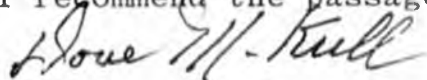
871 SHESS SB 320 - SB 322

SB 32 D COVERAGE FOR THE MEDICALLY NEEDY

In the history of mankind, this is the first generation of extended longevity. Dr. Robert Butler, gerontologist, Director of the National Institute on Aging, has stated that this over-65 generation can expect to live to be from 125 to 150 years. For those who retired at 65, this means that they will live on a fixed income for one-third to one-half of their lives. With inflation, the dollars saved for old age, wither to 35¢ or less.

In 15 years, health costs for the aging have increased 500%. Lower-middle-income aging persons with increased medical bills are rapidly becoming paupers. Becoming a pauper, or an indigent person, not only reduces the person to full dependency upon government, but it also reduces the feeling of self worth and creates a feeling of failure. For Older Alaskans, this is devastating. They feel that they lose control over their own lives. They ask themselves "How long will this last?". Suicide is a way out, especially for older men who protected their wives and provided for them.

I recommend the passage of this bill



Dove M. Kull, M.S. W., A.C.S.W., Member of the State Committee on Services to the Elderly

CARE

P.O. Box 3-488
2200 E. 42ND AVE. • ANCHORAGE, ALASKA 99501

January 28, 1980

The Senator Glen Hackney
Chairman- Health, Education, and
Social Services Committee
Alaska State Legislature
Pouch U
Juneau, Alaska 99811

Re: Testimony for Committee Hearings
January 28, 1980
Senate Bills 320, 321, & 322

Dear Senator Hackney:

SB 320 and SB 321

The "medically needy" of the State of Alaska are in great need of the relief that these two bills would provide by broadening income standards. We see, on a frequent basis, dignity being destroyed and families broken as individuals slightly over-income attempt to cope with the increasing costs of catastrophic illness. Legislation providing for the financial gaps in health care has long been needed. We commend the Interim Committee on Services on the Elderly for identifying this as a priority need.

SB 322

We wish to express our strong support for the concept of payment to certain institutions and agencies for Medicaid-eligible persons on the basis of prospectively determined rates. We believe that a "prospective rate" system in the State of Alaska would greatly enhance the quality of care available for a cost-effective dollar. The consequences of this bill are far reaching and of a major importance to the future of health care in this state. Detailed comments on this proposed legislation will be provided to you in the near future. I regret that this is not available to you at this time, but we do want to provide you with accurate and careful consideration on the details of this bill, while at this time expressing our firm conviction that "prospective rates" can be an appropriate solution to a crucial problem.

Respectfully yours,

HEALTH CARE SERVICES - ALASKA, INC.

Donna M. Stephens

Donna M. Stephens, Administrator
Careage House & Nakoyia Health Care Centers

Dick Wilson, Administrator
Careage North Health Care Center

DMS:DW:mlc

POSITION PAPER
ON
SENATE BILLS 320 AND 321

"An Act authorizing state medical assistance payments under the program of general relief assistance for persons who are 'medically needy'; and providing for an effective date."

"An Act authorizing Medicaid-reimbursable assistance payments for persons who are 'medically needy'; and providing for an effective date."

Senate Bill 320 and Senate Bill 321 would establish a medically needy program for persons who meet all the eligibility requirements for cash assistance to the aged, blind or disabled, except that their countable income exceeds the applicable cash assistance need standard. Medically needy would allow eligible persons to use a portion of their excess income to meet their medical need by spending down to the cash assistance need standard. After they have made payment the medically needy program would provide the remaining coverage necessary.

The Department is awaiting financial data on medically needy programs in other states in an effort to put together a fiscal note for this legislation. While the bills approach the question of medically needy coverage only for aged, blind or disabled persons, the fiscal note will also present information that will include medically needy coverage for persons who meet all AFDC eligibility requirements except income. Half of the required information has arrived and a fiscal note is being prepared. Preliminary analysis has shown that this program will cost in excess of $1 million.

Initial contact with federal staff indicates they will not authorize 50% federal financial participation under Medicaid unless the medically needy program includes coverage of the existing AFDC category as well as the aged, blind, and disabled categories. This federal position appears supported by the federal regulations but not by the federal statutes creating the Medicaid program. If the Department of Health, Education, and Welfare is unwilling to provide financial participation for a medically needy program that does not include AFDC coverage, it may be less costly to the State to include the AFDC category (because of the 50% federal financial participation) than to have a state only medically needy program limited to aged, blind, and disabled persons. Because of the question concerning federal financial participation, both bills would be needed to assure some type of medically needy program may be created.

Two identified gaps exist between the current Medicaid and Catastrophic Illness programs. First the Catastrophic Illness program has a minimum deductible or $1,000 per illness making it impossible for many people to receive coverage for minor cost illnesses, catastrophic or otherwise, when their income exceeds the existing income limits for Medicaid coverage. Second, the catastrophic illness program has largely excluded

nursing home coverage. Several persons whose income exceeds the income limits for Medicaid coverage are being covered on a special exception basis under general relief-medical (GR-Med) simply because there is no other coverage available to meet their high medical costs. This coverage then depletes the funds available for other persons eligible to receive GR-Med coverage. A medically needy program would provided additional coverage in these two areas.

The Department does not oppose the addition of a medically needy program which covers the aged, blind, and disabled categories, however, we must oppose passage of S.B. 320 and S.B. 321 as implemented would require substantial funding increases to the Governor's Budget and such a change has not been approved by the Governor's Budget and Management Division or the Budget Review Committee.

Recommended by: Rod Betit, Director, Division of Public Assistance — 1/25/80 (DATE)

Approved by: Helen D. Beirne, Commissioner, Department of Health and Social Services — 1/25/80 (DATE)

POSITION PAPER/Department of Health & Social Serv

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Health
BRU, Program, or Subprogram(s) Affected General Relief-Medical and Medicaid
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES	*	*	*	*	*	*
200 TRAVEL	*	*	*	*	*	*
300 CONTRACTUAL	*	*	*	*	*	*
400 COMMODITIES	*	*	*	*	*	*
500 EQUIPMENT	*	*	*	*	*	*
600 LAND & STRUCTURES	*	*	*	*	*	*
700 GRANTS, CLAIMS, ETC.	*	*	*	*	*	*
TOTAL	*	*	*	*	*	*

FUNDING (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
GENERAL FUND	*	*	*	*	*	*
FEDERAL FUNDS	*	*	*	*	*	*
OTHER (Specify Fund Source)	*	*	*	*	*	*

POSITIONS

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
FULL TIME	*	*	*	*	*	*
PART TIME	*	*	*	*	*	*
TEMPORARY	*	*	*	*	*	*

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

*Detailed Fiscal Note to be developed. See Position Paper for detailed explanation of delay.

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: Rod Betit Date: 1/25/80
Division/Office: Public Assistance PH: 465-335
Department of Health & Social Services

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Approval DHSS Mgt. & Bdgt: [signature] Date: 1/25

Page ____ of ____

SB 321

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION X
ARCADE PLAZA BUILDING
1321 SECOND AVENUE
SEATTLE, WASHINGTON 98101

HEALTH CARE
FINANCING ADMINISTRATION
Medicaid Bureau

Dr. Helen Beirne, Commissioner
Department of Health & Social Services
Pouch H-01
Juneau, Alaska 99811

Dear Dr. Beirne:

This is in response to a January 4, 1980, letter from Ms. Deborah Behr of your staff. Ms. Behr's letter requested our review and comments regarding three proposals scheduled to be presented to the current session of the Alaska legislature. This letter contains our comments regarding two drafts of Senate bills, identified as Work Orders (WO) #7522 and #7531.

WO #7522 proposes a Medicaid funded medically needy program for those who would be cash recipients under the State Supplementary Payments (SSP) program except for the level of their income.

Federal regulations at 42 CFR 435.310(a) require that states which provide medically needy coverage include coverage to families and children.

Therefore, WO #7522 would not comply with requirements of 42 CFR 435.310(a).

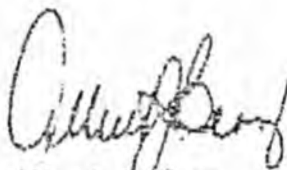
In addition, any medically needy program must utilize requirements of 42 CFR, Part 435, Subpart I in determining financial eligibility of medically needy individuals.

WO #7531 proposes a state-only funded medically needy program for those who would be cash recipients under the Alaska SSP program except for the level of their income.

Since no federal funds would be involved in such a program, it is beyond our role to comment on the technical correctness of that

If we can be of further assistance in either of the above discussed areas, please contact Mr. Ken Call at (206) 442-0506.

Sincerely,



Albert J. Benz
Regional Medicaid Director

cc: Deborah Behr

TO: (name, organization, address, phone)	FROM: (name, organization, phone)
Dr. Helen Beirne, Commissioner Department of Health & Social Services Pouch H-01 Juneau, Alaska 99811 465-3030	Ken Call 2-0506 DHEW/HCFA/Medicaid/MS 709

Total Pages:	FAX Machine Phone Number:	Date:
2	465-3005/3774	January 24, 1980

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ISSUES RAISED/ANCHORAGE PUBLIC HEARINGS

1. Duplication and overlap of services/comprehensive state policy
2. Residential care in rural Alaska
3. Audits of aging grants
4. State and federal expenditures on aging
5. Lack of information on aging programs/single agency/reorganization
6. People falling through the cracks
7. Outreach workers
8. Long-term care coverage: (1) Medicaid; (2) Medicare; (3) private companies
9. Senior housing
10. In-home services/homemakers
11. Paperwork
12. Operational funds for senior centers
13. Local control of aging programs
14. Anchorage Pioneers' Home addition/longevity bonus
15. State match for Office on Aging
16. Appropriations for rural services
17. Catastrophic relief
18. Senior day care
19. Property tax exemption

Summary of Public Hearing/Anchorage September 10, 1979

The following is an edited version of comments made at the public hearing. The tapes containing the complete testimony are available through the committee office in Juneau, or through the Legislative Council.

PRESENT

The hearing was called to order at 1:30pm by Sen. Pat Rodey, chairman of the committee. All 11 members of the committee were present. Also in attendence were 104 participants (see attachment).

Rodey explained the purpose of the committee, and then allowed each member of the committee to introduce him/herself.

HEALTH AND SOCIAL SERVICES

Helen Beirne, commissioner of Health and Social Services, was the first to testify. She explained that her department has long been interested in coming up with alternative forms of care for the aging, and that a study completed some 18 months ago revealed that there are, in fact, a number of examples of duplication and overlap in the provision of services. She said she was "delighted" that the legislature had created this committee.

Allen Korhonen, deputy commissioner of Health and Social Services, gave a slide presentation explaining the programs for the elderly presently operated by the department (see exhibit #17). He cited the need for a "consistent policy on services to the aging", particularly in view of the changing needs since many of the programs were first established. He also mentioned that the department was failing to provide equivalent residential care in rural Alaska compared to urban Alaska.

ADMINISTRATION

Bill McMurtry, manager of the Anchorage Pioneers' Home, testified regarding programs operated by the Department of Administration: Pioneers' Homes and Longevity Bonus. The latter started in 1973 as an incentive to keep the older Alaskans from moving outside. In June, 1979, there were 7,353 recipients at a total cost of $13,607,000. He said the program would continue to increase until 1984, when it would start to taper off due to the requirement for 25 years of residency beginning before statehood. (EDITOR'S NOTE: This is inaccurate. Theoretically, the last persons to be eligible to claim longevity bonus payments would be those who were born on Jan. 2, 1959, in Alaska. Those persons - if they lived to be 100 years old - could still be collecting payments in the year 2059. In fact, the "tapering off" will not take place until the year 2005, by which time the number of recipients will be nearly double the number today.)

The total budget for the Pioneers' Homes is $10,800,400, he said. That is for four homes with a residency of approximately 500, with beds of approximately 520. Started in 1913 in Sitka, he said the program was designed for pioneers 65 years or older who have lived in the state for 15 years, with a physical or financial need to be admitted to the Pioneers' Home, and stay there until he decides to move or passes on.

COMMUNITY AND REGIONAL AFFAIRS

Louise Crane and LaDonna Brown, from the Department of Community and Regional Affairs, were next to testify. Crane told of the housing program which grew out of a $7.5 million bond issue passed in 1976. Approximately $1.7 million still remains. The money was used to provide about 400 units of senior citizens' housing in 28 Alaskan communities. Designed to maxi-

mize the leverage of federal dollars, the program requires the person to spend no more than one-quarter of their income on housing. Brown testified about the property tax and renters' eqivalency program (see exhibit # 2).

Lloyd Robinson, a planner with the Department of Public Transportation/ Public Facilities, testified next about the single program for the aging run by DOT/PF: UMPTA. (See exhibit #8.) This completed the presentations by the administration.

DOT/PF

Regarding a question from Rodey about accountability of grants' program, Helen Bierne said all of the grants are audited regularly by - in some cases - all three levels of government. The specific process enacted for those programs under the Office on Aging, according to Danny Plotnick, director, is "We require each grantee to submit both a monthly narrative report and a quarterly financial report. In addition to these, we require each grantee to perform annually - and not less than once every two years - a complete aduit report on their own."

AUDITS

"Our audits are not as program- and performance-oriented, at the present time, as they should be. We're interested in that the money gets to the place it's going, if it's spent in the way they said they were going to spend it in the grant. And we would like to think that we are going to get better performance audits in the future." This from Commisioner Bierne.

In response to a question from the audience, Korhonen said the Office on Aging is presently funded 95 percent by the federal government and five percent by the state. Discussion ensued about the need to provide accurate figures broken down by federal and state appropriations for all aging programs.

OFFICE ON AGING

In response to a question from Bill O'Connor, Plotnick said,in comparison to offices on aging in other states, Alaska gets the minimum amount because the allocations are based on population of elderly; we, of course, have the smallest number in the nation.

In response to a question from Margaret Mitchell regarding the dental grant appropriated by the legislature, he explained that $25,000 was granted to the Southcentral Dental Society, on a one-time basis, "to provide a pilot demonstration program for needy elderly persons in the Anchorage area."

DENTAL GRANT

Doris Southall questioned whether the $1.2 million under winterization was all for seniors. Louise Crane answered it is for all low-income people in Alaska. Anchorage uses about 40 percent of its money on elderly; from a budget of approximately $350,000. The rest of the money is administered by RuralCap. Some boroughs are not part of the program, e.g. Mat-Su Borough.

WINTERIZATION

Hazel Heath asked how a senior citizen is supposed to find out about these programs. Ted Drahn responded that "as long as significant resources for older people are largely from the federal government, I think that it tends to operate in a way to take responsibility off of state and local governments." He added that the resources for getting the information out come largely through the 22 programs being supported by the Older Americans Act.

LACK OF INFORMATI

SINGLE AGENCY

"One of the things that this points up is that we have no central way in this state of consolidating information about old people. That was one of the reasons why this committee came into existence. There is no single agency in state government that has responsibility for the development of policy toward aging." Heath added that the problem is in how the information "filters down" to the person in the local community.

Sen. Glenn Hackney asked Commissioner Bierne if she saw the need for a division on the elderly with Health and Social Services. She said, "Right now, in our division of Social Services, we have Adult Protective Services. There's very little funding coming through our Adult Protective Services; most of it's going through the Office of Aging. I would see no problem whatsoever - and I think it would be better coordinated - if there was indeed within that division, a section or a subdivision of Adult Protective Services and Child Protective Services." She added that a division on elderly would be all right, but her concern is "when you call elderly 65 and older, then we have a large gap of people who are not being served between 21 and 65. But, if we could make arrangements so that we are not doing a disservice to the other age groups, I would say a Division on Aging - Adult Protective Services - whatever one would wish to call it, would be commendable."

ADULT PROTECTIVE SERVICES

She said that Adult Protective Services means development of "levels of care". In response to another question, she said, "I don't think we're being innovative enough in our Office of Aging. I think we are getting federal money, and we're following federal criteria. In order to become innovative, we do have to spend state money. If you're going to call the Division on Aging or Elderly, or Adult Protective Services something from 21 on up, then we would get into a much broader-scope difinition - which I would like to see so we're taking care of all the people." She agreed that if we do have a state policy on aging, it would be to appropriate a minimum amount of state funds in order to get an optimum amount of federal funds."

Edna Adrian commented at this time that senior citizens programs are too often the first ones cut by the Department of Health and Social Services.

From questioning, it was revealed that persons who want additional information about any of the individual programs should write to the appropriate department for details.

SALVATION ARMY

Lennie Kapuscinski, from the Anchorage Salvation Army, spoke of additional needs of that organization: parking, more space and more money.

Virginia Blanchard, a resident of the Anchorage Pioneers' Home, was next to testify. She is 73-years old. She criticized the committee for the building in which the hearing was conducted (APU Student Center) because of the numerous steps both inside and outside the building. She criticized the flyer distributed by the committee: "I think this has been badly put together. Number one, they left off the name of one of the committee members - which was an oversight. Number two, it doesn't give the proper information, it has mixed up state and federal monies." She asked to have the flyer reprepared [illegible] accurately differentiate between state and federal. She also asked to [illegible] the figures on Pioneers' Homes broken down by debt

service on each facility. She also wanted the flyer to show the offsets, for example, money paid by residents of the homes. She questioned the amount of money appropriated for the Kotzebue Senior Center. She questioned the absence of any mention in the handout prepared by the Department of Health and Social Services of aging programs relating to drug abuse, a problem she cited as serious. She praised the Pioneers' Home in Anchorage.

She said she would be opposed to putting all the aging programs under Health and Social Services. She favors keeping Pioneers' Homes and the Longevity Bonuse under Administration. She did say, however, that the Office on Aging should become a division. She also said, "I am opposed to direct appropriations that should be under the department in their program, and aren't."

REORGANIZATION

Doris Southall, a member of the Governor's Advisory Committee on Aging from Fairbanks, testified next. Her greatest concern is for people on moderate or fixed income. "They do not come under subsidized rent, food stamps, welfare, Social Security Supplement or Medicaid." She said these are "proud people" who want to stay in their own homes; the state needs to do more for them. She said that Medicare is of little value. Only retired state employees and teachers have good insurance coverage, she said. She also criticized the private companies. She also lamented the fact that senior housing, particularly in Fairbanks, is not restricted solely to seniors (handicapped are included).

FIXED INCOME

Regarding the income limitations on the winterization program, she said if the federal government puts the limitations on, then perhaps the state government should get involved. Outreach workers are the key persons in the aging network, she said, because "they see more people every year than any of us."

OUTREACH WORKERS

Dove Kull spoke up here in support of Mrs. Southall's statements, and cited her experience with senior housing in Juneau in which the citizens there were successful in getting an increase in allowable income. She also mentioned the state housing committee which is supposedly looking into the possibility of foundation funding for senior housing. She urged all seniors to work together.

SENIOR HOUSING

Betty Warren, chairperson for the Governor's Advisory Committee on Aging, testified next. She cited the problems that seniors have with wills. She stressed the importance of having a will before you pass away. She also stressed the importance of keeping people in their own homes, and said she supports additional funding for programs aimed at that. Much discussion ensued regarding wills, and Ted Drahn urged the people present to consider community colleges as a resource for help with wills.

WILLS

Regarding in-home care, Dove Kull spoke of the need to refund home nursing, and to add the component of health to homemakers.

IN-HOME CARE

Hanna Miller, director of the senior program in Nome, spoke next. She has been working there for five years, and laments the increasingly heavy burden of paperwork. This is a particular problem fo Natives, many of whom have not had much schooling. She cited a problem with homemakers - not enough personnel. She asked for help in that area, as well as for a new senior center. Senior centers need funding sources too, for operation. She added that she is grateful for the help already provided by the state.

PAPERWORK

She also mentioned the need for more services to help people stay in their own homes.

INSTITUTIONALIZATION

John Hauser, an administrator for Health Care Services, Alaska Inc., testified next. Because of his experience in the nursing home business, he has seen many proud people forced into welfare because of the high cost of institutional care. Consequently, he said, "My personal feeling is anti-institutionalization of people." He added that he supports the state providing home support services. He said he would submit written testimony. He cited the apparent differing policies between Administration and Health and Social Services - the former supporting institutionalization and the latter, deinstitutionalization. He called for a single policy, and he favors keeping people in their own homes.

MEDICARE

He said, "As far as I'm concerned Medicare is a lousy insurance policy. It pays halfway decent in the hospital setting, halfway decent in the outpatient setting, but lousy in the nursing home situation. Less than three percent of the people that are put into nursing homes in the nation, qualify for Medicare." He said many studies have shown that Medicare is not cost-justifiable. Other problems he mentioned with Medicare are: limits in the number of physician visits per month, the limits on the amount of treatment per month. Because many people who enter nursing homes have no one to represent them, he sees the need for the state to consider "some good guardianship legislation, or else have some legal services available." He said his corporation has had no success with community colleges or Legal Services.

GUARDIANSHIP

MEDICAID

He mentioned the proposed regulations about to go into effect on the Medicaid program, and said they might be appropriate for the lower 48, but were unsatisfactory here. He spoke in favor of additional senior centers, particularly a mechanism for funding operating services.

SENIOR CENTER

On a question from Sen. Glenn Hackney, Hauser said the total cost for the three facilities they own averaged out to $101/day - that includes three different levels of care.

ADMINISTRATION

Bill McMurtry spoke up from the audience at this point to say, "I'd like to go on record for the Department of Administration: we are 100 percent in favor of the home care program. He said the average age of the people in the Pioneers' Home is 80-years old. On a question from Jewel Jones, he said that approximately 10 percent of the people presently in the Anchorage home wouldn't be there if there were better home services.

Dennis Murray, director of the senior programs in Kodiak, testified next. He submitted written testimony from the board in Kodiak. It cites as the first priority need: the state should recognize that the best way to deliver services is at the local community level, and to do that, a multi-purpose senior center is probably the most viable means. To that end, he said, the state needs to develop a state policy supporting that. He cited the problems faced by programs like his which are supported entirely by diminishing federal dollars. He opposes using political clout as a basis for funding; a policy would be better.

LOCAL CONTROL

COORDINATION

The second priority is for better consolidation and coordination in the delivery of services. The third priority is for more and less expensive long-term care alternatives. He cited the case of a man from Kodiak who in six and a half months spent $26,000 in the Kodiak and Anchorage facility. He said Pioneers' Home was not an alternative in this case because he was terminally ill. "In my opinion, in my community, the best use of aging funds, is not to build another facility, but to appropriately utilize the one we have." There are 14 elderly presently in the Kodiak long-term care facility; 11 of them qualify as Pioneers. All are Medicaid-sponsored. Regarding homemakers, he stressed that Kodiak wants local control. He also submitted a resolution from the Kodiak Island Borough Health Resources Advisory Committee which urged the committee to introduce legislation "to authorize and provide sufficient funding for the decentralized home health care program, which will allow local areas to receive funding and provide such services,"

ANCHORAGE PIONEERS' HOME

Harold Maxwell, a resident of the Anchorage Pioneers' Home, spoke next. He praised the Pioneers' Home program as the best in the country. Regarding a nursing home adjacent to the present home, he said, "That is as it should be. It's a place where those who have entered the Pioneers' Home with the idea of their remaining years among friends, that they would be able to be near those friends when they approach the dying time." He favors immediate construction of the $7.5 million facility.

SALVATION ARMY

Bruce Kovarik, the division comptroller for the Salvation Army, testified next about Salvation Army programs. He said the funding for his program comes from the federal government through the Office on Aging. Additional sources are contributions from participants of the programs, and money from within the Salvation Army network. He also cited local in-kind contributions and volunteer hours. He recommended that state tax dollars be used to help programs like the Salvation Army. He also urged the state to do a better job getting out information about what is available, and to communicate more with other states about better ways to provide services. He spoke against increased limitations on local programs. Regarding residential care, he informed the committee that, effective 7/1/79, the Salvation Army closed its Palmer-Susitna residence, which did not receive state support for its operation. He said it was closed because it did not have enough business. "Purely and simply, we closed because we could not compete with the Pioneers' Homes and the subsidized programs in the rest of the state. We only charged $390/month for our senior residents, and provided room and board. Just as short as two years ago, that program was full with 21 seniors who wanted to be there." He added, "I hope that the committee will be aware that there are other means besides state, federal or local tax dollars, for accomplishing a given end.

RESIDENTIAL CARE

AUDITS

Regarding audits, he said many programs do independent audits on their own, as well as state and federal programs. He said audit exceptions are common, and that's a problem. They need to know what risks are involved in assuming state or federal programs. He praised the committee, urged state funding for the Office on Aging, praised them, and asked for an Anchorage office for the Office on Aging.

Bob Lohr, executive director for the Upper Tanana Development Corporation in Tok, testified next. He described the programs he runs in

their region - transportation, meals, homemakers (through CETA) - and said funding does indeed need to be differentiated between federal and state. "Rural Alaskans, especially Alaska Natives, have totally inadequate access to services for the elderly." One of the reasons for this he cited as federal regulations which don't apply to rural Alaska. That's why he thinks it's so important to consider state funding - because state dollars do not come under the "unreasonable federal restrictions".

RURAL ALASKA

Additional problems he cited as:

* inadequate funding for programs for the elderly;
* lack of coordination in delivery mechanisms (supports a division on aging - provided there is sensitivity to rural problems); based on the record, he said, Community and Regional Affairs and the Governor's Office would be most appropriate.

REORGANIZATION

He suggested that the state match - dollar for dollar - federal funds received in the state through the Office on Aging. He said that doubling of resources would still only meet "between 20-33 percent of the present need." He praised the homemakers program, but asked for additional funds for it. He also said that in the provision of any services to rural Alaska, Native corporations have proven to be the most efficient, and future funding should come through them. He added that his corporation receives about $300,000 through different programs to serve about 100 elderly.

STATE MATCH

NATIVE CORPORATIONS

Next to testify was Bill O'Connor of the Salvation Army. Regarding the proposed senior center in Anchorage, he noted that Salvation Army would like to be a sponsor of the center. His concerns relate to the lack of planning, the lack of a needs assessment, and the lack of input by local Native organizations. He wondered where the operational monies for the center would come from.

ANCHORAGE MULTI-PURPOSE SENIOR CITIZENS' CENTER

Edna Adrian, a member of the Mayor's Commission on Senior Citizens in Anchorage, was next to testify. She stated her support for the statements of Bob Lohr, particularly in the area of local control. She praised the efforts of the Easter Seals Society, but said "there is no way this program should be statewide." Her first priority is in-home support services. She also criticized the breakdown on the committee flyer. She cited the need for an Area Agency on Aging office in Anchorage so "we would be able to go to bat for ourselves." She is opposed to duplication of services, which she said does exist. She said there is too much money going into nursing homes in the area. She favors ICF and congregate living, but is appalled at the state paying for empty beds in nursing homes. She also said that Catastrophic relief under Medical Relief is inadequate. Additionally, she agreed with earlier comments about the need to take care of people who fall through the cracks.

LOCAL CONTROL

IN-HOME CARE

AREA AGENCY ON AGIN

NURSING HOMES

Chuck Mundorff, the consultant on aging for the Anchorage Community Mental Health Center, testified next. According to his experience, the greatest needs are with mental health problems relating to social isolation. He also cited the need for a comprehensive policy on aging on the state level for better coordination. He mentioned a commission on agi g as an alternative. He spoke in favor of the homemakers program, and a day-care program for seniors. He said three big reasons why seniors like to stay in their own homes are:

* self determination

ISOLATION

* retain a sense of autonomy
* continue traditional roles in familiar environment

RECOMMENDATIONS

He also recommended funding through the Office on Aging to operate multi-purpose senior centers around the state. Similarly, he advocated state match for the Office on Aging, "especially to help in the employment of seniors". Lastly, he urged the use of Title XX monies for senior day-care centers - funding which he said occurs in other states.

HOMEMAKERS' PROGRAM

On a question from Sen. Hackney regarding the specific needs for additional homemaker support, he said, even more important than additional funds is provision of consistent reliable service. He also mentioned that he sees two or three families a week in need of homemaker services. He said it would probably make good administrative sense to create an umbrella agency to oversee homemakers and home health programs. Art Holmberg noted that last year, the division of social services was forced to lapse over $200,000 in homemaker funds because of the inability of the service provider (Alaska Federation of Natives) to provide that service in the rural areas. He didn't anticipate that problem with Easter Seals.

RED CROSS

Pat Bonney and Jerry Ivey from the Red Cross spoke next. They mentioned that the Red Cross runs a home nursing program. The funds come from CETA. The local program is modeled after a national Red Cross program. There are 15 volunteer instructors.

CENTER FOR GERONTOLOGY

Chuck Hines testified next to inform the committee of a proposal submitted by Alaska Pacific University to establish a Center for Gerontology in Anchorage. The center would provide the means for people to receive academic credit in the area of aging; it would also provide training opportunities for the many agencies involved with services for the aging.

PROTECTIVE SERVICE

John Thomas, a 40-year Alaskan resident, spoke next. He mentioned the need for protective services for persons incapable of taking care of their own money. Regarding the Longevity Bonus, he suggested paying for that program from the interest of the Permanent Fund. He also recommended adding $50/month to the present $150/month. He spoke of the need for more employment opportunities for seniors.

PROPERTY TAX EXEMPTION

Waldo and Ruby Coyle spoke next on the property tax exemption program administered by the Department of Community and Regional Affairs. Mrs. Coyle said C&RA has put a limit on that program to only five acres. She said their whole homestead was exempt in 1977 and 1978, the first two years they were eligible. However, in 1979, only five acres were exempt. She said she received a letter from C&RA at the time stating their policy of only exempting one acre inside boroughs and five outside. She said this is at variance with state statutes, though apparently efforts are underway to change the administrative regulations in that regard to place that restriction into effect officially. The Administrative Regulations Review Committee recommended against that change, however, because it doesn't relate to state law.

RECREATION

Florence Orr testified to say that people who stay in their own homes need recreational activities, and she hopes that the committee will support continued funding for the Caverly Senior Center which provides these services.

ANCHORAGE PIONEERS HOME ADDITION

Ed Dodd, chairman of the Pioneers' Home Advisory Board, testified next. He questioned the delay on the Anchorage addition. He said once the 75-bed addition is completed, the cost of operating will come to $1,020,000 per year - a figure he compared to the $3,500 000 he said it would cost for equivalent care in private nursing homes. He criticized the Kotzebue Senior Center, noting that his advisory committee advised against it because of the extreme cost. He also criticized the cost and quality of care at Nakoyia.

Poldine Carlo mentioned here that Natives in the villages also don't like to leave their own homes, but appreciate it when they have a facility in their own community - like in Kotzebue - to which they can go when they need to.

Lorena Showers closed the hearing by speaking of the need for the multi-purpose senior center in Anchorage.

The Anchorage members of the committee reconvened the hearing three days later, on September 14, to receive additional comments from the project directors under the Office on Aging, many of whom were unable to attend the earlier meeting. Their testimony follows.

Dennis Murray presented written testimony prepared by the project directors urging more state support for in-home services (see exhibit #9).

Beth Bishop with the Southeast Nutrition program urged the state to match federal monies through the Office on Aging. She said many local communities in southeast don't have any local money to use for that purpose. Priorities would depend on local communities, but if the state made some additional money available, much more of what is presently being provided could be offered.

SENIOR CENTERS

Loretta French, from the Chugiak Senior Center, spoke next. She explained their program, and cited the need for operational funds for the senior centers. She stressed she meant program monies.

LONGEVITY BONUS

Doris Southall added that she would support a bill which would allow seniors receiving the Longevity Bonus to go outside for longer periods of time and still receive payments. She also said she would support cost-of-living increases for retired teachers and state employees.

HOME HEALTH CARE

Ellen Evans of Bethel testified that the biggest problem in Southwest Alaska is the lack of home health care. She said, "There is nothing." She added that Natives need an alternative, in times of need, to going to the Alaska Native Hospital in Anchorage.

Referred: Health, Education & Social Services and Finance

BY THE RULES COMMITTEE BY REQUEST OF THE LEGISLATIVE COUNCIL (for the Interim Committee on Services for the Elderly)

IN THE SENATE

PROPOSED COMMITTEE SUBSTITUTE
SENATE BILL NO. 320

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An act authorizing state medical assistance payments under the program of general relief assistance for persons who are 'medically needy'; and providing for an effective date."

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

*Section 1. AS 47.25.120 is amended to read:

Sec. 47.25.120. ELIGIBILITY FOR ASSISTANCE. Financial assistance may be given under AS 47.25.120 - 47.25.300 [, SO FAR AS PRACTICABLE UNDER THE CONDITIONS IN THIS STATE,] to

(1) a needy person who is eligible under the regulations of the department; and

(2) an aged, blind or disabled person who does not receive a payment under the old age assistance program (AS 47.25.610) the aid to the blind program (AS 47.25.620 - 47.25 780), or the aid to the permanently and totally disabled program (AS 47.25.790 - 47.25.970) because the person's income exceeds the income standards of those programs, but who has incurred medical expenses which equal or exceed the difference between the person's monthly income and 133 1/3% of the income standard under one of these programs.

*Section 2. AS 47.25.300 is amended by adding a new paragraph to read:

(5) "aged" means a person who is age 60 or older.

*Section 3. This Act takes effect July 1, 1980.

Per Guthrie

Suggested draft Language

SB 320

(3) A person age 60 ~~64~~ who meets all the requirements under the Old Age Assistance program (AS 47.25.610), except age, but does not receive a payment because the person's income ~~is~~ income exceeds the income of standard of that program, but who has incurred medical expenses which equal or exceed the difference between the person's monthly income and 133 1/3 % of the income standard under that program.

Underlined

Section 2 - This Act takes effect July 1, 1980

Talked Joe Guthrie 3-28-80 redo

Office Copy

Introduced: 1/15/80
Referred: Health Education & Social Services and Finance

BY THE RULES COMMITTEE BY REQUEST OF THE LEGISLATIVE COUNCIL (for the Interim Committee on Services for the Elderly)

1 IN THE SENATE

2 SENATE BILL NO. 320

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 ELEVENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act authorizing state medical assistance payments
7 under the program of general relief assistance for
8 persons who are 'medically needy'; and providing for an
9 effective date."

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

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14 UNDER THE CONDITIONS IN THIS STATE,] to

15 (1) a needy person who is eligible under the regulations
16 of the department; and

17 (2) an aged, blind or disabled person who does not receive a
18 payment under the old age assistance program (AS 47.25.430 - 47.25.610),
19 the aid to the blind program (AS 47.25.620 - 47.25.780), or the aid to
20 the permanently and totally disabled program (AS 47.25.790 - 47.25.970)
21 because the person's income exceeds the income standards of those pro-
22 grams, but who has incurred medical expenses which equal or exceed the
23 difference between the person's monthly income and the income standard
24 applicable to him under a program for which he would otherwise qualify.

25 * Sec. 2. This Act takes effect July 1, 1980.

26

27

28

29

SB
321

S 321 S. HESS An act requiring medicaid reimbursement ... payments for persons who are "medically needy"

By Rules Committee request of the Legislative Council

Introduced - 1-15-80
Logged 1-15-80
Referrals - Finance
Comm Meeting 1-28-80 - held

~~SB 322~~ SB 321

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION X
ARCADE PLAZA BUILDING
1321 SECOND AVENUE
SEATTLE, WASHINGTON 98101

HEALTH CARE
FINANCING ADMINISTRATION
Medicaid Bureau

Dr. Helen Beirne, Commissioner
Department of Health & Social Services
Pouch H-01
Juneau, Alaska 99811

Dear Dr. Beirne:

This is in response to a January 4, 1980, letter from Ms. Deborah Behr of your staff. Ms. Behr's letter requested our review and comments regarding three proposals scheduled to be presented to the current session of the Alaska legislature. This letter contains our comments regarding two drafts of Senate bills, identified as Work Orders (WO) #7522 and #7531.

WO #7522 proposes a Medicaid funded medically needy program for those who would be cash recipients under the State Supplementary Payments (SSP) program except for the level of their income.

Federal regulations at 42 CFR 435.310(a) require that states which provide medically needy coverage include coverage to families and children.

Therefore, WO #7522 would not comply with requirements of 42 CFR 435.310(a).

In addition, any medically needy program must utilize requirements of 42 CFR, Part 435, Subpart I in determining financial eligibility of medically needy individuals.

WO #7531 proposes a state-only funded medically needy program for those who would be cash recipients under the Alaska SSP program except for the level of their income.

Since no federal funds would be involved in such a program, it is beyond our role to comment on the technical correctness of that

If we can be of further assistance in either of the above discussed areas, please contact Mr. Ken Call at (206) 442-0506.

Sincerely,

Albert J. Benz
Regional Medicaid Director

cc: Deborah Behr

TO: (name, organization, address, phone)	FROM: (name, organization, phone)
Dr. Helen Beirne, Commissioner Department of Health & Social Services Pouch H-01 Juneau, Alaska 99811 465-3030	Ken Call 2-0506 DHEW/HCFA/Medicaid/MS 709

Total Pages:	FAX Machine Phone Number:	Date:
2	465-3005/3774	January 24, 1980

Remarks:

IF RETRANSMISSION IS NECESSARY, CALL: FTS 399-4527

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_X_ Call extension 0506 (We will pick up copies)

Form DV 77

POSITION PAPER/Department of Health & Social Services

POSITION PAPER
ON
SENATE BILLS 320 AND 321

"An Act authorizing state medical assistance payments under the program of general relief assistance for persons who are 'medically needy'; and providing for an effective date."

"An Act authorizing Medicaid-reimbursable assistance payments for persons who are 'medically needy ; and providing for an effective date."

Senate Bill 320 and Senate Bill 321 would establish a medically needy program for persons who meet all the eligibility requirements for cash assistance to the aged, blind or disabled, except that their countable income exceeds the applicable cash assistance need standard. Medically needy would allow eligible persons to use a portion of their excess income to meet their medical need by spending down to the cash assistance need standard. After they have made payment the medically needy program would provide the remaining coverage necessary.

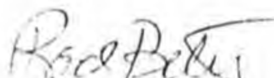
The Department is awaiting financial data on medically needy programs in other states in an effort to put together a fiscal note for this legislation. While the bills approach the question of medically needy coverage only for aged, blind or disabled persons, the fiscal note will also present information that will include medically needy coverage for persons who meet all AFDC eligibility requirements except income. Half of the required information has arrived and a fiscal note is being prepared. Preliminary analysis has shown that this program will cost in excess of $1 million.

Initial contact with federal staff indicates they will not authorize 50% federal financial participation under Medicaid unless the medically needy program includes coverage of the existing AFDC category as well as the aged, blind, and disabled categories. This federal position appears supported by the federal regulations but not by the federal statutes creating the Medicaid program. If the Department of Health, Education, and Welfare is unwilling to provide financial participation for a medically needy program that does not include AFDC coverage, it may be less costly to the State to include the AFDC category (because of the 50% federal financial participation) than to have a state only medically needy program limited to aged, blind, and disabled persons. Because of the question concerning federal financial participation, both bills would be needed to assure some type of medically needy program may be created.

Two identified gaps exist between the current Medicaid and Catastrophic Illness programs. First the Catastrophic Illness program has a minimum deductible or $1,000 per illness making it impossible for many people to receive coverage for minor cost illnesses, catastrophic or otherwise, when their income exceeds the existing income limits for Medicaid coverage. Second, the catastrophic illness program has largely excluded

nursing home coverage. Several persons whose income exceeds the income limits for Medicaid coverage are being covered on a special exception basis under general relief-medical (GR-Med) simply because there is no other coverage available to meet their high medical costs. This coverage then depletes the funds available for other persons eligible to receive GR-Med coverage. A medically needy program would provided additional coverage in these two areas.

The Department does not oppose the addition of a medically needy program which covers the aged, blind, and disabled categories, however, we must oppose passage of S.B. 320 and S.B. 321 as implemented would require substantial funding increases to the Governor's Budget and such a change has not been approved by the Governor's Budget and Management Division or the Budget Review Committee.

Recommended by: 
Rod Betit, Director
Division of Public Assistance

1/25/80
(DATE)

Approved by:
Helen D. Beirne, Commissioner
Department of Health and Social Services

1/25/80
(DATE)

ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Senate Bills #320 and #321
Title "'Medically needy' Under General Relief and Medicaid"
Requested by Senate HESS Committee Date 1/25/80

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Health
BRU, Program, or Subprogram(s) Affected General Relief-Medical and Medicaid
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES	*	*	*	*	*	*
200 TRAVEL	*	*	*	*	*	*
300 CONTRACTUAL	*	*	*	*	*	*
400 COMMODITIES	*	*	*	*	*	*
500 EQUIPMENT	*	*	*	*	*	*
600 LAND & STRUCTURES	*	*	*	*	*	*
700 GRANTS, CLAIMS, ETC.	*	*	*	*	*	*
TOTAL	*	*	*	*	*	*

FUNDING (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
GENERAL FUND	*	*	*	*	*	*
FEDERAL FUNDS	*	*	*	*	*	*
OTHER (Specify Fund Source)	*	*	*	*	*	*

POSITIONS

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
FULL TIME	*	*	*	*	*	*
PART TIME	*	*	*	*	*	*
TEMPORARY	*	*	*	*	*	*

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

*Detailed Fiscal Note to be developed. See Position Paper for detailed explanation of delay.

Original. Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: Rod Betit Date: 1/25/80
Division/~~Office~~: Public Assistance PH: 465-3355
Department of Health & Social Services

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

Approval DHSS Mgt. & Bdgt: [signature] Date: 1/25/80

Page ____ of ____

MEDICALLY NEEDY COVERAGE UNDER MEDICAID

321

Under federal laws the Medicaid program has the flexibility to provide medical coverage for individuals whose income exceeds the present limits of the Adult Public Assistance (APA) program. Coverage may be provided by the State of Alaska by amending AS 47.07.020 to allow for payment of medical services on behalf of medically needy aged, blind, and disabled Alaskans. Although the medically needy program also may be used to extend Medicaid coverage under AFDC, it is most urgently needed for persons who are ineligible for APA coverage due to excess income.

If an individual's countable income exceeds the current need standard under the APA program, they are not eligible for Medicaid regardless of the cost of their medical need. Cases are encountered almost daily by the Division of Public Assistance where an applicant has an identifiable medical need but their income exceeds the need standard. Under current program limitations, these persons must be denied and they will have to meet their own medical needs. In some instances they may be eligible for the state funded Catastrophic Illness program. In a few instances, where the individual has been institutionalized, the Commissioner of the Department of Health and Social Services has been forced to waive the income limitations under the state funded General Relief Medical program in order to provide financial assistance for extremely expensive on-going medical needs. In one case alone, the Division has paid almost $4000 per month using GRM funds for nursing home care provided to a comatose patient for over two years, simply because his income from Social Security exceeds the income limitation by less than $100 per month! A medically needy program would allow an individual's excess income to be applied to their cost of care with Medicaid covering the balance.

By establishing a medically needy program under Medicaid for aged, blind, and disabled Alaskans, the State would accomplish three purposes:

1. Individuals with on-going medical needs would not have to choose between necessary health care and heating their homes or buying groceries.

2. Individuals with severe health care problems requiring home care, extended hospitalization, or nursing home care would not have to sell their homes in order to pay their medical expenses.

3. Individuals requiring long term care at home or in a nursing home would not have to choose between staying in Alaska or going outside just because the cost of care in Alaska is higher than in other states.

The creation of a medically needy program would take some pressure off of GRM and Catastrophic Illness, two programs that are already facing potential revenue shortages in attempting to meet the cost of medical care for needy Alaskans. Any funding for a medically needy program for the aged, blind, or disabled would be in addition to those already available. The major difference between a medically needy program under Medicaid and any similar proposal is that 50% federal funding is available to provide for the coverage and to meet the costs of administering the program.

CARE
P.O. Box 3-488
2200 E. 42ND AVE. • ANCHORAGE, ALASKA 99501

January 28, 1980

The Senator Glen Hackney
Chairman- Health, Education, and
Social Services Committee
Alaska State Legislature
Pouch U
Juneau, Alaska 99811

Re: Testimony for Committee Hearings
January 28, 1980
Senate Bills 320, 321, & 322

Dear Senator Hackney:

SB 320 and SB 321

The "medically needy" of the State of Alaska are in great need of the relief that these two bills would provide by broadening income standards. We see, on a frequent basis, dignity being destroyed and families broken as individuals slightly over-income attempt to cope with the increasing costs of catastrophic illness. Legislation providing for the financial gaps in health care has long been needed. We commend the Interim Committee on Services on the Elderly for identifying this as a priority need.

SB 322

We wish to express our strong support for the concept of payment to certain institutions and agencies for Medicaid-eligible persons on the basis of prospectively determined rates. We believe that a "prospective rate" system in the State of Alaska would greatly enhance the quality of care available for a cost-effective dollar. The consequences of this bill are far reaching and of a major importance to the future of health care in this state. Detailed comments on this proposed legislation will be provided to you in the near future. I regret that this is not available to you at this time, but we do want to provide you with accurate and careful consideration on the details of this bill, while at this time expressing our firm conviction that "prospective rates" can be an appropriate solution to a crucial problem.

Respectfully yours,

HEALTH CARE SERVICES - ALASKA, INC.

Donna M. Stephens

Donna M. Stephens, Administrator
Careage House & Nakoyia Health Care Centers

Dick Wilson, Administrator
Careage North Health Care Center

DMS:DW:mlc

~~SB 322~~ SB 321

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION X
ARCADE PLAZA BUILDING
1321 SECOND AVENUE
SEATTLE, WASHINGTON 98101

HEALTH CARE
FINANCING ADMINISTRATION
Medicaid Bureau

Dr. Helen Beirne, Commissioner
Department of Health & Social Services
Pouch H-01
Juneau, Alaska 99811

Dear Dr. Beirne:

This is in response to a January 4, 1980, letter from Ms. Deborah Behr of your staff. Ms. Behr's letter requested our review and comments regarding three proposals scheduled to be presented to the current session of the Alaska legislature. This letter contains our comments regarding two drafts of Senate bills, identified as Work Orders (WO) #7522 and #7531.

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Therefore, WO #7522 would not comply with requirements of 42 CFR 435.310(a).

In addition, any medically needy program must utilize requirements of 42 CFR, Part 435, Subpart I in determining financial eligibility of medically needy individuals.

WO #7531 proposes a state-only funded medically needy program for those who would be cash recipients under the Alaska SSP program except for the level of their income.

Since no federal funds would be involved in such a program, it is beyond our role to comment on the technical correctness of that

If we can be of further assistance in either of the above discussed areas, please contact Mr. Ken Call at (206) 442-0506.

Sincerely,

Albert J. Benz
Regional Medicaid Director

cc: Deborah Behr

TO: (name, organization, address, phone)	FROM: (name, organization, phone)
Dr. Helen Beirne, Commissioner Department of Health & Social Services Pouch H-01 Juneau, Alaska 99811 465-3030	Ken Call 2-0506 DHEW/HCFA/Medicaid/MS 709

Total Pages:	FAX Machine Phone Number:	Date:
2	465-3005/3774	January 24, 1980

Remarks:

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4-30-80

SB.321

Juvia Love,
P.O. 5243
Ketchikan,
ak.

Ph: 225-2791

wants priority & notification of hearing.

SB
322

SB 322 S. HESS 79-80
By Rules Comm by [illegible] whatever

An Act authorizing payment for services provided by [illegible] institutions and [illegible] to medicaid-eligible persons on the basis of [illegible] determined [illegible] respective

Introduced 1-15-80
Logged 1-15-80
Referral Finance
Comm. meeting 1-28-80 — held 3-17-80 - held 4-21-80 - held
Comm action

Notify Bob Ogden (Medicaid) Ph: 3055
Ph: 3355

Notify Rick Urion
364-2315

Notify Jack Buck - St. Ann's Nursing Home 586-3883

Jim Burns 6-2611
Bartlett Hospital
New position paper (additional [illegible])

ALASKA STATE HOSPITAL ASSOCIATION INC.

5401 CORDOVA STREET
PHONE: 277-1633

ANCHORAGE, ALASKA 99503

January 25, 1980

Senator Glenn Hackney
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney:

Careful consideration has been given to the following proposed legislative bills and we would appreciate at this time providing you and your committee with the following comments, which we hope will be of value in your considerations.

S.B. #308 - ASHA Endorses

S.B. #309 - ASHA Endorses

S.B. #320 - ASHA (Qualified) Endorsement

Presently lacks specific definition of eligibility defining "medically needy".

S.B. #321 - ASHA (Qualified) Endorsement

Increasing the number of eligible claims paid under the state medicaid program, which is unable to keep up with those presently eligible, may compound an already less than satisfactory system. This bill also does not speak to the eligibility of family members of those who would be elibible under this proposal.

S.B. #322 - ASHA (Unqualified) Opposition

The question that needs to be asked is, the basis on which this bill would be justified. A review of the data contained on pages (4&5) of the 1980 ASHA Cost Containment Report shows:

1. Alaska has the smallest number of licensed beds per 1000/population.

2. Alaska has the smallest number of admissions per 1000/population.

3. Alaska has the highest per capita income in the nation.

4. Alaska has the lowest hospital expense per capita as per cent of per capita income.

5. Alaska hospital expenses per admission is within $6.00 of the national average, and is lower than all but one of the states which now have a "perspective hospital reimbursement rate control program".

WHY DOES ALASKA NEED A PERSPECTIVE REIMBURSEMENT PROGRAM SINCE WE LEAD THE NATION IN THE SHORTEST LENGTH OF STAY AND APPROXIMATE THE NATIONAL AVERAGE ON EXPENSE PER ADMISSION?

If such legislation is passed, particularly this bill, we would ask, "who would determine and how would the determination of a fair rate for the reasonable costs" be calculated. What type of interim adjustments would be allowed during the reimbursement period for our present inflation? Would the prospective rate be by type of service? cost per patient day? by occupied beds? regionally or state wide rate? etc. There appear to be a number of unanswered questions at this time.

Colorado had a rate control program and has just resinded that law. New York has just completed a study which indicates that 25% of hospital cost can be attributed to government regulations. We feel that voluntary cost containment is a better way to accomplish this control.

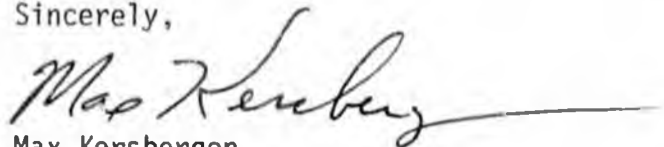
Due to the question of need for this type of legislation and the information obtained from other states concerning ineffectiveness and costs, we recommend that action on this bill be deferred until a greater analysis of the information supporting its need or justification is presented.

S.B. #323 - ASHA (Qualified) Endorsement

As written, this is a blank check authorization, we recommend that stated monitary guidelines be incorporated in the bill by program or catagory of service. How the program will administer these funds should also be spelled out.

Thank you for consideration of our comments, and if we can be of further service by presenting supporting data or testimony, please contact us at your convience.

Sincerely,



Max Kersbergen
Exective Director

MK/ic

BARTLETT MEMORIAL HOSPITAL

P. O. BOX 3-3000 • JUNEAU, ALASKA • TELEPHONE (907) 586-2611
MILE 3 — GLACIER HIGHWAY

February 20, 1980

Senator Glenn Hackney, Chairman
Senate HESS Committee
Pouch V
Juneau AK 99811

SENATE BILL No.322 - "PROSPECTIVE RE-IMBURSEMENT"

Bartlett Memorial Hospital supports the intent of the bill. Prospective reimbursement negotiations would give both the State and the health care facility some concrete figures for budgeting.

However, this is an extremely complex issue that requires an orderly well planned program. Since October 1977, hospitals have been working with HEW's Health Care Financing Administration on the System for hospital Uniform Reporting (SHUR). This has evolved into the Annual Hospital Report (AHR) and it is hoped that this proposal will be accepted. (see attached excerpt)

UNIFORM REPORTING: All health care facilities must be set-up on a uniform data base. The above mentioned AHR should be the keystone for this procedure. We recommend that the State of Alaska utilize one of the major national accounting firms for this step. This outside agent shoud be mutually agreed upon by the hospitals and the State.

This cost should not be passed on to the hospital's patients; it should be borne by the State of Alaska.

RATE NEGOTAITION: Concurrently, have a national accounting firm (the same or another) establish a procedure for prospective rate setting. Subject procedure to be arrived at mutually with the hospitals. Place this procedure into effect after the data base year has been completed.

RATE APPEALS: Utilize a national accounting firm as an arbitrator on all appeals. This will preclude the need for an expensive rate commission and eliminate more bureaucracy.

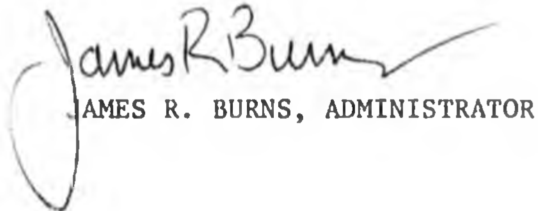
Senator Glenn Hackney, Chairman
Senate HESS Committee
Page 2

SENATE BILL No. 322 - PROSPECTIVE RE-IMBURSEMT (con'd)

PROPOSED TIME SCHEDULE:

1st Year - set-up the reporting system
2nd Year - establish one year data base
3rd Year - negotiate rate

Every additional cost must be passed on to the patient or third party payor. Containment of cost is our goal - new legislation/rules must be cost effective for all concerned. I will assist in any way to provide information to your committee.



JAMES R. BURNS, ADMINISTRATOR

Kaple: New report "dramatically" changed from SHUR

The Annual Hospital Report (AHR) is a "dramatically changed document" from the proposal it replaces — SHUR, the System for Hospital Uniform Reporting — and takes into account the hospital industry's concerns about cost and burden.

This is the opinion of James M. Kaple, Ph.D., acting director of the Office of Research, Demonstrations and Statistics of the Health Care Financing Administration (HCFA).

Kaple

Kaple noted, however, that "the one issue the industry raised and we disagreed upon and therefore have not changed is the linkage of uniform reporting and reimbursement."

"We clearly believe," he said, "that the data contained in the new Annual Hospital Report is that on which to base reimbursement decisions. It does not make sense, in my opinion, to put in place two reporting systems — one to gather uniform reporting data and another upon which to base reimbursement decisions.

Data for reimbursement purposes

"Furthermore, Congress tended to believe that this data should be linked and used for reimbursement purposes. In fact, the General Accounting Office (GAO) studied our implementation approach to Section 19 of P.L. 93-641. GAO's conclusion, presented in testimony, was that Congress did intend the use of this information for reimbursement purposes.

"Nevertheless, we have made a lot of changes, which are clearly responsive to the industry's request that the burden be reduced and the cost of collecting the data and maintaining it be reduced."

Kaple, noting the controversy that the SHUR proposal generated in 1979, said that "we have changed a great number of the reporting requirements that were contained in the original system — with an eye on reducing the burden on hospitals filling out the report and reducing the cost of maintaining and reporting the information."

"The resulting Annual Hospital Report," he explained, "takes into account virtually all of the specific comments on ways to reduce the reporting burden that were generated by the industry. There were one or two issues in which there were compromises. But, basically, we took the industry's recommendations on most of the burden and cost reduction issues."

Kaple commented:

"The Annual Hospital Report will become the cost information upon which reimbursement will be predicated for the federal programs. It will be an integral part of our operating program. The purpose of the report is to collect uniform, operable cost and utilization information for our operating programs. It has been developed in such a way that it also should provide information for other parts of the department and other users at the state and local levels. This was done purposely in an effort to try to reduce the redundant reporting burden that hospitals now face from various segments of the third party payor industry and other regulators.

HCFA to collect data

"We, for example, will be collecting the facility data through the Annual Hospital Report as opposed to having a separate system managed by the National Center for Health Statistics.

"We also will be supplying information to planners from this report on the range of services and the utilization of service by institutions in their areas. Again, this will preclude the necessity of developing new reporting systems specifically to support those activities.

"Internally, this report will, for the first time, provide us with a comparable uniform data base on which to analyze trends and costs in the hospital industry. We will be working directly with the fiscal intermediaries to bring the Annual Hospital Report data, possibly in summary form, into the central office for policy review and analysis and to support decisions on these programs within the Administration."

Kaple says there probably will be no increase in the size of his division's present staff to handle the report data.

"In the long run," he noted, "there may be some cost savings through the introduction of a uniform reporting system at the source of the data. We will use fiscal intermediaries to manage and reduce the data. Our early discussions with Blue Cross and certain other intermediaries suggest that receiving the data in the uniform form probably will permit management of the information with no net increase in personnel at the intermediary level. In the central office, we will be receiving the data in machinery that will actually expedite our collection and management of the information."□

Deregulation: A Report from Colorado Hospitals

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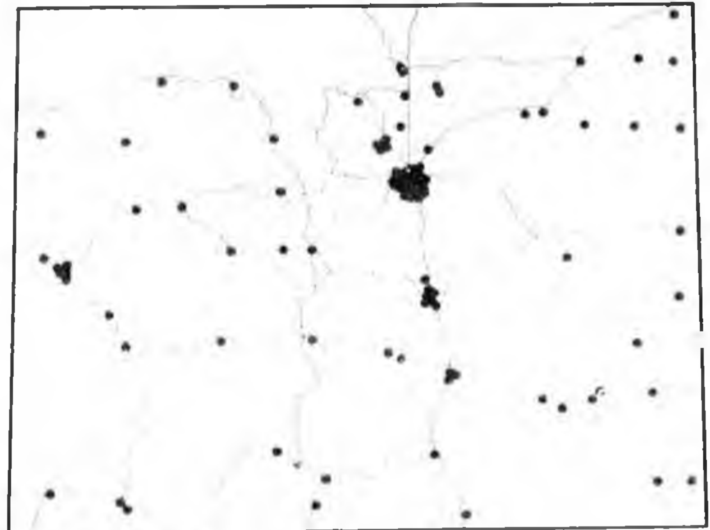
We are the 105 Colorado hospitals employing 40,000 people and caring for more than 460,000 patients each year.

These facts distinguish us from a "national average," much as Colorado distinguishes itself from the rest of the nation by its natural resources and quality of life.

Quality health care is available in Colorado, yet the cost of the average hospital stay in Colorado is still 6.3% below the rest of the nation, even as Denver's Consumer Price Index (CPI) climbed to 8% above the national CPI.



Location:

50 Rural
31 Denver
24 Other cities

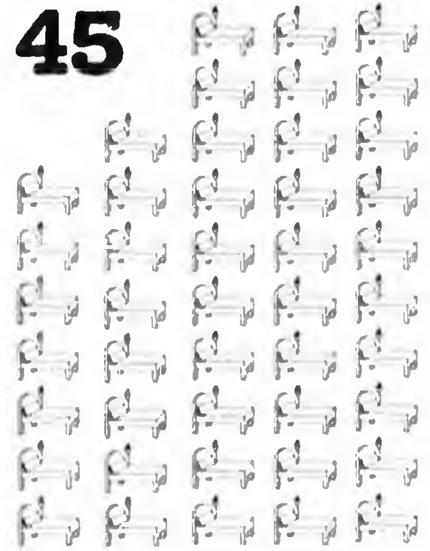
Type:

53 Non-government, not-for-profit
40 State and local government
7 Investor-owned
5 Federal

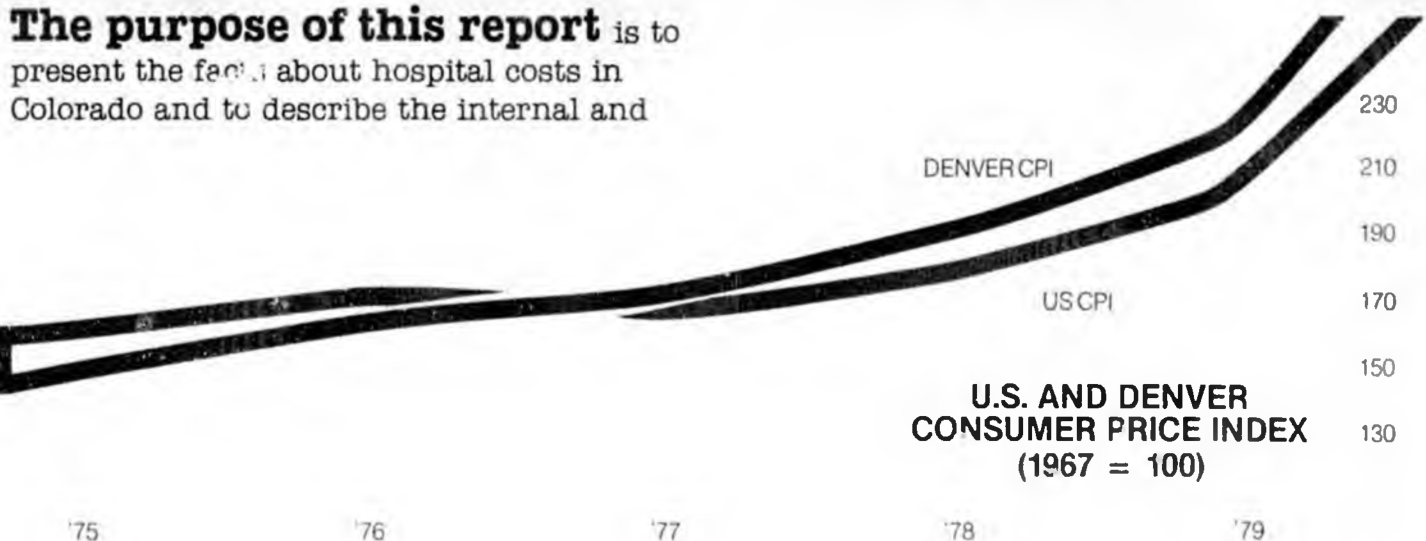
200 Beds & Over

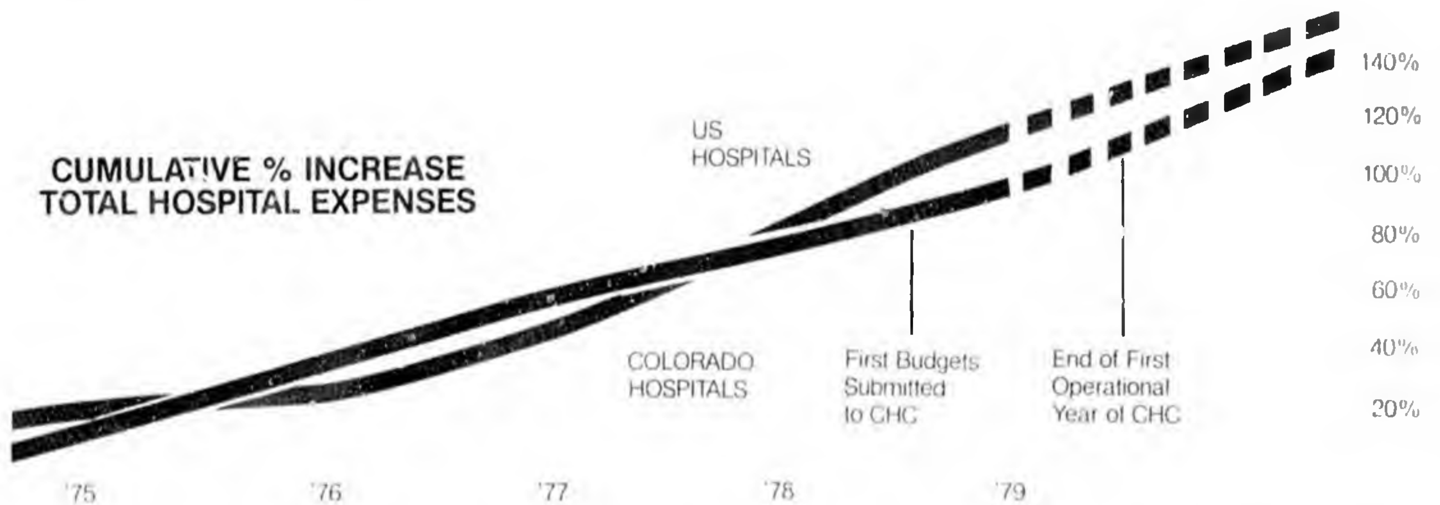
50-199 Beds

6-49 Beds



The purpose of this report is to present the facts about hospital costs in Colorado and to describe the internal and





Colorado hospitals are proud that our costs are 6.8% below the national average, even as Denver's CPI climbed to 8% above the national CPI. This leveling-off trend in hospital expenses started a full two years before the Commission began reviewing budgets. During the period CHC has been in operation, costs in Colorado have closely paralleled the national average, indicating no measurable impact by the Commission.

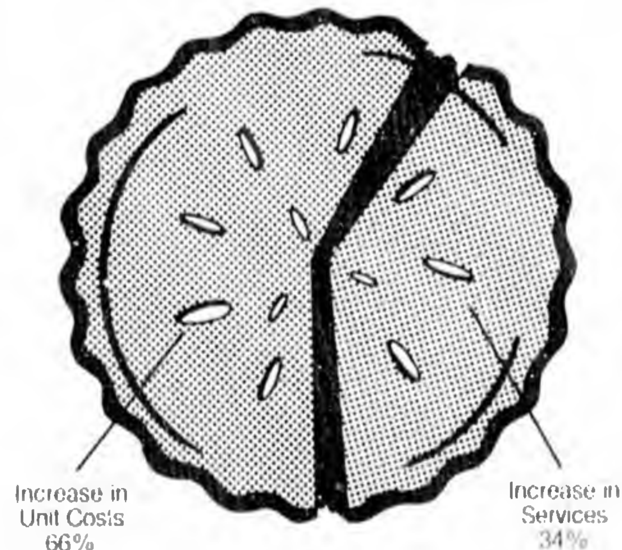
external forces that have brought us to this point. We will trace the recent history of voluntary cost containment efforts and hospital cost regulation to provide the information needed to make decisions about the quality, cost and availability of health care in the 1980's. We will make the following points:

1. Other than general inflation, improved quality and availability of care is the main reason for the increase in hospital costs.
2. Colorado hospitals have led the effort to contain health care costs long before the rush to regulation.
3. The responsibility and accountability of hospitals to their communities for the quality, cost and availability of health care must remain with the local representatives on Boards of Trustees.
4. The Colorado Hospital Commission failed, practically and philosophically.
5. Nationwide, the hospital industry's own "Voluntary Effort" to contain health care costs is working.

Where it all started. The first hospitals were charitable institutions where people went to die. Care was simple and mortality high. Health professionals, as we know them today, did not exist. The average "hospital" stay lasted several weeks and cost less than $5 per day.

By the early 1900's scientifically-educated physicians and trained nurses were providing increasingly effective care, and some insurance companies were writing policies that covered hospital care. Most people, when they could afford to, were still paying their own hospital bills.

The Causes of Hospital Expense Increases



Total Hospital Expenses = Unit Costs × Growth

Unit Costs	Growth
Labor Costs	Population Growth
Prices of Goods Hospitals Purchase	Aging Population
Capital Expenditures	Technology
Expanded Regulations	Expansion of Coverage
Quality Changes	Government Programs
	Private Insurance
	Growth of Real Income
	Specialization

External factors, ranging from inflation to increased demand for services, have greatly contributed to the increase in hospital expenses.

In the 1930's hospital reimbursement plans were introduced, providing hospitalization coverage for many patients who would have otherwise been unable to afford hospital care. After World War II, medical science gave us wonder drugs, new equipment and advanced surgical methods. Better quality medicine cost more, but insurance paid for more hospital care. With more people demanding hospital care, and with more effective treatments available, "reimbursement" from "third-party-payors" became more complex.

Under contracts with Blue Cross, hospitals were reimbursed based on **costs,** while other insurance carriers and private patients paid **charges.** Because insurors guaranteed prompt, full payment, hospitals allowed them discounts. Thus began a system of different levels of payment for the same service. Cost-based reimbursement systems provided no incentive for holding down costs since hospitals and physicians were paid retrospectively for whatever they spent.

In fact, these cost-based payment mechanisms were used in Medicare and Medicaid programs to encourage growth and spending as a means of promoting wider availability and improved quality of health care.

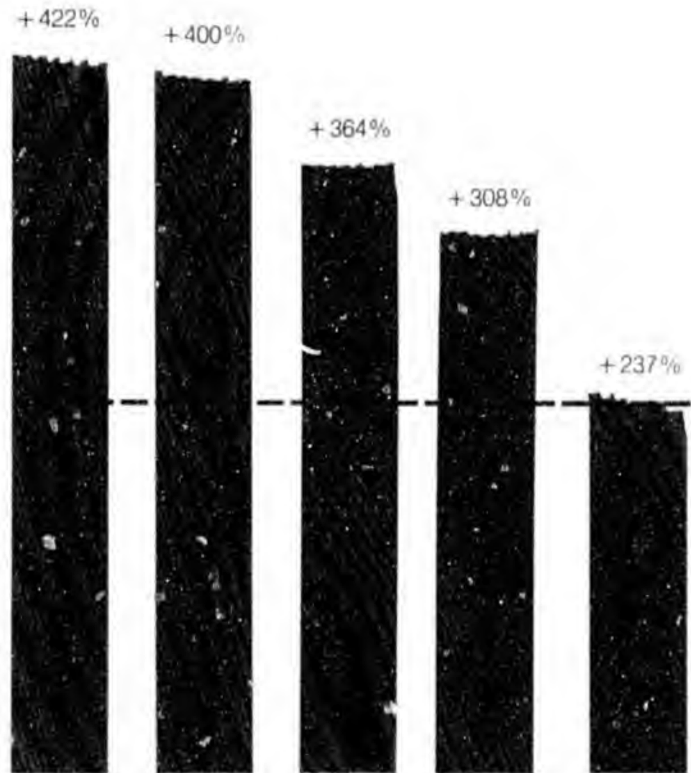
In 50 years the effectiveness of medical treatment grew, the availability of services grew, the demand for health care grew and so did costs. Everything grew and everyone called it progress.

Why costs went up. With the advent of the government insurance programs, Medicare and Medicaid, in the mid-1960's, the rise in health care costs began to exceed general inflation. The causes can be grouped into four broad categories:

- ☐ Increased demand for services
- ☐ General inflation
- ☐ Government regulation
- ☐ More effective care

Demand created an intensive period of growth for the whole health industry. One third of the total increase in hospital costs is due to increased demand for services. In 1955, America's hospitals admitted 21 million patients — in 1975, 36 million. In the same period outpatient visits increased from 126 million to 255 million annually. Under Hill-Burton financing, the federal government encouraged communities to build or renovate 60 hospitals in Colorado. More people, with greater access to health care and more comprehensive insurance coverage, demanded more hospital services.

Simple **inflation** accounts for more than 50% of the increases in hospital costs. Supplies, services and staff cost more each year. Malpractice insurance rates have risen 450% over the last 5 years. Salaries and benefits (60% of total hospital expenditures) have increased rapidly to catch up with other industries.



Hospital care is more effective, more available and of higher quality than ten years ago, yet the cost of the average hospital stay has not increased nearly as much as the cost of government

Regulation, bureaucracy and "red tape" have added significantly to the cost of health care. In the last 15 years, Medicare, Medicaid, EEOC, NLRB, OSHA and Fair Labor Practices contributed to rising expenses. A New York study identified 164 agencies regulating hospitals. Compliance with these regulations costs $40 per patient day. The list on page 10 shows the agencies and regulations that affect hospitals in Colorado. Last year HEW alone issued almost 600 new or proposed health-related regulations. At the same time the Colorado Hospital Commission was requiring hospitals to submit up to 100 pages of budget information.

Rising hospital costs also reflect more **effective care** resulting from new treatments and technology. Because these improvements cure diseases, save lives and speed recovery, hospital care today cannot be realistically compared to 50, 25 or even 10 years ago. Intensive care units save 100,000 lives a year. The heart attack recovery rate has gone from under 50% in 1946 to over 85% today. Twenty-five years ago x-ray therapy, chemotherapy, hemodialysis and many orthopedic and

surgical procedures did not even exist. Health care costs more today than it did in 1940, but during that same period, life expectancy rose from age 63 to 72½ years.

In the 1960's the Great Society could afford guns, butter and men on the moon. Health care quality and availability increased substantially and no one counted costs. In the 1970's, the nation's outlook shifted to conservation, accountability and allocation of scarce resources. The last ten years have given us tremendous medical advances and the highest quality of health care in the world.

What happened in Colorado.

Early in the 1970's, Colorado hospitals became increasingly involved in cost containment measures. Hospital management introduced more effective systems and developed a wide range of cooperative programs, such as group purchasing, combined data processing and other shared services. Colorado hospitals also became more involved in the legislative process, developing the 1973 prospective reimbursement legislation. This law created a pilot project which successfully demonstrated the cost savings incentives of a prospective payment system and provided a basis for developing a uniform accounting and reporting system. In 1975 and 1976 the Colorado legislature considered hospital rate review systems, but ultimately rejected them. Colorado hospitals actively opposed these early measures because they were poorly drafted and certain to undermine the quality and availability of health care.

By 1977, several hospital cost containment bills had been proposed nationally. However, Colorado hospitals were already working with former State Representative Frank Traylor (R-Jefferson Co.) to draft a bill for Colorado that would address issues without sacrificing local control over the quality and availability of care. These efforts resulted in HB 1582, which a majority of Colorado hospitals supported. The act provided for three commissioners to prospectively review

hospital budgets, to approve the level of charges for each institution, and to provide for more equitable payment by all third-party-payors. HB 1582 was signed into law in July, 1977, and the Colorado Hospital Commission began its work in October.

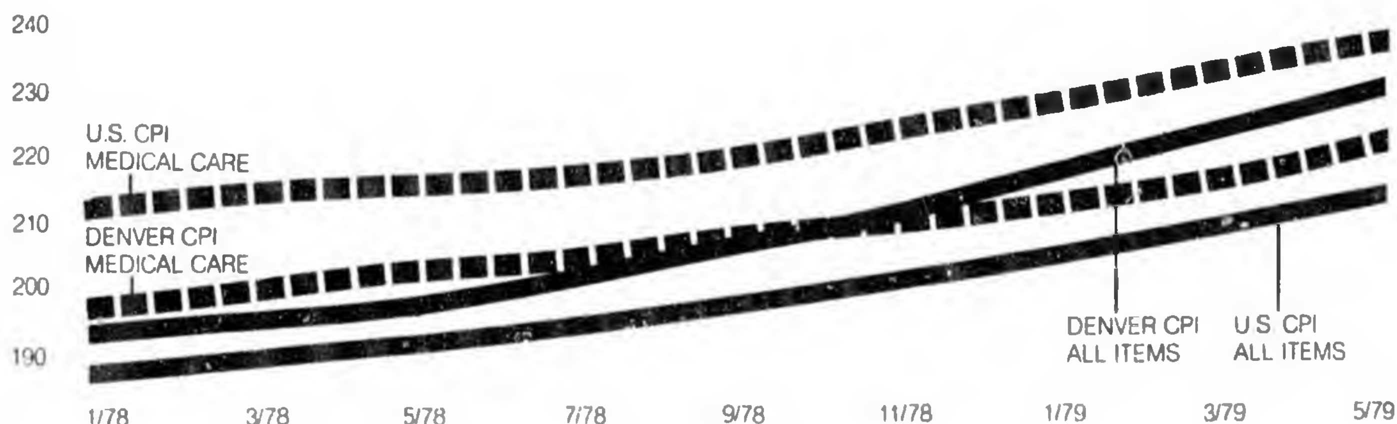
The optimism of both hospitals and legislators was ultimately proved wrong. Within one year it became clear to many legislators that the Commission had become a perfect example of ill-advised, bureaucracy-ridden rules and regulations. Frustration with this system finally prompted legislators to seek repeal of the Commission. The legislation (SB-38) was introduced in January, 1979, by Colorado Senate President Fred Anderson (R-Loveland), one of the original sponsors of HB 1582.

Hospitals did not initiate the effort to repeal the Commission. Over a full year they had met with the commissioners frequently to suggest constructive changes to make the system work. When these efforts finally proved fruitless, hospitals supported the effort to repeal. Third-party-payors, the Governor's office and several consumer groups opposed the repeal measure. The Senate passed SB-38 quickly by a 2/3 majority. At the request of the Governor, the House added amendments postponing the repeal date to March, 1980,and giving the Governor discretionary power to remove the commissioners. The amended version of SB-38 was passed and signed by the Governor on May 18, 1979, repealing the statute that had created the Colorado Hospital Commission, effective March 1, 1980.

Why the hospital commission failed. The primary problem with the Colorado Hospital Commission was bureaucracy. From the very beginning, the Commission was counter-productive. It got off to a slow, disorganized start, fell behind and never caught up. It created frustrations by adopting an adversary stance and compounded it with legalistic procedures and arbitrary decisions.

- On the key issue of financial requirements for hospitals, the Commission seemed to act contrary to the intent of the legislation. The rules developed by the Commission allowed for no growth and development funds for hospitals to modernize and replace equipment in the future. Because of Commission actions, some hospitals had to use financial reserves for current operations.
- The Commission's budget review process concentrated on forms — over 40 pages of them. The forms, taken directly from the Maryland rate review system, were complicated, often not applicable, sometimes misleading and occasionally illegible. In some instances the Commission required accounting contrary to generally accepted practice in the hospital industry.
- Rule-making sessions often altered the intent of the law, especially on the issue of payment differentials for third-party-payors. The law decreed that they must be "quantified" to be allowed. No quantification took place.
- The Commission hearings were adversarial and this negative environment discouraged the resolution of substantive issues.
- The Commission created so much paperwork that both hospitals and the Commission staff staggered under the weight.
- After two years of operation, the Commission still had not defined what constituted compliance, nor had it put

U.S./DENVER MEDICAL CARE COSTS



Since January, 1978, the medical care component of the CPI is up 11.9% nationally and 11.5% in Denver. The gap has remained roughly the same, indicating no measurable impact by the Colorado Hospital Commission. The overall Denver CPI increased substantially compared to the rest of the nation.

into place the uniform accounting system the law required.

☐ Overall, the Commission did little to reduce expenditures, especially when the direct and indirect costs of compliance are calculated.

In the Commission's Report to the Governor, three different methods are used for measuring effectiveness. The three justifications show savings of $28 million, $18 million or $9 million, depending on the method of computation. Detailed examination of the $28 million, the $18 million and the $9 million figures reveals basic fallacies in the arguments and supporting data.

The data available on actual hospital costs shows that Colorado continues to parallel the national trend. The graph on page 3 shows the comparison between Colorado and the rest of the nation for total hospital expenses. The graph above shows the comparison between medical care costs in Denver and the rest of the nation, measured by the Consumer Price Index. Costs began leveling off before the Commission came into being and have shown no measurable deviation from the national (non-regulated) trend since the Commission completed its first cycle of budget reviews.

$28 MILLION?

The Commission uses CPI figures to claim that $28 million was saved as the rate of increase of the Denver CPI medical care cost component dropped below the overall Denver CPI. The graph above shows that medical costs in Colorado have followed the national trend, while the overall Denver CPI has escalated considerably.

$18 MILLION?

The Commission uses rate of increase data from several sources to claim $18 million in savings as the difference between

the level of approved budgets in Colorado and the target of the national Voluntary Effort. Aside from having the wrong data and attempting to compare apples and avocados, review of the actual expenses (shown in graph on page 3) shows no deviation from the national trend.

$9.8 MILLION?

The Commission cites $9.8 million removed from budget submissions as savings, but over $6.3 million of that was in requests for growth and development. The rules on these other financial requirements have since been changed to effectively eliminate the $6.3 million "saved."

No substantial evidence exists to show that the Commission saved any money. Comparisons between Colorado and non-regulated states indicate conformance to the national trend.

The Colorado Hospital Commission failed. On the practical level, it was not worth the paperwork, the bureaucracy and the estimated $1.8 million cost of compliance. Philosophically, it removed the responsibility and accountability from the locally appointed/elected Boards of Trustees, who should be making the community decisions on the quality, cost and availability of health care.

Where do we go from here: local board responsibility.

Among the nine states that have regulated hospital costs, Colorado is the first to repeal a hospital rate review system. This happened two years after the Commission had been voted in with the support of Colorado hospitals. Other states, federal bureaucrats and congressional leaders are watching to see what happens next.

Now that the Legislature has passed SB-38 repealing the Colorado Hospital Commission, Colorado has an opportunity to show that local control, accountability and responsible management can work. Hospital Boards have the authority and the will to make a voluntary approach to cost containment work without undermining the quality and availability of health care in their communities. Certainly local Trustees, elected or appointed from the community, can better judge what the local hospital should provide than governmental bureaucrats in distant capitols.

To assist local hospital Boards, Colorado hospitals are now implementing **InitiatiVE**, a program to monitor, analyze and report health care costs. This system will provide comprehensive management information to individual hospital Boards, and comparative data on similar-sized hospitals, regionally and nationally. Aggregate data on all participating hospitals in Colorado will be compiled quarterly through the Colorado Hospital Association. In coordination with the Colorado Voluntary Effort, this statewide data with national and regional comparisons will provide the public with the facts on health care costs in Colorado. A sample of this quarterly report is on page 10.

Regulatory and bureaucratic efforts to contain hospital costs have failed. The voluntary approach is working nationwide. A reporting system for hospitals that can assist local Boards of Trustees as a management tool and provide the public with aggregate data is the best way to contain costs while preserving local control over the quality and availability of health care in Colorado.

Colorado hospitals fully support the intent of SB-38 as passed by the legislature and signed by the Governor.

Regulation in Colorado: A partial list

Federal Legislation

National Health Planning and Development Act
Public Health Services Act
- Health Manpower Shortage Areas

Health Manpower Training Act
Nurse Training Act
Hill-Burton Act
Medicare
Medicaid
Social Security Amendments of 1972
Equal Employment Opportunity Act
Unemployment Compensation
Workmen's Compensation
Fair Labor Standards Act
Occupational Safety and Health Act
Equal Credit Opportunity Act
Uniform Anatomical Gift Act
Sherman Anti-Trust Act
Federal Record Keeping Requirements

Colorado Legislation

Colorado Certificate of Public Necessity
Colorado Hospital Budgetary Review
Health Facility Licensure Requirements
- Colorado Health Facility Standards

Health Professional Licensure Requirements
Colorado Occupational Safety and Health Act
State Wage Orders
Colorado Medical Records Access
Colorado Patient Grievance Mechanism

Federal Agencies

Department of Health, Education and Welfare
- Social Security Administration
- Health Care Financing Administration
- Public Health Service
  - Emergency Medical Services
  - Division of Alcohol, Drug Abuse and Mental Health
  - Food and Drug Administration
  - Division of Health Resources
- Civil Rights

Equal Employment Opportunity Office
Department of Labor
Department of Justice
- Immigration and Naturalization Service

Drug Enforcement Administration
Atomic Energy Commission
Environmental Protection Agency
Department of Interior
- Bureau of Indian Affairs

Consumer Product Safety Commission
Department of Transportation
- Highway Safety Administration

Internal Revenue Service
Federal Communications Commission
Federal Trade Commission
Occupational Safety and Health Administration
Veterans Administration
Treasury Department
- Bureau of Alcohol, Tobacco and Firearms

Colorado Agencies

Department of Social Services
Department of Local Affairs
Department of Labor and Employment
Civil Rights Commission
Colorado Health Care Financing Authority
Department of Regulatory Agencies
- Colorado Hospital Commission
- Insurance Commission
- Board of Medical Examiners
- Board of Pharmacy
- Practical Nurse Board
- Board of Nursing
- Board of Phys al Therapy

Department of Health
- Health Facilities Review Council
- Board of Health
- State Health Coordinating Council
- Emergency Medical Services
- Alcohol and Drug Abuse
- Medical Care Regulation and Development
  - Licensing & Certification
  - State Health Planning and Development Agency

Local Government

Health Departments
Zoning Commissions
Land Use Commission
Building Codes
Fire and Safety Codes

SAMPLE: InitiatiVE Report

	Sample Quarter '79
Cost Per Stay (Adj.)	1400.89
Cost Per Patient Day (Adj.)	232.66
Gross Revenue Per Adj. Patient Day	246.80
Medical & Surgical Nursing Units — % Occupancy	63.2
— Average Length of Stay	6.4
— Nursing Paid Hours Per Patient Day	7.27
— % RN s in Nursing Service	45.1
Total Hospital Paid Hours Per Adj. Patient Day	24.63
— Salary Per Adj. Patient Day	142.76
— Non-Salary Expense Per Adj. Patient Day	88.55
— Housekeeping Hours Per 1,000 Sq. Ft.	38.64
Laundry Hours Per 100 Lbs	3.75
Days of Net Revenue in Accounts Receivable	66.61
Total Number of Beds	12,380
Hospitals Reporting	89

COLORADO MEDIAN		MOUNTAIN STATES MEDIAN			U.S. MEDIAN		
Comparative Quarter '78	% Change	Sample Quarter '79	Comparative Quarter '78	% Change	Sample Quarter '79	Comparative Quarter '78	% Change
1264.81	10.8	1429.22	1274.19	12.2	1465.95	1311.63	11.8
197.63	17.7	230.52	205.51	12.7	195.46	172.58	13.3
216.85	13.8	244.54	216.99	12.7	208.04	183.97	13.1
63.4	—	59.7	60.8	-1.8	71.3	70.4	1.2
6.4	—	6.2	6.2	—	7.5	7.6	-1.3
7.50	-3.0	8.05	8 00	.6	7.25	7.24	—
42.0	7.4	39.7	37.3	6.4	35.1	34.1	2.9
24.75	—	24.87	24.44	—	21.89	21.91	—
121 28	17.1	140.29	123.92	13.2	113.49	101.18	12.2
75.59	17.1	88.43	80.16	10.3	80.90	70.33	15.0
35.03	10.3	39.53	37.00	6.8	41.08	40.65	1.1
3.92	-4.3	3 80	3.91	-2.8	3.25	3.35	-3.0
68.15	-2.2	77 62	81 86	-5.2	67.01	69.27	-3.3
12,242	1.1	51,520	50,739	1.5	696,850	671,910	3.6
88		397	391		3196	3196	

Quasi-Public/Voluntary Agencies

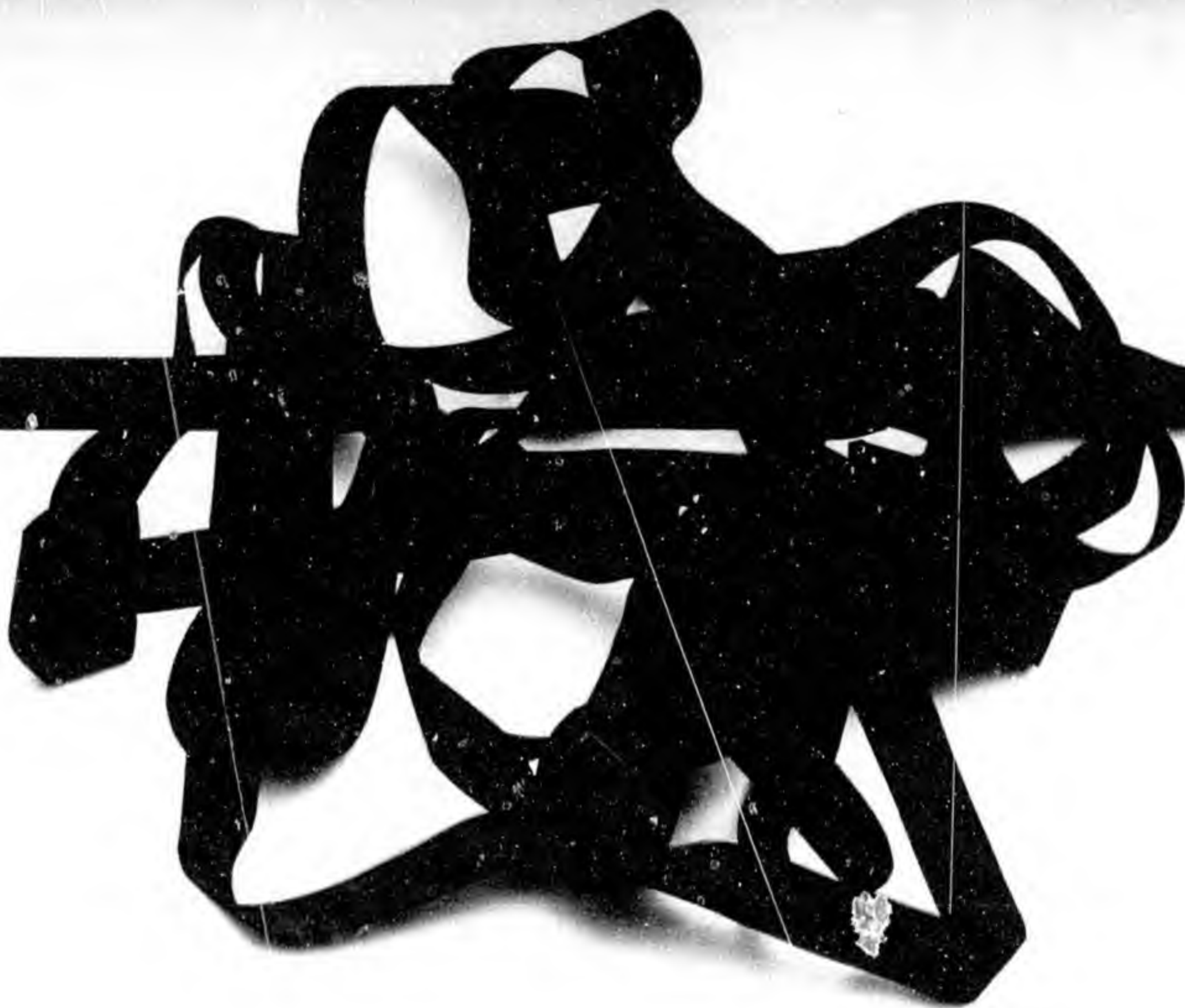
Joint Commissi n on Accreditation of Hospitals (JCAH)
American Osteopathic Association (accreditation)
Colorado Foundation for Medical Care
Professional Standards Review Organization
American Institute of Certified Public Accountants
Financial Accounting Standards Board
Cancer Registry of American College of Surgeons
Health Systems Agencies I, II, and III

Sources for Statistical Data

Consumer Price Index (U.S. Dept. of Labor)
American Hospital Association National Panel Survey
Colorado Hospital Association
AHA/CHA Survey Sample
National Voluntary Effort to Contain Health Care Costs
Hospital Financial Management Association

Backgro nd Reading on Hospital Rate Regulation

1. Maurice Moore, "Deregulation in Colorado: A Special Report," Review, (August 1979), 14-23.
2. Alain C. Enthovan, Ph.D., "Health Care Costs: Why Regulation Fails, Why Competition Works, How to Get There From Here," National Journal (May 26, 1979), 885-889.
3. Robert Austin Milch, M.D., "An Overview of the Economics of Health Care," World, (Autumn 1976), 30-35.
4. "Policy Brief Number 1, State Regulation of Hospital Expenses," American Hospital Association Office of Policy Studies (April 12, 1979), 1-9.
5. David Stockman, M.C., "The Administration's Case For 'Hospital Cost Containment': A Critical Analysis," Washington Memo, (May 16, 1979), 1-77.



Member Hospitals in the Following Cities:

Akron
Alamosa
Aspen
Aurora
Boulder
Brighton
Brush
Burlington
Canon City
Cheyenne Wells
Colo. Springs
Cortez
Craig
Del Norte
Delta
Denver Area
Durango
Eads
Englewood
Estes Park
Fairplay
Florence
Fort Collins
Fort Lyon
Fort Morgan
Fruita
Glenwood Springs
Grand Junction
Greeley
Gunnison
Haxtun
Holyoke
Hugo
Julesburg
Kremmling
La Jara
La Junta
Lakewood
Lamar
Las Animas
Leadville
Longmont
Loveland
Meeker
Monte Vista
Montrose
Pueblo
Rangley
Rifle
Rocky Ford
Salida
Springfield
Steamboat Springs
Sterling
Trinidad
USAF Academy
Vail
Walsenburg
Walsh
Wheat Ridge
Wray
Yuma

COLORADO HOSPITAL ASSN. 2140 South Holly, Denver, Colorado 80222 (303) 758-1630

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

POUCH H 01 – JUNEAU 99811

April 25, 1980

Document# 90-80

The Honorable Glenn Hackney
Chairman, Senate HESS Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney:

In the course of testimony on Senate Bill 312 - State Aid for Service Programs for the Benefit of Older Alaskans - the Committee requested that the Department provide a priority listing for additional state service dollars. The Committee asked that the list be based on broad categories of services in order to allow the proposed Older Alaskans Commission latitude in defining the specific services to be covered.

The Office on Aging in our Department prepared the enclosed priority listing and is available to provide further clarification, if needed. The contact person who coordinated the preparation of the project is Danny Plotnick, who can be reached at 465-4903.

Thank you for allowing us the opportunity to comment on the matter.

Sincerely,

Deborah E. Behr
Special Assistant to
the Commissioner

Enclosure
cc: Senator Frank Ferguson
Senator Mike Colletta
Senator Bettye Fahrenkamp
Senator Arliss Sturgulewski
Senator Pat Rodey
Jim Kelly
DHSS, Office on Aging

06-F38LH

OFFICE ON AGING PRIORITIES FOR ADDITIONAL SERVICE DOLLARS

- April, 1980 -

Priority	Category of Service	Examples
1	Services to sustain more older persons in the least restrictive home environments	Increased availability of homemaker and home health services; adult day care; home repair
2	Services to fill gaps in health care	Purchase of hearing aids, eyeglasses, dentures; supplementary health screening and maintenance
3	Cost-effective alternatives to traditional nutrition service delivery methods	Bush meal services; shopping services; native and ethnic foods services; special diet services
4	Services to provide economic stability	Additional senior employment job slots; cottage industries
5	Services to increase accessibility to other services	More transportation; expanded and improved information and referral services; more out-reach; bush transportation
6	Services to upgrade the knowledge and skills of service deliverers to enable them to provide services more effectively	Service provider staff, board/council, volunteer training; circuit rider training
7	Services to provide social stimulation and combat isolation	More recreational and leisure-time services; visitor services; continuing education
8	Services to help older Alaskans receive public benefits to which they are entitled and resolve legal problems	Legal assistance; public benefits counseling
9	Services to extend lifetime productivity and promote feelings of usefulness	Volunteer programs, such as foster grandparents; continuing education
10	Counseling support	Personal counseling; tax counseling; employment counseling

STATE OF ALASKA

Interdepartmental Route Slip

TO: Mail Station	Department
3100	Legislature

Attention: Senator Ferguson

- [ ] Approval
- [ ] Signature
- [ ] Comment
- [ ] Contact Me
- [ ] Prepare Reply
- [ ] For Your File
- [ ] Note & Return
- [ ] Initial & Return
- [ ] Return as Requested
- [ ] Return for Approval
- [ ] Necessary Action
- [x] For Your Information

Remarks: Cap. Bldg. – Rm 123

FROM: Mail Station	Department
01000	DHSS

By: L. Rodriguez

Date: 4/25/80

02-002(Rev. 2/80)

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

POUCH H 01 – JUNEAU 99811

April 25, 1980

Document# 90-80

The Honorable Glenn Hackney
Chairman, Senate HESS Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

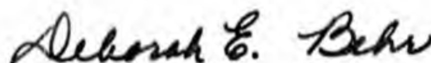
Dear Senator Hackney:

In the course of testimony on Senate Bill 312 - State Aid for Service Programs for the Benefit of Older Alaskans - the Committee requested that the Department provide a priority listing for additional state service dollars. The Committee asked that the list be based on broad categories of services in order to allow the proposed Older Alaskans Commission latitude in defining the specific services to be covered.

The Office on Aging in our Department prepared the enclosed priority listing and is available to provide further clarification, if needed. The contact person who coordinated the preparation of the project is Danny Plotnick, who can be reached at 465-4903.

Thank you for allowing us the opportunity to comment on the matter.

Sincerely,



Deborah E. Behr
Special Assistant to
the Commissioner

Enclosure
cc: Senator Frank Ferguson
Senator Mike Colletta
Senator Bettye Fahrenkamp
Senator Arliss Sturgulewski
Senator Pat Rodey
Jim Kelly
DHSS, Office on Aging

06-F38LH

OFFICE ON AGING PRIORITIES FOR ADDITIONAL SERVICE DOLLARS

- April, 1980 -

Priority	Category of Service	Examples
1	Services to sustain more older persons in the least restrictive home environments	Increased availability of homemaker and home health services; adult day care; home repair
2	Services to fill gaps in health care	Purchase of hearing aids, eyeglasses, dentures; supplementary health screening and maintenance
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STATE OF ALASKA

Interdepartmental Route Slip

TO: Mail Station	Department
3100	Legislature

Attention: Senator Fahrenkamp

- [ ] Approval
- [ ] Signature
- [ ] Comment
- [ ] Contact Me
- [ ] Prepare Reply
- [ ] For Your File
- [ ] Note & Return
- [ ] Initial & Return
- [ ] Return as Requested
- [ ] Return for Approval
- [ ] Necessary Action
- [x] For Your Information

Remarks:

Assembly Bldg.
Room 200

FROM: Mail Station	Department
0600	DHSS

By: L.H. Rodriguez   Date: 4/25/80

02-002(Rev. 2/80)

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

POUCH H 01 – JUNEAU 99811

April 25, 1980

Document# 90-80

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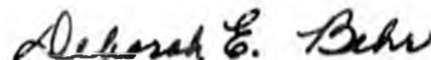

Deborah E. Behr
Special Assistant to
the Commissioner

Enclosure
cc: Senator Frank Ferguson
Senator Mike Colletta
Senator Bettye Fahrenkamp
Senator Arliss Sturgulewski
Senator Pat Rodey
Jim Kelly
DHSS, Office on Aging

06-F38LH

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- April, 1980 -

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STATE OF ALASKA

Interdepartmental Route Slip

TO: Mail Station	Department
3100	Legislature

Attention: Senator Colletta

- [ ] Approval
- [ ] Signature
- [ ] Comment
- [ ] Contact Me
- [ ] Prepare Reply
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- [ ] Note & Return
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- [x] For Your Information

Remarks:

Cap. Bldg.
Rm 111

FROM: Mail Station	Department
0600	DHSS

By	Date
L. H. Rodriguez	4/25/80

02-002(Rev. 2/80)

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER POUCH H 01 – JUNEAU 99811

April 25, 1980

Document# 90-80

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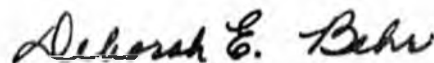

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Special Assistant to
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Senator Mike Colletta
Senator Bettye Fahrenkamp
Senator Arliss Sturgulewski
Senator Pat Rodey
Jim Kelly
DHSS, Office on Aging

06-F38LH

OFFICE ON AGING PRIORITIES FOR ADDITIONAL SERVICE DOLLARS

- April, 1980 -

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STATE OF ALASKA

Interdepartmental Route Slip

TO: Mail Station	Department
3100	Legislature
Attention: Senator Sturgulewski	

- ☐ Approval
- ☐ Signature
- ☐ Comment
- ☐ Contact Me
- ☐ Prepare Reply
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- ☐ Note & Return
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- ☐ Return as Requested
- ☐ Return for Approval
- ☐ Necessary Action
- ☑ For Your Information

Remarks: Assembly Bldg Room 100

FROM: Mail Station	Department
0600	DHSS
By: LA Rodriguez	Date: 4/25/80

02-002(Rev. 2/80)

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

POUCH H 01 – JUNEAU 99811

April 25, 1980

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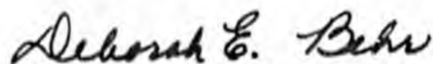

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DAN HUMPHREY - CPA - SEATTLE
West Vir. / S. Carolina has set up program for those two states
Fractious patients are as much care as more severly disabled co-operative patients.
Rate setting Commission or other entity.

Chris Beardsley
opposes - at this time

Provider & reimbursement Co.

Chris Beardsley left this memo for you. SB 322

3-19-80
3:05 P.m

Senator Hackney:

The Alaska State Hospital Assoc. met this morning and passed a motion relating to suggested language you could use for a Committee Substitute for SB 322 (re. to prospective rate setting for medicaid/medicare eligible patients). It was unanimously endorsed by all members including the long term care people.

A typed up version of this language will be submitted to you as soon as we can get it to you (probably within a couple of weeks).

A skeleton outline of the language includes:

1. A 2½ year study commission
2. Commission membership qualifications will be outlined.
3. although it may not be noted, the intent ~~[illegible]~~ probably would be to have the Commission be appointed by the Governor.
4. A suggested funding amount will be indicated (for per diems, transportation, making up of a report and hiring a consultant), however, we would appreciate your guidance and suggestions as to whether the amount is too little or too much.

Thank you for your help & guidance, and should you have any questions, please call me or Al Camosso.

Chris Beardsley

CS for House Bill 374

DRAFT

IN THE LEGISLATURE OF THE STATE OF ALASKA ELEVENTH LEGISLATURE - SECOND SESSION.

For an Act entitled: "An Act relating to nursing home care for elderly persons."

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

* Section ___. AS 47.25.301

Sec. 47.25.301. PURPOSE. It is declared as a matter of public concern that elderly persons in this state receive necessary quality nursing home care that they need. Certain elderly persons on fixed or low-incomes have been denied access to care because of the inability to pay.

Sec. 47.25.302. ELIGIBLE PERSONS. All residents of the state who are 65 years or older and determined to be needy based on regulations adopted by the department are eligible to receive assistance under this chapter. Eligibility shall be reviewed by the department as frequently as considered necessary.

Sec. 47.25.303. ~~MEDICAL~~ NURSING HOME CARE ASSISTANCE PAYMENTS. The payment and the length of time for which a ~~medical~~ NURSING HOME CARE assistance payment is granted are left to the discretion of the commissioner and may vary from a small sum to an amount not exceeding the existing rate paid under 47.07.010-.080. The commissioner may require the patient and the family to contribute to the cost of care.

Sec. 47.25.304. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include ONLY skilled and intermediate nursing home care.

Sec. 47.25.305. REIMBURSEMENT OF PROVIDERS. According to the provisions of this chapter, the department of health and social services shall reimburse providers of medical care for allowable unpaid costs of skilled or intermediate nursing home care.

VENDOR PAYMENTS

Sec. 47.25.306. CALCULATION OF THE PATIENT'S SHARE. (a) The department shall ~~adjust~~ establish, by regulation, a formula to determine the

patient's share of ~~institutional~~ nursing home care expenses, based on the applicant's annual gross income, number of dependents, amount of assets, and forthcoming third-party payments.

(b) In applying the formula to determine the applicant's share, the total gross income and the total assets of the family of the applicant may be taken into account with the following exceptions:

(1) the applicant's permanent place of abode;

(2) one noncommerical vehicle;

(3) tools, equipment, vehicles and other assets required in a trade of business;

(4) ordinary household and personal effects;

(5) $1,000 of liquid assets;

(6) all nonliquid assets unless such an exclusion would bring about an inequitable result; however, all income derived from such property shall be taken into consideration in determining the recipient's gross income;

(7) inalienable shares in a Native corporation created under the Alaska Native Claims Settlement Act, P.L. 92-203; 43 U.S.C. § 1601 et seq., for the period of their inalienability as specified in the Act;

(8) Alaska longevity bonus payments;

(9) any other assets specifically restricted for the use of the recipient by state or federal law;

(10) assets received by the applicant as a custodian, guardian, conservator, or trustee for another are not considered assets of the custodian, guardian, conservator, or trustee himself.

Sec. 47.25.307. OBTAINING ASSISTANCE BY FRAUD. A person is guilty of a violation of AS 47.25.120 - 47.25.300 if he (1) by a statement, representation, or impersonation which he knows is false or by another fraudulent device, obtains or attempts to obtain or aids or abets another to obtain (A) assistance to which he is not entitled, (B) greater assistance than he is entitled to, or (C) payment of a forfeited ~~grant or~~ allowance; (2) aids and abets in buying or otherwise disposing of the property of the recipient of assistance for the

DRAFT

purpose of avoiding liability for the assistance granted; or (3) gives false or incorrect information, knowing it to be false or incorrect, as part of the procedure to obtain assistance, even if he does not actually obtain or use the assistance.

Sec. 47.25.308. PENALTY FOR VIOLATION. A person who violates a provision of AS 47.25.120 - 47.25.300 is guilty of a misdemeanor, and upon conviction is punishable by a fine of not more than $1,000, or by imprisonment for not more than one year, or by both.

Sec. 47.25.309. DEFINITIONS. In this chapter (1) "applicant" means a person is IN NEED OF NURSING HOME CARE ~~to has suffered a catastrophic illness~~ and is applying for assistance in this chapter or is the subject of an application for assistance under this chapter;

(2) "commissioner" menas the commissioner of the department of health and social services;

(3) "department" means the department of health and social services;

(4) "family" means two or more persons related by blood or marriage or adoption living as one economic unit;

(5) "liquid assets" means assests which can be readily converted to cash;

(6) "nonliquid assets" means all assets which are not liquid assets;

(7) "permanent place of abode" means a dwelling, or a dwelling unit in a multiple dwelling, including lots and outbuildings or an appropriate portion of these, which are necessary to convenient use of the dwelling unit;

(8) "provider" means a licensed hospital, licensed skilled nursing home, or licensed intermediate care facility. ~~providing skilled or intermediate care needs which has provided services not excluded by AS 47.08.050 to an applicant;~~

(9) "third-party payments" means payments of medical expenses related ~~to a catastrophic illness~~ the nursing home care by sources other than

DRAFT

the applicant or the ~~committee~~, including but not limited to state and federal medical assistance programs, private health insurance, employment-related health insurance, military health insurance, workmen's compensation, violent crimes compensation, Indian Health Service of the United State Department of Health, Education, and Welfare, and awards in legal actions.

DRAFT

3-7-80

SB322 Prospective Reimbursement

The hospitals don't want this bill --- Nursing homes do.

Rod Betit explained line 13 mentioned in position paper. Hospitals & etc. use of the words intermediate and skilled- by adding "skilled we spell it out for them. He further mentioned that you had stated you might favor a CS and eliminate hospitals??????Max Kersbergen, executive director of Alaska State Hospital Assn. along with members thereof will be in Juneau March 17th,18th and 19th. They have left their afternoons open should you schedule this bill on any of days mention ed..

Good IDEA

Let me know that I can advise them.

MJ.

Last meeting we had on this bill was Jan.28th at which time we also had SB 320, SB321 and the minutes reveal that YOU said quote "We are treating these three bills more or less in the same package. Actually the first two are, I think it's safe to say, and either/or type of situation. Either we take one concept or the other. One being that the Sate of Alaska pays and the other being that the federal government pays half the money. I think that that's something we are going to have to work out philosophically as to whether we think it's worth the $500,000 or whatever to get the federal government involved.."

Our agenda reveals SB 320 and SB321 scheduled for March 17th. Do you wan't to add SB322 inasmuch as Alaska State Hospital Association will be here. March 17th is a Monday, the 19th is a Wednesday and these members will still be here in Juneau sooooo you have your choice as to whether you desire to have 3 bills of this type on one day or hold SB322 until Wed. the 19th.

INTRODUCTION OF BILLS (Senate)(cont'd)

Medicaid Reimbursable Payments

SENATE BILL NO. 322, by the Rules Committee by request of the Legislative Council (for the Interim Committee on Services for the Elderly. Repeals and re-enacts AS 47.07.070 regarding medicaid reimbursable payments to providers of health care. States payments to institutions for medicaid-eligible persons shall be made on the basis of a "prospective determination of fair rates for the reasonable costs of services rendered...." Provides Act effective July 1, 1980.

Introduced January 15 and referred to HE&SS and Finance.

ALASKA STATE HOSPITAL ASSOCIATION INC.

5401 CORDOVA STREET
PHONE: 277-1633
ANCHORAGE, ALASKA 99503

Mary - note - file SB322
⑤

February 26, 1980

Senator Glenn Hackney
Chairman - Health, Education, and
Social Services Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Hackney:

I am writing to indicate an opportunity for the Alaska State Hospital Association members to provide direct testimony on S.B. 322, during the spring meeting scheduled in Juneau on March 17-19. We have left our afternoons open for legislative availability, therefore, if your committee has questions or wished to have direct provider input we would gladly make any necessary arrangements.

You already have our position paper, however, we would offer still further testimony if you feel it would be meaningful.

Sincerely,

Max Kersbergen

Max Kersbergen
Executive Director