(9): 595.
- ⁶ U.S. Bureau of the Census, Statistical Abstract of the United States: 1995.
- ⁷ American Health Care Association
- ⁸ Wooldridge, Wilfred E. "Why Nursing Home Insurance?" Missouri Medicine October 1991; 88(10): 694.
- ⁹ U.S. General Accounting Office Report to Congressional Requesters. Long Term Care: Diverse Growing Population Includes Millions of Americans of All Ages. 1994: 4.
- ¹⁰ Public Attitudes, 17.
- ¹¹ Health Care Financing Administration. Health Care Financing Review. Summer 1995: Volume 16, Number 4.
- ¹² Cohen, Marc A., Nanda Kumar, and Stanley S. Wallack. "Long Term Care Insurance and Medicaid." Data Watch. Fall, 1994; 134.
- ¹³ Health Insurance Association of America, Who Buys Long-Term Care Insurance?: 1994-95 Profiles and Innovations in a Dynamic Market. 1995; 16.
- ¹⁴ *Ibid.*, 18.
- ¹⁵ *Ibid.*, 27.
- ¹⁶ Cohen, Marc A., Nanda Kumar, and Stanley S. Wallack. "Who Buys Long Term Care Insurance?" Health Affairs Spring 1992; 11(1):211.
- ¹⁷ Lewin, -VHI, Inc. Long Term Care: Background Facts on Use and Financing June 1993; 23.
- ¹⁸ *Ibid*; 23.
- ¹⁹ Health Insurance Association of America, Who Buys Long-Term Care Insurance?: 1994-95 Profiles and Innovations in a Dynamic Market. 1995; 29.
- ²⁰ Tenser, James. "Long Term Care Insurance: The Rx for a Graying America." Business & Health Mid-March 1992; 56.
- ²¹ Health Insurance Association of America. Policy and Research Findings: "Long-Term Care Insurance in 1994." March 1996; 2.
- ²² American Health Care Association/Gallup Organization, March 1993.

**UNIFORM GUARDIANSHIP AND PROTECTIVE
PROCEEDINGS ACT (1997)**

Drafted by the

**NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS**

and by it

**APPROVED AND RECOMMENDED FOR ENACTMENT
IN ALL THE STATES**

at its

**ANNUAL CONFERENCE
MEETING IN ITS ONE-HUNDRED-AND-SIXTH YEAR
IN SACRAMENTO, CALIFORNIA
JULY 25 – AUGUST 1, 1997**

WITH PREFATORY NOTE AND COMMENTS

COPYRIGHT © 1997

By

**NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS**

June 17, 1998

UNIFORM GUARDIANSHIP AND PROTECTIVE PROCEEDINGS ACT (1997)

The Committee that acted for the National Conference of Commissioners on Uniform State Laws in preparing the Uniform Guardianship and Protective Proceedings Act (1997) was as follows:

THOMAS L. JONES, University of Alabama, School of Law, P.O. Box 5557,
University Station, Tuscaloosa, AL 35486, *Chair*
RHODA B. BILLINGS, Wake Forest University, School of Law, P.O. Box 7206,
Winston-Salem, NC 27109
CLARKE A. GRAVEL, P.O. Box 369, 76 St. Paul Street, Burlington, VT 05402
MERRILL MOORES, 244 N. College Avenue, Indianapolis, IN 46202
ELWAINE F. POMEROY, 1415 S.W. Topeka Boulevard, Topeka, KS 66612
ROBERT C. ROBINSON, P.O. Box 568, Portland, ME 04112-0568
RICHARD V. WELLMAN, University of Georgia, School of Law, Athens, GA 30602
REBECCA C. MORGAN, Stetson University, College of Law, 1401 61st Street South,
St. Petersburg, FL 33707, *Reporter*

EX OFFICIO

BION M. GREGORY, Office of Legislative Counsel, State Capitol, Suite 3021,
Sacramento, CA 95814-4996, *President*
W. JACKSON WILLOUGHBY, Placer County Municipal Court, 11546 B Avenue,
Auburn, CA 95603, *Chair, Division B*

EXECUTIVE DIRECTOR

FRED H. MILLER, University of Oklahoma, College of Law, 300 Timberdell Road,
Norman, OK 73019, *Executive Director*
WILLIAM J. PIERCE, 1505 Roxbury Road, Ann Arbor, MI 48104, *Executive Director*
Emeritus

Copies of this Act may be obtained from:

NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS
211 E. Ontario Street, Suite 1300
Chicago, Illinois 60611
312/915-0195

Prefatory Note

The Uniform Guardianship and Protective Proceedings Act (1997) replaces the previous Act of the same name, which was approved by the National Conference of Commissioners on Uniform State Laws in 1982. The 1997 Act may be enacted either as a free-standing Act or as part of the Uniform Probate Code (U.P.C.). States that wish to enact the Act as part of the U.P.C. should consult Article 5, Parts 1-4 of the U.P.C. for the official text of the Act as conformed to the Code's definitions and general provisions.

The topics covered in this Act include minors' guardianships, adults' guardianships, and conservatorships of minors and adults. The Act is divided into five articles. Article 1 contains definitions and general provisions applicable to both guardianships and conservatorships, including provisions that relate to the office of guardian and conservator and to the jurisdiction of the courts, many of which were scattered in different sections of the prior Act. Article 2 contains provisions on guardianships for minors, whether by the court or the parent. Article 3 contains provisions for guardianships for incapacitated persons, who will most often be adults, but who may also be minors whose need for guardianship is unrelated to their age. Article 4 covers conservatorships and other protective arrangements for both minors and adults, including the procedures for appointment of conservators and the process for implementing a protective arrangement. Article 5 contains boilerplate provisions common to Uniform Acts.

The revisions to the Uniform Guardianship and Protective Proceedings Act were precipitated by a two year study by the A.B.A. Senior Lawyers Division Task Force on Guardianship Reform. The Task Force consisted of representatives not only of the Senior Lawyers Division, but also of other A.B.A. entities, including the Real Property Probate and Trust Law Section and the Commissions on Legal Problems of the Elderly and Mental and Physical Disability Law, as well as a variety of other groups interested in guardianship, such as AARP and the National Senior Citizens Law Center. The Task Force generated a report that served as the starting point for the redrafting of the Uniform Guardianship and Protective Proceedings Act. The drafting committee of the Uniform Law Commissioners began the drafting of the revision in 1995. The revised Act was approved at the 1997 Annual Meeting of the National Conference of Commissioners on Uniform State Laws, with technical amendments offered at the 1998 Annual Meeting of the National Conference of Commissioners on Uniform State Laws, and offered to the A.B.A. for the approval of its House of Delegates at its annual meeting in 1998.

Significant developments in the areas of guardianship and conservatorship occurred in the late 1980s and early 1990s, as states revised their guardianship and conservatorship statutes. The 1982 Act, with its emphasis on limited guardianship and conservatorship, was groundbreaking in its support of autonomy. This revised Act builds on this and the revisions occurring in the states, by providing that guardianship and conservatorship should be viewed as a last resort, that limited

guardianships or conservatorships should be used whenever possible, and that the guardian or conservator should always consult with the ward or protected person, to the extent feasible, when making decisions.

Many other substantial changes are contained in the revised Act. The following summarize some of the more significant ones.

The definition of incapacitated person is based on functional abilities, recognizing that a person may have the capacity to do some things while needing help with others. Before a guardian may be appointed for an adult or a minor for reasons other than age, the individual must be determined to be incapacitated, that is, the individual is "unable to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate technological assistance." (Section 102(5)). If assistive technology is available that may enable the individual to receive and evaluate information or to make or communicate decisions, then the individual may not be an "incapacitated person."

A parent or spouse may appoint a guardian to take office immediately upon the need. In both Articles 2 and 3 are provisions for a parental or spousal appointment of a "standby" guardian: by a parent for a minor child under Article 2 and by a parent for an adult disabled child or by a spouse for an incapacitated spouse under Article 3. The addition of these provisions was spurred by the increasing number of single-parent families in the United States as well as by the recognition that adults are living longer and may need assistance in their later lives. The standby provisions are available in a wide variety of situations where there is a need for a guardian to step in immediately upon the occurrence of an event, without seeking prior court approval. The appointment may be used by all parents of minor children as well as for the spouse of an incapacitated adult or the parent of an adult disabled child.

A guardian or a conservator should be appointed only if there are no other lesser restrictive alternatives that will meet the respondent's needs. The Act encourages the use of alternatives to guardianship or conservatorship and views the appointment of a guardian or a conservator as a last resort. The court may not appoint a guardian for an incapacitated person unless the court makes a finding that the respondent's needs cannot be met by any less restrictive means. (Section 311(a)(1)(B)). The visitor appointed by the court to investigate the appropriateness of the guardianship or conservatorship requested for an adult, must investigate whether alternatives are available and report this to the court. (Sections 305(e), 406(e)).

Additionally, the Act specifies procedural steps which must be met before a guardian for an incapacitated person or conservator may be appointed or a protective order entered. Specific information is required in the petition (Sections 304, 403), the respondent must be personally served with the notice of the hearing and the petition at least fourteen days in advance of the hearing and others must receive copies (Sections 113, 309, 404), and the court must appoint a visitor

(Sections 305, 406). Enacting jurisdictions must choose between requiring counsel only if requested by the respondent, recommended by the visitor, or if the court otherwise orders (Alternative 1 to Sections 305(b) and 406(b)), or requiring counsel for the respondent in all cases (Alternative 2 to Sections 305(b) and 406(b)). In guardianships, the court must order a professional evaluation of the respondent if the respondent requests one or the court determines one to be appropriate (Section 306), while in a conservatorship proceeding, the court may order a professional evaluation. (Section 406(f)). The respondent and proposed guardian or conservator must attend the hearing unless excused by the court for good cause. (Sections 308(a), 408(a)).

Emphasized throughout the Act are the concepts of limited guardianship and limited conservatorship. Only when no alternative to guardianship or conservatorship is available should the court create a guardianship or conservatorship. Courts are directed to tailor the guardianship or conservatorship to fit the needs of the incapacitated person and only remove those rights that the incapacitated person no longer can exercise or manage. (Sections 311(b), 409(b)). If an unlimited guardianship or conservatorship is requested, the petition must state why a limited guardianship or conservatorship is not being sought. (Sections 304(b)(8), 403(c)(3)). The guardian or conservator must take the views of the ward or protected person into account when making decisions. The guardian must maintain sufficient contact with the ward so that the guardian knows of the capabilities, limitations, needs and opportunities of the ward (Sections 207(b)(1), 314(b)(1)). The guardian or conservator must encourage the ward or protected person to participate in decisions, to act on his or her own behalf, and to develop or regain capacity to manage personal or financial affairs. (Sections 314(a), 418(b)). The guardian must consider the ward's expressed desires and personal values when making decisions (Section 314(a)), while the conservator, in making decisions with respect to the protected person's estate plan, or the court, in deciding on a protective arrangement, must rely, when possible, on the decision the protected person would have made. (Sections 411(c), 412(b)).

The position of the drafting committee is that appointment of counsel should not be mandated in every guardianship under Article 3 or every conservatorship under Article 4. The Act instead provides alternative provisions on whether counsel will be required in guardianship proceedings for incapacitated persons and in conservatorship proceedings. Sections 305(b) and 406(b). The enacting jurisdiction chooses between requiring counsel only when requested by the respondent, recommended by the visitor, or otherwise ordered by the court, or requiring counsel for the respondent in all cases. The appointment of counsel is in addition to the requirement that a visitor be appointed, a requirement in all proceedings where a guardian for an incapacitated person is requested or where the appointment of a conservator is sought. Sections 305(a) and 406(a).

The committee which drafted this Act prefers Alternative 1 to sections 305(b) and 406(b). Under the committee's preferred process, a visitor is appointed in every

proceeding for appointment of a guardian under Article 3, with counsel appointed on the respondent's request, the visitor's recommendation, or the court's determination that counsel is needed. (See Section 305). Concomitantly, in Article 4, a visitor is appointed in every case where a petition for appointment of conservator is filed and may be appointed when a protective arrangement is sought and the respondent is not already represented by counsel. (See Section 406). Alternative 2 for sections 305(b) and 406(b) is included at the request of the American Bar Association (A.B.A.) Commission on Legal Problems of the Elderly.

The burden of proof in establishing a guardianship or conservatorship is clear and convincing evidence, (See Sections 311, 401) while the burden of proof for terminating a guardianship or conservatorship is prima facie evidence. (See Sections 318(c), 431(d)). This distinction was made in recognition that a guardianship or conservatorship, as vehicles that take away from individuals their rights, should require a higher burden of proof (and thus more protections) to establish than should be required to restore rights to an individual.

Monitoring of guardianships and conservatorships is critical, and the Act requires guardians to present a written report to the court within thirty days of appointment and annually thereafter (Section 317), while the conservator is required to file a plan and an inventory with the court within sixty days of appointment and annual reports thereafter. (Sections 418(c), 419, 420). Both the guardian and the conservator, in their reports, make recommendations as to whether the guardianship or conservatorship should be continued or modified. The court is required to establish a monitoring system. (Sections 317(c), 420(d)). The court may use visitors as part of the monitoring system. (Sections 317(b), 420(c)). Suggestions on what an effective monitoring system should contain can be found in Sally Balch Hurme, STEPS TO ENHANCE GUARDIANSHIP MONITORING (A.B.A. 1991)

H&C Based Program Structure

Possible legislation relating to
Home Health Agencies

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

Sec. 18.20.090. Disclosure of information. (a) The department shall make reports concerning annual inspections and investigations of the facilities or entities it licenses in this chapter, including statements of deficiencies and approved plans of

1 correction, available to the public within 14 calendar days after the information is
2 made available to the facility or entity being reviewed.

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

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

6 **Article 2. Home Health Agencies.**

7 **Sec. 18.28.110. Purpose; applicability.** (a) The purpose of AS 18.28.110 -
8 18.28.190 is to promote safe and adequate home health services for individuals by
9 setting standards for home health agencies that will ensure quality of care, safeguard
10 patient's rights, and otherwise protect public health, safety, and welfare.

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

13 **Sec. 18.28.120. Powers of department.** The department may

14 (1) license and supervise home health agencies;

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

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

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

27 **Sec. 18.28.130. License required.** (a) An entity that establishes, conducts,
28 or represents itself to the public as a home health agency or an organization that
29 provides coordinated home health services for compensation must have a license from
30 the department authorizing it to be a home health agency under AS 18.28.110 -
31 18.28.190.

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

Sec. 18.28.140. Application for license. Application for a license to operate a home health agency shall be made to the department on a form provided by the department and shall be accompanied by applicable fees established by the department under AS 18.28.130.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) "home health agency" is a public agency or private organization, or

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

5 (5) "parent home health agency" means a licensed home health agency,
6 which may have branches or subunits;

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

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

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

5 (5) "parent home health agency" means a licensed home health agency,
6 which may have branches or subunits;

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

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

Assisted Living Regulations

Division of Senior Services Licensed Assisted Living Homes

Alfaro	Thanla	Thanla's Adult Foster Care	1747 Wickersham Drive	Anchorage	99507	563-6028	4
Blue	Mary	Mary's Comfort Care	4424 East 7th	Anchorage	99508	338-9848	2
Bruce	Sheri	Health Care Bridges	2521 Tradewind Dr.	Anchorage	99516	345-0496	5
Burch	Barbara	Burch's Adult Assisted Living Home	1941 Olympc Drive	Anchorage	99515	344-9312	5
Castillo	Juliet	Lakeview Home	4030 Defiance Street	Anchorage	99504	338-2712	3
Collins-I	Richard	Golden Years-Cleveland Avenue	1701 Cleveland Ave	Anchorage	99517	561-5053	16
Collins-II	Richard	Golden Years-89th Avenue	2721 W 89th Avenue	Anchorage	99502	243-0068	16
Collins-III	Rick	Golden Years-Trena Street	5520 Trena Street	Anchorage	99507	243-0068	5
Cuanan,RN	Florence	Immaculate Concepcion Home	7110 Miranda Drive	Anchorage	99507	522-5871	5
DeMoss,RN	Jack	Chevigny House Elder Care	6400 Chevigny Street	Anchorage	99502	243-5100	2
Drayton-I	Candace	Dignified Home Life Care-I	371 Bolln St. Apt B	Anchorage	99504	333-2838	5
Drayton-II	Candace	Dignified Home Life Care II	371 Bolln St. Apt A	Anchorage	99504	333-2838	5
Franks	Sorina	Our Lady of Carmen Assisted Living Home	8101 E 2nd Avenue	Anchorage	99504	337-6631	1
Jennings	Mila	Tumagain Adult Foster Home	2812 West 29th	Anchorage	99503	243-4115	5
Johnson	Mertis	Easy Living AFC	7710 Maryland Avenue	Anchorage	99504	333-1846	5
Marlow	Kelly	Burch's Assisted Living Home II	3120 West 71st Avenue	Anchorage	99502	245-2250	4
Nolan	Irene		11740 Chlnook Drive	Anchorage	99516	345-6420	4
Norment	Lina	St. Martin's Adult Foster Home	8330D Spruce Street	Anchorage	99507	522-3917	4
Pedraza	Roswitha	Sunset Home Care for Alzheimer	441 Bonnie Jean Court	Anchorage	99515	522-6869	6
Perez	Patricia	St. Augustine's Assisted Living Home	610 Clippership Court	Anchorage	99515	345-9690	4
Rabb,RN	Marilyn	Amazing Grace Family Living	3401 Korovin Bay Circle	Anchorage	99515	522-7644	4
Regacho	Rodolfo	Elena's Place	8551 Arctic Blvd AptA	Anchorage	99515	344-7607	2
Rivera,RN	Nora	Adela Assisted Living Home	7940 Ladasa Place	Anchorage	99508	522-2783	5
Rodriguez	Stephanie	Helping Hands Assisted Living	1601 Birchwood Street	Anchorage	99508	277-9430	4
Samet	Sue	Providence Horizon House	4140 Folker Street	Anchorage	99508	261-4140	65
Scott	Ellen	Scott's Home Care	3450 Corona Circle	Anchorage	99517	243-4394	2
Valdez	Eva	Our Lady of Lourdes	1931 Greendale Drive	Anchorage	99504	333-4692	5

Division of Senior Services Licensed Assisted Living Homes

Valdez,RN	Carol	Holy Family Adult Foster Home	8800 Witherspoon Circle	Anchorage	99504	338-7570	5
Vowell	John	Anchorage Pioneer's Home	923 West 11th Avenue	Anchorage	99501	278-3414	224
Knodel	Doreen	N. Slope Borough Sr Hlth Svcs A.L. Progra	5452 Northstar Street	Barrow	99723	852-0276	5
Hervey	Ruthann	Ruthie's Eldercare of Alaska	20636 Jehovah Jireh Stre	Chugiak	99567	688-2002	3
Stull, R.N.	Anna	Chuglak Assisted Living Apartments	22424 N Birchwood Loop	Chugiak	99567	688-8999	25
Luckhurst	Patty		2334 Aleknagik Lake Roa	Dillingham	99576	842-5167	1
Davis-I	Armegene	Jean's Place	17244 Santa Maria Dr	Eagle River	99577	894-1481	3
Davis-II	Armegene	Jean's Place II	17528 Meadow Creek	Eagle River	99577	894-1480	3
Edmunds	Pat	Hand in Hand Care	17408 Kantishna Drive	Eagle River	99577	898-7283	4
Wolfe	Sheila A.	Bear Mountain Manor	10210 Crest View Lane	Eagle River	99657	894-9001	4
Cash	Debbie	Debbie's Fireside Home	3291 Jefferson Drive	Fairbanks	99709	479-7100	4
Dawkins	Mary	Tri-Love Care	827 22nd Avenue	Fairbanks	99701	458-8213	3
Montano	Eileen	Fairbanks Pioneers' Home	2221 Eagan Avenue	Fairbanks	99701	456-4372	101
Oligney	Lucille	Oligney Assisted Living Home	70 Steelhead Road	Fairbanks	99709	479-5007	5
Pierce	Thelma	Summer Shades Residential Care	319 6th Avenue	Fairbanks	99701	458-5909	8
Powell	Helen	Rocking Years	1913 Jack Street	Fairbanks	99709	451-0806	5
Regitano	John	Alaska Forget-Me-Not	3100 South Cushman Str	Fairbanks	99701	452-1648	7
Robinson	Selma	Robinson Assisted Living	509 Wilcox	Fairbanks	99709	479-5208	3
Townsend,RN	Judy	The Center of Care	120 Pepperdine Drive	Fairbanks	99709	479-4557	5
Westling	Cathy	Downtown Care	110 2nd Avenue	Fairbanks	99701	458-7780	10
Calhoun	Judy	Friendship Terrace	250 Herndon Avenue	Homer	99603	235-7655	40
Young-Williams	Valerie	Road Runners' Retreat ALH	59475 East End Road	Homer	99603	235-3678	5
Holt	Douglas E.	Juneau Pioneers' Home	4675 Glacier Highway	Juneau	99801	780-8422	48
Smith	Linda	Linda's House	5952 Montgomery Street	Juneau	99801	780-6754	5
Edmands	Larry	Hazel J. Edmands Elder Care	53030 Aurora Avenue	Kasilof	99610	282-0498	5
Dalhaug	Dee	Park Avenue Manor	3815 Baranof Avenue	Ketchikan	99901	247-8747	3
Dalhaug - II	Dee	The Manor	808 Schoenbar	Ketchikan	99901	225-8747	4

Division of Senior Services Licensed Assisted Living Homes

Thompson	Phyllis	Ketchikan Pioneers' Home	141 Bryant Street	Ketchikan	99901	225-4111	47
Schaeffer	Mary	Kotzebue Sr. Citizens Cultural Ctr.	561 Wolverine Drive	Kotzebue	99752	442-3590	20
Colette	Barbara	Mom And Pops.	363 Park Way	North Pole	99705	488-4751	3
Lane-I	Monta Faye	Arctic Hearth I	109 East 5th Street	North Pole	99705	488-9159	5
Lane-II	Monta Faye	Arctic Hearth II	118 East 5th Street	North Pole	99705	488-8880	4
Shoemaker	Betty	Country Manor	1941 Christine Drive	North Pole	99705	488-0983	3
Allen	Wandamae		618 E. Eklutna Street	Palmer	99645	745-0540	1
Angle	Heidi	Heidi's Place	Mile 4, Bodenbug Loop	Palmer	99645	745-1731	5
Hartman	Karen	Karen's Place	940 South Dimond	Palmer	99645	746-4023	4
Hartman	Debbie	Debbie's Place	Mile 12 Old Glen Highway	Palmer	99645	746-8147	2
Mangus	John	Our House	3201 Sparrow Court	Palmer	99645	745-0733	8
Marley	Norma	Enchanted Garden Assisted Living	Last house, Maud Rd	Palmer	99645	745-4605	3
McRoberts	Lyn	Lyn's Place	17865 Pine Needle Way	Palmer	99645	745-4252	5
O'Connor	Bill	Palmer Pioneers' Home	250 East Fireweed	Palmer	99645	745-4241	82
Rasch	Sarah	Assisted Country Living	Mile 1.5 Maude Road	Palmer	99645	745-8402	3
Weinrick	April	Avalon Haven	1205 Tranquility	Palmer	99645	746-4220	3
Kaster	Cheryl	The Source	21632 Morning Drive	Peters Cre	99577	888-8222	14
Eldridge	Suzanne	Questa Woods Assisted Living		Seward	99664	224-5830	5
Schutter	Lois	Schutter's Adult Care Home	210 Bear Drive	Seward	99664	224-3690	6
Smith	Julia	Sitka Pioneers' Home	120 Katlian Street	Sitka	99835	747-3213	102
Cunningham	Betty	Country Living	35410 Hi Court	Sterling	99872	282-8543	4
Spires	Emmilia	Myrtle Marie Moudy Assisted Home	#1 Veterans Way	Talkeetna	99878	733-2340	3
Roberts	Kathy	Tanana Regional Elders Residence	Front Street	Tanana	99777	368-7244	14
Sehm	Linda & Dou	A Helping Hand Eldercare	2571 Tait Drive	Wasilla	99687	373-7940	5
Wodkowski	Ginny	Pleasant Acre	2nd drive, Lucky Shot Ro	Willow	99688	495-6842	2
Bjorge	Linda	Bjorge Enterprises	127 Church Street	Wrangell	99929	874-2766	4

DMHDD Approved Assisted Living Homes

9/23/98

ABDUL-HAQQ, SAUDA	1210 LATOUCHEM	ANCHORAGE 99501	SAUDA ABDUL-HAQQ	272-6850	2 ASETS	1210 LATOUCHEM
ACOSTA, LYDIA	6811 E 11TH AVE	ANCHORAGE 99504	LYDIA ACOSTA	337-1965	2 PVT CARE	6811 E 11TH AVE
AGAPE ALH (DOUGLAS)	PO BOX 105042	ANCHORAGE 99510	ANA K. DOUGLAS	243-6814	4 PVT CARE	4025 HALE COURT
AGELESS CARE SVC - PIONEER (CHERRY ST)	3936 ROUNDTOP CIR	ANCHORAGE 99504	ALEXANDRIA FERRY	337-8026	8 PVT CARE	5421 PIONEER DR
AGELESS CARE SVC - EVERGREEN	3936 ROUNDTOP CIRCLE	ANCHORAGE 99504	ALEXANDRIA FERRY	337-8026	8 PVT CARE	3420 EVERGREEN
ALANTZ, MANUEL	3634 E 17TH AVE	ANCHORAGE 99508	MANUEL ALANTZ	276-1046	2 ASETS	3634 E 17TH AVE
ANCHOR HOUSE	1023 W 26TH AVE #101	ANCHORAGE 99503	JACQUE WINGFIELD	274-7391	50 PVT CARE & SUC	1037 & 1023 W 26TH
ARCA - BRYN MAWR	2211 ARCA DRIVE	ANCHORAGE 99508	MARGARET LOWE	277-6677	6 ARCA	5000 BRYN MAWR
ARCA - CAMROSE	2211 ARCA DR	ANCHORAGE 99508	DOUG MacELWEE	277-6677	3 ARCA	6100 CAMROSE DRIVE
ARCA - CASTLE COURT	2211 ARCA DR	ANCHORAGE 99508	DOUG MacELWEE	277-6677	3 ARCA	4939 CASTLE COURT
ARCA - COLLIE HILL WAY	2211 ARCA DRIVE	ANCHORAGE 99508	MARGARET LOWE	277-6677	3 ARCA	2636 COLLIE HILL WAY
ARCA - JAY CIRCLE	2211 ARCA DRIVE	ANCHORAGE 99508	STEVE WILLIAMS	277-6677	3 ARCA	810 JAY CIRCLE
ARCA - LIONHEART	2211 ARCA DR	ANCHORAGE 99508	STEVE WILLIAMS	277-6677	3 ARCA	5256 LIONHEART
ARCA - WINTERHAVEN	2211 ARCA DRIVE	ANCHORAGE 99508	STEVE WILLIAMS	277-6677	3 ARCA	840 WINTERHAVEN
BALTS, MARK A	6430 BRIDGET DR	ANCHORAGE 99502	MARK A BALTS	249-6623	2 ASETS	6430 BRIDGET DR
BANDELOW'S ASSISTED LIVING	8000 LITTLE DIPPER AVE P	ANCHORAGE 99504	DEBORAH BANDELOW	338-1928	4 HOPE FH	8000 LITTLE DIPPER AVE #
BARRAS, KEVIN	9599 BRAYTON DR #422	ANCHORAGE 99507	KEVIN BARRAS	522-3316	2 ASETS	9599 BRAYTON DR #422
BARTHOLOMEW, LINDA	3511 E 65TH AVE	ANCHORAGE 99507	LINDA BARTHOLOMEW	349-9269	3 ASETS	3511 E 65TH AVE
BATES, PATRICIA/THOMAS	8104 COUNTRY WOODS DR	ANCHORAGE 99502	THOMAS & PATRICIA B	349-6568	1 HOPE FH	8104 COUNTRY WOODS DR
BENSON, BRIAN	P.O. BOX 200256	ANCHORAGE 99520	BRIAN BENSON	337-3165	1 HOPE FH	210 MCCARREY GLEN APT
BRAATEN, FONDA	PO BOX 241624	ANCHORAGE 99524	FONDA BRAATTEN/PO	349-1439	1 HOPE FH	1317 BASI 72ND STREET
BURKE, LINDA	8921 BOULDER BAY CR	ANCHORAGE 99507	LINDA BURKE	522-8921	2 ASETS	8921 BOULDER BAY CR
CAROLYN HOME	323 DAVIS ST	ANCHORAGE 99508	CAROLYN COCKERIA	333-1794	2 ASETS/HOPE	323 DAVIS ST
COGGER, ANTHONY	3705 ARTIC #1222	ANCHORAGE 99503	ANTHONY COGGER	245-5407	1 ASETS	8119 SEAVIEW ST
COUNCIL'S	1018 WEST 71ST AVENUE	ANCHORAGE 99518	PRECIOUS OR LONNIE	561-3335	1 ASETS	1018 WEST 71ST AVENUE
EASTSIDE ASSISTED LIVING	149 MICHAEL COURT	ANCHORAGE 99504	MARY A. COOK	333-8118	5 PVT CARE	149 MICHAEL CT. APT 2
FITCHETTS ASSISTED LIVING	2481 RIDGEWAY AVE	ANCHORAGE 99504	MARY FITCHETT/PR	333-0737	1 HOPE FH	2481 RIDGEWAY AVE
GOMEZ, JUAN	4034 Reka Dr #L5	ANCHORAGE 99508	JUAN GOMEZ	929-7855	2 ASETS	4034 Reka Dr #L5
GRANT, LINDA	601 NORTH BUNN	ANCHORAGE 99508	LINDA GRANT	274-3234	3 ASETS	601 NORTH BUNN
GREATLAND HOME	P.O. BOX 211553	ANCHORAGE 99521	MIKE & ANJIE HUFF	333-5921	7 ASETS	8015 E 4TH AVE
HENNING, BRUCE & EVA JO	620 JACK ST	ANCHORAGE 99551	EVA JO HENNING/JOAN	346-0784	2 HOPE FH	620 JACK ST
HOFFMAN, JUANITA E.	11000 HIDEWAY LAKE DR	ANCHORAGE 99516	JUANITA E. HOFFMAN	346-4853	2 HOPE FH	11000 HIDEWAY LAKE DR
HOPE - BLACKBERRY	540 W INTL AIRPORT RD	ANCHORAGE 99518	PRECIOUS P. COUNCIL	564-7479	3 HOPE	6050 BLACKBERRY ST
HOPE - CELESTIAL COURT	540 W INTL AIRPORT RD	ANCHORAGE 99518	CHRIS MILLER	564-6801	2 HOPE	11339 CELESTIAL COURT
HOPE - CHEROKEE	540 W INTL AIRPORT RD	ANCHORAGE 99518	CHRIS MILLER	564-6801	2 HOPE	6130 CHEROKEE WAY
HOPE - CURVELL	540 W INTL AIRPORT RD	ANCHORAGE 99518	PAMILIA HUNSUCK	564-7409	4 HOPE	15000 CURVELL DR
HOPE - FURROW RANCH	540 W INTL AIRPORT RD	ANCHORAGE 99518	LAURA RUDILL-ROJE	564-7419	5 HOPE	3911 FURROW CREEK RD
HOPE - GREENDALE (EMMANUEL)	540 W INTL AIRPORT RD	ANCHORAGE 99518	MARY BECKENMAN	564-7477	3 HOPE	1800 GREENDALE DR

Page 2

MADDEN, CHERYL K/MICHAEL W	2802 W 30TH APT #5	ANCHORAGE	99503	CHERYL K & MICHAEL	243-2699	1 HOPE FH	2802 W 30TH APT #5
McGREW, MARY & JOHNNY	3543 ALEXANDER AVE	ANCHORAGE	99504	MARY E McGREW	276-6751	3 ASETS	3543 ALEXANDER AVE
NEW CONCEPT	354 S FLOWER	ANCHORAGE	99506	CINDY S. PHILBY	338-1557	16 PVT CARE & SCC	354 SOUTH FLOWER
NEW CONCEPT II	354 S FLOWER	ANCHORAGE	99508	CINDY S. PHILBY	338-1557	16 PVT CARE & SCC	702 NORTH BURN
PARKSIDE CARE - ROSEWOOD	309 E 24TH AVE	ANCHORAGE	99503	LESLIE OREBAUGH	563-5405	16 PVT CARE & SCC	3722 PARSONS
PARKSIDE CARE - PARKSIDE	309 E 24TH AVE	ANCHORAGE	99503	LESLIE OREBAUGH	563-5405	16 PVT CARE & SCC	309 E 24TH AVE
PASOL HOME	2902 W 31ST	ANCHORAGE	99517	PETER C. PASOL	243-5859	2 ASETS	2902 W 31ST
PICKARD, GARRY	1200 W DIAMOND #1119	ANCHORAGE	99515	GARRY PICKARD	522-5598	1 ASETS	1200 W DIAMOND #1119
PINECREEK	309 E 24TH AVE	ANCHORAGE	99503	JULIE HENRYMAN/KAR	258-9993	16 PVT CARE & SCC	341 N BURN
RHOADES, DAWNETTE	1331 BADGER LANE	ANCHORAGE	99516	DAWNETTE RHOADES	345-2114	1 ASETS	1331 BADGER LANE
RIETH, BETTY	3410 EIDE #1	ANCHORAGE	99503	BETTY RIETH/NELSON	561-4705	2 HOPE FH	3410 EIDE STREET #1
ROBINSON, VERNON/KELLY	3221 PUSSYWILLOW ST	ANCHORAGE	99501	VERNON/KELLY ROBI	338-4608	2 ASETS	3221 PUSSYWILLOW ST
ROTHFUSS, A.P.	9910 CHELATNA CIR	ANCHORAGE	99515	ALBERT (ALLEN) F. RO	341-7692	3 HOPE FH	9910 CHELATNA CIR
SHELDON, TAMRA A	P.O. BOX 21-2711	ANCHORAGE	99521	TAMRA A. SHELDON	337-1800	2 ASETS	1116 STATE ST, APT #3 & #4
STERN'S ASSISTED LIVING	3802 DEBORAH LANE	ANCHORAGE	99504	BRUCE FARNSWORTHY	333-6903	2 HOPE FH	3802 DEBORAH LANE
TANADA HOUSE	PO BOX 140988	ANCHORAGE	99514	SUZANNE BEYER	333-2866	16 PVT CARE & SCC	4010 E 8TH AVE
TAMMER, JOSEPHINE	6141 GROSS DRIVE	ANCHORAGE	99507	JOSEPHINE E TAMMER	563-9472	2 ASETS	6141 GROSS DRIVE
TINGLER, JANICE	PO BOX 112821	ANCHORAGE	99511	JANICE TINGLER	276-3711	2 ASETS	2201 MINERVA WAY
WIGGS ADULT FOSTER HOME	1006 BENCH COURT	ANCHORAGE	99504	CITA WIGGS	333-3473	3 ASETS	1006 BENCH COURT
WILLARD, LISA	2440 COTTONWOOD	ANCHORAGE	99508	DREW MCCARTHY	561-5335	1 HOPE FH	2440 COTTONWOOD
WILSON HOME	2581 LYVONA LANE	ANCHORAGE	99502	SCOTT WRESE/CHRIS	248-2382	2 HOPE FH	2581 LYVONA LANE
BCS - BAUTISTA HOUSE	BOX 2188	BETHEL	99559	GLORIA HAWKINS	543-2762	12 BCS	381 4TH AVE
BCS - MALONE HOME	BOX 2188	BETHEL	99559	GLORIA HAWKINS	543-2762	8 BCS	1801 CHIEF EDIE HOFFMAN
CRISIS RESPIRE CENTER - CR	P.O. BOX 328	BETHEL	99559	Phil White	543-6107	6 YKHC	#62 TRAILER COURT
ROBRECHT, FREDERICK J. JR	PO BOX 520524	BIG LAKE	99632	FREDERICK J ROBRECHT	892-6574	2 ASETS	STREET OF TRANQUILITY
WILSON, DAVID A	P.O. BOX 671474	CHUGIAK	99567	DAVID A WILSON	688-7148	1 HOPE FH	24445 HIFARTHSTONE DR
BEAKLY, JOHN	PO BOX 70	CRAIG	99921	JOHN BEAKLY/MELANI	826-3048	1 CC	230 BEACH ROAD
HOPE - YUKUKUT HOME (DILLINGHAM)	PO BOX 715	DILLINGHAM	99576	JOHN CARRA	842-2117	4 HOPE	2301 SOCKEYE CIRCLE
FLOORE, PATREYA D (WARNER)	2224 GREAT WESTERN ST	DOUGLAS	99824	P. FLOORE/SHOSHI GRE	586-8226	1 REACH	2224 GREAT WESTERN ST
MACOMBER, PATRICIA	19003 CITATION ROAD	EAGLE RIVER	99577	PAT MACOMBER/JEFF	691-8687	2 HOPE FH	19003 CITATION CIRCLE
ICMHC ADULT GROUP HOME - CR	122 1ST AVE, SUITE 5	FAIRBANKS	99701	JOHN E KOCSS	452-5673	11 ICMHC	1700 MOORE STREET
FRA - COWLES HOUSE	805 AIRPORT ROAD	FAIRBANKS	99701	EMILY F. ENNIS	456-8901	5 FRA	1426 22ND STREET
FRA - RUBY HOUSE	805 AIRPORT ROAD	FAIRBANKS	99701	EMILY F. ENNIS	456-8901	4 FRA	2505 RUBY AVE
JOHNSON, LOREN/GERI	4201 KACHEMAK WAY	HOMER	99603	LOREN OR GERI JOHNS	235-6327	4 PVT CARE	4201 KACHEMAK WAY
JAMI - SHATTUCK HOUSE CR	BOX 22090	JUNEAU	99802	JANIS CARTER, JAMI	463-6828	10 JAMI	306 W 7TH STREET
REACH - MARK ALAN HOME	PO BOX 34197	JUNEAU	99803	RENEE GAYAHRT	586-8228	5 REACH	1814 MARK ALAN DR
REACH - NORTHLAND HOME	PO BOX 34197	JUNEAU	99803	RENEE GAYAHRT	586-8228	5 REACH	9377 NORTHLAND DR
SHEWEY, JEANNIE	1651 RENNINGER ST C-201	JUNEAU	99801	J SHEWEY/SHOSHI	586-8226	1 REACH	1651 RENNINGER ST C-201

OLSEN'S	PO BOX 9476	KETCHIKAN	99901	WAYNE & MARY ANN	225-2001	2 CC	4604 N TONGASS HWY
HOPE - VIEWCREST (KODIAK)	1623 MILL BAY ROAD	KODIAK	99615	PATRICK KROSS	486-5011	4 HOPE	3194 VIEWCREST
LAKE STREET HOUSE	PO BOX 256	KOTZEBUE	99752	KAREN REEVE	442-2224	4 MANILAQ ASSO	HOUSE 818 LAKE STREET
CHARLES BOARDING HOME	HC 02 BOX 7786	PALMER	99645	FORREST CHARLES	745-3412	19 PVT CARE	MILE 5.5 OLD GLEN HWY
HILL, MARY J	HCS BOX 9722A	PALMER	99645	MARY J HILL	745-8322	2 SELS - MAT-SU	13900 CURRICABARK RD
HOPE - RESOLUTION BAY (WASILLA)	310 PIONEER PARKWAY	PALMER	99645	JOAN NELSON	564-7469	2 HOPE	2750 RESOLUTION BAY
RODGERS RANCH	PO BOX 1460	PALMER	99645	JIM RODGERS	745-0559	2 SELS - MAT SU	16655 CRANBERRY
HOPE - DIAMOND (SEWARD)	PO BOX 1931	SEWARD	99664	DONNA ZIEBER	224-3540	1 HOPE	2508 DIAMOND
SLAC GROUP HOME	PO BOX 1015	SEWARD	99664	KIMBERLY E. SORIANO	224-5257	5 SEWARD LUE AC	1400 CHAMPERLAIN DRIVE
ASHLEY'S HOME	P.O. BOX 2795	SOLDOTNA	99669	CHARLES MYRICK	260-3569	1 RURAL HI	44155 SHIRLEY'S WAY
FCS - RIVER HILLS	35270 K-BEACH, STE. 36	SOLDOTNA	99611	JANICE GAUTHIER	262-6331	3 FCS	36710 RIVER HILLS DR.
FCS - WALNUT	35270 K-BEACH, STE. 36	SOLDOTNA	99611	JANICE GAUTHIER	262-6331	3 FCS	1083 WALNUT
KENNEL, NANCY JEAN	35520 FERN FOREST	SOLDOTNA	99669	NANCY JEAN KENNEL	262-0633	1 RURAL HI	35520 FERN FOREST
COTTONWOOD	P.O. BOX 1310	VALDEZ	99686	SUE BRADY	835-4504	4 HORIZONS	825 COTTONWOOD
EAGLE HOUSE	P.O. BOX 1310	VALDEZ	99686	SUE BRADY	835-4504	4 HORIZONS	3411 EAGLE STREET
FORAKER HOUSE	P.O. BOX 1310	VALDEZ	99686	SUE BRADY	835-4504	3 HORIZONS	136 FORAKER STREET
DeHART, LIANNE	P.O. BOX 875065	WASILLA	99687	LIANNE DeHART/JORD	745-5065	1 HOPE FH	6300 EAST BOGARD RD
FULL CIRCLE	PO BOX 870186	WASILLA	99687	ELAINE CRAINE	373-3110	3 DDARES, INC	1160 SUSITNA DRIVE
JENNY'S HOME	PO BOX 872040	WASILLA	99687	JENNY McFARLEY/VAL	357-8049	2 HOPE FH	1040 PITTMAN RD
THE BONDING PLACE	PO BOX 877222	WASILLA	99687	THERON/MARY BOND	373-3788	1 HOPE FH	NHN TRDMOTOR STREET
VANDERMARTIN	PO BOX 870244	WASILLA	99687	DANA VANDERMARTIN	357-1136	2 DSS-SELS	6001 EASTERN ST

Issue Brief: Rural Long Term Care Project

The Division of Senior Services received funding for FY99, through the Alaska Mental Health Trust Authority, to implement a rural long-term care development proposal. This project will focus on capacity building for home and community-based services in the rural regions of Alaska.

The funding includes a temporary position of Associate Coordinator, travel and contractual funding. The Division of Senior Services is currently in the hiring phase with the position. The MHTA has approved funding for two years for this project.

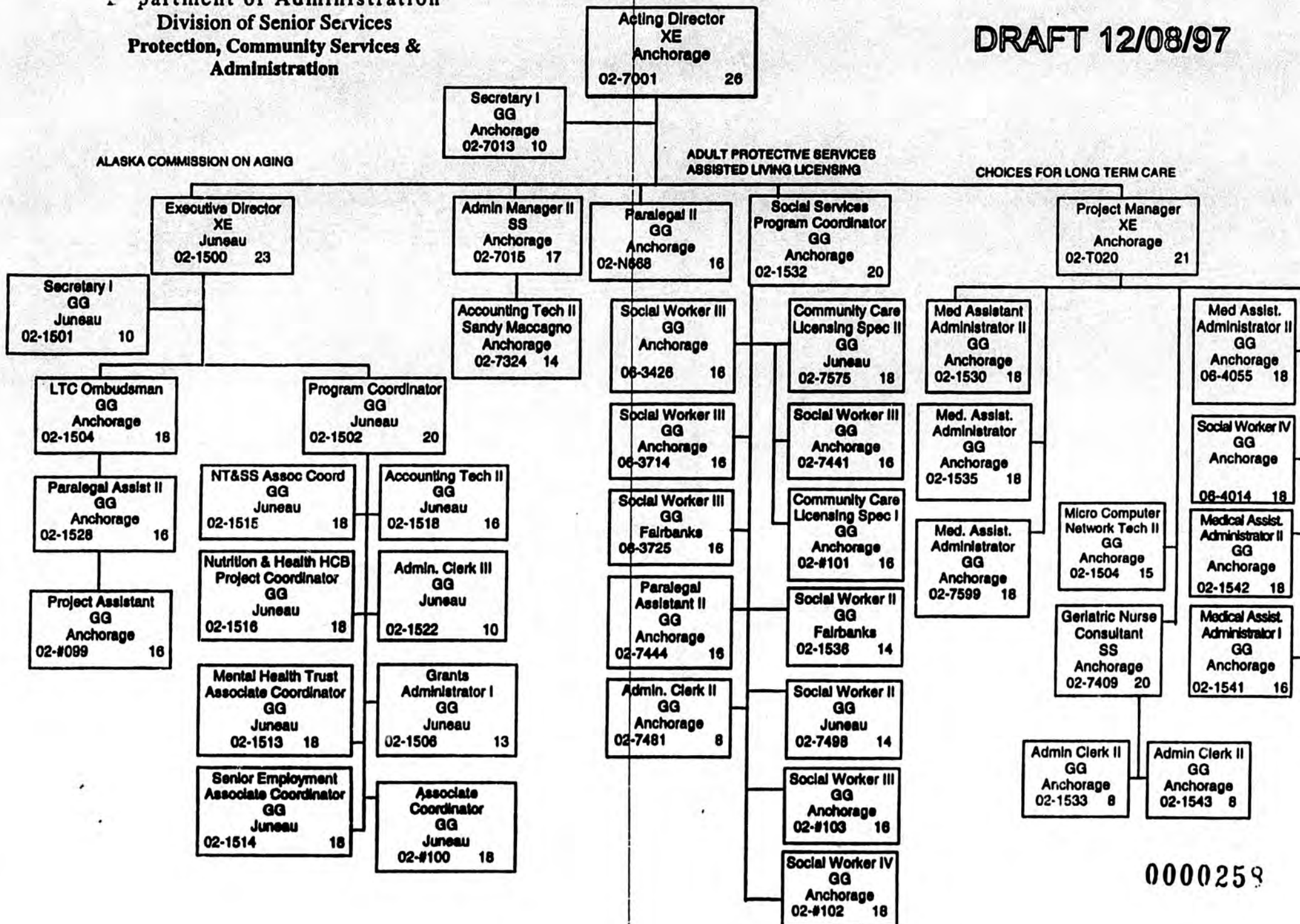
The project is designed to be community focused. Five communities will be selected that have planning interest in this area. They will be assisted in developing implementation for increased home and community-based services in their delivery area. This will include working with local government and tribal authorities, other state agencies, and federal entities as possible for funding and other services available.

The outcome for this project is to have increased home and community-based services, specifically assisted living, personal care attendant and care coordination, available in these communities by the end of FY00. This will increase job and business opportunities in these areas, as well as service options.

Consolidation of Programs

Department of Administration
Division of Senior Services
Protection, Community Services &
Administration

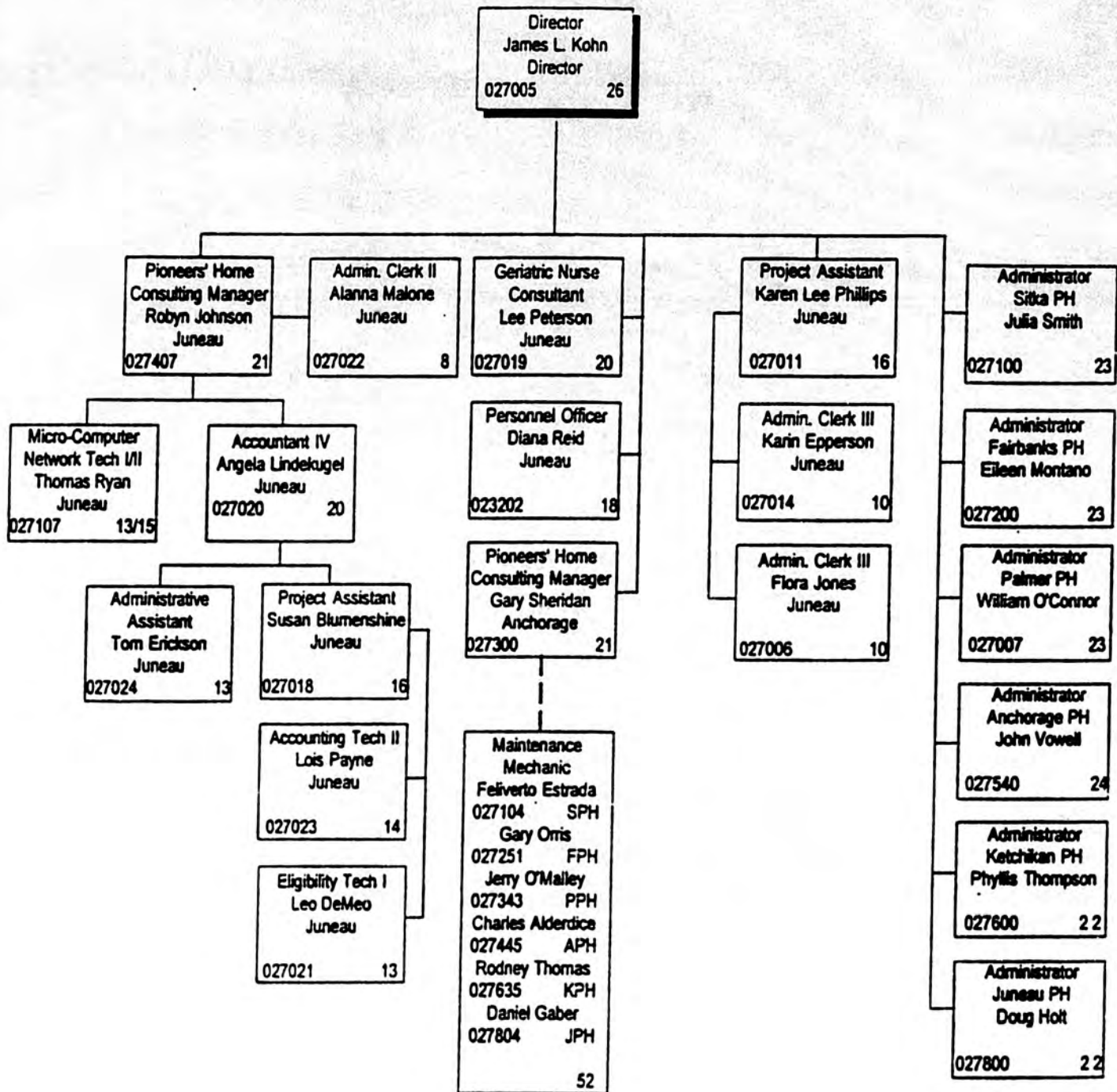
DRAFT 12/08/97



0000258

Department of Administration Division of Alaska Longevity Programs

0000154



REVENUE: Restricted Interagency Receipts					CONTACT: Kay Burrows 269-3666			
FUNDING SOURCE CODE	FUND	REVENUE ACCOUNT	COLLOCATION CODE	PRIOR YEAR FY 97 ACTUAL	CURRENT YEAR FY 98		FY 99 GOVERNOR	FY 00 FORECAST
					AUTHORIZED	CASH ESTIMATE		
1007	11100	59080		1,143.3	803.0	667.4	480.9	480.7
1007	11100	59080				377.2	390.0	390.0
							186.5	186.5
TOTALS				1,143.3	803.0	1,044.6	1,057.4	1,057.2

EXPLANATION:

59080 - Interagency Receipts - \$667.4 in Interagency Receipts are received through a Reimbursable Services Agreement (RSA) with the Department of Health & Social Services, Division of Medical Assistance (DMA). These receipts fund the CHOICE for the Elderly program. The funds are Medicaid-reimbursable, and are used to continue oversight of home and community based waiver services for elderly who would otherwise be eligible for more expensive nursing home care. An additional \$377.2 in I/A for FY98 will be received through an unbudgeted Reimbursable Services Agreement (RSA) with the Dept. of Health and Social Services (DH&SS). These interagency receipts are for the Pre-Admission Screening Program transferred to the Division of Senior Services in FY98; and a C-5 for FY99 is included in this budget submission (\$390.0) for budgeted interagency receipts to continue this program. For FY99 it is estimated that another 186.5 I/A receipts will be needed to maintain current services provided by the CHOICE For Elderly Program (Long Term Care Unit) and the administrative management of all the programs.

Page 1 of 1

Revised Date:

FY 99

**Restricted Revenue
Detail
Form C21B**

AGENCY Department of AdministrationBRU Senior ServicesCOMPONENT Protection, Community Services & Administration #2083

0000267

OREGON DEPARTMENT OF HUMAN RESOURCES



The Oregon Long-Term Care Model: Fusing Quality and Client Choice

April 27, 1998



Presentation by Roger Auerbach, Administrator, Senior and Disabled Services Division, to the National Chronic Care Consortium, 1998 Spring Working Session, April 27, 1998, Portland, OR.

It is a particular honor to be able to speak to a group so committed to working on the challenges posed by caring for people with chronic illnesses. As we look at the people served in Oregon's Medicaid long-term care system, it is obvious that chronic illness is a significant contributor to their impairment. Through better management and prevention of chronic illness, we can help our mutual clients enjoy a better quality of life . . . until the end of life. I hope that my appearance here today will open doors between the aging network and the private health care system. Only in partnership can we begin to tackle the challenges presented by an ever aging society. Today my goals are to familiarize you with what we call the Oregon model of long-term care, to demonstrate how such a system can work with private providers for better outcomes for our mutual clients and ask your support for efforts to better coordinate care funded through Medicare and Medicaid programs.

The Evolution of the Oregon Model

To begin, we need to look back two decades. Oregon faced a tremendous financial crisis in the late 1970s and early 1980s. At that time, the state was in a major recession due to a significant downturn in wood products, the state's major industry. Oregon was also experiencing unsustainable growth in its nursing facility expenditures. From 1974 to 1979, Oregon's nursing facility caseload increased more than 30 percent, while the population of Oregonians aged 75 and older was growing by only 14 percent. The rate of inflation in nursing facility cost was over 100 percent, while medical inflation was about 80 percent.

These stark financial realities forced Oregon's Legislature to take a long and hard look at the Medicaid long-term care program. There was no way that this growth could be maintained while the state coffers were shrinking. In 1981, the state legislature took action and consolidated the state's unit on aging and its Medicaid long-term care program. The new Senior Services Division was charged with containing the costs of long-term care. In characteristic Oregon style, the preferences of our state's citizens were also incorporated into the cost-containment mandate: the division was to ensure that any long-term care system also embody the human values of independence, dignity, privacy and choice.

The new state policy set forth in 1981 stated that the long-term care network was to support the preference of frail elderly (and later, people with disabilities) who wanted long-term care services in their own home, and that nursing facilities should be a last resort. The law also required that cost savings realized from a slower growth of nursing facility caseload be reinvested in community-based care.

Shortly after the creation of the division, Oregon received a Title XIX waiver that allowed the state to spend Medicaid nursing facility dollars on community-based care. It was expected that the state would move toward a system in which there would be as many people in community-based care as in nursing facilities.

Since 1981, Oregon's Medicaid long-term care program has evolved to strongly support the principle that all Oregonians who need long-term care services can access services that are affordable, desirable, and support an individual's independence, choice, and dignity. As the division developed resources for Medicaid eligible individuals and other low-income or socially and economically disadvantaged persons, the value of community-based care also grew in the eyes of private pay consumers and their families.

The Success of the Oregon Model

Far exceeding our initial goal of serving half of our clients in nursing facilities and half in the community, we now serve 75 percent of our Medicaid clients in home and community-based care settings. Despite a 98 percent growth in total caseload since 1985, Oregon's nursing facility caseload has dropped almost 9 percent, while the percentage served in home-and community-based care has grown 224 percent.

Private pay consumers are also choosing community-based care at a much higher rate than 15 years ago. Oregon's system increases choices for all Oregonians and these cost-effective alternatives slow the pace at which long-term care consumers spend-down to Medicaid eligibility, thus helping to hold down the growth of the publicly-funded, long-term care caseload.

However, the pressure of increased demand continues. Oregon, like other states, is experiencing rapid growth in two indicator populations for long-term care use: the 85+ population and the 18-64 (younger) disabled population.

I'd like to spend a little time discussing Oregon's long-term care options. They include: respite care, adult day care, in-home care, adult foster care, residential care, assisted living facility care, and nursing facility care.

Respite care services give families and other care givers temporary relief from providing care for frail adults. Companionship, light assistance, recreational activities, and security are provided in a client's home, out of home in a group setting, or overnight in a residential setting. We believe strongly that respite care fosters a healthier quality of life for both the care giver and care receiver.

Adult day services can help people with physical and cognitive impairments remain independent. They are offered in a variety of centers around Oregon. People with chronic or progressive health problems can be served by adult day services; the clients most often

served in this setting have difficulty performing familiar daily tasks, have lost initiative, motivation or memory, or need a safe environment and supervision. Adult day programs typically provide socialization, reminiscing, recreational exercise, counseling, support groups, information, nutritious meals and snacks, health monitoring, and art/music therapy. Some day centers also offer nursing, physical therapy, and personal care.

In-home services are the most rapidly growing and popular part of Oregon's long-term care system. These services include help with personal or health care needs and housekeeping. Nursing services and home delivered meals can also be arranged. In-home services include:

- Meal preparation
- Shopping and transportation
- Home health services
- Assistance with medication
- Housekeeping and laundry
- Medication management
- Money management
- Assistance with medical equipment
- Dressing and personal hygiene assistance

Adult Foster Homes

Adult foster homes are private residences licensed to provide care to five or fewer residents. They offer room and board and personal care from a care giver in the home 24 hours a day. Planned activities and medication management are available, and some provide transportation services, private rooms, or nursing services. A wide variety of residents are served in adult foster homes, from those needing only room, board and minimal personal assistance to those residents needing full personal care and skilled nursing tasks. The care provided depends on the client's needs and the skills, abilities, and training of the provider. Adult foster homes are inspected, licensed, and monitored by the state or by the local Area Agency on Aging.

Assisted Living Facilities

Assisted living facilities have six or more private apartments. They are fully wheelchair accessible and offer full dining room services, housekeeping and call systems for emergency help when needed. Registered nurse consultation is available. Physical care and additional health care supervision and assistance can be provided in the client's own apartment. Organized activities and transportation are available. These facilities follow guidelines that promote the residents' right to privacy, personal choice, and independence. Assisted living facilities are inspected, licensed and monitored by Senior and Disabled Services Division.

Residential Care Facilities

Residential Care Facilities serve six or more residents. They offer room and board with 24-hour supervision, assistance with physical care needs, medication monitoring, planned activities, and often transportation services. Some offer private rooms and some

registered nurse consultation services. They are inspected, licensed and monitored by the state.

Nursing Facilities

Nursing Facilities provide nursing care on a 24-hour basis in a more institutional environment. They provide skilled care, rehabilitation, and end-of-life care. Nursing facilities are required to have licensed nursing staff in the facility 24 hours per day. Many residents have medical and behavioral needs that cannot be met in other care settings. Nursing facilities are inspected, licensed, and monitored by the state, in compliance with both state and federal regulations.

One Aspect of Quality: Care Planning and Case Management

Oregon's long-term care delivery system is built on a highly diverse service delivery network. The law creating our system supported the concept of local control that services would be coordinated by a system that was as close to the consumer as possible. In Oregon, we contract with local Area Agencies on Aging that choose to administer these programs.

Our success in developing community-based care and discouraging unnecessary institutionalization of seniors and people with disabilities has been built on our case management system. The quality of life of Oregon's long-term care consumers, as well as the success of community-based care providers, depends on appropriate placements and good care planning. Through our case management system, consumers get information and assistance, assessment, and planning. Case managers work with clients to ensure that a care plan matches a client's needs, values, and preferences. A comprehensive assessment allows for a care plan to be built on the consumer's existing social network as well as the resources available in the community. Oregon's long-term care system is not a one-size-fits all model. Each client is an individual, and clients with similar impairments can live in a wide variety of settings: in a nursing facility, a foster home or in his or her own lifetime home.

The case manager's care planning also takes advantage of available funding for care: a plan can encompass a consumer's own private funds, Medicaid, Medicare, Older Americans Act Services, and private charitable services.

A good care plan and case management will also maximize those programs to ensure the ongoing quality of life and attention to health status of an individual client. Case managers can help consumers take advantage of health screenings and health education opportunities. Similarly, utilizing Medicare's preventive health screening benefits can help a case manager identify a client who is losing bone density. The care plan can then incorporate efforts to avoid risky behaviors that may result in a fall and a broken hip. Good case management can enhance the health status of a chronically ill person; it can prevent decline, injury, and unnecessary institutionalization.

Case management can also play a critical role in the management of chronic illnesses. Case managers can be an early warning system for preventing acute episodes. In this way and others, Oregon's case managers can serve as a critical link between the long-term care

system and the acute care system. This population needs personal and consistent communication to enhance their health status and quality of life.

Case management should have a critical role in the future of our health and long-term care delivery systems. For seniors (and people with disabilities), Oregon's case managers and community network can help eliminate the redundancies: one person can connect social, health, and long-term care services.

Another aspect of quality: Licensing and monitoring

An important aspect of quality is the licensing process for nursing facilities, adult foster homes, residential care facilities, and assisted living facilities. Traditionally, the regulation of long-term care has been focused on structure and capacity.....fire/life safety, adequate staffing, care plan documentation, and other similarly concrete items. The licensing process includes inspection, issuing reports based on inspections or complaint investigations, and sanctioning deficient facilities. This punitive approach, however, has been insufficient to bring about improvement in quality of care and quality of life for long-term care consumers. It really only focuses on minimal compliance and does not sufficiently address outcomes of care or consumer satisfaction.

We are redesigning our licensing process to focus on outcome measures, consumer satisfaction, and facility quality improvement. We are emphasizing technical assistance and problem solving with providers and assisting them with developing their own internal quality improvement systems. We are working with provider associations to deliver joint training on specific areas needing improvement.

Since 1994, we have been working with selected nursing facilities, 35 to date, to develop continuous quality improvement systems within their facilities. Our goal is to help facilities be proactive in problem solving to break the roller coaster cycle of poor compliance with Medicare and Medicaid regulation. This has been a successful project in terms of increasing morale and participation of facility staff and demonstrating better outcomes in the survey process. We're also working with provider associations to design quality improvement models for community based care facilities.

While the traditional regulatory methods are good tools, they only ensure minimum compliance: true quality care means much more than successfully meeting a checklist of structural and safety guidelines. It means listening to consumers' needs and employing quality improvement methods to achieve a high quality of life for those people in care.

In Oregon, we are working to develop more meaningful measurement and monitoring activities that reinforce our standards and give providers good and clear information about our expectations. We will continue to support long-term care providers as they strive to provide high quality care.

Consumers and other purchasers of services provided by all health and long-term care in government providers are looking for the best value for their money. A challenge for us is providing information that will allow consumers to compare not only cost, but also quality across care settings. We are exploring methods to disseminate this information electronically, so that families have access to the up-to-date information they need to

choose the best and most appropriate long-term care settings. Too often, consumers have to make long-term care decisions quickly and without a lot of support. The public needs more information about the range of long-term care settings available and the quality differences among providers.

A more educated public will help the health and long-term care delivery systems be more accountable and achieve higher quality. A well-educated health care consumer can use information to become a healthier person and enjoy a better life.

The Challenges

I don't want to suggest that this is a system without flaw. We are constantly challenged by quality issues, provider payment, and recruitment/retention issues, ensuring sufficient services in all geographic areas and balancing client desires for choice against the need to control costs.

Quality improvement remains an ongoing process that is most successful when we have collaboration with consumer advocates, providers and members of the health care community. In Oregon, our community-based care settings are home to some very impaired people. It is essential we write policy and develop training that speaks to care outcomes and consumer satisfaction.

We must also look for ways to support front-line caregivers in all care settings with training and technical assistance. We will continue to emphasize nurse consultation and delegation as important principles for community-based care giving.

Providing needed technical assistance and monitoring to so many diverse providers is also a definite challenge. Monitoring nursing facilities with concentrated numbers of residents is easier in many respects, than monitoring 2,000 adult foster homes located in urban and rural areas throughout the state. Teaching providers quality improvement strategies is an even greater challenge, but one which must be accomplished if we are to make quality an integral part of care giving.

We believe that the lower cost of home and community-based care, as well as its popularity with consumers, warrant an enhanced investment in quality assurance efforts. In Oregon, Senior and Disabled Services Division continues to strive toward better quality care across our long-term care system and wants that enhanced investment.

We also are challenged by a lack of capacity. Certain geographic areas continue to be under-served and not enough options are available in all areas.

Provider payment continues to be problematic. As the acuity level of community-based care clients increases, Oregon is challenged to find simple ways to appropriately and adequately reimburse these providers.

Recruitment and retention is a major issue in a low unemployment economy. Direct care worker turn-over rates are very high. Many workers do not have benefits or paid time off; they work in a traditionally undervalued field. Some solutions are simply monetary, but we must also identify ways to make care giving a more attractive profession.

Finally, balancing client desire for choice against the need to control costs is one aspect, but the other is creating choices that suit the needs and preferences of a changing aging society. We will continue to be accountable to the public that is funding long-term care, but sensitive to the desires of our clients.

Oregon's efforts to link community services and Medicaid long-term care have resulted in more care options and a higher quality of life for Oregonians who need long-term care. In the future, states like Oregon need to learn how to better link up with Medicare and other payers and providers in the acute care system to continue to improve care. Aging networks and especially Medicare risk contractors ought to be joining in cooperative relationships across the country as we are in Oregon, to develop more ways to work together on preventing and managing chronic health problems.

As we look for ways to address our mutual clients' needs at the state and local level, we also need to look for ways for us to work together to address the lack of coordination of Medicare and Medicaid services. I know that many of you in this audience are frustrated by the often conflicting and massive federal rules and regulations which prevent us from managing the health of our clients across these two funding systems. Clients don't get the services they need in a cost effective manner; providers spend too much time trying to figure out how to get paid for needed patient services.

I am working with state Medicaid programs across the country to address this lack of coordination between Medicare and Medicaid to reduce the administrative complexity and paperwork and mitigate the cost-shifting between these two federal programs. Some states are trying to address this lack of coordination by proposing federal waivers to promote integration of services. Some are exploring changes in federal regulation to address these issues. But we all agree: lack of coordination hurts clients, frustrates providers, caregivers, and states local government and burdens all taxpayers.

So, in addition to asking you to reach out to and work with some of our outstanding community providers in the aging and disability networks across the country, I am also asking you to become involved in efforts to reform the Medicare and Medicaid system so that we all can deliver more effective services for our clients and the taxpayers.

We face great challenges in caring for an increasing elderly population, many of whom have chronic illness. I applaud the work you are doing and very much want us to be partners to improve the quality of life and health status of those in our care.

Senior and Disabled Services Division
Roger Auerbach, Administrator
500 Summer Street, NE - Salem, OR 97310-1015
(503) 935-5811

If you have questions about Senior and Disabled Services Division,
e-mail to: SDSD.info@state.or.us
E-Mail questions or comments about this site to: SDSD Webmaster

<http://www.sdsd.hr.state.or.us> . . April 15, 1998

[Top of Page](#)

Missions & Measures

Draft Draft Draft 9/30/98

Program: Pioneers Homes

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

Mission.

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

Performance measures.

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

Missions & Measures – Draft 10/2

Draft Draft Draft

Program: Senior Services

Statutory reference: § 47.65

Mission.

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

Missions & Measures – Draft 10/15/98

Draft Draft Draft

Program: Senior Services – Commission on Aging

Statutory reference: § 47.65

Mission.

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

Measures.

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

Missions & Measures – Draft 10/15/98

Draft Draft Draft

Program: Senior Services – Residential Choices

Statutory reference: § 47.65

Mission.

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

Measures.

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

Missions & Measures – Draft 10/8

Draft Draft Draft

Program:	Senior Services
Project:	Data Integration Project
Authority:	

Mission

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

Performance measures.

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

Missions & Measures – Draft 10/2

Draft Draft Draft

Program:	Senior Services
Project:	Grant Management System
Authority:	

Mission

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

Performance measures.

Develop evaluation criteria for grant management that promotes

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

Implement evaluation criteria by 6/30/01.

Certificate of Need

Issue Brief: Revising the Certificate of Need Criteria to Control Costs/Promote Choice

Definition: The Certificate of Need (CON) process, created as a tool to control health care costs, empowers the state to decide whether proposed changes in the health care industry are needed before they are implemented. Under Alaska's law, only major additions or expansions to the system are reviewed, currently defined as any project in which a million dollars or more will be spent. Projects deemed to be routine replacement or maintenance are not required to go through the CON process.

Findings:

There is a potential in Alaska for many new nursing beds to be built. If built, these beds will cost the state a great deal of money. It is estimated that the senior population in Alaska will grow from 31,398 in 1997 to 80,927 by the year 2015. In FY 1997, the Alaska Medicaid program spent \$43.8 million for 720 licensed nursing home beds. There were 23 beds per 1,000 seniors and 87% of the beds were occupied in September 1998. If all the current beds are needed and the future need for beds remains constant, the number of beds could grow to 1,861 by 2015. This would be more than a 250% growth in the beds and would cost Medicaid an additional \$109.5 million annually unless other solutions are found. Additionally, new nursing home beds will compete in the Medicaid budget with home and community based services.

There is a loophole in Certificate of Need law that allows construction of new nursing beds without a CON review if the cost is under \$1 million. This provision limits consideration of other important factors including appropriate planning, demonstration of need, and cost effectiveness.

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 reflect public participation and support. They should help

balance out the long-term care system by insuring a mix of services consistent with community needs and desires to have alternative choices. Proposed projects should convincingly demonstrate need through sufficiently high projected utilization rates to justify the expenditures. 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. The 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. It is critical to recognize the financial impact on the Medicaid program of nursing home bed expansions.

Alternatives/Impacts and Costs:

A plan for the distribution and growth of nursing beds needs to be developed jointly between the Department of Health and Social Services, the Division of Senior Services, and the other interested organizations. Although there will be continued growth of nursing home beds, unnecessary growth must be avoided.

Recommendation:

The Department recommends passing legislation to adopt the Certificate of Need recommendations developed by the Legislative Working Group on Long-Term Care (1997).

CHAPTER 6: CERTIFICATE OF NEED PROGRAM

How The Program Works

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

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

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

Current Standard Of Review

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

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

Limitations Of Current Standard Of Review

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

Recommendations For Principles To Guide The Certificate Of Need Process

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

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

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

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

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

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

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

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

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

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

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

- if subject to the certificate of need process the application is reviewed by the Department to assure that it complies with all criteria,
- if the proposed expansion of service (through the addition of new or replacement nursing beds) is projected to cost the State more than \$3,000,000 in Medicaid reimbursement for operating and capital costs⁴ 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	PROPOSED ADDITIONS	
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	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 <u>alternatives</u> • 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.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF ADMINISTRATIVE SERVICES

TONY KNOWLES, GOVERNOR

P.O. BOX 110650
JUNEAU, ALASKA 99811-0650
PHONE: (907) 465-3082
FAX: (907) 465-2499

March 24, 1998

The Honorable Gary Wilken
Alaska State Senate
Room 510
Juneau, Alaska 99801

RE: Follow up to Chapter 84, SLA 96, a moratorium on construction of new nursing home beds

Dear Senator Wilken:

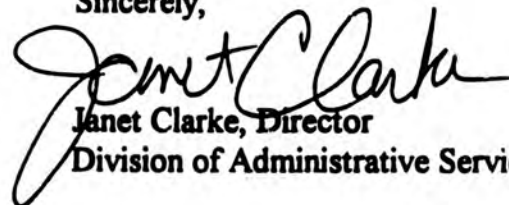
The attached pages outline the current status of efforts to control nursing bed costs and provides information on what the department plans to do to ensure that only those nursing home beds that are needed are built. Two years ago, when the moratorium was passed, there were plans for 147 new nursing beds costing \$11 million annually. Today there are 106-108 beds planned costing \$7.1-\$7.3 million annually, however, only \$1.9 million annually is expected to come from state general fund dollars.

The moratorium was passed to allow time to develop alternatives to nursing beds and to assess what could be done to promote cost containment. Over the last two years, the number of licensed assisted living beds has increased from 369 to 460 and all pioneer home beds have been converted from nursing beds to assisted living. The attached documents propose continuing the effort to maintain moderate growth by adopting regulations and standards of review that will ensure that only needed beds are built.

The Department believes that nursing bed growth and its effect on Medicaid costs needs to continue to be monitored. We expect that a majority of the new growth outlined in the attached pages will be added during the next two years.

If you have any questions, please contact me.

Sincerely,



Janet Clarke, Director
Division of Administrative Services

Enclosures

cc: Karen Perdue, Commissioner, Department of Health and Social Services
Mark Boyer, Commissioner, Department of Administration
Allison Elgee, Deputy Commissioner, Department of Administration
Jay Livey, Deputy Commissioner, Department of Health and Social Services
Elmer Lindstrom, Special Assistant, Department of Health and Social Services
Bob Labbe, Director, Division of Medical Assistance
Kay Burrows, Director, Division of Senior Services
Members of the Legislative Working Group on Long-Term Care

Update on the Moratorium on Nursing Bed Construction

The Moratorium on Nursing Home Beds Expires May 1, 1998

This document is written to alert the legislature of ongoing efforts to control growth of nursing beds and control Medicaid costs. In June 1996, Chapter 84, SLA 96 was passed into law, placing a moratorium on construction of new nursing home beds. The law was passed due to concerns over the potential rapid growth of nursing home beds with plans for 147 new nursing beds costing \$11 million annually. The moratorium was passed to allow time to develop alternatives to nursing beds and to assess what could be done to promote cost containment.

When the moratorium was passed, a Legislative Working Group was established to analyze the long-term care system and make recommendations for future actions. The working group completed their analysis and published a report on the long-term care system. This report determined that Alaska is heading for a crisis in its future ability to provide and pay for senior services, given the projected growth in Alaska's senior population. One of the recommendations of the Legislative Working Group was to strengthen the State certificate of need process.

Changes to the Certificate of Need Program

The Department of Health and Social Services proposes to adopt certificate of need regulations that would include review standards that will address some of these issues. The new standards for nursing beds will be added to a new application packet and will include:

- A minimum occupancy rate that must be achieved before new beds are allowed;
- A map that delineates service regions;
- Regional requirements for home and community based services before new beds are allowed; and
- Minimum numbers of beds required for any new rural or urban facility.

The new certificate of need regulations will also clean-up references to non-existing entities, prohibit division or phasing a project to avoid certificate of need, allow suspension of an application for a year for planning purposes, allow a minimal application process for minimal modification of a project, define what the Commissioner can use in decision making and limit allowable cost increases to 15%. The revised regulations and the application packet are nearly complete and must go through a public comment period before they can be adopted. We hope to have the public comment period completed by the end of June, 1998, and the new regulations adopted by August, 1998.

The following page lists the new construction projects that we expect to be developed within the next four years and an estimate of the impact that each may have on the Medicaid budget.

Potential Nursing Home Bed Growth 1998

Letter of Intent or Plans Received & Yr Finished	Number of Beds Planned	Est. Cost of Construction	Ann Medicaid Interest Cost	Ann Medicaid Depreciation	Ann Medicaid Operating Cost	Annual State Gen Fund Cost
Heritage Place (98)	15 beds	\$ 750,000?	None	\$ 22,800	\$ 768,618	\$ 316,567
Kotzebue (06?)	15 beds	\$ 4,530,000	Unknown	\$ 460,000	\$ 1,800,000	No State Funds
St. Ann's Care Ctr (99)	44 NH/10AL	\$14,600,000	\$ 938,753	\$ 426,320	NO NEW	\$ 546,029
So. Peninsula Hosp (99)	10 beds	\$ 3,500,000?	None	\$119,000?	\$ 1,043,744	\$ 465,098
Veterans Home (?)	?	?	?	?	?	No State Funds
Conversions:						
AK Regional Hosp* (98)	16 beds	\$ 488,000	Already Built	\$ 16,592	\$ 312,403	\$ 131,598
AK Regional Hosp (98)	16 beds	\$ 488,000?	None?	\$ 16,592?	\$ 312,403	\$ 131,598
Sitka Community (98)	4 beds	\$ 125,000	None?	\$ 10,000	\$ 646,406	\$ 262,562
Kotzebue (98?)	2-4 swing	\$ 125,000?	None?	\$ 10,000?	\$ 187-374K	No State Funds
Total	106-8 beds built: (2-4 swing, 22-24 converted, 44 replaced)	\$ 24,118,000	\$938,753	\$ 1,074,712	\$ 5.1-5.3M	\$1.9 M

DHSS/DAS/F&P March 23, 1998

Summary:

If all the beds were built:

- Annual Medicaid expenditures would increase by \$7.1 to \$7.3 million;
- The cost in State General Fund dollars is estimated at \$1.9 Million, annually;
- It is expected that Kotzebue and the Veterans project will be funded by 100% federal funds;
- Maniilaq Association (Kotzebue) recently completed a document entitled "Needs Assessment and Service Options for Elders of the Maniilaq Region." The study projects a need for 14 to 20 beds in the next 20 years and recommended co-location with the hospital;
- Homer has a new 40 bed assisted living facility which it has been having difficulty filling, probably due to not enough clients that need that level of care and affordability;
- * Alaska Regional - 16 of the beds have already been built and are currently reimbursed by Medicare only. ARH wants a license change for these beds to allow Medicaid reimbursement and wants to convert 16 more acute beds to nursing beds for a total of 32.

Methodology:

- Operating costs for beds are based on the January 31, 1998, per diem and Medicaid occupancy rates published by the Alaska DHSS, Division of Medical Assistance, Section of Health Facility Licensing and Certification.
- The per diem rate used for swing beds is \$256.49.
- Respective per diem and Medicaid occupancy rates used for existing facilities are: Sitka - \$553.43 and 73%; Heritage Place - \$179.24 and 76%; St. Ann's (Juneau) - \$261.08 and 73%; and South Peninsula - \$336.43 and 85%.
- The Kotzebue estimate was calculated using data from Quyaana Care Center in Nome: (\$565.20 and 100%).
- Estimates of depreciation for construction were figured using 25 years for new structures, 10 years for remodeling.
- Alaska's portion of Medicaid costs paid by the State general fund is 40%.
- Alaska Regional costs were taken from prior estimates of \$918,833 per year and acute Medicaid rate of 34%. . No nursing beds are at this level currently. These rates may change to a higher percent of Medicaid patients if the beds become Medicaid certified.
- St. Ann's interest cost is from the CON application; operating costs of \$3,445,623 weren't counted because the new facility will not add additional beds, therefore, those costs do not represent an increase in annual Medicaid costs.

ALASKA NURSING HOMES CENSUS

AS OF: AUGUST 31, 1998

*Sent to
Julia Peterson
for LTC review*
PAGE 1 OF 3

FACILITY	MEDICAID PER DIEM RATE	CERTIFIED & LICENSED BEDS	MEDICAID		MEDICARE	OTHER *	TOTAL CENSUS	VACANT BEDS	% OCCUPANCY OF TOTAL BEDS	
			ICF	SNF					OVERALL	MEDICAID
AK REGIONAL HOSP. TRANS. CARE (Anc.)	N/A	16	N/A	N/A	13	3	16	0	N/A	N/A
CORDOVA COMMUNITY MEDICAL CENTER LTC***	420.82	10	7	0	0	1	8	2	80%	70%
DENALI CENTER (Fairbanks)**	314.74	90	46	15	12	9	82	8	91%	68%
HERITAGE PLACE (Soldotna)*****	179.24	45	26	9	3	6	44	1	98%	78%
KETCHIKAN GENERAL HOSPITAL LTC***	345.21	46	10	1	6	2	19	27	41%	24%
MARY CONRAD CENTER (Anchorage)**	230.69	89	75	9	2	3	89	0	100%	94%
PROVIDENCE EXTENDED CARE CENTER (Anchorage)**	216.54	224	96	75	21	18	210	14	94%	76%
PROVIDENCE KODIAK ISLAND MEDICAL CENTER***	382.43	19	11	0	2	2	15	4	79%	58%
PETERSBURG MEDICAL CENTER LTC***	258.46	14	12	0	0	2	14	0	100%	86%
QUYAANA CARE CENTER (Nome)****	565.20	15	14	0	1	0	15	0	100%	93%
SITKA COMMUNITY HOSPITAL LTC***	569.09	8	4	1	0	3	8	0	100%	63%
SOUTH PENINSULA HOSP. LTC (Homer)***	331.52	20	18	1	0	1	20	0	100%	95%
ST. ANN'S CARE CENTER (Juneau)**	261.08	44	22	8	6	4	40	4	91%	68%
WESLEY REHABILITATION CARE CENTER (Seward)***	233.99	66	24	2	2	1	29	37	44%	39%
WRANGELL GENERAL HOSPITAL LTC***	319.79	14	13	0	1	1	15	-1	107%	93%
TOTAL		720	378	121	69	56	624	96	87%	69%

* Includes VA, private pay, insurance & other

** Effective 1/1/98 - 12/31/98

*** Effective 7/1/98 - 6/30/99

**** Effective 10/1/97 - 9/30/98

***** Effective 1/1/98 - 12/31/98


SHELBERT LARSEN, ADMINISTRATOR
DIVISION OF MEDICAL ASSISTANCE (907) 561-8081
HEALTH FACILITIES LICENSING & CERTIFICATION
DATE 9/9/98

ALASKA SWING BED CENSUS

AS OF: AUGUST 31, 1998

PAGE 2 OF 3

FACILITY	MEDICAID PER DIEM RATE	MEDICAID SWING BEDS						% OCCUPANCY OF TOTAL BEDS	
			MEDICAID	MEDICARE	OTHER •	TOTAL CENSUS	VACANT BEDS	OVERALL	MEDICAID
CENTRAL PENINSULA HOSPITAL (SOLDOTNA)**	\$256.49	4	0	2	0	2	2	50%	0%
CORDOVA COMMUNITY MEDICAL CENTER**	\$256.49	4	0	0	0	0	4	0%	0%
PROVIDENCE KODIAK ISLAND MEDICAL CENTER**	\$256.49	4	1	0	0	1	3	25%	25%
PETERSBURG MEDICAL CENTER **	\$256.49	4	0	0	1	1	3	25%	0%
PROVIDENCE SEWARD MEDICAL CENTER**	\$256.49	2	0	0	0	0	2	0%	0%
SITKA COMMUNITY HOSPITAL**	\$256.49	4	0	2	1	3	1	75%	0%
SOUTH PENINSULA HOSPITAL**	\$256.49	4	0	1	0	1	3	25%	0%
VALDEZ COMMUNITY HOSPITAL**	\$256.49	6	1	0	0	1	5	17%	17%
VALLEY HOSPITAL (PALMER)**	\$256.49	4	0	0	0	0	4	0%	0%
WRANGELL GENERAL HOSPITAL**	\$256.49	4	1	0	0	1	3	25%	25%
YUKON-KUSKOWIM REGIONAL HOSPITAL (BETHEL)**	\$256.49	3	0	0	0	0	3	0%	0%
TOTAL		43	3	5	2	10	33	23%	7%

- * Includes VA, private pay, insurance & other
- ** Effective 1/1/98 - 12/31/98


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

9/9/98
 DATE

PSYCHIATRIC HOSPITAL CENSUS

AS OF: AUGUST 31, 1998

PAGE 3 OF 3

PSYCHIATRIC BEDS	PER DIEM RATE	CERTIFIED BEDS	CURRENT OCCUPANCY			TOTAL CENSUS	VACANT BEDS
			MEDICAID UNDER 21	65 & OVER	NON- MEDICAID		
ALASKA PSYCHIATRIC INSTITUTE* Anchorage	\$767.04	95	8	5	54	67	28
CHARTER NORTH HOSPITAL Anchorage	N/A	74	20	0	10	30	44

*Effective 7/1/98 - 6/30/99


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

9/9/98
 DATE

____ BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY

Introduced:

Referred:

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to the certificate of need program for nursing care facilities and
2 other facilities; and providing for an effective date."

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

4 * Section 1. FINDINGS. The legislature finds that

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

8 (2) it is anticipated that the long-term care system in Alaska will face a crisis in
9 its ability to provide services to a growing and increasingly aging population by the 21st century
10 unless the system can provide services in a more efficient and appropriate manner;

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

14 (4) moderate assumptions about population and inflation would project that over

1 \$545 million will be needed to pay for long-term care services in Alaska by the year 2015;

2 (5) this situation demands a shift from the current significant reliance on costly
3 institutional care to a more balanced continuum of home-based and community-based services;

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

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

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

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

13 (7) appropriate planning is necessary to ensure that, when the moratorium is no
14 longer in effect, a certificate of need for new or replacement nursing home beds is not approved
15 without

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

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

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

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

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

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

28 **Sec. 18.07.021. Administration** [OFFICE OF PLANNING AND RESEARCH].

29 The [OFFICE OF PLANNING AND RESEARCH IN THE] department shall administer
30 the certificate of need program under this chapter and perform other functions prescribed
31 in this chapter.

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

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

- 5 (1) construction of a health care facility;
6 (2) alteration of the bed capacity of a health care facility; or
7 (3) addition [OR ELIMINATION] of a category of health services
8 provided by a health care facility.

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

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

15 **Sec. 18.07.041. Standard of review for applications for certificates of need**
16 **relating to non-nursing home beds.** The department [OFFICE] shall grant a sponsor
17 a certificate of need or modify a certificate of need that authorizes beds other than
18 nursing home beds or that is for a health care facility other than a nursing home if
19 the availability and quality of existing health care resources or the accessibility to those
20 resources is less than the current or projected requirement for health services required to
21 maintain the good health of citizens of this state.

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

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

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

- 30 (1) whether the sponsor recognized statewide, regional, and community
31 needs in planning for the project;

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

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

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

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

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

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

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

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

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

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

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

30 Sec. 18.07.061. Modification and termination of activities. The certificate
31 holder shall apply to the department [OFFICE] for a modification of the certificate

1 before terminating part of the activities authorized by the terms of issuance, but the
2 certificate holder is not required to obtain the acquiescence of the department [OFFICE]
3 before terminating all the activities authorized by the certificate. If a certificate holder
4 terminates all of the activities authorized by a certificate, the certificate holder is required
5 to notify the department [OFFICE] 60 days before termination and to surrender the
6 certificate to the department [OFFICE] within 30 days of termination.

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

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

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

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

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

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

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

29 (a) The department [OFFICE], a member of the public who is substantially
30 affected by activities authorized by the certificate, or another applicant for a certificate of
31 need may initiate a hearing to obtain modification, suspension, or revocation of an

1 existing certificate of need by filing an accusation with the commissioner as prescribed
2 under AS 44.62.360. A revocation, modification, or suspension of an outstanding
3 certificate may not be undertaken unless it is in accordance with AS 44.62.330 -
4 44.62.630.

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

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

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

13 (d) A certificate of need may be revoked if

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

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

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

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

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

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

26 * Sec. 11. AS 18.07.111(2) is amended to read:

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

29 * Sec. 12. AS 18.07.111 is amended by adding a new paragraph to read:

30 (13) "nursing home bed" means a bed not used for acute care in which
31 nursing care and related medical services are provided over a period of 24 hours each day

1 to individuals admitted to the health care facility because of illness, disease, or physical
2 infirmity.

3 * Sec. 13. AS 18.07.111(11) is repealed.

4 * Sec. 14. TRANSITION. (a) A matter described in AS 18.07.031 that is authorized under a
5 certificate of need issued before the effective date of this Act shall be reviewed and completed
6 in accordance with the applicable statutes and regulations as they existed on the day before the
7 effective date of this Act.

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

11 * Sec. 15. This Act takes effect immediately under AS 01.10.070(c).

Background Information on the Certificate of Need Bill

In 1996, the legislature placed a two-year moratorium on construction of new nursing beds and created a Working Group on Long Term Care to analyze issues relating to long-term care and the certificate of need program. The Working Group published a summary of information and findings as a result of their research and analysis of the long-term care system and certificate of need program. The analysis of the long-term care system found that:

- The existing long-term care system will continue to face a crisis in the twenty-first century unless services are provided in a more efficient and appropriate manner.
- In 1996, the state spent \$120 million on long-term care services for approximately 5,000 Alaskans, approximately \$80 million of which was from the state general fund.
- Moderate assumptions project that \$545 million will be needed to pay for long-term care services in Alaska by the year 2015.
- The senior population with severe impairments is expected to increase 185% from 3,933 in 1996, to 11,225 in 2015.
- There needs to be a shift away from reliance on costly institutional nursing home care to a more balanced continuum of home and community based services.

The moratorium and other regulation of the growth of nursing home beds has had a positive effect on the development of the long-term care system over the last two years. Plans for new nursing home beds were reduced in scope, delayed, or changed to include assisted living beds while more than 60 assisted living beds were added to the system. Although most of the planned new nursing bed construction has been delayed or reduced in scope, there are still plans to build up to 234 nursing home beds in the next 5 to 15 years. This would increase Medicaid costs by up to \$20 million annually of which \$10 million would be in state general fund dollars.

Since the moratorium will soon be over, there needs to be a more appropriate method to review and control new or replacement nursing beds. This bill proposes that the certificate of need review process be improved by adding new standards for nursing beds. The current standards only allow consideration of quality, availability and accessibility. The proposed standards will add consideration of whether a nursing bed project is the most cost effective, appropriate alternative; is consistent with existing plans; and has demonstrated long-term need, feasibility, and less reliance on state general funds. By adopting new standards of review for nursing bed projects we will be able to limit growth to only those nursing beds that are really needed and thereby enhance the growth of less costly home and community based services.

Nationally, there is a trend to convert underutilized acute or other beds to long-term care. Most conversions cost under \$1 million and therefore cannot be reviewed under current state law. This bill requires the conversion of acute or other beds to nursing beds to go through the certificate of need process even if the cost is under the \$1 million threshold. Currently, only conversion of assisted living or residential beds to nursing beds are required to submit a certificate of need application. All conversions should be required to go through the certificate of need review process in order to ensure that proper planning takes place, new nursing beds demonstrate that they are truly needed, to ensure that new beds are distributed properly, and to limit costs to the state.

SECTIONAL ANALYSIS OF PROPOSED CHANGES TO THE CERTIFICATE OF NEED LAW

SECTIONS

Sec. 2. AS 18.07.021. Administration All references to the "Office of Planning and Research" and "State Health Planning and Development Agency" are changed to "department" or "staff."

***Sec. 3. AS 18.07.031(9)(3). Certificate of need required.** Current law requires submission of a CON for a service which is being eliminated. Also, new language in (b) requires anyone who converts any facility or part of a facility into nursing home beds to submit a CON.

Sec. 5. Sec. 18.07.041. Standard of review for applications for certificates of need for non-nursing home bed projects: This section is amended to refer only to non-nursing bed projects. A separate section AS 18.07.043 is added to set a new standard for nursing facilities.

Sec. 6. Sec. 18.07.043. Standard of review for applications for certificates of need for nursing home beds: This section is added for nursing beds only. New standards of review for projects that increase nursing beds include consideration of planning efforts, demonstration of need, adequacy of home and community based services, cost of care, alternatives, and quality, as recommended by the Legislative Working Group on Long Term Care.

ANALYSIS

AS 18.07.021 These organizations no longer exist as separate entities within the department. This is a "clean-up" revision of the statute which is easier for readers to understand.

AS 18.07.031(9)(3) No CONs have ever been received for eliminating a service because the cost is under \$1 million. The only exception might be the demolition of a building, which we do not want to review. A facility cannot be required to continue to offer a service that the state doesn't pay for. For (b), most conversions would cost under \$1 million so could not be reviewed leaving a loophole in CON law that would have the potential to lead to significant increases in new beds and Medicaid costs.

AS 18.07.041 Since the current issues were related to the potential increase in the number of nursing beds, a separation is made between the way nursing beds are reviewed and non-nursing bed projects. As a result, the proposed bill keeps current standards for non-nursing bed projects, but adds new standards for nursing bed projects.

AS 18.07.043. This section is added for nursing beds because current standards of availability, quality, and accessibility are not sufficient for assessing the current or projected need for new beds. Other important principles including appropriate planning, demonstration of need, and cost effectiveness are included in the standards to ensure that there is a mix of services that is consistent with community needs and desires and enhances availability of more patient choices.

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. _____

Revision Date: _____
Title: An Act relating to certificates of need for
nursing home beds and providing an effective date
Sponsor: _____
Requestor: Governor's Office

Dept. Affected: Health and Social Services
BRU: Administrative Services
Component: Health Planning and Facilities Management
COMPONENT SERIAL NO. 2020
See also (SN#): _____

Expenditures/Revenues:

(Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	70.0	70.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS						
TOTAL OPERATING	70.0	70.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
-----------------------------	------------	------------	------------	------------	------------	------------

CHANGES IN REVENUES ()	0.0	0.0	0.0	0.0	0.0	0.0
--------------------------------	------------	------------	------------	------------	------------	------------

FUND SOURCE

(Thousands of Dollars)

1002 Federal Receipts	35.00	35.00	0.00	0.00	0.00	0.00
1003 GF Match	35.00	35.00	0.00	0.00	0.00	0.00
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health	0.0	0.0	0.0	0.0	0.0	0.0
Other (please specify)	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	70.0	70.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME	none	none	none	none	none	none
PART-TIME	none	none	none	none	none	none
TEMPORARY	none	none	none	none	none	none

Estimate of any current year (FY98) cost: \$0.0

ANALYSIS: (Attach a separate page if necessary)

Chapter 84, SLA 96 placed a moratorium on nursing home beds and established a working group on long-term care. One of the recommendations of the Legislative Working Group on Long-Term Care that was established by Chapter 84, SLA 96, was that it is of primary importance to develop a State long-term care plan which outlines the existing and desired long-term care system in a comprehensive manner. Certificate of need applicants would be required to demonstrate how well their proposal would fit in with these plans. As a result of the need for this planning, this bill will require contracting with a consultant to develop the State long-term care system plan; which outlines the existing and desired system, including researching trends in care and determining how those trends will develop in Alaska; identifying barriers to the use of home and community based services; determining where gaps in services are located and developing long term plans for filling the gaps; holding public meetings and public hearings to gain public participation in plan development; publishing and distribution of the plan; developing estimates of future issues and needs in the regions and better distribution of services; and updating the plan. This bill is a cost saving measure designed to avoid potential future costs to the state general fund of up to \$9.8 million annually due to construction of up to 234 new nursing home beds in the next 5 to 15 years.

Prepared by: Janet Clarke
Division: Administrative Services
Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services

Phone: 465-3015
Date: 11/14/97
Date: 11/17/97

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE
For further distribution information, call the Governor's Legislative Office

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. _____

Revision Date: _____
Title: Certificate of Need
Sponsor: _____
Requestor: GOVERNOR

Dept. Affected: Health and Social Services
BRU: Medical Assistance
Component: Medicaid Facilities
COMPONENT SERIAL NO. 230
See also (SN#): _____

Expenditures/Revenues:

(Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
----------------------	--	--	--	--	--	--

CHANGES IN REVENUES ()						
-------------------------	--	--	--	--	--	--

FUND SOURCE

(Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: \$0.0

ANALYSIS: (Attach a separate page if necessary)

This legislation does not have a direct impact on the Medical Assistance budget. However, failure to control the development of nursing facility beds will result in the need to increase funding for the Medicaid Facilities component of the budget.

The following page shows the potential impact to the Medicaid budget of continuing to develop nursing homes as the primary way to serve long term care needs instead of relying more heavily on a home and community-based long term care services. It is based on projections developed for *Long Term Care in Alaska: Recommendations for Reform*, by Ladd and Associates. While it is impossible to determine the precise impact of a stronger certificate of need law on nursing home construction, this estimate does demonstrate the magnitude of the potential budget impact.

Prepared by: Jon Sherwood
Division: Medical Assistance
Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services

Phone: 465-3355
Date: 11/12/97
Date: 11/14/97

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE
For further distribution information, call the Governor's Legislative Office

ANALYSIS (cont.):

In the last few years, the Division of Administrative Services has identified nine proposed projects to create new or expand existing nursing facilities. If all of these projects were built, it would add over 200 beds to nursing home capacity in Alaska. As about 85 percent of nursing home residents are on Medicaid, and state statute uses a cost-based reimbursement method for nursing beds, this could increase Medicaid expenditures on nursing facilities by more than \$20 million annually.

Even without this legislation, it is unlikely that all of these projects would be developed in the near future. The actual increase to the Medicaid budget would likely be smaller, phased in over a longer period of time. But given the anticipated growth in Alaska's senior population, it is almost certain that the demand for long term care services will grow over time. It is only a question of how much of that demand is met through nursing facility services.

In Long Term Care in Alaska: Recommendations for Reform, written by Ladd and Associates in 1996, the cost of providing long term care services through the existing mix of nursing home and community-based services was compared to the cost of providing long term care under a system where nursing capacity was initially held constant, and most of the growth in long term care services would come through home and community-based services. This legislation would allow the state to ensure that future development of the long term care system more closely resembles the latter scenario.

The projections below reflect the difference in cost between these two scenarios in the Ladd report. The costs have been moved back to adjust for the impact of the two-year nursing home moratorium currently in place. Hence, 1995 costs in the Ladd report are shown as FY 99 costs in this comparison. This analysis shows that it could cost over \$9 million more by FY 04 if nursing home beds continue to play their current role in meeting the need for long term care in Alaska.

	(\$ in thousands)					
	<u>FY 99</u>	<u>FY 00</u>	<u>FY 01</u>	<u>FY 02</u>	<u>FY 03</u>	<u>FY 04</u>
Existing LTC System	\$ 82,116	\$ 85,411	\$ 88,969	\$ 92,721	\$ 96,668	\$ 100,929
LTC System w/ Strong CON statute	<u>\$ 82,116</u>	<u>\$ 83,342</u>	<u>\$ 84,822</u>	<u>\$ 86,664</u>	<u>\$ 88,946</u>	<u>\$ 91,818</u>
Difference	0.0	2,069.0	4,147.2	6,057.2	7,722.0	9,111.0

Source: *Long Term Care in Alaska: Recommendations for Reform*
Ladd and Associates, Austin Texas, March, 1996, page 82.

QUESTIONS REGARDING THE CERTIFICATE NEED PROGRAM

Rep. Hanley has asked if the State could repeal the CON law as it relates to nursing home beds and add language to the Medicaid statute that says we will not necessarily pay for new beds.

The State is mandated by federal Medicaid law to offer nursing facility services to Medicaid eligible individuals on a statewide basis. Under the federal law, the state cannot choose to avoid making those services available. This means that technically, the state Medicaid program cannot deny access to nursing facility care to an eligible person who has a medical need for such care. Prior to the passage of the Balanced Budget Act of 1997, states were required to have payment rates for facilities that took into account the costs that were incurred. That provision (Boren amendment) has been repealed to provide greater state flexibility in rate setting. However, Alaska has its own state law that has similar provisions. Thus, under current law, the state Medicaid program cannot either limit admission nor payment for those individuals who qualify and choose to reside in a nursing facility. Although nursing facility services are mandated, there are four methods that can be used control Medicaid costs: limiting facility construction, limiting facility enrollment, limiting admissions, and controlling the Medicaid rates. Each method serves a useful purpose and no single method is a panacea to control Medicaid costs. Each has separate regulations and statutes and in a separate section of DHSS.

I. LIMIT CONSTRUCTION OF NEW BEDS: The state currently limits the number of new beds that are built through the certificate of need (CON) program. CON could be made stronger by strengthening the CON law to include all new beds and stricter review criteria.

A. **Pros:** CON is a useful tool to prevent unnecessary nursing bed growth. It has saved the state millions in the past. The other three methods leave loopholes for constructing new beds that the CON program currently catches.

B. **Cons:** Currently, beds can be converted or added without a CON review if costs are under \$1 million. CON needs to be strengthened by adding new review criteria such as the cost to the system, and the availability of alternatives to nursing beds. Current law should be changed to require all new nursing beds to go through the review process.

II. LIMIT ENROLLMENT (CERTIFICATION) OF NEW FACILITIES: The federal Medicaid law allows states to refuse to enroll a nursing facility in the Medicaid program if new beds will create excess capacity. This tool could be used to avoid enrollment of new facilities if there were no CON.

A. **Pros:** Only enrolled programs receive Medicaid payments. New, unnecessary facilities or unneeded existing facilities could be denied enrollment.

B. **Cons:** Disenrollment has never been done before. This program is not now used to stop growth of nursing beds. Alaska's current federal authority to restrict enrollment is an all or none approach. Under current law, existing facilities must be entirely enrolled or disenrolled, not just new beds. Disenrolling an existing facility cannot be done if it would cause an area bed shortage. An aggressive disenrollment policy could be subject to successful legal challenge. Conversions of acute beds to nursing beds could not be stopped without disenrolling the entire facility. There are many empty acute beds at nursing facilities colocated with hospitals. A facility that builds unneeded beds could only be disenrolled if the state develops a review process, defines regions and criteria to judge "need." This resembles elements of the CON process. Strengthening this program would only be needed if the CON program is eliminated.

III. LIMIT THE NUMBER OF RESIDENTS ADMITTED: Many states avoid the admission of some new nursing home residents by providing home and community based alternative services. To ensure that seniors are referred to alternatives, many states have developed a strong pre-admission screening program. The State recently started a pre-admission screening pilot project.

A. **Pros:** Pre-admission screening has worked well in many other states. It reduces inappropriate nursing home admissions and helps seniors stay home longer, thereby reducing costs.

B. **Cons:** A statewide team of assessors must be in place to review all potential admissions and flexible care alternatives must be in place in the community. Some areas of the state do not have alternatives or assessment teams. Medicaid cannot force people to choose other alternatives if they are eligible for nursing home level of care and want to go to a nursing home.

IV. LIMIT THE AMOUNT OF MONEY PAID PER NURSING HOME RESIDENT: Alaska has had high rates of payment because of the limited number of nursing homes in the state. If Medicaid rates are reduced, addition of new beds will be less attractive. Rate reduction could be done in several ways: 1) Alaska has a flat rate which could be changed to case mix reimbursement which pays different amounts for different levels of service; 2) A type of managed care program might be developed for long-term care services which would pay a specific amount for each senior in a catchment area. This per capita payment would permit the use of either alternative services or nursing home care.

A. **Pros:** Rate setting can be a viable means of saving state dollars. Managed care is a cost control measure in acute care services that is a rapidly growing trend Nationally. Per capita payments provide incentives for providers to promote use of lower cost services.

B. **Cons:** To lower Medicaid rates, the Alaska "Boren" law that requires payment of all "reasonable" costs must be repealed. Managed care for LTC using a per capita payment mechanism is virtually untried in other states. Since this population has both Medicare and Medicaid coverage, making such a program work is very complex and a major challenge. As a result, only a few states that already have other extensive managed care programs are just now beginning to explore it for LTC. To make it work in Alaska, about 10,000 participants need to be enrolled to adequately spread the risk to the managed care plan. No region in Alaska has more than 2,000 seniors who needing these services. Also, there are currently no managed care programs in Alaska to start with and parts of the state would probably be left out due to small senior populations. Areas left out would likely be open to new beds being built. Facilities know that Alaska must buy LTC services. Since there is only one provider in an area in most cases, there is little or no incentive to negotiate a lower price for services.

H&SS Staff Recommendation: Although the Department finds value in each of the four approaches, it recommends that the CON program be retained and the CON law should be strengthened. CON is particularly effective in preventing unnecessary expansion of existing facilities and conversions of acute beds to nursing beds. None of the other options adequately provides a method to determine need for new beds or for stopping construction of unnecessary nursing beds. The Department has developed draft legislation as promised in response to the CON moratorium. Passing new CON legislation would give the State greater control over the construction and conversion of long-term care beds by adding new, more effective review criteria for CON applications and by requiring all new long-term care beds to be reviewed.

If CON legislation is not feasible, regulations could be promulgated which would put in place **SOME, BUT NOT ALL** of the CON criteria in the proposed CON law. However, without a new law, the very important provision that allows the state to consider the cost of new beds and the impact on the Medicaid budget could not be included.

All Funding Sources

**Longevity Bonus Forecast Report
FY 1999 and FY 2000**

1999 Fiscal Year Forecast

Base Estimate Warrants	287,025
Low Estimate Warrants	279,892
High Estimate Warrants	294,258
Base Estimate Payments	\$62,728,750
Low Estimate Payments	\$61,168,333
High Estimate Payments	\$64,312,083

Fiscal Year 2000 Forecast

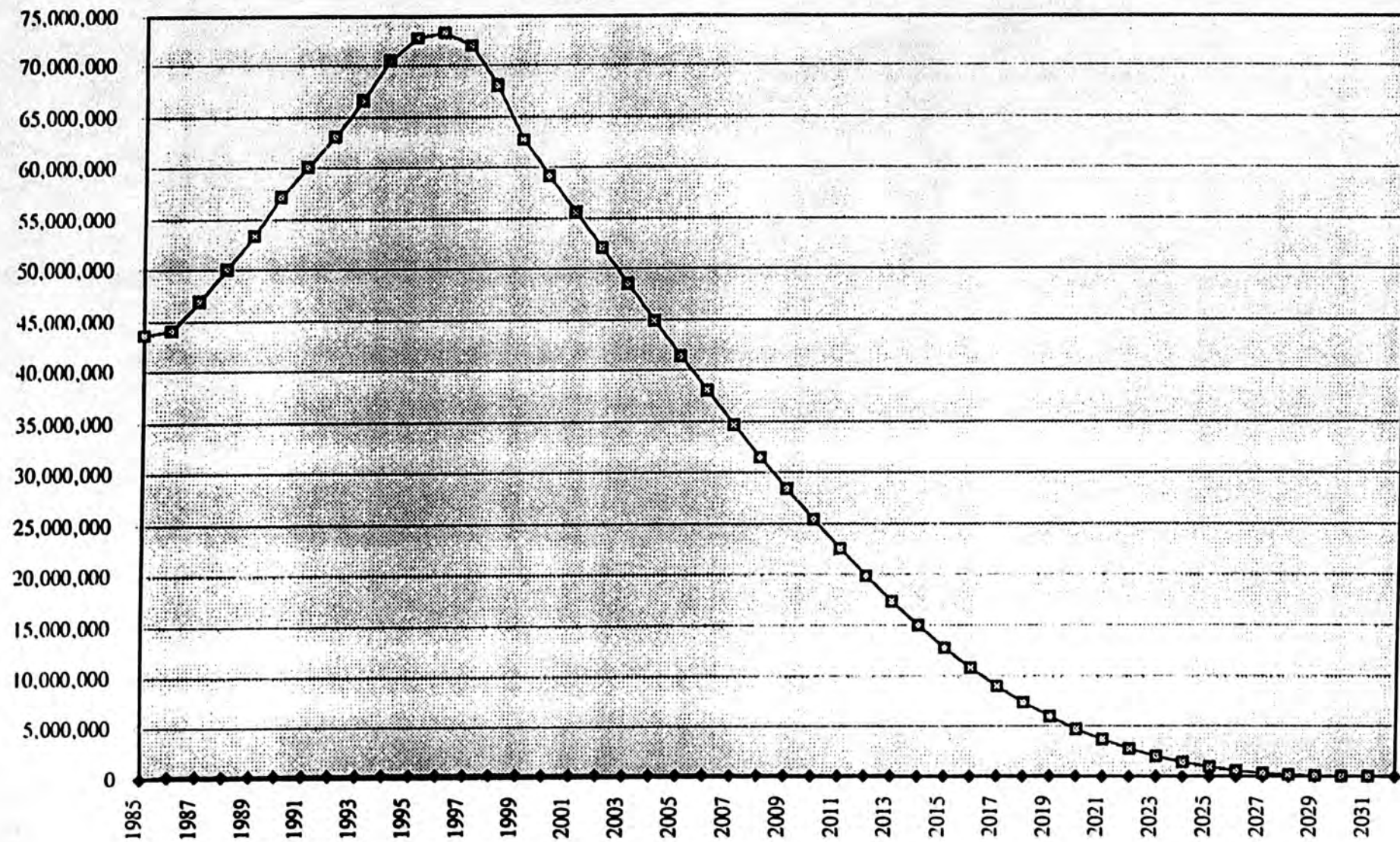
Base Estimate Warrants	271,683
Low Estimate Warrants	264,950
High Estimate Warrants	278,475
Base Estimate Payments	\$59,171,667
Low Estimate Payments	\$57,702,083
High Estimate Payments	\$60,650,833

**Per September 24, 1998 Forecast Run

0998Forecast.xls

	A	B	C	D	E	F	G	H	I	J	K	L	M	N								
2	Table 1: Calendar Year and Fiscal Year Forecast Through 2040																					
4	Re-calibrating Tools			1998								1999										
5							\$	250	\$	200	\$	150	\$	100	\$	250	\$	200	\$	150	\$	100
6	0.00%	0.000%	Add. of Base	Base Estimate Warrants	205,200	26,400	29,000	32,800	192,800	25,500	28,100	31,900										
7	2.50%	2.50%	Below Base	Low Estimate Warrants	200,100	25,700	28,300	32,000	187,800	24,900	27,400	31,100										
8	2.50%	2.50%	Over Base	High Estimate Warrants	210,400	27,100	29,700	33,600	197,400	26,200	28,800	32,700										
10	** last date worked 9/24/98 **			Base Estimate Payments	\$ 51,300,000	\$ 5,280,000	\$ 4,350,000	\$ 3,280,000	\$ 48,150,000	\$ 5,100,000	\$ 4,215,000	\$ 3,190,000										
11				Low Estimate Payments	\$ 50,025,000	\$ 5,140,000	\$ 4,245,000	\$ 3,200,000	\$ 46,950,000	\$ 4,980,000	\$ 4,110,000	\$ 3,110,000										
12				High Estimate Payments	\$ 52,600,000	\$ 5,420,000	\$ 4,455,000	\$ 3,360,000	\$ 49,350,000	\$ 5,240,000	\$ 4,320,000	\$ 3,270,000										
14					1998	Calendar Year Total				1999 Calendar Year Total												
15									(\$250+\$200+\$150+\$100)													
17					Base Estimate Warrants	293,400				Base Estimate Warrants	278,100											
18					Low Estimate Warrants	286,100				Low Estimate Warrants	271,200											
19					High Estimate Warrants	300,800				High Estimate Warrants	285,100											
21					Base Estimate Payments	\$64,210,000				Base Estimate Payments	\$60,655,000											
22					Low Estimate Payments	\$62,610,000				Low Estimate Payments	\$59,150,000											
23					High Estimate Payments	\$65,835,000				High Estimate Payments	\$62,180,000											
25					1999	Fiscal Year Total				2000 Fiscal Year Total												
26					58.3%	1998				58.3%	1999											
27					41.7%	1999				41.7%	2000											
29					Base Estimate Warrants	287,025				Base Estimate Warrants	271,683											
30					Low Estimate Warrants	279,892				Low Estimate Warrants	264,950											
31					High Estimate Warrants	294,258				High Estimate Warrants	278,475											
33					Base Estimate Payments	\$62,728,750				Base Estimate Payments	\$59,171,667											
34					Low Estimate Payments	\$61,168,333				Low Estimate Payments	\$57,702,083											
35					High Estimate Payments	\$64,312,083				High Estimate Payments	\$60,850,833											

**Longevity Bonus Program Phase-out (amounts from FY85 - FY98 are actual expenditures;
amounts from FY99 on are estimates)**



STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF ADMINISTRATIVE SERVICES

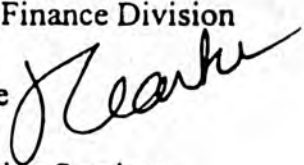
TONY KNOWLES, GOVERNOR

P.O. BOX 110650
JUNEAU, ALASKA 99811-0650
PHONE: (907) 465-3082
FAX: (907) 465-2499

MEMORANDUM

DATE: October 8, 1998

TO: Fred Fisher
Legislative Fiscal Analyst
Legislative Finance Division

FROM: Janet Clarke 
Director
Administrative Services

SUBJECT: FY98 Senior Program Expenditures

The Department of Health and Social Services is providing the following information you requested regarding FY98 expenditures for Senior Programs.

Supplemental Security Income (Federal SSI payment)	\$ 5,100.0
Adult Public Assistance (for aged) includes PDF HH funding source	\$16,080.7
Longevity Bonus Hold Harmless	\$ 2,472.7
Food Stamps for Elderly	\$ 650.0
Medicaid - Services for Elderly	\$51,454.8
General Relief Medical - Nursing Homes	\$ 0.0

Please note that the Medicaid amount has been amended from the October 1, 1998, memo to include all services to elderly. If you have questions concerning this information, please contact me at 465-3082.

cc: Karen Perdue, Commissioner
Jay Livey, Deputy Commissioner
Elmer Lindstrom, Special Assistant
Bob Labbe, Director, Medical Assistance
Jim Nordlund, Director, Public Assistance
Lisa Emerson, Budget Analyst, Administrative Services
Randy Moore, Administrative Manager, Public Assistance
Randy Super, Administrative Manager, Medical Assistance
Verne Skagerberg, Budget Analyst, Administrative Services
Jim Galea, Budget Analyst, Administrative Services

DATE: October 19, 1998

TO: Long Term Care Task Force

FROM: Kay L. Burrows
Director
Senior Services

SUBJECT: FY 98 Senior Program Expenditures

The Division of Senior Services is providing the following information as requested regarding FY98 expenditures for Senior Programs.

Longevity Bonus Program	\$67,591.9
Pioneer Homes	\$30,475.0
Protection, Admin	\$ 4,807.1 (includes seven program areas)
NTS grants	\$ 5,199.2
Senior Emp. Grants	\$ 1,744.3
HCB grants	\$ 3,301.6
PCA grants	\$ 1,730.2

If you have questions concerning this information, please contact me at 269-3666.

Medicare – Present/Future

COB	Description	UB 92 Crossovers						combined cos sum Professional Crossovers						Straight Claims			Totals					
		Unduplicated Recipients	Medicare Billed	Medicare Paid	Coinsurance	Deductible	Medicaid Paid	Unduplicated Recipients	Medicare Billed	Medicare Paid	Coinsurance	Deductible	Medicaid Paid	Unduplicated Recipient	Medicaid Billed	Medicaid Paid	Unduplicated Recipients	Medicare Billed	Medicare Paid	Coinsurance	Deductible	Medicaid Paid
01	Inpatient Hospital Services	5,247	\$72,338,609	\$39,530,227	\$2,265,119	\$2,967,338	\$5,177,555	1,899	\$9,148,987	\$3,202,553	\$87,578	\$180,785	\$267,526	299	\$8,971,654	\$4,632,686	5,850	\$81,487,476	\$42,732,780	\$2,352,697	\$3,168,123	\$10,077,787
03	Inpatient Psychiatric Services	7	\$49,477	\$41,846	\$0	\$5,212	\$5,212	0	\$0	\$0	\$0	\$0	\$0	16	\$328,599	\$222,037	22	\$45,477	\$41,846	\$0	\$5,212	\$227,249
07	Outpatient Hospital Services	4,970	\$11,085,835	\$5,327,948	\$1,991,223	\$224,005	\$2,206,103	2,330	\$3,171,419	\$799,353	\$451,134	\$46,633	\$496,966	1,614	\$2,571,436	\$1,355,809	6,331	\$14,267,054	\$6,127,301	\$2,442,357	\$270,638	\$4,058,879
09	Personal Care Services	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	1,155	\$9,724,864	\$9,704,916	1,155	\$0	\$0	\$0	\$0	\$9,704,916
10	Short Term LTC Services	0	\$151,864	\$76,380	\$19,924	\$0	\$19,924	0	\$0	\$0	\$0	\$0	\$0	11	\$311,980	\$240,759	19	\$151,864	\$76,380	\$19,924	\$0	\$260,683
11	SNF Services	329	\$7,705,603	\$3,418,503	\$1,318,441	\$19,601	\$1,277,159	0	\$0	\$0	\$0	\$0	\$0	399	\$22,676,271	\$17,881,455	568	\$7,705,603	\$3,418,503	\$1,316,441	\$19,601	\$19,158,614
12	ICF Services	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	775	\$108,565,893	\$90,961,877	775	\$0	\$0	\$0	\$0	\$90,961,877
13	ICF/MR Services	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	23	\$4,391,531	\$4,253,223	23	\$0	\$0	\$0	\$0	\$4,253,223
14	Chiropractic Services	0	\$0	\$0	\$0	\$0	\$0	247	\$95,726	\$56,880	\$14,225	\$6,071	\$20,298	1	\$595	\$499	248	\$95,726	\$56,880	\$14,225	\$6,071	\$20,796
17	Mental Health Services	0	\$0	\$0	\$0	\$0	\$0	1,317	\$1,900,101	\$684,405	\$572,821	\$94,892	\$685,818	1,228	\$17,779,790	\$16,708,848	1,873	\$1,900,101	\$684,405	\$572,821	\$94,892	\$17,372,662
22	X-Ray Services	0	\$0	\$0	\$0	\$0	\$0	199	\$56,992	\$18,914	\$4,748	\$2,832	\$7,558	10	\$2,108	\$1,342	209	\$56,992	\$18,914	\$4,748	\$2,832	\$8,900
23	Laboratory Services	0	\$0	\$0	\$0	\$0	\$0	137	\$21,447	\$7,884	\$1,971	\$869	\$2,840	1,798	\$509,545	\$244,584	1,872	\$21,447	\$7,884	\$1,971	\$869	\$247,425
24	Outpatient Surgery Services	72	\$135,620	\$62,260	\$11,325	\$1,687	\$12,919	252	\$532,767	\$187,544	\$47,494	\$1,232	\$48,726	41	\$75,407	\$36,366	204	\$532,767	\$187,544	\$47,494	\$1,232	\$48,726
26	Home Health Services	4	\$10,241	\$8,112	\$2,028	\$100	\$2,127	187	\$140,817	\$40,389	\$10,103	\$1,155	\$11,185	66	\$383,016	\$277,887	255	\$10,241	\$8,112	\$2,028	\$100	\$2,127
27	Family Planning Services	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	22	\$4,147	\$3,285	22	\$0	\$0	\$0	\$0	\$3,285
30	Prescription Drugs	0	\$0	\$0	\$0	\$0	\$0	495	\$945,908	\$460,482	\$115,444	\$4,898	\$118,293	7,298	\$36,520,993	\$31,340,475	7,349	\$945,908	\$460,482	\$115,444	\$4,898	\$118,293
31	Medical Supplies Services	0	\$0	\$0	\$0	\$0	\$0	350	\$391,916	\$182,962	\$45,964	\$10,170	\$56,130	2,284	\$3,178,108	\$2,800,005	2,446	\$391,916	\$182,962	\$45,964	\$10,170	\$56,130
32	DME Services	0	\$0	\$0	\$0	\$0	\$0	1,725	\$5,428,981	\$2,335,007	\$587,377	\$75,336	\$661,595	885	\$466,903	\$412,944	2,041	\$5,428,981	\$2,335,007	\$587,377	\$75,336	\$1,074,539
34	Prosthetics & Orthotics	0	\$0	\$0	\$0	\$0	\$0	180	\$365,600	\$256,015	\$63,903	\$2,308	\$65,809	144	\$99,303	\$86,667	279	\$365,600	\$256,015	\$63,903	\$2,308	\$65,809
36	Drug Abuse Center	0	\$0	\$0	\$0	\$0	\$0	18	\$5,644	\$1,978	\$895	\$828	\$1,722	187	\$484,081	\$401,828	205	\$5,644	\$1,978	\$895	\$828	\$403,550
37	Transportation Services	229	\$287,589	\$148,732	\$44,312	\$5,972	\$50,284	2,221	\$1,972,227	\$1,069,169	\$268,248	\$22,388	\$287,255	2,829	\$5,646,178	\$5,386,531	4,049	\$2,259,796	\$1,217,901	\$312,560	\$28,359	\$5,724,070
39	Accommodation Services	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	1,145	\$794,443	\$786,721	1,145	\$0	\$0	\$0	\$0	\$786,721
41	Nutrition Services Under 21	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	1	\$20	\$20	1	\$0	\$0	\$0	\$0	\$20
43	Physician Services	2	\$309	\$167	\$62	\$0	\$62	7,337	\$35,543,544	\$13,065,172	\$3,381,010	\$823,751	\$4,163,004	2,409	\$5,404,892	\$3,823,755	7,528	\$35,543,544	\$13,065,172	\$3,381,010	\$823,751	\$7,986,821
45	Dental Services	0	\$0	\$0	\$0	\$0	\$0	3	\$871	\$393	\$98	\$0	\$98	803	\$456,835	\$316,121	805	\$871	\$393	\$98	\$0	\$316,121
47	Vision Services	0	\$0	\$0	\$0	\$0	\$0	780	\$1,001,461	\$246,250	\$61,682	\$19,811	\$81,255	1,692	\$255,143	\$242,547	2,192	\$1,001,461	\$246,250	\$61,682	\$19,811	\$323,802
48	Pediatric Services	0	\$0	\$0	\$0	\$0	\$0	660	\$214,862	\$116,604	\$29,307	\$15,663	\$44,728	2	\$390	\$385	662	\$214,862	\$116,604	\$29,307	\$15,663	\$45,113
49	Midwifery Services	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	28	\$9,481	\$6,952	28	\$0	\$0	\$0	\$0	\$6,952
50	Advanced Nurse Practitioners	0	\$0	\$0	\$0	\$0	\$0	309	\$634,516	\$303,008	\$75,890	\$15,693	\$91,532	105	\$24,006	\$18,815	379	\$634,516	\$303,008	\$75,890	\$15,693	\$110,347
51	Rehabilitative Services	0	\$0	\$0	\$0	\$0	\$0	509	\$755,551	\$425,853	\$135,221	\$9,490	\$144,378	174	\$266,578	\$220,473	596	\$755,551	\$425,853	\$135,221	\$9,490	\$364,849
53	Hearing Services	0	\$0	\$0	\$0	\$0	\$0	140	\$14,299	\$6,114	\$1,599	\$2,081	\$3,642	424	\$532,888	\$393,404	503	\$14,299	\$6,114	\$1,599	\$2,081	\$397,044
54	Occupational Therapy	0	\$0	\$0	\$0	\$0	\$0	1	\$670	\$378	\$94	\$0	\$94	1	\$103	\$103	2	\$670	\$378	\$94	\$0	\$198
56	FGHC	0	\$0	\$0	\$0	\$0	\$0	408	\$269,244	\$891,397	\$41,908	\$1,241	\$42,983	0	\$0	\$0	406	\$269,244	\$891,397	\$41,908	\$1,241	\$42,983
58	ESRD Services	99	\$4,340,086	\$3,023,406	\$758,874	\$9,663	\$765,703	1	\$5,930	\$4,571	\$1,143	\$0	\$1,143	22	\$125,666	\$123,421	100	\$4,340,086	\$3,023,406	\$758,874	\$9,663	\$765,703
60	Care Coordination	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	1,073	\$3,088,678	\$3,085,092	1,073	\$0	\$0	\$0	\$0	\$3,085,092
68	Residential Habilitation	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	194	\$13,778,543	\$13,639,607	194	\$0	\$0	\$0	\$0	\$13,639,607
70	Day Habilitation	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	53	\$834,994	\$822,873	53	\$0	\$0	\$0	\$0	\$822,873
71	Supported Employment	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	42	\$867,272	\$853,076	42	\$0	\$0	\$0	\$0	\$853,076
73	Intensive Active Treatment/Therapy	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	5	\$32,592	\$32,592	5	\$0	\$0	\$0	\$0	\$32,592
74	Chore Services	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	146	\$262,938	\$261,782	146	\$0	\$0	\$0	\$0	\$261,782
76	Specialized Equipment and Supplies	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	335	\$414,079	\$409,338	335	\$0	\$0	\$0	\$0	\$409,338
78	Environmental Modifications	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	87	\$511,413	\$497,715	87	\$0	\$0	\$0	\$0	\$497,715
77	EPST Screening	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	15	\$331	\$331	15	\$0	\$0	\$0	\$0	\$331
80	Rural Health Services	0	\$0	\$0	\$0	\$0	\$0	219	\$134,373	\$50,324	\$17,270	\$2,223	\$19,493	0	\$0	\$0	219	\$134,373	\$50,324	\$17,270	\$2,223	\$19,493
81	Meals	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	271	\$477,905	\$470,089	271	\$0	\$0	\$0	\$0	\$470,089
82	Specialized Private Duty Nursing	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	1	\$200	\$200	1	\$0	\$0	\$0	\$0	\$200
83	Transportation	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	328	\$329,949	\$326,945	328	\$0	\$0	\$0	\$0	\$326,945
84	Residential Supported Living	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	280	\$6,668,186	\$6,371,896	280	\$0	\$0	\$0	\$0	\$6,371,896
85	Adult Day Care	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	149	\$1,488,908	\$1,453,893	149	\$0	\$0	\$0	\$0	\$1,453,893
86	Respite Care	0	\$0	\$0	\$0	\$0	\$0	0	\$0	\$0	\$0	\$0	\$0	224	\$2,568,719	\$2,530,848	224	\$0	\$0	\$0	\$0	\$2,530,848
88	Physician IHS Clinic	0	\$0	\$0	\$0	\$0	\$0	21	\$11,179	\$8,546	\$2,226	\$404	\$2,630	0	\$0	\$0	21	\$11,179	\$8,546	\$2,226	\$404	\$2,630
Totals		7,003	\$98,111,194	\$51,637,581	\$8,409,309	\$3,253,577	\$9,517,048	8,263	\$62,764,911	\$24,426,123	\$6,019,353	\$1,340,554	\$7,306,696	8,630	\$261,857,534	\$223,652,604	8,994	\$158,876,105	\$76,063,703	\$12,428,682	\$4,594,130	\$240,478,349
Percent Paid		53.73%						38.92%						85.41%			47.88%					
*Deductible Percentage		33.67%						18.21%									26.99%					

Information from MMS paid claims only DOS 7/1/95 - 6/30/98, DOP 7/1/95 - 10/7/98.

*Deductible Percentage is the deductible amount divided by the sum of the deductible amount plus the coinsurance amount.

Alaska

Year	ClinicalLab	DME	HHA	Hospice	IP_Payments	IP_Passthru	SNF	SNF_SwingBed	Outpatient
1993	\$594,783	\$1,570,191	\$5,597,428	\$6,138	\$57,102,243	\$5,460,316	\$1,797,672	\$413,166	\$11,259,429
1994	\$559,605	\$2,178,271	\$7,108,746	\$218,479	\$62,079,003	\$5,180,436	\$1,873,648	\$493,251	\$12,369,636
1995	\$649,802	\$2,905,079	\$9,475,697	\$310,376	\$76,053,207	\$5,487,810	\$2,468,137	\$633,422	\$15,246,995
1996	\$700,758	\$2,896,168	\$12,378,636	\$587,395	\$85,125,779	\$4,023,590	\$3,336,734	\$660,752	\$18,136,015
1997	\$564,756	\$2,966,286	\$12,662,898	\$648,831	\$91,560,902	\$4,039,975	\$4,416,397	\$569,361	\$20,485,238
Note:									

DUAL ELIGIBLE PATIENTS

In an effort to contain Medicaid expenditures, Alaska Medicaid pays Medicare premiums, deductibles, and coinsurance on behalf of Medicaid recipients eligible for Medicare benefits. Medicaid is the payer of last resort, required to pay only when other payment alternatives have been exhausted.

Medicare coverage is available for certain services provided in nursing facilities.

In recent years, the department has encouraged nursing facilities to bill Medicare for services provided to dual eligibles.

This urging has achieved limited results on short stays as generally nursing facilities have billed Medicare for an increasing number of inpatient short stays. (Medicare Part A) All nursing facilities, however, are still not certified to provide Medicare and Medicaid services in all beds, and that can limit the amounts billed to Medicare if a Medicare certified bed is not available.

Nursing facilities have not billed Medicare Part B ancillary services, including occupational therapy and physical therapy, when Medicare Part A coverage is not available.

Annual general fund savings to the Medicaid program could reach \$400,000 if nursing facilities did bill Medicare for Medicare services provided to dual eligibles, and the facilities would still receive full Medicare payment.

The department could mandate such a process by providing full explanation to the nursing facility industry through the regulatory process, and removing Medicare eligible services from Medicaid payment rates leaving the facilities to bill Medicare for the service. Medicaid eligible services not covered by Medicare would then be incorporated into the Medicaid payment rate as the payer of last resort.

RECOMMENDATION

The Department of Health and Social Services make every effort, by regulatory or if necessary statutory means, to assure Medicare fully funds long term care services provided to dual eligible patients.

STATE OF ALASKA
Department of Health and Social Services
Medicaid Rate Advisory Commission

Report on Medicare and Medicaid Long Term Care Patient Days
Data from Facility Medicare Cost Reports, Worksheet S-3

Facility	1992		1993		1996		1997	
	Medicare Patient Days	Medicaid Patient Days	Medicare Patient Days	Medicaid Patient Days	Medicare Patient Days	Medicaid Patient Days	Medicare Patient Days	Medicaid Patient Days
Cordova Community Medical Center	0	3,558	0	3,123	63	2,861	48	3,144
Fairbanks Memorial Hospital	2,183	20,926	2,576	21,049	3,414	23,212	3,427	21,698
Heritage Place	902	12,299	1,267	12,424	1,075	13,792	946	14,056
Ketchikan General Hospital	1,293	6,489	831	5,536	1,709	5,007	1,712	4,139
Mary Conrad Care Center	0	30,736	0	30,855	1,016	30,050	1,173	29,452
Norton Sound Regional Hospital	0	4,221	0	2,532	0	5,348	0	5,264
Petersburg Medical Center	42	4,371	105	4,247	186	4,126	163	4,159
Providence Extended Care Center	2,379	68,319	3,668	67,394	6,657	64,109	6,693	62,858
Saint Ann's Care Center	0	12,497	0	12,363	646	11,428	1,180	11,325
Sitka Community Hospital	-	-	-	-	59	1,608	333	1,197
Wesley Rehab and Care Center	0	15,515	0	13,797	238	14,854	354	13,159
Wrangell General Hospital	88	3,009	152	2,635	281	3,883	75	3,936
TOTAL	6,887	181,940	8,599	175,955	15,344	180,278	16,104	174,387

Federal LTC Funding

Issue Brief: Medicaid's level of care requirement for persons with Alzheimer's Disease is too restrictive.

Definition: Alzheimer's Disease and Related Disorders' (ADRD) refer to cognitive impairments that are progressive and degenerative in nature, and as a result of adult onset, require supervision and cueing from other individuals in order to adequately and routinely perform activities of daily living and instrumental activities of daily living. Persons whose sole diagnosis is Alzheimer's Disease and Related Disorders (ADRD) do not typically require daily supervision by medical professionals such as nurses.

Findings:

In order to be eligible for nursing home and home and community based services from Alaska's Medicaid program, applicants must be low-income and require skilled nursingⁱⁱ or intermediate careⁱⁱⁱ. The criteria for this care is that a person requires professional nursing supervision or rehabilitation services. Persons whose sole diagnosis is ADRD typically do not meet these criteria and consequently, the Alaska Medicaid program will not pay for nursing homes or home and community based services for them.

Alaska is only one of two states whose Medicaid eligibility requirement for nursing home and home and community based services includes that the patient "requires professional-level medical supervision".

Persons with ADRD may have great difficulty living without assistance, particularly since these individuals are not eligible for (Medicaid-funded) home and community based waiver services. In addition, it should be noted that many of these people are receiving respite care, adult day care, and Pioneers' Home services which are paid for in part by the State's General Fund.

Reducing the "professional-level medical supervision" eligibility requirement for ADRD patients would have budget implications for the State particularly since federal law requires that the home and community

Draft: Medicaid's level of care requirement for persons with
Alzheimer's Disease is too restrictive, Page 1
For Consideration by LTC Design Team, 10-16-98

based waiver services have the same eligibility level as nursing homes. Under federal law, people who receive home and community based waiver services must be given the option of receiving nursing home care instead.

Although ADRD-only patients are not receiving services under the Medicaid program, many ADRD patients have other medical complications that meet the professional-level medical supervision requirement and therefore, are receiving Medicaid-funded nursing home or home and community based services. This situation creates an inequity among people with ADRD; some may have most of their needs met through the Medicaid programs, others cannot.

Alternatives/Impacts and Costs.

One alternative is for the State to reduce the standard for eligibility for (nursing home and) home and community based waiver services.^{iv} This alternative has budget implications for the State. Some states have reduced the budget impacts by requiring that all long-term care patients receive care plan counseling. In both Indiana and Oregon, the effect of such a requirement has been to place residents in the least restrictive, often lowest cost long-term care setting. This usually has the effect of prolonging the time that a resident can pay for their own care, and therefore, reduces the potential cost to the Medicaid program.

Assuming the eligibility standard for home and community based waiver services is changed, the Division of Senior Services does not currently have sufficient internal capacity to take on the additional ADRD patients who may apply for home and community based waiver services. Further, it is unknown what if any increase in demand for home and community based services might arise as a result of the change in the eligibility standard. It should be noted that while there is a need to increase the internal capacity in the Division of Senior Services to handle additional waiver applications, if not provided, the cost to the state could be much more substantial since these patients are likely to be placed in nursing homes.

**Draft: Medicaid's level of care requirement for persons with
Alzheimer's Disease is too restrictive, Page 2
For Consideration by LTC Design Team, 10-16-98**

Recommendation:

The Administration should prepare a detailed timeline and budget for changing the State's standard for eligibility for (nursing home and) home and community based waiver services. Any change in this level of care must identify sources of funds and/or legislative commitment to this expansion.

Definition from the Alaska Commission on Aging.

" Skilled nursing care is typically provided under the direction of a physician to a patient in an unstable condition requiring nursing level observation and assessment and treatment.

" Intermediate care is also typically under the direction of a physician but to a patient with a long-term illness or disability whose condition is relatively stable, where the emphasis is on maintenance, and the patient is nearing recovery and discharge. The state's policy is that "admission to intermediate care will not be authorized solely to provide supervision, protective custody, routine medication management, or assistance with personal services", see page Q-2, 1998 Desktop Manual for Care Coordinators, Alaska Department of Administration, Division of Senior Services.

" This change could be accomplished by amending the Department of Health and Social Services' regulations.

* "Description of Beneficiary Group and Service Delivery System for Adults with Alzheimer's Disease and Related Disorders", Alaska Commission on Aging. August 1998.

**Draft: Medicaid's level of care requirement for persons with
Alzheimer's Disease is too restrictive, Page 3
For Consideration by LTC Design Team, 10-16-98**

Senate

S. Con. Res. 95

Expressing the sense of Congress with respect to promoting coverage of individuals under long-term care insurance.

IN THE SENATE OF THE UNITED STATES

May 12, 1998

Mr. DODD (for himself and Mr. Grassley) submitted the following concurrent resolution; which was referred to the Committee on Finance.

CONCURRENT RESOLUTION

Expressing the sense of Congress with respect to promoting coverage of individuals under long-term care insurance.

Resolved by the Senate (the House of Representatives concurring),

SECTION 1. PROMOTION OF COVERAGE OF INDIVIDUALS UNDER LONG-TERM CARE INSURANCE.

(a) **FINDINGS** - The Congress finds the following:

- (1) As the baby boom generation begins to retire, funding Social Security and Medicare will put a strain on the financial resources of younger Americans.
- (2) Medicaid was designed as a program for the poor, but in many States Medicaid is being used for middle income elderly people to fund long-term care expenses.
- (3) In the coming decade, people over age 65 will represent up to 20 percent or more of the population, and the proportion of the population composed of individuals who are over age 85, who are most likely to be in need of long-term care, may double or triple.
- (4) With nursing home care now costing \$40,000 to \$50,000 on average per year, long-term care expenses can have a catastrophic effect on families, wiping out a lifetime of savings before a spouse, parent, or grandparent becomes eligible for Medicaid.
- (5) Many people are unaware that most long-term care costs are not covered by Medicare and that Medicaid covers long-term care only after the person's assets have been exhausted.
- (6) Widespread use of private long-term care insurance has the potential to protect families from the catastrophic costs of long-term care services while, at the same time, easing the burden on Medicaid as the baby boom generation ages.

(7) The Federal Government has endorsed the concept of private long-term care insurance by establishing Federal tax rules for tax-qualified policies in the Health Insurance Portability and Accountability Act of 1996.

(b) **SENSE OF CONGRESS** - It is the sense of the Congress that -

- (1) the Federal Government should take all appropriate steps to inform the public about the financial risks posed by rapidly increasing long-term care costs and about the need for families to plan for their long-term care needs;
- (2) the Federal Government should take all appropriate steps to inform the public that Medicare does not cover most long-term care costs and that Medicaid covers long-term care costs only when the beneficiary has exhausted his or her assets;
- (3) the Federal Government should take all appropriate steps not only to encourage employers to offer private long term care insurance coverage to employees, but also to encourage both working-aged people and older citizens to obtain long-term care insurance either through the employees or on their own;
- (4) appropriate committees of Congress, together with the Department of Health and Human Services and other appropriate Executive Branch agencies, should develop specific ideas for encouraging Americans to plan for their own long-term care needs;
- (5) the congressional tax-writing committees, together with the Department of the Treasury should determine whether the tax rules for long-term care insurance need to be modified to ensure that the rules adequately facilitate the affordability of long-term care insurance; and
- (6) the National Summit on Retirement Income Savings should consider the importance of planning for long-term care in its discussion of retirement security.

H. 202
H. Con. Res. 210

Expressing the sense of Congress with respect to promoting coverage of individuals under long-term care insurance.

IN THE HOUSE OF REPRESENTATIVES

February 5, 1998

Mr. Shays (for himself, Mrs. JOHNSON of Connecticut, Mr. GREENWOOD, Mr. LIPINSKI, Mrs. KENNELLY of Connecticut, Mr. KEGULA, Mr. LAFALCE, Mr. FARR of California, Mr. FROST, and Mr. GOODE) submitted the following concurrent resolution, which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, and Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

CONCURRENT RESOLUTION

Expressing the sense of Congress with respect to promoting coverage of individuals under long-term care insurance.

Resolved by the House of Representatives (the Senate concurring),

SECTION 1. PROMOTION OF COVERAGE OF INDIVIDUALS UNDER LONG-TERM CARE INSURANCE.

- (a) FINDINGS - The Congress finds the following:
- (1) As the baby boom generation begins to retire, funding Social Security and Medicare will put a strain on the financial resources of younger Americans.
 - (2) Medicaid was designed as a program for the poor, but in many States Medicaid is being used for middle income elderly people to fund long-term care expenses.
 - (3) In the coming decade, people over age 65 will represent up to 20 percent or more of the population, and the proportion of the population composed of individuals who are over age 85, who are most likely to be in need of long-term care, may double or triple.
 - (4) With nursing home care now costing \$40,000 to \$50,000 on average per year, long-term care expenses can have a catastrophic effect on families, wiping out a lifetime of savings before a spouse, parent, or grandparent becomes eligible for Medicaid.
 - (5) Many people are unaware that most long-term care costs are not covered by Medicare and that Medicaid covers long-term care only after the person's assets have been exhausted.
 - (6) Widespread use of private long-term care insurance has the potential to protect families from the catastrophic costs of long-term care services while, at the same time, easing the burden on Medicaid as the baby boom generation ages.

(7) The Federal Government has endorsed the concept of private long-term care insurance by establishing Federal tax rules for tax qualified policies in the Health Insurance Portability and Accountability Act 1996.

(b) SENSE OF CONGRESS - It is the sense of the Congress that --

- (1) the Federal Government should take all appropriate steps to inform the public about the financial risks posed by rapidly increasing long-term care costs and about the need for families to plan for their long-term care needs;
- (2) the Federal Government should take all appropriate steps to inform the public that Medicare does not cover most long-term care costs and that Medicaid covers long-term care costs only when the beneficiary has exhausted his or her assets;
- (3) the Federal Government should take all appropriate steps not only to encourage employers to offer private long term care insurance coverage to employees, but also to encourage both working-aged people and older citizens to obtain long-term care insurance either through the employees or on their own;
- (4) appropriate committees of Congress, together with the Department of Health and Human Services and other appropriate Executive Branch agencies, should develop specific ideas for encouraging Americans to plan for their own long-term care needs;
- (5) the congressional tax-writing committees, together with the Department of the Treasury should determine whether the tax rules for long-term care insurance need to be modified to ensure that the rules adequately facilitate the affordability of long-term care insurance; and
- (6) the upcoming National Summit on Retirement Income Savings should consider the importance of planning for long-term care in its discussion of retirement security.

AMERICAN HEALTH CARE ASSOCIATION

Meeting the Needs of an Aging Nation

Testimony

before the

SENATE SPECIAL COMMITTEE ON AGING

March 9, 1998

**PAUL WILLGING, Ph. D.
Executive Vice President
American Health Care Association**

Provided by ASHNHA

The need for senior health care reform is great and the process to achieve positive change is already underway. This hearing is one key example. Another is the National Bipartisan Commission on the Future of Medicare. The Commission was established by the Balanced Budget Act of 1997 to explore ways to ensure the fiscal integrity of Medicare, a program that provides for the acute care needs of America's seniors. These forums open the door for new thinking and the improved restructuring of a comprehensive health care financing system – a system that can meet both the acute and long term care needs of seniors in a progressive and compassionate way.

Today, senior health care needs (acute and long term care) are met by a patchwork of government programs. Indeed, most Americans now receiving long term care services under Medicaid are also receiving benefits under the Medicare program. They are simply receiving both sets of services in a totally uncoordinated and badly mismanaged system, mismanaged not by reason of incompetence, but simply as a result of inherent complexities of any system bifurcated because of its location between two separate political entities: Federal and State government.

The American Health Care Association has begun working with other health care provider organizations, consumer and insurance groups, business leaders and policy makers to recommend a comprehensive health care system – a system that creates a seamless system for meeting senior needs for acute and long term care.

Central to our approach is the concept that people who *can* pay for their own long term care *should* pay for that care. A 1995 Luntz public opinion survey found that most Americans support that concept. 76 percent surveyed said they want the government to shift long term care out of the current Medicaid program and into one that is rooted in private long term care insurance. A Gallup poll found that more than eight out of ten Americans said it made sense to develop a reform policy that encourages people to buy long term care insurance, but that the government must continue to provide care for the "genuinely destitute."

Our approach embraces that public opinion in four key principles which state that, as a nation, we must:

tax incentives is one option. Enforcing laws that prohibit asset transfers for the purpose of qualifying for government assistance, establishing the purchase of a long term care insurance policy as a prerequisite to transferring assets and eliminating the barriers to family supplementation of a loved-one's care are additional options.

To provide all Americans with care that is efficient and cost-effective, we must create a competitive marketplace. Consumers must have the freedom to choose the most appropriate setting for their care, whether it be at home, in a community-based program or in a nursing facility. They must also have a variety of financing options available to pay for their care. This is critically important because no single care or financing option can meet the needs of all Americans. What works for some one person in Brooklyn, New York may be ill-suited for another in Billings, Montana. What works for Alzheimers patients may be wholly inappropriate for diabetics or those with Parkinsons disease.

In a competitive marketplace created by this new system, the decisions consumers make regarding where to spend their long term care dollars will not only work to hold costs down, but to also to enhance the quality of care they receive. Insurers and providers would be held accountable for the quality of care they provide as measured by quality outcome indicators that are privately validated, scored and publicly reported. Having that information readily available will greatly aid consumers in making informed choices.

The need for long term care reform is compelling. Failure is not an option since it would deny older Americans access to quality long term care and deny them the dignity and independence they rightfully deserve. Continuing to allow a welfare system – Medicaid – to work like an entitlement for the majority will bankrupt the federal budget and cripple American taxpayers.

AHCA commends the committee for taking a long look at the growing crisis in long term care financing. Clearly, the entitlement system in its existing structure will not be able to withstand the demographic demands that will be placed on it. Private sector ways and means must be harnessed in partnership with public programs and resources. We are committed to working with you to create an economically sound, quality-oriented

GOVERNMENT

Jay
**BENEFITS
UPDATE**

EMPLOYEES

July 1998

July 1998

THE SEGAL COMPANY

OFFICE: BUREAU

LONG-TERM CARE INSURANCE: A BENEFIT WHOSE TIME HAS COME?

As America ages, longevity improves and the cost of health care continues to climb, interest in long-term care coverage is expected to grow. Accordingly, some observers have dubbed long-term care coverage the "next great employee benefit."

Long-term care insurance is used to defray the costs of caring for any person who needs assistance performing basic activities of daily living (ADLs). Generally, there are six ADLs: dressing, bathing, eating, toileting, continence and transferring into and out of bed or chairs. Long-term care coverage is usually triggered when an individual is unable to perform two or more ADLs or is struck by a cognitive impairment (such as Alzheimer's Disease). There is often an elimination period of, say, 90 days before benefits commence.

With the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), premiums

The following additional topics are covered in this issue of *Government Employees Benefits Update*:

- ♦ Washington Update: There May Yet Be More Life in the 105th Congress
- ♦ Year-2000 Compliance Update

We hope that you continue to find this publication interesting and informative. If you have comments or would like additional information about any of the topics discussed in the *Government Employees Benefits Update*, please contact Cathie Eitelberg, director of The Segal Company's government practice. She can be reached by phone at (202) 833-6437, by fax at (202) 833-6490 or by E-mail at ceitelberg@segalco.com.

for long-term care coverage and unreimbursed expenses for long-term care services are eligible for the medical expense deduction (subject to a floor of 7.5 percent of income) for federal income tax purposes. This change in tax status for long-term care

THE SEGAL COMPANY'S YEAR-2000 COMPLIANCE EFFORTS

The Segal Company is aware of the potential impact on plan sponsors and our business of the Year-2000 computer problem. This problem arose because many computer programmers have used two digits to represent years — for example, "98" instead of "1998" — which means that those computer programs are unable to determine whether "00" represents the year 2000 or 1900. Our company is undertaking a disciplined multi-step approach to address the Year-2000 computer problem. With the help of independent computer consultants, we are engaged in a detailed assessment of the likely effects of the Year-2000 computer problem on our computer hardware, operating systems, programs, data-feeds, external interfaces and facilities.

The Segal Company's clients are being informed about the company's Year-2000 compliance status, and are being encouraged to contact all vendors to assure that they are taking appropriate action. The Segal Company expects to achieve full Year-2000 compliance by June 1999.

For more information about The Segal Company's Year-2000 compliance efforts, please visit the following page of our Web site: <http://www.segalco.com/about/y2k.cfm>.

Provided by Karen Perdue

Atlanta Boston Chicago Cleveland Denver Edmonton Hartford Houston Los Angeles Minneapolis New Orleans
New York Phoenix St. Louis San Francisco Seattle Toronto Washington, D.C. West Palm Beach

insurance premiums will enable more Americans to afford the coverage and, in turn, may increase employees' demand for such insurance to be offered as a benefit.

THE NEED FOR LONG-TERM CARE

According to some estimates, as many as 41 million — or one in six — Americans require assistance performing everyday life activities. Although everyone is an accident or unexpected illness away from requiring long-term care, the elderly are disproportionately represented in the ranks of those requiring assistance with everyday activities.

The aging of the huge baby-boom generation (*i.e.*, the generation born between 1946 and 1964), combined with increased life expectancy in the United States, will cause the elderly population to grow substantially in the next 30 years. The United States Administration on Aging (AOA) estimates that the elderly population in the United States will increase from over 33 million in 1995 to nearly 62 million by the year 2025. Increased life expectancy will lead to larger numbers of people living with activity limitations for longer periods of time. These factors assure that the demand for long-term care will continue to rise for the foreseeable future.

THE FINANCIAL IMPACT

The prospect of financing long-term care services for oneself or for a family member is an intimidating one. Depending on the nature and severity of the condition, the onset of a condition requiring long-term care services could present a significant drain on time, energy and financial resources of the afflicted individual and his or her family.

If care in a nursing home or other institutional setting is required, the financial ramifications are imposing. The average annual cost of nursing home care was \$37,000 in 1995 (the most recent year for which statistics were available). For many Americans, a lifetime of savings could be decimated after even a moderate stay in a nursing home.

Expenditures on long-term care services for the elderly in the United States in 1995 were estimated by the United States General Accounting Office (GAO) to be almost \$91 billion. The Government accounted for almost \$55 billion of the spending in that year, primarily through Medicare and Medicaid. The bulk of the remaining costs were borne

by individuals and their families. The GAO estimates that total expenditures for long-term care will double in the next 25 years. Because long-term care is often provided by friends and relatives through informal arrangements, individuals will directly bear a considerable portion of the burden. Indeed, long-term care is one of the largest unfunded liabilities facing Americans today.

THE BENEFITS OF LONG-TERM CARE COVERAGE: CAREGIVING RELIEF AND PEACE OF MIND

A major problem that individuals face in arranging for long-term care for themselves and their families is the fact that long-term care services are not covered by conventional private health insurance policies. Moreover, long-term care services are generally not covered by Medicare, although Medicare's home health care benefit has increasingly been used to fund certain long-term care services. Medicaid has been the largest public payer of long-term care, but it is available only after an individual has become impoverished by spending down his or her assets.

Private long-term care insurance is a relatively new product. By 1995, 125 insurers were offering long-term care insurance policies, and more than 4 million policies had been sold. Long-term care insurance is sold on an individual and group basis, but most Americans are not covered under such policies. An increasing but still small number of employers provide group long-term care coverage for their employees. Nonetheless, most people who have purchased coverage have done so on an individual basis, where premiums are 20 to 30 percent higher than comparable group coverage.

Where employers offer long-term care insurance, the average age of purchasers is 41. Young and old employees alike understand the value of long-term care coverage and take advantage of the opportunity to obtain coverage at the lower cost associated with a group plan. The federal income tax deduction for long-term care insurance premiums created by HIPAA will no doubt further fuel this demand.

LONG-TERM CARE COVERAGE IN THE PUBLIC SECTOR

The State of Alaska was the first state government employer to offer long-term care coverage when, in 1987, coverage was made available to retired

state employees. Since then, a number of other public-sector employers have followed Alaska's lead. Nevertheless, relatively few state and local government employees are eligible for employer-sponsored long-term care coverage.

According to the 1994 Employee Benefits Survey by the Bureau of Labor Statistics (BLS), 4 percent of state and local government employees in the United States were eligible for long-term care insurance. Eligibility for long-term care insurance was higher for state employees (8 percent) than for local employees (2 percent). Moreover, the BLS survey indicated that government employees in North Central states (8 percent) were by far more likely to be offered coverage than government employees in other regions (4 percent in the West, 3 percent in the South, and 1 percent in the Northeast).¹

Federal employees are not presently offered long-term care insurance. The House Government Reform and Oversight Subcommittee on Civil Service, however, is in the process of drafting a bill that would offer federal employees and retirees the option of purchasing long-term care coverage for themselves, their parents and their in-laws. It is expected that the bill would make coverage available beginning January 1, 2000.

SEGAL COMPANY SURVEY OF STATE LONG-TERM CARE OFFERINGS

To determine the prevalence of long-term care insurance among all state employee benefit plans, The Segal Company conducted a survey last fall. The survey found that the following 10 states give their employees and/or retirees the option to purchase long-term care insurance: Alaska, California, Connecticut, Georgia, Nebraska, Nevada, North Dakota, Ohio, South Carolina and Wisconsin.

Since the survey was conducted, Colorado, Kansas, North Carolina and Washington have also created long-term care insurance programs for their employees. Enabling legislation has passed in Minnesota and Oregon, clearing the way for long-term care insurance to be offered to state employ-

¹ The BLS classifies the North Central states as: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota and Wisconsin. Western states include: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington and Wyoming. The Southern region is comprised of: Alabama, Arkansas, Delaware, the District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia. The Northeast consists of the following states: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont.

TEAMWORK AND LEADERSHIP TRAINING AT THE SEGAL COMPANY

The Segal Company has a long history of educating our professional staff in such core consulting areas as actuarial services, health care, compliance and administration about trends and issues in the employee benefits field. These sessions also serve as forums for exchanging ideas and experiences among staff members throughout the Company.

On June 15 - 17, 1998, about 100 staff members attended a special conference devoted to large and small group discussions about setting goals and solving problems: The Segal Company's 1998 Leadership Conclave. Participants worked with colleagues from other offices and areas of expertise in order to promote Company-wide teamwork which The Segal Company strongly believes will help enhance the level of service that we provide to all of our clients.

ees. Also, Montana is in the developmental stages of implementing a group long-term care insurance plan. Other states may be involved in the same process but did not offer that information when answering the limited number of survey questions.

Perhaps the most unique long-term care offering is that of California, where the California Public Employees' Retirement System (CalPERS) fashioned the nation's first self-funded long-term care program. Coverage is available to employees of the State of California and other public agencies that participate in the CalPERS program.

In all states offering long-term care coverage to their employees, the coverage is fully paid by the employee with no state contribution toward the premium cost. Employees in these states pay for their chosen coverage through payroll deductions.

While the survey only asked states to identify long-term care coverage that was exclusively and officially endorsed by the states, The Segal Company suspects that long-term care coverage is available to employees in even more states through payroll deduction arrangements that are allowed informally. It is not uncommon among state agencies to allow varying kinds of insur-

Continued on page 6

WASHINGTON UPDATE:

THERE MAY YET BE MORE LIFE IN THE 105TH CONGRESS

There are not many "legislative days" left in this, the last, session of the 105th Congress because members want to adjourn no later than Labor Day in order to campaign for reelection. Nevertheless, in the time remaining before the session wraps up, there is a possibility that some benefits legislation will be passed.

Retirement savings and health consumers' rights continue to be central topics for both Congress and the Administration. Frustration with managed care has not fallen on deaf congressional ears. Working its way through the legislative process is a consumers' "Bill of Rights" that would give managed care participants more choice and flexibility and place new requirements on plan sponsors.

HEALTH CARE LEGISLATION — CONSUMERS' RIGHTS

Health care was recently designated the "Issue of the Decade" by *The Wall Street Journal*. Reflecting the general concern that led to this distinction, Congress is considering several different proposals for reform of the managed health care industry. Senate Democrats have proposed a Patients' Bill of Rights Act. Senators Tom Daschle (D-SD) and Edward Kennedy (D-MA) have promised to attach this as an amendment to any bill considered by the Senate. The Senate Republican leadership also has a Patients' Bill of Rights Act (S.2330). The Senate bill would not apply to public-sector plans.

On July 24, 1998, the House passed the Republican-sponsored Patient Protection Act of 1998 (H. R. 4250) by a narrow 216 - 210 vote. The passage of the Republicans' bill followed the defeat of legislation supported by the Clinton Administration and House Democrats. This bill combines health care consumer protection with traditional Republican concerns such as medical malpractice damage caps. It also expands Medical Savings Accounts (MSAs) and small

employer purchasing coalitions. The bill includes information disclosure requirements, expedited claims procedures, new appeals processes, the "prudent person" standard for emergency room treatment, elimination of "gag clauses," and access to specialists without prior referral. It applies to public-sector plans, but allows them to opt out of compliance with the bill's consumer-protection provisions. The bill will now be considered by the Senate. If passed in its present form, the bill is expected to be vetoed by President Clinton.

Congress may take up managed health care reform in September (after its August recess). Managed care is reportedly the one issue that has Republicans concerned about retaining their majority status in Congress. Therefore, it is possible that some type of reform will be passed this year.

RETIREMENT SECURITY FOR THE 21ST CENTURY ACT (H.R. 3788)

H.R. 3788, which was introduced on May 5th by two members of the House Ways and Means Committee, Congressmen Rob Portman (R-OH) and Ben Cardin (D-MD), contains provisions that enhance portability, increase savings opportunities and impose a new penalty for early distributions from §457 plans. This bill incorporates the portability provisions that had been part of legislation sponsored earlier by Congressman Earl Pomeroy (D-ND). Organizations representing public retirement systems and deferred compensation plans have worked to include provisions that will enhance savings and the preservation of pension assets.

If signed into law, H.R. 3788 would:

- Permit in-service asset distributions from §457 plans to purchase service credit in an employer's defined benefit plan,
- Permit workers who change jobs to roll eligible distributions among §457, §403(b), §401(k) plans and IRAs,

Box continues on page 5

Box continued from page 4

- Increase the maximum annual tax-deferred limit for §457, §403(b) and §401(k) plans to \$15,000, and the catch-up §457 cap to \$30,000 in each of the three years prior to normal retirement.
- Permit individuals who are at least 50 years old to make additional contributions of up to \$5,000 to §457, §403(b), §401(k) and other salary-reduction plans.
- Extend the 10 percent early distribution penalty to amounts of \$50,000 or more distributed from a §457 plan, if the assets were rolled in from a plan other than a §457 plan, and
- Index both the \$30,000 catch-up cap and the \$5,000 cash-out cap for inactive accounts.

Tackling a comprehensive pension bill such as H.R. 3788 in the time remaining will be difficult. If no action is taken this year, many of the above-mentioned provisions can be expected to be reintroduced in the next Congress.

SOCIAL SECURITY REFORM

Although many bills to reform both Social Security and the tax system have been introduced and much debate on both subjects is likely, little action is expected in this Congress. The House has passed legislation to establish, yet again, a Social Security Reform Commission. So far, Senate leaders have shown little interest in the concept. Their attitude, which is shared by many other policy leaders, is that the major components of reform have already been identified: (1) later retirement ages, (2) higher payroll (FICA) taxes, (3) privatization through individual accounts and (4) means testing.

As this *Government Employees Benefits Update* went to press, the House Democrats were working on a comprehensive reform proposal. An unanswered question for the drafters of this bill is whether it will require universal coverage of newly hired state and local government workers. In May, State ad-

ministrators from Colorado, Massachusetts, Nevada and Ohio testified before the House Ways and Means Subcommittee regarding their respective states' retirement systems, each of which was designed when states and localities were prohibited from participating in Social Security. These systems all provide benefits that are more cost-effective and advantageous to their members than a combination of Social Security and plan benefits would be.

The first six months of the next Congress will provide a window of opportunity for major Social Security reform. In 1983, the year in which the last major Social Security reform law was passed, the same timing proved successful. That congressional session immediately followed, as the 1999 session will, a mid-term congressional election and was just prior to a presidential election.

TAX REFORM

Any tax reform in the coming months is likely to be minor. Prior to congressional elections, the debate over how to "use" any budgetary surplus — Social Security solvency, reduction of national debt or tax cuts — will move to center stage. One proposal (H.R. 3097) would strike the entire existing tax code, but only if a replacement were enacted by Congress by July 4, 2001. Although serious tax code revamping will be left to the next Congress, there may be some small changes prior to the election, such as the repeal of the so-called "marriage penalty," which occurs when a married couple pays more in taxes than would two individual taxpayers filing separate returns.

NATIONAL SUMMIT ON RETIREMENT SAVINGS

This congressional activity on Social Security Reform served as a backdrop to the National Summit on Retirement Savings, which took place in Washington, D.C. on June 4 - 5, 1998. The 239 participants, representing a cross-section of organizations involved in employee benefits and retirement education, examined the state of retirement savings and explored how to educate

Box continues on page 6

Box continued from page 6

Americans about the need to create a secure financial future. Among the invited participants were several state treasurers, state retirement administrators and public union representatives. Delegates discussed barriers to savings, as well as ways employers can help workers save. The two-day conference included several major panel discussions followed by working sessions where the delegates developed recommendations on retirement savings policy and outreach activities.

One high-powered panel on retirement security included President Bill Clinton, Vice President Al Gore, Senate Majority Leader Trent Lott, House Speaker Newt Gingrich and House Minority Leader Richard Gephardt — demonstrating that the importance of pension savings is a key issue at all political levels. Preliminary reports indicate that suggestions to encourage retirement savings will include easing administrative and tax barriers, especially for small businesses and segments of the population that have low rates of participation in retirement arrangements. Additional information about the Summit can be obtained through its Web site (www.saversummit.org) or by calling the Department of Labor's Pension and Welfare Benefits Administration (PBWA) at (202) 219-8233. A report summarizing the events and recommendations of the

Summit will be published by the American Savings Education Council in the fall.

OTHER ISSUES

The following are among the other recent developments from Washington:

- Medicare and Social Security are in better shape. In April, the trustees for the Medicare and Social Security funds announced that the financial outlook for the programs, due to the strong economy, has improved, pushing solvency out to years 2008 and 2032, respectively.
- The Securities and Exchange Commission launched an investor education program. SEC Chairman Arthur Levitt Jr., kicked off the "Facts on Savings and Investing Campaign" to educate the public about financial security and the impact of investment fees on returns.
- The PWBA has released a primer on 401(k) fees. This primer is geared to the 401(k) plan participant and focuses on what questions to ask about fees and how to assess their impact on long-term returns. In 1997 a study on 401(k) fees and expenses was conducted by the PWBA. Both documents are available on the DOL's Web site (www.dol.gov/dol/pwba). ■

Continued from page 3

ance products to be sold on a non-endorsed basis. Under such arrangements, a full range of insurance products is offered to employees by agents who are permitted to solicit on state premises. Illinois, Kentucky and Virginia each volunteered that long-term care coverage is available to their employees in this manner. Long-term care insurance may therefore be available to more state employees than could be measured by our survey.

ESTABLISHING A LONG-TERM CARE INSURANCE PLAN

Several issues confront public-sector employers that set out to formulate long-term care insurance

programs for their employees. Defining eligibility under the program to include employees' spouses, dependents and/or parents is a crucial issue which ultimately determines the scope and cost of the program. A non-exhaustive list of other issues which must be tackled includes:

- Definition of the insured event.
- Duration over which the policy would pay benefits.
- Average daily benefit.
- Elimination period.
- Services covered.

AHCA NOTES

AHCA's Newsletter for Assisted Living, Nursing Facility, and Subacute Care Providers

HCFA Moves Forward With Nursing Home Initiative

The Health Care Financing Administration (HCFA) has begun work on implementing President Clinton's July nursing facility initiative and has been given a mandate to tighten enforcement of nursing facility standards as a result of a congressional hearing.

In a meeting with representatives of the American Health Care Association, HCFA officials described plans for redefining the term "poor performing facility" within the survey, certification and enforcement process; imposing civil monetary penalties (CMPs) for each instance of a serious chronic deficiency; and more frequent surveys of facilities of large chains if more than 25 percent of their facilities are considered poor performers.

HCFA has proposed redefining the poor performer tag to apply to facilities that receive two level G deficiencies or higher during its last two surveys. Level G deficiencies and higher apply when there is actual harm on an isolated, patterned, or widespread basis. Level H deficiencies or higher are used to designate substandard quality of care. In a letter to HCFA Administrator Nancy-Ann Min

DeParle, Paul Willging, AHCA executive vice president, said that while AHCA believes the term "poor performing facility" should be redefined, the definition HCFA has proposed is too broad. Under that definition, facilities can receive a level G deficiency in one area, correct the problem, then receive a level G deficiency in another unrelated area, and be labeled a poor performer, Willging says.

"Historically, facilities that have received a deficiency cited at the G level have been good providers who have reliable systems in place and who not only immediately correct the deficiency but also sustain compliance with individual regulations over a period of time," Willging said. Lumping these facilities into the same category as facilities that caused very serious injury to a resident on repeated occasions exceed the intent and scope of federal nursing facility standards, he said.

AHCA also opposed HCFA's proposal to impose CMPs for every case of a serious chronic deficiency. According to AHCA research, there is no correlation between the

continued on page 2

Coalition Releases Assisted Living Guidelines

Assisted living standards should be set using outcomes-based quality measures linked to performance and customer satisfaction ratings, a coalition of provider and consumer groups said.

The Assisted Living Quality Coalition released a report Aug. 13 that aims to provide a framework for quality initiatives in assisted living facilities and guidelines to help state

policymakers set minimum quality standards.

The report also calls for the establishment of an independent umbrella organization, known as the National Assisted Living Quality Organization (NALQO), to "house the ongoing work of revising the [quality initiative] framework and the guidelines to states," as well as developing and validating new measurement tools for consumer satisfaction and clinical and functional outcomes.

The coalition consists of the National Center for Assisted Living (NCAL), the assisted living arm of the American Health Care Association (AHCA); the Alzheimer's Association; the American Association of Homes and Services for the Aging; the American Association of Retired Persons (AARP); the American Seniors Housing Association; and the Assisted Living Federation of America. Top executives of the organizations, which held a joint press conference to release the report, agreed that the report represented an unprecedented level of

continued on page 7

In this issue:

GAO Looks at HCFA's Nursing Home Initiative 2

AHCA's Response to the GAO Report 3

Assisted Living Quality Coalition Report 4

AHCA's Response to the Assisted Living Quality Coalition Report 5

AHCA's Response to the Assisted Living Quality Coalition Report 6

AHCA's Response to the Assisted Living Quality Coalition Report 7

Provided by Dennis Murray

GAO Looks Into HCFA Survey System

The Government Accounting Office (GAO) recently launched a probe of the Health Care Financing Administration's (HCFA) enforcement of federal nursing facility regulations in four states.

The investigation will target enforcement systems in Michigan, California, Pennsylvania, and Texas. According to GAO, the investigation stems from a Congressional request in response to allegations that state regulators have been too lenient in their enforcement of nursing facility standards. A report is due to Congress by January 1999.

GAO said its investigations will look at:

- The number of facilities found to be out of compliance with state and federal regulations and the prevalence of repeat violations;
- How state agencies and HCFA respond to noncompliant facilities;
- The consistency of enforcement across facilities and states; and
- Whether HCFA's oversight of the enforcement process is adequate.

Representatives from the American Health Care Association (AHCA) recently met with GAO staff to discuss the study and expressed their concerns with its design. The study will

be based on sustained compliance, that is, the absence of repeated deficiencies. However, GAO staff acknowledged that repeated deficiencies as identified by the study would not necessarily indicate the same deficiency or the same specific regulation cited again for the same reason.

"The goal of enforcement," Paul Willing, AHCA executive vice president, is to ensure prompt compliance after deficiencies are identified. To expect enforcement to prevent future occurrences presumes an incorrect standard of effectiveness and incorrectly presumes that remedies are to be used as punishment."

Willing said the GAO study is designed to seek out the worst cases, but it will not necessarily find out where and why enforcement does work. The study will not compare the effectiveness of enforcement before and after implementation of the enforcement regulation and will not consider which remedies are effective in returning facilities to compliance. As a result, AHCA has urged the GAO to modify the study methodology.

Survey & Certification

HCFA Moves Forward With Nursing Home Initiative

*continued from
page 1*

application of CMPs and the percent of facilities that come back into compliance. In fact, the research showed that states that recommend CMPs frequently and states that never use CMPs are equally likely to have the same compliance rate upon revisits.

In the meeting with HCFA officials, Willing suggested an alternative to the CMP proposal: that for all deficiencies cited at level H or higher, there be an immediate remedy with no grace period or allowance for correction.

HCFA also is mulling elimination of the grace period for all facilities owned by a chain when that chain had at least 25 percent of facilities categorized as poor performers. AHCA has questioned whether HCFA and state agencies have the statutory authority to hold facilities that are part of a chain to a higher standard.

The Clinton Administration sent to Congress draft legislation that would implement the measures contained in the president's nursing facility initiative.

Generally, the legislation would allow Medicare- and Medicaid-certified nursing facilities to hire feeding and hydration assistants, require criminal background checks for all prospective employees, and create a national registry of nursing facility workers convicted of abusive acts.

The bill would allow facilities to hire individu-

als to assist residents to eat or drink, but they would not be allowed to provide any other nursing services, and could not be a licensed nurse, certified nurse assistant, or volunteer.

The bill outlines the training that would be required, including recommended amounts of food and hydration, methods of providing food and hydration, and recognition of symptoms of malnutrition and dehydration. The actual design of the training, including the number of hours required, would be left to the states to decide.

AHCA has a long standing position in favor of a national criminal background check system and last year partnered with the National Association of Attorneys General to call for its implementation.

"While we may have some minor concerns with the wording of the feeder legislation, we nevertheless, fully and unequivocally support the concepts contained in the legislation," Willing said in the letter.

However, AHCA says the cost of the background check, up to \$50 per individual, should be lowered. Facilities could pass the cost on to applicants, but could not bill Medicare or Medicaid.

AHCA maintains that the high cost of these checks would be an additional deterrent to attracting staff, and that these costs should be covered by Medicare and Medicaid programs.

OIG Responds To Provider Concerns On False Claims Act

Health care providers, practitioners, and suppliers will not be subject to the civil monetary penalty (CMP) laws or prosecution under the False Claims Act (FCA) for billing errors, honest mistakes, or negligence, according to Health and Human Services Inspector General June Gibbs Brown.

In a letter to the American Health Care Association (AHCA), Brown said the Office of the Inspector General (OIG) will concentrate its law enforcement efforts on improper claims "that are made intentionally, or with reckless disregard for the truth, or with deliberate ignorance of the truth." When billing errors, honest mistakes, or negligence result in improper payments, the provider will be asked to return the funds, but without penalties, Brown said.

OIG provides investigative and audit services in many health care fraud cases, but the Department of Justice (DOJ) has the exclusive legal authority to institute an action under FCA, including whether to file a case, whether cases will be handled centrally or by individual United States Attorneys, whether there is sufficient evidence to proceed with a case, and whether to enter into a settlement of FCA liability. When cases are settled, OIG is responsible for the issue of whether the provider will be excluded from federal health programs or whether a corporate integrity agreement will be imposed on the provider.

Provider groups, including AHCA and the

American Hospital Association, have expressed concern about inappropriate use of FCA authority, and had sought legislation limiting the use of FCA. In June, however, OIG and DOJ issued guidelines for FCA action that responded to many provider concerns. The OIG guidelines called for equitable treatment of providers, provider guidance and communication, and minimum monetary thresholds or percentage error rates in determining which providers will be referred to DOJ. Providers have objected to the lack of the minimum threshold or percentage error rate for FCA actions in the DOJ guidelines.

False Claims Act

AHCA representatives met with the Inspector General in early August to discuss a variety of issues, including concerns that providers are being prosecuted for innocent billing errors.

"I want to assure you that I am personally committed to increased cooperation with, and guidance from, the health care industry," Brown said in a letter to AHCA.

The letter, although dated two days before the meeting, responded directly to AHCA's concerns, and was "somewhat reassuring," according to David Seckman, AHCA's vice president for regulatory affairs. OIG has posted on its website (www.dhhs.gov/progorg/oig) information about outreach efforts designed to promote industry compliance.

OIG Calls For Reduction In PPS Rates

The new prospective payment system (PPS) for skilled nursing facilities (SNFs) will overpay facilities if corrections for improper payments in the base year are not made, the Department of Health and Human Services' Office of the Inspector General (OIG) said.

In a letter accompanying the report reviewing the development of PPS for SNFs by the Health Care Financing Administration (HCFA), Inspector General June Gibbs Brown said OIG does not believe HCFA's rate methodology adequately adjusts for medically unnecessary care and the amount of improper payments that have been made to SNFs.

"If these incorrect payments are not eliminated from the base period costs, an unwarranted financial windfall will be realized by the SNF providers," Brown said.

Brown pointed to Medicare audits that found \$2.4 billion in improper payments to SNFs in fiscal year 1996, and \$629 million in fiscal 1997. OIG also said it could not find in HCFA methodology any mention of how recently issued salary equivalency guidelines were included in the development of PPS.

OIG recommended that proposed rates be further reviewed and adjusted downward to reflect the amount of improper payments in the base year costs. In the preamble to the recently issued interim final PPS rule, HCFA indicated it was proposing to examine the extent to which the base period costs reflect costs that were inappropriately allowed.

In a letter to HCFA Administrator Nancy-Ann Min DeParle, Paul Willging, executive vice president of the American Health Care Association (AHCA), said

Prospective Payment

AHCA is "unequivocally opposed" to any reductions in the base year to reflect alleged medically unnecessary services.

"We believe that HCFA correctly interpreted the intent of Congress in using payments for all costs incurred by SNFs in the base year, that the cost reduction sought by OIG has already been accomplished through a \$12.59 billion budget impact on SNFs, and that the OIG's studies do not support the need for any further adjustment," Willging said.

Medicare Reformers Urged To Consider Long Term Care

America's health care system lacks cohesion with the acute care needs of seniors falling under Medicare and the long term care needs of seniors coming under "a patchwork quilt of 50 separate long term care programs," Paul Willging, executive vice president of American Health Care Association (AHCA), told the National Bipartisan Commission on the Future of Medicare.

Those state long term care programs defy reasonable management due to the difficulty of dealing with the "dual-eligibles" who receive acute care benefits at the national level and long term care at the state level, Willging said.

Willging was invited to testify along with other provider groups, think tanks, and interested parties that submitted reform proposals in response to the commission's request for solutions to shore up the Medicare program. Much of the debate centered on prescription drugs and Medigap supplementary private insurance plans, but AHCA told the commission that they must also consider long term care issues.

Willging urged the commission to inform the nation's senior population of the liability they face if long term care services are needed. He also called for the creation of a commission "to examine our nation's long term care financing policy and develop innovative new solutions for the improved restructuring of a public/private health care financing system that can meet the

acute and long term care needs of America's seniors."

In response to Willging's recommendations, Rep. Bill Thomas (R-Calif.) said there was no need for a new commission and that long term care does indeed fall under the purview of his commission.

Thomas said the commission will discuss whether Medicaid benefits provided to Medicare beneficiaries should be incorporated into the Medicare program. Thomas also suggested that the commission must look at three funding streams to meet the needs of seniors: Medicare, Medicaid, and Social Security. "If we're going to deal with a comprehensive long term living—which occasionally requires medical attention—problem, then we ought to look at all of the resources available to us and maximize the impact of those dollars to benefit those particular seniors," he said.

The three-pronged approach mirrors a long term care financing reform proposal that AHCA is developing that would bring the long term care portion of Medicaid into the purview of the federal government to secure, in combination with Medicare and Social Security, adequate care for the elderly.

The commission must make its recommendations to Congress and the president by March 1, 1999.

Medicare Commission

Bill Would Fund Adult Day Care Services

Rep. Pete Stark (D-Calif.) has introduced legislation to allow Medicare recipients who qualify for home health benefits to attend adult day care centers to receive the same services they would get at home.

The Medicare Substitute Adult Day Care Services Act would allow Medicare patients to choose adult day care centers as an alternative to home care. The adult day care service provision would take effect on Jan. 1, 1999.

In his remarks to the House, Stark pointed out that the providers of home health services visit patients at their homes but are not present at the home most of the day. In addition, since many frail patients cannot be left alone for extended periods, their home caregivers are often unable to maintain jobs outside of the home, he said.

Stark said adult day care services would provide patients with day-long supervised care, which they often do not have at home, while providing relief to the home caregiver.

Adult day care services would be billed at a flat rate of 95 percent of the cost of home health care services. The cost savings would stem from the elimination of the travel costs of

home health visits. Day care would include the home health benefit as well as transportation, meals, and therapeutic activities.

The bill also has a "budget neutrality provision," which would allow the Secretary of Health and Human Services to change the payment percentage rate for adult day care services if the cost of day care services turn out to be higher than for traditional home health care.

To participate in the Medicare home care program, adult

day care centers would need to meet the same standards as home health agencies, but day care centers would not be required to be "primarily" involved in providing skilled nursing and therapy services. The legislation recognizes that day care centers provide services for patients with diverse requirements, so skilled nursing services and therapy services may not always be their primary activity, Stark said.

Cosponsors of the bill include Reps. Ben Cardin (D-Md.), Jerry Kiecicka (D-Wis.), and John Lewis (D-Ga.). The bill has been referred to the House Ways and Means Committee and the House Commerce Committee.

Adult Day Care

Guidelines Issued For Cutting Medication Errors

In an attempt to reduce the number of medication errors caused by improper labeling and packaging, industry and government groups have joined together to produce a voluntary set of guidelines for all health care organizations and professionals who dispense medications.

The most recent recommendations from the National Coordinating Council for Medication Error Reporting and Prevention, in which the American Health Care Association participated, encourage reporting actual and potential medication errors to internal, local, and national reporting programs, said William Ellis, chair of the Council and executive director of the Foundation of the American Pharmaceutical Association.

The Council recommends health care organizations do the following to reduce medication errors:

- Install mechanisms for internal reporting of actual and potential problems;
- Foster a favorable environment to improve medication use procedures;
- Create systematic approaches to identify and evaluate actual and potential causes of problems;

■ Report medication errors using the Food and Drug Administration's MedWatch program and/or the United States Pharmacopeia Practitioners' Reporting Network, which functions as a quasi-public institution to develop public standards; and

■ Prevent future medication mistakes by improving both medication systems and staff performance.

The group says medication errors can be reduced by using devices such as bar-codes, making sure

pharmaceuticals are appropriately stored from bulk delivery until the time that medication is dispensed, and clarifying labels and label designs when medications are repackaged.

For instance, when similar medications are in storage, the drugs should be differentiated and there should be special procedures for storing high-risk drugs such as concentrates and paralyzing agents, the council said.

For more information, contact the council, at 800-822-8772, or visit the council's Internet site at <http://www.nccmerp.org>.

Medication Errors

Coalition Releases Assisted Living Guidelines

continued from page 7

cooperation between consumer and industry groups, and that such alignment is critical to ensuring that assisted living remains customer-focused and operates in an appropriate framework of quality standards.

The report is a "clear commitment from diverse organizations that when it comes to representing the interests of customers, we can work together toward a common purpose," said Paul Willging, executive vice president of AHCA, speaking on behalf of NCAL.

The coalition's report identifies 21 quality initiative recommendations, eight of which relate to the duties of the proposed NALQO. The first tasks the coalition recommends for NALQO is the development and validation of performance measures of consumer satisfaction and clinical and functional performance outcomes.

The coalition also recommends establishing and regularly updating guidelines for states to develop their own minimum quality standards. These guidelines should be tested against outcomes data, the report said. NALQO would assist the states as they implement the quality standards.

In addition, the coalition recommends that NALQO develop model practice protocols and intervention strategies for common problems; determine methods for recognizing excellent performance by facilities; promote consumer choice and a competitive marketplace by ensur-

ing that consumers have the information they need to comparison shop; and provide a forum for discussing risk factors that affect financial underwriting.

Separately, NCAL's Assisted Living Steering Committee unanimously approved a zero tolerance policy for NCAL and assisted living providers.

"NCAL supports a zero tolerance policy in cases of abuse and neglect of the elderly and disabled," the policy reads. "NCAL believes that poor performing facilities that refuse to correct incidences of abuse and neglect should not be allowed to continue to operate."

The steering committee also adopted as the official NCAL definition of assisted living, the definition from the Assisted Living Quality Commission report, which says an assisted living setting is:

■ A congregate residential setting that provides or coordinates personal services, 24-hour supervision and assistance, activities, and health-related services;

■ Designed to minimize the need to move;

■ Designed to accommodate individual residents' changing needs and preferences;

■ Designed to maximize residents' dignity, autonomy, privacy, independence, and safety; and

■ Designed to encourage family and community involvement.

Article Calls Medicare Choices 'Bewildering'

The combination of rising insurance costs, decreasing benefits, and an increasing number of choices to supplement Medicare is "bewildering" to senior citizens, charges a story in the September issue of Consumer Reports, published by watch dog group Consumers Union.

The magazine story suggests senior citizens are more interested in stability of coverage rather than an increased number of options.

The story contends that Medicare-supplemental insurance premiums are up 35 percent since 1994, and health maintenance organizations, which had been able to keep a lid on costs, are starting to cut back on coverage of services such as drugs and vision care.

To suggest that most seniors are befuddled by Medicare coverage choices is "shamelessly condescending," the Health Insurance Association of America said in response.

News in Brief

HCFA Releases Draft MDS Manual

The Health Care Financing Administration (HCFA) has released on the Internet a draft version of the state operations manual (SOM) on minimum data set (MDS) transmission and automation.

The draft document includes:

- An explanation of the documents released in draft form;
- Information on privacy and confidentiality of MDS;

■ Guidance to surveyors with modifications to survey tag numbers, regulatory text, and survey probes, as well as guidance reflecting the final MDS rule from December 1997; and

■ Policy on facilities' release of resident's MDS information.

The manual is available at HCFA's website at www.HCFA.gov/medicare/hsqb/mds20, or from AHCA's website (www.ahca.org) in the "What's New" section.

AHCA Notes (ISSN: 0279-1692) is published by the American Health Care Association, 1201 L Street, NW, Washington, DC 20005. Published every month. Twelve issues in 1998. Copyright © 1998 by AHCA. Reproduction in whole or part prohibited without written authorization from the copyright holder. Subscriptions are \$10 per year, included in membership dues. Second class postage paid at Washington, D.C. Postmaster: send address changes to AHCA Notes, 1201 L Street, NW, Washington, DC 20005. (USPC 948-940). ■ Audrey Heer, Editor ■ Jean Lee, Editorial Assistant, Production Coordinator ■ The American Health Care Association is the nation's largest federation of assisted living, nursing facility and subacute providers. AHCA has 50 affiliated organizations, together representing nearly 11,000 individual facility members continuously providing nursing and personal care services to approximately one million elderly, convalescent, and chronically ill residents.

AHCANOTES

American Health Care Association
1201 L Street, NW
Washington, DC 20005

POSTAGE PAID

HERITAGE PLACE
232 ROCKWELL
SOLDOTNA AK 99669-7411



Senate Resolution Backs Long Term Care Insurance

The U.S. Senate urges all Americans to plan for future long term care needs, under a resolution introduced by Sens. Chris Dodd (D-Conn.) and Charles Grassley (R-Iowa) to express the Senate's position on promoting long term care insurance.

The resolution is virtually identical to one introduced in the House of Representatives by Rep. Chris Shays (R-Conn.) several months ago. The resolution calls on the government to:

- Inform the public about the financial risks posed by rapidly increasing long term care costs and about the need for families to plan for their long term care needs;

- Inform the public that Medicare does not cover most long term care costs and that Medicaid covers long term care only when the beneficiary has exhausted his or her assets;

- Encourage employers to offer private long term care insurance coverage to employees and to encourage working-aged and older individuals to obtain long term care insurance; and

- Determine whether the tax rules for long term care insurance need to be modified to ensure that the rules adequately facilitate the affordability of long term care insurance.

Meanwhile, witnesses at a hearing on the development of rules for long term care insurance contracts that will qualify for tax-deductible status said it is still not evident whether the rules can be finalized by year end. Proposed rules were published in January,

implementing changes made by the 1996 Health Insurance Portability and Accountability Act (HIPAA). Testifying at the hearing, the Health Insurance Association of America (HIAA) called for the finalization of the proposed regulations as soon as possible.

"At least in part due to the publication of swift guidance, the transition to qualified contracts has been smooth. The

qualified long term care insurance market is

Secure Care Notes

flourishing," said Randy Hardock, a partner with Washington, D.C.-based law firm Davis & Harman, on behalf of HIAA. "Preliminary HIAA data indicate that a substantial majority of long term care insurance policies sold today are qualified. Taxpayers can now have certainty regarding the tax treatment of what they have just bought, just as Congress intended. In addition, the consumer protection standards imposed on qualified contracts help ensure that all consumers purchasing qualified long term care insurance policies are being treated fairly."

HIAA also urged the panel developing the regulations on long term care insurance to make the effective date of the rules one year after the final guidance is issued to give insurers time to apply the regulations to their contracts and policies. The group also called for a broad interpretation of HIPAA to 'grandfather' in as many existing policies as tax-deductible as possible.

AHCPR Survey Tracks Growth In Long Term Care

Nearly one in five nursing facilities have specialized units for residents with Alzheimer's disease or other special-need residents, an industry-wide survey by the Agency for Health Care Policy and Research (AHCPR) found.

Slightly more than 19 percent of all nursing facilities had one or more special-needs units at the start of 1996, with more than half of those units dedicated to residents with Alzheimer's or related dementia.

Because of the dramatic growth in the number of Americans over 75, the current nursing facility population is more frail than ever and requires more specialized care, said AHCPR Administrator John Eisenberg. Almost half (47.7 percent) of all nursing facility residents have some form of dementia.

Eisenberg said that while data from earlier years was not directly comparable, it appears that the number of Alzheimer's units continues to grow at 15 percent to 20 percent per year. Remaining special-care nursing units were dedicated to subacute care, ventilator therapy, reha-

bilitation, or those with terminal illnesses.

The survey, called the Medical Expenditure Panel Survey, found that nearly 1.6 million individuals were receiving care in about 16,800 nursing facilities, filling about 89 percent of the 1.8 million certified or licensed beds. The number of nursing facilities has increased 20 percent since 1987 while the number of beds has increased 19 percent.

The survey found that nearly two-thirds of nursing facilities operated for profit, and that 68 percent of those for-profit facilities were part of a multi-facility chain.

The complete first round of survey results are available through AHCPR's web site at www.ahcpr.gov. Later this year AHCPR will publish full-year nursing facility data for 1996, and in 1999 will publish a detailed analysis of a number of topics, including: functional health status of residents; resident use of inpatient hospital and physician services and prescription medicines; and use, spending and source of payment for nursing facility care.

Miller's Trust

STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

TONY KNOWLES, GOVERNOR

P.O. BOX 110660
JUNEAU, ALASKA 99811-0660
PHONE: (907) 465-3355
FAX: (907) 465-2204

September 9, 1998

Representative Joe Ryan
716 West 4th Avenue
Anchorage, Alaska 99501

Dear Representative Ryan:

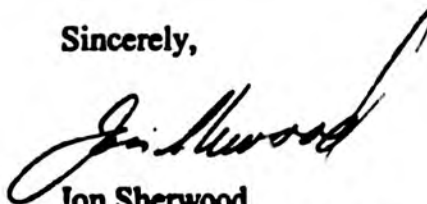
At the August meeting of the Long Term Care Task Force, you requested that I provide you with information on Medicaid trusts. I am enclosing three documents: Section 1917(d)(4) of the Social Security Act (also cited as 42 USC 1396p(d)(4)), which is the federal statute pertaining to Medicaid trusts; Alaska Statute 47.07.020(f), the state statute pertaining to Medicaid trusts; and Section 5028 of the Alaska Medicaid Manual, which further elaborates state policy on Medicaid trusts.

Trusts created under these authorities have proven effective at allowing people to qualify for Medicaid. They are most commonly used by people in need of long term care, either nursing homes or home and community-based waivers. Basically, people are able to impoverish themselves voluntarily by placing money in excess of Medicaid income standards into the trust. When they die, the corpus of the trust must be used to repay Medicaid.

However, because trusts are legal documents that have effects that can extend beyond Medicaid eligibility, it may be difficult for people to use these trusts without creating hardships in other parts of their lives. While there are always exceptions to any generalization, it is probably fair to say that the more dependents an individual has and the more complicated their financial situation is, the less workable these trusts are.

I would be happy to discuss these issues further with you or your staff.

Sincerely,



Jon Sherwood
Program Officer, Eligibility and Long Term Care

Enclosures

cc: Karen Perdue

ont.)

individual (other than a
is residing in such
t two years immedi-
comes an institution-
ained by the State)
ch permitted such
in such an institu-

spouse or to anoth-
pouse,
l's spouse to anoth-
pouse,

(including a trust
ed solely for the
l in subparagraph

g a trust described
the benefit of an
sabled (as defined

ite (in accordance
tary) that (i) the
s¹⁷² either at fair
ration, (ii)¹⁷³ the
ose other than to
s transferred for
to the individual;

established by the
y the Secretary),
due hardship as
lished by the

in asset held by
rsons in a joint
it, the asset (or
ed to be trans-
either by such
eliminates such

For the effective date,
Vol. III, P.L. 103-66,
Vol. II, P.L. 103-66,

sts". For the effective

For the effective date,

ts". For the effective

all assets transferred

r the effective date,

r the effective date,

Vol. III, P.L. 103-66,
e effective date,
P.L. 103-66.

(4) A State (including a State which has elected treatment under section 1902(f)) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the State plan.¹⁷⁴

(5) In this subsection, the term "resources" has the meaning given such term in section 1613, without regard to the exclusion described in subsection (a)(1) thereof.

(d)(1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this title, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

(2)(A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

(i) The individual.

(ii) The individual's spouse.

(iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) In the case of a trust the corpus of which includes assets of an individual (as determined under subparagraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.

(C) Subject to paragraph (4), this subsection shall apply without regard to—

(i) the purposes for which a trust is established,

(ii) whether the trustees have or exercise any discretion under the trust,

(iii) any restrictions on when or whether distributions may be made from the trust, or

(iv) any restrictions on the use of distributions from the trust.

(3)(A) In the case of a revocable trust—

(i) the corpus of the trust shall be considered resources available to the individual,

(ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and

(iii) any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c).

(B) In the case of an irrevocable trust—

(i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual,

P.L. 103-66, §13611(a)(2)(F), added this sentence. For the effective date, see Vol. II, P.L. 103-66, §1361.

the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income—

(I) to or for the benefit of the individual, shall be considered income of the individual, and

(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c); and

(ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c), and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.

(4) This subsection shall not apply to any of the following trusts:

(A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1614(a)(3)) and which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this title.

(B) A trust established in a State for the benefit of an individual if—

(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),

(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this title, and

(iii) the State makes medical assistance available to individuals described in section 1902(a)(10)(A)(ii)(V), but does not make such assistance available to individuals for nursing facility services under section 1902(a)(10)(C).

(C) A trust containing the assets of an individual who is disabled (as defined in section 1614(a)(3)) that meets the following conditions:

(i) The trust is established and managed by a nonprofit association.

(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1614(a)(3)) by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such

income on the
could be made
individual, and
me—
shall be consid-

red a transfer of
(c); and
y income on the
y circumstances
as of the date of
date on which
assets disposed
and the value of
ch subsection by
om such portion

owing trusts:
ual under age 65
3)) and which is
d by a parent,
or a court if the
trust upon the
ual to the total
al under a State

benefit of an
Social Security,
mulated income

maining in the
to an amount
on behalf of the
, and
available to indi-
V), but does not
als for nursing

individual who is
ts the following

by a nonprofit

ach beneficiary
it and manage-

l solely for the
fined in section
gal guardian of
court.

3 in the benefi-
ficiary are not
state from such

remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this title.

(5) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes that such application would work an undue hardship on the individual as determined on the basis of criteria established by the Secretary.

(6) The term "trust" includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies.¹⁷⁹

(e) In this section, the following definitions shall apply:

(1) The term "assets", with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action—

(A) by the individual or such individual's spouse,

(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse, or

(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(2) The term "income" has the meaning given such term in section 1612.

(3) The term "institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1902(a)(10)(A)(ii)(VI).

(4) The term "noninstitutionalized individual" means an individual receiving any of the services specified in subsection (c)(1)(C)(ii).

(5) The term "resources" has the meaning given such term in section 1613, without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.¹⁸⁰

APPLICATION OF PROVISIONS OF TITLE II RELATING TO SUBPOENAS

SEC. 1918. [42 U.S.C. 1396q] The provisions of subsections (d) and (e) of section 205 of this Act shall apply with respect to this title to the same extent as they are applicable with respect to title II, except that, in so applying such subsections, and in applying section 205(1) thereto, with respect to this title, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.¹⁸¹

¹⁷⁹P.L. 103-66, §13611(b), added subsection (d). For the effective date, see Vol. II, P.L. 103-66, §13611(e).

¹⁸⁰P.L. 103-66, §13611(c), added subsection (e). For the effective date, see Vol. II, P.L. 103-66, §13611(e).

¹⁸¹P.L. 103-296, §108(d)(5), inserted "except that, in so applying such subsections, and in applying section 205(1) thereto, with respect to this title, any reference therein to the Commissioner

1396 — 1396p (Title XIX,

al penalties, under state statute, tioner for fraud in connection with aid, medicare, or similar welfare medical services. 32 ALR4th 671. of pharmacy or pharmacist for nnection with supplying prescrip- ith 390.

state for whom the Social e medical assistance under

on, the following optional al participation are eligible

ut not receiving assistance — 615 (Title IV-A, Social J.S.C. 1381 — 1383c (Title

intermediate care facility, under one of the federal

re department, for whom ds, and who are in foster

do not meet income and / income under 42 U.S.C. receive a mandatory state re not in a skilled nursing supplementary payment; who are in an institution y retarded and who are eral aid to families with

income while in the facility me benefit rate under 42 ould not be eligible for an or other facility;

who are receiving active ble as determined by the Act, Aid to Families with

and not covered under (a) leral aid to families with nd support of both their

covered under (a) of this he federal aid to families

who the department has ance because of a special

need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 — 25.23.220;

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

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

(B) the department has determined that

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

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

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

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

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

(c) Receipt of medical assistance under this chapter is considered to be an additional benefit to these individuals and does not affect other assistance payments, federal or state, for which the recipient is eligible.

(d) Additional groups may not be added unless approved by the legislature.

(e) Notwithstanding (b)(4) of this section, a person is not eligible for Medicaid benefits until a final determination is made on the eligibility of that person for benefits under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act).

(f) A person may not be denied eligibility for medical assistance under this chapter on the basis of a diversion of income, whether by assignment or after receipt of the income, into a Medicaid-qualifying trust that, according to a determination made by the department,

(1) has provisions that require that the state will receive all of the trust assets remaining at the death of the individual, subject to a maximum amount that equals the total medical assistance paid on behalf of the individual; and

(2) otherwise meets the requirements of 42 U.S.C. 1396p(d)(4).

(g) A person's eligibility for medical assistance under this chapter may not be denied or delayed on the basis of a transfer of assets for less than fair market value if the person establishes to the satisfaction of the department that the denial or delay would work an undue hardship on the person as determined on the basis of criteria in applicable federal regulations. (§ 1 ch 182 SLA 1972; am § 1 ch 105 SLA 1974; am § 1 ch 117 SLA 1975; am § 1 ch 221 SLA 1976; am § 1 ch 11 SLA 1978; am § 1 ch 132 SLA 1982; am § 13 ch 138 SLA 1982; am § 3 ch 105 SLA 1986; am § 1 ch 119 SLA 1988; am § 38 ch 168 SLA 1990; am § 1 ch 76 SLA 1993; am § 17 ch 102 SLA 1994)

Delayed amendment. — Under §§ 38-42, ch. 107, SLA 1996, paragraphs (b)(1), (5), (7), (8), and (9) are amended to read as follows: "(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act, Supplemental Security Income) or a federal program designated as the successor to the aid to families with dependent children program;

"(5) persons under age 21 who are in an institution designated as an intermediate care facility for the

mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

"(7) persons under age 21 who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

"(8) persons under age 21 and not covered under (a) of this section, who would be eligible for benefits

QUALIFYING INCOME TRUSTS (Miller Trusts)

A qualifying income trust (sometimes called a Miller trust after a court case that established the right to use them) must meet the following requirements:

- (1) The trust must be composed only of income to the individual, including accumulated interest in the trust; and
- (2) Upon the death of the individual, the State receives all amounts remaining in the trust, up to an amount equal to the total medical assistance paid on behalf of the individual.

Income placed in a qualifying income trust does not have to be irrevocably assigned to the trust. Therefore, income such as Social Security payments, certain federal pensions, state PERS and TRS that is not ordinarily assignable may go into the trust without being considered available to the individual. This policy differs from trust policy that applies prior to August 11, 1993. If an individual would be eligible for an AFDC payment or and APA payment using Medicaid policy for counting trust income, but is not eligible for these cash assistance programs because they apply a different policy to trust income, the individual is eligible for Medicaid. See Sections 5240 and 5580 for further information.

Resources: If a qualifying income trust is irrevocable, the principal of the trust is not considered available. If the trust is revocable, the principal is considered available; use APA policy to determine the amount of resources available to the individual.

Income: Income placed into a qualifying income trust and income earned by a qualifying income trust is not considered income to the individual for the purpose of determining eligibility for Medicaid.

Payments made from these trusts are considered income for eligibility purposes. Use SSI policy to determine countable income. In general, you may use APA rules for counting income, except that vendor payments for food, clothing, and shelter are considered income. However, the amount of vendor payments that count as income cannot exceed the sum of \$20 plus one-third of the appropriate SSI eligibility standard. Do not count vendor payments in excess of this amount as income. Note that payments made from the trust to nursing facilities for care received are not considered income.

Posteligibility: Income placed into a qualifying income trust is considered income for posteligibility purposes. Add it to other income received by the individual to calculate posteligibility cost of care liability. Because income received by the trust has already been subjected to posteligibility, do not consider payments from the trust for posteligibility purposes.

Law Offices Of
ALASKA LEGAL SERVICES CORPORATION
1016 West Sixth Avenue, Suite 200
Anchorage, AK 99501
Phone: (907)272-9431
Fax: (907)279-7417

MEMORANDUM

TO: David Pree
CC: Marcia Rom
FROM: Katherine Alteneder *[initials]*
RE: Miller Trusts
DATE: September 13, 1998

INTRODUCTION

Pursuant to federal law, 42 USC 1396p(d), individuals may establish irrevocable trusts to receive their excess income, thereby allowing them to qualify for Medicaid coverage. These trusts are commonly referred to as "Miller Trusts," in reference to the landmark case Miller v. Ibarra, 746 F.Supp. 19 (D.Colo. 1990), establishing this trust mechanism.¹

The Medicaid program is a joint federal/state program providing medical assistance to the disabled and elderly under strict financial criteria. The financial criteria include income and resource limits, depending on the particular type of assistance needed and the applicant's family situation.

The federal regulations give some leeway to the states to decide how to administer certain aspects of the Medicaid program. One of these areas is the level of income permitted in order to qualify for Medicaid. Most states have a "medically needy" standard, in which the state simply receives the individual's income and pays for their care costs. Other states have an "income cap" rule, setting a limit on the amount of income a person can have in order to qualify.

¹ Just so that you have a little sense of history, the Miller case addressed the interplay between judicially created trusts and federal provisions for something called Medical Qualifying Trusts. To make a long story short, as a result of the Miller litigation, Medicaid Qualifying Trusts were done away with when the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) was enacted, repealing 42 USC 1396a(k). In its place, Congress inserted a set of general trust rules. P.L. 103-66 Sec. 13611(b), codified at 42 USC 1396p(d). Congress also enacted three specific exceptions to the general trust rules, one of which was narrowly designed to allow the establishment of so-called "Miller" trusts. See 42 USC 1396p(d)(4)(B).

THE ALASKA MODEL

Alaska is an "income-cap" state.² The capped amount results in disqualification of many individuals due to excess income, even though they still do not have enough income or resources available to cover their medical needs.³ A Miller Trust, or irrevocable income trust, is a mechanism that allows people who do not qualify for Medicaid coverage, based solely on their income, to qualify by assigning their income to a trust. This trust does not shield the beneficiary's funds from state access, rather it serves as a pass-through accounting mechanism.

The accounting is fairly simple, differing according to the need level of the beneficiary. There are three models: nursing home; Choice Waiver⁴; and "walking-around."⁵ Under each of these models, the state receives whatever remains in the trust upon the death of the beneficiary.

Under the nursing home model, the beneficiary's income is put in the trust, allowable expenses -- such as insurance co-pays, limited income to the spouse not in a nursing home, and a \$75 personal expense allowance among other enumerated expenses -- are paid, and the remaining income is flushed out to the nursing home. Under the Choice Waiver model, the beneficiary's income goes into the trust, an amount equalling the current income cap for Medicaid nursing home eligibility is given to the beneficiary for living expenses (currently \$1492), and the excess goes to pay medical expenses. Under the "walking-around" model, all of the beneficiary's income goes into the trust, and they are paid a monthly needs allowance that equals the income cap for Medicaid eligibility (currently \$917).

WHO SHOULD MAKE A MILLER TRUST

In screening whether a Miller Trust is appropriate for an individual, we employ a three part analysis that I have summarized below.

Miller Trust Screening:

Physical Criteria

1. Does the person fit into a Medicaid category?

² The current 1998 income cap for an individual receiving Medicaid is \$917 per month. For nursing home applicants, the income cap is \$1492. The last list of "income-cap" states I had was as follows, although I am fairly confident there have been changes to this list: Alabama, Alaska, Arizona, Arkansas, Colorado, Delaware, Florida, Idaho, Iowa, Kansas, Louisiana, Mississippi, Nevada, New Mexico, Oregon, South Carolina, South Dakota, Texas and Wyoming.

³ As we discussed on the phone, the populations most likely to create a Miller Trust are those with high prescription medication expenses, or those needing the level of care provided by a nursing home, since these expenses are covered under Medicaid, but excluded from Medicare.

⁴ Choice Waiver refers to Alaska's Medicaid "home and community based waiver" program, which, in a nutshell, permits Medicaid eligible persons requiring nursing home level of care to remain at home and to avoid institutionalization until such time as their care needs become acute.

⁵ "Walking-around" refers to those people who do not require the nursing home level of care, rather they are "walking-around." For instance, people in this category might have cancer and require ongoing chemotherapy treatments and medication.

Elderly(65+)
Disabled (under Social Security criteria)
Minor child (<21)
Caretaker for minor child

2. Does the person meet level-of-care needs for the particular type of Medicaid coverage sought?

Resource Criteria

1. Is person resource eligible? (varies with category, coverage, marital status; exempt resources; ceiling or non-exempt resources)

2. Has person transferred assets in recent past? (relevant look-back period depending on category)

Income Criteria

1. Is person over the income limit for the category?
2. Will Medicaid pay the particular bill worrying the person? (generally only medical bills)
3. Are person's medical bills high enough to warrant the trust?
4. Can client meet non-medical expenses and survive on what trust rules allow them to get out?

DEVELOPING ISSUES

These trusts are a vital mechanism for medically needy persons whose income puts them slightly over the income for Medicaid. We have assisted dozens of individuals in establishing their Trusts, and for the most part, the mechanism is running very smoothly. However, one difficulty we have observed is that trustee fees are not among the items for which the Trust may pay. For needy elderly or disabled Alaskans with no friends or family to serve as trustees, this can create an extreme hardship. Responding to this concern, Marcia Rom, who preceded me as the Director of the Senior Law Project, and Una Gandhir, a private attorney, recently completed a nationwide study of the administration on Miller Trusts, with the support of a grant from the Alaska Mental Health Trust Authority. Their recommendations included amending the regulations to allow for payment of administration costs out of the trust income, or establishing an independent funding source to pay a fixed fee for Trust administration. In the course of their study, Rom and Gandhir also concluded that it would be extremely beneficial to develop standardized Miller Trust forms, and to establish specific guidelines and oversight mechanisms for Trust administration when a beneficiary chooses a professional administrator.

CONCLUSION

I hope this provides a useful summary of the Miller Trust. The most important thing to keep in mind about these trusts is that people are truly impoverished when they decide to use this mechanism. Their medical needs will be covered under Medicaid, but they will permanently lose all of their disposable income. For those who are not institutionalized, living expenses are sometimes impossible to meet on the extremely limited income allotted to them. It is a big step, and should not be entered into lightly.

Should you have any questions, or need additional or more in depth

information, please do not hesitate to contact me, Marcia Rom, who is now the Supervising Attorney in our Anchorage Office, or Andy Harrington, the Supervising Attorney in our Fairbanks office. Andy was instrumental in establishing some of the first Miller Trusts in the state, and remains an expert in this area. He can be reached at 907-452-5181.

DRAFT**DECLARATION OF IRREVOCABLE TRUST**

_____, hereinafter referred to as Settlor, establishes this Trust this ____ day of _____, 1998.

ARTICLE I - NAME OF TRUST

This Trust shall be known as the _____ IRREVOCABLE INCOME TRUST. The beneficiaries of this Trust are _____ during his lifetime and the State of Alaska after his death.

ARTICLE II - APPOINTMENT OF TRUSTEE

Settlor hereby appoints _____ as Trustee of this Trust.

ARTICLE III - TRUST ESTATE

This Trust is to be composed only of pension, and Social Security, and other income receivable by (and accumulated income in the Trust), including but not limited to retirement pension payments. No "resources," as that term is defined for purposes of Social Security, are to be deposited into the trust. In accordance with the Health Care Financing Administration (HCFA) Region X "State Agency Letter Number 94-27," and the HCFA "State Medicaid Manual" section 3259.7(C), although the trust is irrevocable, Settlor's right to receive the income is not being irrevocably transferred to the Trust. Rather, each income payment as it is deposited into the Trust is irrevocably committed to the Trust.

ARTICLE IV - DISPOSITION OF INCOME AND PRINCIPAL

4.01 Distributions While the Beneficiary is Neither a Nursing Home Resident Nor Enrolled in Project Choice

DRAFT

(a) While the Beneficiary is not a nursing home resident and not enrolled in Project Choice, the Trustee shall pay to or expend for the benefit of the Beneficiary such amounts as can be disbursed while maintaining the Beneficiary's eligibility for Medicaid in accordance with the Alaska Public Assistance and Medicaid manuals and the HCFA "State Medicaid Manual" section 3259.7(c)(4). Disbursements from the Trust in any given month directly to the Beneficiary, or to third parties under such circumstances that Medicaid policy deems such disbursements to be income to the Beneficiary, cannot, when combined with any other countable income for that month (and, if the Beneficiary is living with his spouse, the spouse's countable income for that month), exceed the "Adult Public Assistance Need Standard" of the State of Alaska for the Beneficiary's household configuration, currently set at the following amounts:

- \$917, if the Beneficiary lives alone independently,
- \$758 , if the Beneficiary lives in another's household,
- \$1103, if the Beneficiary marries and he and his spouse live together independently and the spouse is neither disabled nor over 65 years old,
- \$871, if the Beneficiary marries and he and his spouse live together in another's household and the spouse is neither disabled nor over 65 years old,
- \$1359, if the Beneficiary and spouse live together independently and the spouse is either disabled or over 65 years old,
- \$1129, if the Beneficiary and spouse live together in another's household and the spouse is either disabled or over 65 years old.

(b) Income to the Trust which is not disbursed in accordance with the preceding paragraph may be disbursed to pay bills or expenses on the Beneficiary's behalf only if (1) such disbursements are made directly to the third-party vendors and not to the Beneficiary or the Beneficiary's spouse, and (2) such disbursements do not count as in-kind income under the applicable regulations of the Supplemental Security Income program, 20 CFR 416.1102 and 1103. That is, moneys can be disbursed to third-party vendors for items which are not food, clothing or shelter, and which cannot be used to obtain food, clothing or shelter. Such purchases may include: medical care and services not covered by Medicaid; social services; and excluded nonliquid resources under 20 CFR 416.1210 et seq. (other than food, clothing and shelter).

DRAFT

(c) Income to the Trust not disbursed in accordance with (a) or (b) above can be used to pay income tax which may be owed by the Trust (not those taxes owed by the Beneficiary), or administrative attorney's fees which the Trust is obligated to pay.

(d) Income to the Trust not disbursed in accordance with (a), (b) or (c) above can be used to pay third-party vendors for food, clothing and shelter expenses of the Beneficiary *only if* the disbursements from the Trust directly to the Beneficiary under subsection (a) above during that month are reduced by the appropriate amount under either the "one-third reduction rule" or the "presumed value rule", 20 CFR 416.1130 et seq., whichever applies to the Beneficiary's then-present living situation.

(e) Income to the Trust not disbursed in accordance with (a), (b), (c) or (d) above shall be accumulated in the Trust.

4.02 Distributions While the Beneficiary is Not a Nursing Home Resident But Is Enrolled in Project Choice (Home and Community Based Waiver Program)

(a) While the Beneficiary is not a nursing home resident but is enrolled in Project Choice, the Trustee shall pay to or expend for the benefit of the Beneficiary such amounts as can be disbursed while maintaining the Beneficiary's eligibility for Medicaid, in accordance with 42 USC 1396a(q), 42 USC 1396p(d)(4)(B), 42 USC 1396r-5(b), (d) and (e), 42 USC 1396a(r), and section 5670 of the Alaska Medicaid Manual. Disbursements from the Trust in any given month directly to the Beneficiary, or to third parties under such circumstances that Medicaid policy deems such disbursements to be income to the beneficiary, cannot, when combined with the Beneficiary's other countable income for that month, exceed the "Nursing Home 300% Eligibility Standard" of the Division of Medical Assistance of the State of Alaska, currently \$1452 per month.

(b) As long as the Beneficiary is enrolled in Project Choice, the Trustee is to expend funds disbursed from the Trust each month in accordance with the Project Choice budget approved by the applicable agencies. Within the limits of that budget, the Trustee may expend funds disbursed from the Trust each month in accordance with the "post-eligibility" requirements

DRAFT

of the Division of Medical Assistance of the State of Alaska for Project Choice, currently found at section 5670 of the Alaska Medicaid Manual. Funds are to be disbursed in the following order:

- (1) The Trustee is to disburse a Personal Needs Allowance to the Beneficiary of that amount which, when combined with the Beneficiary's other countable income, will bring the Beneficiary's total monthly countable income to the "Nursing Home 300% Eligibility Standard" of the Division of Medical Assistance of the State of Alaska (currently \$1482).
- (2) If the Beneficiary is married, the Trustee may next disburse to the Beneficiary's spouse an amount sufficient to bring the spouse's total income up to the monthly spousal allowance limit (currently \$2019) per month). To avoid any problems with a potential transfer-of-assets penalty under 42 USC 1396p(c), these particular disbursements of the Trust estate are to be used by the Trustee only for the benefit of the Beneficiary's spouse so long as the Trust exists, and cannot be distributed by the Trustee to any other individuals or entities for any other purpose. Any disbursements made to the Beneficiary's spouse are to be payable only to the Beneficiary's spouse and not jointly to the Beneficiary and the spouse, so that these disbursements are not mistakenly treated as income to the Beneficiary under 42 USC 1396r-5(b).
- (3) If the Beneficiary has dependent family members (children under age 21, children over 21 who may be claimed by either spouse as a tax dependent, or parents and/or siblings of either spouse who may be claimed by either spouse as a tax dependent), the Trustee may then disburse to the Beneficiary's spouse (if the spouse is caring for such family members) or to the family members themselves or other appropriate individuals, the appropriate amount under section 5670(3) of the Alaska Medicaid Manual. If such dependent family members are living with the Beneficiary's spouse, the Trustee is to disburse an amount sufficient to bring each dependent's total income up to the dependent-living-with-spouse allowance limit (currently \$673 per month). If such dependent family members are living elsewhere, the Trustee is to disburse an amount sufficient to bring the total income for such dependents up to the Aid to Families with Dependent Children (AFDC), or successor Alaska Temporary Assistance Program (ATAP), need standard for a household of that number of dependents under an "adult not included" household (currently \$517 for one and an additional \$117 for each additional dependent). Any disbursements made to the Beneficiary's spouse are to be payable only to the Beneficiary's spouse and not jointly to the Beneficiary and the spouse, so that these disbursements are not mistakenly treated as income to the Beneficiary under 42 USC 1396r-5(b). Any disbursements made to or on behalf of dependents of the Beneficiary similarly are not to be payable to the Beneficiary solely or jointly.
- (4) If the Beneficiary has Medicare or other insurance premiums, the Trustee may next disburse funds to the insurer to pay those premiums. Such disbursements are to be made directly to the insurer in accordance with 20 CFR 416.1103(a)(6) so that they do not count as income to the Beneficiary.
- (5) If the Beneficiary has incurred medical expenses not covered by Medicaid or private health insurance (including expenses from before the Beneficiary

became eligible for Medicaid), the Trustee may next disburse funds to the payees to pay those expenses. Such disbursements are to be made directly to the provider in accordance with 20 CFR 416.1103(a)(1) so that they do not count as income to the Beneficiary.

DRAFT

If the Alaska Division of Medical Assistance changes its policies to permit additional allowances, the Trustee may, at Trustee's discretion, disburse funds for those allowances also. If the Alaska Division of Medical Assistance modifies or revokes one of the above-listed allowances, the Trustee is to modify the disbursements to conform to the new policies.

(c) After all permissible allowances, any remaining funds in the Trust may, within the constraints of the Project Choice budget, be paid directly to any provider of medical care or services to the Beneficiary. In accordance with the Health Care Financing Administration Region X "State Agency Letter Number 94-27," the Trustee shall make these payments at intervals specified by the Alaska Division of Medical Assistance; in the absence of explicit directives, these payments shall be made monthly. Such disbursements are to be made directly to the provider in accordance with 20 CFR 416.1103(a)(1) so that they do not count as income to the Beneficiary.

(d) Income to the trust which is not disbursed in accordance with (a), (b) or (c) above, shall be accumulated in the Trust.

4.03 Distributions While the Beneficiary is a Nursing Home Resident

(a) While the Beneficiary is a nursing home resident, the Trustee shall pay to or expend for the benefit of the Beneficiary such amounts as can be disbursed while maintaining the Beneficiary's eligibility for Medicaid, in accordance with 42 USC 1396a(q), 42 USC 1396p(d)(4)(B), 42 USC 1396r-5(b), (d) and (e), 42 USC 1396a(r), and section 5670 of the Alaska Medicaid Manual. Disbursements from the Trust in any given month directly to the Beneficiary, or to third parties under such circumstances that Medicaid policy deems such disbursements to be income to the beneficiary, cannot, when combined with the Beneficiary's other countable income for that month, exceed the "Nursing Home 300% Eligibility Standard" of the Division of Medical Assistance of the State of Alaska, currently \$1482 per month.

(b) As long as the Beneficiary is a resident of a Nursing Home, the Trustee is to expend funds disbursed from the Trust each month in accordance with the "post-eligibility" requirements

DRAFT

of the Division of Medical Assistance of the State of Alaska for Medicaid coverage of nursing home patients, currently found at section 5670 of the Alaska Medicaid Manual. Funds are to be disbursed in the following order:

- (1) The Trustee is to disburse the first \$75.00 each month to the Beneficiary as a Personal Needs Allowance. Since this amount does count as income to the Beneficiary, the Trustee can only disburse that portion of the \$75.00 which, when combined with the Beneficiary's other countable income, does not cause the Beneficiary's total countable income for that month to exceed \$1482.
- (2) If the Beneficiary is married, and the Beneficiary's spouse is not institutionalized, the Trustee may next disburse to the Beneficiary's spouse an amount sufficient to bring the spouse's total income up to the monthly spousal allowance limit (currently \$2019 per month). To avoid any problems with a potential transfer-of-assets penalty under 42 USC 1396p(c), these particular disbursements of the trust estate are to be used by the Trustee only for the benefit of the Beneficiary's spouse so long as the Trust exists, and cannot be distributed by the Trustee to any other individuals or entities for any other purpose. Any disbursements made to the Beneficiary's spouse are to be payable only to the Beneficiary's spouse and not jointly to the Beneficiary and the spouse, so that these disbursements are not mistakenly treated as income to the Beneficiary under 42 USC 1396r-5(b).
- (3) If the Beneficiary has dependent family members (children under age 21, children over 21 who may be claimed by either spouse as a tax dependent, or parents and/or siblings of either spouse who may be claimed by either spouse as a tax dependent), the Trustee may then disburse to the Beneficiary's spouse (if the spouse is caring for such family members) or to the family members themselves or other appropriate individuals, the appropriate amount under section 5670(3) of the Alaska Medicaid Manual. If such dependent family members are living with the Beneficiary's spouse, the Trustee is to disburse an amount sufficient to bring each dependent's total income up to the dependent-living-with-spouse allowance limit (currently \$673 per month). If such dependent family members are living elsewhere, the Trustee is to disburse an amount sufficient to bring the total income for such dependents up to the Aid to Families with Dependent Children (AFDC), or successor Alaska Temporary Assistance Program (ATAP), need standard for a household of that number of dependents under an "adult not included" household (currently \$517 for one and an additional \$117 for each additional dependent). Any disbursements made to the Beneficiary's spouse are to be payable only to the Beneficiary's spouse and not jointly to the Beneficiary and the spouse, so that these disbursements are not mistakenly treated as income to the Beneficiary under 42 USC 1396r-5(b). Any disbursements made to or on behalf of dependents of the Beneficiary similarly are not to be payable to the Beneficiary solely or jointly.
- (4) If the Beneficiary has Medicare or other insurance premiums, the Trustee may next disburse funds to the insurer to pay those premiums. Such disbursements are to be made directly to the insurer in accordance with 20 CFR 416.1103(a)(6) so that they do not count as income to the Beneficiary.
- (5) If the Beneficiary has incurred medical expenses not covered by Medicaid

DRAFT

or private health insurance (including expenses from before the Beneficiary became eligible for Medicaid), the Trustee may next disburse funds to the payees to pay those expenses. Such disbursements are to be made directly to the provider in accordance with 20 CFR 416.1103(a)(1) so that they do not count as income to the Beneficiary.

(6) If the Beneficiary is single and without dependents, and the Beneficiary has a home, and the Beneficiary's physician has certified the Beneficiary is likely to return home within six months, the Trustee may then disburse funds in the amount of the single non-institutionalized Adult Public Assistance standard (currently \$917) to maintain the Beneficiary's home. Since this amount may count as income to the Beneficiary, the Trustee can only disburse that portion of this amount which, when combined with the Beneficiary's other countable income, does not cause the Beneficiary's total countable income for that month to exceed \$1482).

If the Alaska Division of Medical Assistance changes its policies to permit additional allowances, the Trustee may, at Trustee's discretion, disburse funds for those allowances also. If the Alaska Division of Medical Assistance modifies or revokes one of the above-listed allowances, the Trustee is to modify the disbursements to conform to the new policies.

(c) After all permissible allowances, the remaining funds permitted to be disbursed from the trust in any particular month are to be paid to the nursing home providing care to the Beneficiary to help meet the Beneficiary's cost of care. In accordance with the Health Care Financing Administration Region X "State Agency Letter Number 94-27," the Trustee shall make these payments at intervals specified by the Alaska Division of Medical Assistance; in the absence of explicit directives, these payments shall be made monthly. Such disbursements are to be made directly to the provider in accordance with 20 CFR 416.1103(a)(1) so that they do not count as income to the Beneficiary.

(d) Income to the trust which is not disbursed in accordance with (a), (b) or (c) above, shall be accumulated in the Trust.

4.04 Management of the Trust

(a) Should the Beneficiary become a resident of a state other than Alaska, the above references to standards, allowances, or other amounts set by the Alaska Division of Medical Assistance shall be replaced by parallel references to the standards, allowances and other amounts set by the Medicaid agency of the state in which the Beneficiary becomes a resident.

(b) The Trustee shall administer the Trust in such a way as to maintain the Beneficiary's eligibility for Medicaid services, or medical coverage under any similar or successor programs. The Trustee shall take into consideration the applicable resource and income limitations of any public assistance programs for which the Beneficiary is eligible when determining whether to make any distributions. The Trustee need not administer the Trust in such a way as to maximize the Beneficiary's cash income from public assistance sources.

(c) In the event the Trustee is requested by any department or agency to release the principal or income of the Trust, in excess of the amounts authorized by paragraph 4.01, 4.02 or 4.03 above, to or on behalf of the Beneficiary to pay for equipment, medication, or services that other agencies or organizations are authorized to provide, or in the event the Trustee is requested by any department or agency administering such benefits to petition the Court or any other administrative agency for the release of Trust principal or income for this purpose, the Trustee shall deny such request and is directed to defend, at the expense of the Trust created herein, any contest of this Trust or attack of any nature. The Trustee shall have complete discretion in the defense of any such claim, including the management of all litigation which might result. Trustee is also authorized, in Trustee's complete discretion, to settle, in whole or in part, or otherwise compromise any such claim or litigation.

(d) No interest in the principal or income of this Trust shall be anticipated, assigned, or encumbered, or be subject to any creditor's claim or to legal process, prior to its actual receipt by Beneficiary. No part of the corpus hereof, nor principal or undistributed income, shall be subject to the claims of voluntary or involuntary creditors for the provision of care and services, including residential care, by any public entity, office, department or agency of any state, or of the United States or any other governmental agency, except as provided in paragraph 4.05(b) below.

4.05 Termination and Disposition

(a) This Trust will terminate upon the Beneficiary's death.

(b) Upon termination of the Trust, after any remaining reasonable administrative

DRAFT

expenses relating to this Trust have been paid, the Trustee shall distribute and deliver the residue as follows: to the extent that the Alaska Medicaid program (or the Medicaid program of another state) has expended funds on behalf of the Beneficiary, the Trustee is directed to reimburse the Alaska Division of Medical Assistance up to the amount of such expenditures (and if the Beneficiary has received Medicaid benefits from another state, the Trustee is to reimburse that state's Medicaid agency, reimbursing each state in proportion to the amounts expended by that state); following that, the Trustee is directed to deliver the entire remainder of such residue (if any) to the beneficiary's estate.

(c) At the request of, or with the consent of, the Alaska Division of Medical Assistance, the Trustee may make advance payments on the obligation under paragraph 4.05(b) above to use the remaining corpus (if any) upon termination to reimburse the Alaska Division of Medical Assistance for medical expenditures made for the Beneficiary. The Trustee may do this by disbursing the accumulated income in the Trust to the Alaska Division of Medical Assistance at such times and in such amounts as the Trustee in her discretion deems advisable. Such disbursements are to be credited against the Trust's obligation under paragraph 4.05(b) above.

4.06 Additional Powers of Trustee

The Trustee may seek the counsel and assistance of any state and local agencies that have been established to assist the handicapped or mentally disabled, and may consult with any other appropriate persons or agencies. However, the Trustee shall not in any event be liable to Beneficiary, the remainder beneficiaries of the Trust or any party for her acts as Trustee hereunder so long as the Trustee acts reasonably and in good faith. For example, the Trustee shall not be liable for the failure to identify each and every program or resource that might be available to Beneficiary on account of her disabilities.

ARTICLE V - TRUST ADMINISTRATIVE AND PROTECTIVE PROVISIONS

5.01 Jurisdiction

This Trust shall be administered expeditiously consistent with its terms, free of judicial

DRAFT

intervention and without order, approval or other action by any court, subject only to the jurisdiction of a court being invoked by the Trustee or other interested parties or as otherwise provided by law.

5.02 Inalienability

The Beneficiary shall not have any right to anticipate, sell, assign, mortgage, pledge or otherwise dispose of or encumber all or any part of the Trust estate nor shall any part of the Trust estate including income, be liable for the debts or obligations of the Beneficiary or be subject to attachment, garnishment, execution, creditor's bill or other legal or equitable process, except as provided in paragraph 4.05(b) above.

5.03 Benefits Payable to Trustee

Trustee shall not be obligated to undertake litigation for collection of any benefits or assets payable by reason of the death of Beneficiary, including but not limited to such benefits under life insurance policies, employee benefit plans or other contracts, plans or arrangements providing for payment or transfer at death which are payable directly to her unless she is indemnified to her satisfaction against any liability and the expenses of such litigation. Payment of Trustee and the receipt of or release by her shall fully discharge any payor, and no payor need inquire into or take notice of this Declaration of Trust or see to the application of such payment. Notwithstanding anything in this Declaration of Trust to the contrary, any benefits or assets payable to this Trust shall not be subject to the claims against the estate of Beneficiary nor shall such benefits be subject to the control of the personal representative of Beneficiary nor be included in the property administered as part of the probate estate of Beneficiary until released to the estate by the Trustee.

5.04. Irrevocability

This Trust is not revocable by the Settlor, the Beneficiary or the Trustee. This Trust terminates only in accordance with Paragraph 4.05 above.

ARTICLE VI - POWERS OF TRUSTEE**6.01 Grant**

In administering this Trust, the Trustee shall have all the powers and duties granted to, or imposed upon, trustees by the laws of the State of Alaska, as now existing or hereafter amended to liberalize such powers, except that, in addition, limitation, or modification thereof, the Trustee shall have the following rights, powers and duties:

a. Waiver of Accounting

The Trustee shall not be required to render any periodic accounting. However, upon written request of the Beneficiary, the Beneficiary's attorney, any court-appointed conservator, or a court-appointed Visitor, the Trustee shall furnish the Superior Court and the Beneficiary with an itemized statement showing all of the receipts, disbursements and distributions during the last accounting year of the Trust and how they were credited to, or debited from, the income and principal accounts of the Beneficiary's beneficial interest, and a list of, and the approximate value of, each item of property comprising such beneficial interest at the end of such year. The records of Trustee with respect to the Trust estate shall be open at all reasonable times to the inspection of the Beneficiary and his/her accredited representatives.

b. Trust Management

The Trustee shall hold, manage, care for, and protect the Trust as a fiduciary. Subject only to the duties and restrictions otherwise provided by this Trust or by applicable law, the Trustee may perform every act in the management of the Trust that individuals may perform in the management of like property owned by them free of any trust, and the Trustee may exercise every power with respect to each item of property of the Trust which individuals owning like property free of trust may exercise. By way of illustration, but not of limitation, the Trustee shall have the following powers and, except to the extent inconsistent with this Trust, those now or hereafter conferred by law:

(i) Manage Property

To manage and control any property for any period of time, though

commencing in the future or extending beyond the terms of this Trust

(ii) Sell Property

To sell at public or private sale, contract to sell, grant options to purchase, convey, exchange, transfer, and otherwise deal with the Trust property and any investments thereof for such price and upon such terms as the Trustee deems advisable.

(iii) Carry Insurance

To carry insurance against such risks and for such amounts and on such terms as the Trustee deems necessary or advisable for the protection of the Trust or the Beneficiary hereunder; to purchase health, accident, and/or hospitalization insurance for the benefit of the Beneficiary hereunder; to continue in effect or to terminate any such insurance; and to pay, from income or principal, any premiums or other charges.

(iv) Register Property in Name of Trustee

To cause any property, real or personal, which may be delivered to or acquired as an asset of the Trust to be registered in the name of the Trustee.

(v) Control Claims

To settle, compromise, contest, prosecute or abandon claims or demands in favor of, or against, the Trust.

(vi) Exercise Powers Until Final Distribution

To exercise all powers and authority, including any discretion, conferred herein after the termination of any Trust created hereunder until such Trust is fully distributed.

(vii) Perform Necessary Acts

Perform other acts necessary or proper for the prudent administration of the Trust, including execution and delivery of necessary instruments and issuance of full receipts and discharges.

(viii) Employment of Agents

The Trustee may employ such agents, attorneys, accountants, brokers,

investment counselors, custodians and appraisers as deemed reasonable; necessary; rely with acquittance upon their legal, tax, investment, or other expert advice, and pay their reasonable fees for their services from the Trust estate.

(ix) Accounting Methods and Equitable Adjustments

The Trustee may select such method of accounting as she deems appropriate. The Trustee shall determine the allocation of receipts and disbursements between income and principal in accordance with the Uniform Principal and Income Act or other similar legislation then in effect.

(x) Trust Expenses

The Trustee shall disburse such amounts from the income or principal of the Trust as the Trustee, in her sole discretion, may from time to time deem necessary or advisable for administrative expenses relating to this Trust, including reasonable attorney's and accountant's fees if, in the Trustee's sole discretion, other satisfactory provisions have not been made for the payment of such expenses.

(xi) Distribution

Trustee may make any payments under this Trust (1) to the Beneficiary's guardian or conservator, (2) to any person deemed suitable by Trustee, or (3) by direct payment of the Beneficiary's expenses.

ARTICLE VII- TRUSTEE SUCCESSION AND ADMINISTRATIVE PROVISIONS

7.01 Resignation

The Trustee may resign by giving thirty days written notice to the Probate Master of the Superior Court for the State of Alaska, Third Judicial District in Anchorage, 303 K Street, Anchorage, AK 99501), and to the Beneficiary, effective at the end of thirty days.

7.02 Vacancy

If the Trustee shall fail to qualify or cease to act, the Superior Court of Alaska shall be authorized to appoint one or more successor Trustees.

DRAFT**7.03 Representative of Beneficiary**

In the event that a guardian or conservator is appointed for the Beneficiary, the conservator of the Beneficiary, or if none, the guardian of such person, may act for the Beneficiary for all purposes under the administrative provisions of this Trust, subject to any constraints on the conservator/guardian set by the appointing court.

7.04 Rights of Successors

Every successor Trustee shall have all the title, rights, powers, privileges and duties conferred on or imposed upon the original Trustee, without any conveyance or transfer. No Trustee need examine the accounts, records and acts of any previous Trustee or any allocation of the Trust estate unless specifically ordered by the court; nor will such successor Trustee be responsible for any act or omission to act on the part of any previous Trustee.

7.05 Corporate Fiduciary

Any corporate successor to the Trust business of a corporate Trustee shall become the successor corporate Trustee with like powers, duties and obligations.

7.06 No Bond

No Trustee, or any successor, shall be required to give any bond in any jurisdiction, and if, notwithstanding this direction, any bond is required by any law, statute or rule of court, no sureties shall be required.

7.07 Compensation

Any Trustee shall be entitled to reasonable compensation commensurate with the services actually performed and to reimbursement for expenses properly incurred.

ARTICLE VIII - MISCELLANEOUS**8.01 Definitions**

Except as otherwise provided, definitions of terms in this Trust shall be as defined in the Alaska Probate Code as amended after the date of this Trust.

The term "countable income" as used in sections 4.01(a), 4.02(a), 4.03(a) and elsewhere

DRAFT

means income counted for SSI purposes under 20 CFR 416.1102 et seq., as modified by the Alaska Medicaid Manual sections 5020, 5025, and 5630.2. It does not include the Beneficiary's Permanent Fund Dividend (PFD) or Alaska Longevity Bonus (ALB), as long as these are required under state or federal law to be disregarded in determining the Beneficiary's eligibility for Medicaid or equivalent medical assistance. As long as the statutory disregards applicable to the PFD or ALB respectively remain in effect, they are not required to be deposited into the Trust, and need not be taken into account by the Trustee in computing the amount to be disbursed from the Trust to the Beneficiary.

8.02 Governing Law

This Trust shall be construed in accordance with, and governed by, the laws of the State of Alaska.

8.03 Number and Gender

Unless some other meaning and intent is apparent from the content, the plural shall include the singular, and vice versa, and masculine, feminine and neuter words shall be interchangeable.

Signed by _____, Settlor, this ____ day of _____, 1998

SETTLOR

STATE OF ALASKA)
)ss.
THIRD JUDICIAL DISTRICT)

SIGNED, SWORN TO AND ACKNOWLEDGED before me by John Happe, as Settlor of the John Happe IRREVOCABLE TRUST, this ____ day of _____, 1998.

Notary Public in and for Alaska
My commission expires: _____

DRAFT

Signed by _____, who accepts the office of Trustee of this Trust on the _____ day of _____, 1998.

TRUSTEE

STATE OF ALASKA)
)ss.
THIRD JUDICIAL DISTRICT)

SIGNED, SWORN TO AND ACKNOWLEDGED before by _____, as Trustee of the _____ IRREVOCABLE TRUST, this _____ day of January, 1998.

Notary Public in and for Alaska
My commission expires: _____

CHOICE Program Funding

**Comparison of HCB Waiver Costs
with Cost of Equivalent Institution
Using HCFA 372S Data**

<u>Older Alaskans</u>		<u>FY 96</u>	<u>FY 97</u>
Total Waiver Recipients		206	411
Average Waiver Service Cost	\$	10,374	\$ 11,151
Average Medicaid Non Waiver Service Cost	\$	4,692	\$ 4,984
Total Average Cost per Waiver Recipient	\$	15,066	\$ 16,135
Average Institutional Cost		\$ 55,428	\$ 53,267
Average Medicaid Non Institutional Cost		\$ 1,918	\$ 1,852
Total Average Cost per Institutional Recipient	\$	57,346	\$ 55,119
Difference between Waiver and Institutional Cost	\$	42,280	\$ 38,984
 <u>Adults with Physical Disabilities</u>		 <u>FY 96</u>	 <u>FY 97</u>
Total Waiver Recipients		66	88
Average Waiver Service Cost	\$	15,398	\$ 19,171
Average Medicaid Non Waiver Service Cost	\$	9,430	\$ 14,497
Total Average Cost per Waiver Recipient	\$	24,828	\$ 33,668
Average Institutional Cost		\$ 58,855	\$ 56,210
Average Medicaid Non Institutional Cost		\$ 4,096	\$ 3,523
Total Average Cost per Institutional Recipient	\$	62,951	\$ 59,733
Difference between Waiver and Institutional Cost	\$	38,123	\$ 26,065
 <u>People with Mental Retardation or Developmental Disabilities</u>		 <u>FY 96</u>	 <u>FY 97</u>
Total Waiver Recipients		138	341
Average Waiver Service Cost	\$	31,732	\$ 44,085
Average Medicaid Non Waiver Service Cost	\$	4,030	\$ 6,817
Total Average Cost per Waiver Recipient	\$	35,762	\$ 50,902
Average Institutional Cost		\$ 120,882	\$ 104,842
Average Medicaid Non Institutional Cost		\$ 3,170	\$ 2,371
Total Average Cost per Institutional Recipient	\$	124,052	\$ 107,213
Difference between Waiver and Institutional Cost	\$	88,290	\$ 56,311
 <u>Children with Complex Medical Conditions</u>		 <u>FY 96</u>	 <u>FY 97</u>
Total Waiver Recipients		58	70
Average Waiver Service Cost	\$	21,366	\$ 21,954
Average Medicaid Non Waiver Service Cost	\$	19,630	\$ 21,438
Total Average Cost per Waiver Recipient	\$	40,996	\$ 43,392
Average Institutional Cost		\$ 126,763	\$ 120,658
Average Medicaid Non Institutional Cost		\$ 26,377	\$ 25,277
Total Average Cost per Institutional Recipient	\$	153,140	\$ 145,935
Difference between Waiver and Institutional Cost	\$	112,144	\$ 102,543

Note: The HCFA 372S Report compares actual HCB waiver spending to projected Medicaid spending on institutional recipients at comparable age and level of care.

**Waiver and Nursing Facility Spending FY 97 and FY 98
Top 100 in Each Category**

Information pulled from STARS on 10/1/98 and 10/2/98.

Waiver expenditures are based on claims with eligibility codes o

Long Term Care (LTC) expenditures are based on all claims for

Claims are based on DOS 7/1/96 - 6/30/98 and DOP >= 7/1/96.

Waiver and Nursing Facility Spending FY 97 and FY 98
Top 100 in Each Category

Rank	Adult Waiver		Old Age Waiver		MR/DD Waiver		Kids Waiver		LTC	
	FY97 PAID	FY98 PAID	FY97 PAID	FY98 PAID	FY97 PAID	FY98 PAID	FY97 PAID	FY98 PAID	FY97 PAID	FY98 PAID
1	\$249,486	\$97,665	\$85,161	\$82,308	\$222,768	\$245,640	\$211,499	\$170,137	\$195,176	\$202,847
2	\$97,923	\$83,607	\$67,151	\$76,265	\$216,195	\$222,992	\$196,140	\$129,409	\$183,360	\$202,095
3	\$86,998	\$79,954	\$62,116	\$72,476	\$210,465	\$219,712	\$152,029	\$117,519	\$183,104	\$199,029
4	\$86,824	\$76,645	\$61,962	\$65,525	\$197,173	\$204,529	\$121,764	\$110,804	\$182,496	\$197,354
5	\$75,935	\$68,282	\$57,908	\$63,849	\$176,571	\$184,257	\$118,374	\$105,354	\$181,837	\$195,568
6	\$70,732	\$64,123	\$57,860	\$62,754	\$151,605	\$172,111	\$117,716	\$103,224	\$177,456	\$193,939
7	\$67,856	\$61,532	\$54,941	\$54,717	\$143,384	\$158,492	\$101,250	\$103,110	\$176,538	\$193,755
8	\$67,337	\$57,436	\$52,984	\$53,802	\$143,307	\$156,980	\$93,679	\$102,674	\$175,093	\$192,314
9	\$66,825	\$56,934	\$52,497	\$51,620	\$142,945	\$147,135	\$92,380	\$100,020	\$173,710	\$191,295
10	\$65,396	\$56,213	\$50,640	\$51,227	\$141,911	\$145,236	\$84,766	\$93,598	\$171,766	\$191,216
11	\$64,454	\$55,583	\$49,337	\$50,557	\$136,471	\$144,114	\$80,669	\$92,741	\$170,666	\$189,239
12	\$64,160	\$53,919	\$47,177	\$48,910	\$135,900	\$140,923	\$77,129	\$85,478	\$170,345	\$183,245
13	\$57,018	\$50,892	\$46,134	\$48,544	\$135,248	\$140,263	\$76,981	\$81,108	\$167,865	\$170,494
14	\$54,065	\$49,843	\$45,814	\$46,885	\$134,926	\$140,193	\$72,160	\$78,950	\$165,985	\$165,671
15	\$50,434	\$47,729	\$45,174	\$46,243	\$134,452	\$135,850	\$69,538	\$78,357	\$165,487	\$153,165
16	\$48,836	\$46,668	\$44,733	\$46,056	\$134,013	\$134,952	\$68,329	\$76,523	\$162,726	\$150,837
17	\$48,706	\$45,538	\$44,422	\$45,547	\$131,917	\$134,308	\$63,701	\$76,391	\$155,459	\$150,794
18	\$47,010	\$45,426	\$44,028	\$45,198	\$131,299	\$133,626	\$61,961	\$71,401	\$149,696	\$147,962
19	\$45,982	\$44,959	\$44,006	\$44,396	\$130,867	\$132,009	\$57,324	\$71,171	\$149,656	\$146,384
20	\$45,953	\$44,715	\$43,892	\$43,985	\$130,560	\$131,029	\$54,517	\$70,449	\$148,385	\$144,834
21	\$45,789	\$43,606	\$43,078	\$43,557	\$130,312	\$129,383	\$54,505	\$68,715	\$148,327	\$137,685
22	\$45,566	\$43,177	\$42,574	\$43,001	\$129,567	\$128,813	\$51,993	\$63,037	\$147,426	\$136,776
23	\$45,539	\$42,057	\$41,770	\$43,000	\$129,010	\$128,311	\$50,430	\$60,048	\$147,367	\$135,410
24	\$44,901	\$41,906	\$41,587	\$42,481	\$128,864	\$127,371	\$49,933	\$59,508	\$145,111	\$135,397
25	\$44,574	\$39,669	\$41,571	\$42,287	\$128,452	\$125,845	\$48,466	\$57,112	\$144,519	\$134,527
26	\$43,095	\$39,242	\$40,849	\$41,809	\$128,391	\$126,122	\$47,019	\$55,548	\$143,848	\$134,373
27	\$43,083	\$37,217	\$39,741	\$41,796	\$127,328	\$126,115	\$46,610	\$53,721	\$143,362	\$132,782
28	\$42,986	\$36,558	\$38,772	\$41,726	\$125,460	\$124,563	\$42,437	\$52,790	\$142,425	\$130,022
29	\$42,942	\$35,790	\$38,671	\$41,683	\$125,448	\$124,169	\$42,425	\$51,214	\$141,150	\$128,665
30	\$42,766	\$33,400	\$38,645	\$41,654	\$125,309	\$124,044	\$41,153	\$48,673	\$140,458	\$128,078
31	\$42,304	\$32,445	\$38,350	\$41,312	\$124,168	\$123,922	\$38,970	\$48,424	\$136,978	\$127,826
32	\$40,537	\$32,291	\$38,134	\$41,050	\$123,608	\$123,411	\$38,545	\$45,257	\$136,846	\$127,762
33	\$39,994	\$32,175	\$37,800	\$41,050	\$122,162	\$123,001	\$37,653	\$44,692	\$136,717	\$126,527
34	\$38,087	\$31,965	\$37,072	\$40,816	\$121,902	\$121,976	\$36,319	\$44,579	\$136,015	\$125,913
35	\$36,590	\$31,681	\$36,847	\$39,906	\$121,810	\$119,697	\$33,799	\$42,178	\$135,930	\$125,778
36	\$35,056	\$31,598	\$36,233	\$39,870	\$119,870	\$119,430	\$32,783	\$38,717	\$135,596	\$125,544
37	\$33,743	\$31,425	\$35,954	\$39,800	\$119,115	\$117,388	\$32,218	\$38,105	\$131,637	\$124,556
38	\$31,890	\$30,725	\$35,396	\$39,582	\$115,071	\$115,673	\$32,176	\$35,437	\$130,023	\$124,459
39	\$30,827	\$30,023	\$35,260	\$39,483	\$107,311	\$115,527	\$31,735	\$31,591	\$129,472	\$124,449
40	\$30,543	\$29,875	\$35,202	\$39,258	\$98,936	\$114,974	\$31,647	\$31,364	\$129,199	\$124,347
41	\$30,401	\$29,077	\$34,814	\$39,017	\$97,954	\$111,861	\$31,046	\$31,199	\$127,951	\$123,798
42	\$29,579	\$29,031	\$34,543	\$38,726	\$94,906	\$110,624	\$30,914	\$30,303	\$127,733	\$123,617
43	\$28,488	\$27,459	\$34,436	\$38,442	\$91,541	\$110,340	\$30,339	\$29,791	\$127,059	\$123,161
44	\$28,148	\$27,367	\$34,422	\$38,404	\$83,298	\$109,379	\$29,578	\$28,575	\$126,805	\$123,082
45	\$28,071	\$27,048	\$34,261	\$37,847	\$79,961	\$106,862	\$28,940	\$27,896	\$124,109	\$122,640
46	\$27,594	\$25,317	\$34,115	\$37,817	\$79,856	\$106,294	\$28,242	\$27,624	\$123,276	\$122,490
47	\$27,077	\$25,307	\$34,040	\$37,508	\$79,393	\$104,814	\$24,211	\$26,973	\$122,645	\$122,486
48	\$26,528	\$25,107	\$33,376	\$37,183	\$77,804	\$104,542	\$23,910	\$26,230	\$122,643	\$121,213
49	\$26,129	\$24,423	\$33,330	\$37,173	\$76,101	\$104,174	\$23,193	\$25,306	\$122,448	\$120,659
50	\$25,409	\$22,608	\$33,279	\$37,152	\$75,722	\$103,108	\$23,129	\$24,807	\$121,605	\$120,641
51	\$24,559	\$22,445	\$32,691	\$36,966	\$75,706	\$102,718	\$21,041	\$23,609	\$120,984	\$120,582
52	\$24,144	\$22,244	\$32,625	\$36,907	\$74,022	\$101,182	\$19,890	\$22,364	\$120,969	\$120,360
53	\$23,769	\$21,513	\$32,612	\$36,904	\$73,782	\$100,560	\$19,862	\$21,306	\$120,442	\$119,939
54	\$23,443	\$19,395	\$32,508	\$36,693	\$72,593	\$99,785	\$19,841	\$21,041	\$120,248	\$119,828
55	\$23,400	\$19,222	\$32,354	\$36,691	\$71,095	\$99,090	\$18,791	\$20,662	\$119,782	\$119,687
56	\$22,855	\$18,598	\$32,223	\$36,524	\$69,978	\$98,884	\$18,246	\$20,152	\$119,642	\$119,602
57	\$22,561	\$18,571	\$32,147	\$36,440	\$68,864	\$97,594	\$18,211	\$20,101	\$118,884	\$119,488
58	\$21,422	\$18,216	\$31,958	\$35,948	\$68,605	\$95,684	\$17,896	\$19,014	\$117,245	\$119,251
59	\$21,374	\$18,211	\$31,836	\$35,684	\$66,908	\$95,271	\$17,348	\$17,745	\$117,224	\$119,072
60	\$20,320	\$18,181	\$31,762	\$35,251	\$66,249	\$93,447	\$13,708	\$15,532	\$116,320	\$118,623

**Waiver and Nursing Facility Spending FY 97 and FY 98
Top 100 in Each Category**

Rank	Adult Waiver		Old Age Waiver		MR/DD Waiver		Kids Waiver		LTC	
	FY97 PAID	FY98 PAID	FY97 PAID	FY98 PAID	FY97 PAID	FY98 PAID	FY97 PAID	FY98 PAID	FY97 PAID	FY98 PAID
61	\$20,210	\$18,169	\$31,761	\$35,246	\$66,129	\$92,926	\$12,922	\$15,116	\$116,255	\$118,214
62	\$19,970	\$18,084	\$31,165	\$35,219	\$64,936	\$91,307	\$12,153	\$12,507	\$115,754	\$117,743
63	\$19,845	\$17,668	\$31,145	\$35,209	\$64,296	\$91,278	\$11,701	\$11,685	\$115,751	\$117,621
64	\$17,748	\$16,256	\$31,055	\$35,157	\$64,230	\$89,887	\$11,611	\$11,575	\$115,706	\$117,499
65	\$16,301	\$15,324	\$30,600	\$35,143	\$63,701	\$89,760	\$11,083	\$11,328	\$115,666	\$117,401
66	\$15,245	\$14,855	\$30,580	\$35,100	\$63,489	\$89,129	\$10,046	\$10,094	\$115,459	\$116,949
67	\$15,221	\$14,381	\$30,531	\$35,022	\$62,765	\$88,762	\$9,897	\$7,822	\$115,411	\$116,809
68	\$14,836	\$14,184	\$30,146	\$34,910	\$62,515	\$88,298	\$8,590	\$7,644	\$115,385	\$116,809
69	\$14,829	\$13,676	\$29,967	\$34,586	\$61,233	\$87,035	\$7,029	\$5,157	\$115,127	\$116,618
70	\$13,802	\$13,662	\$29,784	\$34,026	\$61,005	\$86,806	\$6,110	\$4,812	\$114,955	\$116,567
71	\$13,347	\$13,495	\$29,776	\$33,765	\$60,844	\$86,138	\$5,813	\$4,659	\$114,633	\$115,982
72	\$11,942	\$13,414	\$29,596	\$33,714	\$59,405	\$84,964	\$845	\$3,614	\$114,166	\$115,822
73	\$11,915	\$12,750	\$29,479	\$33,690	\$59,343	\$83,713	\$0	\$3,377	\$114,071	\$115,750
74	\$11,888	\$12,378	\$29,423	\$33,622	\$59,340	\$82,911		\$200	\$113,851	\$115,287
75	\$10,362	\$12,367	\$29,258	\$33,204	\$59,055	\$82,874			\$113,568	\$114,872
76	\$8,878	\$12,336	\$29,214	\$33,130	\$58,414	\$82,867			\$113,383	\$114,544
77	\$8,745	\$12,296	\$29,096	\$33,064	\$58,385	\$82,283			\$112,905	\$114,376
78	\$8,590	\$12,191	\$28,962	\$32,911	\$58,011	\$82,257			\$112,784	\$113,894
79	\$7,274	\$12,024	\$28,546	\$32,704	\$57,745	\$82,072			\$112,711	\$113,585
80	\$7,250	\$11,910	\$28,220	\$32,542	\$57,713	\$81,612			\$112,631	\$113,524
81	\$4,609	\$9,770	\$28,170	\$32,516	\$57,692	\$80,585			\$112,627	\$112,608
82	\$4,429	\$9,677	\$28,113	\$32,485	\$57,621	\$80,560			\$112,481	\$112,358
83	\$3,509	\$8,892	\$28,086	\$32,341	\$57,528	\$80,547			\$112,450	\$112,260
84	\$3,298	\$8,489	\$27,977	\$32,338	\$57,487	\$79,889			\$112,171	\$112,229
85	\$2,916	\$8,132	\$27,968	\$32,335	\$57,458	\$78,921			\$112,150	\$112,168
86	\$2,648	\$8,065	\$27,878	\$32,266	\$57,331	\$77,489			\$112,006	\$111,912
87	\$1,140	\$7,838	\$27,771	\$32,252	\$57,068	\$77,447			\$111,719	\$111,028
88	\$762	\$7,671	\$27,622	\$32,237	\$57,067	\$77,175			\$111,551	\$110,757
89	\$532	\$7,394	\$27,020	\$32,199	\$56,784	\$77,109			\$110,819	\$110,426
90	\$315	\$7,243	\$26,776	\$32,041	\$56,628	\$77,097			\$110,599	\$110,346
91	\$209	\$7,081	\$26,653	\$31,682	\$56,111	\$77,024			\$110,067	\$109,825
92	\$193	\$6,899	\$26,472	\$31,468	\$56,072	\$76,436			\$109,373	\$109,567
93	\$36	\$5,738	\$26,393	\$31,259	\$55,756	\$76,188			\$109,237	\$108,693
94	\$14	\$5,580	\$26,193	\$31,235	\$55,685	\$74,437			\$109,186	\$108,650
95		\$5,528	\$26,187	\$31,180	\$54,995	\$73,579			\$109,016	\$108,579
96		\$5,465	\$26,053	\$31,099	\$54,652	\$73,260			\$108,943	\$108,522
97		\$5,313	\$25,857	\$31,074	\$54,609	\$72,924			\$108,793	\$108,296
98		\$5,224	\$25,479	\$30,716	\$54,540	\$72,667			\$108,627	\$108,279
99		\$4,881	\$25,477	\$30,639	\$54,495	\$72,637			\$108,376	\$107,867
100		\$4,598	\$25,378	\$30,635	\$54,346	\$72,438			\$108,312	\$107,646
average	\$32,562	\$27,747	\$36,306	\$39,852	\$94,249	\$109,966	\$46,012	\$47,013	\$131,259	\$130,950

FY96 100 most expensive

Information pulled from STARS on 2/23/96

Expenditures are based on claims with eligibility codes of 40 - 45.

Claims are based on DOS 7/1/95 - 6/30/96 and DOP >= 7/1/95.

Expenditure Rank	Type of Waiver	Months Eligible	FY96 (DOS) Expenditures
1	old age	12	\$53,611.66
2	old age	12	\$41,980.74
3	old age	12	\$41,046.57
4	old age	12	\$40,304.91
5	old age	12	\$39,912.13
6	old age	12	\$39,308.40
7	old age	12	\$38,475.02
8	old age	12	\$37,511.45
9	old age	12	\$37,124.83
10	old age	12	\$37,104.68
11	old age	12	\$36,612.04
12	old age	12	\$36,151.95
13	old age	12	\$35,899.08
14	old age	12	\$35,670.17
15	old age	12	\$35,013.55
16	old age	12	\$34,447.12
17	old age	12	\$34,233.64
18	old age	12	\$33,911.55
19	old age	12	\$33,777.17
20	old age	12	\$32,884.10
21	old age	11	\$32,378.36
22	old age	12	\$32,361.65
23	old age	12	\$30,872.46
24	old age	12	\$30,487.77
25	old age	12	\$29,944.27
26	old age	8	\$29,822.00
27	old age	12	\$29,719.05
28	old age	10	\$29,284.85
29	old age	12	\$28,829.27
30	old age	12	\$28,626.81
31	old age	12	\$28,581.64
32	old age	12	\$28,260.14
33	old age	12	\$28,146.00
34	old age	12	\$28,105.72
35	old age	12	\$28,094.97
36	old age	10	\$27,919.48
37	old age	12	\$27,816.88
38	old age	12	\$27,520.80
39	old age	12	\$27,471.09
40	old age	12	\$27,309.34
41	old age	8	\$26,854.24
42	old age	12	\$26,844.58

FY96 100 most expensive

43 old age	12	\$26,793.97
44 old age	12	\$26,124.43
45 old age	12	\$25,404.85
46 old age	12	\$25,368.92
47 old age	11	\$25,324.74
48 old age	12	\$25,264.54
49 old age	12	\$24,409.30
50 old age	12	\$24,106.57
51 old age	12	\$23,788.76
52 old age	12	\$23,505.23
53 old age	12	\$23,090.95
54 old age	2	\$22,993.43
55 old age	12	\$22,411.06
56 old age	8	\$22,291.65
57 old age	12	\$21,706.73
58 old age	11	\$21,554.47
59 old age	12	\$21,359.59
60 old age	12	\$21,068.20
61 old age	11	\$20,703.72
62 old age	12	\$20,499.08
63 old age	6	\$20,336.01
64 old age	7	\$20,004.28
65 old age	12	\$19,881.15
66 old age	12	\$19,776.28
67 old age	10	\$19,660.03
68 old age	6	\$19,522.29
69 old age	12	\$19,334.78
70 old age	12	\$19,045.55
71 old age	9	\$18,381.98
72 old age	12	\$18,263.27
73 old age	7	\$17,343.49
74 old age	11	\$16,856.19
75 old age	7	\$16,764.80
76 old age	4	\$16,722.99
77 old age	5	\$16,513.67
78 old age	9	\$16,104.63
79 old age	12	\$16,002.32
80 old age	11	\$15,851.14
81 old age	9	\$15,366.13
82 old age	7	\$15,034.07
83 old age	5	\$14,943.56
84 old age	6	\$14,937.33
85 old age	6	\$14,147.72
86 old age	8	\$13,929.50
87 old age	5	\$13,800.41
88 old age	12	\$13,626.58
89 old age	12	\$13,616.95
90 old age	4	\$13,530.49
91 old age	12	\$13,371.70

FY96 100 most expensive

92	old age	11	\$13,215.11
93	old age	12	\$12,842.54
94	old age	5	\$12,785.59
95	old age	4	\$12,443.16
96	old age	5	\$12,408.18
97	old age	5	\$12,258.16
98	old age	12	\$11,879.57
99	old age	10	\$11,868.68
100	old age	7	\$11,835.28

FY96 25 most expensive

Information pulled from STARS on 2/23/98.

Expenditures are based on claims with eligibility codes of 30 - 35; 70 - 75; and 80 - 82.

Claims are based on DOS 7/1/95 - 6/30/96 and DOP >= 7/1/95.

Expenditure Rank	Kids Waiver		Adult Waiver		MR/DD Waiver	
	Months	FY96 (DOS)	Months	FY96 (DOS)	Months	FY96 (DOS)
	Eligible	Expenditures	Eligible	Expenditures	Eligible	Expenditures
1	12	\$157,245.48	12	\$66,585.57	12	\$124,078.58
2	12	\$151,392.35	12	\$65,867.65	12	\$95,648.81
3	7	\$125,766.36	12	\$57,553.78	12	\$71,787.91
4	12	\$121,524.68	1	\$56,785.00	12	\$69,959.47
5	12	\$100,440.30	12	\$49,641.55	12	\$69,842.15
6	12	\$91,977.15	12	\$49,428.82	12	\$69,237.19
7	12	\$74,968.61	12	\$49,072.50	12	\$63,962.22
8	12	\$72,228.27	12	\$48,455.08	12	\$62,612.36
9	8	\$67,979.48	6	\$47,484.60	12	\$61,635.36
10	10	\$67,409.98	12	\$45,961.83	12	\$61,086.69
11	12	\$54,773.76	12	\$44,215.72	12	\$60,274.02
12	12	\$52,599.45	8	\$43,900.07	12	\$56,280.66
13	6	\$50,108.45	12	\$43,633.19	12	\$55,826.59
14	12	\$50,030.02	12	\$43,371.47	12	\$55,320.00
15	12	\$49,660.15	12	\$43,204.33	12	\$54,711.45
16	12	\$45,476.30	11	\$39,639.33	12	\$54,453.59
17	12	\$45,068.85	12	\$37,900.37	12	\$53,697.82
18	12	\$43,362.45	10	\$33,928.89	12	\$53,517.20
19	12	\$41,597.95	2	\$33,914.86	12	\$53,037.43
20	12	\$40,538.51	12	\$33,449.87	12	\$53,018.13
21	5	\$39,024.92	2	\$32,236.29	10	\$52,723.67
22	12	\$38,684.17	6	\$28,675.07	12	\$52,624.84
23	12	\$36,649.40	12	\$28,379.95	12	\$52,459.24
24	7	\$35,392.26	7	\$26,217.04	12	\$52,391.44
25	5	\$30,773.27	12	\$25,893.22	12	\$52,068.41

LTC Private Insurance

Issue Brief: Long-Term Care Insurance

Definition: Long-term care typically refers to a wide range of services for people with a prolonged physical illness, disability or cognitive disorder. Long-term care services aim to help people with chronic conditions compensate for limitations in their ability to function independently and may include daily activities in the home, respite care, home health care, adult day care, and care in a nursing home.

Findings:

Medicare does not provide for the custodial long-term care services that so many elderly need.

Most Americans do not have long-term care insurance nor will they be able to afford it. According to AARP, only six percent of elderly Americans have private insurance policies and most studies estimate that only 10 to 20 percent of the elderly can afford good-quality private long-term care insuranceⁱ.

As a result, the responsibility for paying for the long-term care services rests on individuals until they deplete their saving and become eligible for the Medicaid program. Nationwide, 35 percent of the Medicaid program budget goes to long-term care, a percentage almost certain to grow as baby boomers ageⁱⁱ.

The most significant reason that Americans are not purchasing long-term care insurance policies is the high premium cost, particularly for those most likely to purchase them, namely persons 65 and older. Premiums escalate as people age. Data from the Health Insurance Association of America shows that policies that pay \$100 a day for nursing care and \$50 a day for home care average \$1,881 for those who buy at age 65, jumping to \$5,889 for those age 79ⁱⁱⁱ. Policies are costly in part because most are sold individually and carry high administrative costs. Preexisting condition limitations provisions also exclude some from the market.

Most long-term insurance policies are bought by upper-middle and upper-income elderly persons with substantial assets. As such, their purchase is expected to have a limited impact on public spending (Medicaid). Medicaid savings, resulting from the purchase of long-term care plans, are projected at 2 - 4 percent for policies sold to the elderly.^{iv}

Alternatives/Impacts and Costs:

Given the limitations of the current market for private long-term care insurance, public subsidies to promote its purchase are often proposed. One approach is to provide employers with a tax subsidy for the purchase of policies. A tiny but expanding market of employer-sponsored insurance has developed. However, in a key difference from acute care policies where employers historically have paid a large share of the cost of the insurance, most employers are offering them on an employee-pay-all basis.

Some state governments like other employers are promoting long-term care coverage to their own employees. Alaska was the first state to offer long-term care as an optional benefit at the time an employee retires. The plan design is now 10 years old and the retirement boards are meeting to review it and its increased costs.

A second strategy is to provide a tax deduction or credit to individuals for the purchase of private long-term care insurance. Tax incentives for employers and individuals were part of HIPAA. A significant problem with tax incentives is the probability that most of the tax incentives will be for people who would have purchased policies anyway^v.

A third strategy is to waive some or all of the Medicaid asset depletion requirements for purchasers of qualified long-term care plans. Four states are participating in a related long-term care insurance demonstration project funded by the Robert Wood Johnson Foundation. Under the project, individuals with long-term care insurance who reach their maximum benefit coverage are allowed to become eligible for Medicaid and keep all or some of their assets. To date, more than 28,000 policies are in place.

All of these strategies will undoubtedly encourage Americans to purchase long-term care insurance, but to what extent is not known.

ⁱ The Urban Institute. "Can Private Insurance solve the Long-term Care Problems of the Baby Boom Generation?", Washington, D.C., March 9, 1998.

ⁱⁱ National Conference of State Legislatures. "Long-Term Care Insurance: States Seek to Encourage Sales", *State Health Notes*. Washington, D.C., Volume 19, No. 284, September 14, 1998.

ⁱⁱⁱ Government Accounting Office. "Long-Term Care: Baby Boom Generation Presents Financing Challenges". Washington, D.C. GAO/T-HEHS-98-107, March 9, 1998.

^{iv} The Urban Institute.

^v Ibid.

LTC Choice

A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

presented by the

Center for Long-Term Care Financing

"Dedicated to ensuring quality long-term care for all Americans"

Public Release Date: September 1, 1998

Stephen A. Moses, President
David M. Rosenfeld, Chief Counsel
800 Fifth Avenue, Suite 4100
Seattle, Washington 98104-3122

Phone: 206-447-1340
Fax: 206-447-1341

E-mail: Stephen Moses: smoses@centerltc.com
David Rosenfeld: david@centerltc.com
Center: info@centerltc.com
Web Site: <http://www.centerltc.com>

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

No part of this report may be reproduced in any form or by any electronic or mechanical means, including the use of information storage and retrieval systems, without permission from the copyright owner. Federal law provides for penalties of up to \$100,000 and up to one year of imprisonment for copyright infringement.

*LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle***Table of Contents****Executive Summary***How can America solve the long-term care financing problem?iii***Preface***What is the Center for Long-Term Care Financing?1***Introduction***What is the long-term care financing puzzle?3***Historical Perspective***How did America's long-term care system become so dysfunctional?5***A Conflict of Paradigms***Why do most Americans ignore the risk of long-term care until it is too late?11***A Phalanx of Fallacies***Why does a fundamental misunderstanding of the long-term care problem still persist?15***Discussion***Why don't people plan ahead for long-term care and buy private insurance?19***Summary of the Problem***What is the bottom line?23***Public Policy Recommendations***What needs to be done to ensure quality long-term care for all Americans?25***LTC Choice***How can America afford universal access to top-quality long-term care?27***Conclusion***Do we have the courage of our convictions?31*

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

- We demonstrate that the solution to the long-term care financing puzzle is to persuade people to consider and to confront the risk of long-term care while they are still young, healthy, and affluent enough to save or insure privately.
- We offer a simple, cost-free solution called *LTC Choice*.
- *LTC Choice* requires the United States Government to provide information about long-term care risk and financing options to all citizens as soon as possible, but no later than their 65th birthdays.
- Under *LTC Choice*, every individual may choose to show proof of private insurance or adequate financial reserves to pay for long-term care and thus abstain from public financing entirely and avoid all other reporting requirements.
- Alternatively, anyone who is unable or chooses not to show proof of private long-term care financial protection would have to acknowledge formally in writing that any future eligibility for publicly financed long-term care is contingent upon spending down nearly all his or her income and assets for care expenses first.
- Requiring all citizens to confront the *LTC Choice* long before the insurable event occurs will radically increase the proportion of Americans who plan responsibly for long-term care and drastically reduce the incidence of artificial impoverishment to qualify for Medicaid.
- With over \$10 trillion about to pass by inheritance to the baby boomers from the WWII generation, Americans have no shortage of private money to save or insure for long-term care.
- All we need to do is eliminate the perverse incentives in the current system that enable denial of long-term care risk and discourage responsible, early planning.

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

Executive Summary

How can America solve the long-term care financing problem?

- The publisher of this study, the Center for Long-Term Care Financing, is dedicated to ensuring high quality long-term care for all Americans.
- The problem of how to finance long-term care for the baby boom generation rivals Medicare and Social Security as the most serious social policy challenge facing the United States.
- Today, America's long-term care service delivery and financing system is fragmented, dysfunctional, and plagued by problems of access, quality, reimbursement, discrimination and institutional bias.
- Nevertheless, we know exactly what we would like our country's long-term care system to provide: universal access to top-quality care for rich and poor alike in the least institutional settings possible.
- Pundits, politicians and policy-makers recognize the problem; they know what the solution should look like; why can't they get the job done? That is the long-term care financing puzzle.
- In this report, we explain how America's long-term care system came to its current sorry state by tracing the history of long-term care financing since the establishment of Medicaid and Medicare.
- We disprove and discard the conventional wisdom that catastrophic long-term care spend-down is widespread and therefore requires expanded public financing.
- We prove and adopt the position that virtually everyone can obtain public financing of long-term care through Medicaid or Medicare after being stricken by chronic illness. This fact explains why so few people plan ahead for the risk of long-term care.

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

Preface

What is the Center for Long-Term Care Financing?

This report is the first public policy paper of the Center for Long-Term Care Financing. Another version of this paper will be published as the chapter on long-term care financing in Ken Dychtwald's forthcoming anthology *Toward Healthy Aging*.

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

The Center for Long-Term Care Financing advocates public policy that targets scarce public resources to the neediest, while encouraging people who are young, healthy and affluent enough, to take responsibility for themselves. We believe that private insurance and investment can guarantee quality long-term care for prosperous seniors and help save the Medicaid long-term care program for the truly needy. Toward these ends, the Center offers a range of fee-for-service products to public and private clients including consulting, publishing, training and public speaking. The Center for Long-Term Care Financing also publishes a periodic on-line news service called "LTC Bullets" which covers the latest information and trends in long-term care financing. This publication is available free of charge.

The two principals in the Center for Long-Term Care Financing have many years of experience between them in the fields of long-term care policy, public welfare, aging, law and social work. Stephen Moses was formerly Director of Research for LTC, Incorporated and a senior analyst for the Health Care Financing Administration and the Office of Inspector General of the U.S. Department of Health and Human Resources. He is nationally recognized as an

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

expert and innovator in the field of long-term care. David Rosenfeld is an attorney and MSW with a growing reputation as an author and speaker on long-term care issues. He specializes in ethical questions affecting elder law. Biographical profiles of Mr. Moses and Mr. Rosenfeld are provided at the end of this report.

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

Introduction

What is the long-term care financing puzzle?

Long-term care in the United States is more than a challenging public policy problem. It is a fascinating puzzle as well. In fact, the question "How will we pay for the needs of a rapidly aging population?" raises a whole continuum of conundrums. For example, why does a prosperous nation like ours warehouse its World War II generation in welfare-financed nursing homes? Why are most Americans in denial about the risks of long-term care when the media warn us constantly about an impending demographic Armageddon? Why do we agree on so many of the problems and solutions of long-term care service delivery and yet fail year after year to initiate decisive corrective action? This report will answer these questions, solve the underlying puzzle, and propose an affordable public policy solution.

Conventional wisdom and scholarly consensus agree: America faces a potentially cataclysmic long-term care financing crisis in the foreseeable future. The evidence of impending danger lies everywhere we look: undeniable trends in aging demographics; reduced availability of informal caregivers; doubts about the quality of formal long-term care; inadequate supply of low-cost home- and community-based services; rapidly escalating nursing-home expenses; poorly structured delivery systems; dwindling public finances; increasingly resistant taxpayers; declining ability or willingness of families to pay privately for long-term care; cracks in our public and private pension systems; and the approaching retirement of the baby boom generation. These are the elements of consensus on the problem.

Just as the public and the experts have come to agree on the problems, they also concur on the architecture of an ideal long-term care system. Certain optimal features show up consistently in task-force reports, think tank studies, policy papers, and published articles. These

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

include: generous eligibility for assistance; integrated acute and long-term care; easy access at a single point of entry; quality control; case or care management; uniform client needs assessment; asset protection; home- and community-based care; nonmedical social services (such as housekeeping and personal care); adult day care; respite care; supportive housing such as assisted living and adult foster homes; pre-admission screening; custodial, skilled, and sub-acute nursing-home care; services to meet the special needs of geriatric, developmentally disabled, mentally ill, and other patients; and coordination of public financing sources (primarily Medicaid and Medicare). These are the elements of consensus on the solution.

Here is the puzzle: We know what is wrong with long-term care in the United States. We know how to design an optimal service delivery system. We live in the world's wealthiest society. Why can't we come together politically and professionally to get the job done?

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

Historical Perspective

How did America's long-term care system become so dysfunctional?

Academics, pundits, and politicians have struggled for decades with the challenge of financing long-term care. Grand designs for reform like the Pepper Commission's report and the Clinton Health Plan have failed to attract public support. Incremental changes like expanding Medicaid (nursing home) and Medicare (home health) coverage have hastened the current fiscal crisis. When nothing you do seems to work, but your predicament is so desperate you cannot give up, the best strategy is to examine your premises.

Most scholarship on long-term care focuses on the *status quo*, laments the familiar problems, advocates the usual solutions, and blames inaction on a lack of money caused by stingy taxpayers and cold-hearted politicians. If there is a fundamental underlying fallacy in our approach to long-term care, this commonplace analysis will not identify or correct it. The sad fact is: if we keep doing what we have always done, we will keep getting what we have always gotten. Instead, we must ask ourselves: *How did our long-term care system come to be the way it is?* and *What do we need to do differently to achieve more desirable results?*

In 1965, America was just starting to have a serious problem with long-term care. People were living longer, but dying more slowly—of chronic illnesses that caused frailty and cognitive impairment. Older Americans needed more and more long-term care at the very time when women, the traditional caregivers, were entering the formal workforce in much greater numbers. This was when a prosperous private market in low-cost home- and community-based services, geriatric care management, and long-term care insurance might have developed in the United States. It did not.

LTC Choice. A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

Instead, with every good intention, the new federal Medicaid program offered publicly-financed long-term nursing-home care. This benefit, initially unencumbered by transfer of assets restrictions and estate recovery requirements, confronted families with a very difficult choice. They could pay out-of-pocket for the home care and community-based services seniors prefer or they could accept nursing-home care paid for by the government. Most people chose the safety and financial benefits of the government's Medicaid option. Therefore, the market for home care withered, private long-term care insurance failed to develop, and Medicaid-financed nursing-home care flourished.

The nursing-home industry took full advantage of this new public financing source by building many new facilities. To have failed to do so would simply have been bad business. As fast as the industry could build them, the new nursing-home beds filled with Medicaid residents. Stunned by the cost, Medicaid attempted to control the construction of new beds with Certificate of Need (CON) programs based on the principle that "we cannot pay for a bed that does not exist." By the mid-1970s, health planning for nursing homes was in full swing. It worked. Fewer new beds were built.

Capping bed supply, however, predictably drove up price and demand. The nursing-home industry raised charges to compensate for the limitation on new beds. What the government saved by restricting bed supply, it lost to nursing-home rate increases. Consequently, Medicaid nursing-home costs grew faster than ever. In response, Medicaid capped reimbursement rates. This move impelled the nursing-home industry to increase private-pay reimbursement rates to compensate. The more the government pushed Medicaid rates down, the more the industry pushed private-pay rates up. So began the highly problematic differential

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

between Medicaid rates and private-pay rates. Today, on average, Medicaid pays only 80% of private-pay rates.

Higher private-pay rates made Medicaid more attractive than ever to private payers. The public's desire to obtain public assistance for long-term care expenses led to pressure on legislators to loosen standards for Medicaid eligibility. A long process of eligibility bracket creep gradually made Medicaid nursing-home benefits available even to upper middle-class people. Anyone who had or could obtain the expertise to manipulate Medicaid's highly elastic eligibility rules became eligible. A whole sub-practice of law—Medicaid estate planning—developed to take advantage of this new opportunity. Artificial self-improvement, touted frequently in the national media and in local financial planning ads, became a clever solution to the long-term care financing problem.

With the supply and price of nursing-home beds capped by government fiat and with Medicaid eligibility increasingly generous, nursing-home occupancy skyrocketed to an average of 95% nationally. Given high demand and severely limited supply, nursing-home operators could fill their beds easily with low-paying Medicaid patients. To achieve adequate operating margins, however, nursing homes had to attract a sufficient supply of full-paying private patients or cut costs drastically. Yet, if they tried to attract more lucrative private payers with preferred treatment or accommodations, the nursing homes were deemed guilty of discrimination against Medicaid patients. If they tried to cut costs instead, they came under fire for technical violations or quality problems. In response, Congress and state governments pressured the industry to provide higher quality care without discriminating against low-paying Medicaid recipients. Given the program's fiscal duress, however, Medicaid could not offer higher reimbursement rates to achieve these goals.

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

Caught between the rock of low reimbursement and the hard place of quality mandates, the nursing-home industry put up a strong fight. Armed with the Boren Amendment, a federal law that required Medicaid to provide reimbursement adequate to operate an efficient nursing facility, many state nursing-home associations took the battle to court. By this time, however, state and federal Medicaid expenditures were increasing so quickly and taxpayers had become so reluctant to pay for growing public spending that large increases in Medicaid nursing-home reimbursements were out of the question, regardless of which side won the lawsuits. The issue is moot now, of course, because the Boren Amendment was repealed by the Balanced Budget Act of 1997.

In the meantime, a wave of academic speculation in the late 1970s indicated that paying for home- and community-based services (HCBS) instead of nursing-home care could save a lot of money. For years, therefore, Medicaid has experimented with HCBS waivers as a cost-saving measure. In time, however, hard empirical research produced a near consensus that (desirable as they are) home- and community-based services do not save money overall. Medicaid and, more recently, Medicare expenditures for long-term personal and home care have soared in tandem with nursing-home expenditures. It remains true, ironically, that because of the public's aversion to nursing-home care, institutional bias is Medicaid's strongest cost containment tool, one of its gravest deficiencies, and the biggest single obstacle to the expansion of privately-financed home- and community-based long-term care services.

In a nutshell, just as heavy demand was building for a privately financed senior services market in the 1960s, Medicaid co-opted the trend by providing easy access to subsidized nursing-home care. Confronted with a choice between paying out-of-pocket for a lower level of care or receiving a higher level of care at much less expense, seniors and their families made the

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

predictable economic choice. Naturally, the potential market for long-term care insurance and privately-financed home- and community-based services languished. Medicaid nursing-home caseloads and expenditures increased rapidly and drastically. In response, Medicaid capped bed supply and reimbursement rates, which led inevitably to excessively high occupancy, private-pay rate inflation, discrimination against low-paying Medicaid patients, and serious quality of care issues.

Over time, Medicaid nursing-home care acquired a national reputation for impeded access, dubious quality, inadequate reimbursement, widespread discrimination, pervasive institutional bias, and excessive cost. Medicaid remains, nonetheless, the only way middle-class people can pay for long-term care without selling their homes nor, if they are clever, liquidating their savings. That is why so many otherwise independent and responsible Americans fail to buy private insurance while they are young and healthy enough to qualify for it and afford it, and end up looking to Medicaid planning as the only way to save their estates or their inheritances. It is the reason why a huge proportion of America's proud World War II generation is dying on welfare in nursing homes.

Today, these historical trends have almost run their course. We are on the verge of a promising, but perilous, new world of long-term care. We are floundering forward, compelled by necessity to change the system somehow. Both the private marketplace and public policy are pushing long-term care in a more consumer-friendly direction. Nursing-home occupancy is declining, with the percentage of occupied beds having dropped from the mid-nineties to the mid-eighties in the past decade. The trend toward privately-financed assisted living is exploding. Medicare has entered the arena with rapid growth in its home care and skilled nursing components. New buzz words dominate our professional jargon. We look to concepts like

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

capitation, managed care, dual eligibles, and integration of acute and long-term care for new hope.

Is our dream of a seamless long-term care delivery and financing system just around the next bend in public policy? Or are we at risk of making the same mistakes as in the past, but on a wider scale and with more disastrous consequences? To answer these questions, we need to find a fresh perspective on the past, present, and future of long-term care financing.

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

A Conflict of Paradigms

Why do most Americans ignore the risk of long-term care until it is too late?

Whether one reads a newspaper article, a scholarly journal or a full-length book about long-term care financing, one invariably finds an argument that goes something like this:

Long-term care, especially nursing-home care, is extremely expensive. Very few Americans can afford \$3,000 to \$5,000 per month in extra out-of-pocket expenses. Therefore, when stricken by the tragedy of Alzheimer's, Parkinson's, or stroke, most people spend down their life's savings quickly and collapse into poverty. Once impoverished, they qualify for Medicaid, which steps in to pay their bills. Consequently, Medicaid nursing-home costs are skyrocketing, and the government's ability to meet growing long-term care needs is severely strained.

This scenario—call it the *welfare paradigm*—comports with some of the facts. For example: nursing homes *are* very expensive; Medicaid *is* a means-tested public assistance program; approximately two-thirds of all residents in nursing homes *do* receive Medicaid; and Medicaid *does* suffer from severe financial problems. But let us set these matters aside for a moment, step back from the actual long-term care financing system, and ask: If the welfare paradigm is valid, what would we logically expect the long-term care marketplace to look like?

If long-term care impoverishes large numbers of Americans and forces them onto welfare, we would certainly expect seniors and their families: (1) to worry and plan years in advance about the potentially catastrophic costs of long-term care; (2) to avoid nursing-home care as long as possible because of its expense and because of their preference to stay at home; (3) to demand high-quality, low-cost, home- and community-based care alternatives that delay institutionalization and impoverishment; (4) to utilize home equity conversion products (such as reverse annuity mortgages) that can finance home care and postpone liquidation of the family home; and (5) to purchase private long-term care insurance that can protect against catastrophic financial loss caused by home or institutional care.

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

In practice, the opposite of these reasonable expectations holds true. First, most families do not plan in advance for the risk of long-term care. That is why so many of them end up in crisis with nowhere to turn but to public assistance. Second, nursing-home care is often the first choice for care, not the last resort. That is why so many people end up in nursing homes who could be cared for at home more comfortably and for less cost. Third, the home- and community-based care sector of the long-term care marketplace has been very slow to develop. That is why many people have no viable choice besides nursing-home institutionalization when a health crisis strikes. Fourth, home-equity conversion has failed, to date, as a private sector financial product, despite strong encouragement from the government. That is why home equity, which is the single biggest financial asset of seniors, goes virtually untapped as a source of financing for quality long-term care. Finally, only about six percent of seniors have purchased private long-term care insurance. That is why nursing-home costs are devastating to most people when they do occur.

The Entitlement Paradigm

Clearly, much of what we would expect rational economic decision makers to do if the welfare paradigm were valid simply does not happen. Instead of torturing the old paradigm to account for these anomalies, we might consider a different view—call it the *entitlement paradigm*:

In America today, people can ignore the risk of long-term care, avoid the premiums for private insurance, wait to see if they ever require formal care and, if necessary, shelter all their income and assets to qualify (virtually overnight) for nursing-home benefits paid for by Medicaid.

Viewed from the standpoint of the entitlement paradigm, the puzzling behavior described above would be far more comprehensible. For example, people do not plan ahead for long-term care because they can wait until the last minute and receive publicly-financed care. They often go to

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

nursing homes instead of home care first, despite their preferences, because Medicaid pays generously for nursing-home care, but covers very little home care. Few people want to take advantage of home-equity conversion to finance long-term care or insurance premiums because Medicaid exempts the home and all contiguous property regardless of value. Finally, long-term care insurance is unpopular because most people will not pay full dollar for something they can get from the government at a deep discount.

Thus, if the entitlement paradigm is valid, if Medicaid provides easy access to highly subsidized long-term care, we can easily understand why most people are eligible for Medicaid even before they enter a nursing home,¹ why Medicaid nursing-home census and costs have increased rapidly for many years, why induced demand makes Medicaid financing of home care prohibitively expensive, and why private financing of nursing-home care is declining instead of increasing as a proportion of total costs.² Furthermore, if the entitlement paradigm is valid, many exciting new public policy options open up for us. For example, it could be possible to save taxpayers a lot of money and to empower many more Americans to pay privately for top-quality long-term care simply by making Medicaid a little less desirable and by providing a stronger incentive for people to plan ahead to avoid public assistance. In other words, the solution to the long-term care financing puzzle may reside in merging the two paradigms to gain the benefits of

¹ In fact, the data show that 72.9% of single people, 85.4% of married people, and 77.7% of all people are eligible for Medicaid already when they enter a nursing home. (Frank A. Sloan and May W. Shayne, "Long-Term Care, Medicaid, and Impoverishment of the Elderly," *The Milbank Quarterly*, Vol. 71, No. 4, 1993, p. 585.)

² In 1987, private out-of-pocket expenditures accounted for 49.3% of total nursing-home costs nationally; Medicaid paid for 43.9%; and Medicare paid for 1.4%. In 1996, private out-of-pocket expenditures accounted for 31.4% (down 17.9% since 1987); Medicaid paid for 47.8% (up 3.9%); and Medicare paid for 11.4% (up 10.0%). (Source for 1987 data: personal communication with Helen Lazenby, Health Expenditure Analyst, Health Care Financing Administration on February 16, 1989; source for 1996 data: Katharine R. Levit, *et al.*, "National Health Expenditures, 1996," *Health Care Financing Review*, Vol. 19, No. 1, Fall 1997, p. 195.)

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

the welfare system without incorporating its negatives and to eliminate the problems of the entitlement paradigm without sacrificing its advantages.

There is no point, however, in exploring these possibilities further unless the entitlement paradigm is valid. Unfortunately, to most people familiar with the long-term care financing system, the entitlement paradigm will seem highly dubious. Critics of the entitlement paradigm will cite federal and state laws that appear to require impoverishment to qualify for Medicaid. Furthermore, most experts accept the welfare paradigm without challenging it. Certainly, as yet, no one has made the case in the mainstream gerontological literature that the welfare paradigm is invalid and that the entitlement paradigm is a much better model of reality.

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

A Phalanx of Fallacies

Why does a fundamental misunderstanding of the long-term care problem still persist?

The welfare paradigm—the perspective that our long-term care financing system's biggest problem is widespread catastrophic spend-down—is invalid. But the welfare paradigm is surrounded by a phalanx of fallacies that shelter it from critical scrutiny. The entitlement paradigm—the perspective that the United States has a publicly-financed long-term care entitlement program that impedes market-based solutions the public prefers—is valid. But the entitlement paradigm contradicts conventional wisdom and must be proved. The remainder of this report will refute the welfare paradigm, confirm the entitlement paradigm, and draw public policy recommendations that follow logically from these conclusions.

A key fallacy of the welfare paradigm is that most people who need long-term care spend down their life's savings and fall, sooner or later, into the social safety net of Medicaid. The truth is very different. Seventy-eight percent of all people who enter nursing homes are already eligible for Medicaid before they are admitted to this expensive level of care.³ The vast majority of all patient days in America's nursing homes are paid for by someone other than the patient. Medicaid alone pays at least in part for 71.7% of all nursing-home patient days.⁴ In 1996, more than three-fourths of all dollars paid for nursing-home services came from a combination of publicly-financed programs including Medicaid (47.8%), social security "spend-through"

³ See footnote #1.

⁴ McKnight's Long-Term Care News, December 1996, p. 3 citing HCIA's Guide to the Nursing Home Industry, 1996.

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

(12.8%),⁵ Medicare (11.4%), veterans' benefits and other government sources (2.3%), and from private health insurance (5.2%) or patient out-of-pocket income (not assets).⁶ Empirical evidence of widespread catastrophic asset spend-down in nursing homes is nonexistent. In fact, numerous academic studies recently proved that only 15% to 25% of Medicaid nursing-home patients spent down to qualify (including those who did so artificially through asset divestiture), instead of the 50% to 75% previously thought.⁷

Another important fallacy of the welfare paradigm is that Medicaid eligibility requires impoverishment. The truth is very different. Virtually anyone, regardless of income or assets, can qualify quickly and easily for nursing-home care paid for by the government. Most states place no limit on how much income someone can have and still qualify for Medicaid nursing-home benefits. If one's total medical costs—including nursing-home care—approximate or exceed one's income, one is eligible. Even in the toughest "income cap" states, the median elderly person—in terms of income and assets—qualifies easily for Medicaid nursing-home

⁵ Social security spend-through refers to income most seniors collect in the form of social security benefits which must be contributed toward their cost of care when they receive nursing-home services paid for by Medicaid. According to HCFA: "An estimated 41 percent...of out-of-pocket spending for nursing home care was received as income by patients or their representatives from monthly social security benefits." (Helen C. Lazenby and Suzanne W. Letsch, "National Health Expenditures, 1989," *Health Care Financing Review*, Vol. 12, No. 2, Winter 1990, p. 8.) Applying this percentage to the proportion of nursing-home costs paid out-of-pocket in 1996 (31.4%) gives an estimate of social security spend-through of 12.8% for 1996.

⁶ Katharine R. Levit, et al., "National Health Expenditures, 1996," *Health Care Financing Review*, Vol. 19, No. 1, Fall 1997, p. 195. The proportion of out-of-pocket costs attributable to patient income, other than social security spend-through, is unknown but substantial. Seniors often receive income from their investment assets, for example, which would be spent for long-term care before dipping into the assets themselves. Consequently, the total portion of nursing-home costs paid by sources other than patients' assets could approach as much as 80% to 90%.

⁷ Two or three dozen "spend-down" studies were conducted in the late 1980s and early 1990s. They are easily accessible in the scholarly literature. Some of principal authors were Mark Meiners, Brian Burwell, Joshua Wiener, Korbin Liu, Pam Doty, and Kenneth Manton.

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

benefits without complicated estate planning.⁸ The "Miller income trusts" authorized by the Omnibus Budget Reconciliation Act of 1993 lifted the lid on income caps altogether for most people.

The widely reported \$2,000 Medicaid eligibility limit on assets is highly misleading. Medicaid recipients can keep unlimited exempt assets—such as a home, a business, and a car—of any value. Many other assets are exempt as well. Converting nonexempt assets such as cash into exempt assets such as home equity is the easiest and most commonplace method of Medicaid planning. For married people, qualifying for Medicaid is even easier than for single people. Couples can shelter up to an additional \$80,760 in assets and \$2,019 per month in income as of 1998. Furthermore, these levels increase annually with inflation.

For the well-to-do who can afford professional legal advice, even these generous eligibility limits are easily overcome. Any competent Medicaid estate planner can deliver Medicaid nursing-home eligibility almost overnight to practically anyone for less than the cost of one month in a private nursing home.⁹ The same advisors can evade estate recovery liability for their clients with equal facility. As explained below, these facts remain true despite strong initiatives taken by Congress and the President in 1993, 1996, and 1997 to close Medicaid loopholes, mandate estate recoveries, and criminalize asset transfer advice.

⁸ The Medicaid income cap increases every year with inflation. For 1998, it was \$1,482 per month or \$17,784 per year as compared to an average annual income (in 1995) of \$16,484 for elderly males and \$9,335 for elderly females. (Department of Health and Human Services, Administration on Aging, "A Profile of Older Americans: 1996," Washington, D.C., December 1996, <http://www.aoa.dhhs.gov/aoa/pages/profil96.html>, p. 6.)

⁹ See the box insert on the next page.

*LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle***Welfare for the Well-To-Do**

Hundreds of law journal articles over the past 15 years attest to the fact that Medicaid is available to anyone with enough money to hire the right attorney. The following are typical passages from two mass media legal self-help books that provide Medicaid estate planning advice to the lay public.

"So is there any practical way to juggle assets to qualify for Medicaid—before losing everything? The answer is yes! By following the tips on these pages, an older person or couple can save most or all of their savings, despite our lawmaker's best efforts...Here are the best options: Hide money in exempt assets...Transfer assets directly to children tax-free...Pay children for their help...Juggle assets between spouses...Pass assets to children through a spouse...Transfer a home while retaining a life estate...Change wills and title to property...Write a durable power of attorney...Set up a Medicaid Trust...Get a divorce..." (Armond D. Budish, *Avoiding the Medicaid Trap: How to Beat the Catastrophic Costs of Nursing-Home Care*, Henry Holt, New York, 1989, p. 34.)

"We have committed an act of piracy—we have broken into the Fort Knox of Government benefits and uncovered the best legal strategies available to you for claiming your share of the gold from the Government's treasure chest....We'll explain how you can 'strike gold' in the social security [including SSI], Medicare, and Medicaid programs....With this book we are handing you the treasure map, deciphered from a mine of unintelligible government rules and regulations." (Amy and Armond D. Budish, *Golden Opportunities: Hundreds of Money-Making, Money-Saving Gems for Anyone over Fifty*, Henry Holt and Company, New York, 1993, p. xiii.)

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

Discussion

Why don't people plan ahead for long-term care and buy private insurance?

Shall we assume, therefore, that because government pays for or subsidizes most nursing-home care in the United States, seniors are intentionally planning to go on welfare and into nursing homes if they ever need formal long-term care? Is that why so many of them fail to buy insurance or pay privately for lower levels of care? No! Most people simply do not worry or care about who pays for long-term care. They do not know whether the source of funding is Medicaid, Medicare or Make-a-Wish. They are aware, however, that *somebody* else pays and that the horror stories that magazine articles and insurance agents tell them about losing their life's savings can be ignored with impunity. Ironically, they are right.

The easy, almost universal availability of publicly-financed nursing-home benefits enables widespread public denial concerning long-term care risk. People only insure against real risks, and they naturally hesitate to pay full price for something that is easily available by government subsidy. If the social safety net suddenly disappeared, if people really had to become impoverished before the government helped them out, they would quickly realize they could no longer enjoy the luxury of their denial. They would plan ahead for long-term care risks, buy insurance, tap home equity, employ geriatric care managers to find and coordinate the best available free or fee services, and pay privately for the lowest, least expensive, and best levels of care they could afford.

The social safety net is not going to disappear, however. The third rail of politics—senior benefits—retains sufficient voltage to stifle any politician who might attempt to eliminate long-term care benefits completely. Fortunately, there is a better way to solve the problem and we already have many of the legislative and bureaucratic tools in place to implement it. The

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

Omnibus Budget Reconciliation Act of 1993 (OBRA '93), President Clinton's first budget, provided much of what is needed. OBRA '93 closed many of the loopholes that made Medicaid eligibility so attractive and required every Medicaid program in the country to recover benefits paid from the estates of deceased recipients. In essence, OBRA '93 told the middle class: "Medicaid is a loan, not a grant. If you don't want to die on welfare and pay for the privilege, then buy long-term care insurance, pay privately for the long-term care services you prefer, and leave public assistance for the poor." The Health Insurance Portability and Accountability Act of 1996 (HIPAA or the Kennedy/Kassebaum Act) went even further. It criminalized certain Medicaid asset transfers executed for the purpose of qualifying for public assistance. HIPAA also made private long-term care insurance more attractive by making the premiums tax-deductible.

Why haven't these changes in public policy already unleashed the full potential of market-based solutions like supportive housing, home equity conversion, private geriatric care management, and long-term care insurance? Unfortunately, America has an entrenched welfare industry that thrives on impoverishing people artificially and profiteering from their dependency. Thousands of Medicaid estate planners throughout the United States work assiduously to pry back open the eligibility loopholes closed by OBRA '93 and to weaken estate recovery. Numerous well-intentioned legal assistance and seniors' organizations aid and abet the private bar by referring affluent seniors to for-profit Medicaid planners. The Health Care Financing Administration (HCFA), which administers Medicaid and Medicare, does not enforce OBRA '93 aggressively, provides little technical assistance to the states, and openly advises Medicaid estate planners on how to circumvent the law. State Medicaid programs, which are experts at providing benefits and spending money, have little aptitude for or interest in controlling eligibility or

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

collecting from estates. Many Medicaid eligibility workers actually help people spend down artificially to qualify for nursing-home benefits. The Balanced Budget Act of 1997 diluted the provisions in HIPAA '96 by targeting criminal penalties for asset transfers at Medicaid planners and other financial advisers, while exonerating their clients. Finally, the Medicaid planners and their professional association have mounted a nationwide public relations campaign to repeal criminalization altogether or have the law declared unconstitutional. As so often happens, our public policymakers, and the interest groups that lobby them, have one foot on the accelerator and one foot on the brake of privatizing long-term care financing.

Clearly, the conventional wisdom that public assistance is available only to people after they have impoverished themselves paying for long-term care (the welfare paradigm) is wrong. The reality is that most people qualify easily for Medicaid nursing-home benefits, and virtually anyone can qualify quickly with the right advice (the entitlement paradigm). Consequently, it should come as no surprise that most people in America do not worry in advance about long-term care, that they end up in nursing homes on Medicaid instead of in the less institutional settings they prefer, and that they fail to tap the equity in their homes for long-term care expenses or to purchase private insurance.

Fortunately, this state of affairs is reversible. Today, the political imperatives to reduce government spending and curb entitlements have opened a pathway to major reform. We no longer need to effect incremental change to an obsolete welfare program that is morally, intellectually, and financially bankrupt. By virtue of its excessive cost and its reputation for serious access and quality problems, Medicaid is finished as a long-term care financing system for the middle class. America stands poised on the brink of a revolutionary new approach to long-term care financing.

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

Summary of the Problem

What is the bottom line?

The 1970s should have been the golden age of long-term care in America. The gerontological wedge pushed into American demographics during that decade could have opened an era of unprecedented entrepreneurial problem-solving. By now, we would have a market-driven continuum of care seamlessly covering everything from chore services to assisted living to sub-acute care. We would also have an infrastructure of long-term care insurance and home equity conversion to finance it. Public welfare might still have a role to play in long-term care, but that role would not be the tragedy of perverse incentives and unsatisfactory outcomes it is today.

Instead, with every benevolent intent, Medicaid co-opted long-term care by the late 1960s. It impeded the private market for low-cost senior services and housing and discouraged the development of private long-term care insurance by providing free or subsidized nursing-home care. It created a Frankenstein's monster of institutional care by targeting public money only to nursing homes. It stifled competition, thereby impairing access and quality, by constricting bed supply and reimbursement rates artificially. It drove the middle-income consumer out of the private long-term care marketplace by creating a ponderous, publicly-financed monopsony. In time, Medicaid choked the nursing-home industry almost to death with regulations intended to correct the very problems the program itself engendered. Nevertheless, in the absence of affordable alternatives and the means to pay for them, middle-class Americans in the hundreds of thousands are still being directed into Medicaid-financed nursing homes by well-intentioned public administrators and Medicaid estate planning attorneys.

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

Public Policy Recommendations

What needs to be done to ensure quality long-term care for all Americans?

What is the solution? Obviously, we cannot dismantle Medicaid overnight and leave the old, the sick, and the frail to fend for themselves. Rather, the first step is to preserve and improve a publicly-financed long-term care program for the truly poor. To command good access and high quality, however, such a program must be able to pay market rates for every appropriate level of care. That will be expensive.

The only way to pay for such a program is to divert the middle class and affluent away from it and into private financing alternatives. This can only be achieved by imposing a strong means test, eliminating all eligibility loopholes, and strictly enforcing estate recovery rules. There is no other option. We have to give Medicaid back to the poor and show everyone else how to plan ahead and remain self-sufficient.

We cannot compel middle-class Americans to impoverish themselves, however, before they receive any assistance from their government. That policy already failed. It invites resentment, fraud, and legal circumvention of the rules. Instead, we must provide a kinder alternative to families who need long-term care, but cannot afford to pay for it without devastating themselves financially.

Given the precarious state of government entitlements, however, public funding for a new middle-class long-term care program is nonexistent. Any new program will have to pay its own way. Fortunately, adequate privately-held resources are readily available in this country to finance market-driven supportive housing and long-term care. In fact, \$1.5 trillion lies illiquid and untapped today in seniors' home equity alone and another \$10 trillion is about to fall into the laps of the baby boomers in the form of inheritance. The secret is to unlock these resources and

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

put them to work paying for long-term care. Forcing seniors to sell their homes or consume their estates before they can get help is not an acceptable strategy, however. The desire to preserve the family homestead and pass on a legacy is too deeply ingrained in American culture. We must find a more creative, less draconian approach. We recommend *LTC Choice*.

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

LTC Choice

How can America afford universal access to top-quality long-term care?

A better approach to long-term care financing is to let seniors keep their income and assets (including their homes) as long as these resources are needed to support themselves or their immediate dependents. When someone requires care for which the family has insufficient cash flow to pay, let the government guarantee payment of the bill for whatever private service the family chooses. Simultaneously with the initiation of this public assistance, tally the family's income and assets, secure the entire estate with a binding legal encumbrance, and subtract the government-sponsored contributions from the ledger every month. Whatever the family is able and chooses to contribute toward the cost of care is not subtracted from the ledger. Everything the government or its agent contributes plus interest depletes their estate and is recovered upon the death of the last surviving exempt dependent relative. If the ledger is depleted entirely, then the family is completely destitute and eligible for a newly reformed and financially reinvigorated Medicaid program, i.e., welfare.

This approach, call it *LTC Choice*, has many advantages over the current situation. Middle-class seniors regain their dignity: it is not welfare if you pay it back. Vulnerable elderly people get red-carpet access to top-quality care: there is never a shortage of preferred long-term care beds or services for full-paying customers. Consumers return to the market place: someone else may pay the monthly bill, but it all comes out of the family's estate in the long run, so buyers will be wary of price and quality. Providers receive the full market price for their services: home care companies, assisted living facilities, nursing homes, and even hitherto unforeseen purveyors of housing and care will compete avidly to offer the best possible services for the lowest possible fee. Government and the taxpayers save money: the only up front cost, which is

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

more than compensated by savings in the old Medicaid colossus, is a loan guarantee program to attract private lenders to fund the fully collateralized system.

The biggest advantage to *LTC Choice*, however, is the change in consumer behavior it will engender. Families will know with strict certainty that they cannot ignore the substantial risk of long-term care. The choices will become stark for 40- and 50-year-olds. Plan now and buy insurance while you are young and healthy and good coverage is inexpensive. Or, take your chances, hope for the best, accept a dollar for dollar loss to your estate if you ever have to rely on the public program, and explicitly assume the risk that you may ultimately lose everything, including your home equity, and become dependent on welfare.

Confronted with genuine risk like this, more people will choose to insure privately than in the past. Fortunately, good insurance policies that cover home care, assisted living, and nursing-home care are already easily available and affordable to most non-elderly people. Those who cannot afford coverage, such as many older people, may seek private home equity conversion to generate a sufficient cash flow to pay their premiums. Heirs, especially adult children who will stand to lose their inheritances entirely otherwise, are likely to encourage their elders to purchase insurance coverage and may also help to pay the premiums. Instead of rewarding people for ignoring the risk, avoiding the premiums, and taking advantage of the public dole as the current system does, this approach rewards responsibility and exacts a gradual and predictable penalty for irresponsibility.¹⁰

¹⁰ One sure way to derail the privatization of long-term care financing and destroy its promise is to make publicly-financed long-term care even more attractive to consumers than it already is. The damage done by easily accessible Medicaid nursing-home benefits has been mitigated by the fact that most people do not want to go to nursing homes. If grand plans now under discussion to pool Medicaid and Medicare monies and provide home- and community-based services for dual eligibles are implemented without a strongly enforced means test and mandatory estate recovery, dire consequences will follow. Expanded public financing for more desirable kinds of care will not merely exacerbate the "woodwork factor" of induced demand as

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

Obviously, for *LTC Choice* to succeed, it cannot be abused and manipulated as Medicaid has been. We will have to assure that the public understands the high probability of needing long-term care and that individuals and families, not the government, are primarily responsible for this huge potential expense. Therefore, before they are too old, frail or sick to save or insure for their own protection, the federal government should deliver comprehensive information on long-term care to aging Americans and require them to make a tough choice about how they intend to protect themselves from this risk. The tough choice is whether or not they will insure privately or rely on the *LTC Choice* program. If they insure privately, or earmark sufficient assets permanently for long-term care, their problem is solved. If they choose to rely on the government-backed *LTC Choice* program, they must report annually on their income and assets in order to secure their estates as collateral and to eliminate the problem of artificial self-im impoverishment which has plagued the Medicaid program. Of course, every American will always be free to dispose of personal wealth as he or she sees fit. The *LTC Choice* program merely requires that no one who expects to receive public assistance in the future may spend, divest, divert or shelter wealth that could have been used to pay for long-term care.

The best time to present these hard realities of long-term care to the public is as early as possible, but no later than when they sign up for Social Security and Medicare. At this time of life, seniors and their families are most sensitive to the financial and health security challenges of aging. Most of them remain relatively secure financially and insurable. When it sends

other writers have warned, it will make Medicaid estate planning more attractive to consumers and more lucrative to elder law practitioners. It will inhibit the market for privately-financed chore services, home care, assisted living, and geriatric care management. And it will decimate demand for private long-term care insurance. Public benefits have always been and will always remain starved for financing. Our only hope to achieve a fully financed, universally available, comprehensive long-term care service delivery system is to draw as heavily as possible on private financing and depend on public resources only to cover the interstices of need left unfilled by the private market.

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

information on Medicare and Social Security to aging Americans, the federal government should also provide advice and guidance on the risks and costs of long-term care, on low-cost home- and community-based services options, on home equity conversion, on private long-term care insurance and on the *LTC Choice* alternative once it is enacted.

LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle

Conclusion

Do we have the courage of our convictions?

Long-term care for a rapidly aging population presents an enormous challenge to the United States. Our country must meet this challenge while simultaneously confronting similar strains on Social Security and Medicare. To preserve our prosperity and protect our elderly, we will need to reassert the traditional values of freedom, independence, and individual responsibility that brought economic greatness to America in the first place. A simple public policy, with which most of our countrymen will agree, would suffice to achieve this goal if unstintingly observed:

We have very limited dollars available for public assistance. We must take care of the truly poor and disadvantaged first. The middle class and well-to-do should pay privately for long-term care to the extent they are able without suffering financial devastation. Prosperous people who rely on public assistance for long-term care should reimburse the taxpayers before giving away their wealth to heirs. Seniors and their heirs who wish to avoid such recovery from their estates should plan ahead, purchase private long-term care insurance, and pay privately for the care of their choice when the time comes.

LTC Choice is a viable, simple, and cost-free means to implement this policy and solve the long-term care financing puzzle once and for all. We need only the vision to see the way, the courage to embrace the change, and the will to follow the course.

Stephen A. Moses

Biographical Profile



Stephen Moses is President of the Center for Long-Term Care Financing in Seattle, Washington. The Center promotes universal access to top-quality long-term care by encouraging private financing and discouraging welfare financing of long-term care for most Americans. Previously, Mr. Moses was Director of Research for LTC, Inc., a Medicaid state representative for the Health Care Financing Administration and a senior analyst for the Inspector General of the U.S. Department of Health and Human Services.

Mr. Moses is widely recognized as an expert and an innovator in the field of long-term care. *McKnight's Long-Term Care NEWS* named him "one of the 100 most influential people in long-term care." *Nursing Homes* magazine reported "there is probably no more articulate spokesperson for privately financed long-term care than Stephen Moses."

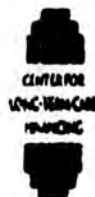
Steve Moses has directed numerous national studies for the federal government, state governments, and private organizations on Medicaid nursing home eligibility, asset transfers, estate recoveries and private long-term care financing. He specializes in problems associated with "Medicaid estate planning," i.e., the practice of artificially impoverishing affluent people to qualify them for public assistance.

Moses is credited with having "forged the framework" for the Omnibus Budget Reconciliation Act of 1993, which attempted to bring Medicaid eligibility loopholes under control. He helps state Medicaid programs curtail Medicaid estate planning and encourage private insurance as an alternative to public welfare financing of long-term care for the middle class.

Mr. Moses' articles appear often in distinguished publications like *The Gerontologist*, *The Journal of Accountancy*, *Contemporary Long-Term Care*, *Best's Review*, *National Underwriter* and *LTC News & Comment*. He is the author of "Health and Long-Term Care Insurance," a chapter in Clark Boardman Callaghan's legal treatise, *Advising the Elderly Client*. He has testified before half of America's state legislatures and he frequently addresses professional conferences in the fields of law, aging and insurance.

Steve Moses' recommendations are quoted regularly in the national media including the "CBS Evening News," PBS's "Frontline" and "The Financial Advisors," CNN, *The New York Times*, *Newsweek*, *USA Today*, *Forbes*, *The New Republic*, *Smart Money*, *National Journal*, and Jane Bryant Quinn's syndicated column. He appears in a public television documentary entitled "The Aging of America: The Dilemma of Long-Term Care." His talk radio appearances on health care reform are unique, provocative, and are increasingly in demand.

Mr. Moses' latest project was to write a chapter for a new anthology entitled *Toward Healthy Aging*, edited by best-selling author Ken Dychtwald of *Age Wave* renown.



Center for Long-Term Care Financing 800 5th Avenue Suite 4100 Seattle, WA 98104
Phone (206) 447-1340 Fax (206) 447-1341 E-mail: smoses@nwlink.com

David M. Rosenfeld

Biographical Profile



David Rosenfeld is Vice President and Chief Counsel for the Center for Long-Term Care Financing. The Center promotes universal access to top-quality long-term care by encouraging private financing and discouraging welfare financing of long-term care for most Americans. Mr. Rosenfeld publishes and speaks throughout the United States on public versus private financing of long-term care and related issues.

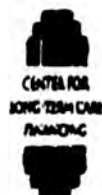
Mr. Rosenfeld recently presented "*Medicaid Estate Planning: Moral Relativity and the Shell Game*" at several national conferences and debated a nationally recognized Medicaid planning attorney. He is authoring a provocative article on protecting seniors from financial abuse in a prominent academic journal.

He has published or been quoted in *Kiplinger's Personal Finance Magazine*, *LTC News & Comment*, *Bureau of National Affairs Health Care Fraud Report*, *American Bar Association Journal*, and others.

Mr. Rosenfeld is a graduate of Case Western Reserve University School of Law (JD) and CWRU's Mandel School of Applied Social Sciences (MSW). He co-founded the Center for Long-Term Care Financing after serving as the Counsel for Public Policy with LTC, Incorporated. Previously, Mr. Rosenfeld practiced law with two Seattle firms where he specialized in insurance defense litigation, and clerked for United States District Court Judge Paul R. Matia and Ohio Attorney General Lee Fisher. His experience also includes a tenure with the United States Senate Judiciary Committee.

Mr. Rosenfeld's educational and professional background has enhanced his ability to build meaningful relationships with key constituencies in the long-term care community. He has developed an innovative interdisciplinary learning program called "*All-Aboard*" to bring together senior service professionals for the benefit of mutual clients.

Mr. Rosenfeld is a member of the American Bar Association's Center for Professional Responsibility, the ABA's Ethics 2000 Advisory Council, and several state and local professional associations.



Center for Long-Term Care Financing 800 5th Avenue Suite 4100 Seattle, WA 98104-3122
Phone: (206) 447-1340 Fax: (206) 447-1341 E-Mail: DMR@LTC@aol.com

ADOPTED BY EXECUTIVE (EX) COMMITTEE MARCH 18, 1997
TO BE CONSIDERED BY THE NAIC PLENARY IN JUNE, 1997

**1997 INSERT TO THE NAIC
SHOPPER'S GUIDE TO LONG-TERM CARE INSURANCE**

**NEW TAX CHANGES AFFECTING LONG-TERM CARE
INSURANCE PREMIUMS AND BENEFITS**

Congress passed a new law in 1996 called the Health Insurance Portability and Accountability Act. Starting in the 1997 tax year, this law may let you deduct all or part of the premium for a long-term care (LTC) insurance policy. Your LTC premium can be added to your other deductible medical expenses. To claim a tax deduction, all of your medical expenses must be more than 7.5% of your adjusted gross income.

Not all long-term care contracts are tax qualified. Policies must meet certain federal standards before you can deduct the premium. These policies are called *tax qualified* or *qualified long-term care insurance contracts*. Benefits you receive from a qualified LTC policy are generally not taxable as income. Benefits received from a policy that is not a qualified LTC policy may be taxable as income.

The Health Insurance Portability and Accountability Act makes changes to the Internal Revenue Code. The Department of Treasury is responsible for developing regulations giving direction as to how the law should be applied. **These regulations have not yet been completed. It is important to understand that uncertainty exists.** Companies will use their own interpretation of some policy provisions (such as when benefits are triggered) until the Department of the Treasury issues regulations.

How will I know if the premium for my long-term care insurance policy qualifies for a tax deduction?

- LTC policies issued before January 1, 1997 are automatically qualified.
- LTC policies issued on or after January 1, 1997 must be qualified (meet federal standards) before you can deduct the premium. These standards are discussed below.

The maximum amount you can add to your other deductible medical expenses is based on your age at the end of each tax year.

Age	Limit on Deduction
40 years old or less	\$200
41 to 50 years old	\$375
51 to 60 years old	\$750
61 to 70 years old	\$2000
71 years old or older	\$2500

*See your personal tax advisor for information
On how these changes could affect you.*

LTC Insurance for Retirees

CHAIR
HOUSE HEALTH, EDUCATION
& SOCIAL SERVICES COMMITTEE

VICE-CHAIR
HOUSE JUDICIARY COMMITTEE

MEMBER
LEGISLATIVE BUDGET & AUDIT COMMITTEE
HOUSE SPECIAL COMMITTEE ON OIL & GAS
SELECT COMMITTEE ON LEGISLATIVE ETHICS

Alaska State Legislature



REPRESENTATIVE CON BUNDE

District 18

DURING SESSION
STATE CAPITOL, ROOM 104
JUNEAU, AK 99801-1182
(907) 465-4843 (800) 882-4843

DURING INTERIM
718 W. FOURTH AVE.
ANCHORAGE, AK 99501-8189
(907) 258-8188

E-MAIL

Representative_Con_Bunde@legis.state.ak.us

October 15, 1998

Mr. Dennis Murray
Heritage Place
232 Rockwell
Soldotna, AK 99669

Dear Mr. Murray;

Sheila Peterson of Sen. Gary Wilken's office asked me to gather some information for you about the long-term care (LTC) insurance program offered to retirees from the state of Alaska's.

I spoke with Lisa Tourtellot, Benefits Supervisor, Alaska Department of Administration, Division of Retirement and Benefits (907) 465-4460, and hope the information she shared with me will provide answers to questions about the plan.

First off, the specific provisions of the program (enrollment, premiums, covered expenses etc.) are outlined on the attached pages from the state Retiree Group Insurance Information Booklet from May, 1998).

The LTC policy is relatively popular with Alaska retirees, about 50 percent of whom take advantage of their single opportunity to enroll upon retirement. Of the 18,839 state retirees covered by medical insurance as of June, 1998, 8,309 had signed up for LTC insurance. Almost half of those, or 3,479, had also enrolled their spouses.

By way of background, Alaska began offering LTC insurance to retirees (PERS, STERS, elected officials, judicial employees) in 1987. At this time, Alaska was one of first public entities to offer such insurance, and it was a popular option. Some retirees were denied enrollment in first year because they did not meet certain health standards, while others declined to enroll because of the cost.

In the years since, many other such insurance plans have become available, and Alaska's may no longer be the best deal. Accordingly, the Retirement Board is considering a major overhaul over the next six months, including raising the benefit level (currently \$125 per day for services received inside Alaska, and \$75 per day for services Outside.)

Dennis Murray
October 15, 1998
Page 2

Benefit levels notwithstanding, Alaska's LTC insurance comes fairly close to meeting informal national standards. One difference is that Alaska's policy includes home assistance, while most other plans sell it as a separate rider.

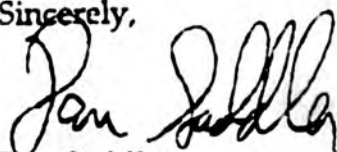
Premiums are based on age of retiree at retirement, and do not rise with age.

<55 years old \$16.10/month
>85 years old \$412/month
most average \$21-55/month.

I have not yet received an answer on the question of how much the state pays out in services compared to how much it receives in premiums, but expect to hear back from Ms. Tourtellot soon.

I hope this information is helpful, though I am afraid it may be a little short on answers to some deeper policy questions you may be seeking to answer. Please contact me if I can be of any further assistance.

Sincerely,



Dan Saddler
Staff to Representative Con Bunde

Enc. Retiree Group Insurance Information pages

LONG-TERM CARE PLAN HIGHLIGHTS

- Requires a deductible period of 90 days of covered long-term care before benefits begin.
- Pays for covered expenses after the deductible period up to a lifetime maximum benefit of \$200,000.
- Pays a maximum daily benefit for a nursing care facility of \$125 within Alaska and \$75 outside Alaska, after the deductible period.
- Pays a maximum daily benefit for a home convalescent care facility of \$75 within Alaska and \$40 outside Alaska, after the deductible period, up to a lifetime maximum of \$50,000.

COVERED LONG-TERM CARE EXPENSES

Benefits are available for covered expenses for conditions that require long-term care.

Covered expenses are those expenses incurred for medically necessary care received in connection with a Covered Program of Care (see page 76) when:

- initial certification by the facility or individual responsible for the supervision of nursing or other services and the attending physician confirms the need for services as prescribed and specified as appropriate in the Covered Program of Care; and

- recertification requests confirm the ongoing need for services as prescribed and specified in the Covered Program of Care.

Long-term care benefits are available for medically necessary services and supplies which, as determined by the claims administrator, are needed to diagnose, care for, or treat a physical or medical long-term care condition. Care is considered medically necessary when it involves:

- skilled or intermediate nursing care, or
- home convalescent care,

AND it provides:

- nursing services,
- nursing supervision,
- occupational therapy services,
- physical therapy services, or
- speech therapy services.

Services must be appropriate and essential for the treatment or maintenance of the disease or injury or for essential personal care services that are necessary as a result of a covered disease or injury. "Essential personal care services" means the physical dependence of an individual who requires continual human assistance in at least two of the following activities of daily living: eating, dressing, toileting, transferring, and walking. Long-term care provides coverage for custodial care when it is received in connection with a Covered Program of Care. The benefit amount is based on where services are received.

The patient's attending physician must order the needed care. The care received must not be at the insistence of, or for the convenience of, the patient or the patient's family.

A physician is a person who is licensed to practice medicine (M.D.) in the state where services are rendered and is practicing within the scope of that license.

HOW LONG-TERM CARE BENEFITS ARE PAID

Benefit Period

A benefit period begins on the first day of a Covered Program of Care and ends 30 days after the Covered Program of Care is no longer necessary.

Deductible

You must first meet the deductible period of 90 days of covered long-term care. Only one deductible period applies during any one benefit period. At the end of any benefit period, any subsequent Covered Program of Care will be subject to the deductible period before any benefits are paid.

Coinsurance

After you meet the deductible, the Plan pays 100% of the usual, customary and reasonable charges for covered long-term care services. See specific daily maximums in the Nursing Care Facility and Home Convalescent Care Facility sections that follow.

Usual, Customary and Reasonable Charges

Payment is based on usual, customary and reasonable charges (see pages 8-9) for covered services. Charges or fees in excess of usual, customary and reasonable, as determined by the claims administrator, are your responsibility to pay.

Lifetime Maximum Benefit

The maximum lifetime benefit for each person for all covered long-term care expenses is \$200,000.

Covered Program of Care

A Covered Program of Care is a written program of care that an attending physician prescribes for medically necessary care and treatment in a nursing care facility or a home convalescent unit. This treatment must include one or more of the following services:

- registered nursing;
- licensed practical nursing;
- home health aides (provided through a home health care agency);
- physical therapy;
- occupational therapy; or
- speech therapy.

The claims administrator determines whether the Covered Program of Care is the most appropriate course of action. This determination will be made after receiving evidence furnished by your doctor.

Pre-existing Conditions Limitation

No benefits are payable for any care provided or begun during the first 12 months of coverage which is as a result of a pre-existing condition. Pre-existing conditions are conditions for which you received diagnosis, tests, or treatment (including

taking medication) during the three consecutive months before the most recent day you became covered under this plan.

Nursing Care Facility Benefits

If you or your covered spouse incurs covered expenses for skilled or intermediate nursing care while confined in a nursing care facility, the Plan will pay a benefit for each day of care after the deductible period (90 days).

Maximum Daily Benefit

The maximum daily benefit for a nursing care facility is \$125 within Alaska, and \$75 outside Alaska. The Plan will pay an amount equal to the lesser of the usual, reasonable, and customary charges for the covered expenses or the maximum daily benefit.

Facility Definition

A nursing care facility is an institution or part of an institution that:

- is licensed to provide inpatient care for persons convalescing from injury or disease, skilled nursing care or intermediate nursing care by an R.N. or L.P.N. under the direction of an R.N.; or physical restoration services to help patients reach a degree of bodily functioning that permits self-care in essential daily living activities;
- provides services for its patients and under the full-time supervision of a physician or R.N.;
- provides nursing services by licensed nurses (seven days a week on the day shift), under the direction of a full-time R.N.;

- maintains a complete medical record on each patient;
- has an effective utilization review plan;
- is not, other than incidentally, a place for rest, custodial or educational care or care of the aged, or a place for care of people with mental disorders, chemical dependency, or mental retardation.

Excluded Nursing Care Facility Benefits

No benefits are payable for:

- expenses or services which are covered under the group health plan; or
- the cost of food or preparation of meals if separate from the cost of the room

Home Convalescent Care Benefits

If you or your covered spouse incurs covered expenses for home convalescent care while confined in a home convalescent unit, the plan will pay a benefit for each day of care after the deductible period (90 days).

Maximum Daily Benefit

The maximum daily benefit for a home convalescent unit is \$75 within Alaska, and \$40 outside Alaska. The Plan will pay a benefit equal to the lesser of the usual, reasonable and customary charge for the covered expenses or the maximum daily benefit.

Lifetime Maximum Benefit

The maximum lifetime benefit for home convalescent care for each covered person is \$50,000.

Definitions

Home convalescent care must be:

- provided through a home health care agency and performed by a registered graduate nurse (R.N.), licensed practical nurse (L.P.N.), or home health aide; or
- performed in an adult day care center, or
- performed by a licensed, certified, or registered occupational therapist, speech therapist, or physical therapist.

A home convalescent unit is:

- your home or any other private home;
- a home for the retired or the aged;
- an institution which provides residential care; or
- an adult day care center.

It is not a hospital, sanitarium, or nursing care facility.

A home health care agency is an agency or organization that meets all the following requirements:

- It is mainly engaged in and, if required, is licensed to provide skilled nursing services and other therapeutic services.
- It has policies set up by a professional group associated with it. This group must have a physician and at least one R.N. to govern the services provided.
- It keeps a complete medical record on each patient.
- It has a full-time administrator.

An adult day care center is an organization that provides a program of adult day care that meets all the following requirements:

- It is established and operated as an adult day care center in accordance with any applicable laws.
- Its staff includes:
 - a full-time director;
 - one or more R.N.s in attendance during operating hours for at least four hours a day;
 - enough full-time staff members to maintain a client-to-staff ratio of eight to one or better;
 - a dietician;
 - a licensed physical therapist; and
 - a licensed speech therapist.
- It operates at least five days a week for a daily minimum of six hours and a daily maximum of twelve hours.
- It maintains a written record of medical services given to each client.
- It has established procedures for obtaining appropriate aid if a medical emergency occurs.

Excluded Home Convalescent Care Benefits

No benefits are payable for:

- expenses or services which are covered under the group health plan; or
- the cost of food or preparation of meals.

Skilled Nursing Care

Skilled nursing care is care furnished under a physician's orders which:

- requires the skills of technical or professional personnel; and
- is provided daily (five days a week for restoration services) either directly by or under the supervision of licensed, certified medical professionals. Care must be part of a Covered Program of Care.

Intermediate Nursing Care

Intermediate nursing care is care furnished under a physician's orders which combines a medically oriented program of simple treatment plans under the supervision of licensed, certified, or registered medical professionals, with emphasis on:

- physical activity;
- intellectual stimulation; and
- social motivation.

LONG-TERM CARE EXPENSES NOT COVERED

Limitations and Exclusions

The following services are not covered and no benefits are payable:

- A covered program of care which starts within 12 months after a person's effective date and is caused by a

pre-existing condition. Any condition which was diagnosed or treated within the 90-day period before the individual's effective date is considered a pre-existing condition.

- A loss caused by declared or undeclared war or any such act.
- A loss caused by mental disease or disorder without demonstrative organic disease, excluding Alzheimers.
- A loss caused by a suicide attempt or an intentionally self-inflicted injury.
- A confinement in a government institution, unless an individual is legally obligated to pay a charge.
- Services received or expenses incurred on any day that an individual is confined to a hospital.
- Services or expenses which are covered by a State of Alaska group medical plan.
- Services received or expenses incurred outside the United States.
- Services provided by a person who usually resides in the covered individual's home or is a member of the covered individual's family, or when the person performing the service normally does not charge for the service.
- Services received for which the covered individual is not legally obligated to pay.
- Services received which are covered under Medicare.
- Services received that are not medically necessary.
- Services received that the claims administrator determines are not usual, reasonable and customary.

LONG-TERM CARE GENERAL PROVISIONS

In addition to the general provisions described on page 85, the following provisions apply to the Long-Term Care Plan.

This Plan covers only losses resulting from nonoccupational, accidental bodily injuries and nonoccupational diseases.

Nonoccupational Disease

A disease is considered nonoccupational only if it does not arise out of any work for pay or profit and does not result from any work-related disease. However, if a covered individual provides proof to the claims administrator that a person covered under workers' compensation (or other similar laws) is not covered for a particular disease under that law, that disease will be considered nonoccupational, regardless of its cause.

Nonoccupational Injury

An injury is nonoccupational only if it is an accidental bodily injury. It cannot arise out of or in the course of any work for pay or profit or in any way result from an injury that does. However, if a covered individual provides proof to the claims administrator that a person covered under workers' compensation (or other similar laws) is not covered for a particular disease under that law, that injury will be considered nonoccupational, regardless of its cause.

Lifetime Maximum Benefit

No more than \$200,000—the lifetime maximum benefit—will be payable during the lifetime of any individual.

Benefits After Coverage Termination

If coverage terminates because the group policy is discontinued, the Plan will continue to provide benefits for individuals who are under a Covered Program of Care on the date of the discontinuance. This coverage will continue only until the earlier of:

- the date the individual is no longer under a continuous and uninterrupted Covered Program of Care;
- the date of an individual's death; or
- the date that any applicable maximum is exhausted.

Applicable Law and Venue

This policy, issued and delivered in the State of Alaska, is governed by the laws of the State of Alaska. Any and all suits or legal proceedings of any kind that are brought against the State must be filed in the First Judicial District, Juneau, Alaska, within three years from the deadline for filing a claim.

The claims administrator will not attempt to reduce or deny a benefit payable for loss on the grounds that a disease or condition existed before coverage became effective if the loss occurs more than two years from the date coverage began. This provision will not apply to conditions specifically named as excluded from coverage on the date of the loss.

Right of Examination

The claims administrator has the right and opportunity to examine, at its own expense, an individual who is the basis of any claim as often as it may reasonably require during the pending claim, or while benefits are being paid.

Other Provisions

The following additional provisions apply to your coverage:

- You cannot receive multiple coverage under this Plan. Spouses insured as retirees cannot be eligible dependents.
- If, under this Plan, a misstatement of facts affecting your coverage occurs, the actual facts will be used to determine the coverage in force.

State of Alaska Retiree

Long Term Care Plan

Covers care which is medically necessary to diagnose or treat a long term care condition or to provide at least two essential personal care services such as eating, dressing, transferring, and walking.

Deductible	90 days of covered services
Lifetime Maximum	\$200,000 per person
Coinsurance	100% up to daily maximums
Nursing Home Daily Maximum	\$125 in Alaska/ \$75 outside Alaska
Home Convalescent Care Daily Maximum	\$75 in Alaska/\$40 outside Alaska
Home Convalescent Care Lifetime Maximum	\$50,000 per person
Pre-existing Conditions Limitation	Nothing paid for services started in first 12 months of coverage due to pre-existing condition
Coordination of Benefits	Does not coordinate with other plans
Premiums	Based on age at enrollment

Age at enrollment	Monthly Premiums
Under 50	\$ 16.10
50-54	\$ 21.45
55-59	\$ 26.80
60-64	\$ 48.25
65-69	\$ 80.45
70-74	\$128.70
75-79	\$193.05
80-84	\$294.95
85 & over	\$412.90

This is just a brief summary - full details are included in the Retiree Group Insurance Information Booklet.

Comments

ALASKA STATE LEGISLATURE



REPRESENTATIVE ALLEN KEMPLER

October 8, 1998

TO: Senator Gary Wilken
Rep. Con Bunde
Long Term Care Task Force

FM: Rep. Allen Kempler *AKC*

RE: Gero-Psychiatric Specialist

Gary and Con,

Recently I met a gero-psychiatric specialist who discussed how useful this type of expert could be within our senior services systems. This specialist could help keep elders out of hospitals and help reduce medication costs through better diagnoses. Keeping elders in the least expensive, least restrictive environments as long as possible with a focus on prevention would be one goal for such a position.

I would propose that the Task Force consider such a specialist as one way to help with long term care.

If I can provide more information, please let me know.

SESSION
STATE CAPITOL
JUNEAU, ALASKA 99801-1182
(907) 465-2435
(907) 465-6615 FAX
1-800-550-2435

INTERIM
716 W. 4TH AVENUE
ANCHORAGE, ALASKA 99501
(907) 258-8190

Comment Card



Long-Term Care Task Force Alaska State Legislature

A 12-member task force of legislators, state officials and private citizens recently began the task of reviewing Alaska's system of providing long-term care.

This review process is the first step in developing an equitable plan for providing long-term care for all Alaskans. By filling out this comment card, your input on this important topic will be provided to the Alaska State Legislature.

If you require more time or more space to make your comments, you are welcome to send them directly to Senator Gary Wilken, LTC Task Force Co-chairman, at the address provided on the other side of this card.

Name: Liz Lucas

Address: 2880 Fritz Cove Rd.
Juneau, AK. 99801

Please provide your comments on:

- how to improve current long-term care services;
- possible funding options for long-term care;
- projected future care demands and how to address the need;
- other issues relating to long-term care services.
- Easy access to various health agencies in community. "One stop shopping." One call gives them the help they need. There should be a follow-up call to see if they are satisfied.
- Quality care and reasonable cost is imperative.
- Large emphasis on prevention! Across state, in communities, legislature. Stress savings.
- Encourage geriatric training for nurses and all levels of home and health care providers.

Print in available spaces concerning health care.

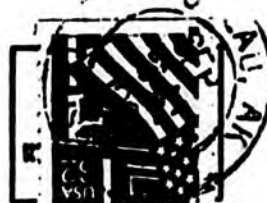
There is a Tribal work experience in Barrow (Contact Margaret Glastetter) that intrigued me. If a patient is confined to the house, a person is hired to take care of this person. The tribe pays \$7 - the family pays \$7 - total, \$14 per hr. Shared economic load. Could this concept be carried out in other places across the state?

WIC program - could it be modified to meet the needs of seniors?

Please fold on dotted line, tape the Comment Card closed and mail.

Thank you for participating in the review of Long-Term Care services.

Senator Gary Wilken, Co-chairman
Long-Term Care Task Force
State Capitol Building, Room 510
Juneau, AK 99801-1182



Elizabeth E. Lucas
2880 Fritz Cove Rd
Juneau, AK 99801

Comment Card



Long-Term Care Task Force Alaska State Legislature

A 12-member task force of legislators, state officials and private citizens recently began the task of reviewing Alaska's system of providing long-term care.

This review process is the first step in developing an equitable plan for providing long-term care for all Alaskans. By filling out this comment card, your input on this important topic will be provided to the Alaska State Legislature.

If you require more time or more space to make your comments, you are welcome to send them directly to Senator Gary Wilken, LTC Task Force Co-chairman, at the address provided on the other side of this card.

Name: Frances Purdy
Address: 3601 C #260
Anchorage AK 99503

Please provide your comments on:

- how to improve current long-term care services;
- possible funding options for long-term care;
- projected future care demands and how to address the need;
- other issues relating to long-term care services.

Develop long term care ombudsman/advocate
for persons under 65 years of age who use or
need long term care services

Increase & consolidate advocacy/oversight and
ombudsman services (mental health advocate,
substance abuse services advocate, mental health
trust beneficiary complaint resolution, long term
care ombudsman, citizen's foster care review
Extend Medicaid to care services for Alzheimer's
care

Move assisted living home licensing out of Division of
Seniors and Division of Mental Health/Developmental
Disability to work with Nursing Home Licensing

Place stamp here.
The Post Office will
not deliver mail
without proper
postage.

Senator Gary Wilken, Co-chairman
Long-Term Care Task Force
State Capitol Building, Room 510
Juneau, AK 99801-1182

Thank you for participating in the review of Long-Term Care services.

Please fold on dotted line, tape the Comment Card closed and mail.
Certification of Hospice, Home Health - perhaps
moving this group out of Division of Medical
Assistance or leaving it there & just
consolidating the functions of licensing &
certification.

Comment Card



Long-Term Care Task Force Alaska State Legislature

A 12-member task force of legislators, state officials and private citizens recently began the task of reviewing Alaska's system of providing long-term care.

This review process is the first step in developing an equitable plan for providing long-term care for all Alaskans. By filling out this comment card, your input on this important topic will be provided to the Alaska State Legislature.

If you require more time or more space to make your comments, you are welcome to send them directly to Senator Gary Wilken, LTC Task Force Co-chairman, at the address provided on the other side of this card.

Name: Pat Dooley
Address: 8011 Wistaria Street
Anchorage, Alaska 99502

Please provide your comments on:

- how to improve current long-term care services;
- possible funding options for long-term care;
- projected future care demands and how to address the need;
- other issues relating to long-term care services.

- Identify gaps in services
(from senior point of view)
- partner with private sector
to provide services & "stretch"
dollars
- tailor services to the community
being served
- look at quality of life issues -
finding for Podiatry, glasses, hearing
aiders, glasses, respite care, mental
health services
- consider consolidated funding -
current process fragmented & confusing -

this fragmentation decreases access.

Fund senior centers and
mobile senior service vans or
programs - in a village for example
come 1x/month & podiatry, optometry,
audiologist, mental health services, education
& support groups, health screening such
as mammograms, PSA, immunizations

Fund multiple levels of dementia
care - Day care programs, respite care
support & education of caregivers

Regulation of all paid caregivers
Not just CNAs, but all PCTs, PCAs, NAs &

Please fold on dotted line, tape the Comment Card closed and mail. ^{care} coordinator

Thank you for participating in the review of Long-Term Care services.

Senator Gary Wilken, Co-chairman
Long-Term Care Task Force
State Capitol Building, Room 510
Juneau, AK 99801-1182

Place stamp here.
The Post Office will
not deliver mail
without proper
postage.

Comment Card



Long-Term Care Task Force Alaska State Legislature

A 12-member task force of legislators, state officials and private citizens recently began the task of reviewing Alaska's system of providing long-term care.

This review process is the first step in developing an equitable plan for providing long-term care for all Alaskans. By filling out this comment card, your input on this important topic will be provided to the Alaska State Legislature.

If you require more time or more space to make your comments, you are welcome to send them directly to Senator Gary Wilken, LTC Task Force Co-chairman, at the address provided on the other side of this card.

Name: Sandy Murray
Address: PO Box 237
Seldovia AK, 99663

Please provide your comments on:

- how to improve current long-term care services;
- possible funding options for long-term care;
- projected future care demands and how to address the need;
- other issues relating to long-term care services.

- More qualified caregivers are needed. These are very special people.
- Make it available to all in need of it somehow.
- Fund with money from savings of phase out of longevity bonus. Also use these funds to fund insurance coverage for all Alaskans.
- Use preventive practice to hopefully decrease long term care clients.
- As Alaskans age more seniors will need long term care eventually
- need to plan ahead

The main thrust should be to keep Alaskans healthy longer thru preventing good mental attitudes, good nutrition, exercise and general well being. Education is important. Keep the minds and bodies alert & active. Good senior programs, funding and care givers are essential. Research into dementia and other diseases. The money spent will pay off in the long term. I think.

Please fold on dotted line, tape the Comment Card closed and mail.

Thank you for participating in the review of Long-Term Care services.

Senator Gary Wilken, Co-chairman
Long-Term Care Task Force
State Capitol Building, Room 510
Juneau, AK 99801-1182

Place stamp here.
The Post Office will
not deliver mail
without proper
postage.

Comment Card



Long-Term Care Task Force Alaska State Legislature

A 12-member task force of legislators, state officials and private citizens recently began the task of reviewing Alaska's system of providing long-term care.

This review process is the first step in developing an equitable plan for providing long-term care for all Alaskans. By filling out this comment card, your input on this important topic will be provided to the Alaska State Legislature.

If you require more time or more space to make your comments, you are welcome to send them directly to Senator Gary Wilken, LTC Task Force Co-chairman, at the address provided on the other side of this card.

Name:

Sue Sanet

Address:

Providence Horizon House
4140 Father St A/A 99508 261-4140

Please provide your comments on:

- how to improve current long-term care services;
- possible funding options for long-term care;
- projected future care demands and how to address the need;
- other issues relating to long-term care services.

Review funding sources for assisted living - low-income via choice program have more access to assisted living.

Look at end of life services - not everyone can have hospice in home but don't need to be in an institution - nursing home/hospital sponsor hospice houses through public/private funding

Review how Balanced Budget Act is harming the fine home health services that are offered in Alaska

Review the four years the Medicaid waiver program has been in existence what's working - what's not -

What are the housing challenges for - chronic alcoholic, chronically mentally ill, middle & upper income elderly, middle age disabled who don't qualify for present senior housing folks

- Quality Assurance for all adult programs instead of reacting to complaints
Develop a 20 year Plan!! - Thank you

Please fold on dotted line, tape the Comment Card closed and mail.

Thank you for participating in the review of Long-Term Care services.

Senator Gary Wilken, Co-chairman
Long-Term Care Task Force
State Capitol Building, Room 510
Juneau, AK 99801-1182

Place stamp here.
The Post Office will
not deliver mail
without proper
postage.

Comment Card



Long-Term Care Task Force Alaska State Legislature

A 12-member task force of legislators, state officials and private citizens recently began the task of reviewing Alaska's system of providing long-term care.

This review process is the first step in developing an equitable plan for providing long-term care for all Alaskans. By filling out this comment card, your input on this important topic will be provided to the Alaska State Legislature.

If you require more time or more space to make your comments, you are welcome to send them directly to Senator Gary Wilken, LTC Task Force Co-chairman, at the address provided on the other side of this card.

Name: DANIEL K. KARMUN

Address: P.O. Box 819

NOME, AK 99762

Please provide your comments on:

- how to improve current long-term care services;
- possible funding options for long-term care;
- projected future care demands and how to address the need;
- other issues relating to long-term care services.

CONTINUED DELIBERATIONS FOR REMEDIES

PARTNERSHIP WITH FUNDING SOURCES

DELIBERATIONS ON FUTURE TO BE HEERED

KEEP ON TOP OF ISSUES

Comment Card



Long-Term Care Task Force Alaska State Legislature

A 12-member task force of legislators, state officials and private citizens recently began the task of reviewing Alaska's system of providing long-term care.

This review process is the first step in developing an equitable plan for providing long-term care for all Alaskans. By filling out this comment card, your input on this important topic will be provided to the Alaska State Legislature.

If you require more time or more space to make your comments, you are welcome to send them directly to Senator Gary Wilken, LTC Task Force Co-chairman, at the address provided on the other side of this card.

Name: DON HOOVER

Address: 1029 Kodiak St. FAIRBANKS, AK 99709

Please provide your comments on:

- 1 • how to improve current long-term care services;
- 2 • possible funding options for long-term care;
- 3 • projected future care demands and how to address the need;
- other issues relating to long-term care services.

① Increased regulation standardization of nursing and assisted living facilities operation

② For those over age 60 - an automatic deduction from their Alaska State Dividend to help with their probable co-pay needs for Long Term Care insurance, or as seed money for coverage.

③ Promote general education on the rapid growth of senior needs + population. The older - the probable more need for long term care.

④ Make Alzheimer's eligible for Medicaid in Alaska

Comment Card



Long-Term Care Task Force Alaska State Legislature

A 12-member task force of legislators, state officials and private citizens recently began the task of reviewing Alaska's system of providing long-term care.

This review process is the first step in developing an equitable plan for providing long-term care for all Alaskans. By filling out this comment card, your input on this important topic will be provided to the Alaska State Legislature.

If you require more time or more space to make your comments, you are welcome to send them directly to Senator Gary Wilken, LTC Task Force Co-chairman, at the address provided on the other side of this card.

Name: Anna Stull RN, Administrator
Address: Chugiak Assist. Living
22424th Birchwood Dr, Chugiak AK
99567

Please provide your comments on:

- how to improve current long-term care services;
- possible funding options for long-term care;
- projected future care demands and how to address the need;
- other issues relating to long-term care services.

Reduce the ratio of patient care givers - Quality
care cannot be given when c/was have
10-14 patients assigned to them & they
are responsible for their Total care during
their shift. More supervisory staff req.

I have no quick cure for funding. I
know the present costs are outrageous
and prohibitive. Many Conrad charges
10,000 monthly. Care costs & wages
do not reflect this amt.

One answer to future demands &
needs would be to encourage more
private LTC facilities & funding to maintain them

Comment Card



Long-Term Care Task Force Alaska State Legislature

A 12-member task force of legislators, state officials and private citizens recently began the task of reviewing Alaska's system of providing long-term care.

This review process is the first step in developing an equitable plan for providing long-term care for all Alaskans. By filling out this comment card, your input on this important topic will be provided to the Alaska State Legislature.

If you require more time or more space to make your comments, you are welcome to send them directly to Senator Gary Wilken, LTC Task Force Co-chairman, at the address provided on the other side of this card.

Name: Judy Warren
Address: P.O. Box 164
Sterling, AK. 99672

Please provide your comments on:

- how to improve current long-term care services;
- possible funding options for long-term care;
- projected future care demands and how to address the need;
- other issues relating to long-term care services.

More \$ for disease research -
Put focus on prevention &
wellness through education
make Health Fair priorities -
especially in remote areas. -
Possibly a State HMO plan
to make insurance affordable -
Affordable Housing -

Comment Card



Long-Term Care Task Force Alaska State Legislature

A 12-member task force of legislators, state officials and private citizens recently began the task of reviewing Alaska's system of providing long-term care.

This review process is the first step in developing an equitable plan for providing long-term care for all Alaskans. By filling out this comment card, your input on this important topic will be provided to the Alaska State Legislature.

If you require more time or more space to make your comments, you are welcome to send them directly to Senator Gary Wilken, LTC Task Force Co-chairman, at the address provided on the other side of this card.

Name: KATHERINE V Ferguson

Address: 1829 JACK ST
FAIRBANKS, AK 99709

Please provide your comments on:

- how to improve current long-term care services;
- possible funding options for long-term care;
- projected future care demands and how to address the need;
- other issues relating to long-term care services.

Do NOT Allow Seniors or anyone to become
impoverished to stay long time in LTC facility
in order to receive Medicare.

Funding - Find the means somehow from
STATE coffers - Permanent fund Dividends?

FUTURE CARE needs will increase -

Sometimes AKans need to go "outside"
to afford - try to prevent such from
happening -

Would be interested in what options
might be?

Comment Card



Long-Term Care Task Force Alaska State Legislature

A 12-member task force of legislators, state officials and private citizens recently began the task of reviewing Alaska's system of providing long-term care.

This review process is the first step in developing an equitable plan for providing long-term care for all Alaskans. By filling out this comment card, your input on this important topic will be provided to the Alaska State Legislature.

If you require more time or more space to make your comments, you are welcome to send them directly to Senator Gary Wilken, LTC Task Force Co-chairman, at the address provided on the other side of this card.

Name: Peggy A. Burgin

Address: 1530 W. 11th Ave
Anchorage AK 99501

Please provide your comments on:

- how to improve current long-term care services; ✓
- possible funding options for long-term care; ✓
- projected future care demands and how to address the need; ✓
- other issues relating to long-term care services.

Availability to all seniors.

Comment Card



Long-Term Care Task Force Alaska State Legislature

A 12-member task force of legislators, state officials and private citizens recently began the task of reviewing Alaska's system of providing long-term care.

This review process is the first step in developing an equitable plan for providing long-term care for all Alaskans. By filling out this comment card, your input on this important topic will be provided to the Alaska State Legislature.

If you require more time or more space to make your comments, you are welcome to send them directly to Senator Gary Wilken, LTC Task Force Co-chairman, at the address provided on the other side of this card.

Name: CLIFFORD DARNELL

Address: P.O. Box 520955

Big Lake, AK 99652

Please provide your comments on:

- how to improve current long-term care services;
- possible funding options for long-term care;
- projected future care demands and how to address the need;
- other issues relating to long-term care services.

Keep long care services in
area that people already live in.
Put a cap on Dividend
at \$1,000 & designate part for
long term care, seniors, and
or Education on all levels.

Comment Card



Long-Term Care Task Force Alaska State Legislature

A 12-member task force of legislators, state officials and private citizens recently began the task of reviewing Alaska's system of providing long-term care.

This review process is the first step in developing an equitable plan for providing long-term care for all Alaskans. By filling out this comment card, your input on this important topic will be provided to the Alaska State Legislature.

If you require more time or more space to make your comments, you are welcome to send them directly to Senator Gary Wilken, LTC Task Force Co-chairman, at the address provided on the other side of this card.

Name: _____

Address: _____

Please provide your comments on:

- how to improve current long-term care services;
- possible funding options for long-term care;
- projected future care demands and how to address the need;
- other issues relating to long-term care services.

- Change rate structure for
assisted living reimbursements.
- Fund capital costs for more homes,
then leverage of AHFC and other
monies. Provide more incentives
for Private Home.
- Don't rely on personal annuities from
a portion of the Perm Fund.
- Recognize that there is a role for the
State Govt. We have the financial
health in the State to make it more
possible for Seniors to continue to live
here.

Comment Card



Long-Term Care Task Force Alaska State Legislature

A 12-member task force of legislators, state officials and private citizens recently began the task of reviewing Alaska's system of providing long-term care.

This review process is the first step in developing an equitable plan for providing long-term care for all Alaskans. By filling out this comment card, your input on this important topic will be provided to the Alaska State Legislature.

If you require more time or more space to make your comments, you are welcome to send them directly to Senator Gary Wilken, LTC Task Force Co-chairman, at the address provided on the other side of this card.

Name: Nenana Tortella Council on Aging
Address: PO Box 205
Nenana 99760

Please provide your comments on:

- how to improve current long-term care services;
- possible funding options for long-term care;
- projected future care demands and how to address the need;
- other issues relating to long-term care services.

Need more Care for
givers
More funding to
many Clinics

Comment Card



Long-Term Care Task Force Alaska State Legislature

A 12-member task force of legislators, state officials and private citizens recently began the task of reviewing Alaska's system of providing long-term care.

This review process is the first step in developing an equitable plan for providing long-term care for all Alaskans. By filling out this comment card, your input on this important topic will be provided to the Alaska State Legislature.

If you require more time or more space to make your comments, you are welcome to send them directly to Senator Gary Wilken, LTC Task Force Co-chairman, at the address provided on the other side of this card.

Name: Beverli A. Thomas
Address: AHFC
PO Box 101020 99510-1020

Please provide your comments on:

- how to improve current long-term care services;
- possible funding options for long-term care;
- projected future care demands and how to address the need;
- other issues relating to long-term care services.

Recognize existing programs
and resources to include all
potential stakeholders.

State organizations are too
territorial.