

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILES 8672
2517 SCOMM 110: LONG TERM CARE TASK FORCE, 1998

5. The increase in median net worth of elderly households was primarily attributable to increased net worth among the 65 to 74 year age cohort. Median net worth of elderly households over age 75 declined slightly, from \$62,865 to \$61,491 over this period (although the standard errors of these statistics exceeds the difference between them). Source: U.S. Bureau of the Census, ***Household Wealth and Asset Ownership: 1988***.
6. Financial assets include savings accounts, savings bonds, checking accounts, money market funds, equity in rental property, equity on stock holdings, equity in a business, mortgages held, IRAs, and Keoghs less any consumer debt.
7. Home equity is defined at the market value of the home minus mortgage or other debt associated with the house.
8. Radner, D. "New Worth and Financial Assets by Age Groups in 1984." ***Social Security Bulletin*** Vol.52(3):2-15, March 1989.
9. These data, drawn from the Survey of Income and Program Participation (SIPP) use a broad definition of disability. Disabled is defined as needing assistance moving around inside or outside the house, getting into or out of bed, or requiring personal care, such as eating, bathing, or dressing. The SIPP, unlike the National Long-Term Care Survey (NLTCs), does not include detailed measures of disability. The NLTCs, on the other hand, does not include detailed measures of income or wealth.
10. Liu, K., Manton, K. and Liu B. "Home Care Expenses for the Disabled Elderly." ***Health Care Financing Review*** Vol.7(2):51-58, Winter 1985.
11. Pauly, M. "The Rational Nonpurchase of Long-Term Care Insurance." ***Journal of Political Economy*** Vol.98(11):153-168, 1990.
12. Spence, D. and Wiener, J.: "Estimating the Extent of Medicaid Spend Down in Nursing homes." ***Journal of Health Politics, Policy and Law*** Vol.15(3):607-626, Fall 1990.
13. Based on single stays, not entire episodes of care.
14. Burwell, B., Adams, E., and Meiners, M.: "Spend-down of Assets Before Medicaid Eligibility Among Elderly Nursing-Home Recipients in Michigan." ***Medical Care*** Vol.28(4):349-362, April 1990.
15. The financial impact on non-institutionalized spouses of nursing home residents was ameliorated substantially by the spousal impoverishment provisions of the Medicare Catastrophic Coverage Act of 1988, one of the few provisions of the Act that was *not* subsequently repealed.
16. Adams, K., Meiners, M. and Burwell, B. ***Medicaid Spend-Down in Nursing Homes: A Synthesis of Recent Research***. Paper prepared for the Office of the Assistant Secretary for Planning and Evaluation, DHHS, under contract HHS-100-88-0041, November 1990.
17. Liu, K., Doty, P. and Manton, K.: "Medicaid Spend-down in Nursing Homes." ***The Gerontologist*** Vol.30(1):7-15, 1990.
18. Wiener, J. and Spence, D.: "Estimating the Extent of Medicaid Spend-Down in Nursing Homes." ***Journal of Health Politics, Policy and Law*** Vol.15(3):607-626, Fall 1990.
19. Short, P., Kemper, P., Cornelius, L. and Walden, D.: "Public and Private Responsibility for Financing Nursing Home Care: The Effect of Medicaid Spend-Down." Paper presented at the 1990 meetings of the American Public Health Association, October 1990.
20. Burwell, B. et al.: "Spend-Down of Assets Before Medicaid Eligibility Among Elderly Nursing

Home Recipients in Michigan."

21. Farbstein, K., Gruenberg, L. and Pattee, C.: "When Nursing Home Spend-Down Occurs: An Analysis of Multiple Episodes of Nursing Home Use From a Discharge Cohort." Study conducted for the Connecticut Partnership for Long Term Care Research Institute, September, 1989.
22. Gruenberg, L., Farbstein, K., Hughes-Cromwick, P., Pattee, C., and Mahoney, K.: "An Analysis of the Spend-Down Patterns of Individuals Admitted to Nursing Homes in the State of Connecticut." Study conducted for the Connecticut Partnership for Long Term Care Research Institute, September, 1989.
23. Bice, T. and Pattee, C.: "Nursing Home Stays and Spend-Down in the State of Connecticut: 1978-1983 Admission Cohorts." Study conducted for Planning and Evaluation, Department of Health and Human Services, October 1990.
24. Farbstein, K. et al: "When Nursing Home Spend-Down Occurs."
25. Adams, K. et al: "Medicaid Spend-Down in Nursing Homes: A Synthesis of Recent Research."
26. Liu, K. et al: "Medicaid Spend-Down in Nursing Homes."
27. Adams, K.: "Enrollment in Medicaid by the Elderly: Which Catastrophe?" Paper prepared for the Office of Research, Health Care Financing Administration under contract no. HCFA-500-86-0016, 1990 (Draft).
28. Essentially, this estimates the percentage of elderly couples who could afford to pay for private care indefinitely for one member, since no assets are needed to pay for care.
29. Hahn, B. and Lefkowitz, D. (November 1992). "Annual Expenses and Sources of Payment for Health Care Services". (AHCPR Pub.No.9300007). National Medical Expenditure Survey Research, Findings 14.
30. Feder, J., Moon, M. and Scanlon, W. (1987) "Medicare Reform: Nibbling at Catastrophic Costs", *Health Affairs* 6, 6-19.
31. Liu, K., Perozek, M. and Manton, K. "Catastrophic Acute and Long-Term Care Costs: Risks Faced by Disabled Elderly Persons".
32. A survey of long term care insurance purchasers indicates that approximately 60 percent of purchasers use liquid assets to help finance insurance premiums.
33. Specifically, one-half of what the family now spends on tobacco, alcohol, and cash contributions to others and the full amount of spending on vehicles, educations, and household equipment and furnishings was subtracted. In addition to the fact that these last three groups of expenditures are discretionary, they also appear in these data in lump sum and thus exaggerate the spending patterns of many families. That is, many families extend their care payments over three or four years but the data on consumer expenditures show the full amount of the cost of the car on the date of purchase regardless of how it is financed.
34. The lower priced policy is a nursing home only policy that covers four years of care after a 100 day waiting period. The higher priced four year policy includes a home care benefit. Both would pay \$80 per day currently and would be adjusted over time for inflation.
35. HIAA, "Who Buys Long-Term Care Insurance?" submitted by LifePlans, 1992.
36. HIAA, 1990.

persons also have few financial assets. What wealth they do have is usually tied up in their homes. Although they are poor or near-poor, most have incomes or assets above Medicaid eligibility levels. Only about eight percent of the elderly living outside of nursing homes are enrolled in Medicaid.

The elderly most at risk of needing long-term care have fewer financial resources than the non-disabled elderly. Poverty among the elderly is strongly associated with (1) being single; (2) living alone; and (3) being very old. This is also the group that is at the highest risk of needing paid long-term care services, since they have high rates of disability and fewer family and friends to provide informal care.

Persons not eligible for Medicaid who have extended nursing home stays are at the greatest risk for experiencing catastrophic financial impacts from long-term care use. The average annual cost of a nursing home stay in 1990 was about \$30,000. About 20 percent of all elderly persons turning age 65 in 1990 will spend a year or more in a nursing home before they die. Although many of these persons will have Medicare and/or Medicaid coverage for all or part of their nursing home stays, many others will be required to pay for most of their nursing home care with private resources. Recent studies indicate that somewhere between 10 and 25 percent of all persons who enter nursing homes spend down to Medicaid eligibility prior to their final discharge.

Although "affordability" is difficult to measure, analyses indicate that very few of the elderly can afford a one-year stay in a nursing home. Almost no elderly couples or individuals can afford to pay for nursing home care without using their accumulated financial assets. Only forty to fifty percent of the elderly could afford to pay for one year of nursing home care without depleting available financial assets. Only ten to twenty percent could afford up to pay for up to four years of nursing home care.

Poor and near-poor elderly persons living in the community, who are not eligible for Medicaid, experience a different type of economic impact--they cannot afford home care. Poor elderly who are eligible for Medicaid can receive publicly-financed home care services at no cost to themselves, although the availability of these services varies significantly from State to State. Poor and near-poor persons not eligible for Medicaid are generally not eligible for publicly-financed services, but cannot afford to buy them privately. These persons have a high likelihood of having unmet needs and/or imposing a heavy care burden on their family members. In these cases, the *economic* impacts can fall on families, rather than the recipients themselves.

Private long-term care insurance provides an opportunity to ameliorate the economic impacts of long-term care use, but not everyone can afford it. Because long-term care insurance spreads the costs of long-term care across users and non-users, more people can afford to buy insurance than can afford to buy long-term care services without insurance. Good candidates for private insurance are persons who have adequate income to pay premiums and adequate financial resources to pay deductibles and co-payments. Higher-priced policies which have inflation protection mechanisms and shorter waiting periods have higher premium costs, but can significantly reduce cost sharing requirements if and when policyholders need care.

Persons who purchase long-term care insurance will have reduced out-of-pocket costs, diminished risk and fear of spending down to Medicaid eligibility, and increased access to quality care. For persons between the ages of 45 and 79, long-term care insurance premiums are generally affordable for 37 percent of single persons and 59 percent of families with more than one adult if they choose to use all their annual savings to pay the premiums. The younger someone begins buying insurance, the more affordable it becomes. In brief, the sooner we start saving for future long-term care needs, the less financial risk we face later on.

Even if the market for private long-term care insurance continues to expand, and achieves significant market penetration, public and private expenditures for long-term care will not be markedly affected over the short term. If 30 percent of the elderly have long-term care insurance coverage in thirty years, Medicaid expenditures for nursing home care would be approximately \$1 billion (in 1989 dollars) less and out-of-pocket payments would be about \$3 billion less than if there were no insurance coverage. However, for those who purchase long-term care insurance, the amount they would otherwise have to pay out-of-pocket for nursing home care would be cut in half.

The risk of incurring catastrophic economic impacts from long-term care use is directly related to delayed planning for future needs. The longer people wait before they begin to plan for their future long-term care needs, the less "affordable" financial protection from high long-term care costs becomes. Currently, people fall into three distinct groups, in terms of their ability to plan for future needs:

- **Persons over age 80.** Persons in this age group face the greatest risks of needing long-term care and incurring severe economic impacts from long-term care use. They are also, in general, the group with the fewest financial resources. For this group, the ability to purchase long-term care insurance is limited, because of age/underwriting restrictions or the cost of insurance. A small percentage can buy some protection by investing significant assets in CCRCs. However, most CCRCs still do not provide financial protection from extended nursing home stays.
- **Persons age 65-79.** Individuals in this age group are less likely to be disabled and, in general, have greater financial resources. They still have opportunities to save for future long-term care needs. Analyses indicate that up to 30-50 percent of this group could afford to purchase long-term care insurance that offered significant financial protection. Persons in this group with low income and assets are less able to purchase insurance and have less incentive to buy insurance, since they have fewer assets to protect. Many will end up on Medicaid if they require extended nursing home care.
- **Persons under age 65.** The vast majority of persons in this age group are not disabled and could afford to buy long-term care insurance at significantly reduced premium costs. Most people in this group do not recognize the need to plan for future long-term care needs, and will not do so without substantial public and private sector initiatives.

The elderly of tomorrow are expected to be financially even better-off than the elderly of today. More will be able to afford to purchase their own long-term care services, although it is also possible that the use of long-term care will also increase, with increasing longevity. The more rapidly individuals start participating in risk pools, and the earlier they start, the more affordable long-term care will be to a greater percentage of the elderly. Medicaid and other public programs will remain the principal payer for most elderly persons with low incomes and assets, because they are not good candidates for private insurance. Moderate and upper-income elderly, who do not purchase financial protection, will continue to risk the possibility of experiencing catastrophic economic consequences if they require extended nursing home care.

IX. NOTES

1. Hanley, et al. "Predicting Elderly Nursing Home Admissions: Results from the 1982-84 National Long Term Care Survey," *Research on Aging*. Sage Publications, Vol.12, No.2, June 1990.
2. For a single elderly persons, 150 percent of the poverty level in 1990 is approximately \$9,300. For an elderly couple, it is approximately \$11,800. Elderly poverty levels are approximately 8 percent lower than the levels for non-elderly persons. Estimates in this section are based on family income, which means that sources of income and amounts for family members under the age of 65 are included for elderly persons living with others. Approximately 31 percent of the elderly live alone, 44 percent live with their spouse only, and the remaining 25 percent live with relatives or others.
3. The new worth concepts used here does not account for human capital, vested pension assets, social security wealth or in kind transfers, such as Medicare.
4. U.S. Bureau of the Census, Current Population Reports Series P-70, No.22, *Household Wealth and Asset Ownership: 1988*, U.S. Government Printing Office, Washington, D.C. 1990.

37. HIAA, 1990.

38. General Accounting Office, "Nursing Homes Admission Problems for Medicaid Recipients and Attempts to Solve Them," HRD-90-135, September 1990.

39. Crystal, S. and Shea, D.: "Cumulative Advantage, Cumulative Disadvantage, and Inequality Among Elderly People." *The Gerontologist* Vol.30(4):437-443, August 1990.

TABLE 1: SOURCES OF INCOME OF THE ELDERLY BY SOURCE OF INCOME				
(in 1990 dollars)				
Family Income Source	Income by Source			
	Low	Modest	Average % of Total	
Percent of Persons	36%	40%	24%	100%
Social Security				
• Percent with Income	94%	98%	93%	95%
• Median Amount ^a	\$5,234	\$8,413	\$9,216	\$6,943
• Average % of Total Income ^b	71%	47%	23%	51%
Pension				
• Percent with Income	28%	66%	68%	52%
• Median Amount ^a	\$1,253	\$3,574	\$8,550	\$3,737
• Average % of Total Income ^b	6%	18%	20%	14%
Employment				
• Percent with Income	14%	35%	54%	32%
• Median Amount ^a	\$2,081	\$6,941	\$18,139	\$7,837
• Average % of Total Income ^b	5%	16%	23%	13%
Asset				
• Percent with Income	62%	92%	97%	82%
• Median Amount ^a	\$467	\$1,769	\$6,161	\$1,677
• Average % of Total Income ^b	7%	15%	23%	13%
Other^c				
• Average % of Total Income ^b	11%	4%	5%	8%
Total Median Income	\$6,834	\$16,442	\$34,208	\$14,846

a. Median amount for persons with income from this source.

b. Average percent of family income for all persons.

c. Other income includes SSI, rental income, and business income.

NOTE: Low income is defined as less than 150 percent of the poverty level; modest income is defined

NOTE: Low income is defined as less than 150 percent of the poverty level; modest income is defined as between 150 and 299 percent of the poverty level and moderate to high income is defined as 300 percent of the poverty level or greater. Family income is based on income from all persons in the family.

SOURCE: Lewin/ICF estimates based on data from the 1984 Survey on Income and Program Participation (SIPP).

TABLE 2. ASSETS OF FAMILIES BY INCOME LEVEL

(in 1990 dollars)

Family Income Source	Family Income Level			
	Low	Modest	Moderate to High	Total
Percent of Persons	36%	40%	24%	100%
Financial^a				
• Percent of Persons with Assets	78%	96%	99%	90%
• Median Amount ^b	\$5,509	\$30,309	\$84,921	\$26,704
Home Equity				
• Percent of Persons with Equity	60%	81%	88%	75%
• Median Amount ^b	\$30,538	\$44,821	\$64,830	\$45,021

a. Financial assets include: savings accounts, savings bonds, checking accounts, money market funds, equity in rental property, equity in stock holdings, equity in a business, mortgages held, IRAs, and Keoughs less consumer debt.

b. Median amount for persons with assets.

NOTE: Low income is defined as less than 150 percent of the poverty level; modest income is defined as between 150 and 299 percent of the poverty level; and moderate to high income is defined as 300 percent of the poverty level or greater as high. Family income is based on income from all persons living in the family.

SOURCE: Lewin/ICF estimates based on data from the 1984 Survey on Income and Program Participation (SIPP).

Family Income Sources				
Percent of Persons	48%	34%	18%	100%
Social Security				
• Percent with Income	95%	98%	96%	96%
• Median Amount ^a	\$5,183	\$7,504	\$8,871	\$6,214
• Average % of Total Income ^b	74%	47%	24%	56%
Pension				
• Percent with Income	26%	62%	66%	46%
• Median Amount ^a	\$1,136	\$3,400	\$8,174	\$3,202
• Average % of Total Income ^b	6%	17%	17%	11%
Employment				
• Percent with Income	6%	25%	51%	21%
• Median Amount ^a	\$2,312	\$9,865	\$17,941	\$10,087
• Average % of Total Income ^b	2%	12%	25%	9%
Asset				
• Percent with Income	68%	94%	97%	82%
• Median Amount ^a	\$528	\$2,506	\$7,713	\$1,663
• Average % of Total Income ^b	9%	19%	28%	16%
Other:				
• Average % of Total Income ^b	9%	5%	6%	8%
Total Median Income	\$6,560	\$15,778	\$33,814	\$11,588
a. Median amount for persons with income from this source.				
b. Average percent of family income for all persons.				
c. Other income includes SSI, rental income, and business income.				
NOTE: Low income is defines as less than 150 percent of the poverty level; modest income is defined as between 150 and 299 percent of the poverty level and moderate to high income is defines as 300 percent of the poverty level or greater. Family income is based on income from all persons in the family.				
SOURCE: Lewin/ICF estimates based on data from the 1984 Survey on Income and Program Participation (SIPP).				

TABLE 5: DISTRIBUTION OF ALTERNATIVE GROUPS OF ELDERLY PERSONS BY FAMILY INCOME LEVEL

(in 1990 dollars)

	Family Income Level			
	Low	Modest	Moderate to High	Total
Non-Disabled Elderly	33%	42%	25%	100%
Elderly Age 75 and Over	48%	34%	18%	100%
Disabled Elderly	52%	31%	16%	100%
Disabled Elderly Age 75 and Over	55%	30%	15%	100%
All Elderly	36%	40%	24%	100%

NOTE: Low income is defined as less than 150 percent of the poverty level; modest income is defined as between 150 and 299 percent of the poverty level and moderate to high income is defined as 300 percent of the poverty level or greater. Family income is based on income from all persons in the family.

SOURCE: Lewin/ICF estimates based on data from the 1984 Survey on Income and Program Participation (SIPP).

TABLE 6: PERCENT OF ELDERLY COUPLES ABLE TO PRIVATELY PAY FOR ONE YEAR OF LONG TERM CARE

(in 1990 dollars)

	Available Resources		
	No Assets	50% of Assets Over 4 Years	50% of Assets Over 1 Year
All Elderly Couples	3.2%	16.1%	48.0%
Disabled Couples	3.4%	18.8%	38.1%

No Assets--Housing, health and personal insurance expenditures are assumed to remain as is. Other expenditures are protected for the community spouse up to two-thirds of the preinstitutionalization level. Assets and asset income are left intact.

50% of Assets over 4 Years--Assumes the expenditures projections listed above, allowing the community spouse all housing, health and personal insurance expenses and 2/3 of everything else. It also effectively requires that the couple devote up to half of its financial assets to the cost of the institutionalization over a four year period.

50% of Assets over 1 Year--An upper bound on the contribution that could be expected from a couple would be to protect housing, health and personal insurance but no expenditures for alcohol, tobacco and ash contribution and only 1/2 of all other expenditures, and to require that the couple use of half of its financial assets in one year.

NOTE: Disability is defined as requiring assistance with personal needs such as eating, bathing, or dressing.

SOURCE: Lewin/ICF and Urban Institute estimates based on a statistically matched data base of 1984 Consumer Expenditures Survey data and 1984 Survey of Income and Program Participation data.

TABLE 7: PERCENT OF ELDERLY COUPLES ABLE TO FINANCE PAY FOR ONE YEAR OF LONG TERM CARE			
	Available Resources		
	No Assets	All Assets Over 4 Years	All Assets In 1 Year
All Single Persons	0.5%	12.3%	39.5%
Disabled Single Persons	0.0%	7.5%	17.0%
No Assets--Housing, health and personal insurance expenditures are assumed to remain as is. Other expenditures are protected for the community spouse up to two-thirds of the preinstitutionalization level. Assets and asset income are left intact. 50% of Assets over 4 Years--Assumes the expenditures projections listed above, allowing the community spouse all housing, health and personal insurance expenses and 2/3 of everything else. It also effectively requires that the couple devote up to half of its financial assets to the cost of the institutionalization over a four year period. 50% of Assets over 1 Year--An upper bound on the contribution that could be expected from a couple would be to protect housing, health and personal insurance but no expenditures for alcohol, tobacco and ash contribution and only 1/2 of all other expenditures, and to require that the couple use of half of its financial assets in one year.			
NOTE: Disability is defined as requiring assistance with personal needs such as eating, bathing, or dressing.			
SOURCE: Lewin/ICF and Urban Institute estimates based on a statistically matched data base of 1984 Consumer Expenditures Survey data and 1984 Survey of Income and Program Participation data.			

TABLE 8: AVERAGE OUT-OF-POCKET EXPENDITURES PER MONTH AND THE PERCENTAGE OF DISABLED ELDERLY PERSONS WITH PRIVATE EXPENSES EXCEEDING 15% AND 20% OF INCOME, 1982				
	Income Per Month			
	All Persons	<\$500	\$500-\$1,000	>\$1,000
Out-of-Pocket				
Average Expenditures Per Month	\$130	\$96	\$148	\$167
Out-of-Pocket Expenditures Exceeding Percentage of Income				
>15%	41%	53%	40%	18%
• Nursing Home Users	87%	90%	89%	72%
• Non Nursing Home Users	35%	47%	33%	12%
>20%	30%	42%	27%	11%
• Nursing Home Users	81%	87%	81%	63%
• Non Nursing Home Users	23%	35%	20%	6%
SOURCE: Liu, K., Perozek, M. and Manton, K. "Catastrophic Acute and Long-Term Care Costs: Risks Faced by Disabled Elderly Persons."				

TABLE 9: PROJECTED NURSING HOME CARE EXPENDITURES FOR 2019

in billions of dollars

	No Long Term Care Insurance Purchase	With Long Term Care Insurance Purchase	Percent Difference
Medicare	\$2.9	\$3.0	3.5%
Medicaid	41.0	39.6	-3.4%
Public	\$43.9	\$42.6	-3.0%
Long Term Care Insurance	0.0	7.5	NA
Out-of-Pocket	57.7	54.3	-5.9%
Private	\$57.7	\$61.8	7.1%
Total	\$101.5	\$104.4	2.9%

NOTE: The long term care insurance policy modeled primarily covers nursing home care and the results assume 30 percent of the elderly purchase long term care insurance.

SOURCE: Brookings/ICF Long Term Care Financing Model.

TABLE 10: LONG-TERM CARE INSURANCE POLICY PREMIUMS

Age of Purchaser	Lower Priced Policy	Higher Priced Policy
45-49	\$285	\$1,025
50-54	377	1,142
55-59	499	1,269
60-64	660	1,559
65-69	933	1,902
70-74	1,355	2,586
75-79	2,008	4,073

NOTE: Both policies are marketed to individuals, not through a group market. The lower priced policy primarily covers nursing home services for four years at \$80 per day, after meeting a 100 day deductible period. The higher priced policy also covers home care benefits at \$40 per visit. Benefit amounts are indexed at five percent the original benefit amount annually.

SOURCE: AMEX, 1990.

TABLE 1. PERCENTAGE OF ELDERLY WITH SAVING AVAILABLE FOR LONG-TERM CARE, BY AGE AND POLICY			
Age	50% of Annual Savings	100% of Annual Savings	Annual Savings Plus Some Discretionary Income
45-54	34-43%	40-46%	52-58%
55-59	26-36%	35-40%	42-50%
60-64	23-32%	31-36%	38-47%
65-74	17-26%	26-33%	31-41%
75-79	6-15%	15-31%	18-35%
Total (55-74)	20-29%	29-35%	35-44%
Total (45-79)	21-30%	29-37%	36-46%

50% of Annual Savings--One-half of the savings available from income after taxes and all current expenditures are subtracted.

100% of Annual Savings--Savings available from income after taxes and all current expenditures are subtracted.

Annual Savings Plus Some Discretionary Income--Savings available from income after taxes less all basic expenditures, one half of what the family now spends on tobacco, alcohol, and cash contributions to others and the full amount of spending on vehicles, education, and household equipment and furnishings are subtracted.

NOTE: The lower percentage is for those who can afford the more expensive policy and the higher percentage under each definition is for those who can afford the lower priced policy.

SOURCE: Lewin/ICF and Urban Institute estimates based on a statistically matched data base of 1984 Consumer Expenditures Survey data and 1984 Survey of Income and Program Participation data.

TABLE 12: PERCENT OF TOTAL ANNUAL SAVINGS AVAILABLE TO COVER DEDUCTIBLES AND CO-PAYMENTS

Age of Head of Household	Savings Definition					
	50% of Savings		100% of Savings		Savings Plus Some Discretionary Income	
	One Policy	Two Policies	One Policy	Two Policies	One Policy	Two Policies
45-54	56-61%	49-60%	60-62%	56-61%	77-79%	74-78%
55-59	57-61%	47-59%	60-62%	57-61%	72-74%	69-73%
60-64	47-52%	37-49%	51-54%	47-52%	64-66%	59-65%
65-74	41-51%	23-41%	51-55%	41-51%	62-67%	53-62%
75-79	34-51%	13-35%	49-59%	34-51%	62-70%	46-63%
Total (55-74)	47-55%	34-49%	54-57%	47-55%	66-69%	60-66%
Total (45-79)	50-57%	38-52%	56-59%	50-57%	70-73%	64-71%

50% of Annual Savings--One-half of the savings available from income after taxes and all current expenditures are subtracted.

100% of Annual Savings--Savings available from income after taxes and all current expenditures are subtracted.

Annual Savings Plus Some Discretionary Income--Savings available from income after taxes less all basic expenditures, one half of what the family now spends on tobacco, alcohol, and cash contributions to others and the full amount of spending on vehicles, education, and household equipment and furnishings are subtracted.

NOTE: The lower percentage is for those who can afford the more expensive policy and the higher percentage under each definition is for those who can afford the lower priced policy.

SOURCE: Lewin/ICF and Urban Institute estimates based on a statistically matched data base of 1984 Consumer Expenditures Survey data and 1984 Survey of Income and Program Participation data.

TABLE 13: EXPECTED DEDUCTIBLES AND COPAYMENTS UNDER LONG-TERM CARE INSURANCE

(in normal dollars)

Long-term Care Insurance Policy ^a	Expected Deductible in 2005	Expected Copayment in First Year	Total
Unindexed	\$16,110	\$27,225	\$43,335
Partially Indexed ^b	\$16,110	\$10,725	\$26,835
Fully Indexed ^c	\$16,110	\$0	\$16,110

a. Policies are assumed to have a 90 day deductible and pay \$80/day in 1990. Nursing home costs are assumed to be \$179/day in 2005 (5.5 percent annual inflation). Policies are assumed to be purchased in 1990.

b. Benefits increase at 5 percent of the original benefit.

c. Benefits increase 5.5 percent annually.

SOURCE: Lewin/ICF estimates.

Good morning Mr. Chairman, members of the Long Term Care Task Force. Thank you for the opportunity to speak with you today regarding a very important topic, long term care.

My name is Marguerite Stetson. ^{Spill} I have lived in Alaska since 1966 and retired from the University of Alaska Fairbanks in 1987. Currently, I am State President of AARP, ^{of volunteers} with a state membership of over 50,000 members; and a national membership exceeding 30 million. Membership is for those persons retired, or working, who are 50 years of age or older.

Since its inception, AARP has been strongly committed to the establishment of a long term care system that provides a continuum of services for all ages including disabled persons. We hear regularly from our members about the challenges they face when requiring long term care, whether it be in their own homes, from a local adult day care health program or from a nursing home. We also know that our national members prefer staying in their own homes as long as feasible. I am quite sure that each of you on this Task Force and others in this room share this same preference. We all want to stay in our homes until we die. The question is: what will it take to make that preference become a reality?

The points I would like to cover today, in the time allotted are the following:

1. a short description of what long term care is;
2. where it is provided;
3. who pays for LTC;
4. issues, concerns and future directions

Long Term Care is a broad range of services needed by persons of all ages with physical or mental impairments, who have lost or never acquired the ability to function independently. It includes personal care, nursing and home health care, rehabilitation, adult day care, case management, social services, and assisting technology. These services are provided in a variety of settings from homes to residential housing to nursing facilities.

You may think of a continuum of care ranging from in-home care as the least restrictive setting to the nursing home which is the most restrictive. LTC services may be needed on a regular or respite basis over a period of several month, several years or a lifetime.

It is true that most people who need LTC live in their own homes. Most LTC is informal, unpaid help which is provided by family and friends. We know that of the 10.6 million Americans who need LTC, 84% live in their own homes and 70-80 percent of the care is provided by family members and friends. Family members are the unsung heroes of our LTC

system. In Alaska there could be a lack of family members causing an increased financial burden on the state.

AARP commends the wisdom of the legislature for supporting the Alaska PROJECT CHOICE which allows Alaskans to stay in their homes as long as possible with community based services. We need more of such program which keep people out of costly institutional settings. We need a range of community programs which include nutrition, social or health care services and a range of alternative housing that make it possible for the person to remain at home or in the community and maintain their independence.

You know that only about 5.1% of the population over 65 is currently in a nursing home. However, the *State Government News* (August 1998) reports that 40% of all Americans will need nursing home care at some time in their lives; therefore, planning for this use is imperative. About 40% of those will stay less than 3 months. This usually occurs when an individual is in a nursing home for rehabilitation following a stroke or fall.

Nursing home care is for those who are chronically ill or recovering from an acute illness and need extended care, but not hospitalization. Persons with a long stay in nursing homes tend to be individuals with chronic or debilitating disease, such as Alzheimer's disease. It is estimated

that 50% of all nursing home residents have a diagnosis of Alzheimers or a related dementia.

As you know, the Pioneer Homes are moving toward specializing in Alzheimers care with residents paying the full cost of care within seven years, resulting in a 30 percent increase in cost of care to residents. The State with pick up costs for those who cannot afford this increase. Current costs for nursing home care in some areas of Alaska exceed \$100,000 per year; this is more than double the average cost of one year in a nursing home in the U.S. According to the August 1998 *State Government News*, it is estimated than in less than 30 years the cost will be closer to \$140,000 for the U.S. Using this estimated increase for the U.S., could Alaska's cost be close to \$350,000 in 30 years?

Alaska still has a smaller percentage of people over 65 living in this state than other states. However, this percentage seems to be growing as the state provides incentives for older people to remain in Alaska. It is estimated that this population could increase 316 percent by 2025; from around 32,000 in 1996 to over 100,000 in 2025.

While there are costs to the state when older persons remain here, there are many more benefits, including the impact on the economy as these persons receive pensions and social security and purchase goods and

services within the state; and the benefit of having these persons volunteer and participate in decisions within their local communities. It is vital to the health of any community to have their "elders" with them.

According to AARP statistics, and probably as a result of budget tightening, there has been a 1.3 percent drop in nursing home residents between 1995 and 1996. There are some licensed adult day care centers in Alaska but probably not a sufficient number of high-quality centers. This may need to increase to provide assistance for those individuals not in nursing homes but needing care. Alaska's occupancy rates in nursing homes, in 1996, was 81 versus 89.9 for the U.S; ranking Alaska as 44. Only Oklahoma and Texas had lower occupancy rates in 1996; four states were not reported. It would appear that Alaska should restrict expansion in this area for the near future. I believe that the legislature has take action on this issue.

The membership of AARP is very concerned about long term care. This care is important for all ages including the disabled in Alaska. The cost of long term care in the home versus an institution is causing economic and social stress as well as a financial hardship on the state and the individual. AARP applauds Alaska's efforts to develop a long range plan for long term care.

Who funds LTC? As you know, states bear substantial responsibility for long term care. You administer federal and state funds, and are responsible for regulating nursing homes and home health agencies to assure that quality services are provided to the citizens of Alaska. You know that spending for LTC has placed a great demand on our state budget.

Eighty percent of the cost for long term care in long term care facilities is paid by Medicaid—for those persons who qualify. The large subsidies for long term care from the state's general fund will increase in the future competing with funding for other state programs.

Good quality in-home care needs to be provided to help people remain in the least restrictive setting. There will need to be affordable ^{Quality} assisted living homes to keep more Alaskans out of nursing homes. Medical transportation needs to be improved, again to assist those individuals that wish to remain independent but can no longer drive themselves.

Perhaps our new ^{Volunteer} AARP Information Center in Anchorage, along with the United Way supported AK Info Data Base, could assist in being a center for information about long term care in Alaska.

Thank you again, for allowing me to present AARP's position on long term care. AARP welcomes the opportunity to work with you in shaping a

Long Term Care plan and to provide you with any further information you may require.

The following long-term care principles are designed to guide the Association's efforts to bring about comprehensive reform and establish a public long-term care program. These principles do not address every specific issue relating to long-term care, but they do provide criteria for evaluating and comparing reform proposals. They also serve to guide the Association in its participation in the public debate about long-term care reform at both the federal and state level.

UNIVERSAL COVERAGE. Long-term care services should be available to all people who need them, regardless of age or income. The long-term care program should base eligibility for services on a person's physical and cognitive or other mental functioning, including limitations in performing activities of daily living (e.g., eating, bathing, and dressing) and a person's need for supervision. Uniform national assessments should determine whether a person meets the eligibility criteria for the program and what type and level of care a person needs.

COMPREHENSIVE COVERAGE. A national public long-term care program should provide a comprehensive range of services. These services should include (1) in-home assistance; (2) community services; (3) long-term care services in a full range of supportive housing options; (4) institutional care; (5) rehabilitative services; and (6) long-term care related transportation services. Long-term care should be provided in the least restrictive setting possible.

SUPPORT FOR INFORMAL CARE. The new public program should assist, not replace, current informal caregivers. Families and friends need access to supportive services so that they are not unreasonably burdened and can continue to provide care. The services should include respite care, adult day care, and other types of assistance, such as an expanded dependent care tax credit.

PHASED-IN IMPLEMENTATION. Implementation of the public program must be phased in to ensure orderly development of the new system. Expansion of services should be accompanied by development of a long-term care infrastructure, including health care personnel, that will permit the delivery of a comprehensive range of home, community, and institutional services. The program should not be phased in on the basis of income or assets.

SHARED RISK. The principles of social insurance (e.g., Social Security or Medicare) and shared risk must be extended to long-term care. Under social insurance programs, individuals pay into the system and are then entitled to benefits when they are needed. By spreading the cost across the entire population, universal protection can be achieved in an affordable, equitable manner for everyone.

ADEQUATE PUBLIC FINANCING. The new long-term care program should be financed primarily through taxes earmarked to a trust fund. Revenue sources could include payroll taxes, increased estate and gift taxes, income taxes, and modest premiums. The new public program must be financed through taxes and premiums so that it does not increase the federal deficit.

PRIVATE SECTOR INVOLVEMENT. The new public program must provide a solid foundation for protection which the private sector can build. The private sector could supplement the public program with insurance products similar to Medigap policies that would cover the program's copayments and deductibles as well as services that the public program does not provide. Any private-sector approach (e.g., long-term care insurance) should be subject to strong standards to protect consumers from inadequate products.

ADEQUATE REIMBURSEMENT. Payment to providers of long-term care services must be reasonable and provide appropriate incentives to deliver quality care. Reimbursement systems for home, community, and institutional care must respond to clients' needs, promote delivery of quality care, and recognize the outcomes of care provided to clients.

COST CONTAINMENT. Cost containment mechanisms must be built into the new long-term care system. Use of services could be controlled by providing a defined set of services to beneficiaries. Modest deductibles and copayments also could be included. However, people with low incomes should be protected.

QUALITY ASSURANCE. The federal and state governments should assure delivery of quality care under the new long-term care program. Quality assurance systems for nursing homes and home health agencies should be swiftly and vigorously enforced. In addition, new methods of assuring the quality of other home and community services must be found.

MARGUERITE STETSON

STATE GOVERNMENT NEWS....AUGUST, 1998

health

The aging of America

With the prospect of 54 million Americans being over the age of 65 within two decades, the need for long-term health care is increasing rapidly.

BY ANNE C. LAYZELL

Anne C. Layzell is a policy analyst with CSG: Midwest, (630) 830-0210.

the council of state governments 17

NURSING HOME

Nobody likes to be told they are getting old. But in the case of the U.S. population, it's true.

Once thought of as a nation of young people, the United States quickly is becoming elderly. Declining fertility rates, longer life spans, better health care and an aging baby boomer generation are contributing factors. Soon persons 65 years old and older in this country will outnumber the young.

In 1900, there were 3.1 million people age 65 or older in the United States. By 2020, this population is expected to reach 54 million, representing about one out of every six Americans. In addition, a large portion will be over the age of 85 — a group that is most likely to need assistance with everyday activities.

Public burdens

This trend is proving to be problematic for policy-makers. More elderly in

the population means more need for long-term care. And the increased demand for these services is making states nervous about how to pay for them. The average cost of one year in a nursing home is more than \$40,000. U.S. Care, a chronic care management company, predicts that in less than 30 years the cost will be closer to \$140,000 per year. Considering the current median net worth of retired households is about \$74,000, it would take less than two years at today's nursing home care cost level to wipe out a life savings.

Since Medicare and most private health insurance policies generally do not pay for long-term care, many people look to public financing to fund their nursing home or home health care needs. Last year, according to the American Health Care Association, Medicaid paid for the care of 68 percent of all nursing home residents. Consequently, Medicaid accounts for more than 65 percent of all public dol-

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lars spent on long-term care.

In recent years, Medicaid has consumed 20 percent or more of total state expenditures, according to the General Accounting Office. Most experts agree that this level of Medicaid spending

of long-term care insurance, discouraging the transfer of assets and expanding attempts to recover the cost of Medicaid from the estates of beneficiaries. Long-term care insurance reduces Medicaid spending by providing a

expensive for those who need them. An average policy can cost more than \$2,000 a year for a healthy 65-year-old, and the cost increases with age.

Many states are providing tax incentives to encourage people to purchase insurance policies before the premiums become too expensive. Last year, the Minnesota Legislature adopted a law that provides an income tax credit for long-term care insurance premiums. The statute allows residents to take a credit for 25 percent of premiums, not to exceed \$100, that were not deducted for federal income tax purposes.

For those facing long-term care expenses, however, the prospect of paying for services is not as daunting as the possibility of not having any assets to leave to their families. Current federal law requires a person to spend down their nonhousing assets to \$2,000 before applying for Medicaid assistance to pay for long-term care. Because of this, many decide to transfer their as-



cannot continue without drastic cutbacks in state budgets. Because of this, many state lawmakers are seeking to reform the long-term care system as a way to end the heavy reliance on Medicaid dollars.

States can use a number of strategies to control spending on long-term care services. Joshua Wiener of the Urban Institute's Health Policy Center says most strategies fall into three broad categories: increase private resources to offset state expenditures on Medicaid; reform the delivery system for these services to provide care in a more cost-effective manner; or reduce Medicaid eligibility, reimbursement and service coverage.

State attempts to bring more private resources into the long-term care system focus on encouraging the purchase

safety net for low- and middle income families. It also provides financial benefits to consumers who purchase a plan by allowing them to retain many of their assets.

Efforts to encourage people to buy long-term care insurance have been relatively unsuccessful. Currently, less than 5 percent of Americans have this type of coverage. The problem is that most of the available policies are too

sets so they look poor on paper yet still leave an inheritance.

To avoid this situation, some states have created public/private partnerships between the state and the long-term care insurance industry. These partnerships allow people to buy state-approved policies that protect some of their assets while they remain eligible for Medicaid.

A partnership created in 1993 al-



One out of three of us will need long-term care at some point in our lives. However, fewer than one in 20 Americans have purchased insurance to pay for it, forcing Medicaid to pick up the tab instead. To control Medicaid spending, states are looking for new ways to finance long-term care services for the elderly.

lows New Yorkers to purchase a policy to help pay for the first three years of nursing home care or the first six years of home health care. Once the policy expires, the individual automatically is eligible for Medicaid. The policy protects existing assets but the policy holder must spend down income in accordance with Medicaid rules once Medicaid takes effect.

Postponing expensive care

Wisconsin may serve as a model among states controlling spending through reform of their delivery system. In the 1981-83 biennial budget, the state created what some have called a pioneering program to reduce the costs of long-term care delivery.

The Community Options Program encourages home health and community care to keep people out of more expensive care until absolutely necessary. The program is based on the assumption that if there are services available at the county or community level, people will remain independent and in their homes longer. Critics argue, however, that the system has evolved into a bureaucratic nightmare as Wisconsin residents seeking long-term care assistance must weed through more than 40 state and county programs to determine their eligibility.

In his 1998 State of the State address, Wisconsin Gov. Tommy Thompson pledged to overhaul the system again by pumping more than \$10 million into long-term care. His new plan, called Family Care, is projected to be in place by 2000. Pilot programs in several counties have begun. Based on the popular "one-stop shopping" model, the Family Care plan will allow seniors to go to a single source in the county for information about long-term care options. The information will allow

them to plan ahead to avoid exhausting their assets.

Arguing that the state can't afford to continue paying for the current system of long-term care, Thompson said the program will curb costs by consolidating services and focusing on home health care. However, the Wisconsin

Fast facts:

- The first baby boomers will become elderly on Jan. 1, 2011 — followed by the 75 million others in that generation.
- Forty percent of all Americans will need nursing home care at some time in their lives.
- Sixty percent of those over 65 will be unable to care for themselves at some point.
- The average cost of one year in a nursing home is about \$40,000.
- Long-term care costs in the U.S. will grow to \$225 billion by 2000.
- Only 4 percent of Americans have purchased long-term care coverage.
- Currently, the government pays about 65 percent of all long-term care costs.

Sources: The U.S. Bureau of the Census; U.S. Care

Legislative Fiscal Bureau suggests that the new plan could raise costs by encouraging more residents to enter the program if it means they will not have to live in a nursing home.

Curbing costs

Conventional strategies for controlling state spending on long-term care include reducing nursing home reimbursement rates and limiting the supply of available beds. Until recently, federal regulations governed state re-

imbursement practices, requiring "reasonable and adequate rates" to allow for quality care. Opponents argued that this centralized control mechanism forced many states to spend more than necessary on nursing homes because it assumed that rates were uniform throughout the country. The recent repeal of the regulation allows states to set their nursing home rates based on average state cost.

Another option states have is to reduce or freeze the number of nursing home beds. This strategy assumes that by limiting the supply, seniors — especially those on Medicaid — will find cheaper alternatives such as home health care. Twenty states have instituted a moratorium on the expansion of nursing home beds, including North Dakota, South Dakota, Texas, Louisiana and Maine. These states either have stopped construction of new facilities or capped the number of beds available in existing facilities. In addition, most other states require nursing homes to receive a certificate of need before constructing new facilities or adding new beds.

With baby boomers fast approaching retirement, states have major interests in long-term care for the elderly. Solutions listed here might not work in every state. Therefore, each state will have to determine the best course of action for its residents and its budget. □

CSG resources

Read more about our aging population in *Firstline Midwest*, April 1998, available from CSG's Midwestern office, *State Trends*, Summer 1998, available from CSG's publication sales department, (800) 800-1910, and *The Second Half of Life*, from CSG-WEST.

MARGUERITE STETSON

PUBLIC POLICY INSTITUTE

MEDICAID AND LONG-TERM CARE FOR OLDER PEOPLE

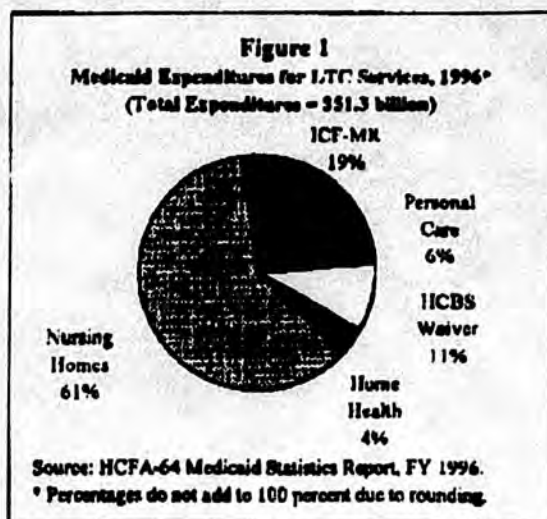
Introduction

The Medicaid program was designed to provide coverage for health care and nursing home services to the poor. Today, one-third of all Medicaid spending pays for long-term care, making Medicaid our nation's largest source of payment for long-term care services. Medicaid funding is shared between federal and state governments and, consistent with federal law, each state has flexibility in designing and administering its Medicaid program.

Medicaid's role in providing coverage for long-term care is critically important to older people with disabilities, since Medicare -- the nearly universal source of acute health care coverage for people age 65 and older -- covers few long-term care services.

Services

Each state's Medicaid program *must* pay for nursing home care for eligible persons age 21 and older. Medicaid is also required to pay for home health services for individuals who would qualify for nursing facility coverage. Home health services include skilled nursing and, at state option, a number of therapies. State Medicaid programs have the *option* of covering other long-term care services that can include personal care (help with daily activities such as bathing and dressing and related household help), Intermediate Care Facilities for the Mentally Retarded (ICF/MR), and home and community-based services (HCBS) under a "waiver" of federal Medicaid rules. Using the Medicaid waiver option, states provide a range of home care services, which may include personal care, transportation, respite care, homemaker, chore, and other related services.



Eligibility

In general, individuals must meet strict income and asset rules to be eligible for Medicaid. In most states, aged or disabled adults who are eligible for Supplemental Security Income (SSI) are also eligible for Medicaid. In 1998, the federal SSI limits for individuals are \$494 per month in countable income and no more than \$2,000 in countable assets.

Special *income* eligibility rules pertain to persons who receive Medicaid long-term care services in a nursing home or through a waiver program. Individuals whose income is not adequate to cover their health and long-term care costs can usually qualify for these long-term care services, even if their income exceeds the SSI standard. To qualify, however, individuals must contribute nearly all their income to pay for their care.

In addition to meeting financial eligibility criteria, such individuals must meet the state's *functional* eligibility criteria to receive Medicaid-covered long-term care services. These criteria vary across the states, but generally include both health status and physical and cognitive functioning.

FS Number 18R

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Preventing Spousal Impoverishment

Special income eligibility rules pertain to nursing home residents whose spouses reside in the community. To prevent the high cost of long-term care from impoverishing the spouses of nursing home residents, Congress enacted special laws that *require* states to protect the income and assets of community-dwelling spouses. In 1998, each state must allow a spouse to retain \$1,326 per month (this amount will increase to \$1,357 in July 1998), and states *may* allow a spouse to protect as much as \$2,019 per month. In addition, states must allow the spouse to retain the *greater* of \$16,152 in assets or half the couple's joint assets up to \$80,760. States are allowed to apply these rules to the spouses of individuals who receive home and community-based services under a "waiver," but not all states exercise this option.

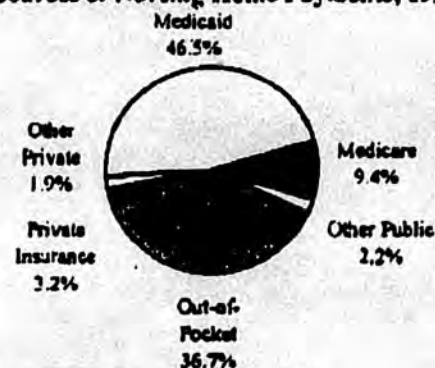
Medicaid Spending

In 1996, the Medicaid program spent \$51.3 billion paying for long-term care. Of this amount, \$40.8 billion (80 percent) paid for institutional care and \$10.5 billion (20 percent) paid for home and community-based care. Figure 1 illustrates Medicaid long-term care expenditures, by type of service.

These expenditures make Medicaid the single largest payer of long-term care services in the U.S., paying for nearly half (46.5 percent) of nursing home costs in 1995. Figure 2 illustrates the sources of payment for nursing home care in the U.S.

Because the average cost of care in a nursing home was about \$46,000 per year in 1995, most people who need extended nursing home care rely on Medicaid for at least a portion of the cost of their care. About one-third of people who enter a nursing home are eligible for Medicaid upon admission, while another third deplete their assets paying for care and then turn to Medicaid to pay for the portion of care that exceeds their income.

Figure 2
Sources of Nursing Home Payments, 1995



Source: HCFA, Office of the Actuary, 1996.

*Percentages do not add to 100 percent due to rounding.

Issues and Concerns

Although the majority of people who need long-term care prefer to remain at home, Medicaid spending for long-term care remains heavily weighted toward institutional care. States have been working to provide more services in home and community-based settings; however, progress has been slow. Medicaid provided nursing home services to 1.7 million persons in 1995, while home and community-based waiver programs served approximately 500,000 individuals.

Secondly, because Medicaid was designed as a program for the poor, its eligibility criteria are quite restrictive. Many individuals must deplete their life savings before they can qualify for Medicaid to cover the cost of the care they continue to need.

Finally, some policymakers are concerned that individuals attempt to "game the system" by sheltering or giving away their assets to qualify for Medicaid. Recent laws have attempted to eliminate this practice.

Written by: David Kasman and Natalie Graves
Tucker

AARP Public Policy Institute
February 1998

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Alaska State Legislature

SHARON CLARK

SENATOR
MIKE MILLER

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Senate
SB 321

While in Juneau
State Capitol
Juneau, Alaska
99801-1182
Ph: (907) 465-4976
Fax: (907) 465-3883

Senate District 0

"An Act relating to assisted living homes."

Assisted living homes, formerly called adult foster care homes, and facilities that provide a home-like environment for seniors and people who have a disability and need assistance with everyday living activities. The program is under the Department of Administration, Division of Senior Services.

This program is regulated by the old general assistance regulations that need to be revisited and updated to be in line with the standard of care that is practiced by the other Assisted Living Programs. The cost of care is grossly outdated and has not been adjusted to the current care standards or to reflect the cost of providing a level of care.

The purpose of this legislation is to increase the daily rate paid to Assisted Living Homes by the State for vulnerable adults that are unable to provide safely for their own medical, emotional and personal care needs.

Currently the rate paid by the State is \$34.50 per day. SB 321 would increase the daily rate to a minimum of \$70 per day based on individual care. There has not been a rate increase since 1983.

I respectfully request your consideration in passing SB 321.

CS FOR SENATE BILL NO. 321()
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTIETH LEGISLATURE - SECOND SESSION

BY

Offered:

Referred:

Sponsor(s): SENATOR MILLER

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to assisted living homes; and providing for an effective date."

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

3 * Section 1. AS 47.07.070 is amended by adding a new subsection to read:

4 (h) This section does not apply to the minimum daily reimbursement rate
5 specified by law under AS 47.24.017 or AS 47.25.195(f) for assisted living homes.

6 * Sec. 2. AS 47.24.017 is amended by adding a new subsection to read:

7 (d) If the protective services under this section include the placement of a
8 vulnerable adult in an assisted living home at the state's expense, the minimum daily
9 reimbursement rate to the assisted living home for the vulnerable adult is \$70. The
10 department may, under its regulations, provide for a daily rate higher than \$70 if the
11 additional care provided to the vulnerable adult in the assisted living home justifies the
12 additional reimbursement. In this subsection, "assisted living home" means an assisted
13 living home licensed under AS 47.33.

14 * Sec. 3. AS 47.25.195(b) is amended to read:

15 (b) Except as provided in (f) of this section, a [A] health facility receiving

1 a payment under this chapter is subject to the requirements of AS 47.07.070 -
2 47.07.075.

3 * Sec. 4. AS 47.25.195(c) is amended to read:

4 (c) Except as provided in (f) of this section, if [IF] insufficient money is
5 appropriated to fund medical assistance under AS 47.25.120 - 47.25.300 when taking
6 into consideration projected use and the health facility payment rates established in
7 accordance with (b) of this section, the department may, by regulation, establish at any
8 time in the fiscal year a prospective pro rata reduction of the facilities' established
9 payment rates that will be paid by the department for services provided by facilities
10 under AS 47.25.120 - 47.25.300.

11 * Sec. 5. AS 47.25.195(d) is amended to read:

12 (d) Notwithstanding (a) - (c) of this section, the department may enter into
13 agreements with a facility to provide services at a payment rate lower than the rate
14 established in accordance with (b) of this section, except that the department may
15 not enter into an agreement with an assisted living home to provide services at a
16 daily reimbursement rate lower than \$70.

17 * Sec. 6. AS 47.25.195(e) is amended to read:

18 (e) For purposes of this section,

19 (1) "assisted living home" means an assisted living home licensed
20 under AS 47.33;

21 (2) "health facility" includes a hospital, skilled nursing facility,
22 intermediate care facility, intermediate care facility for the mentally retarded,
23 rehabilitation facility, inpatient psychiatric facility, home health agency, rural health
24 clinic, and outpatient surgical clinic.

25 * Sec. 7. AS 47.25.195 is amended by adding a new subsection to read:

26 (f) Notwithstanding other provisions of this section and the provisions of
27 AS 47.07, if the assistance provided to a needy person under AS 47.25.120 - 47.25.300
28 includes the initiation or continuation of placement of the person in an assisted living
29 home at the state's expense, the department's minimum daily reimbursement rate to
30 the assisted living home for the person is \$70. This minimum rate is not subject to
31 reduction under (c) of this section. The department may, under its regulations and

1 under the procedures of AS 47.07.070 - 47.07.075, provide for a daily rate higher than
2 \$70 if the care provided to the needy person in the assisted living home justifies the
3 higher reimbursement. A daily rate higher than \$70 for assisted living homes may be
4 reduced under (c) of this section, but not below \$70.

5 * Sec. 8. APPLICABILITY. The minimum daily reimbursement rate set under
6 AS 47.24.017(d), enacted by sec. 2 of this Act, and AS 47.25.195(f), enacted by sec. 7 of this
7 Act, applies to services provided on or after July 1, 1998, and is not dependent on the
8 adoption of regulations of the Department of Health and Social Services.

9 * Sec. 9. This Act takes effect July 1, 1998.

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. SB 321

Revision Date: _____
Title: * An act related to assisted living homes...

Department Affected: Administration
BRU: Senior Services
Component: Protection, Community Services, Administration

Sponsor: Senator Mike Miller
Requestor: (S) HES

COMPONENT SERIAL NO. 2083

EXPENDITURES/REVENUES:

(Thousands of Dollars)

OPERATING EXPENDITURES	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	1,819.0	1,819.0	1,819.0	1,819.0	1,819.0	1,819.0
MISCELLANEOUS						
TOTAL OPERATING	1,819.0	1,819.0	1,819.0	1,819.0	1,819.0	1,819.0

CAPITAL EXPENDITURES						
----------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
------------------------	--	--	--	--	--	--

FUND SOURCE:

(Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	1,819.0	1,819.0	1,819.0	1,819.0	1,819.0	1,819.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
OTHER						
TOTAL	1,819.0	1,819.0	1,819.0	1,819.0	1,819.0	1,819.0

Estimate of any current year (FY 98) cost: \$ none

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

This bill would require the Department of Administration to increase the rate paid to assisted living homes under the existing general relief assistance program to a base rate of \$70 a day. The current payment system administered by the Division of Senior Services is based on three levels of client need and related services provision by assisted living homes. An assisted living home rate schedule is attached which describes the rates which this bill would require the state to pay for assisted living services in the six regions of the state at each of the three levels of care starting with a base rate of \$70 a day in Anchorage. The six regions are paid according to geographical cost of living differentials. Taking into account geographical cost differentials and a system of three levels of care beginning with a base rate of \$70 a day, a budget of \$1,819.0 is needed annually to fund this bill.

Recommendation: This bill is consistent with the existing adult protective services program objective to provide financial assistance to eligible vulnerable adults who are in need of assisted living resources for both protection and supportive services under AS47.24. The current base rate of \$30 a day is not adequate to meet rising costs of providing assisted living care. A rate increase is overdue. This bill would require substantial funding which has not been approved by OMB. This bill would allow for improving the current system of general relief payment by increasing rates to an adequate amount based on levels of care statewide. The bill needs to be amended to include the Department of Administration. The supporting statute is AS47.24 Protection of Vulnerable Adults.

Prepared by: Dwight Becker
Division: Senior Services

Phone: 269-3674
Date: 2/23/98

Approved by Commissioner: Mark Boyer
Agency: Department of Administration

Date: 3/24/98

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FISCAL NOTE

STATE OF ALASKA BILL NO. SB 321

1998 LEGISLATIVE SESSION

ANALYSIS: (continued)

Calculation of General Relief Payment by State

The general relief payment made by the state is the amount needed to supplement the client's contribution to meet the rate indicated in the specific geographic region and according to the level of services provided. The average contribution of the clients is the adult public assistance payment standard of \$856 per month or \$28.14 per day. Normally client's are not able to contribute during the first month of placement, as they have no money and have normally not qualified for benefits. They must apply for benefits. Therefore, about 20% of the total of 29,200 days paid by the state are paid at the full rate without any contribution by clients.

Services provided by General Relief Program

80 clients per month x 365 days = 29,200 days of service per year

Days of Service by Region

Anchorage	65% of 29,200 days =	18,980 days
Palmer/Wasilla	5%	= 1,460
Southeast	5%	= 1,460
Northern	15%	= 4,380
Western	5%	= 1,460
N/Western	5%	= 1,460
		<u>29,200 days</u>

Cost per Region which includes both State and Client Payments

Anchorage	\$80.00 per day average	x	18,980	=	1,518,400
Palmer/Wasilla	83.23	x	1,460	=	121,515
Southeast	80.00	x	1,460	=	116,800
Northern	92.02	x	4,380	=	403,048
Western	106.42	x	1,460	=	155,373
N. Western	110.42	x	1,460	=	<u>161,213</u>
Total					\$ 2,476,349

Client Contribution Towards Payment for Assisted Living

\$856 payment standard per mo. x 12 mo. / 365 days = \$28.14 per day

(20% of the days are not contributed towards due to emergency situations and due to the time period needed for client to become eligible for benefits)

80% of 29,200 days x \$28.14 per day = \$657,350

The General Relief Assistance payment by the State as required by this bill.

\$2,476,349 minus \$657,350 = \$1,818,999

Proposed Assisted living Daily Rate Payment Schedule

Region	Level 1	Level 2	Level 3
Anchorage	70.00	80.00	90.00
Palmer/Wasilla	72.80	83.23	93.58
Southeast	70.00	80.00	90.00
Northern	80.50	92.02	103.48
Western	93.08	106.42	119.66
N. Western	96.58	110.42	124.16

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. SB 321

Revision Date: _____
Title: An act relating to Assisted Living Homes

Dept. Affected: Health and Social Services
BRU: Community Mental Health Grants
Component: Services for the Chronically Mentally Ill
COMPONENT SERIAL NO. 800
See also (SN#): _____

Sponsor: Miller
Requestor: Senate (HES)

Expenditures/Revenues:

(Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	1,661.7	1,711.6	1,762.9	1,815.8	1,870.3	1,926.4
MISCELLANEOUS						
TOTAL OPERATING	1,661.7	1,711.6	1,762.9	1,815.8	1,870.3	1,926.4

CAPITAL EXPENDITURES						
----------------------	--	--	--	--	--	--

CHANGES IN REVENUES ()						
-------------------------	--	--	--	--	--	--

FUND SOURCE

(Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health	1,661.7	1,711.6	1,762.9	1,815.8	1,870.3	1,926.4
Other (please specify)						
TOTAL	1,661.7	1,711.6	1,762.9	1,815.8	1,870.3	1,926.4

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: \$0.0

ANALYSIS: (Attach a separate page if necessary)

The Department of Health and Social Services, Division of Mental Health and Developmental Disabilities serves approximately 138 individuals in Assisted Living Home environments with a FY98 budget of \$622.2. The number of individuals receiving support for Assisted Living Home services authorized by the Adult Residential Care regulations varies each year. 7AAC 47.450 -470 governs the fee structure for Adult Residential Care and has not been revised since 1982. Adult Residential Care is now referred to as Assisted Living Home services. The lack of cost of care adjustments to the Adult Residential Care fee structure jeopardizes the future of Assist Living Homes. Assisted Living options is a cost-effective alternative to institutional care for individuals choosing to remain in their home communities. Development of the Assisted Living Home industry is very important for our Long-Term Care Plan for the State of Alaska. Also, it is a residential care approach that all disability groups support. This fiscal note is based on a zero population growth. It will fix the system as it now exists. Growth in community based services for Mental Health consumers is addressed in the "API Community Implementation Plan" dated October 31, 1997, published by J.L. Mitson & Associates. This growth is not included in this fiscal note. Growth for the developmentally disabled consumer is provided in the Community Developmental Disabilities Grants Component FY99 budget.

[Signature]

Prepared by: Derrill L. Johnson
Division: Mental Health and Developmental Disabilities

Phone: 465-4827 or 465-3370
Date: 02/25/98

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services

Date: 3/25/98

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ANALYSIS (cont.):

Page 2
SB-321
Fiscal Note

The following rationale was used to develop the needed General Fund increase to implement SB-321 as written and remains the same for the amendment proposed by the Department noted on the bill analysis:

Current Practice

DMH&DD augments the cost of care by an avg. daily rate: \$12.35 /day *

Consumer contributes entitlements avg. monthly \$850

Less Personal allowance \$ -75

\$775 = avg. daily rate: \$25.48/day**

Average paid for total care in an Assisted Living Home \$37.83/day

* FY98 Budget of \$622,200 divided 138 served = \$4509 divided 365 days=\$12.35/day

**Consumer Entitlements (SSI/SSA/AD) = \$850 avg. - \$75 personal allowance = \$775/month divided 365 days = \$25.48/day

Proposed in SB-321 with Recommendations

Currently DMH&DD augments the cost of care by an avg. daily rate: \$12.35/day

Consumer contributes entitlements avg. monthly \$850

Less increase Personal allowance -\$100

\$750 = avg. daily rate: \$24.66/day ***

Average now available after the increased personal allowance: \$37.01/day

Needed increased augmentation by DMH&DD to equal \$70/day avg. \$32.99/day ****

Total to be received by the Assisted Living Home \$70.00/day

*** Consumer Entitlements (SSI/SSA/AD) = \$850 avg.-\$100 personal allowance = \$750/month divided 365days= \$24.66/day

**** Additional daily rate funding with zero growth in the population to fix the Assisted Living Homes system as it pertains to the Department of Health and Social Services.

The Department of Health and Social Services, Division of Mental Health and Developmental Disabilities will need an increase in General Funds of \$1,661,707 (\$32.99/day x 365days = \$12,041.35 x 138 served = \$1,661,706 for FY99. These funds will utilize to bring the existing Assisted Living Home placements to a level of care that will meet their health and safety needs. The average cost of care should remain around \$70/day. Some individuals will require supports costing less than \$70/day, while others may need additional supports exceeding \$70/day. The Department believes that with funds requested and the needed regulatory changes, the Assisted Living Home industry can become a viable option. Additionally, and of equal importance, these changes will ensure the health and safety of all served. Subsequent fiscal year's calculations have been planned with zero population growth for this bill. The Department did add a three-percent inflation factor for each fiscal carried forward.

The Alaska Mental Health Trust Authority has shown interest in the idea of a multi-year system change approach to address the funding needed to fix the Assisted Living Homes service system. They have indicated interest in receiving a jointly backed proposal from the Departments and planning boards impacted by the need to maintain the existing Assisted Living Home service system.

FISCAL NOTE

STATE OF ALASKA
1998 LEGISLATIVE SESSION

BILL NO. CS SB 321 (HES)

Revision Date: _____
 Title: Relating to assisted living homes
 Sponsor: Miller
 Requestor: Senate (HES)

Dept. Affected: Health and Social Services
 BRU: Medical Assistance Admin
 Component: Health Purchasing Group
 COMPONENT SERIAL NO. 243
 See also (SN#): _____

Expenditures/Revenues:

(Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGES IN REVENUES ()						
--------------------------------	--	--	--	--	--	--

FUND SOURCE

(Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY99) cost: \$0.0

ANALYSIS: (Attach a separate page if necessary)

Under Section 7 of Committee Substitute for Senate Bill 321 would allow, but not require, the Department to pay assisted living facility rates above \$70 per day if established under the procedures of AS 47.07.070-47.07.075, which establishes a cost-based rate setting process under the Medicaid Rate Advisory Commission for Medicaid-enrolled health facilities.

The Department does not anticipate a cost of this provision, as the Department does not anticipate using the Medicaid Rate Advisory Commission to establish assisted living facility rates.

3/11/98
 Prepared by: Jon Sherwood
 Division: Medical Assistance
 Approved by Commissioner: Karen Perdue, Commissioner
 Agency: Department of Health & Social Services

Phone: 465-3355
 Date: 03/18/98
 Date: 3/18/98

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State of Alaska
Office of the Long-Term Care Ombudsman

3601 C Street, Suite 260
Anchorage, Alaska 99503-5209
Telephone (907) 563-6393
1-800-730-6393 Fax (907) 561-3862



FRANCES PARRY

The Office of the Long Term Care Ombudsman is a program under 42 USC 3058(g) and AS 44.21.231 for the benefit of persons 60 years of age or older. The Long Term Care Ombudsman has authority to:

- **Investigate and resolve complaints of abuse, neglect and financial exploitation made by or on behalf of residents' of nursing homes and assisted living homes.**
- **Investigate and resolve complaints related to health, welfare, safety or rights in long term care, senior housing or other residential circumstances or associated with long term care services.**
- **Pursue administrative, legal or other appropriate remedies on behalf of an older Alaskan who resides in a long term care facility.**
- **Provide information and referral regarding long term care services for seniors and administrative and technical assistance on long term care services for seniors.**
- **Monitor the development and implementation of federal, state, and local long term care laws and policies;**
- **Promote the development of citizens' organizations and train volunteers.**

OFFICE OF THE LONG-TERM CARE OMBUDSMAN

The Office of the Long-Term Care Ombudsman (OLTCO) is mandated by Public Law 102-375 and Alaska Statute 44.21.231. The OLTCO has jurisdiction to investigate and resolve complaints made by or on behalf of Alaskans age 60 and over when the issue centers around a decision, action, or failure to act by a long-term care provider or their representative, or when issues adversely affect Alaskan senior's health, safety, welfare, or rights. The OLTCO also advocates for the needs of the seniors when their situation involves problems with public housing, public assistance or benefits, government agencies or grant programs, public utilities, health care facilities, and health care providers. To resolve complaints, the OLTCO may subpoena and compel the attendance of witnesses, require that evidence be produced, administer oaths, and examine individuals under oath in relation to complaints. In addition the OLTCO is mandated to pursue administrative, legal and other appropriate remedies on behalf of older Alaskans in long-term care. Under certain circumstances, a report of the investigation may be distributed and available to the public upon removal of confidential information or consent by the complainant.

The OLTCO serves the state with two staff persons and nine trained and active Volunteer Long-Term Care Ombudsman.

The size, distribution, and makeup of Alaskan facilities vary:

Skilled Nursing facilities: 16 nursing homes in 14 different communities with a total of 797¹ beds. Skilled nursing facilities range in size from 5-224 beds.

Assisted Living Homes: The Division of Senior Services has 69 licensed homes with a total of 1,063 beds. The Division of Mental Health and Developmental Disabilities has 136 licensed homes with 826 beds.

Senior Housing: There are 2,000+ senior housing apartments throughout the state.

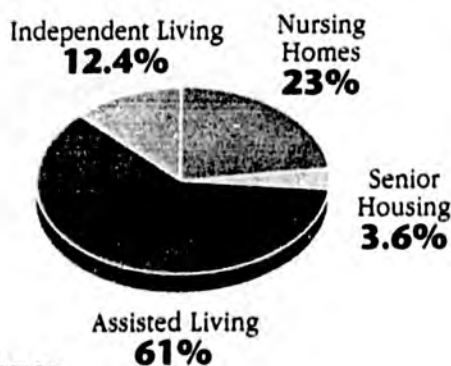
In FY 97 the OLTCO opened 261 cases which included 418 complaints; an additional 98 complaints were referred to other agencies for enforcement and resolution, for a total of 516 complaints.

¹With the phaseout of Harborview Development Center/Sourdough Place in Valdez, the total number of nursing home beds in Alaska will drop by 80 beds. There were only 16 residents in the facility in its final year. The last resident was moved to a community placement November 15, 1997. The building is now closed while the Department of Corrections makes plans for future use.

Long-Term Care Ombudsman
FY 97 Statistics

516 Total Complaints Received

161 Total Requests for Consultation and Assistance



OLTCO
Complaint Sources

Examples of complaints resolved with assistance from the Office of the Long-Term Care Ombudsman (OLTCO):

A resident living in senior housing was having difficulty taking care of herself (cooking, bathing, shopping, cleaning the apartment, taking medication on time) without assistance. Neighbors called Adult Protective Services to intervene and assist the senior to gain access to social and health services. Even though somewhat confused, the senior feared if she agreed to assistance she would be placed in a nursing home against her will. The OLTCO assisted the senior and her family in reaching agreement on a durable power of attorney which would allow her son to coordinate the services to be brought into her home, but limited his ability to place her in a nursing home. The senior agreed to personal care and medical services through CHOICE and is able to remain in her own home.

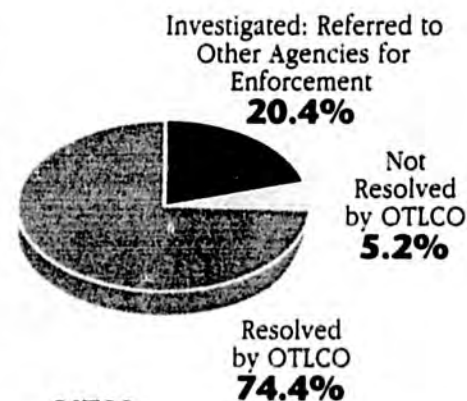
The OLTCO received word that a resident in an assisted living home was being neglected. Upon investigating the complaint, the reviewer found that the resident's care plan did not address the rehabilitation needs of the resident, who had recently been discharged from the hospital following a massive stroke. Through intervention by the OLTCO, the assisted living home staff were given training on proper transfer techniques. The resident's personal dignity concerns were addressed in such a way that staff understood to not show the resident's bare body or underclothing when lifting her out of a chair. The family was assisted in negotiating a realistic plan of care for their mother, which included physical rehabilitation, mental health, recreation, social activities, daily care, and personal preferences.

A 77-year-old woman contacted the OLTCO because she was living in a hotel with her dog after being evicted from an apartment complex. The OLTCO connected her with legal services and a private-sector care coordinator to find housing and support services. She moved into an assisted living home that was unable to meet her needs. The senior moved out and was not heard from for a few months. She recontacted the OLTCO from a homeless shelter. The OLTCO and a local senior center advocate coordinated to rebuild the senior's willingness to try a match with another care coordinator. She now lives in senior housing with her dog and is accepting home-based services. She maintains periodic contact with the OLTCO office to report her happiness with the present arrangement.



Free statewide
telephone number
to reach the
Long-Term Care
Ombudsman:

1-800-730-6393



OLTCO

Disposition of Complaints

ALASKA CAREGIVERS ASSOCIATION

109 E. 5th Avenue, North Pole, AK 99705

(907)-488-9159

August 19, 1998

Rep. Con Bunde, Chairman
Long-Term Care Task Force
716 W. 4th Avenue
Anchorage, AK 99501

Representative Bunde and Members of the Task Force:

I want to thank you for allowing me to speak on behalf of all the assisted living homes in Alaska. In recognition of the importance of the service assisted living homes provide, Senator Mike Miller introduced SB 321. All of you need to sign on in support of this legislation next session.

I have spoke many times about the need to have an increase in the General Relief pay rate for indigent, frail, and elderly who are alcoholics, mentally ill and demented. These people make up the majority of the population in assisted living homes. We in assisted living homes provide a service Alaska can not do without, in that we save you money. We take people in an emergency situation when Denali Center and the pioneers home do not.

I hear state agencies talk about improving qualifications of people delivering assisted living services. If you want to improve these services, you must be willing to pay for these services. Our association has members who have completed a national training funded by the Division of Senior Services. We are national certified administrators. About 14 in Fairbanks and 20 to 30 in Anchorage. We in assisted living under the present general relief are paid \$1.44 an hour or \$34.50 a day. These people live with us 24 hours a day. We don't go home at the end of the day. We don't work 9 to 5. We work at least from 6 a.m. to 12 midnight and can expect to be waked up during the night.

The pioneer's home gets reimbursed at a rate up to \$9,000 a month. CNA's get \$12.00 an hour. There is a lot of disparity between \$12.00 an hour \$1.44 an hour.

Able bodied people are currently reimbursing the state at a \$90.00 for being incarcerated in state corrections facilities, but the state expects assisted living facilities to provide intensive care for disabled adults for \$34.50 a day.

As for the money, you all must find it. I can no longer go to members of my organization and tell them there is no money. I believe that federal funds designated for alcoholism programs and state funds from the mental health trust can be and should be used to provide assisted living services to products of alcohol and drug abuse, as well as, the mentally ill.

We take people after they no longer can live in their own home. We are not asking for the same compensation per occupant as the pioneer home or Denali Center receives, but we are required to operate under the same regulations as them.

Without increased funding, we can no longer accept general relief clients. We will only be able to accept private pay clients. This will force the State to find money to build more state operated nursing homes.

We also need to have the pay to assisted living be in a more timely manner. We do some very hard work. I would ask that each of you take one of these seniors or indigent people one week at \$34.50 a day or \$1.44 per hour and then tell me that we are getting paid an appropriate fee for all that we do.

With the decrease at API and Harborview, you can find some of the clients at assisted living homes at \$34.50 a day, especially in Anchorage.

I know that the elder home in Fairbanks has refused Alaskan Native general relief clients because of the \$34.50 a day. I know because two of my clients are Alaska Natives refused services at the Elder Home. The native associations get all kinds of grants from state and federal sources. Why then don't they accept Alaska Natives on general relief at "Forget Me Not?" Now they are constructing a new facility with public and native funds. I have a problem with that. I built my home out of my pocket, not state or federal funds. We can not compete with their methods of getting money, yet we are taking clients they consider excess baggage.

Just be fair with us, is what I want you to do. Treat us with respect and help us to remain in business. You have no idea what is coming down the pike with frail elders. We have the 50 to 60 year-old-generation who abused their health so badly, that you will appreciate the frail elderly we now are taking care of. When you meet the "Boomers" just hide and watch and you will go crazy looking for money then.

Thank you for your time and consideration.

Sincerely,



Monta Faye Lane

MONTA FAYE LANE



ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the Rep. CON-Bunde

Committee Name

Committee on Long Term Care Task Force Dated 8-19-98

Bill / Subject

WE MUST HAVE SENATE BILL 321 BE PASSED THIS NEXT SESSION.
MAYBE THERE COULD BE A FUND SET UP FOR SOME OF THE REPLACEMENT
COST OF THE ASSISTED LIVING HOMES.
WITH OUT THIS INCREASE SOME HOMES WILL CLOSE, SOME NEW
HOMES MAY NEVER OPEN.
WE MUST BE REVIEWED MORE OFTEN THAN 15 YEARS, OR COMPLETELY FAIL OUR SENIORS
INCREASE'S ~~should~~ SHOULD BE AS STATE EMPLOYEES RECEIVE INCREASE'S IN
WAGES OR STIPENDS.
THE MONEY FROM THE STATE NEEDS TO BE IN A MORE TIMELY MANNER,
NOT 45 TO 60 DAYS BEHIND. OUR WORK IS UP FRONT SO SHOULD THEY
PAY BE.
YOU CAN'T PAY \$15.00 PER HR FOR CNA'S WHEN YOU ONLY GET \$34.50 A DAY
I DON'T HAVE EMPLOYEES BECAUSE I CAN'T AFFORD THE WAGES, THE BENEFITS,
THE VACATIONS, I CAN'T DO THIS IF I DIDN'T HAVE THE LANE COMPANY
BURNER SERVICE FOR THE LAST 10 YEARS. I SUPPORT THIS HOME FROM
THIS BUSINESS ALSO. PLEASE COME VISIT US. THANK YOU.
ABOUT PHARMACY I CAN'T HAVE TIME TO RUN TO ALL TOWN FOR MEDS, IT IS MORE LIKELY I WOULD SUGGEST
A CLOSER PHARMACY. NOT JUST.

SIGNED:

Monta Faye Lane

Testifier

Alaska Penguin Assoc. / Arctic Health Assisted Living

Representing

109 E 5th Ave. North Pole, AK 99705

Address / Phone Number

1-907-488-9159 Fax 907-488-7979.



ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the REP CON BUNNIE
Committee Name

Committee on _____ Dated _____

Bill / Subject

PAGE 2.

I WOULD LIKE TO INVITE ~~ALL~~ ^{ALL} OF
YOU ON THIS BOARD TO PLEASE IF YOU
ARE IN MY AREA TO PLEASE COME TO VISIT
MY ASSISTED LIVING HOME TO SEE WHAT IT IS
LIKE. HOW IT IS OPERATED! HOW WE LIVE
WITH ALL OUR PEOPLE. COME TAKE SUPPER WITH
US I'M AN EXCELLENT COOK. COME SEE US.

Mona Lane

50 R-6 of the people
Testifying were Alaska Penguin Assoc. Members:
Pat Edmonds, Anna Stalls, Sue Summit, Leslee Orbaugh,
Candice Drayton, + one more I didn't get the name. ...
In Feb, Mona Faye, Les Westling, Merimon Luffin,

SIGNED:

Mona Faye Lane
Testifier

Representing

Address / Phone Number

RYN NIEVA MOSS



ALASKA STATE LEGISLATURE

Please enter into the record my testimony to the Long Term Care task Force
Committee on SB 321 Dated 8/19/98
Bill / Subject Committee Name

I have seen and talked to Monto Faye's clients. She is very devoted to her clients and they have told me she treats them like family. I am here to say that there is a definite need to increase payments for assisted living.

Most assisted living clients are people with Alzheimers, or with medical or mental problems related to alcohol and drug abuse.

In FY'97 the legislature authorized \$17.3 million in alcohol & drug grants and \$24.8 in mental health funding. That's a total of \$42.1 million spent for alcohol, drug & mental health spending. The fiscal notes on SB 321 total \$3.7 million. I believe federal funds earmarked for alcohol and drug program and mental health funds should be used to increase assisted living payments.

SIGNED:

Lynn N. Moss
Testifier

Lynn N. Moss

Rep Vezev's Constituents
Representing

119 N. Cushman, Rm 211, Fairbanks, AK 99701
Address / Phone Number

907-456-5081

SCOMM

110:3

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

COMMITTEE CALENDAR

Worksession

TAPE(S)

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

NOTE:

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

ONE TERM CARE TASK FORCE

1/1/80

DS, JH, ME, JR, CB, GW, DM, J &

Bill Brown - NCLF

Carole Brown

Frank Kunk

Allyn

Bill

Mark Kelly

FRX WASH

Carl King

Greg Manning

DM M4

K. Brown

030

GW - were at 14th and 10th

will look up 14 to 10, a few can for 12-14 weeks
- will look up, will look that day P most
will stay on schedule

051

CB & JH LEFT will come up of rough draft legislation
by end of November (most) a then can say yes and LHS

053

068 are not sure clear report for legislation

070

JG Quality of LT Care

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

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

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

A) INDYS - P contract w/ independent PCAs

- paid 65 p m FY 97

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

B) Agency based

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

140

KB

144

GW

145

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

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

~170

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

SOLUTIONS

178 ~~GW~~

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

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

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

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

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

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

265 DM some require LSN to dispense
drugs & training

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

1/A

280

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

290

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

295

KB requires HS diploma
75 hrs - approved curriculum by DIV. SERVICES
CPR training
immunizations
1st and 2nd

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

318

GW HS + 2 wks
if we raise training required, must we raise pay

KB - were denied

328

16 - developing career ladder

333

rebel story, & benefits

338

KB $\approx$ 100+ only PCA, - but we don't know
2-300 total

1/A
343 JH -

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

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

372 DM - a

CB as requirements go up, so does cost

384 JR - my wife is RN & only 49

388 Catherine Hayes -

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

940 PM KP MR

425 CB -

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

1/A
438

[general consensus]
56 - no argument

CB - in spite of difficulties, we'd like to make
CNA PCH more available

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

CB - concerns noted - not all are best served by CNA PCH

464 Delly Sommer DS

this is new topic for me

what are CNA requirements

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

496 CB -

498

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

its market driven by region, & by regulation

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

524 NB

agency PCH

?

- CNA gets more

1/A
530 CB -

KB - CNAs do have internships

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

CB - includes OOT?

DM - about 70-80 split classroom/practicum

540 JS PGAs have supervising nurse

560 CB - they

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

JS same

577 KH when this problem

KB only PCA is required to have

588 DS - could DM but rate differs

594 DM AGENCY monitor requires RN ~~for~~ does everything who is also the supervisor
- (we call em PCAs, but they are CNAs)

C

CB - anyone need help w/ acronyms?

DMs A
B

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

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

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

ongoing education

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

072 - CB - endless prob, few solutions

074 JG SOL

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

(B) pilot project some different models

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

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

1/B

(D) -

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

108

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

138 -

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

147

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

156

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

168 CB

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

174 JR

- what happens when

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

1/B

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

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

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

OW

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

KB

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

261 CB - independent

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

1/B

289

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

298 CB

VULNERABLE ADULTS

do we need more legislation to deal of vulnerable adults

310 AB

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

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

CB

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

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

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

1/B
430 CB

Are gonna leave for ~~now~~ a while

2 questions - Should we address vulnerable adults

② is FIV EXPLOITATION part of LTCPP jurisdiction

460 KP - ~~YES~~ YES

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

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

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

501 FP - yes -

511 JH - robots magnitude

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

536 JR

559 FP

1/B

FP

2 different groups
of 2000
each are 2 different groups
of 2000
each

591 JS

593 FP

598 GW

601 FP

- they guarantee more needs its own last force

624 AE
On conference w/ they were

TAPE 98-10, SIDE A

022 AE

022 FP

022 MP

they interesting
about place to live in NH, but few I live there

019 AE

AE - we just get report increase, MHT & no guardrails
in AE - at (indicates) little info of interest

035 KB

- can't explain reasons

036 DH

if we need to wrap up by 035 we may need
accelerated

HM to R554
022 DM

problem is double power of city -

2/A

024 GW

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

038 DM

all power of atty

FP

guardians

045 GW

We'll recommend that the issue of guardianship
be evaluated

our deadline is 12/17/98

053 KP

We'll leave that issue

064 JR

GW

Chen can delay, or appt a subcommittee
I think we

068 FP

AK KSN of Conservator & Guardianship Is

072 KB

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

080 GW

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

or let's recommend

? 2/A

087 JH let's offer our support to — prices

or re: PCA

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

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

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

for these 2 days

A) watch what comes of summit

KB 118 -

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

132 JH - what's this draft law for FOR

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

2/A
AE its financing

150 GW

151 DR

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

162 DR any Medicaid waivers

163 AE NO -

KP

GW

the PCA changes were already passed

170 AE

JH

its an access issue
its funding personnel issue

175 AE

If we were to set fund

178 JH - Its prob in LTC financing...

188 GW

JH

KP

193 DK

PCA/CNA standards - no consensus

I recommend we set standard for care given

211 JH

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

222 GW

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

2/A

JR

230 AE ~~do~~

245 KB - we haven't addressed that in summit

274 OW - REER

① me

②

③

④

OW other thoughts on JG

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

298 OW we've got to move Army.

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

we should make recs on training & salary standards

313 FP one possibility is to use areas of summit

323

SHARON CLARK in Iowa

ACCESS TO LTC

staff to SEN MILLER

353



2/A

363

SHARON CLARK

ACCESS TO LTC

MARGARET SAMUEL - NENTMA - DIR _____ CTR

JAMES DEMMEYER EX DIR COMMUNITY IN AGING

453

KEN JOHNS pres Cap Riv Native Assn

474

- CRNA funded by IHS for health care, & BIA

inc SR, MH

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

~~off~~
~~Wish to see~~

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

2/A

TAPE 98-10, SIDE B

035

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

056

① there for Local LTC

② support 9859

060 06

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

2/B
OGG JR - pre paid bills left up to turn over some
health care prog to

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

1130 AM CB RET.

1/3 of our projects this year relate to LTC

SB MOR

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

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

we need more benefits for LTC services to poor people

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

150 MHT trust income goes to fund innovative approaches to problems
we'll need additional SF

161 JR

2/B
171

~~188 JEFF JESSE~~

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

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

FINANCING -

- Fed Home Loan

- fed low income housing tax credit

- local govt property tax exemptions

Comm Dev Block Grant \$

185 VET -

Couch

288

PERSONAL RECOMMENDATIONS

- leg should provide more seed \$ to
- "capital funds for building assisted living PRO"
- educate assisted living orgs on better business practices
- raise rate state pays for housing subsidy

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

2/B

326

no, but

332 DM

- you talked mostly about buying new facilities
- have you started how connecting existing structures
or building projects with existing things (more)

355 ~~AM~~ SA

anything we finance now needs to meet new fire
codes for elevated things

373 DM -

395 GW let's stay on track

420

MARGARET SANDER - NEWARK
Director

453

forget Brown & should go to Senior Service

476

KB a Annual Levine Rms Study
medium thoughts

~~new security~~

new security information would mean daily not weekly \$68/ks
instead of \$362/day
Jan 83 →

2/B

523

11/15 second phase
- out for comment

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

557

mission & measuring 1st draft

567 AE - could KB address efforts @ 1 stop shopping

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

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

2/A

TAPE 98-11, SIDE A

01/15

CB

000 J. Demmet

5 recommendations - [SEE HANDBOOK]

~~one more~~

065

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

068 JD decline, then rise

3/A

DM 000 back forth

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

2:10pm RESUME

080 DON BITTLE FOX

130 SW. let's agree/disagree on

ACCESS TO LTC RECOMMENDATIONS

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

156 KP - aggressively doing that and welfare

3/A

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

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

184 DS lets keep it on list and discuss more

188 CB maybe discuss more DMH

200 AE

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

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

224 CB our goal is to continue MHT & involvement

232 BILL HORMAN - yes

233 SC

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

3/A

256 CB DELIVERY OF LTC

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

~~the network~~ network prog pays more, & more

PCS

WHIVER ¹⁰

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

311 [JG any questions]

322 JG. POSS SACTIONS

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

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

393 AE - great high range reimbursement attached to rural hospitals

402 CB \$10 asprin

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

3/A

420 CB efficiency of state ~~to~~ efficiency

CB - were not gonna build NH facilities in village

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

441 CB - too small, not now necessary

453 JS - is ———— available now in AK?

455 JS - to very limited extent

468 CB might be good segue into...

474 KP

499 CB

KP

KP

there gonna be big demand for new NH beds

were done good job of implementing LAMP report
Pine

554 CB

is pressure for new beds from builders, or consumers?

555 KP

- from community

CB

want to make

580 DM

- Conf-Certificates of Need (CON)

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

000 PM, continued

021 CB we don't want to free common choice - some plant want to pay NH money for longer services

036 MP - we don't want to pay NH money for longer services in small community - we don't want to pay NH money for longer services in small community of existing

038 CB how many local funds will off-road communities not to pay the bills?

MP we are making a small, pay to NH by itself - (Medicare pays for much of it)

055 CB then for fees from conversation

060 AB Problem up and down - also new long study of rates for out lying - not just increased in 10 yrs - Ben Mullen 1988 Feb months doubled it

110 AB

115 MP

116 AB

117 CB

123 MP

Medicaid reimbursement - Medicaid pays for the full \$ - 60% to 100% of the cost - at est. wanted to provide SPS for all covered

3/B

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

147 KB were trying to streamline Medicaid payors

160 CB of consumer wants 1 stop shopping

161 KB

171 CB

179 AB

all pieces are intertwined - NH demand ~ lack of alternatives

193 CB

RECOMMENDATIONS

199 JS

Oregon has been working since 81

210 AB

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

CB - its delayed ②

216 JS

② pre admission screen before admittance to NH

227 DM

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

250 KB

MB

you've got a position paper
lets number _____

3/B

256 CB

SW

KP

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

268 CB

274 KP

285 KB

289 KP

JG

CB

293 KB

Care coordinators — state and contracted
were got flexible system

308 CB

how do you know cory relation between care coordinators
and gatekeepers

310 KB

318 ~~CB~~ SW — has Oregon

JG

322 KB

DM

CB

JG

CB

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

3/B
336 AE

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

CB REC: improved communication as to options in care

353 KP sometimes going to NH is easiest option
355 CB were creating new options

362 SW Q
CB

369 KP - ~~don't~~ timing:
1) education ~~to~~ may need to be done
2) what when patient requests the gatekeeper's option
388 CB invited KB to sit @ table

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

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

434 KB pilot prog showed that
↓

465 KP

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

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

3/B

488 CB

- seems obvious to me

490 DG

CB

508 FP

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

531 DM

- FP is right - typical AK NH patient is different

575 CB

AK will prob choose from other states

582 AE

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

3/B

TAPE 98-12, SIDE A

607 CB

009 GW

told story on Pioneer Home budget

Why is PH in Dept of ADMIN

in 81 PH was pulled out of HSS cuz of dissatisfaction

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

4/A
034 CB

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

Today was simple - tomorrow we do funding

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

[CB DEP 3.45_m]

050

JACKI ORTELLI ^{do} admin @ Dental Ctr

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

105

108 AE

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

in Pbx

- ① not byre - why fix it?
- ② HSP has focus on children, & may ignore SR SVCS

4/A

131 KP

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

Joint work plan entire ADMIN/HSS

176

we need program budget for this area

- ② Leg confers many activities all in 1 dept not having a program budget
consolidation of program
- ③ TF already has full plate

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

consolidation should address consistent treatment
of different groups

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

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

4/A

Or 228

2 callers on consolidation didn't help clarify

232 AB

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

246

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

there are likely to be ways to improve srsvcs

263 JH

what problem prompted need/demand to consolidate

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

284 FP

~ Quality Assurance & Mgt

"

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

296 DS

324 JR

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

333 BW

Apologize in advance for stinky article last & thank you general

4/A

341 GW

REVIEW COST OF N^{EW} Program

360 RE

385 ME

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

413 LUMBER LIMSTRUM

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

468 GW

whats FN?

470 EL

not sure what you have

482 KP

final impact expect

487 JR

- One had put up CON. preamble

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

533 KP

583 JR

- computer market monopoly

KP

HC is not any elastic commodity

611 LUMBER

community hospitals have NOT lost control



Alaska State Legislature

Long-Term Care Task Force

October 21 - 22, 1998 Meeting

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

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

COMMITTEE CALENDAR

Continuation of October 21, 1998 worksession.

TAPE(S)

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

NOTE:

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