

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILES 8672

2516 SCOMM 110: LONG TERM CARE TASK FORCE, 1998

JOHN SHERWOOD

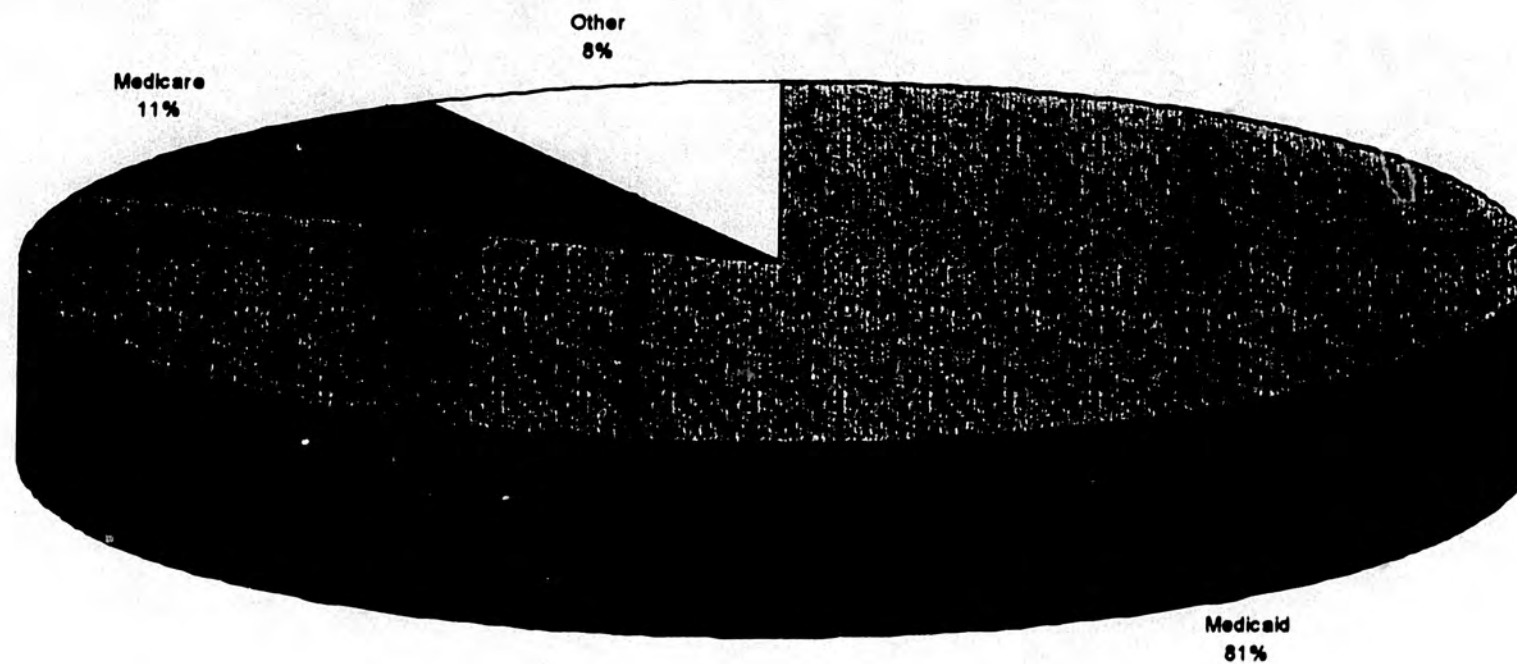
MEDICAID FINANCING OF LONG TERM CARE

A Presentation to the Long-Term Care Task Force

**Jon Sherwood
Division of Medical Assistance
August 18, 1998**

JOHN SHERWOOD

Sources of Payment for Nursing Home Beds
6/98



***Does not include Swing Beds**

Long Term Care: What Does Medicaid Pay For?

- Nursing Homes
- Personal Care Attendant Services
- Home and Community-Based Waivers
 - Care Coordination
 - Respite Care
 - Assisted Living Services (not room and board)
 - Environmental Modifications
 - Chore Services
 - Other HCB Services

Who's Who in Medicaid Long Term Care

Division of Senior Services

HCB Waivers/CHOICE
Nursing Home Authorization
Personal Care Services

Division of Mental Health and Developmental Disabilities

HCB Waivers
ICF/MR Authorization

**Division of
Public Assistance**
General & Financial
Eligibility Determination

**Division of
Medical Assistance**
Administration of
Medicaid

**Medicaid Rate
Advisory Commission**
Facility Rate Setting

First Health
Claims Payment

Special Medicaid Eligibility for Long Term Care

- Higher income limits for nursing home residents
- A special resource allowance for the community spouse of a nursing home resident
- HCB waiver recipients treated as if they lived in nursing homes
- Children living at home who meet an institutional level of care are treated as if they live in nursing homes (TEFRA option)
- People who need expensive long term care can qualify for Medicaid using special trusts to voluntarily impoverish themselves

Financial Eligibility Criteria for Medicaid

	Monthly Income Limit	Resource Limit
Adult Public Assistance (Selected)		
Individual	\$917	\$2,000
Couple - Both Eligible	\$1,359	\$3,000
Institutional/HCB Waiver		
Individual	\$1,482	\$2,000
Community Spouse Resoure Allowance		\$80,760

1998 standards

**Number of Medicaid Clients
In Long Term Care Status
June 93 vs. June 98**

Status	Jun-93	Jun-98
Nursing Home	517	485
Older Alaskans Waiver		396
Adults with Physical Disabilities Waiver		106
Intermediate Care Facility for Mental Retardation	85	0
People with Mental Retardation Waiver		410
Children with Complex Medical Conditions Waiver		65
TEFRA Option for Children Under Age 19		291
Total Medicaid Long Term Care Caseload	602	1,753

Source: Alaska Nursing Home Census, Division of Medical Assistance and
Preliminary MMIS data for FY 98.

**Medicaid Expenditures for Long Term Care
Services Requiring an Institutional Level of Care
(\$ in thousands)**

	<u>FY 93</u>	<u>FY 98</u>
<u>Institution</u>		
Nursing Homes	\$39,902.2	\$44,533.0
ICF/MR	<u>\$7,671.7</u>	<u>\$932.9</u>
Total Long Term Care Institutions	\$47,573.9	\$45,465.9
 <u>Waiver</u>		
Older Alaskans Waiver		\$6,730.8
Adults with Physical Disabilities Waiver		\$1,476.9
People with Mental Retardation Waiver		\$19,369.7
Children with Complex Medical Conditions Waiver		\$1,905.3
Total HCB Waivers	<u>\$0.0</u>	<u>\$29,482.7</u>
 Total Institutional Level of Care Service Expenditures	\$47,573.9	\$74,948.6

Source: Division of Medical Assistance Annual Report for FY 93;
MMIS Report MR O-91.

**People in Care & Medicaid Expenditures
Adults Meeting Nursing Home Level of Care
FY 93 vs. FY 98**

People Receiving Care	Jun-93	Jun-98
Nursing Home	517	485
Older Alaskans Waiver		396
Adults with Physical Disabilities Waiver		106
Total Medicaid Nursing Home Level Caseload	517	987

Expenditures (\$ in Thousands)	FY 93	FY 98
Nursing Homes	\$39,902.2	\$44,533.0
Older Alaskans Waiver ~~(413 Individuals in 97)~~		\$6,730.8
Adults with Physical Disabilities Waiver ~~(91 Individuals in 97)~~		\$1,476.9
Adult Nursing Home Facility and Waiver Service Expenditures	\$39,902.2	\$52,740.7

Note: Nursing Home data may include a small number of children.

Source: Division of Medical Assistance Annual Report for FY 93;
Alaska Nursing Home Census, DMA; MMIS Report MR O-91.

CHRONIC CARE

By: Al Lewis



THE BALANCED BUDGET ACT of 1997 is already reaping results.

The home care subsidiary of Columbia/HCA Healthcare Corp. posted a \$20 million loss in this year's first quarter. Apria Healthcare Group Inc., already a sea of red ink, said its first quarter loss grew to \$6.6 million. At American Homepatient, net revenue and pre-tax income fell by \$6.1 million, though the fast-growing Brentwood, Tenn.-based company still reported a first quarter profit.

All three companies attributed these dramatic declines, in part, to reduced reimbursements under the Balanced Budget Act.

"I think it's fair to say that home health is in a firestorm right now," said Elizabeth Hogue, a Washington D.C.-based health care industry attorney. "My guess is that it will end in about another year or so. But in the meantime it's going to be very difficult."

Under an interim payment system put in place between now and fall 1999, many home care agencies can not even calculate what they will be paid for basic services during this period.

There are new per patient caps imposed, but not all the data on how to calculate the caps have been released.

Hogue said her home care clients' reactions run the gamut: "Some are saying, 'we think we can handle this,' others are sort of suicidal."

In the midst of this uncertainty, many observers wonder about the plight of the chronically ill. How will they fit into a system that is constantly squeezing providers? And how will providers continue to design disease management programs and the like when it appears Medicare and Medicaid reimbursement won't pay for them?

A POSITIVE OUTLOOK

At Amcare Medical Services Inc. in Newton, Mass., Vice President of Business Development Joseph Martini, does not worry about the Balanced Budget Act.

"A lot of that is with the nursing side and that hasn't really affected us," he said. "There have been reductions in reimbursement rates for oxygen therapy and that's affected us. But we are taking the lead in bringing disease management into the home."

For the past four years, Amcare has been developing and operating disease management programs for asthma, chronic obstructive pulmonary disease and obstructive sleep apnea, achieving impressive results.

Amcare's asthma program at one large managed care organization resulted in an 87

percent decrease in hospitalizations and a 66 percent decrease in emergency room visits over two years.

"As people were increasingly watching the dollars, we have been quietly building up evidence that our interventions save money in the long run," Martini said. "With the government, there's no one to really talk to about that. But with managed care organizations, you find a much more receptive audience."

The staffers Amcare sends to homes are trained in respiratory therapy, home care and education. When they go into a home, they not only teach patients how to manage their ailments, but identify factors in their homes that may be exacerbating their conditions, and involve family members in the treatment process.

"We do a complete assessment of the environment," Martini said. "And we help both the patient and the family understand the disease and what they need to do to help manage the disease themselves."

Does Medicare and Medicaid pay for this?

No, says Martini. Amcare works exclusively with managed care providers such as United Healthcare of New England, Harvard Pilgrim Health Care, Blue Cross and Blue Shield of Rhode Island and Neighborhood Health Plan of Rhode Island.

But won't these managed care organizations be forced to abandon home care-based disease management programs under the constraints of the Balanced Budget Act? No, says Martini again.

"If you don't give the chronic patient ongoing care, they're going to wind up in the hospital," he explained. "At managed care organizations, people are looking at patient populations holistically. If you can demonstrate an overall savings and a higher quality of care to the patient, they generally will work with you."

Martini concedes it will be more difficult for home care and disease management companies to work directly with government payors under the Balanced Budget Act, but he believes the act may force more Medicare and Medicaid patients into managed care programs. And that, in turn, expands the pool of prospective patients for his own brand of disease management in the home.

Consequently, in a round about way, he believes the Balanced Budget Act will benefit disease management programs.

"Now, people are going to be much more receptive to what we've been saying for a long time," he said. "We have some ways to help the patient and the family manage the disease process and we can reduce overall costs."

OPTIMISM NOT PERVASIVE

Though Martini and many other players in the emerging disease management arena speak confidently in the face of great unknowns, not everyone is as certain.

"I don't see how this will force Medicare beneficiaries into

managed care," said Hogue. "Besides, managed care plans generally pay even less than Medicare does."

As the government puts the squeeze on health care providers, it is clear only those disease management programs that can actually demonstrate a cost savings will survive. In the grand scheme, those programs are rare.

"We certainly see lots of positive results that show the ability to impact disease," said Mark Zitter, president of The Zitter Group, an outcomes research education and publishing company in San Francisco. "But we see fewer studies that show net cost savings. It's a lot easier to say somebody got better than it is to say how much was saved. That analysis is a bit trickier."

Many say disease management has a long ways to go. Some programs are nothing more than the glorified marketing schemes of pharmaceutical manufacturers. Others show great promise, at least anecdotally, but don't have reliable numbers to back their claims.

Like home care itself, disease management is a phenomenon that is developing regionally. In areas where it is already strong, observers say it is more likely to take hold. But the Balanced Budget Act may have an adverse affect in areas where such programs have not been fully developed.

A NATIONAL FOCUS ON CHRONIC DISEASE

"How we service people with chronic conditions across settings and overtime has a profound effect on our ability to contain healthcare costs," said Richard Bringewatt, president and chief executive officer of the National Chronic Care Consortium. "Simply slashing payments under current structures will not contain costs and ensure quality over the long term."

"It's kind of a mixed blessing," he said of the Balanced Budget Act. "There are some things in it that are good, like a national focus on chronic disease and like a focus on outcomes. But the Act hasn't given enough of a focus on the problem."

Bringewatt's group is part of a national coalition working to make chronic care the focus of Medicare and Medicaid reform.

The group's members include the American Association of Homes and Services for the Aging, the American College of Physicians, the American Hospital Association, the Catholic Health Association of the United States, the National Chronic Care Consortium, the National PACE Association and the Social HMO Demonstration. While members of the coalition have differing views and pursue independent legislative agendas, they are committed to collaboration among purchasers, payors, providers and consumers in finding person-centered, systems-oriented solution to issues of chronic disease and disability.

To the coalition, the equation is simple: People with chronic diseases and disabilities represent the most expensive and fastest-growing group of patients in health care.

According to the groups literature:

disease management

- ♥ Almost 100 million Americans have one or more chronic condition.
- ♥ In the next 25 years, the number of people with chronic conditions will grow by 35 million.
- ♥ Nearly 70 percent of the nation's personal healthcare expenditures is for people with chronic conditions.
- ♥ 90 percent of all morbidity and 80 percent of all deaths are related to a chronic condition.
- ♥ More than one-third of all Americans are at risk of having their chronic condition limit their daily activities.
- ♥ Direct medical costs for people with chronic conditions will nearly double by the year 2050.
- ♥ Medicare and Medicaid cover more than 60 percent of long-term care costs.

To the coalition, the focus of all health care reforms should be reducing incidence rates of chronic disease.

"The national debate is on the wrong stuff," said Bringewatt. "We are caught up with policy fights around places where care is provided as opposed to how people are being served. Instead of focusing on the problem, we're having fights about how much money should go to home health and how much should go to hospitals."

"We're locked into short-term, cost-containment rather than looking at costs as they evolve over time," Bringewatt said. "If you take managed care at its simplest level, one would think that dollars would move to home and community-based services and other kinds of methods that we know to be most cost-effective over time. Yet we seem to be organized in a way that locks in outmoded institutions and then ratchets down their costs. Under this system, dollars won't always float to do what's cost-effective."

The Chronic Care Coloration aims to establish a National Chronic Care Act. "Our intent is to get Congress to shift its focus from ratcheting down costs piece by piece to looking at problems of chronic disease and disability," Bringewatt said.

The coalition also has set several short-term policy objectives:

- ♥ Establish problems of chronic disease and disability as a national priority.
- ♥ Better respond to consumer needs.
- ♥ Integrate Medicare and Medicaid managed care programs for the chronically ill.
- ♥ Simplify and standardize Medicare, Medicaid and other public programs.
- ♥ Provide a broader range of managed care options and establish other integrated payment methods.
- ♥ Offer incentives for all providers to establish new methods consistent within this policy framework.

*bags designed for the
home care provider . . .*



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FOG IN THE FOREST

At the think-tank level it is perhaps easier to see the forest from the trees. At the provider level, many agencies find themselves lost in the woods. Hogue relays a story of a home care provider in Worthington, Texas, that was told that it would only receive \$13.10 per skilled nursing visit under the interim payment system now in place.

"You can't even get someone to look at your house for termites for \$13.10," she exclaims.

Meanwhile, most other agencies do not yet know what their rates will be under the interim payment system. The caps are being set by the Health Care Finance Administration under extremely complicated formulas.

"Can you imagine saying to a business person, we want your services and you are going to provide them for months at a time, but we're just really not quite sure what we're going to pay you for them?" asks Hogue. "If somebody called and said that to me, I'd say you better find yourself another lawyer." How is it exactly that providers are supposed to be in business for all these many months when they do not know what they are being paid?"

Such questions leave many to wonder about the fate of people with the long-term illnesses, especially in a system that not only puts caps on services, but on patients as well.

(more on page 8)

"When you have a per-beneficiary cap, it puts a lot of pressure on agencies to have fewer long-term, high-intensity chronically ill patients," said Hogue.

To make the system work, Hogue said home care providers will favor patients with short-term ailments. How else will they be able to balance out their books to meet the per beneficiary cap?

"Under the old system of reimbursement, all you had was a cost cap and your cost cap was to some extent dependent upon your volume of visits," she said. "It was sort of like a big tent theory. But now with the imposition with this additional per beneficiary cost cap, agencies are saying whoa, we can only take so many of these patients."

"The Balanced Budget Act really means that agencies are likely to be reluctant to take in long-term chronic care patients the way that they used to."

CORRECTIVE ENVIRONMENT

Hogue sees the current payment system, as it applies to home care agencies, as punitive or at least corrective.

"Right now, I think the government is generally convinced there is fraud, abuse and waste in the home care industry and that needs to be fixed," she said. "Also, I think we've always got to account for the fact that home care is a relatively new model of care. We don't really know whether national home care will work from a business perspective or a quality of care perspective. And we cannot answer with verifiable data many of the key questions about home care. It's still an emerging industry and I think that's part of what we're all wrestling with right now."

"What will home care look like in the future? What HCFA is telling us is that it better not look like it's looked like in the past." In the end, Hogue believes the home care industry will prevail over the trials and tribulations of the day.

"It is so consistent with all of the policy objectives we have set for ourselves in this country — keeping people out of institutions and lowering costs. I think it's got a very bright future but for now, I think there are a number of adjustments that home care providers are going to be making."

Though in some ways government-distorted economics are working against chronic care in the short-term, health care providers clearly need to focus on the problems of the chronically ill for the longer haul.

"Just be tenacious about it," Bringewatt said. "Take some risks and do the best you can to prove outcomes and cost reductions, because providers with effective management of chronic diseases and disabilities are going to be the players of the future."

"As we enter the 21st century, that's only going to get more pronounced," he said. "When you consider the aging of Americans and new care interventions that allow us to do things on an inpatient basis, it's going to be those who can solve the problems of chronic disease and disability who will prevail." RR

The national debate
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said Bringewatt. "We
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provided as opposed
to how people are
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JOHN STERWOOD



Medicaid in Alaska Fiscal Year 1997

State of Alaska
Dept. of Health & Social Services
Division of Medical Assistance

*A special thanks to Lisa Simono of the
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contribution of photos used in this report.*

A Message From the Director

Dear Reader,

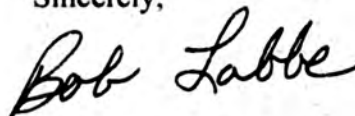
Welcome to the FY97 Annual Report of the Division of Medical Assistance.

This year's report is dramatically different from previous years. It has been streamlined and is presented in an easy-to-read format, allowing quick access to needed data. You will notice that the sometimes lengthy text describing our programs is absent. We have decided to include this information in another of our publications, "Introduction to Medical Assistance in Alaska," which will be produced every other year.

Since our division deals with issues on a very personal level, our annual report must focus more on the human side of medical assistance. Because of that, we are profiling a person who has used the Medicaid system for health coverage and a person who provides services. We feel these two people exemplify the idea behind medical assistance in Alaska: to provide the best possible health care services for those that fit the eligibility criteria.

We hope you find this year's report informative and interesting to read.

Sincerely,



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Table of Contents

Defining Medical Assistance	4
Overview of Medical Assistance	4
Highlights & Initiatives	7
FMAP Change	7
Managed Care Pilot Programs	7
Long Term Care	8
Mental Health Coverage	9
MMIS Reprocurement	10
Provider Fee Schedule	11
Rural Hospital Regulations	11
Facility Cost Containment Regulations	12
Increasing 100% Federal Reimbursement for Natives	12
Instituting Claims with the Indian Health Service	12
Our Beneficiaries	13
Medicaid Eligibles and Recipients	13
Profile: Kristy Hinkle	14
Profile: Dr. William Larson	15
Financial Summary	17
State Only Programs	23
Alternatives to Institutional Care.....	24
Home and Community-Based Care	24
TEFRA.....	24
Personal Care Attendant Services	25
Keeping Children Healthy	25
Medicaid Healthy Baby Program	25
Medicaid Healthy Kids Program	25
Mental Health Services.....	26
Indian Health Service & Tribal Facilities	28
Providers Billing Medicaid	29

Charts, Graphs, and Tables

5	Program Overviews
6	Medicaid Statistics FY94 - FY97
6	FY97 Medicaid Expenditures
6	FY97 Medicaid Eligibles
13	Medicaid Eligibles and Recipients
16	Alaska Medicaid Eligibility by Qualifying Need Standard
17	FY97 Medicaid Expenditures by Categories of Service
18	FY97 Medicaid Expenditure Distribution by Eligibles
19	FY97 Medicaid Eligibles, Recipients & Expenditures by Categories of Assistance
19	Average Yearly Cost Per Medicaid Eligible
20	FY97 Medicaid Expenditures by Categories of Assistance
21	FY97 Medicaid Eligibles, Recipients & Expenditures by Race
21	FY97 Medicaid Eligibles, Recipients & Expenditures by Sex
22	FY97 Medicaid Eligibles, Recipients & Expenditures by Age Group
23	FY97 State Funded Medical Assistance Programs Expenditure Distribution by Eligible
24	Home and Community-Based Care Program FY97 Utilization and Expenditures
25	Total Births in Alaska/Healthy Baby Program/AFDC Births
26	FY97 Community Mental Health Services for Children (under 21 years)
27	FY97 Community Mental Health Services for Adults (age 21 and over)
28	Summary of FY97 IHS Billings by Facility
29	Claim Documents Processed (FY88-FY96)
30	Expenditures and Patient Days Utilized: Long Term Care Facilities
31	Expenditures and Patient Days Utilized: Inpatient Facilities
32	FY97 Total Expenditures Summary with Collocation Code

A Note to Readers Regarding Data Used in This Report

The Medicaid Management Information System (MMIS) is used to process claims for medical services provided to Medicaid recipients and tracks the eligibility of providers and Medicaid beneficiaries. Data extracts from the MMIS claims processing are the basis for the majority of the tables and graphs pertaining to Medicaid program participation and financial activity in the annual report. Readers should be aware that limitations exist in reporting Medicaid data.

The Medicaid program is a dynamic environment. For that reason reports that summarize annual Medicaid program expenditures and provider and beneficiary participation are based on data at a point

in time, e.g., a data "snapshot" of Medicaid taken at June 30, 1997. Program activity is related to claims paid in the period July 1, 1996 through June 30, 1997. A point in time is used because Medicaid eligibility policy allows for eligibility determinations that can be applied retroactively and because persons who were denied eligibility may appeal, which results in a lag time between when a person is determined to be eligible and the period for which that eligibility applies. Similarly, if an expenditure report were based on the dates a person received services instead of when a particular claim was paid, the values would be markedly different from the report based on date of payment.

Assistance

The Division of Medical Assistance, within Alaska's Department of Health and Social Services (DHSS), administers programs that are designed to help residents meet their medical needs: Medicaid and General Relief Medical (GRM). The Permanent Fund Dividend Hold Harmless (PFDHH) and the Alaska Longevity Bonus Hold Harmless (ALBHH) programs are also available to help Medicaid recipients maintain Medicaid eligibility. While the GRM, PFDHH and ALBHH programs are vital to the health care of many Alaskans, this report will emphasize the Medicaid program as it serves more people and requires greater expenditures.

Overview of Medical Assistance

Medicaid is an "entitlement program" created by the federal government, but administered by the state, to provide payment for medical services for low-income citizens. People qualify for Medicaid by meeting federal income and asset standards and by fitting into a specified eligibility. Under federal rules, DHSS has authority to limit services as long as the services provided are adequate in "amount, duration, and scope" to satisfy the recipient's medical needs.

Medicaid began as a program to pay for health care for poor people who were unable to work. It covered the aged, the blind, the disabled, and single parent families. Over the years, Medicaid has expanded to cover more people. For instance, children and pregnant women may qualify under higher income limits and without asset limits. Families with unemployed parents may qualify, and families who lose regular Family Medicaid because a parent returns to work may continue to be covered for up to one year.

There have also been changes in the eligibility rules for people who need the level of care provided in an institution, such as a nursing home. Now, most Alaskans who need — but cannot afford — this expensive care may qualify for Medicaid. In addition, recent changes within the Alaska Medicaid program give some people who need an institutional level of care the opportunity to stay at home to receive that care.

General Relief Medical (GRM) is a 100% state-funded medical assistance program that pays for a very limited amount of health care services for very low income adults who do not qualify for Medicaid. Covered services include limited inpatient hospital stays and prescription drugs for individuals with certain chronic illnesses.

The Alaska Legislature created the **Permanent Fund Dividend Hold Harmless** program (PFDHH) to protect those Medicaid clients who would lose their eligibility as a result of receipt or retention of the Permanent Fund Dividend. Receipt of the PFD

How it works

Eligibility for Medicaid is determined by the Division of Public Assistance according to federal and state rules. The case worker will look at age, income, assets, disability status, and other factors to determine what eligibility category will work. Once determined eligible, the individual will be assigned a unique identification number and issued a Medicaid coupon, which contains information on removable labels. For the most part, recipients are able to choose their own health care provider, but before Medicaid will pay the medical bill, the provider must be enrolled with the Medicaid program. When services are provided, the enrolled provider removes one of the labels and sticks it on a special claim form. Some providers are also able to submit claims electronically. All prescription drug claims are submitted electronically. Before Medicaid reimburses the provider, a claim review is done to make sure the claim fits within acceptable medical and fiscal guidelines. Reimbursement rates for physicians and other private practice providers are established according to a methodology that assigns a relative value to the service provided. Hospital and nursing home rates are established by a special rate setting commission. Except for established recipient cost sharing amounts, providers must agree to accept the Medicaid rate as full reimbursement and not require the recipient to pay more.

may force client income over the qualifying income limit. Under the PFDHH program, the state maintains the client's eligibility for up to four months by using state funds to pay for medical services.

The *Alaska Longevity Bonus Hold Harmless* (ALBHH) program was created by the Alaska Legislature to protect Medicaid clients from losing their Medicaid eligibility as a result of receiving the bonus. Without the program, some recipients would be over the qualifying Medicaid income limit. Starting in October 1991, the ALBHH program underwent a significant reduction as the Division of Medical Assistance took advantage of a federal policy change allowing exemption of ALBHH income for most Medicaid recipients. Relatively small, the ALBHH program in FY97 cost the state \$43,258 to provide services for 10 recipients.

The chart below provides a general overview of the three main programs supported through the Division of Medical Assistance (DMA): General Relief Medical (GRM), Permanent Fund Dividend Hold Harmless (PFDHH), and Medicaid. The distribution of eligible persons is shown according to major groupings of race, age, and location. Expenditures are shown according to major services categories.

	GRM		PFDHH		Medicaid	
FY97 Eligibles	856		764		87,977	
Race Distribution	White	79%	White	47%	White	45%
	Black	9%	Alaska Native	42%	Alaska Native	37%
	Hispanic	3%	Black	4%	Black	6%
	Asian	3%	Asian	2%	Hispanic	4%
	Unknown	2%	Hispanic	2%	Asian	3%
	Alaska Native	2%	American Indian	1%	Unknown	2%
	Pacific Islander	2%	Unknown	1%	Pacific Islander	2%
	American Indian	1%			American Indian	1%
Age	21-44	61%	21-44	75%	21-44	27%
	45-64	36%	45-64	13%	6-14	24%
	15-20	2%	65+	5%	1-5	19%
			15-20	3%	15-20	10%
			6-14	2%	0	7%
			1-5	1%	65+	6%
					45-64	6%
Eligibles by location	Anchorage	46%	Anchorage	25%	Anchorage	34%
	Fairbanks	11%	Fairbanks	7%	Fairbanks	7%
	Wasilla	8%	Wasilla	6%	Wasilla	5%
	Juneau	4%	Palmer	5%	Juneau	3%
	Palmer	4%	Emmonak	2%	Palmer	3%
	North Pole	3%	Kodiak	2%	Ketchikan	2%
	Soldotna	3%	Kipnuk	2%	Kenai	2%
	Ketchikan	2%	Togiak	2%	Soldotna	2%
	Sitka	2%	Nunapitchuk	2%	North Pole	2%
	Homer & Eagle River	1%	Delta Junction	2%	Kodiak	2%
	Kodiak & Big Lake	1%	Soldotna	2%	Homer	1%
Expenditure by Category of Service	Physician	41%	Nursing Home	65%	Hospital	34%
	Hospital	34%	Hospital	13%	Physician	17%
	Pharmacy	15%	Physician	9%	Nursing Home	12%
	Other	6%	Pharmacy	5%	Physician	17%
	Transportation	3%	Mental Health Clinics	3%	Mental Health Clinics	10%
	Nursing Home	1%	Other	3%	Other	8%
			Transportation	2%	Pharmacy	7%
					Waivers	5%
					EPSDT	4%
					Transportation	3%
Expenditures	\$3,412,864.51		\$453,441.69		\$349,170,283.57	

The following table compares changes in the Medicaid program from FY94 to FY97. During FY97, the total number of eligibles grew 0.9% from FY96. The number of recipients grew by 1,571, or 2.3%, compared to a decrease in recipients in FY96 of 131. The increase in recipients could be attributed to several factors, including an increase in the number of people receiving waived services.

Medicaid Statistics FY94 - FY97

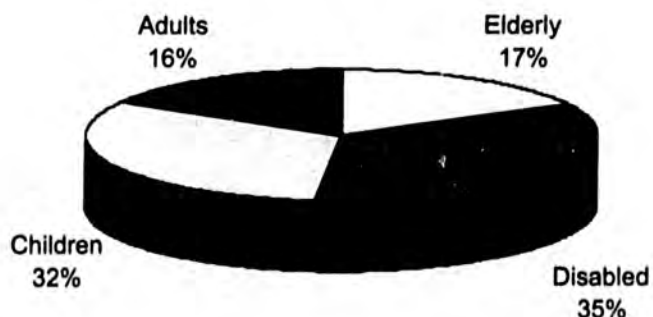
	FY94	% Chg. (94-95)	FY95	% Chg. (95-96)	FY96	% Chg. (96-97)	FY97
Eligibles	83,920	3.0%	86,445	0.8%	87,159	0.9%	87,977
Recipients	69,631	0.2%	69,739	-0.2%	69,608	2.3%	71,179
Pct. of Eligibles Participating	83.0%	-2.8%	80.7%	-1.0%	79.9%	1.3%	80.9%
Cost Per Recipient	\$3,491.42	5.6%	\$3,686.20	9.0%	\$4,016.19	1.5%	\$4,077.75
Cost per Eligible	\$2,896.94	2.7%	\$2,973.82	7.9%	\$3,207.46	2.9%	\$3,299.16
Providers Participating	2,819	2.4%	2,887	8.0%	3,119	7.0%	3,337
Payment Per Participating Provider	\$86,240	3.3%	\$89,045	0.7%	\$89,631	-3.0%	\$86,979
Total Reimb. for Claims Paid**	\$243,111,100	5.7%	\$257,071,900	8.7%	\$279,559,000	3.8%	\$290,250,300
Claim Lines Processed*	2,053,070	0.7%	2,067,963	10.7%	2,289,193	8.3%	2,478,250
Paid Claim Lines	1,847,046	-2.2%	1,807,108	6.1%	1,917,994	8.9%	2,088,176
Processed Claim Lines Paid	90.0%	-2.9%	87.4%	-4.1%	83.8%	0.6%	84.3%
Payment Per Paid Claim	\$131.62	8.1%	\$142.26	2.5%	\$145.76	-4.6%	\$139.00
Paid Claims Per Recipient	26.5	-2.3%	25.9	6.3%	27.6	6.5%	29.3
Pd. Claims Per Participating Provider	655.2	-4.5%	625.9	-1.8%	614.9	1.8%	625.8

*Value slightly underreported; represents processed lines identifiable as Medicaid. Excludes claims denied which lack an eligibility determination.

**Excludes DMHDD general fund dollars for NF & ICF/MR (\$9 million) as well as payments to the Indian Health Service and Medicaid state programs.

The chart below on the right shows the percentage of Medicaid eligible beneficiaries according to typical groupings. The chart on the left shows the percentage of expenditures for direct services provided to persons in the typical groups. Children (less than 21 years of age) account for the majority of the eligible population (60%), but they only cost an average of \$1,773 for services. Adults (ages 21 through 64) cost an average of \$2,227 in FY97. The elderly (age 65 and over) cost \$9,161 per eligible and account for 17% of the eligible population. The most costly eligible group was adults and children with disabilities at \$11,202 per person. Medicaid expenditures derive from the sum of amounts paid for Medicaid facility, non-facility, Indian Health Services, and waived services only.

FY97 Medicaid Expenditures



FY97 Medicaid Eligibles



Highlights & Initiatives

Alaska's Medicaid program realized many changes during fiscal year 1997, including an increase in the Federal Medical Assistance Percentage (FMAP), changes in the federal reimbursement for services delivered to Alaskan Natives, and the initiation of two managed care pilot programs, among others. These changes have helped the state's Medicaid program become more efficient and, to some degree, have increased the availability and number of services provided.

FMAP Change

Since the early 1990s, Alaska has been attempting to change the Federal Medical Assistance Percentage (FMAP) rate for Medicaid. The Federal Poverty Level (FPL), used to determine financial eligibility for assistance programs, has always been adjusted for Alaska to take into account the higher cost of living in the state. However, the formula for determining the federal match rate (which uses a state's per capita income) has never been similarly adjusted. This year, in the Balanced Budget Act of 1997, the federal match rate for Alaska was changed for a three year period from 50% to 59.8%, resulting in an annualized savings of \$29.7 million (the amount for FY98 is less by \$7.4 million because of the overlap of the state and federal fiscal years, resulting in one-quarter funded at the old federal match rate).

Managed Care Pilot Programs

During the 1996 legislative session, Rep. Norman Rokeberg introduced House Bill 393 instructing the Division of Medical Assistance to introduce two managed care pilot projects for the Medicaid beneficiary population. After considerable research, review and planning, the division developed and implemented two managed care pilot projects, Telephone Triage and Care Coordination.

The **Telephone Triage** pilot project began in May 1997 and is offered in three areas of the state: Fairbanks, the Mat-Su Valley, and the Kenai Peninsula Borough. DMA contracted with CareWise, a company with over 14 years of experience to staff the triage call center. The division's Care Management Teams oversee the quality of the service, the marketing of the program, consumer satisfaction, and evaluation of the program's effectiveness. The Telephone Triage pilot project provides 24-hour, 365 day a year access via a toll free number to a highly trained registered nurse. The service is currently available to over 25,000 Medicaid beneficiaries. The triage nurses provide callers with information and guidance on whether to seek medical care immediately, call their doctor, or consider self-care options. The nurses can also refer the caller to a primary care provider in their area if they do not have one.

With permission from the caller, the nurse faxes a chart report to the doctor or receiving health care facility. The pilot project provides immediate access to medical advice so that beneficiaries can choose the appropriate level of care or get medical information. This program decreases inappropriate use of the emergency room and supports the callers in their decision making about seeking care and staying



Approximately 80% of all calls received by the Telephone Triage program are from women who have questions about either their baby's health or their own.

healthy. This program has been very popular and early next spring the division will be evaluating its effectiveness in terms of reducing inappropriate emergency room usage, consumer satisfaction, and clinical outcomes.

The **Care Coordination** pilot project, initiated in June 1997, is designed to coordinate health care services to seriously ill, medically complex Medicaid beneficiaries in the Anchorage area who do not have access to coordination services through any other Medicaid program. PRO-West, the contractor for this project, has a Registered Nurse Care Coordinator in the Anchorage office who works telephonically and in person to collaborate with the patient, the family, and the care providers to assess, plan, implement, monitor and evaluate options and services to best meet the patient's health needs. The division's Care Management Team oversees the quality and effectiveness of this program in terms of patient outcomes, consumer satisfaction, and cost savings. The goal of this project is to assist the patient in getting immediate access to needed medical care minimizing red tape and the duplication of services, while ensuring that the patient has the necessary level of care to reduce the risk of rehospitalization and costly medical complications. The division will be evaluating this pilot project during spring 1998 to determine its effectiveness in terms of improved patient outcomes, consumer satisfaction, and cost savings.

The Division of Medical Assistance has been working with the Yukon-Kuskokwim Health Corporation (YKHC) in Bethel on a managed care pilot project for rural Alaska. While YKHC is developing the capacity to enter into a contractual relationship with Medicaid in the future, the division is focusing on a transportation brokerage waiver with the corporation. Several states have obtained waivers from HCFA for brokering transportation to a private vendor in order to save money and provide services more efficiently; the broker negotiates rates with transportation vendors and takes over the functions of authorizing medically necessary transportation. As half

of the Medicaid transportation budget is used by recipients living in Bethel and the 52 villages in the YK Delta, the division believes that program savings can be addressed by a brokering system while increasing access.

Long Term Care

Over the last several years, home and community-based alternatives to institutional long term care in Alaska have increased dramatically, in part because of expansion of Medicaid coverage of these services. However, it was also becoming apparent that there were significant barriers to accessing this type of care. A number of state agencies were responsible for funding or providing long term care services for Alaskans. People who needed long term care, and people trying to provide it, often had to deal with a number of agencies, points of entry, program requirements, and funding mechanisms; the situation was especially difficult for people who were trying to receive care while remaining at home or in another residential setting. As home and community-based care is often less expensive than institutional care and preferred by the client, the result was a less efficient, less responsive long term care system.

Beginning in FY96, the Division of Medical Assistance began working with other state agencies and providers to streamline access to home and community-based care and to consolidate management of Medicaid long term care services with the state agencies



Alaska's elderly Medicaid population now has the option of receiving home and community-based care instead of relying on nursing homes to provide for their needs. The process for being accepted onto the Older Alaskans waiver, which is handled by the Division of Senior Services, has been significantly streamlined.

responsible for administering other programs for clients who need this care. In FY97, the major emphasis of this effort was to consolidate management of Medicaid home and community-based long term care services with the Division of Senior Services (the elderly and adults with physical disabilities) and the Division of Mental Health and Developmental Disabilities (people with developmental disabilities and for children with complex medical conditions). At the same time, management of home care service grants, previously with the Division of Public Health (DPH), were transferred to DSS. Positions responsible for managing long term care services were transferred from the Divisions of Medical Assistance and Public Health to DSS.

As a result, people can access long term care services, whether Medicaid funded or not, without having to go through the Division of Medical Assistance for approval. This streamlines the process of obtaining long term care services. The division will continue this process further by implementing preadmission care plan counseling, provided by DSS, for people seeking nursing home admission. This counseling will help ensure that clients have access to their choice of services, while avoiding expensive institutional placements unless it represents the client's choice. For information regarding long term care expenditures, please see page 30 of this report.

Mental Health Coverage

Regulations were promulgated by DMA in 1992 that defined Medicaid coverage of mental health clinic and rehabilitation services for adults and children. These regulations implemented legislation (House Bill 545) that added mental health and substance abuse rehabilitation services to the list of Medicaid covered services. This provided a mechanism for reducing general fund expenditures for mental health services grants paid by the Division of Mental Health and Developmental Disabilities (DMHDD) by shifting funding of these expenditures to Medicaid where federal matching funds were available.

Since 1992, Medicaid expenditures for mental health services provided by DMHDD community mental health grantees have more than tripled. Mental health surveillance and utilization review (SURS) cases indicated a need for on-site reviews of CMHC patient records to verify that services paid for by Medicaid were provided in compliance with Medicaid regulations.

As DMHDD is the state agency responsible for the development and administration of programs that provide for the care and treatment of Alaskans who experience mental illness, a joint project between that division and DMA was indicated. The "Mental Health Quality Assurance/Utilization Review Project" was initiated with the general aim of providing the framework for continued federal financial participation for mental health rehabilitation services provided under the Alaska State Plan for Medical Assistance and the DMHDD Community Mental Health Program. The project is designed to result in a quality assurance/utilization review and assessment program for Medicaid mental health services ensuring that clinically appropriate, medically necessary mental health services are provided to Medicaid eligible children and adults in the least restrictive and most appropriate environment. The project prescribes certain functions and deliverables including data gathering, analyses, and reports, technical assistance and training to Medicaid enrolled CMHC grantees, periodic program reviews, and other functions administered by DMHDD.

DMHDD performed the first of these Quality Assurance Reviews (QAR) in February 1996. Based on DMA evaluations of the initial QAR reports, it was determined that further financial review of certain CMHCs was needed. During October 1996, DMA contracted with PRO/West, a professional review organization, to perform on-site reviews of twelve CMHCs. PRO/West performed detailed reviews of the clinical records of thirty recipients with the highest rates of service utilization from each of the twelve CMHCs, comparing these records to billings for Medicaid services. The DMHDD QA reviews and the PRO/West reviews found that overpayments were made to the CMHCs. DMA then requested that these providers repay \$2,162,067 to the Medicaid program.

Several of the CMHCs have appealed these findings and their cases are currently in various stages of the appeal process. The final repayment figure will likely change with the resolution of these appeals.

MMIS Reprocurement

Since 1979, Alaska has moved from a manually intensive, state-operated claims payment system, to a semi-mechanized state/contractor operation, to the current fully mechanized fiscal agent-operated claims processing system known as the Alaska Medicaid Management Information System (MMIS) which is a federally certified MMIS. Operation costs of the system are eligible for enhanced federal financial participation (FFP) matching rate of 75%.

Federal regulations require that MMIS contracts be periodically competitively reprocured. The Division of Medical Assistance prepared and submitted to the federal Health Care Financing Administration (HCFA) an advance planning document requesting an enhanced (90%) FFP for the design development, modification and implementation of a new Medicaid Management Information System. This request would fund a more flexible, responsive, and automated claims processing and information retrieval system which would enhance the state's program management, claims processing, and reporting capabilities. This would be achieved by the new MMIS's incorporation of cost effective technological improvements.

During FY96 the division issued a Request For Proposal (RFP) to procure a new federally certified MMIS. The state received only one bid in response to the RFP. That bid represented a 40% increase in operating costs as well as a \$22 million development effort. The proposer also offered some solutions which were still only in the vendor's conceptual stage. Following extensive negotiation with the vendor to reduce the proposed costs the division during FY97 elected not to award a new fiscal agent contract. The improvements offered in the proposed system were not adequate to justify the high cost and staff resources necessary to implement the system to Alaska's requirements.



Public Health Nurse Carol Histan attends to Kathlynn Payton, one of Kenai's newest residents. The Medicaid Services Unit, a section within the Division of Public Health, administers the Healthy Baby and Healthy Kids programs. For information regarding these programs, please see page 25 of this report, or you may contact the Medicaid Services Unit at (907)465-2845.

DMA has taken time to consider options and to allow the Congress to resolve issues of Welfare and Medicaid reform. The division believes the uncertainty surrounding these national and state programs discouraged potential vendors from participating in the procurement. Additionally, some states have begun to explore different strategies for promoting competition and quality systems. The division will proceed slowly by evaluating these efforts in other states before attempting another reprocurement. Consequently, the division has extended its current fiscal agent contract through December 30, 1999.

Provider Fee Schedule

On February 1, 1997, the division implemented a fee schedule for physicians and other private practitioners that was the culmination of nearly three years of effort. The division hired a contractor in 1994 to create a data base for RBRVS (Resource Based Relative Value Scale) projections and formed a Physician Advisory Committee with volunteer members of the American Medical Association to advise on RBRVS policy and other issues facing the Medicaid program. The division adopted the Medicare RBRVS, which creates a relative value for each medical procedure based on complexity and amount of time necessary to perform the required tasks, related overhead, and malpractice costs. Adoption of the RBRVS replaced the previous system of reimbursement that paid physicians based on historical billing practices, and other practitioners at 80 percent of charges. The fee schedule assures equity in reimbursement among physician specialty types, and adopts a national standard for valuing procedures that receives annual review by a physician committee advised by numerous subcommittees of specialty practitioners.

Rural Hospital Regulations

The utilization of local hospitals in Alaska has declined over the past several years and facilities in rural areas have been stressed by regulation and shrinking revenue. This situation has also contributed to a decline in the professional resources available to these hospitals. As a result, many of the rural hospitals are no longer able to provide the comprehensive level of services to the communities that has traditionally been seen in the past.

In 1996, state regulations required hospitals to be able to provide a wide and traditional spectrum of services. This was problematic for those hospitals unable to provide those services and maintain state licensure. In response to the increasing concerns, the Division of Medical Assistance met early in 1996 with administrators from some of the small rural hospitals and the Alaska State Hospital and Nursing Home Association (ASHNHA) to determine which, if any, state requirements might be altered or repealed to provide regulatory relief to rural hospitals.

Later that year the Department of Health and Social Services proposed to amend, repeal, and adopt regulations in Title 7 of the Alaska Administrative Code dealing with hospital licensure to create two types or levels of acute care hospitals: General Acute Care Hospitals and Rural Primary Care Hospitals. A rural primary care hospital would not be mandated to provide all the services required of a general acute care hospital.

With the approval and implementation of the regulations in May 1997, the first level of limited-service rural hospital was created, which allows for existing rural hospitals to downsize their operations by making some services optional, such as obstetrical, surgical and anesthesia. With this option, rural hospitals can choose to limit services, based on utilization and availability of resources without affecting federal Medicare/Medicaid certification and without the need for waivers to federal or state requirements.

Two hospitals, Providence Seward Medical Center & Cordova Community Medical Center, are currently licensed as Rural Primary Care Hospitals.

Facility Cost Containment Regulations

During the past two years, the Medicaid Rate Advisory Commission (MRAC), under the auspices of the Dept. of Health and Social Services, has been working on formulating and implementing regulations which improve the rate setting process used for hospitals and nursing homes while containing Medicaid program costs. The regulations were implemented in January 1997.

Provisions which improve the rate setting process included expanding and defining timelines for activities in the process; removing penalties to Medicaid payment rates for late filing of reports by facilities; removing unnecessary calculations and reporting forms; providing an opportunity for facilities to amend reports submitted to the department; and adjusting calculations to use more current cost information as the basis for establishing the prospective payment rates.

One provision in the regulations which focused on cost containment applied an occupancy standard in the calculation of nursing facility per diem payment rates. Application of this provision will reduce Medicaid payments to those nursing facilities which maintain surplus bed capacity, and discourage providers from building unneeded nursing facility beds.

Other changes which improved the rate setting process while containing costs for the Medicaid program include expanding by one year the time available to audit and work with facilities to complete the rate setting process; changing and simplifying the manner in which capital is calculated for purposes of Medicaid rate setting; clarifying that certain costs are not allowable for purposes of Medicaid rate setting and reimbursement; revising and clarifying the manner in which the year-end conformance calculation is performed; clarifying problematic definitions previously discovered in the rate setting regulations; and clarifying the calculation of payment rates for new facilities participating in the Medicaid program.

Increasing 100% Federal Reimbursement for Natives

New federal policy released during FY97 expanded 100% federal funding for Medicaid services to Alaskan Natives to include tribal facilities and contract health services. Most contract care funds for Alaskan Natives remain with the Alaska Native Medical Center in Anchorage, as that is the tertiary care center for the native health care delivery system, although some contract care funds are allocated to Fairbanks and Southeast tribal health programs. The division has entered into data agreements with the IHS, and has developed protocols for claiming federal funding for contract health services provided through the private sector in a manner that will maintain an audit trail.

Instituting Claims with the Indian Health Service

Because the IHS was incapable of producing detailed claims, their facilities have submitted claims to the division in summary form since the mid 1980s. Since fall 1996, the division has been working with the facilities to complete and submit claims for hospital and clinic services. The division's goal in accepting IHS claims is to gain data from these facilities on the services provided and the recipients receiving those services, and assure that the IHS facilities will be able to participate as primary care providers in future managed care plans. Some facilities began submitting claims in the summer of 1997, and the division plans to have all IHS facilities submitting claims during calendar year 1998.

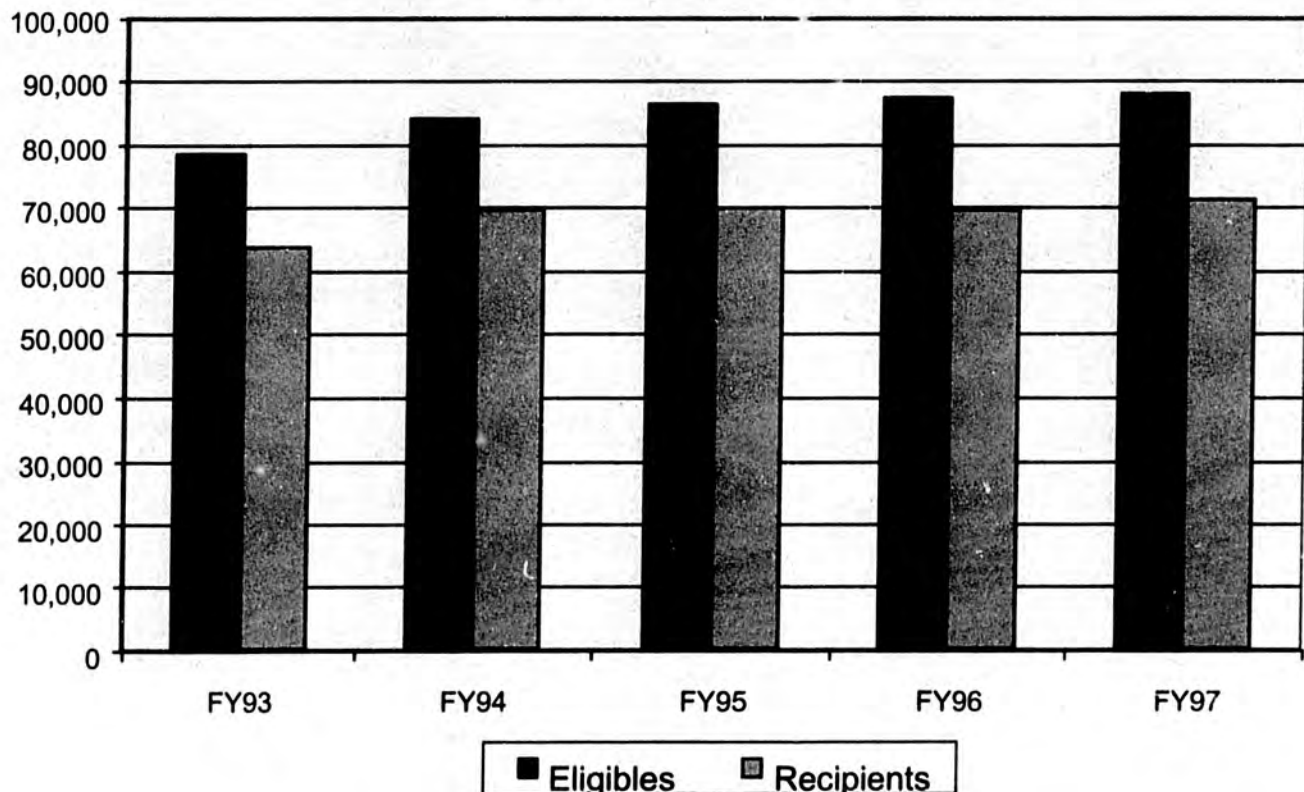
Our Beneficiaries

Medicaid Eligibles and Recipients

The terms "eligibles" and "recipients" are common throughout this report. When a person becomes eligible for Medicaid, he/she may use the benefits available. Once those benefits are used, that person becomes a recipient. The table and graph below show the growth in eligibles and recipients Alaska's Medicaid program has experienced for the past five fiscal years.

Since FY93, the number of eligibles has increased 12.1% while the number of recipients has grown proportionately, by 11.8%. From FY96 to FY97, the number of eligibles grew by 0.9% and the number of recipients grew by 2%. The usage rate of Medicaid services by eligibles has hovered around 80% for the past several years.

Medicaid Eligibles and Recipients



	FY93	FY94	FY95	FY96	FY97
Eligibles	78,418	83,920	86,445	87,159	87,977
Recipients	63,663	69,631	69,739	69,608	71,179
% Usage	81%	83%	81%	80%	81%



Haines resident Becky Hinkle is ecstatic about Alaska's Medicaid program.

"If it weren't for them, Kristy would have dried up and withered away."

Kristy Hinkle was an active 11 year old girl who never thought about eating disorders. She liked Mom's home cooking and she wanted to eat, but she couldn't keep any of it down, and this made her scared.

"I thought I was really sick," Kristy said. "I thought I was going to die."

When both mother and child reached the point of knowing there was something seriously wrong, Becky took her daughter to the Haines Public Health Center for help. There, she found a nurse who also wanted to get to the bottom of what appeared to be a psychological eating disorder, an uncommon problem for an 11 year old.

"She vomited up every meal," said Naomi Kerwin, a Public Health nurse. "They're usually in their teens when they start thoughts of self image and induce vomiting. I've never heard of a kid that young with bulimia."

After seeing doctors and nurses in Haines, Kerwin suggested that Becky take her daughter to see a Juneau pediatrician. It was also suggested that if she could not afford expensive medical care, Becky should apply for Medicaid for her three kids. Since this problem appeared to be very serious, Naomi Kerwin would help expedite the application, along with some help from the Division of Public Health's Medicaid Services Unit.

"The Public Health nurse gave me the information I needed to apply for Medicaid," Becky said. "It took about a week to get on the program. Naomi really helped us out."

Once on Medicaid, the testing in Juneau began. Although Kristy's problem was still thought of as psychological, physical tests were ordered as well.

"She had to drink this stuff that would show what her swallowing was like," Becky said. "Instead of going through smoothly, it would spurt through. The valve near her esophagus just collapsed and closed down."

The magnetic resonance imaging (MRI) test that Kristy had taken left no doubt what the problem was: achalasia, a disorder where visceral openings fail to relax. Instead of needing mental health counseling, it was determined surgery at Children's Hospital in Seattle could correct the problem.

"I was ready for it... kinda scared, though," Kristy said. "I was in the hospital for a day or two after the surgery. I couldn't eat anything, only drink liquid."

Since Kristy's surgery, life has returned to normal for the Hinkles. Becky has taken a job where she can buy health insurance and she no longer needs Medicaid. "I think the last coupon came through in October," she said.

And now that Kristy is back to her old self and eating again: "Chicken and dumplings are my favorite. Mom makes the best."

Dr. William Larson, M MD Faap, has been seeing Medicaid patients in Alaska since 1970. The doctor is a tall quiet man whose eyes light up when you talk about his passion – children. After a brief three years at Elmendorf Air Force Base, Larson has spent more than twenty years in Anchorage as a general pediatrician with the last seven specializing in allergies and Attention Deficit Disorders (ADD).

During the late 1970s, in addition to his growing private practice, Dr. Larson served as the Medical Director at the Anchorage Neighborhood Health Center. Because of the clinic's downtown location and the fact that patients were charged on a sliding scale (based on what they could afford), the clinic served a large number of Medicaid eligible patients.



"I've been seeing Medicaid patients, mostly kids, for twenty seven years," Larson said. "I've never – so far as I know – turned one away in my whole life. I believe Medicaid is one of the better health insurance programs. Medicaid makes medical care available to the poor and the working poor. I worry though, about families caught in the middle, those who don't have health care insurance or Medicaid, who don't receive adequate health care."

"I've known Bill for 25 years. I am a consultant in pediatric gastroenterology, so he and I have shared the care of many children through the years. He is a man of tremendous energy and dedication."

Dr. Clinton B. Lillibridge

As his specialty is children diagnosed with ADD, Larson has strong views on needs for such patients.

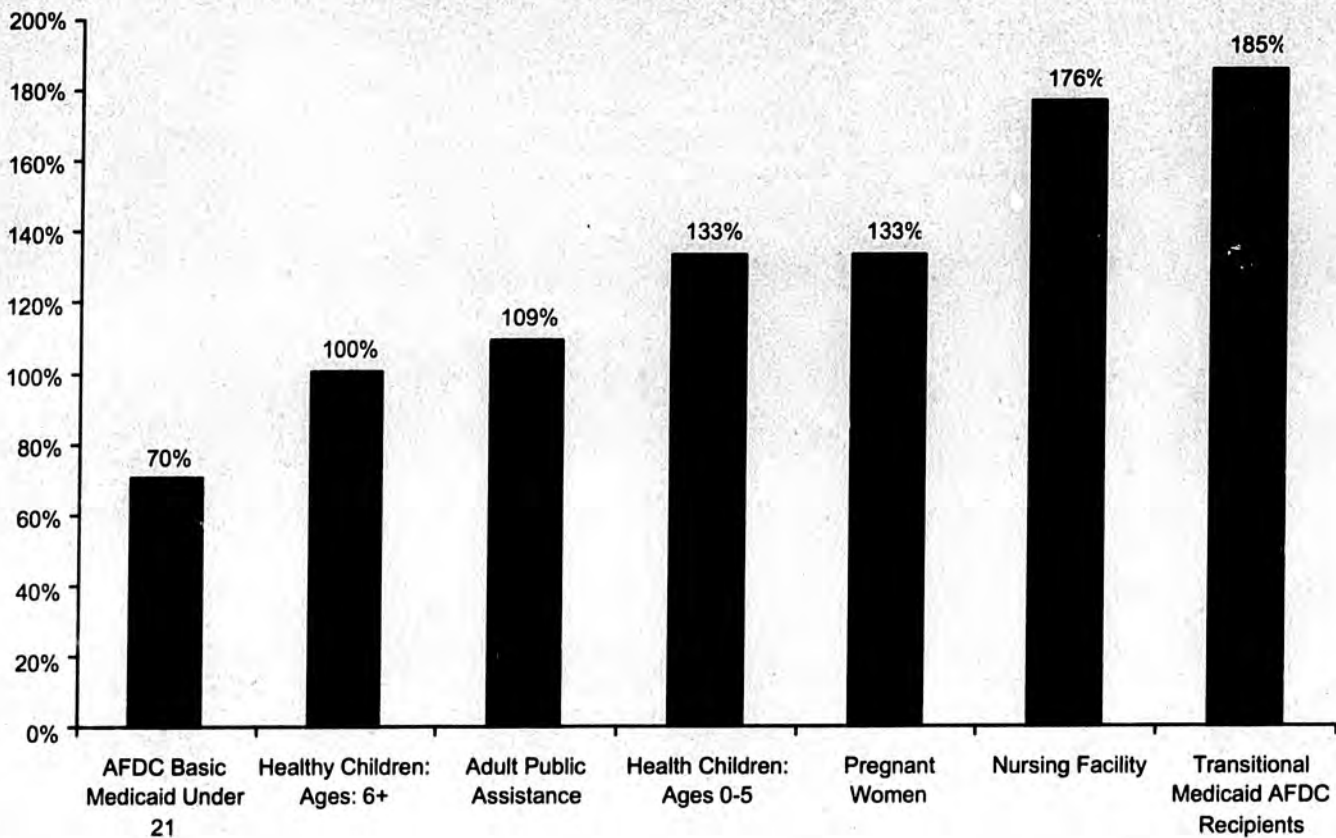
"They need structure and stability at home and in school," he said. "They need an early diagnosis so that their teachers can respond appropriately to their scattered, hyperactive behavior; and they need medication so that they can stay on focus, complete one set of instructions, and move through the day without distractive behavior. They need the same thing adults with ADD need. There is increasing evidence that ADD (which tends to be genetic) doesn't go away."

Over the years, the doctor's young patients have grown up. Not every one of them have graduated with honors, but thanks to Larson's expertise in the field of pediatrics, persistence in

character, and love for children, one vulnerable premature baby the doctor cradled in the palm of his hand 18 years ago is donning a cap and gown this spring.

People receive Medicaid by qualifying for certain cash assistance programs or by meeting Medicaid qualifying need standards. The federal poverty level and the Aid to Families with Dependent Children (AFDC) eligibility standards are updated at different times of the year. The graph and table below compare eligibility need standards and poverty levels in effect on January 1, 1997.

Alaska Medicaid Eligibility by Qualifying Need Standard



% of Poverty	Household Size	Annual Income	Hourly Equivalent
70%	4	\$14,088	\$6.77
100%	4	\$20,070	\$9.65
133%	4	\$26,700	\$12.84
185%	4	\$37,140	\$17.86

Medicaid Hotline

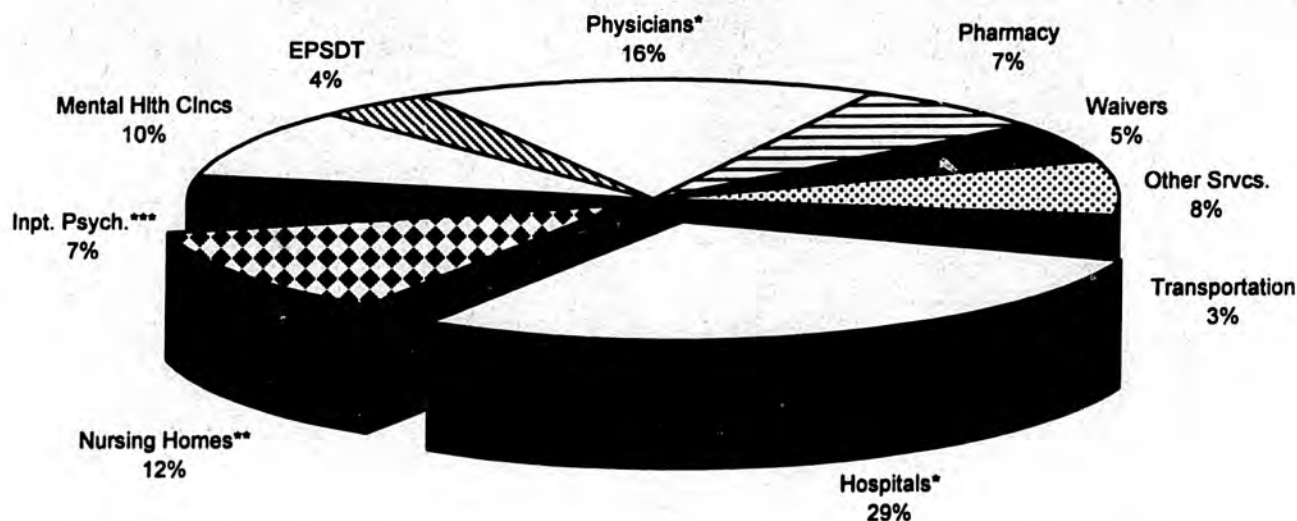
The Medicaid Hotline was initiated in July 1996 and is a service offered to recipients, family members, advocates, and others who call on behalf of recipients. The purpose of the Hotline is to provide consistency of information given to Medicaid customers, to provide accessibility of current information for Medicaid clients, and to serve to empower Medicaid clients regarding their own health care. During FY97, the Hotline received 6,574 calls, an average of 547 per month. The majority of the calls (54%) concerned billing issues and questions about covered services. Thirty-two percent of all callers had their problem resolved with the initial call. Problems requiring research of over 30 minutes accounted for 16% of all calls. The Hotline number is (907)561-2171 and the caller should ask for the Hotline. Collect calls are accepted. After business hours, callers may leave a message and their call will be returned the following business day.

Financial Summary

The pie chart below indicates the distribution of Medicaid funds according to the category of service provided. Hospitals, inpatient psychiatric hospitals, and nursing home facilities account for 48% of the total FY97 Medicaid costs. The chart reflects all Medicaid funds expended, including another \$9.0 million in a general fund match from the Division of Mental Health and Developmental Disabilities.

An increase in waived services from FY96 by 2% indicates that more recipients are moving from nursing home facilities into homecare. Nursing home expenditures fell by 4% compared to FY96.

**FY97 Medicaid Expenditures
by Categories of Service**



	Expenditures (in thousands)	Expenditure Percent
Hospitals*	\$102,592.4	29%
EPSDT	13,297.5	4%
Mental Hlth Clncs	34,639.6	10%
Nursing Homes**	43,775.3	12%
Inpt. Psych.***	24,417.8	7%
Physicians*	57,786.1	16%
Pharmacy	24,935.2	7%
Waivers	18,681.9	5%
Other Svcs.	27,098.2	8%
Transportation	10,958.9	3%
Total	\$358,183.0	100%

* IHS payments included.

** Includes \$1.7 million GF match in DMHDD Budget not reflected in AKSAS report.

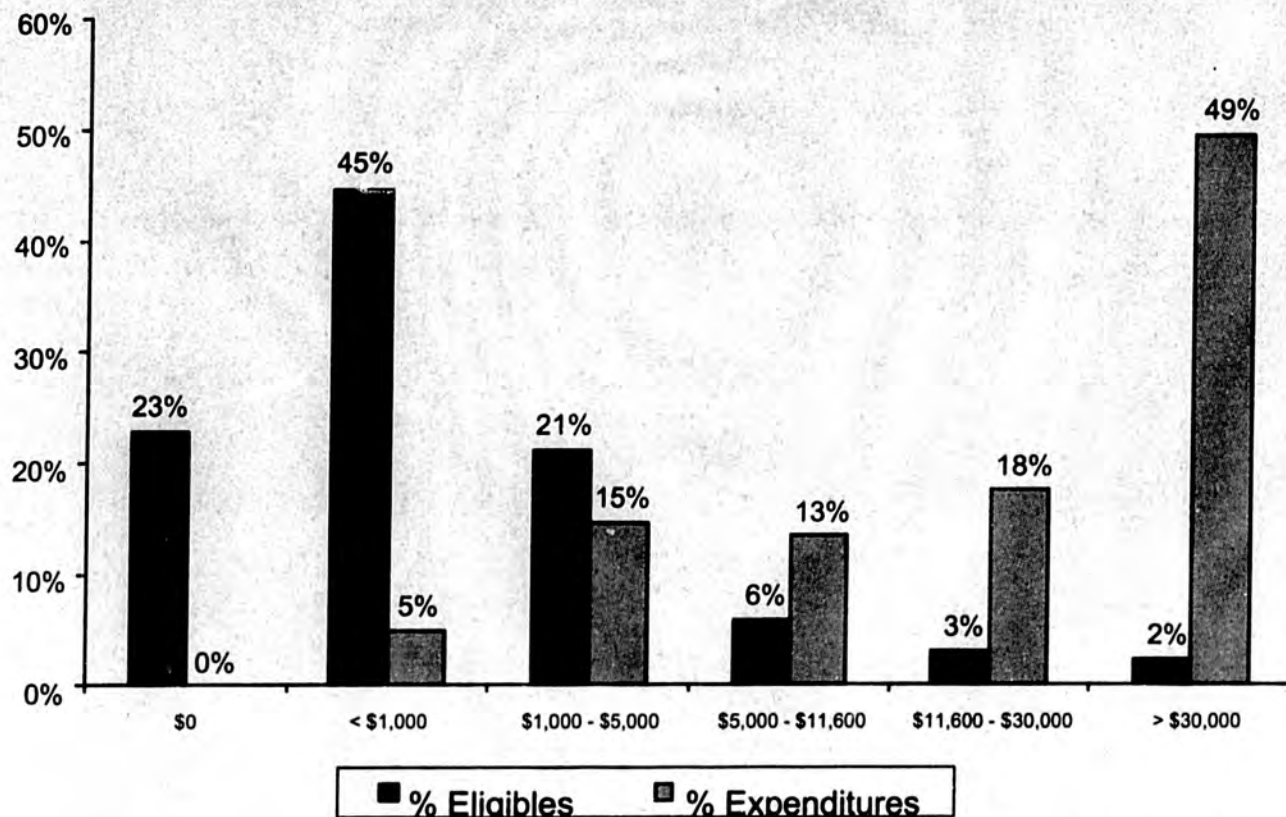
*** Includes \$7.3 million GF match in DMHDD Budget not reflected in AKSAS report.

Bulk of the money

The pie chart above indicates that hospitals and long term care institutions make up almost half (48%) of the total FY97 Medicaid expenditures. The price of the services these facilities provide is set by the Medicaid Rate Advisory Commission.

Community mental health clinics were the fourth largest expenditure for the Medicaid program in FY97. The Alaska Legislature has directed the Division of Medical Assistance to maintain these services at FY97 levels during FY98.

FY97 Medicaid Expenditure Distribution by Eligibles



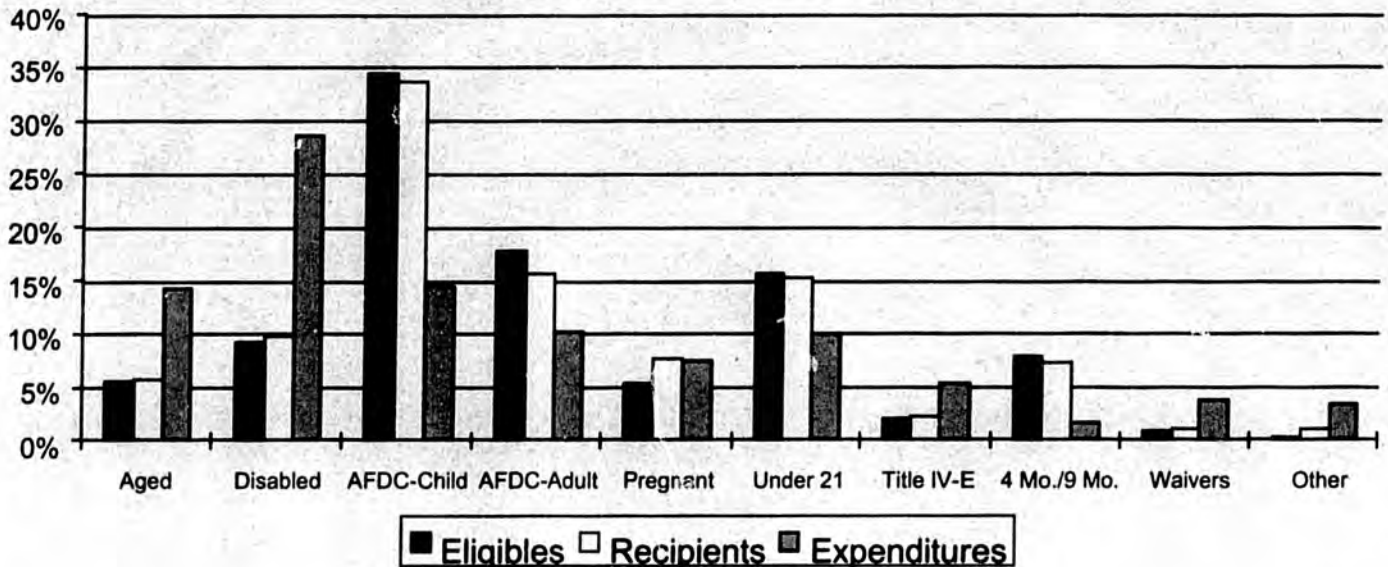
Expenditure Category	Eligibles*	Percent Eligibles	Percent Expenditures	Average Annual Expenditure Per Eligible
\$0	18,391	21%	0%	\$0
< \$1,000	40,191	46%	5%	\$365
\$1,000 - \$5,000	19,125	22%	15%	\$2,282
\$5,000 - \$11,600	5,334	6%	13%	\$7,480
\$11,600 - \$30,000	2,843	3%	18%	\$18,311
> \$30,000	2,093	2%	49%	\$70,133
Total	87,977	100%	100%	\$3,377

* Eligibles count based on last eligibility segment in SFY 1997.



The Early and Periodic, Screening, Diagnosis and Treatment program, commonly called **Healthy Kids**, had over 56,000 children enrolled last year. Of that number, 38% were six to 14 year olds. Babies from birth to one year old accounted for just over 11% of the enrolled children.

FY97 Medicaid Eligibles, Recipients & Expenditures by Categories of Assistance



The chart above shows the relationship among the number of Medicaid eligible people, recipients of services, and the cost of those services as defined within categories of assistance. In some cases, the level of recipients may be greater than eligibles. This is due to this chart being based on date of payment rather than date of service. A Medicaid eligible person may have received services in the prior fiscal year but those services may not have been billed to Medicaid until the current fiscal year. Thus, the recipient count could appear greater than the current eligible count.

As can be seen in the chart, the distribution of eligibles and recipients by categories of eligibility are often disproportionate to the expenditures distribution.

Average Yearly Cost Per Medicaid Eligible

The table on the right displays the average yearly cost per Medicaid eligible from FY87 through FY97. Since FY87, the average cost has increased \$1,337, or 68%.

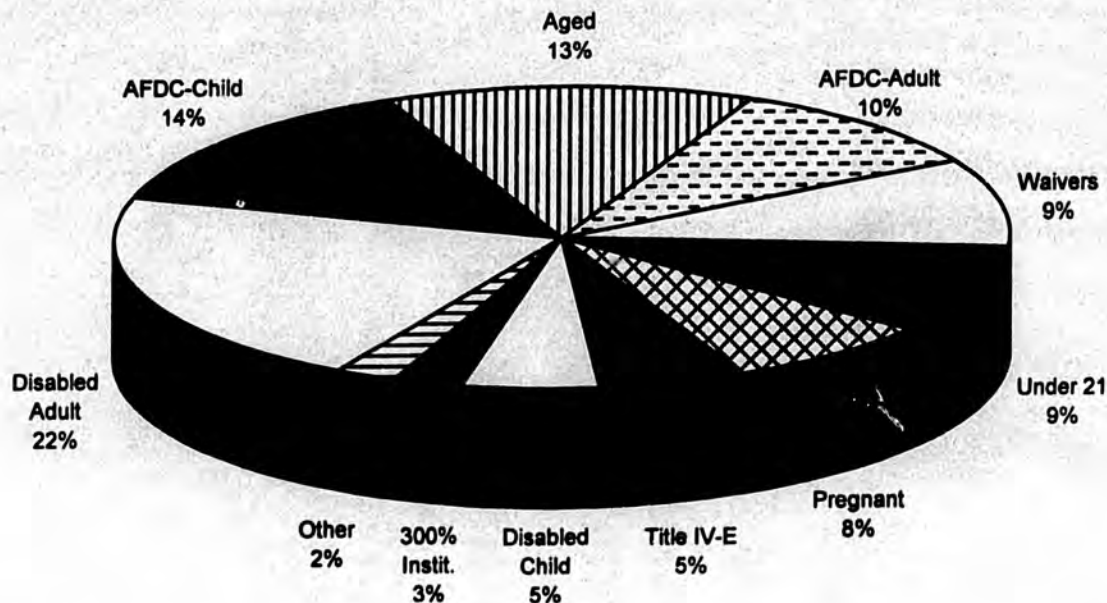
This table is being reported differently than in past fiscal year reports. It now shows "eligible" instead of "recipient" cost. Providing average eligible costs will better help gauge the potential expenditures of the Medicaid program. Also, this table now reflects all Medical assistance services except Indian Health Services and state program expenditures.

A major increase in the average yearly cost per eligible is not a reliable indicator for the cost of adding clients to the Medicaid program. The best cost indicators are the medical condition of new eligibles, the number of individuals within a new eligibility category, and the costs associated with the types of services they utilize.

Year	Ave. Cost*	Eligibles
1987	\$1,962	39,843
1988	\$2,109	43,318
1989	\$2,419	44,625
1990	\$2,728	47,793
1991	\$2,790	57,251
1992	\$2,677	69,286
1993	\$2,602	78,418
1994	\$2,897	83,920
1995	\$2,974	86,445
1996	\$3,207	87,159
1997	\$3,299	87,977

*Rounded

FY97 Medicaid Expenditures by Categories of Assistance



Federally identified categories of medical assistance are broadly defined as: aged, disabled, AFDC children, and AFDC adults. Medicaid eligibility programs are further classified by basis of eligibility for medical care. The pie chart above shows the percentage of FY97 Medicaid expenditures for the various categories of assistance. A reduction in disabled adult expenditures by \$5 million from FY96 most likely had an impact on the \$17 million increase in waiver services from last fiscal year as more recipients are taking advantage of home and community-based care services.

Category	Expenditures	Percent
Disabled Adult	\$62,108,484	22%
AFDC-Child	\$40,449,625	14%
Aged	\$38,164,431	13%
AFDC-Adult	\$29,551,708	10%
Waivers	\$27,345,366	9%
Under 21	\$27,291,932	9%
Pregnant	\$21,999,932	8%
Title IV-E	\$15,301,313	5%
Disabled Child	\$14,042,507	5%
300% Institutional	\$7,648,121	3%
Other	\$6,346,836	2%
Total	\$290,250,255	100%

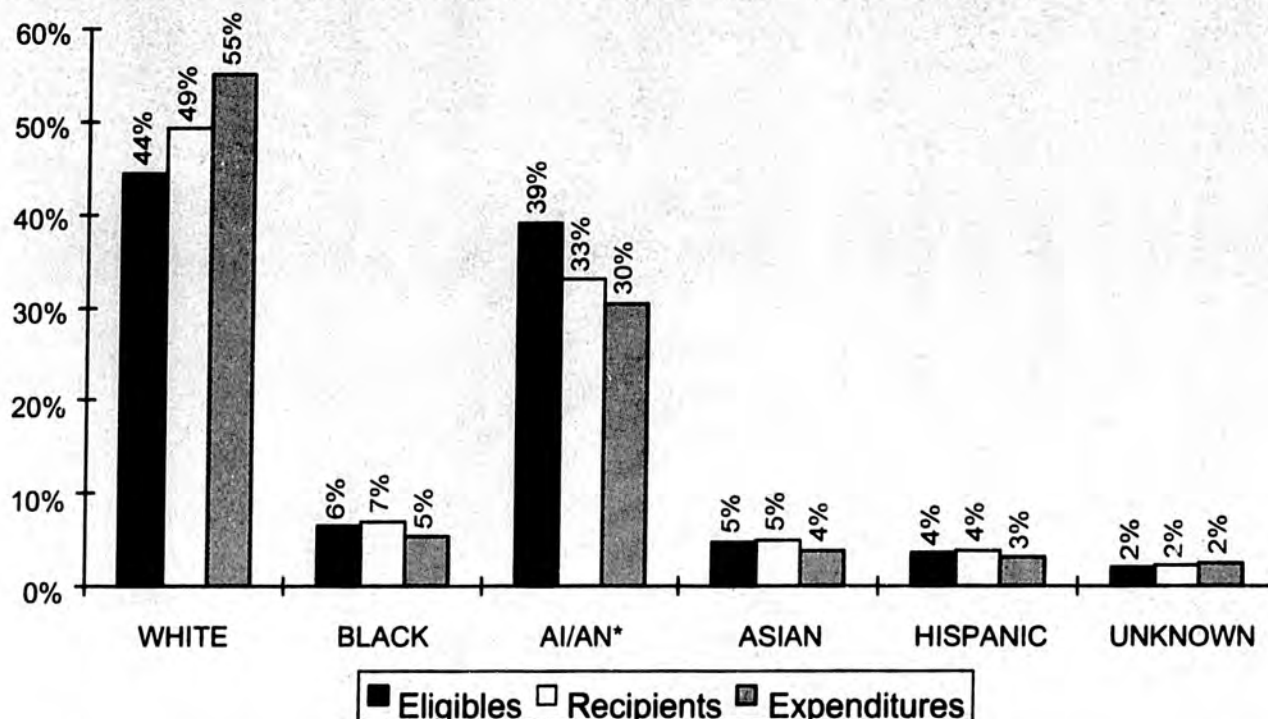
Based on Medicaid claims processed through MMIS. Excludes IHS funds and Reimbursable Service Agreements (RSAs), TPL recovery contracts, and AKSAS adjustments not reflected on MMIS.



Dr. Bruce Chandler is a pediatrician at the Anchorage Neighborhood Health Center. During FY97, there were 3,337 providers participating in the Medicaid program, including doctors, dentists, hospitals, nursing homes, pharmacists, and a variety of other health care professionals and services. The average payment per participating provider in the Medicaid program for FY97 was \$86,979.

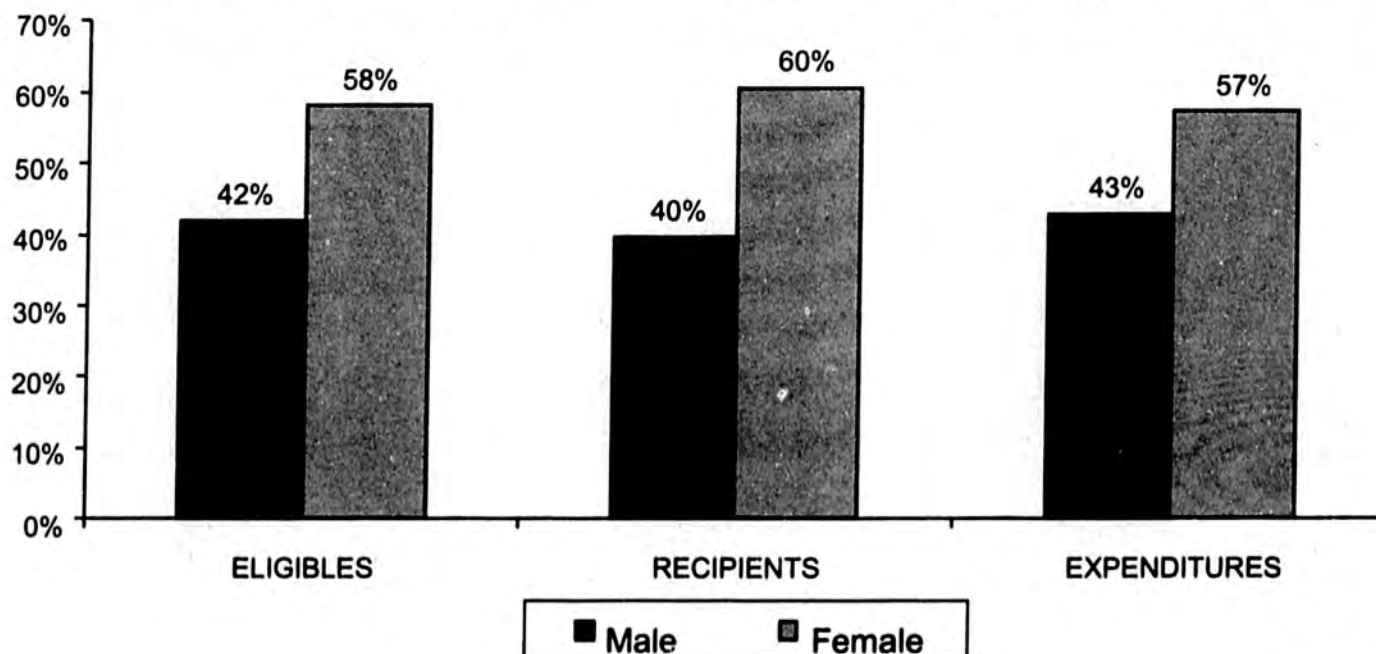
The chart below shows Medicaid eligibles, recipients and expenditures by race. The recipient counts for American Indian (AI) and Alaska Natives (AN) are low because the Indian Health Service (IHS) does not supply that information to the division for IHS claims. The number of eligible persons and the financial information for IHS claims has been otherwise included in the chart below, but the recipient count for the AI/AN category is probably significantly under represented.

FY97 Medicaid Eligibles, Recipients & Expenditures by Race



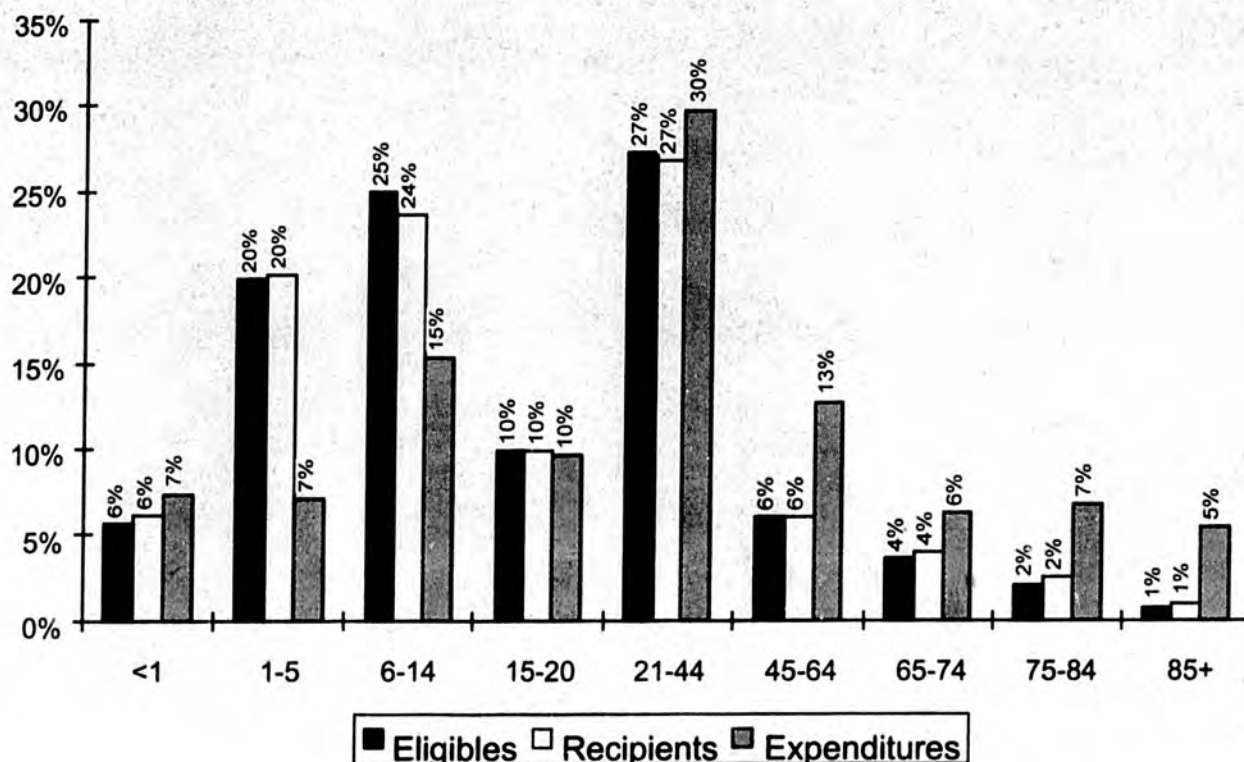
The Medicaid eligible population is approximately 42% male and 58% female, as shown below. Recipients are approximately 40% male and 60% female. Females account for 57% of Medicaid expenditures and males account for 43%. These percentages have changed little, if any, from FY96.

FY97 Medicaid Eligibles, Recipients & Expenditures by Sex



The following chart shows Medicaid eligibles, recipients and expenditures as related to age. Information regarding IHS facilities is not reported.

FY97 Medicaid Eligibles, Recipients & Expenditures by Age Group



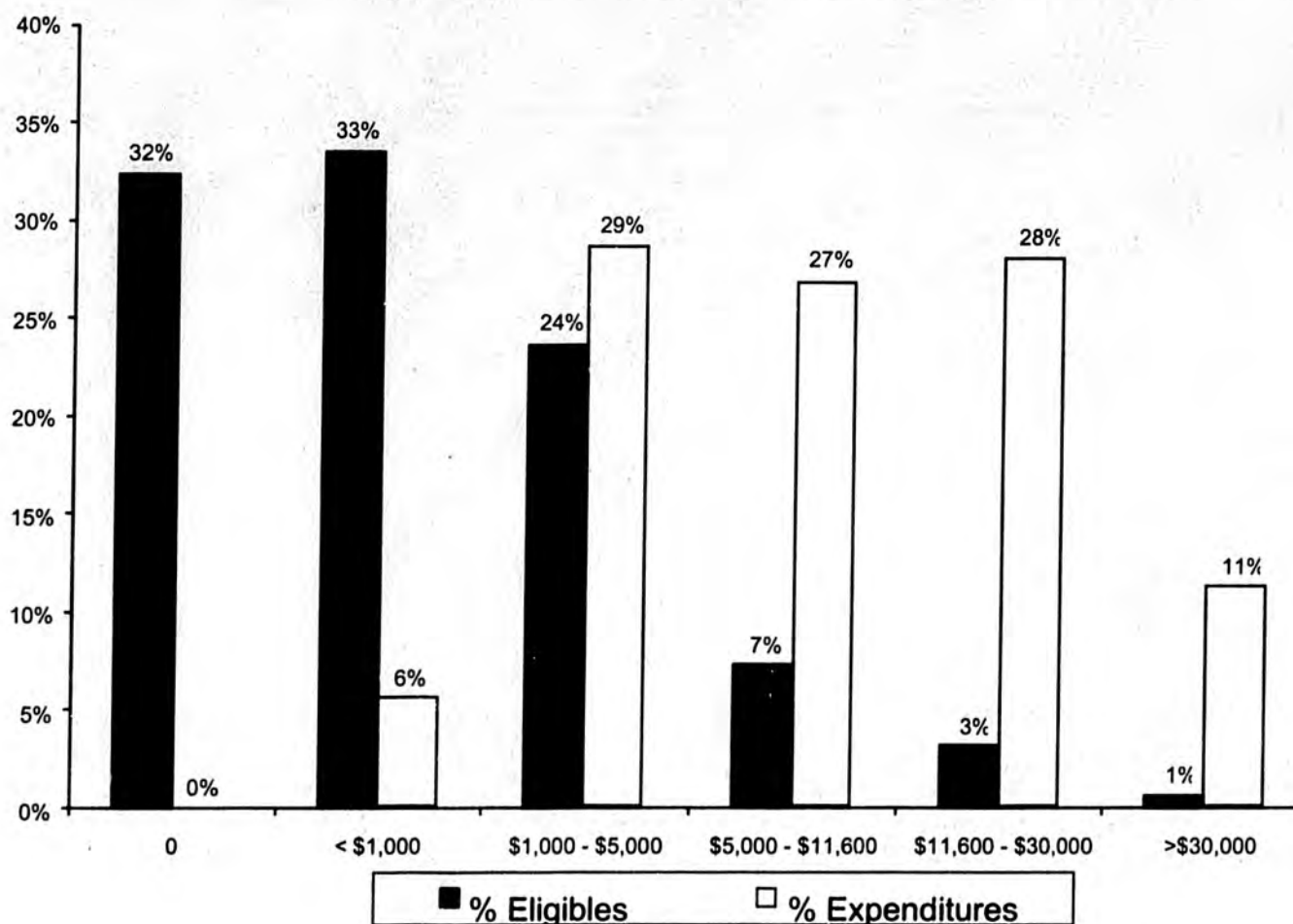
Age	Expenditures	Recipients	Cost Per Recipient	Eligibles	Cost Per Eligible
<1	21,380,206	4,385	\$4,875	4,982	\$4,291
1-5	20,535,914	14,329	\$1,433	17,482	\$1,175
6-14	44,288,377	16,836	\$2,631	21,930	\$2,020
15-20	27,798,684	7,010	\$3,966	8,699	\$3,196
21-44	86,291,398	19,088	\$4,521	23,970	\$3,600
45-64	36,840,960	4,289	\$8,589	5,279	\$6,979
65-74	18,039,022	2,807	\$6,425	3,164	\$5,702
75-84	19,586,460	1,749	\$11,196	1,827	\$10,722
85+	15,489,237	684	\$22,630	644	\$24,053
Total*	\$290,250,257	71,179	\$4,078	87,977	\$3,299

*Excludes Medicaid expenditures for IHS, RSA's, TPL recovery contracts, & AKSAS accounting. Adjustments are not processed thru MMIS.

State Only Programs

The following graph and table illustrate the distribution of expenditures for the state funded General Relief Medical (GRM), Permanent Fund Dividend Hold Harmless (PFDHH), and Alaska Longevity Bonus Hold Harmless (ALBHH) programs. The data demonstrates that 65% of eligibles during FY97 required less than \$1,000 in services to be paid. These expenditures were mostly for physician services and prescription drugs. The data also shows that 1% of the eligibles required \$30,000 or more in expenditures. The majority of this cost can be attributed to inpatient hospital services.

**FY97 State Funded Medical Assistance Programs
Expenditure Distribution by Eligible**



Expenditure Category	Unduplicated Eligibles*	Percent Eligibles	Percent Expenditures	Average Annual Expenditure Per Eligible
0	522	32%	0%	\$0
< \$1,000	540	33%	6%	\$332
\$1,000 - \$5,000	381	24%	29%	\$2,421
\$5,000 - \$11,600	117	7%	27%	\$7,373
\$11,600 - \$30,000	50	3%	28%	\$18,045
> \$30,000	9	1%	11%	\$40,310
	1,619	100%	100%	\$1,995

* Eligibles count based on having a GRM or Hold Harmless eligibility segment in SFY97.
Expenditure amounts are based on services rendered in SFY97 and paid for between 7/1/96 and 9/30/97.

Alternatives to Institutional Care

There are a number of services available for people who desire to receive an institutional level of care within their home. These options are outlined below, along with FY97 expenditure and utilization information. For complete information regarding these services, please contact the agencies responsible.

Home and Community-Based Care

The Medicaid Home and Community-Based Care (HCBC) program allows persons to receive the health care they need in their home rather than an institution. The cost of these waiver services must be no more than the cost of the institutional services which the person would have otherwise required. During FY97, 917 Alaskans chose waiver services, which is almost double the number from FY96. This increase could be attributed to a streamlined application procedure and management consolidation of services. The number of providers participating dropped from 662 in FY96 to 409 during FY97.

The HBCB program is a joint effort among DMA, DMHDD (Dept. of Health and Social Services) and the Division of Senior Services (Dept. of Administration). DSS is responsible for care coordination, client intake, assessment, and care plan development for Older Alaskans and Adults with Physical Disabilities. DMHDD is responsible for Children with Complex Medical Conditions and People with Developmental Disabilities.

Home and Community-Based Care Program FY97 Utilization and Expenditures

Population Served	No. of Recipients	HCBC Expenditures*	Other Medicaid Expenditures	Total Medicaid Expenditures
Children with Complex Medical Conditions	70	\$1,569,842	\$1,663,453	\$3,233,365
People with Developmental Disabilities	343	\$14,797,065	\$2,060,473	\$16,857,881
Adults with Physical Disabilities	91	\$1,542,793	\$1,418,156	\$2,961,040
Older Alaskans	413	\$4,587,075	\$1,982,193	\$6,569,681
Totals	917	\$22,496,775	\$7,124,275	\$29,621,967

*Expenditures reflect claims paid through MMIS during FY97

TEFRA

The Tax Equity and Fiscal Reconciliation Act of 1982 option provides another method for assuring Medicaid coverage for children with disabilities who would otherwise have to live in an institution. This optional eligibility group was added to the Medicaid statute in 1993 to allow children to qualify for Medicaid without counting the income of their parents. During FY97, the Division of Medical Assistance funded services to 245 children under TEFRA. The total expenditure for these services was \$2,459,459.

For more information regarding the TEFRA option, contact the Division of Mental Health and Developmental Disabilities at (907)465-3370.

Personal Care Attendant Services

Personal Care Attendant (PCA) services are intended to enable a person with nontechnical medical care needs to remain at home rather than live in an institutional setting. Medicaid pays for these services when provided by personal care agencies or through independent PCAs enrolled as a provider in the Medicaid program. In FY97, PCA services were provided to 980 people at a cost of \$4,575,022. Personal care agencies provided services to 940 Medicaid recipients; independent PCAs provided services to 65 recipients; and personal care nurses provided services to 26 recipients.

For more information regarding the PCA program, contact the Division of Senior Services at (907)563-5654.

Keeping Children Healthy

The Dept. of Health and Social Services offers two coordinated efforts among the Divisions of Public Health, Public Assistance, and Medical Assistance which are designed to provide services for pregnant women, children, and young adults under the age of 21.

Medicaid Healthy Baby Program

The purpose of the Medicaid Health Baby program is to ensure that pregnant women have timely access to adequate prenatal services in order to lower the rates of infant mortality and morbidity in Alaska. A pregnant woman who has income at or below 133% of the federal poverty level is eligible for the program. Following birth, if the child remains with the mother, the child receives medical care paid for by the program for his/her first year of life.

Total Births in Alaska/Medicaid Births

	1989	1990	1991	1992	1993	1994	1995	1996
Total Births	11,656	11,901	11,688	11,715	11,073	10,590	10,236	10,035
Medicaid Births	2,587	3,221	3,823	4,228	4,220	3,999	4,152	4,660
% of Births to Medicaid Recipients	22%	27%	33%	36%	38%	38%	41%	46%

Reporting period based on calendar year.

Medicaid Healthy Kids Program

Sometimes called Early and Periodic, Screening, Diagnosis and Treatment Program, or EPSDT, the Healthy Kids program helps to detect and treat health concerns early for low income children from birth to age 21. The program is also designed to improve the health status of needy children and to replace crisis-only health care with an orderly system of preventative care.

Healthy Kids Screening

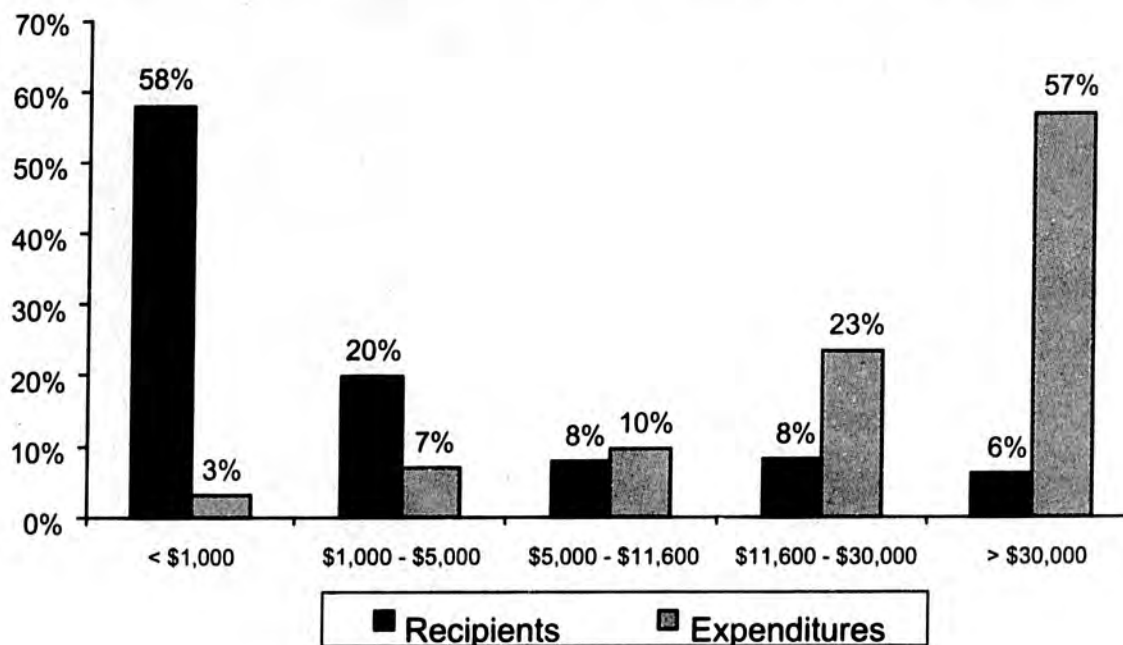
In 1991, the State of Alaska adopted the American Academy of Pediatrics Periodicity Schedule for well child care or "Healthy Kids Screening Schedule." This screening schedule increased the number of screens due for each child by 33%. This periodicity schedule includes six screenings in the first year of life, three in the second, annual screenings) to age six, and then every other year until age 20. For more information regarding the Health Baby or Health Kids programs, contact the Medicaid Services Unit at (907)465-2845.

Mental Health Services

The Division of Medical Assistance works with the Division of Mental Health and Developmental Disabilities (DMHDD) to provide coverage for mental health clinic and rehabilitation services through community mental health clinics. DMA focuses on processing of claims, and financial audit functions. DMHDD is responsible for client advocacy, quality assurance, and administration of non-Medicaid funding sources. Services provided include assessments, various therapies, and medication management. For more information regarding mental health services available through the Medicaid program, contact DMHDD at (907)465-3370.

The following chart shows the expenditure range for children recipients of mental health services. Less than \$1,000 was spent on a majority (58%) of recipients while 6% of the population cost \$30,000 or more for services. These expenditures include FY97 Medicaid payments for children served by DMHDD grants. There were a total of 3,419 unduplicated recipients under 21 that received services in FY97. Total cost of mental health services for this age group was \$22,164,639.

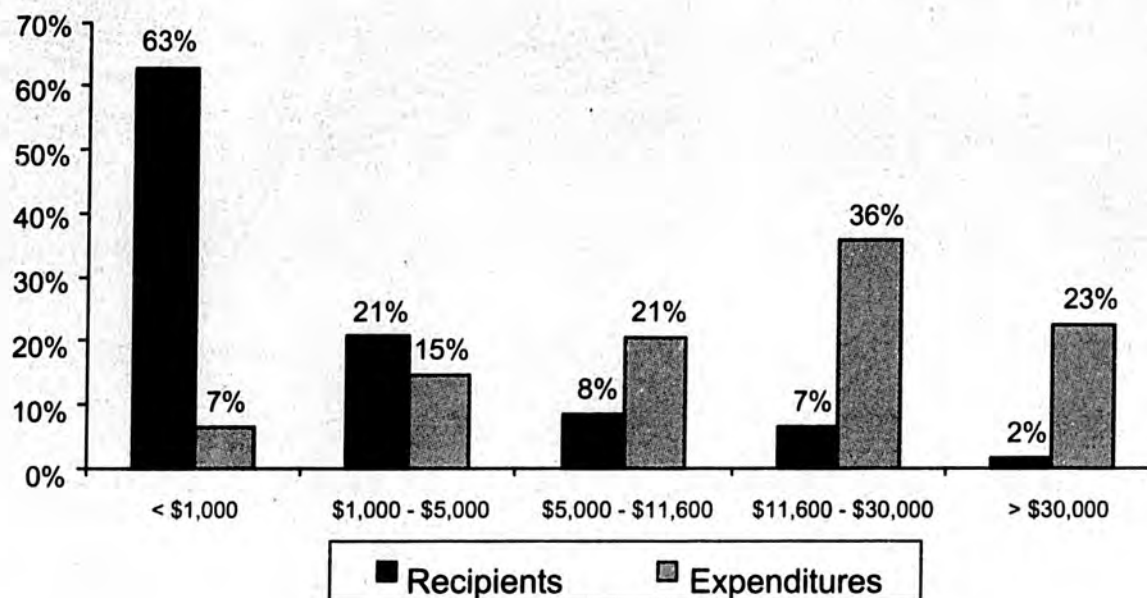
FY97 Community Mental Health Services for Children (under 21 years)



Expenditure Category	Unduplicated Recipients <21 Years		Expenditures	Percent
	Recipients	Percent		
< \$1,000	1,981	58%	\$701,178	3%
\$1,000 - \$5,000	679	20%	\$1,537,688	7%
\$5,000 - \$11,600	266	8%	\$2,153,423	10%
\$11,600 - \$30,000	282	8%	\$5,185,852	23%
> \$30,000	211	6%	\$12,586,498	57%
Total	3,419		\$22,164,639	

The following chart shows the expenditure range for adult recipients of mental health services. Services received by the majority (63%) of recipients cost less than \$1,000 while 2% of the recipients cost in excess of \$30,000 apiece. A total of \$11,540,834 was expended for services to 3,515 people.

FY97 Community Mental Health Services for Adults (age 21 and over)



Expenditure Category	Unduplicated Recipients		Expenditures	Percent
	>=21 Years	Percent		
< \$1,000	2,202	63%	\$764,362	7%
\$1,000 - \$5,000	727	21%	\$1,679,802	15%
\$5,000 - \$11,600	297	8%	\$2,380,545	21%
\$11,600 - \$30,000	231	7%	\$4,114,770	36%
> \$30,000	58	2%	\$2,601,354	23%
Total	3,515		\$11,540,834	

Applying for Medicaid

Medicaid eligibility depends on a number of factors but generally a person must have a low income to qualify. People interested in applying for the Medicaid program may contact a Public Assistance Office or a village fee agent. To apply, a person must fill out an application form and have an interview. The application and interview are confidential. No one will give out information regarding health, income, or other private information regarding the applicant. After reviewing the application, the Public Assistance Office will send the applicant a notice saying whether or not the applicant is qualified. If the application is denied, the notice will indicate why; if the applicant does qualify, the notice will say what benefits are allowed and when they will begin. If a person does not qualify for Medicaid, he/she may always apply again if income, resources, or medical needs change. For more information regarding where a Public Assistance Office is located, persons interested may call toll free 1(888)804-6330.

Indian Health Service & Tribal Facilities

IHS and tribal contract facilities listed below are providers who directly bill DMA by monthly invoice for reimbursement of services rendered to Medicaid eligible patients. All data presented is collected by each facility and does not reflect any claims data in the MMIS. The following table summarizes FY97 IHS recipients, units of service and expenditures for these contract facilities.

Summary of FY97 IHS Billings by Facility

Facilities	INPATIENT			OUTPATIENT		
	Recipients	Days	Amount	Recipients	Visits	Amount
Anchorage	1,530	6,930	\$6,815,576	18,450	35,303	\$8,642,399
Barrow	17	30	\$27,900	436	996	\$239,734
YKHC/Bethel	1,025	2,348	\$2,086,057	18,606	29,919	\$6,647,392
Kanakanak	80	163	\$152,448	2,829	4,219	\$888,801
Kotzebue	268	294	\$292,971	3,183	6,379	\$1,481,239
Mt. Edgecumbe	107	274	\$253,350	2,181	3,192	\$745,813
Fairbanks	-----	N/A	-----	10,446	15,787	\$3,711,038
Juneau	-----	N/A	-----	2,514	4,486	\$901,515
Ketchikan	-----	N/A	-----	2,266	3,715	\$821,446
Metlakatla	-----	N/A	-----	1,314	2,411	\$549,922
Chugumuit	-----	N/A	-----	260	378	\$97,744
Aleutian/Pribilof	-----	N/A	-----	110	211	\$49,547
Other Providers			\$2,582,188			\$3,428,119
Totals	3,027	10,039	\$12,210,490	62,595	106,996	\$28,204,709

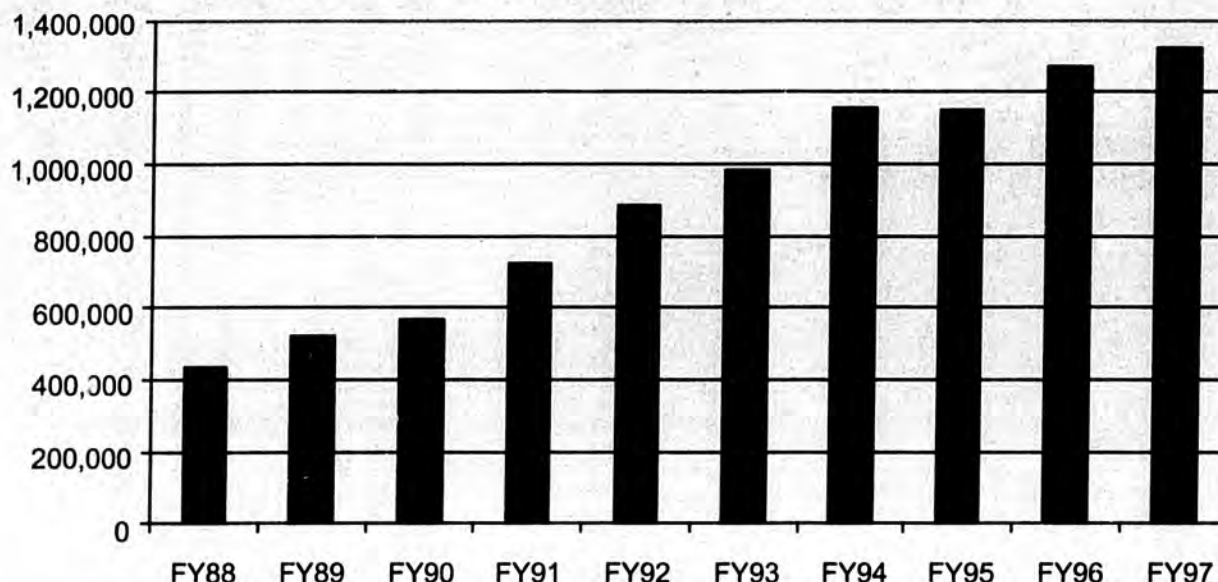


Helen Carius, born at Boxer Bay on St. Lawrence Island, contracted polio when she was 11 years old. She has been self supporting all her life and only became a Medicaid recipient when she was 65 years old. Here she spends time with her daughter, Shirley, and granddaughters Amara and Reine. Helen's wheelchair was provided through the Medicaid program.

Providers Billing Medicaid

The term "claim" in the realm of medical assistance simply means that a provider is billing Medicaid for the services or procedures that he/she has performed for a recipient. The increase in the volume of claim documents processed from FY88 through FY97 is shown below. The total number of claim documents has increased tremendously during this time, which may be attributed in part by providers submitting claims electronically instead of by traditional paper claims. Electronic claims submissions have increased by over 60% from FY88.

Claim Documents Processed (FY88-FY97)



Electronic claims may be submitted by the provider by sending in a computer disk of information or by using a modem to telephonically transfer information. All claims are submitted to First Health Services Corporation, a professional company that the Division of Medical Assistance has contracted with to handle claims, payments, provider relations, and billing procedures. Once the claim is received by First Health, both the provider and recipient are checked for eligibility. If both are eligible, a number of other checks are performed, such as making sure the service or procedure provided is covered by Medicaid, and whether or not there is a third party insurance company involved. Once the claim has been deemed appropriate, First Health will then issue payment to the provider.

Fiscal Year	Average Per Month	Percent Change	Total Annual
88	36,384		436,608
89	43,382	19.2%	520,588
90	47,132	8.6%	565,589
91	60,467	28.3%	725,606
92	73,837	22.1%	886,044
93	81,704	10.7%	980,450
94	96,587	18.2%	1,159,044
95	95,835	-0.8%	1,150,018
96	105,849	10.4%	1,270,191
97	110,511	4.4%	1,326,126

When a recipient goes to a pharmacy and requests a prescription, the pharmacy performs what is called a "point-of-sale" transaction. At the time the prescription is picked up, the pharmacy will go "online" via computer and verify the recipient's eligibility – among other checks – and is essentially submitting a claim for the service being provided at that time.

Currently, 72% of claims received by First Health are electronically submitted. The average amount of time it takes from receipt of the claim to process it is 2.76 days.

Expenditures and Patient Days Utilized: Long Term Care Facilities

The following tables summarize, by facility, expenditures and patient days utilized for long term care institutions and inpatient hospitals. Amounts are based on date of service.

	*Total Days FY95	Avg Daily Cost	**Total Paid FY95	*Total Daily FY96	Avg Paid Cost	**Total Paid FY96	*Total Days FY97	Avg Daily Cost	**Total Paid FY97
SNF and ICF Facilities:									
INSTITUTION									
Providence Extended Care	68,210	\$190	\$12,992,075	68,376	\$192	\$13,139,000	61,548	\$197	\$12,098,810
Denali Center	22,794	232	5,293,611	24,071	263	6,339,772	22,078	291	6,432,795
Mary Conrad	30,176	202	6,104,233	30,751	200	6,156,705	29,587	206	6,102,185
Wesleyan Nursing Home	16,483	193	3,188,753	15,422	193	2,978,125	13,159	196	2,584,082
St. Ann's Nursing Home	12,026	216	2,600,518	12,001	222	2,659,913	10,830	225	2,433,899
Quyaana Care Center	4,762	419	1,995,946	5,052	448	2,261,137	5,104	475	2,426,128
Heritage Place	12,906	154	1,993,973	13,938	154	2,149,315	14,032	157	2,204,441
South Peninsula Hosp.	5,908	364	2,152,706	6,682	349	2,329,810	6,626	303	2,008,353
Kodiak Island Hosp.	4,486	273	1,223,253	4,296	292	1,255,397	4,250	381	1,618,045
Ketchikan Gen. Hospital	5,595	286	1,598,348	4,923	307	1,510,989	4,493	320	1,436,110
Cordova Comm. Hosp.	2,632	433	1,139,836	2,859	392	1,119,686	3,143	398	1,251,573
Harborview Dev. Center	4,564	250	1,143,275	5,384	298	1,603,892	3,689	320	1,181,048
Petersburg Gen. Hosp.	4,222	273	1,152,923	4,196	263	1,104,622	4,256	258	1,097,170
Wrangell Gen. Hosp.	3,378	276	932,647	\$3,945	271	1,070,937	3,936	277	1,090,395
Sitka Community Hosp.	300	199	59,678	1,608	216	347,382	1,197	396	473,963
Kotzebue Sr. Center	0		0	0		0	0		0
Subtotal ICF & SNF	198,442	\$220	\$43,571,775	203,504	\$226	\$46,026,682	187,928	\$236	\$44,438,998
% Change	0%	2%	3%	3%	3%	6%	-8%	5%	-3%
ICF/MR Facilities:									
Harborview Dev. Center	10,393	\$431	\$4,478,004	8,302	\$416	\$3,453,031	4,746	\$455	\$2,159,478
Hope Cottages, Inc.	14,231	\$352	\$5,008,602	13,823	\$357	\$4,929,592	0	\$0	\$0
Subtotal ICF/MR	24,624	\$385	\$9,486,606	22,125	\$379	\$8,382,623	4,746	\$455	\$2,159,478
Totals	154,856	\$343	\$53,058,381	225,629	\$241	\$54,409,305	192,674	\$242	\$46,598,476
Change relative to prior year	-31%		-1%	46%		3%	-15%		-14%

(Admin. wait days not included, GRM days included above)

*Excludes EMC Medicare crossovers

**Excludes Medicare crossovers

FY95 Data Extracted from MR-O-14 run 10/14/97 for DOS 7/1/94-6/30/95.

FY96 Data Extracted from STARS

FY97 Data Extracted from STARS

Expenditures and Patient Days Utilized: Inpatient Facilities

INSTITUTION	*Total Days FY95	Ave Daily Cost	**Total Paid FY95	*Total Days FY96	Ave Daily Cost	**Total Paid FY96	*Total Days FY97	Ave Daily Cost	**Total Paid FY97
Providence	14,429	\$1,433	\$20,675,123	15,945	\$1,492	\$23,796,218	16,366	\$1,672	\$27,367,578
Alaska Regional	4,606	1,777	8,183,306	4,287	1,435	6,153,314	4,833	1,819	8,791,077
Fairbanks Memorial	4,897	1,359	6,656,647	4,828	962	4,643,119	5,073	1,123	5,697,197
Charter North	7,759	833	6,462,125	6,569	819	5,382,950	7,070	777	5,490,249
Valley	2,051	1,570	3,220,252	1,861	1,424	2,650,496	1,823	1,565	2,852,390
Bartlett Regional	1,403	1,131	1,586,378	1,707	1,049	1,790,317	1,607	1,166	1,874,050
Central Peninsula	1,477	1,190	1,757,380	1,496	1,212	1,813,011	1,430	1,200	1,715,844
Ketchikan General	931	1,226	1,141,693	895	1,283	1,147,968	987	1,269	1,252,504
South Peninsula	599	1,620	970,186	606	1,205	730,419	700	1,339	936,954
North Star	4,214	750	3,161,572	3,881	891	3,458,934	917	992	909,549
Kodiak Island	594	1,299	771,883	567	1,304	739,428	590	1,390	820,022
Norton Sound	390	1,484	578,611	292	1,501	438,208	213	1,855	395,117
Alaska Psychiatric	721	498	358,848	715	497	355,347	699	538	375,804
Sitka Community	254	1,422	361,261	218	1,324	288,531	200	1,233	246,555
Valdez Community	84	1,120	94,108	37	1,544	57,113	86	1,153	99,152
Wrangell General	54	1,238	66,876	45	1,489	66,990	55	1,552	85,363
Cordova Community	27	1,079	29,136	45	1,206	54,256	35	1,004	35,133
Petersburg General	20	1,415	28,308	48	1,217	58,433	19	1,357	25,791
Providence Seward	75	1,381	103,542	37	1,778	65,776	23	1,050	24,150
Alaska Children's Svcs.	14,675	252	3,696,059	14,493	254	3,687,020	11,855	254	3,007,486
Totals	59,260	\$1,011	\$59,903,294	58,572	\$980	\$57,377,849	54,581	\$1,136	\$62,001,966
Change relative to prior year	-5%		-3%	-1%		-4%	-7%		8%

*Excludes EMC crossover days

**Excludes crossover expenditures

Data extracted from MR-O-14 run 9/20/95 for DOS 7/1/94 thru 6/30/95.

Data extracted from STARS run 12/9/97 for DOS 7/1/95 thru 6/30/96.

Data extracted from STARS run 12/9/97 for DOS 7/1/96 thru 6/30/97.

FY97 Total Expenditures Summary with Collocation Code *(in thousands)*

Acct	Category of Service	FY96 Actuals	FY97 Actuals
MEDICAID NON-FACILITY			
MEDICAID PHYSICIAN SERVICES			
200	Physician Services	45,267.0	45,098.5
205	Rural Health Clinics	47.7	1,244.6
210	Federally Qualified Health Center	0.0	0.0
	TOTAL MED PHYSICIAN SERVICES	45,314.7	46,343.0
MEDICAID OTHER SERVICES			
221	Transportation	10,382.1	10,958.9
222	Laboratory & Xray	1,344.4	1,349.5
223	Pharmacy	21,675.2	24,935.2
224	Glasses Non-EPSDT	473.1	536.1
225	Pros. Devices-Medical Equip	5,499.3	5,438.2
226	Hearing Services/Equipments	108.0	111.0
227	TPL Recovery Other	(372.0)	(437.3)
240	Mental Health Clinics	28,751.2	34,639.6
241	Nutritionist Services	3.1	4.1
242	Home Health Care	871.0	1,125.8
243	Adult Dental	160.9	80.8
244	Personal Care	3,278.5	3,734.8
245	Chiropractic	65.0	65.0
246	Hospice	9.6	42.7
247	Drug Abuse Center	1,455.7	2,002.0
249	Disability/Blindness Exams	206.9	177.8
250	Waiver Determination	111.0	168.5
260	Family Planning	785.8	687.6
261	Hysterectomy	899.9	623.9
262	Abortion	0.0	0.0
263	Sterilization	657.1	525.6
280	Speech Language Therapy	382.0	611.9
281	Physical Therapy	824.9	1,064.6
282	Occupational Therapy	41.0	62.5
290	QMB Medicaid Services XIX	0.0	0.0
291	QMB Medicare Services XVIII	7.7	12.7
330	Part A Buy-In Premium	2,029.7	2,295.8
331	Part B Buy-In Premium	3,648.6	3,746.4
335	Private Health Ins. Premium	0.0	0.0
	TOTAL MED OTHER SERVICES	83,299.7	94,563.6
MEDICAID EPSDT			
350	EPSDT Dental Care	5,725.0	5,985.1
351	EPSDT Physician Services	117.8	131.3
352	EPSDT Other Services	5.3	0.1
353	EPSDT Laboratory & Xray	1.0	0.1
354	EPSDT Glasses	1.0	
355	EPSDT Therapy	56.7	61.4
356	EPSDT Pros. Devices-Med Equip	5.7	0.5
357	EPSDT Transportation	157.9	152.7
	TOTAL MED EPSDT	6,069.4	6,331.3
399	TPL Recovery Contract	64.9	81.4
	TOTAL TPL RECOVERY CONTRACT	64.9	81.4

Acct	Category of Service	FY96 Actuals	FY97 Actuals
MEDICAID FACILITIES			
MEDICAID HOSPITALS			
400	Inpatient Hospital	55,352.2	56,669.2
405	Inpatient Psych Hospital	9,412.5	6,722.3
410	Outpatient Hospital	13,884.9	14,123.5
415	Outpatient Surgical Centers	723.2	644.9
	TOTAL MED HOSPITALS	79,372.8	78,160.0
MEDICAID NURSING HOMES			
420	Nursing Home Skilled	11,535.8	8,812.3
425	Nursing Home Intermediate	33,492.6	31,222.6
426	OBRA '87 REIMBURSEMENT	35.8	36.7
427	ACS Res Psy Treat	3,729.2	3,104.6
430	Nursing Home Hope ICF MR	5,013.0	161.3
440	Interim Payments	18.0	0.0
	TOTAL MED NURSING HOMES	53,824.4	43,337.6
449	TPL Recovery Contract	52.7	107.7
	TOTAL TPL RECOVERY	52.7	107.7
MEDICAID STATE PROGRAMS			
570	Inpatient Psych - API	214.9	168.3
571	API Dispr Share Adj Payment	7,384.3	7,127.1
575	DOE School Based Services	0.0	1,700.0
576	PH Compass RSA	0.0	540.1
577	CRA Compass RSA	0.0	76.2
578	DOL Tbcco LW Suit DF	0.0	35.0
580	Harborview ICF/MR	1,749.2	1,090.1
581	Harborview ICF	854.9	627.2
582	DADA RSA	70.9	119.9
583	DOE RSA	213.5	0.0
584	DOL-Legal Services RSA 100%	85.0	85.0
585	Public Advocacy RSA	41.3	67.8
587	DOL-Legal Services RSA 50%	154.1	190.0
588	DPS - Background Check	1.7	1.7
589	Disability Determination RSA	51.5	88.8
590	DFYS Identify Svc ND	0.0	14.0
591	DMHDD RSA XIX	919.0	1,146.8
594	OAC Waiver RSA	209.7	691.6
595	CON RSA XIX	65.8	66.7
596	DFYS RSA XIX	215.0	259.5
597	DFYS-MH	752.6	0.0
598	DPH RSA	6,093.4	6,884.8
	TOTAL MED STATE PROGRAMS	19,076.8	20,980.8
MEDICAID INDIAN HEALTH SERVICE			
600	IHS Clinic	7,130.6	9,428.2
610	IHS Inpatient	10,465.7	12,246.0
620	IHS Outpatient	13,024.2	18,908.7
	TOTAL MED IHS	30,620.5	40,582.9
MEDICAID WAIVERS			
OLDER ALASKAN WAIVER			
650	Care Coordination		481.5
651	Residential Support Living		1,828.3

Acct	Category of Service	FY96 Actuals	FY97 Actuals
	OLDER ALASKAN WAIVER, cont.		
652	Chore, PDN, ADC, Respite		1,296.3
653	SME & Environmental Modification		213.9
654	Meal Service and Transportation		224.7
	TOTAL OLDER ALASKAN WAIVER	1,926.0	4,044.6
	ADULT DISABLED WAIVER		
660	Care Coordination		150.1
661	Residential Services		980.9
662	Day Services		125.0
663	SME & Environmental Modification		99.5
664	Chore Services & Respite		154.7
	TOTAL ADULT DISABLED WAIVER	873.7	1,511.2
	MENTALLY RETARD/DEVELOPMENTALLY DISABLED WAIVER		
670	Care Coordination		731.8
671	Residential Services		9,412.1
672	Day Services		1,220.1
673	SME & Environmental Modification		62.7
674	Chore Services & Respite		182.5
	TOTAL MR/DD WAIVER	3,995.5	11,609.2
	CHILDREN W/MEDICALLY COMPLEX CONDITION WAIVER		
680	Care Coordination		140.0
681	Residential Services		1,018.9
682	Day Services		1.0
683	SME & Environmental Modification		112.4
684	Chore Services & Respite		244.5
	TTL CMCC WAIVER	1,096.7	1,516.9
	TOTAL ALL MEDICAID SERVICES	326,276.2	349,170.3
	GENERAL RELIEF MEDICAL		
	GRM HOSPITAL		
900	Inpatient Hospital	1,113.8	684.3
905	Outpatient Hospital	0.2	0.2
	TOTAL GRM HOSPITAL	1,114.0	684.5
930	GRM PHYSICIANS SERVICES	1,080.4	1,148.6
	TOTAL GRM PHYSICIANS SERVICES	1,080.4	1,148.6
	GRM OTHER SERVICES		
939	GRM Other Services	0.0	0.0
940	Pharmaceuticals XIX	0.0	0.0
941	Pharmaceuticals GRM	394.7	488.4
942	Transportation	91.7	118.7
943	Dental Care XIX	0.0	0.0
944	Dental Care GRM	3.5	3.6
947	Pros Device-Medical Equipment	19.2	20.8
950	Independent Labs	16.3	19.3
951	Nursing Home Care	(60.0)	13.3

Acct	Category of Service	FY96 Actuals	FY97 Actuals
	GRM OTHER SERVICES, cont.		
955	Family Planning	2.8	2.3
956	Abortion XIX	654.8	887.8
957	Sterilization (ALL OTHER)	23.2	18.2
958	Abortion GRM	4.8	4.4
	TOTAL GRM OTHER SERVICES	1,151.0	1,576.8
989	TPL Recovery Contract	16.3	2.9
	TOTAL TPL RECOVERY CONTRACT	16.3	2.9
	TOTAL ALL GRM SERVICES	3,361.7	3,412.9
	ALASKA LONGEVITY BONUS HOLD HARMLESS		
790	ALB Hold Harmless	29.4	43.3
	TOTAL ALB HOLD HARMLESS	29.4	43.3
	PERMANENT FUND DIVIDEND HOLD HARMLESS		
750	PFD Hold Harmless Non-Facility	122.8	139.4
760	PFD Hold Harmless Facilities	390.0	314.0
	TOTAL PFD HOLD HARMLESS	512.8	453.4
	TOTAL MEDICAL ASSISTANCE	330,180.1	353,079.8

FY97 Expenditures Summary

MEDICAID NON-FACILITY	134,748.8	147,319.4
Medicaid Physician Services	45,314.7	46,343.0
Medicaid Other	83,299.7	94,563.6
Medicaid EPSDT	6,069.4	6,331.3
Medicaid TPL Recovery	64.9	81.4
MEDICAID FACILITIES	133,249.9	121,605.3
Medicaid Hospitals	79,372.8	78,160.0
Medicaid Nursing Homes	53,824.4	43,337.6
Medicaid TPL Recovery	52.7	107.7
MEDICAID STATE PROGRAMS	19,076.8	20,980.8
MEDICAID INDIAN HEALTH SERVICE	30,620.5	40,582.9
MEDICAID WAIVERED SERVICES	8,580.3	18,681.9
TOTAL ALL MEDICAID SERVICES	326,276.3	349,170.3
GENERAL RELIEF MEDICAL		
GRM Hospital	1,114.0	684.5
GRM Physicians Services	1,080.4	1,148.6
GRM Other Services	1,151.0	1,576.8
GRM TPL Recovery	16.3	2.9
TOTAL ALL GRM SERVICES	3,361.7	3,412.9
ALASKA LONGEVITY BONUS H.H.	29.4	43.3
PERMANENT FUND DIVIDEND H.H.	512.8	453.4
TOTAL MEDICAL ASSISTANCE	330,180.2	353,079.8



Tony Knowles
Governor



Karen Perdue
Commissioner

February 1998

Division of Medical Assistance
PO Box 110660
Juneau, Alaska 99811
(907)465-3355

***"...to promote and protect the well-being of every
Alaskan by investing in families and communities."***

DULCE NOBRE

ALZHEIMER'S ASSOCIATION
ALASKA CHAPTER



Annual Report 1996 - 1997

FY97 BOARD OF DIRECTORS AND STAFF

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240 E. Tudor Road, Suite 110, Anchorage, AK 99503 (907) 561-3313 or (800) 478-1080

FROM OUR PRESIDENT AND OUR DIRECTOR

During the past year, the Alzheimer's Association Alaska Chapter considerably expanded its ability to serve individuals and families dealing with Alzheimer's disease and related disorders (ADRD). Thanks to consistent public and private support our revenue increased substantially, and our dedicated volunteers multiplied in numbers and in their level of commitment.

This growth enabled us to continue to provide outreach and support to families throughout the state, to increase our education programs for professional and lay caregivers, and to support national research efforts. During fiscal year 1997, we strengthened our Care Coordination and Respite Programs through increased staff training and further integration of program operations. Our In-home Respite Program alone delivered over 50,000 hours of care to families statewide, an increase of 67% over the previous year. We also renewed our fund development efforts by recruiting a development director.

As we continue hoping for effective new treatments and a cure, Alzheimer's disease continues taking its toll on Alaskans. By the year 2010, the number of people with Alzheimer's will double to more than 6,000. However, because we believe that the information and support that the Alzheimer's Association provides can ease the hardship of this devastating disease, we will continue working hard to enhance the care and support available to families. In a pro-active stance, in April of '97, our Board began a strategic planning process that will prepare us and guide us into the new century. The plan is optimistic, and filled with hopes about research breakthroughs, while realistic about the challenges that lie ahead.

As a private, non-profit organization we rely on individual and corporate support to meet the expanding needs of families. Therefore, we want to acknowledge all our members and supporters, public and private entities, who realize the importance of the work we do and support our efforts. We are also proud of the commitment of our Board, staff and volunteers as we move through the challenges, towards a world without Alzheimer's.

Jonell M. Snook-Holmes,
President of the Board of Directors.

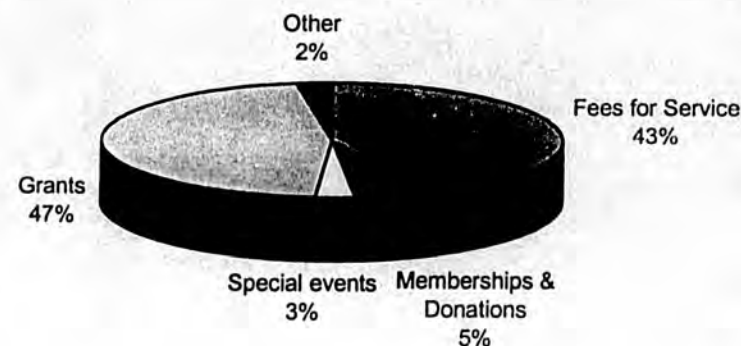
Dulce Nobre
Executive Director



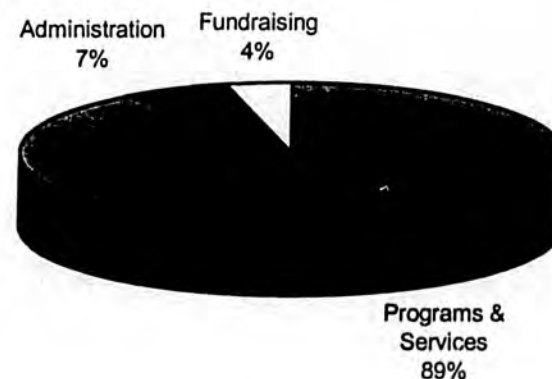
1996 - 1997 FINANCIAL REPORT

The Association ended its fiscal year 1997 with revenue of \$1,680,095, from sources as shown. Overall expenses were \$1,561,074 with almost 90% of expenses attributed to program costs.

FY 1997 REVENUE



FY 1997 EXPENSES



Audited Financial Statements for the year ending June 30, 1997 were

SUPPORT GROUPS

Our support groups meet monthly and bi-monthly throughout the state. Caregivers attend these to discuss problems, share concerns, exchange information and lend each other emotional support. In FY97, more than 340 caregivers attended our 65 support groups.

IN-HOME RESPITE

Our Respite Workers go into the homes and allow caregivers time off for rest, self-care or tasks. Statewide we:

- provided 50,839 hours of in-home respite care for 230 families affected by Alzheimer's Disease and related disorders;
- presented 18 hours of training and continuing education for our 80 respite workers.

CARE COORDINATION

We locate and access community services and resources for adults needing assistance. FY 97 was our second year of operation, and our Care Coordinators served 456 clients in the Anchorage area.

Under a one-time contract with the State Division of Senior Services, to determine needs and identify available resources, we conducted geriatric assessments for individuals living in assisted living homes or on the waitlist for the Pioneers' Homes.

ACTIVITIES TRAINING FOR ASSISTED LIVING FACILITIES

With a grant from the national Alzheimer's Association we developed an Activity Training Curriculum, purchased materials and established an "activities lending closet" which is available to the public. We provided training to 14 assisted living facilities at which we reached 68 care providers and residents.

MEMORY WALK 1996

Our largest event of the year was held for the 4th year in a row, in Anchorage, Fairbanks, Juneau and Homer. It raised \$37,000 and attracted 300 walkers statewide. The top fundraiser in Alaska was Frances Vadla, from Big Lake.

ADVOCACY

We continue to advocate for the rights of individuals coping with ADRD, and for the development of appropriate services. In FY97 we:

- participated in the Public Policy Forum in Washington, D.C., along with 428 other advocates from all over the Nation. Our efforts yielded, among other successes, \$335 million in the overall funding of the National Institute of Health, the largest supporter of Alzheimer's research;
- coordinated advocates' training workshops in Anchorage and Fairbanks.



ANNA FATH

Long Term Care Task Force Meeting
August 19, 1998

Tanana Chiefs Home Care serves the frail elders and the disabled of 43 Interior villages. This geographic area is about the size of Texas and ranges from the Canadian Border West to Holy Cross; from the Brooks range to the Alaska range. There is an elderly population of about 650 in this area. Our clients are mostly Athabascan native elders but several are non-natives who live in the rural villages. Services are currently available in 23 of the villages. Services include Respite, Personal Care Services and Care Coordination. There are 60 clients receiving Personal Care or Respite services from any of 42 providers. There are 12 clients who are on the Home and Community Based Waiver. About 80 clients receive care coordination services. This is a duplicated number since this also includes the PCA and Choice Waiver clients.

Our program allows the client to age in place in his or her home community, close to those they love and with the faces, foods and routines comfortable and familiar to them. Family and friends are supported in caring for their loved ones and the risk of "burnout" is reduced. A year's worth of home care, even with the enhanced services offered by the Choice Waiver is cheaper than the cost of an extended care facility in an urban area. The price of separation from loved ones and land cannot be measured. This is congruent with our mission statement that says that *Home Care will provide compassionate services for the elderly and disabled to have the opportunity to live and die with dignity in their own homes or community*.

This program offers more than just services to the elderly and disabled. It offers training and jobs to members of these rural communities. The personal care attendants are recruited from the villages and receive 3 weeks of training. They sit for the state examination and the majority meet the requirements for licensure as Certified Nurse Aides. Confidence, dedication and pride are just a few of the outcomes for the provider. This work is difficult. These individuals are advocates for their clients and most go "above and beyond" in what they do for the client and the family. They are role models for the practice of the art of nursing. The bonds between client and provider are visible. These individuals and the services they provide are often the fragile link between remaining at home or institutionalization.

There is a program director, Cyndi Nation-Cruikshank who is a social worker. Two program assistants who deal with payroll, timesheets, Medical billing and administrative details. Two RN's who provide the direct supervision and link with the providers in the field. The RN's visit the villages twice per year to perform the assessments and reassessments for the clients. At least once per year every person over the age of 60 is visited to review their health status, home safety, risk factors for illness. Many of the "young elders" are often the primary caretakers of their own frail "very old" parents. In more than one case we have situations where the services offered to a single 90-something client benefit the 70-something kids who have their own problems with arthritis, heart disease, diabetes, etc and are just squeaking by. If they succumb physically or to emotional burnout, that old elder will wind up in assisted living or Denali. I can cite more than one situation where we are getting 3 for the price of 1! The program is explained to them. We also survey what the elders of each community see as their primary needs. There are four resounding needs: more chore services, transportation, community senior housing or assisted living, and friendly visitors. I have seen elders try to sweep snow from the arctic entry or top step, lose their balance and fall; try to get to the post office to pick up mail and fall on the ice; empty a honey bucket; get wood from the pile, wrench a back making a bed or changing the linens or just plain "bummed" because they cannot maintain the standard of housekeeping they were used to when they were younger. The communities are not paved and even in beautiful summer weather the paths and roads are uneven. This confines the elders whose gait is less steady. The isolation is depressing. Just a van or some kind to get to the store or community center would make life easier. I have never met a client who has told me of the burning desire to live in Fairbanks or Anchorage. They all want to live at home. TCC's vision is to establish PCA and Respite services in 30 villages by July, 1999 and initiate chore services in 10 villages by July, 1999.

The services offered at this local level prevent injury, provide comfort, assure compliance with medical regimens. The elders are kept at home longer and healthier. They can end their days in dignity and surrounded by those they love. Ultimately this converts to dollars saved. How we treat the weakest members of our society is a measure of our degree of civilization and humanity. What we do in caring for them is an example for our young people. The example that we set and the infrastructure established for the frail and the old will set the stage for how we will be treated in our dotage or infirmity.

Anna M. Fath RN Coordinator, TCC Home Care

STATE OF ALASKA

STATE INDEPENDENT LIVING COUNCIL

PATRICK REINHART
JUNY KNOWLES, GOVERNOR

1016 W. 6th Avenue, Suite 205
Anchorage, Alaska 99501-1963
Phone: V/TTY (907) 269-3571
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Toll Free: 1-888-330-6488

July 17, 1998

Karen Perdue, Commissioner
Department of Health & Social Services
P.O.Box 110660
Juneau, AK 99811-0660

RE: Proposed PCA Regulations (AS 47.05.010 and 47.07.030)

Dear Commissioner Perdue:

I would like to offer my professional observations regarding the proposed regulation changes to the State's Personal Care Attendant Program (June 10, 1998): AS 47.05.010 and AS 47.07.030.

First, the proposed regulations include some needed changes, but they do not go far enough in making this personal care attendant program the best it can be for our citizens who need these services to live on a daily basis. ***This program should be about consumer choice and empowerment.*** It should be about giving people the tools they need to live free of institutional walls. ***We must take the steps necessary to move the program in that direction, and if it costs more money to do it right, it pales in comparison to the costs of doing it wrong.***

This program, more than any other Medicaid sponsored program, can do the greatest amount of good for our citizens with the severest disabilities and our frail elderly, while at the same time save money which might be spent on expensive institutional care. ***I encourage you, and the Division of Medical Assistance, to hire an independent, outside consultant to review the true costs and benefits (financial and otherwise) of providing a quality an innovative personal assistance services program, such as those in Kansas and Oregon.*** I say this because the fiscal note attached to the proposed regulations describe only the expenses of this program, and not the savings anticipated in other Medicaid funded services, such as avoidable hospitalization and unnecessary incarceration in nursing homes and assisted living homes.

At a conference in May of this year, myself and other Alaskans heard representatives of Kansas and Oregon talk about how their investment in their state's personal assistance service program a few years ago is now reaping much larger benefits for their disabled citizens, as well as decrease their state's Medicaid costs. Plus, we listened to officials from the Health Care Finance Administration talk about how they are encouraging states to look at this very issue and to

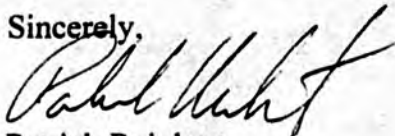
innovate. The message was clear: *there are very few restrictions on what and how states provide personal care attendant services, and how much we spend on it, except for what we place upon ourselves right here at home.* These regulations, therefore, are those restrictions that we place upon ourselves. (Based on what I heard at the one "unteleconferenced" public hearing on July 7, they are not the restrictions that the disability community wanted to hear).

Of general note, the disability community worked very hard to move this program and its services away from the "we'll take care of you" medical model of the past, hence HB 459's provisions to remove the physicians prescription and nurse supervision requirements of the program. We thought the message of these statutory changes was clear. Yet, the language of the proposed regulation continues to speak of "treatment plans", "medical conditions", etc. *Also, there is not one sentence that speaks to the issue of "consumer directed" services, or "consumer managed care",* a point we have been discussing with the Division of Senior Services for well over a year.

Overall, I believe the Department should move forward with these regulations, particularly concerning the issues of reimbursement rates, although I and many others I have spoken with have several reservations which are described in the attached. In my professional opinion, these regulations are only small Band-Aids to a program that should go back to the drawing board altogether. We need to step aside and say "what is the best personal assistance services program we can provide", and then outline the costs and advocate with the Governor and the Legislature to make the statutory changes and get the level of funding we need to do it right. (Kind of like what you all did with the "Smart Start" package for kids). Overall, to do this right, to support people with the severest disabilities and our elderly to stay in their homes, with quality personal assistance services, paid for mostly by the feds, and with the chance to save money in the long run, it should be an easy sell compared to "Smart Start". I know our council is going to work on this very issue as a legislative piece this year. I certainly hope you will join us and support us in this endeavor.

Attached are some specific points of concern regarding the proposed regulations.

Sincerely,



Patrick Reinhart
Executive Director

cc. Mark Boyer, Commissioner, Department of Administration
Bob Labbe, Director, Division of Medical Assistance
Kay Burrows, Acting Director, Division of Senior Services
David Maltman, Governor's Council on Disabilities and Special Education
Joyanna Geisler, Chair, SILC Personal Assistance Services Committee
Jane Demmert, Alaska Commission on Aging

Attachment

**State Independent
Living Council**

1016 West 6th Avenue
Ste. 205

Anchorage, Alaska 99501

Patrick: (907) 269-3571

Karla: (907) 269-3576

Fax: (907) 269-3633

Memo

To: Jon Sherwood, Division of Medical Assistance
From: Patrick Reinhart, Executive Director, State Independent Living Council
CC: Karen Perdue, Mark Boyer, Bob Labbe, Kay Burrows, David Maltman, Joyanna Geisler
Date: 07/20/98
Re: Comments – AS 47-05.010 and AS 47.07.030, "State Personal Care Attendant Program"

Under 7 AAC 43.750(a).....

- (a) Remove from line 6 the words "prescribed by a physician". I was under the impression HB 459 removed this requirement. It seems to be eliminated elsewhere but not here.
- (b) Under section 3, remove the words "treatment plan" and replace with "consumer directed personal assistance service plan". We need to move away from "medical model" terminology. People who use these services may not be sick and may not need treatment, but they could use some help getting out of bed, eating, etc. This is not "treatment", it is assistance.
- (d) See (b) above.

Under 7 AAC 43.760(f).....

- (f) Remove from line 4, the following "...are appropriate for the care of the recipient", and simply say "the living conditions include adequate sanitary conditions for hand washing and waste disposal". Again, medical model terminology is unnecessary.

Also, why define "personal residence" further to include foster homes and assisted living homes? Isn't the first line which describes a personal residence as a place the recipient considers his/her home enough? I am concerned that listing assisted living homes as a specific place where services can be provided will only lead to more people being placed in homes for the purpose of getting these services, particularly if personal care attendant services performed at assisted living homes become a higher priority than those in personal residences in times of budget shortages.

Under 7 AAC 43.765 (c).....

See (b) above, i.e. replace "treatment plan" with "consumer directed personal assistance service plan".

Under 7 AAC 43.790 (b) and (d) – (h).....

- (b) We have been talking with the Division of Senior Services for well over a year about getting away from the whole "time for task" method of calculating the hours of services an individual needs. All reference to "treatment plans" should be stricken and instead, it should read as follows:

"The division will base its reimbursement upon the needs of each individual recipient, as specified in the individual's consumer directed personal assistance service plan, developed jointly by the recipient and a representative of the division. Except as provided in (d) of this section, the division will not reimburse a provider for services not included in the consumer directed personal assistance service plan".

- (d) The proposed plan to limit recipients of pca services to 4 hours/day or 28 hours per week (down from 8 hours and 56 per week), will result in inadequate assistance for recipients. ***The result is likely to be increased hospitalizations of recipients, unnecessary and early entry into nursing homes and assisted living facilities, and a massive increase in the administrative burden of the Division of Senior Services.*** Under these proposed regulations, DSS (or its designee) would have to review and approve or deny all "treatment plans" that require more than 4 hours a day, based on the individual's "medical condition". Allowing flexibility in the hours of services will not break the bank, and if other state's experiences in doing this, such as in Kansas and Oregon, is an indication, then we will save money on the nursing home and assisted living side. Essentially, we should trust the individual recipient in describing their particular needs. The professionals at DSS and its designee's can spot abuses when they exist, and use, if necessary existing Medicaid fraud laws to pursue scofflaws. **TRUST THE CONSUMER.** Do not punish them up front. If the consumer believes this is their program, and they are the managers of it, they are not likely to abuse it. Instead, section d should read:

(d) "When a recipients consumer directed service plan requires personal care attendant services for more than 8 hours per day, or 56 hours per week, the consumer should submit a written justification to the division for approval. If the division approves a consumer directed personal assistance service plan that requires more than 8 hours per day or 56 hours per week, the division will reimburse the personal care agency or the independent personal care provider at the hourly rate provided for in this section or \$200 per day, whichever is less.

(e) No recommended changes.

(f) No recommended changes.

(g) Presently, there is a shortage statewide of independent pca's, and this is the reason why: WE DO NOT PAY THEM ENOUGH. Being a pca is a critically important job, one that is crucial to helping individuals maintain in less restrictive and higher quality living environments, and keep them out of more expensive nursing homes and assisted living settings. The proposed regulation change increases the wage from \$9/hr to \$12/hr. An independent pca must also then pay their own payroll taxes, cover their own medical, retirement, etc.

Recently, I checked with the Municipality of Anchorage, and their starting pay for "swampers", those people who handle our raw sewage, get paid either \$14.17/hr (non-union temporary), or \$12.85 hour (union, permanent). Garbage handlers, on average, make \$15/hr or more. On top of this wage, their employer pays payroll taxes, workman's comp, etc, on their behalf, and they are eligible for medical benefits and retirement packages. What does this say about the State of Alaska if we are willing to pay people who handle our trash and sewage more than those who provide essential, life preserving work for our disabled citizenry.

What is being proposed, \$12/hr, while welcome by independent pca's, is completely inadequate. Why not institute a tiered system be in place for independents. \$12/hr for all new entries in the program, and \$15/hr for all persons who are licensed and practicing (i.e. provided at least 500 hours of pca services, either in an agency or independent, the previous two years. For those who have at least three documented years of service, go to \$18/hr. By doing this, we will actually encourage the number of independents, get people off the waiting list and out of institutions. The division keeps track of hours, so this should not be too difficult to institute.

(h) No proposed changes.

End of comments.

CENTERS FOR INDEPENDENT LIVING ALASKA

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Juneau, AK 99803-5097

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1-800-478-7245 (toll free)
907-225-4735 (Ketch.)
907-225-4753 (Ketch-Fax)

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Access Alaska Anchorage
3710 Woodland Drive, Suite 900
Anchorage, AK 99517

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907-248-8799 (TTY)
907-248-0639 (Fax)
1-800-770-4488 (toll free)

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Kenai Peninsula Independent Living Centers
P.O. Box 2474
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907-235-6236 (Fax)
907-262-6333(Soldotna)
907-224-8711(Seward)
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SPECIALIZED INDEPENDENT LIVING PROVIDERS

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1-800-770-7517 (toll free)

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Alaska Center for Deaf Adults
731 Gambell, Suite 200
Anchorage, AK 99501-3754

907-258-2232 (TTY)
1-800-770-8255 (Relay)
907-279-0341 (Fax)
907-276-3456 (Voice)
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PATRICK REINHART

THE ECONOMIC IMPACT OF LONG-TERM CARE ON INDIVIDUALS

Lisa Alecxih and David Kennell

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I. INTRODUCTION

The major public insurance program for the elderly, Medicare, does not provide long-term care benefits for chronic disabling conditions. Only about 12 percent of the elderly are enrolled in the Medicaid program, either in nursing homes or in the community, and only about five percent participate in any kind of private financing plan for long-term care. Thus, more than four out of five elderly persons lack adequate public or private insurance for long-term care and are vulnerable to the financial risks associated with long-term care use.

Users of formal long-term care services face important economic consequences. These consequences are primarily a function of: (1) the amount of care used; and (2) the user's financial resources. The economic impact of a short nursing home stay is not likely to be great for most people. Nor will the economic impact of long-term care use be significant for the wealthy, regardless of how much care they need. On the other hand, the economic impact on elderly people of moderate means who require extended care can be enormous.

An understanding of the economic impact of long-term care on individuals is a prerequisite for an informed policy debate. Before devising a new set of policies, it is important to understand what effects the current long-term care system has on the elderly, who is most severely affected, and under what circumstances. To this end, this chapter examines the following questions:

- What are the financial resources of the elderly, and how does the economic status of the elderly affect their ability to purchase long-term care services without public assistance?
- How does the use of long-term care affect the financial well-being of those who need care?
- Who can afford long-term care and which groups experience the greatest economic burden?
- What is the combined impact of acute and long-term care costs on elderly persons?
- How affordable are private financing mechanisms for long-term care? What percentage of elderly persons cannot afford to participate in private financing plans?

II. THE FINANCIAL RESOURCES OF THE ELDERLY

The ability of the elderly to buy long-term care services with private resources largely depends upon their personal income and assets. As among the non-elderly population, there is considerable economic diversity among the elderly. Some are very well off, others live in poverty.

Although users of long-term care are generally disabled (particularly the oldest old), it is important to examine the financial resources of both the entire elderly population and the disabled elderly because most users of long-term care have not always been disabled. For example, approximately one-half of all persons entering nursing homes over a two year period were not disabled up to 24 months prior to their

entry. 1

II.A. Economic Characteristics of the Elderly

Most elderly persons (64 percent) live in families with modest incomes (150 to 299 percent of the poverty level) or moderate to high incomes (300 percent of the poverty level or above) as shown in Table 1. However, over one in three elderly persons lives in a poor or near-poor family (income less than 150 percent of the poverty level). 2 In 1990, the median annual income of these poor and near-poor elderly families was \$6,834, or \$570 per month.

The elderly's income is derived from four primary sources: (1) Social Security; (2) pension income; (3) employment earnings; and (4) income from assets (see Table 1). Elderly persons in low-income families live primarily on Social Security, while those with moderate to high incomes receive a much higher percentage of their total income from pensions, employment, and assets. Low income persons receive an average of 71 percent of their total income from Social Security. In contrast, persons with moderate to high incomes receive only 23 percent of their income from Social Security, even though they receive higher Social Security benefits. Twenty percent of their income comes from pensions, 29 percent from employment, and 23 percent from income on assets.

Many elderly persons have substantial asset holdings (both financial assets and home equity) due to the accumulation of wealth over their lifetimes. Indeed, the income and asset characteristics of elderly households are very different from those of non-elderly households. The elderly, in general, have lower incomes, but far greater assets. In 1988, the median net worth of elderly households was about twice that of non-elderly households.³ For example, in 1988, while the median *income* of households under age 35 was about *twice* that of households over the age of 75 (\$24,000 versus \$11,724), the median *net worth* of households over age 75 was approximately ten times that of households under age 35 (\$61,491 versus \$6,078).⁴

In recent years, the average net worth of elderly households has increased, while the average net worth of non-elderly households has declined. Between 1984 and 1988, the median net worth of elderly households increased from \$68,600 to \$73,471 (in 1988 dollars), an increase of 7 percent.⁵ Over the same time period, the median net worth of non-elderly households declined in real terms. For example, the median net worth of households between the ages of 35 and 44 declined by 18 percent over this four-year period.

The distribution of wealth among the elderly is highly skewed towards those with the highest incomes. As shown in Table 2, over 20 percent of poor and near-poor elderly persons have no financial assets whatsoever, whereas almost all elderly persons in the higher income groups have financial assets.⁶ Of those with financial assets, the median amount of assets owned by the poor and poor-near elderly was approximately \$5,510 in 1990. By comparison, the median amount of financial assets owned by elderly persons with modest incomes was about five and half times higher--\$30,310. The median amount of financial assets owned by the highest income group was \$84,920, more than 15 times higher than those in the low income group. The vast majority of the wealth owned by the elderly is owned by those with the highest incomes.

In comparison to financial assets, home equity assets are more evenly distributed across income groups. Although 40 percent of the elderly with low incomes do not have any home equity, those who do have fairly significant amounts.⁷ The median amount of home equity owned by poor and near-poor elderly persons who owned their homes was about \$30,500 in 1990. Although non-poor elderly persons had more home equity, the differential in home equity assets is nowhere near as great as the difference in financial assets (see Table 2). Home equity assets comprise the vast majority of the assets held by poor and near-poor elderly persons. Although elderly persons with higher incomes have more home equity than those with low incomes, it does not comprise a majority of their net worth.

Although the elderly have more wealth than the non-elderly, the percentage of elderly persons with both low income and low wealth is *higher* than the percentage of non-elderly persons with both low income and low wealth.⁸ Low income elderly (those with income less than 150 percent of the poverty level)

constitute over one-third of the elderly population but hold less than five percent of financial assets. This demonstrates the skewed nature of wealth toward higher income elderly.

Older elderly persons are more likely to be poor or near-poor than the younger elderly. As shown in Table 3, 35 percent of elderly persons between the ages of 65 and 74 live in families with low incomes. In comparison, almost two-thirds of the elderly over age 85 live in poor or near-poor households.

The higher rate of poverty among the very old is partly due to their marital status. Many elderly women become poor as a result of their husbands' death, as evidenced by the many poor people over the age of 85 who are widows living alone with a primary source of income of Social Security survivor's benefits. A widow can become poor as a result of her husband's death for three main reasons: 1) a loss of pension income; 2) a decline in Social Security benefits; and 3) the expenses related to her husband's death. Overall, about two-thirds of elderly persons who are poor or near-poor are not married, and over half live alone. The elderly population with the highest rate of poverty are very old widows who live by themselves.

Older age groups among the elderly are at higher risk of needing long-term care. Table 4 takes a closer look at the economic circumstances of persons age 75 and older. As expected, fewer persons age 75 and over are in families in which someone is still working, and fewer have pension income. As a result, almost half of all persons over age 75 are in poor or near-poor families. Median family income for all persons over the age of 75 was under \$1,000 per month in 1990.

II.B. Economic Characteristics of the Disabled Elderly

Of greater relevance to long-term care policy discussions is the economic circumstances of the disabled elderly who most often need to buy long-term care services. Unfortunately, this group is also the least able to afford long-term care services. As shown in Table 5, the disabled elderly are more likely to have low incomes than the non-disabled elderly.⁹ Over half of all disabled elderly persons live in poor or near-poor families. In comparison, only about one-third of the non-disabled elderly have low incomes. Also, median financial assets of the elderly disabled are only about one-third that of the non-disabled.

The lower incomes and assets of the disabled elderly are not simply a function of their disability, but also of their age, marital status, and living arrangements. They are more likely to be old, unmarried, and living alone--other factors that are associated with being poor. In sum, elderly persons at the greatest risk of poverty are also those at the greatest risk of being disabled and needing long-term care.

III. ECONOMIC IMPACT OF LONG-TERM CARE USE

The financial circumstances of the elderly are highly diverse, although elderly persons at the highest risk of needing long-term care are more likely to be poor or near-poor. But what is the actual impact of long-term care use on the elderly? For many, the use of long-term care has minor financial impacts. For others, the impact of long-term care use can be catastrophic. It can cause the depletion of lifetime savings, dramatically reduce one's standard of living, or force someone to purchase less care than they need. Economic considerations also sometimes force people to enter a nursing home even though they would rather be home, just because it is easier to qualify for Medicaid coverage in a nursing home than at home.

III.A. Factors Which Determine the Economic Impact of Long-term Care Use

The financial effects of long-term care use differ according to:

- the *type* of services used;
- the *duration* of care; and

- the *level* of financial resources available to pay for care.

Depending on the interaction of these variables, an individual's long-term care use can have little or no impact, a limited impact, or catastrophic consequences.

Type of Services Used

Nursing home care has a far greater financial impact on the elderly than other types of long-term care. Indeed, nursing home care is the largest out-of-pocket health care cost for elderly consumers, accounting for 42 percent of all out-of-pocket health care payments. At an average price of around \$80 per day in 1990, the cost of a private nursing home stay can build up very quickly.

Not all persons who enter nursing homes, however, suffer severe economic impacts. Many elderly people enter nursing homes for relatively short stays after being in the hospital for an acute illness, where Medicare will pay for the first 20 days of a nursing home stay if the stay meets Medicare skilled nursing facility (SNF) criteria. About 20 percent of all nursing home admissions are covered by Medicare for at least the first part of the stay.

Home care generally has less of a financial impact on the elderly. First, most elderly persons who receive care at home do not use formal (paid) care. At a point-in-time, only about 20-25 percent of the elderly with functional impairments receive formal services in their homes. Of these, according to data collected in the 1982 National Long-Term Care Survey, about half paid for their own care without help from third-party coverage or other sources.¹⁰ In 1982, disabled elderly persons in the community who paid for home care services spent an average of \$222 per month (in 1990 dollars); about half spent less than \$54 per month, and ten percent paid more than \$540 per month.

Data from the 1987 National Medical Expenditure Survey (NMES) provide information on the home health care use of disabled persons over the course of an entire year. These data indicate that nearly one-third of the disabled elderly (32 percent) use formal home care services. For users, the average number of annual visits was approximately 80. Nearly one half of spending for these services was paid out-of-pocket, while Medicare and Medicaid paid approximately 20 and 25 percent respectively.

Both the costs of private nursing home care and of home care vary significantly around the country, largely depending upon local labor costs. In areas with an excess supply of labor, it is possible to hire home care workers at close to the minimum wage, particularly if services are not purchased through a formal home care agency. Private nursing home prices also reflect local labor costs--as well as capital costs and state regulatory costs.

In the aggregate, the elderly spent about \$19.0 billion for nursing home care out of their own pockets in 1989, and about \$2.4 billion for home care. Thus, private payments for nursing home care outweigh spending for home care services by about eight to one.

Duration of Care

How long a person uses long-term care services has considerable influence on the financial impact of using long-term care. Although many elderly may be able to afford \$7,500 for a three-month nursing home stay in 1990, few can afford the \$90,000 required for a three-year stay.

Many elderly persons who use nursing home care experience little financial impact because they have short stays. For example, about 40 to 50 percent of persons turning age 65 in 1990 will enter a nursing home at some point during their remaining lifetime. Of these, one in three will use less than two months of care, in total, over their lifetime. Paying for a two month nursing home stay out-of-pocket in 1990 required a little less than \$5,000 in financial resources, an amount many elderly can afford. And, as discussed above, many of these short stays are partly or fully paid for by Medicare.

On the other hand, about 20 percent of all persons turning age 65 in 1990 will spend a year or more in a nursing home before they die--about 45 percent of all nursing home users. Although many of these

persons will have Medicare and/or Medicaid coverage for all or part of their stays, many others will pay for most of their care privately. At \$30,000 per year, a year or more of nursing home care not covered by Medicare or Medicaid is beyond the means of many elderly persons.

Level of Resources

Obviously, the economic impact of long-term care is also related to the amount of income and assets an elderly person has when they start needing care. Previously, we discussed the diverse financial resources of elderly persons, and the correlation between elderly persons at risk of being poor and near-poor and at risk of needing of long-term care. However, the ability to purchase long-term care services relates not only to one's absolute level of financial resources, but also to other circumstances. For example, even though single persons generally have fewer resources than couples, paying for nursing home care out-of-pocket can be less difficult for single persons who are likely to be permanent nursing home residents because they do not have to maintain a separate household for a non-institutionalized spouse.

In addition, a single person may have less of a need to preserve financial assets. A nursing home resident with a non-institutionalized spouse will want to preserve assets for the future financial security of the spouse. The depletion of assets, in and of itself, is not necessarily a drastic economic event for unmarried nursing home residents, as long as there are sufficient assets to pay for all the care that will be required. In general, the depletion of lifetime savings for a single person is probably less devastating than asset depletion for a couple.

Indeed, asset depletion during the later stages of life is a normal event in "precautionary" theories of savings accumulation and depletion. Just because someone is depleting assets to pay for nursing home care does not mean that they are necessarily suffering a severe economic event.¹¹ People accumulate assets during their lifetimes precisely because they know that they will have to draw upon those assets during their retirement years. The question is whether people have adequately saved for the possibility of needing nursing home care, and what effect the use of long-term care has on someone's use of their accumulated assets over the course of the remainder of their life.

It is often assumed that a person who qualifies for Medicaid coverage upon admission to a nursing home experiences little financial impact because they are "insured" by Medicaid. However, Medicaid nursing home insurance has a very high copayment requirement--all income except for \$30 per month. Thus, persons on Medicaid with relatively high incomes but few assets can still experience significant financial impacts. All income must be applied to the cost of nursing home care, and little or no income is available to pay for "amenities" such as clothing, trips outside the home, hair appointments, birthday presents for relatives, or telephone calls.

Another consideration is that although nursing home care costs more than home care, payments for nursing home care include shelter and food, as well as services. Thus, although someone may have lower out-of-pocket costs for home care services, the economic impact on their standard of living can be much greater, if they have less income left for living expenses. They may use less heating fuel, take fewer baths, eat less well, or not use other medical services, such as taking prescription medicines. The economic impact of using home care services must be assessed both in the context of an individual's financial resources *and* their other living expenses.

In sum, the economic impacts of long-term care use on individuals depends upon the type of care they need, how long they need it, and how well they can afford it. Other factors must also be considered, such as whether a nursing home recipient has a non-institutionalized spouse, and what other living expenses a home care user has reduced in order to pay for formal services.

III.B. Long-Term Care Costs Affect Different Groups of Users

This section discusses how the use of long-term care affects different types of users. We begin by talking about types of long-term care use that have little or no financial impact. Other types of use have a moderate impact; they may significantly affect an individual's economic circumstances, but not to a devastating degree. Finally, there are some persons for whom the use of long-term care turns into a

financial catastrophe.

Little or No Financial Impact

- **Persons recovering from an acute care episode where longterm care services are covered by Medicare.** About 14 percent of all nursing home admissions consist of persons who are both admitted and discharged on Medicare.¹² The vast majority of these persons are discharged prior to using 21 days of care, and therefore they have no co-payment requirements for Medicare-covered days after the 20th day.
- **Persons who qualify for Medicaid in the community in States that have more generous long-term care coverage.** Persons who qualify for Medicaid in the community already have "long-term care insurance," although the degree to which States provide long-term care coverage for Medicaid beneficiaries varies substantially from State to State. Medicaid recipients in States with broad home care coverage may have relatively good access to Medicaid-financed home care services, while recipients in other States may have little or no access, in spite of being "insured." Approximately 2.4 million elderly were Medicaid enrollees in the community in 1990. (8 percent of the elderly population)
- **Persons with mild impairments who receive informal care only from a spouse, family, or friends.** About three out of four persons living in the community with IADL and/or ADL impairments receive no paid care at all. They receive all of their care from spouses, family or friends. It is important to note that not all of these persons experience little or no financial impact from using long-term care. If family members or friends have reduced or terminated employment in order to serve as caregivers, then substantial financial impacts may have occurred, if not directly on the recipient of care, then on the caregiver.

Moderate or Short-Term Financial Impacts

- **Private pay patients with short nursing home stays.** Most nursing home stays are ~~not long~~ stays. Even most persons who are not covered by Medicare or Medicaid when they enter a nursing home experience only moderate financial impacts. About half of all persons who enter nursing homes as private pay patients are discharged in three months or less.¹³ With the average cost of a three-month nursing home stay somewhere between \$7,000 and \$8,000 in 1990, a short-term nursing home stay would have a moderate financial impact, but not a catastrophic impact on most elderly persons.
- **Elderly persons who qualify for Medicaid upon admission to a nursing home.** Research indicates that about half of all elderly persons who are eligible for Medicaid during the first month of their nursing home stay were *not* eligible for Medicaid prior to entering a nursing home.¹⁴ These persons generally have low assets, but too much income to qualify for Medicaid outside a nursing home. Once they enter a nursing home, they must contribute all of their income to the cost of their care, except for a small personal needs allowance of \$30 per month in most States. For these persons, the major financial impact is that they are left with virtually no discretionary income once they enter a nursing home--they have become entirely dependent on Medicaid and the nursing home to provide shelter, food and services.
- **Elderly persons with adequate financial resources.** About 25 percent of the elderly live in families with moderate to high incomes, and which have significant financial assets. The median annual family income of persons in this group in 1990 was about \$34,000. In addition, median financial assets owned by persons in this group was about \$85,000, and almost 90 percent owned additional equity in their homes. Single elderly persons in this income group will generally have sufficient income and assets to pay for several years of nursing home care. For married couples, there may be a more substantial financial impact on the standard of living of the non-institutionalized spouse, given the share of their combined incomes that must be used to pay for private nursing home care.¹⁵

Catastrophic Impacts

- **Elderly persons with moderate income and assets who require extended nursing home care.** About one in four persons who enter nursing homes as private pay clients stay for one year or more. Persons with modest incomes (between \$12,000 and \$25,000 annually) cannot afford the private cost of nursing home care from their current income and must also use their assets to make their monthly nursing home payments. Many persons of moderate means who require extended nursing home care end up depleting *all* of their financial assets and applying for Medicaid coverage. This process is referred to as "Medicaid spend down." Other persons may not ever spend down all the way to Medicaid eligibility levels, but still deplete the vast majority of their total financial wealth before death or discharge. Persons who are discharged alive after depleting most of their life's savings in a nursing home may not be able to be financially independent in the community and may subsequently become eligible for Medicaid or other forms of public assistance (e.g., SSI or food stamps).
- **Poor and near-poor disabled persons living in the community who do not qualify for Medicaid.** Many disabled elderly persons living in the community have income below or slightly above the poverty level, but do not qualify for Medicaid coverage. These persons cannot afford to buy formal home care services, because they have little or no discretionary income. They may also have other out-of-pocket health care costs, such as for prescription drugs and Medicare Part B co-payments for doctor's visits. Severely impaired elderly persons in this group, if they have families, can become heavy burdens on their informal caregivers. Others have long-term care needs which go unmet. Some enter nursing homes, even though they would rather stay at home, simply because they can qualify for Medicaid coverage more easily if they do so. Although many disabled elderly persons fall into this category, reliable estimates are lacking.

In sum, many users of long-term care do not experience severe financial impact as a result of needing long-term care. Either they receive all of their care from informal caregivers, or they only need care for a short period of time, or they have sufficient financial resources to purchase long-term care services even over an extended period of time.

Other people experience severe financial impact as a result of needing long-term care. A group that suffers particularly severe effects from long-term care is middle-class elderly persons who require extended nursing home care. They cannot afford to pay for their care from current income, and end up depleting a substantial amount of their accumulated life savings, or even all of their financial assets, in paying for nursing home care.

Another group which suffer a severe impact is poor and near-poor disabled persons living in the community who need home care services but who do not qualify for Medicaid coverage. Rather than experiencing severe financial hardship, this latter group is more likely to either have unmet, or undermet needs, or to become a burden on their spouses and families providing care. Some States have non-Medicaid programs which provide home care services to this population, but most do not.

IV. MEDICAID SPEND DOWN

People who enter nursing homes, deplete their financial assets, and then apply for Medicaid coverage, are commonly identified as a population which experiences severe financial impacts from using long-term care. This process is commonly referred to as "Medicaid spend down." A number of research studies have been conducted in recent years focusing on the Medicaid spend down phenomenon. This section provides a brief summary of the spend down literature.

Research on Medicaid spend down poses special methodological challenges. Ideally, a study of Medicaid spend down would follow a representative sample of nursing home admissions, and then track changes in nursing home payment sources for all sample members across all episodes of care, until virtually all members of the cohort have died. Existing studies obviously fall short of this ideal, and thus

must be interpreted in the context of specific limitations in data and methods.¹⁶

Two studies of the 1985 National Nursing Home Discharge Survey found that only about 10-11 percent of all persons who entered nursing homes as private pay patients spent down to Medicaid prior to discharge.^{17,18} The major limitation of these studies is that they only examine spend down patterns over a single nursing home stay, and thus do not account for spend down episodes that may occur during prior or subsequent stays. Therefore, they tend to underestimate the rate of Medicaid spend down over all nursing home stays.

A recent study of the Institutional Population Component (IPC) of the 1987 National Medical Expenditures Survey found that 26.3 percent of all elderly persons who entered nursing homes as private pay patients had spend down to Medicaid at the time of the survey.¹⁹ However, because this study looked at current residents, rather than discharges, it oversamples nursing home users with long lengths-of-stay, who are more likely to spend down than residents with shorter stays. This sampling approach is therefore likely to bias estimates of spend down upward.

Other studies have looked at spend down patterns in individual States. One study showed that 27 percent of all nursing home users in Michigan who were eligible for Medicaid at some point in 1984 had begun their stay as a private pay patient.²⁰ Several studies have been conducted of the Connecticut Nursing Home Patient Registry, a unique data set which has tracked all nursing home users in that State since 1977. A study of a discharge sample showed that 39 percent of all Medicaid discharges had begun their stay as a private pay client, and about 17 percent of all persons who had begun their stay as private pay client had spent down to Medicaid.²¹ This study also documented the importance of looking at the experiences of nursing home users over multiple nursing home admissions, since 77 percent of all persons who had spent down had more than one nursing home stay.

Two other studies using the Connecticut Nursing Home Patient Registry have tracked nursing home admission cohorts. One study of a one-year admission cohort showed that 21 percent of all persons admitted as private pay had spent down after 7-8 years, and 39 percent of all persons who ever qualified for Medicaid had begun their stay as a private payer.²² Another study which looked at successive admission cohorts over six years found roughly similar results: 22 percent of persons beginning their stay as private payers had spent down, and about 44 percent of all persons who received Medicaid at some point during their stay had begun their stay as private pay patients.²³

One observation from the State-specific studies is that it appears that Medicaid spend down patterns differ significantly from State to State. For example, comparisons of the Connecticut nursing home population with the National Nursing Home Survey sample suggest that nursing home users in Connecticut are more likely to begin their stay as private payers, and are less likely to spend down, than the national average.²⁴ This may be due to the fact that the elderly in Connecticut are wealthier, on average, than the national elderly population.

These findings again underscore the observation that the financial impact of being a long-term care user can vary greatly depending upon where one lives. There is a less devastating impact in States where the elderly, on average, have more financial resources to pay for care (i.e. wealthier States) and where State Medicaid programs provide broader long-term care coverage.

Not all persons spend down to Medicaid as a result of an extended nursing home stay. In fact, the spend down research suggests that between 40 and 55 percent of persons who spend down do so within six months of nursing home admission.²⁵ Thus, many persons who spend down are persons of modest means who spend their available assets rapidly once they enter a nursing home, and qualify for Medicaid soon after admission.

A few efforts have been made to estimate the extent to which elderly persons spend down to Medicaid eligibility levels outside of a nursing home. One study estimated that although the likelihood of spending down to Medicaid increases dramatically once an individual enters a nursing home, that the actual number of disabled elderly persons who convert to Medicaid is higher in the community.²⁶ However, data on the extent to which out-of-pocket costs for long-term care and other health care services cause

elderly people to spend down to Medicaid eligibility levels in the community are lacking. Other research suggests that health care costs are not the major contributing factor.²⁷

IV. THE AFFORDABILITY OF LONG-TERM CARE

Research on how people pay for nursing home care provides only part of the picture on the economic impact of long-term care use on individuals. For example, although we can conduct research on the extent to which people are able to pay privately for nursing home care without spending down to Medicaid, this does not give us information about the specific economic impact on these individuals. The spend down research looks at the economic impact of nursing home use on individuals through a relatively narrow lens. Even among people who never spend down to Medicaid, severe economic impact can occur. To what extent are people selling their homes in order to stay off Medicaid? Are children helping to pay for their parents' care? What level of financial resources did these individuals begin their nursing home stay with, and how much remained when they left?

In addition, data on the number, or percentage, of people who spend down to Medicaid over time do not convey the complete picture. To what extent are Medicaid spend downers people who may be qualifying for Medicaid prematurely because they have successfully protected their assets through "Medicaid estate planning" strategies? How many have been able to keep their homes and still qualify for Medicaid? How does Medicaid spend down affect community spouses? In sum, although some research has been conducted on the economic impact of long-term care costs on individuals, there is much that is still not known.

Another lens that can be used to look at the economic impact of long-term care on individuals is to estimate the "affordability" of long-term care for *potential* users of long-term care living in the community. In this approach, we estimate the ability of noninstitutionalized elderly persons to finance a potential nursing home stay out of their annual savings or discretionary income.

Development of these estimates requires assumptions about what constitutes "affordability." First, the resources an individual has "available" to pay for care must be determined. What changes in lifestyle and financial status should be expected of elderly persons when they require long-term care services? Also, what role does the depletion of financial assets play in defining "affordability"? In brief, out of an individual's or family's total income and assets, how does one define what is affordable and what is not?

With these caveats in mind, analyses of the ability of the elderly to "afford" long-term care were conducted using alternative measures of affordability. These measures were used to assess the percentage of persons over the age of 65 who could afford to purchase *one year of privately-financed nursing home care*. The analyses focus on the affordability of nursing home care, as opposed to home care, because nursing home costs pose the greater financial risk to the elderly.

Different measures of affordability were developed for couples and individuals. Other factors being equal, nursing home care is more affordable to individuals because there is no need to preserve income and assets for the non-institutionalized spouse. However, as discussed in Section I, elderly couples generally have more financial resources than do individuals. Thus, estimates of the affordability of long-term care for couples and individuals are presented separately below.

Couples

For nursing home care to be affordable for an elderly couple, adequate income must be preserved for the community dwelling spouse for fixed expenses, such as housing, and health and other types of insurance. These costs would not decline when one spouse is institutionalized. Other household expenses (food, transportation, clothing) would also continue, although at a reduced level. Three measures of "affordability" were developed for couples:

- The "No Assets" definition estimates the percentage of couples who could afford one year of nursing home care for one spouse entirely from combined total income, without depleting any

assets.²⁸ Further, the cost of nursing home care is defined as affordable only if the community spouse did not experience a decline in available income for current household expenditures. Thus, the couple's housing, health and personal insurance expenditures were assumed to be unavailable to pay for long-term care. All other expenditures were assumed to be protected for the community spouse at a level two-thirds of the couple's pre-institutionalized level, meaning one-third of these expenditures were considered available to pay for care.

- The **"50% of Assets Over 4 years"** definition estimates the percentage of couples who could afford one year of nursing home care if they used up 50 percent of their combined financial assets (excluding home equity) over a four-year period. Protected income for the community dwelling spouse is defined the same as above. This definition essentially indicates the percentage of couples who could afford to pay for up to four years of care before depleting 50 percent of their financial assets.
- The **"50% of Assets in 1 year"** definition estimates the percentage of couples who could afford one year of nursing home care if they used up to 50 percent of their financial assets in one year. Further, it also allows the community spouse to keep only 50 percent of all non-housing, health, and personal insurance expenditures. Finally, previous household expenditures for alcohol, tobacco, and charitable contributions are made available to pay for care.

Using these alternative definitions of affordability, we found that from 3 to 48 percent of elderly couples could afford to pay privately for a one year stay in a nursing home (see Table 6). Only three percent of couples could afford to pay for care without using any of their financial assets (at the defined protected income level for the community spouse). If couples use their financial assets at a rate that would deplete 50 percent of their assets over four years, about 16 percent could afford a one year nursing home stay (also a four-year stay). Only when half of all financial assets are assumed to be immediately spent down, and a lower protected income for the community spouse is assumed, does the proportion of families able to afford a year of care approach 50 percent.

We also examined available resources for couples aged 65 and older where at least one spouse was disabled. We defined disability to include persons who require assistance with personal needs such as eating, bathing, or dressing. These disabled individuals who reside in the community are at greatest risk of needing nursing home care in the near future and hence represent an alternative group to consider when estimating who could afford to pay privately for nursing home care. The results are quite similar to those for all couples.

Single Persons

Different measures of affordability were used for single persons, since there is no community-dwelling spouse who must still meet basic consumption needs. Because the institutionalized person's needs for food and other basic living expenses would be met by the nursing home, many current expenditures are foregone. Thus, fewer expenses need to be subtracted from total income in determining the amount of income available to pay for nursing home care.

Nonetheless, one consideration is whether someone who owns a home is allowed to keep the home in case the individual is able to return to the community. If so, expenses for maintaining the home in a nursing home user's absence must be deducted.

Another difference between couples and singles arises in the treatment of financial assets, because it is not necessary to assume that half of the financial assets need to be reserved for the community dwelling spouse. All assets are potentially available to pay for nursing home care.

Thus, for single persons, the following three definitions of affordability were used:

- **No Assets.** This definition estimated the percentage of single persons who could afford one year of nursing home care without depleting any financial assets. It was assumed that a homeowner would be allowed to maintain an owned home by excluding housing-related expenditures from

available income (aside from purchases on new household equipment or furnishings). The individual is also assumed to continue current spending on insurance, personal care needs, reading, apparel, and services and miscellaneous expenses.

- **All Assets over 4 Years.** This definition is the same as the "no assets" definition except that it assumes that all assets are used to pay for care over a four-year period. It essentially indicates the percentage of persons who could afford to pay privately for nursing home stays of up to four years.
- **All Assets in 1 Year.** This definition assumes all financial assets are spent over one year. The amount of income available to pay for care is the same definition used in the prior two definitions.

The findings indicate that somewhat smaller percentages of single persons could afford to pay for one year of nursing home care than elderly couples (see Table 7). This is somewhat surprising, given that the definitions employed allow a higher percentage of income and assets to be available to pay for care for single persons. However, as previously discussed, single elderly persons have lower average incomes and assets than elderly couples.

As also shown in Table 7, the most likely users of nursing home care, the disabled elderly living alone, have the least ability to meet their own needs. Almost none of these individuals could pay for care without using their financial assets, and even then, only about 17 percent could afford up to one year of care.

VI. IMPACT OF ACUTE CARE EXPENDITURES ON THE DISABLED ELDERLY

Elderly persons with chronic disabling conditions are likely to also have expenses for acute medical care in addition to their long-term care requirements. Even though most acute care expenditures are covered by public or private insurance, the costs of recurring prescriptions, doctor's visits, and hospital stays due to deductibles, copayments, and non-covered services can add up very quickly. Some data on the out-of-pocket expenses of the elderly and the use of acute care services by the disabled elderly are available, but there are limited data on the interaction and combined out-of-pocket burden of acute and longterm care needs.

VI.A. Out-of-Pocket Acute Care Expenses of the Elderly

Out-of-pocket medical expenditures for services other than long-term care can be a financial burden for many elderly persons. In 1987, the most recent year of available data, 94 percent of the non-institutionalized elderly had some type of health care expenditure. The average annual expenditure for these persons was approximately \$4,560. Twenty-one percent of these expenditures, or nearly \$1,000 were financed out-of-pocket, while Medicaid covered a little less than one-half, and private insurance covered 16 percent. The remaining 16 percent of average expenditures among the elderly were financed by Medicaid, other public programs (such as the Indian Health Service), Worker's Compensation, charity and other private sources.²⁹

The elderly spend, on average, almost 12 percent of their income for out-of-pocket *acute* medical expenses. One-fifth of the elderly spend more than 15 percent, and one-tenth spend over 20 percent of their income.³⁰

Out-of-pocket medical expenditures are a particular problem for low income elderly persons. Persons with income less than \$10,000 in 1986 spent an average of 14 percent of their income on medical expenses, double the share of income spent by persons with income above \$10,000. For the lower income group, one-third spent more than 15 percent of their income, compared to 6 percent for those with higher incomes. The out-of-pocket medical expenses causing the expenditure of these high percentages of income are not very large; two-thirds of the low income group spending over 15 percent

of their income had out-of-pocket expenses of less than \$1,500.

VI.B. Acute Care Use of the Disabled Elderly

The disabled elderly are at greater risk of high out-of-pocket acute care medical expenses than the non-disabled population. Poor health and high levels of impairment for the disabled elderly population increase the use of medical care. In 1984, three-quarters of the severely impaired elderly population reported being in poor to fair health compared to one-quarter of the non-impaired population. Severely impaired elderly persons had over twice the number of physician contacts and three times the probability of a hospital stay in a year than the non-impaired population. The severely impaired elderly population was also more likely to rely on Medicare coverage alone than the non-impaired elderly population, resulting in a higher liability for Medicare copayments and non-Medicare covered services.

An analysis of the average out-of-pocket expenditures per month for disabled elderly persons found that 94 percent of this group had out-of-pocket health care expenditures, and the average per month for all elderly disabled persons was close to \$130 in 1982. Out-of-pocket expenditures were distributed by type of service as follows: 42 percent for acute care services (hospital stays and physician care); 20 percent for prescription medicines; 14 percent for home and community-based services; and 25 percent for nursing home care.³¹

The level of out-of-pocket expenditures for health care services among the disabled elderly increases with income level. For example, average monthly expenditures for those with monthly income greater than \$1,000 were approximately \$167 while those with monthly income less than \$500 spent approximately \$96 per month out-of-pocket. (See Table 8) However, disabled elderly with lower income have a much higher likelihood of spending over 15 percent of income on out-of-pocket health expenses. Overall, 41 percent of the disabled elderly spent more than 15 percent of their income on out-of-pocket health expenses. Among those with monthly income greater than \$1,000 per month, 18 percent spend more than 15 percent of income, while 53 percent of those with monthly income of \$500 exceeded this level. Nursing home use was the biggest contributor to catastrophic expenses. The probability of nursing home users having out-of-pocket health care expenditures in excess of 15 percent of income was over two and one-half times that of non-nursing home users.

VII. THE POTENTIAL IMPACT OF PRIVATE LONG-TERM CARE INSURANCE

Private long-term care insurance, and other risk-pooling mechanisms, can mitigate the financial impacts of long-term care on individuals by spreading long-term care costs across users and non-users of services. However, a key issue in the policy debate is the affordability of private long-term care insurance. This section examines three important questions regarding the potential impact of private long-term care insurance for reducing out-of-pocket costs for long-term care:

- What impact can private long-term care insurance have on public and private expenditures for long-term care?
- How affordable is private long-term care insurance?
- Who is a good candidate for purchasing long-term care insurance?

The section focuses on the potential impacts of private long-term care insurance, as opposed to other private financing mechanisms, such as CCRCs and home equity conversions, because it is the most prevalent risk pooling mechanism, and likely to have the greatest impact on the future financing of long-term care. Other private financing mechanisms will also have impacts, but probably to a lesser extent.

VII.A. The Potential Impact of Long-Term Care Insurance on Public and Private

Expenditures for Long-term Care

Even though there has been dramatic growth in the private long-term care insurance market over the last seven years, private insurance is not likely to have a major impact on public and private expenditures for long-term care in the short run. First, only a small percentage of elderly persons currently have insurance, and even most of those who do are not likely to need long-term care (submit claims) for another ten to twenty years. Consequently, in examining the potential impact of long-term care insurance on public and private expenditures, one must project this impact into the relatively distant future.

According to estimates generated from the Brookings/ICF Long-Term Care Financing Model, between 10 and 30 percent of the elderly will have private long-term care insurance coverage by the year 2020, thirty years from now. This estimate assumes that there will be no major changes in public policy, or in the private sector, to make private insurance more affordable than it is today, for example, by changing the tax status of employer and employee contributions to private long-term care insurance premiums.

This increased market penetration of private insurance is projected to occur for the following reasons:

- Continued growth in real incomes among the elderly will make private insurance more affordable to a greater percentage of the elderly.
- Private insurance will be more widely available, and individuals will have more opportunities to purchase insurance at younger ages, further increasing its affordability.
- The value of the elderly's financial assets will also continue to grow, increasing the demand for the asset protection provided by insurance (i.e. the financial risks of long-term care use will increase).
- The elderly will become more aware of the need to protect themselves from the financial risks of long-term care, further increasing demand.
- The group market will continue to grow, increasing the availability of policies with lower premiums.

Under these market penetration assumptions, it is estimated that private long-term care insurance will finance approximately three to seven percent of all nursing home costs by the year 2020, depending on the price and coverage offered by the policies which are purchased.

This level of increased private insurance coverage would lower both out-of-pocket expenditures for purchasers and Medicaid expenditures. Table 9 shows projected public and private expenditures for nursing home care in 2018 under two alternative scenarios: (1) the long-term care insurance market does not develop and no one has insurance; and (2) long-term care insurance is purchased by 30 percent of the elderly.

Compared to a future in which no one has private insurance, it is estimated that 30 percent coverage would reduce aggregate out-of-pocket expenditures for nursing home care by approximately six percent. Increased private insurance would also reduce Medicaid spending by about three percent, since fewer elderly would be forced to spend down to Medicaid eligibility. The percentage of total long-term care expenditures financed by Medicaid would decline from 40.4 percent without insurance to 37.9 percent with insurance coverage.

For individual purchasers of insurance, reductions in out-of-pocket expenditures for long-term care would be substantial. In the long run, policyholders would pay about half as much out-of-pocket for nursing home care as they would have paid without insurance (44 percent of the total cost, instead of 88 percent). Long-term care insurance would cover approximately half of annual nursing home expenditures for purchasers in 2018. Medicaid expenditures for insurance purchasers would only be about one-third of what they would have been had insurance not been purchased.

VII.B. How Affordable is Private Insurance?

The affordability of private long-term care insurance is a subject of heated debate. It is an issue that is central to discussions concerning whether the majority of the elderly can afford to protect themselves from the high costs of long-term care, or whether public financing mechanisms are necessary to provide adequate protection.

The concept of "affordability" has a number of dimensions, and people differ greatly on whether or not they think they can "afford" to buy a certain product. The following factors should be considered:

- The affordability of private long-term care insurance will vary depending upon the breadth and depth of coverage which a policy offers. The price of long-term care insurance varies according to the specific coverage terms of the policy. For example, a policy with a long waiting period (deductible) costs less than a policy with a short waiting period, because most nursing home stays are short.
- The concept of affordability also rests on assumptions about the percentage of income which can be allocated to the purchase of insurance. Some researchers have defined insurance to be affordable if it costs less than 5 or 10 percent of family income. But this standard ignores family circumstances that dictate whether such a share of income is feasible. Many families may not have that much to spare, while, for others, a 10 percent share of income may not be too large a commitment. Also at issue is whether potential purchasers might use asset holdings to pay for long-term care insurance.³²
- As previously discussed, the cost of private insurance goes up significantly with age. Thus, affordability also relates to when people first purchase insurance. In essence, private long-term care insurance involves saving for the future, and the younger someone starts saving, the more affordable insurance becomes.
- The current and future affordability of private insurance may differ, depending upon relative increases in the real cost of insurance and real family incomes.

The Brookings/ICF Long-term Care Financing Model was used to conduct a series of analyses on the affordability of private long-term care insurance, using different assumptions about the amount of "available resources" families have to purchase insurance. However, it is necessary to point out that not all individuals who could afford to purchase insurance under these assumptions will actually do so. Families may elect to use "available resources" for other types of needs, such as saving for a child's education or meeting projected retirement needs. Moreover, because long-term care insurance is often promoted as a means for protecting assets, a family devoting all of its savings to the purchase of insurance will have fewer assets to protect. Consequently, all of these definitions should be viewed as alternative estimates of who *could* afford to purchase insurance, not who *will* purchase insurance.

Three alternative definitions of "available resources" were used in the analysis:

- *50% of Annual Savings.* This definition assumes that half of all annual savings, after taxes and all household expenditures are subtracted, are available to purchase insurance. This means that the family's spending patterns would remain unchanged and that they would not use any of their assets to buy insurance.
- *100% of Annual Savings.* This definition assumes that all the family's annual savings available from income, after taxes and all household expenditures are subtracted, are used to purchase insurance. Like the first definition, the family's spending patterns would remain unchanged and no assets would be used to buy insurance.
- *Annual Savings Plus Some Discretionary Income.* This definition assumes that the family would forgo all of its annual savings plus some of its other expenditures in order to afford a long-term care insurance policy. The definition assumes that, if necessary, families would sacrifice on some

luxury items and forgo big ticket purchases to come up with a sufficient amount to pay the cost of premiums.³³

It is important to note that *none* of the definitions require families to use any of their accumulated assets to buy insurance, and only the third definition assumes families will change their usual spending patterns.

We compared these estimates of available resources with the premium costs of two prototype long-term care insurance products. The costs of these prototype policies, by age of purchase, are presented in Table 10. Annual premium costs range from \$285 for the lower-priced policy for purchasers in the youngest age group (45-49) to \$4,073 for the higher-priced policy for persons in the oldest age group (age 75-79).³⁴

The results indicate that:

- the percentage of persons able to afford a policy declines with age; this occurs primarily because premiums increase with the age of initial purchase;
- for single persons from age 55 to 74, about 20-44 percent of the elderly could afford a policy under the range of assumptions used (see Table 11);
- far fewer single persons over the age of 75 could afford to buy a policy, particularly a higher-priced policy that includes coverage of home care services;
- for couples headed by a person from age 55 to 74, 34-69 percent could afford a policy. Affordability is higher for couples because they have higher incomes (and more savings) and because they can buy one policy. (See Table 12.)

Additional analyses were conducted to assess the affordability of private insurance using both income and asset criteria, instead of just income criteria. Persons with fewer than \$10,000 in financial assets were considered unable to afford a policy. These persons also have less incentive to buy insurance because they have fewer assets to protect.

Adding asset criteria reduces the percentage of persons able to afford insurance. For example, 37 percent of single adult households between the ages of 45 and 79 could afford the lower-priced policy if they used 100 percent of their annual savings. If we restrict consideration to only those who have at least \$10,000 in financial assets, the percentage who could afford a policy drops to 20 percent.

The Health Insurance Association of America (HIAA) sponsored a survey of purchasers of long-term care insurance age 55 and older in 1990.³⁵ Although the data do not permit determination of the purchase rate of long-term care insurance (the number of purchasers over the total number of persons) because the data are not weighted to be a representative sample, it does offer information concerning the characteristics of purchasers compared to the general population.

Among persons age 55 and older, purchasers of individual longterm care insurance tend to be younger elderly persons with higher levels of income, assets and education than the general population. Purchasers are more likely to be between the ages of 65 and 74 than the general population (58 percent versus 34 percent). This confirms that in 1990 people tend to make purchase decisions as they get closer to an age of needing longterm care. The small proportion of the oldest old among purchasers also demonstrates the effect of underwriting and the fact that some companies did not offer policies to persons over age 80. In 1990, over 70 percent of purchasers have household income of \$20,000 or more compared to 36 percent of the general population age 55 and older. Over 40 percent of purchasers have liquid assets greater than \$100,000 compared to seven percent among the general population. Finally, over 60 percent of purchasers had some post-high school education while only 18 percent did among the general population. Unfortunately, the reported data do not permit an analysis of the reasonableness of assumptions using premiums as a percent of income as an affordability criteria.

VII.C. Who is a Good Candidate for Insurance?

In examining prospects for the future growth of the long-term care insurance market, another relevant question is: Even for those who can afford to buy insurance, is it an appropriate purchase? Long-term care insurance can serve a number of objectives. Its primary objective is to reduce out-of-pocket costs that might otherwise deplete, even exhaust, someone's accumulated net worth. It also reduces the risk and fear of spending down to Medicaid eligibility. Private insurance can also improve access to better quality care.

However, for private long-term care insurance to serve these objectives, individuals must not only have sufficient resources to pay premiums, but also the resources to cover copayments and deductibles after they become eligible for insurance benefits. Although it is difficult to establish appropriate income and asset standards for the purchase of private long-term care insurance, persons should be able to afford the premiums required, the deductibles (which routinely amount to several thousand dollars), and the copayments associated with long-term care products.

To address this issue, estimates of the deductible amounts and annual copayments required for someone who bought a policy in 1990, and then entered a nursing home 15 years later were made. We assumed that the policy paid \$80 per day, with a deductible period of 90 days. We also assumed that the individual had purchased an unindexed policy, and that nursing home prices had increased by 5.5 percent per year over the 15 year period, leaving the insurance purchaser with a significant copayment for daily costs over the \$80 benefit amount.

Under these assumptions, the deductible would cost \$16,110 and the individual's first year's copayments would have been \$27,225 in the year 2005 (see Table 13). In 1990 dollars, the deductible is equivalent to \$8,900 and the copayments are equal to \$15,100. This means that the individual who bought this policy would have approximately \$24,000 in cost sharing for the first year in a nursing home, in 1990 dollars.

Policies which are partially or fully-indexed will have lower cost sharing requirements when claims against the policy are actually made. As shown in Table 13, if an individual purchased a fully indexed policy, the required cost sharing for the first year of nursing home use would only amount to \$16,110 (or \$8,900 in 1990 dollars). However, the premiums for this type of policy are higher. First year cost sharing requirements for someone who purchased a partially-indexed policy would lie in-between these two amounts: the purchaser would need \$26,835 to pay first year costs above and beyond covered benefits (\$14,900 in 1990 dollars).

Consequently, in assessing the "affordability" of long-term care insurance, one must take into account not only the actual premium cost of the policy, but also the depth of coverage which the policy will provide when benefits are paid down the road. While some individuals may be able to "afford" one of the lower-priced policies, such as those which do not include protection against inflation, these policies may actually provide very limited or no protection whatsoever, because cost sharing requirements will consume all of the policyholder's resources in deductibles and copayments prior to paying many benefits. In essence, people who would spend down to Medicaid eligibility levels relatively quickly (e.g. within six months of nursing home entry) are probably not good candidates for private insurance.

The purchase of long-term care insurance is primarily of value to persons with substantial incomes and assets to protect. For most couples, the primary motivation is to ensure that the income and assets of the non-institutionalized spouse will be protected if one of them enters a nursing home. For single individuals, the primary motivation is to protect their estates from being depleted, so that they may pass their estates on to their heirs. Nearly one-half of the purchasers of long-term care insurance in 1990 cited minimizing financial exposure and protecting family resources as the most important reason for purchase.³⁶ Preserving income and assets for one's own self is rarely a primary objective, because most persons with extended nursing home stays do not return home.

However, even people who have no spouse and no desire to protect their estates for their heirs may have an additional objective in purchasing private insurance--staying off Medicaid. Over 90 percent of purchasers in 1990 cited avoiding dependence on Medicaid as a very important or important reason for

purchasing long-term care insurance.³⁷ Some Medicaid recipients have reduced access to nursing homes. In particular, they may have limited access to better quality nursing homes.³⁸ Even individuals who enter higher quality homes as private pay clients are not guaranteed that they will stay in those homes once they spend down to Medicaid. They may have a hospitalization, and then find that no bed is available in their prior home upon hospital discharge. Thus, to the extent that insurance coverage enables an individual to sustain or to guarantee private pay status for a longer period, purchasers of private long-term care insurance may have preferred access to a wider range of nursing homes, including better quality homes.

In addition, policies covering home care may increase access to these services by making them more affordable to persons who cannot qualify for means-tested public benefits. This, in turn, can decrease dependence on informal care, giving the disabled elderly more control over how much functional assistance they receive as well as when, how, and by whom assistance is provided. With greater ability to pay for home care, the elderly disabled may worry less about being a burden on family and friends, and their families may worry less about whether they are receiving the care they need. In the HIAA survey of purchasers, 30 percent cited avoiding dependence as the most important reason for purchasing long-term care insurance.

In some cases, home care coverage may also help the disabled elderly sustain independent living; that is, it may help to avoid or postpone moving in with adult children, or at a minimum rely less on informal support systems. However, in order for home care to aid in independent living, elderly long-term care insurance beneficiaries may have to forgo asset protection and supplement their home care insurance benefits with sizable out-of-pocket payments. For this reason, stand-alone home care policies are also likely to be inappropriate for individuals with low incomes and assets even though these policies are oriented more toward increasing access to and affordability of services rather than asset protection.

Coverage for home care services can result in much higher premium costs. Premiums for policies that cover both nursing home and home care are often double the cost of policies that cover nursing home care only. Much of the variation in premiums for home care is the result of the uncertainty among insurers about the future use of home care benefits among policyholders. In addition, it is more difficult to define the "insured event" for home care services, since it does not entail a clearcut event such as a nursing home admission. Thus, it is unclear, at this point in time, whether current home care benefits offered in long-term care insurance policies are worth the additional cost because of the limited circumstances under which benefits will be paid and the lack of a well-developed service delivery system to provide the benefits.

VIII. CONCLUSIONS

The economic impact of long-term care on individuals depends primarily on the types of services they use, the duration of their care, and their available financial resources. Many elderly persons with long-term care needs experience little or no financial impact, others experience moderate economic impacts, and still others experience catastrophic impacts on their financial well-being. Understanding of the diverse economic impacts of long-term care use on individuals is key to informed debate about future directions in Federal and State long-term care policy. Although we have learned much in recent years about the economic impacts of long-term care, there is still much that is not well understood.

Economically, the elderly are a highly diverse population. Contrary to what many people believe, the incomes of individuals and families do not become more equal as they enter retirement. In fact, there is considerable evidence that there is greater economic diversity among the elderly population than among the non-elderly.³⁹ Wealth among the elderly is even more unevenly distributed than income. Those elderly with the highest incomes own the vast majority of all financial assets.

A significant percentage of the elderly are poor or near-poor, with few financial assets. About 36 percent of the non-institutionalized elderly live in families with incomes below 150 percent of the poverty level, which was \$11,800 for an elderly couple and \$9,300 for a single individual in 1990. Most of these