ALASKA LEGISLATURE COMMITTEE FILES 1999-2000 8672
10048 SENATE HEALTH EDUCATION & SOCIAL SERVICES

Changing the Culture

- Accountability. We all must agree on results we seek.
- Consistency in purpose and direction. Needs to be a way of life, a way of thinking.

What we have done

- Trained boards & departments in results-based planning.
- Agreed on some basic language & results in the CIMHP process.

CIMHP
Comprehensive
Integrated
Mental Health
Program

Results we are looking for

- Are Trust beneficiaries healthy?
- Are they safe?
- Are they economically secure?
- Are they productively engaged or in school?
- Are they living with dignity, as valued members of their communities?

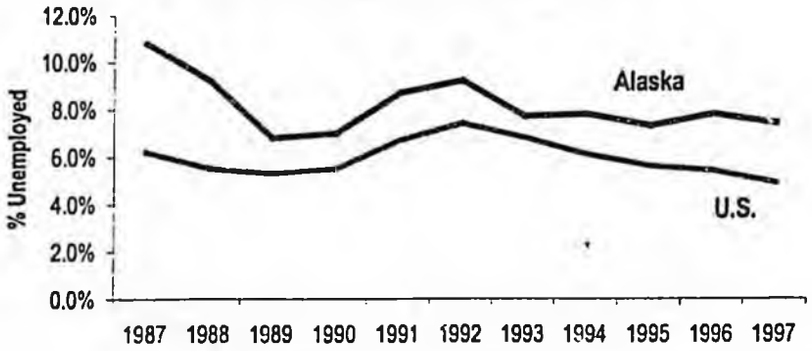
Examples of indicators

- To see if Alaskans are healthy, look for
  - rates of alcohol consumption & alcohol-related deaths
  - rate of hospital admission for mental illness, substance abuse, disability, or aging problems
  - rate of preventable birth defects
- To see if beneficiaries are healthy compared to all Alaskans, look for
  - chronic alcohol use
  - rate of admission to hospitals
  - rates of disabling conditions

RESULT #4: PRODUCTIVELY ENGAGED, EMPLOYED,CONTRIBUTING

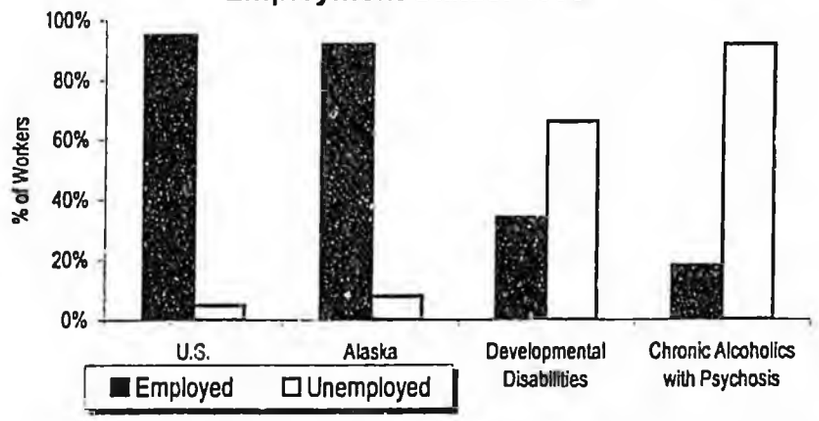
Indicator Baselines:

Unemployment: Alaska and U.S.



Government Information Sharing Project, Oregon State University, http://govinfo.kerr.orst.edu/

U.S., Alaska and Trust Beneficiary Employment Status: 1996



Government Information Sharing Project, Oregon State University, http://govinfo.kerr.orst.edu/

Response to Mental Health Trust Authority Request for Recommendations, Advisory Board on Alcoholism and Drug Abuse, June 1996

Alaskans with Developmental Disabilities: A Report to the Mental Health Trust Authority on the Status and Living Conditions of the Beneficiaries, Governor's Council on Disabilities and Special Education, July 1996

The Story Behind the Baselines: Data on employment, unemployment, hours and wages are collected and published monthly by the Alaska Department of Labor.

Unemployment in Alaska varies greatly with the season. In 1996, the statewide rate of unemployment ranged from 9.7% in January to 5.5% in August. Unemployed rates also vary according to region or community. Traditional methodologies for determining unemployment do not work well in Alaska's smaller, more remote villages, where few jobs are available. Many people in these communities rely on a traditional subsistence lifestyle. Hunting, fishing and gathering wild foods form the basis of a non-cash economy. Often, people living in these communities have given up on actively seeking employment and are not counted in local or state statistics. In many of these communities, it is estimated that more than 75% of the adults are not working at cash jobs.

There is currently limited data available on the employment status of beneficiaries of the Alaska Mental Health Trust Authority. The Advisory Board on Alcoholism and Drug Abuse reported that 92% of the chronic alcoholics with psychosis who receive state funded substance abuse services are unemployed. Approximately two-thirds (66%) of adults with developmental disabilities in state services are unemployed.

National sources estimate that up to 65% of adults with a variety of disabilities are unemployed. Even when Trust beneficiaries are employed, they are often in part-time, low paying jobs. Beneficiaries remain in these jobs because, if they worked longer hours or made more money, they would lose their eligibility for Medicaid, which is often their only source of health insurance.

Current Efforts to Turn the Curve: Some of the strategies that are proving effective at increasing employment opportunities for beneficiaries are employment training programs like those provided by the Division of Vocational Rehabilitation and the Private Industry Council. Developmental disability and mental health employment support programs provide on-the-job employment readiness training and support for workers. Senior employment programs provide many seniors with jobs as senior volunteers and helps train seniors to acquire unsubsidized employment. The Alaska Legislature is currently considering a bill that would allow people with disabilities to retain Medicaid coverage while working. Programs like elder care and respite make it possible for caregivers of people with Alzheimer's Disease to continue working.

Requesting Funding Recommendations

RFR Process

Four boards recommend funding to the Trust:

- Budget recommendations to the Trust should be result-oriented.
- Boards describe their overall strategies.
- Boards explain how budget recommendations help Trust beneficiaries.
- Boards help track progress of programs we fund.

GOVERNOR'S COUNCIL ON DISABILITIES AND SPECIAL EDUCATION

INVESTING IN RESULTS
OUTCOME BASED DECISION MAKING

Alaskans who experience developmental disabilities want results, not activities, from programs. They also want outcome measures in place so they can determine if their desired results are being achieved. The results that Alaskans with disabilities want and some proposed outcome measures are presented below across the six major life domains: community living, education, employment, health care, housing and transportation.

COMMUNITY LIVING

Results	Outcome Measures
Every individual is a valued, participating member of his or her community.	• Number and percent of people who are registered voters • Decrease in funds expended for services provided in institutions (e.g. API, hospitals, nursing homes or jail)
People receive prevention and early intervention services.	• Number and percent of people, especially infants and toddlers, who need fewer specialized services • Decrease in the incidence of high cost crisis situations

EDUCATION

Results	Outcome Measures
Students reach their educational goals and potential.	• Number and percent of students who graduate from high school with jobs or post-secondary education plans in place • Number and percent of students who are making progress in classrooms with children who do not have disabilities • Number and percent of students who meet or exceed performance standards

EMPLOYMENT

Results	Outcome Measures
People get and keep employment consistent with their interests, abilities and needs.	• Number and percent of people who maintained employment at 6, 12, 24 and 36 months • Number and percent of people who own their own businesses • Number and percent of people who are employed in jobs with health care benefits

HEALTH CARE

Results	Outcome Measures
People are healthy and benefit from the full range of needed health care services.	• Decrease in the utilization of high cost acute care or emergency room services • Number and percent of low birth-weight babies • Number and percent of survivors of head injuries or spinal cord injuries

HOUSING

Results	Outcome Measures
Adults choose where and with whom they live.	• Number and percent of people who own their own homes • Number and percent of people who are living safely in the community

TRANSPORTATION

Results	Outcome Measures
People are able to get to where they want to go when they want to go.	• Increase in the availability of accessible transportation • Number and percent of people who use less expensive fixed route systems as compared to those who use paratransit systems

The results presented here are not unique to people who experience developmental disabilities. However, Alaskans who experience disabilities are less likely to achieve these results than the average Alaskan. People who experience disabilities have identified a number of reasons for this discrepancy, including:

1. their unique needs for physical accessibility, access to transportation, assistive technologies, and individualized and family supports;

2. the general lack of public awareness about the needs, rights and responsibilities of people who experience disabilities; and

3. limited incomes, which further prevent their full participation in community life.

Harborview Developmental Center

What we said we would do

- Close HDC.
- Move residents to community.
- Re-allocate funds to more effective programs.

What we did

- Partnered with AHFC & DHSS for special needs housing.
- Subsidized cost of HDC for 3 fiscal years.
- Supported development of necessary community services.

How well we did

- HDC closed 12/31/97.
- Everyone moved to community
- Services funded to meet individual needs.

Strategies: Rewarding success

- Re-distribute HDC funds to DD services
  - serve people waiting longest
  - minimal "core" services
  - small safety net

Validating & monitoring investment

- Funded a deinstitutionalization study.

Date: February 29, 19

ICF/MR and IMH Census

Psychiatric Beds	Per Diem Rate	Certified Beds	Current Occupancy				Current Census	Vac Bed
			Medicaid			Non-Medicaid		
			Total	Under 22	Over 65			
Alaska Psychiatric Institute, Anchorage	252.24	174	17	16	1	100	117	57
Charter North Anchorage	N/A	60	18	18	-0-	38	56	4

ICF/MR Beds	Per Diem Rate	Certified Beds	Current Occupancy		Total Census	Vacant Beds
			Medicaid	Non-Medicaid		
Harborview Developmental Center, Valdez	202.00	64	56	2	58	6
Hope Cottages, Anchorage	261.49	40	40	-0-	40	-0-

Karen Martz 5/10/88

Karen Martz Date
Division of Medical Assistance
(907) 561-2171

ICF/MR AND IMH CENSUS

AS OF: DECEMBER 31, 1997

PSYCHIATRIC BEDS	PER DIEM RATE	CERTIFIED BEDS	CURRENT OCCUPANCY			TOTAL CENSUS	VACANT BEDS
			MEDICAID UNDER 21	MEDICAID 65 & OVER	NON-MEDICAID		
ALASKA PSYCHIATRIC INSTITUTE Anchorage	$758.48	114	2	0	70	72	42
CHARTER NORTH HOSPITAL Anchorage	N/A	74	17	0	11	28	46
NORTH STAR HOSPITAL Anchorage	N/A	34				0	34

ICF/MR BEDS	PER DIEM RATE	CERTIFIED BEDS	CURRENT OCCUPANCY		TOTAL CENSUS	VACANT BEDS
			MEDICAID	NON-MEDICAID		

1/7/98

SHELBERT LARSEN, ADMINISTRATOR — DATE
DIVISION OF MEDICAL ASSISTANCE (907) 561-8081
HEALTH FACILITIES LICENSING & CERTIFICATION

Become State in the Nation that has No Developmental Disability as the Responsibility

Hope Cottages ICFs-MR

What we said we would do

- Close the ICFs-MR.
- Move residents to smaller community settings.
- Re-allocate funds to more effective programs.

What we did

- Partnered with AHFC & DHSS for special needs housing.
- Supported development of necessary community services.

How well we did

- ICFs-MR closed 7/1/96.
- Everyone moved to community settings of their choice.
- Services funded to meet individual needs.

Strategies: Rewarding success

- Re-distribute ICF-MR funds to DD Waiver services

Housing

What we said we would do

- Partner with AHFC on institution closure.

What we did

- Closed Harborview & Hope ICFs.
- Special Needs Housing with AHFC, DHSS, & DSS.

How well we did

- Institution residents now in community.
- People can stay home with housing modifications.

What we are doing

- Moving long-term API residents into community-based housing.
- Domiciliary care for chronic alcoholics.
- Pioneer Homes renovations.
- Facility & ADA upgrades.
- AHFC loan program changes.

Strategies: rewarding success

- Include AHFC funding in MH budget.
- Homeless Assistance Program.
- Match for Federal & Other Grants for transitional housing programs.
- Special Needs Housing: first at DHSS, now at AHFC.

Validating & monitoring investment: Look for

- AHFC training for communities on accessing housing finance for vulnerable populations
  - Clarifying roles for housing & supports

Alcohol and Drug Abuse

Culture change predates the Trust

- Leg Audit promoted change

What we did

- Learned from the data.
- Funded domiciliary program in Fairbanks, in partnership with AHFC's Special Needs Housing.
- Funded case management and day treatment for people with dual diagnosis.
- Funded trauma study with Providence
- Funded enhanced detox beds at Clitheroe.

Strategies

- Increase enhanced detox: API community implementation project.
- Fund women's services in places their children can also stay.
- FAS prevention.

Validating & monitoring investment

- Educate providers on leveraging funds for domiciliary care.
- Watch Homeward Bound Project.

Department of Corrections

What we said we would do

- Fund a study of Trust beneficiaries in DOC custody.
- Fund a planner at DOC to ensure collaboration on behalf of beneficiaries.

What we learned

- 19% of people at DOC have mental illness & 29% have significant drug or alcohol problems.
- 38% of women at DOC have mental illness.
- No services for women with mental illness.

What we did

- With LB&A & DOC, developed a strategy to create & fund a women's mental health unit.
- Fully funded women's unit for FY98.
- Funded the planner.

How well we did

- Women's unit opened late 1/98.
- Integrated DOC & mental health planning.

Strategies

- Fund 2/3 of the women's unit for FY99.
- Increased 6th Ave. jail mental health staff.
- Hired UW psych interns.
- Funded misdemeanant diversion project.

Validating & monitoring investment

- Improvement in mental health status of individuals with mental illness at DOC.
- # of people diverted by misdemeanant project.

Healthy Families

What we said we would do

- Fund pilot program that offered results-based services.

What we did

- Fund expanded pilot program FY97, 98, and 99.

How well the program did

- Serving 303 families in 8 communities as of 9/30/97.
- decreased child abuse rates for participants.
- increased employment rates.

Strategy:

Validating & measuring investment

- Fund the program evaluation in FY99 and FY00.
- 94% of families had no abuse or neglect, when 30% would have (statistically validated instruments used on Lower 48 groups).
- Estimated DFYS cost savings of $169-225,000 (DHSS, DPH, MCFH).

Seniors

What we said we would do

- Pilot for mental health needs of elderly
- Develop data system to track senior service use

What we did

- Dementia training kit & distance education.
- Increased care coordination for seniors.
- Pioneer Homes renovations
- Construct adult day care in Chugiak & Palmer

How well we did

- Dementia training across the state.
- Care coordination promotes better use of community resources.

What we are doing now

- Identifying beneficiaries in senior services.

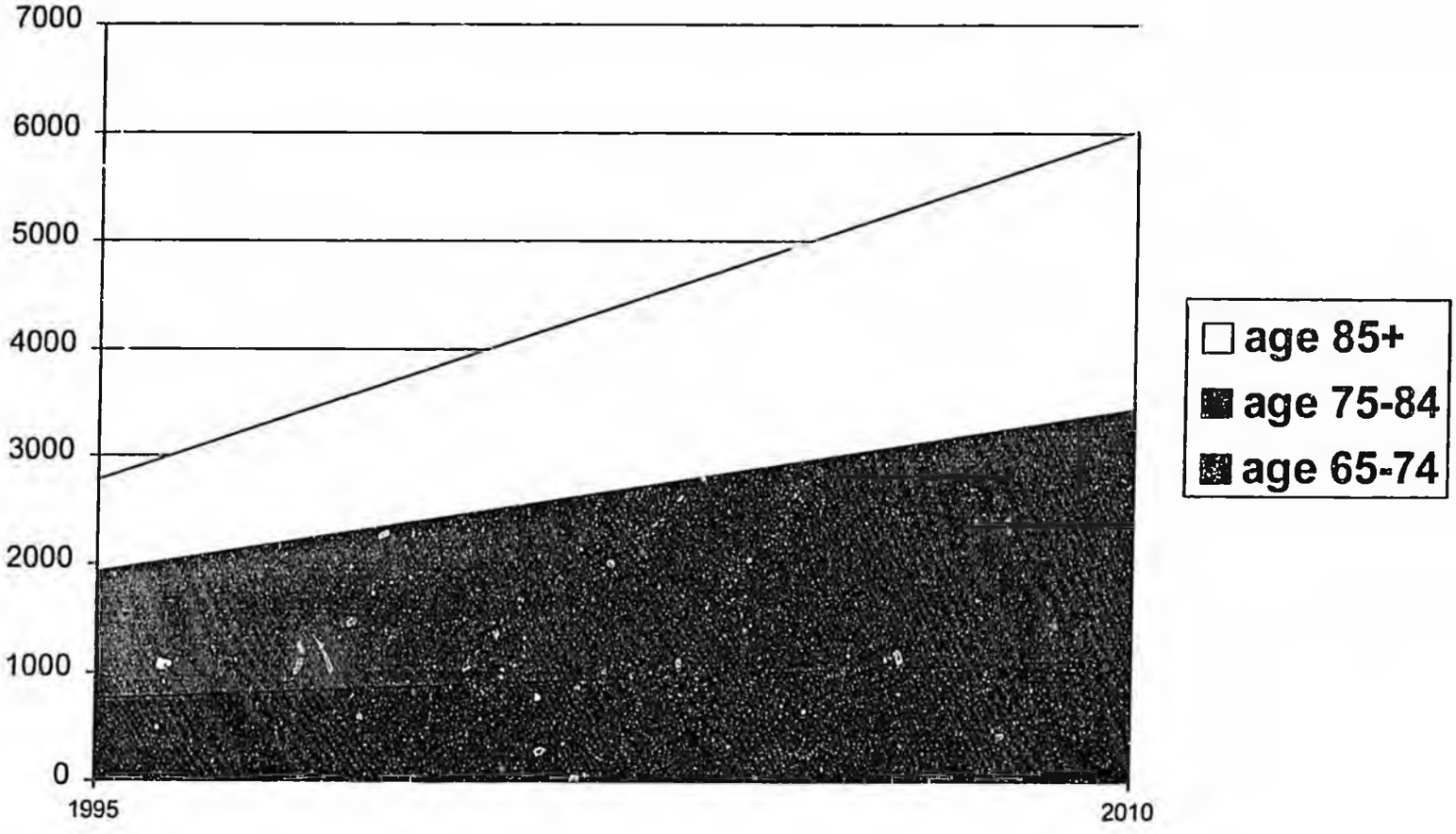
Strategies

- Hire Pioneer Home Aides.
- Build capacity: riding the wave.
- Re-invest savings from the Longevity Bonus to senior programs.
- Supplement General Relief--long term care funding.

Validating & monitoring investments

- Assisted Living Rate Study
- Re-engineering the Guardianship system.
- Adult Protective Services/General Relief data system.
- *Look for ACoA Data base systems to tell how many people used services.*

Dementia growth 1995-2010



Mental Health

What we said we would do

- Divert people from hospitalization.
- Move individuals from Sourdough at Harborview into community.
- Pilot an independent care coordination model for disturbed children.

What we did

- Funded diversion & crisis respite.
- Closed Harborview.

How we did

- Hospitalizations are down.
- Individuals from Sourdough are in communities.
- Independent care coordination is hard to implement.
- Community mental health Medicaid costs are stabilizing.

What we are doing now

- Quality Assurance audits.
- Developing a QA program.
- Developing program standards.
- Managed mental health care study.

Strategies

- Closely track Medicaid expenditures for mental health services.
- Managed care review--best uses of mental health funds.
- Enhanced services to people who have mental illness and who are drinking.

Validating & monitoring investment

- Community services should result in decreased hospital need.
- Are consumers healthier? Safer? More economically independent?

Mental Health Quality Assurance

- *Consumer Satisfaction/Quality of Life* An increase in consumer satisfaction and positive outcomes from services.
- *Quality of Services* Development of combined integrated administrative standards (MH/DD/ILP) and refinement of specific direct service delivery standards.
- *Fiscal Accountability* The need to monitor the use of State dollars (both Medicaid and grant funds) used by grantees of DMHDD.
- *Follow-up/Plan of Improvement* To ensure that corrective action is taken when the need for change is identified.
- *Cost Effectiveness of Site Reviews* A consolidated review process that is efficient and useful to service providers, consumers, and the State while costing less than multiple fragmented reviews.
- *Combined and Strengthened On-Site Reviews with minimal disruption* Consolidate the strengths of the various past site review processes coupled with combined team to minimize community disruption (number of site visits) associated with multiple site reviews.

Economic Security

What we said we would do

- Help Trust beneficiaries at risk of losing SSI, APA, & Medicaid because of federal rule changes.

What we did

- Funded SSI re-determination for alcoholics with psychosis & children with disabilities.

How well we did

- Estimated 1,000 beneficiaries would lose benefits; about 150 actually lost SSI and Medicaid.

What we are doing now

- Funding an Economic Development Consortum using existing small business development sources.

Strategies

- Analysis of economic impacts on seniors of declining income, learning how seniors pay their way.

Validating & monitoring investment

- Funding a cooperative effort on Employment Initiatives
  - finding out what helps beneficiaries stay employed.

Better use of existing resources

- Mental Health Managed Care Study
  - emerging indicators: housing, employment
- Waiver Review
  - 5 years of DD waivers
- Coordinated transportation
  - leverages federal funds
- Data integration
  -- comparing info across systems
- Assessment of facilities
  - prioritizing upgrades
- Task force on insurance coverage for mental health and substance abuse services
- Guardians for vulnerable adults

FY00 Operating & Capital Recommendations

GF/MH Base	$118,077.6
Adjustments to GF/MH Base	$4,045.5
GF/MH (w/o API capital)	$9,365.0
AHFC	$3,562.5
Trust funding	$9,038.0

Flood Governor's Office c̄ letter to
support & include in Governor's
bill ASST lir.

SB

48

FISCAL NOTE

STATE OF ALASKA **BILL NO.** SB 48
1999 LEGISLATIVE SESSION

Revision Date/Time (Note if correction) _____ Dept. Affected Commerce & Economic Development
Title An Act relating to Health Insurance provided and provisions relating to the Comprehensive Health Insurance Association BRU Insurance
Component Insurance
Sponsor Senator Mackie
Requester _____ Component Serial No. 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY99) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill has no fiscal impact on this component.

Prepared by Marianne K. Burke, Director Phone 465-2215
Division Insurance Date/Time 2/18/99 3:13 PM
Approved by Commissioner Deborah B. Sedwick Date 2/19/99
Agency Commerce & Economic Development

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SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/28/99

FURTHER: Labor and Commerce

Date of 5-Day Notice: 2-18-99
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/2/99

HESS Committee considered SENATE BILL NO. 48

"An Act relating to health insurance provided by and provisions relating to the Comprehensive Health Insurance Association."

and recommends:

[✓] be **replaced** with ____ CS SB 48 (HES) (HESS)

[ ] adopt **previous** ____ CS _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to the _____ Committee

Senate Bill:
[ ] same title
[ ] new title

House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR#_____

SIGNING DO PASS	*DP*	*OTHER RECOMMENDATIONS*	*NR*	*DNP*	*AM*
	✓		✓		
			✓		
CHAIR:	✓	*CHAIR:*			

NEW FISCAL NOTE(S):

Department	Date	Zero	Fiscal
Commerce and Economic Development	2/24/99	✓	

PREVIOUS FISCAL NOTE(S):*

Department	Date	Zero	Fiscal

[ ] **APPROPRIATION -- no fiscal note**

***include fiscal notes accompanying Governor's bill**

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ALASKA STATE LEGISLATURE

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SENATOR JERRY MACKIE

SENATE MAJORITY LEADER

February 10, 1999

MEMORANDUM

To: Senator Miller, Chair
Senate Health & Social Services Committee

From: Senator Mackie

Re: SB 48, Comprehensive Health Insurance.

I would much appreciate your scheduling SB 48 for a hearing in the HESS committee at the earliest convenience. The sponsor statement, sectional, and other support documentation is forthcoming.

Thank you for your attention to this request.

SENATE DISTRICT C Kodiak Island/Southeast Islands
Senator_Jerry_Mackie@legis.state.ak.us

Comprehensive
Health
Insurance
Association
P.O. Box 240723
Anchorage, AK 99524-0723

February 2, 1999

The Honorable Jerry Mackie
Alaska State Senate
State Capitol Room 427
Juneau, AK 99801-1182

Dear Senator Mackie:

I was very pleased to hear from your aide, Dave Gray, today regarding the legislation introduced in SB 48. In response to the discussion he and I had concerning this legislation, I would like to indicate in writing the reasons that the Board supports these changes to AS 21.55. In fact, this legislation was developed by the Comprehensive Health Insurance Association's Board of Directors. The Board is composed of five representatives from the top health insurers in Alaska and two consumer members. The Board has spent many hours of basically volunteer time managing this program. Several of us have been with the Board since it was formed in late 1992. We have a passion to make it work the best that it can for the citizens of Alaska.

It is for that reason that we have developed these proposed changes; to make the program work better and more efficiently. I can assure you that these changes will in no way reduce the options provided to the policyholders. In fact it should make it easier for citizens to prove that they qualify while giving the Board greater flexibility in managing the program and reducing the administrative costs.

Specifically, this legislation amends AS 21.55 to

1. Allow the Board greater flexibility to design more cost effective health insurance plans for individuals eligible for coverage under the CHIA plan.
2. Increase the number of potential administrators of the CHIA by eliminating the requirement that the administrator be an insurer.
3. Allow greater flexibility in evaluating an administrator and in setting the terms of the administrative contract.

4. Simplify administration by decreasing the number of declinations required for eligibility.
5. Make technical corrections relating to the determination of premium rates, terminology, premium payment modes, board member terms, definitions and voting at Board meetings.
6. Give the Director of Insurance a more effective and appropriate mechanism to enforce the requirement that members pay their share of the CHIA assessments on a timely basis.

I believe that Director Burke indicated that the Division of Insurance was also in support of this legislation. The Board is appreciative of the assistance that the Division gives it in administering the program.

Finally, it is necessary that I indicate that a few minor changes to the legislation as introduced last year and again this year, are desirable. These changes are described in an attachment. Also enclosed with this letter, please find a Sectional Analysis of the legislation

The Board is enthused about the advancement of this legislation. We stand ready to aid in whatever way we can. If you would like to have one or more of us testify at any hearings, please let us know so that we can arrange schedules to comply. If you have need of any other information please let us know. My telephone number is (402) 351-2534. My fax is (402) 351-5944 and my e-mail is cecil.bykerk@mutualofomaha.com.

Sincerely,

Cecil D. Bykerk, FSA, MAAA
Chair, Comprehensive Health Insurance Association

cc: Director Marianne Burke

Attachments

REQUESTED CHANGES TO SB 48

Please note the items in blue on the attached marked copy of SB48.

In Sections 2, 3, 4 and 20, the indicated changes are of a technical nature so as to properly define or to make proper reference.

The change in the maximum out-of-pocket limit in Section 7 of the bill from $2,500 to $1,500 was originally requested by the consumer members of the Board. This change would ensure that at least one plan of insurance would be offered that had a maximum out-of-pocket limit of $1,500.

The change in Section 14 would provide for more effective and appropriate enforcement of the requirement that members pay their share of the CHIA assessments on a timely basis.

These changes were unanimously endorsed by the Board and fully supported by the Division of Insurance.

We hope that these changes can be made with minimal disruption to the process. We apologize that the original legislation submitted in 1998 failed to incorporate these changes.

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SENATOR JERRY MACKIE

SENATE MAJORITY LEADER

Sponsor Statement

SB 48, State Health Insurance

The board of directors of the Comprehensive Health Insurance Association developed this proposed legislation. The association makes individual health insurance available to residents who are high risks or are federally defined eligible individuals. The association's directors represent the principal providers of health insurance in Alaska. The legislation has the support of the Division of Insurance.

This legislation amends AS 21.55 to

1. Allow the board greater flexibility to design more cost effective health insurance plans for individuals eligible for coverage under the CHIA plan.
2. Increase the number of potential administrators of the CHIA by eliminating the requirement that the administrator be an insurer.
3. Allow greater flexibility in evaluating an administrator and in setting the terms of the administrative contract.
4. Simplify administration by decreasing the number of declinations required for eligibility.
5. Make technical corrections relating to the determination of premium rates, terminology, premium payment modes, board member terms and voting at board meetings.
6. Give the director of insurance a more effective and appropriate mechanism to enforce the requirement that members pay their share of the CHIA assessments on a timely basis.

The legislation will allow the board to mange the CHIA in a more cost effective and efficient manner. Also, the legislation is particularly important in light of the new federal requirements and the use of CHIA as the mechanism to guarantee portability of health insurance coverage to federally eligible individuals.

SENATE DISTRICT C Kodiak Island/Southeast Islands
Senator_Jerry_Mackie@legis.state.ak.us

Sectional Analysis

"An Act relating to the Comprehensive Health Insurance Association"

Section. 1. AS 21.55.020

Amendments to this section clarify the voting methodology to be used in board and association meetings and establish reasonable terms for members of the board.

Current law defines the voting methodology to be used at association meetings as premium weighted. However, this methodology is not appropriate for board meetings, since the public members would not have a vote and the small insurers would essentially have no vote due to the fact that, Alaska's health insurance market is overwhelmingly dominated by only a few carriers. Therefore, amendments to this section clarify that each member receives only one vote at board meetings giving proper representation of the members of the board.

Sec. 2. AS 21.55.100(a)
Sec. 4. AS 21.55.100(d)
Sec. 6. AS 21.55.120(a)
Sec. 7. AS 21.55.120(c)

Amendments to these sections allow the board greater flexibility in developing cost-saving health benefit plans for high risk individuals by expanding the deductible, coinsurance and out-of-pocket maximum options and providing for more appropriate out-of-pocket limits in relation to the deductible. These changes will also allow for the development of a structure that encourages more cost-effective use of services.

Sec. 3. AS 21.55.100(c)

Amendments to this section clarify that coverage under the CHIA plan is available to all persons eligible under the chapter which is consistent with AS 21.55.100(a) and (d).

Sec. 9. AS 21.55.150

Amendments to this section eliminate the conflict between the requirement that the premium rates not be excessive or inadequate and the requirement that premium rates not be greater than 200% of standard premium rates. CHIA is essentially a pool for uninsurable health insurance risks, which means in general that the premium rates will not be adequate to cover the costs.

Also, the current requirements regarding the calculation of the premium rates are amended to allow additional flexibility in determining the premium rates. Current statute requires that the premium rates be based on standard rates of the top 5 insurers in the state. Since there are fewer than 5 significant individual comprehensive health insurers in the state, this basis for calculating the premium rates results in the use of rates that are not necessarily appropriate for the Alaska market.

Sec. 10. AS 21.55.200
Sec. 23. AS 21.55.500

The amendments to these sections allow greater flexibility in selecting an administrator and strengthen the criteria under which a plan administrator will be evaluated.

Since the inception of CHIA, only one insurer has offered to administer the plan. Amendments to these sections will increase the number of potential administrators by eliminating the requirement that the administrator be an insurer. This should result in reduced administrative costs by opening the door to many other entities that have an expertise in administration of individual health insurance type contracts. The greater number of bidders should result in better bargaining power for CHIA in negotiating administrative fees and services. CHIA's administrative expenses are currently the highest in the nation.

Sec. 11. AS 21.55.210
Amendments to this section will allow greater flexibility in evaluating an administrator and in setting the terms of the administrative contract.

Sec. 14. AS 21.55.220(d)
The first amendment to this subsection will give the director a more effective and appropriate mechanism to enforce the requirement that members pay their share of the CHIA assessments on a timely basis. This amendment establishes a monetary penalty for failure to pay within the established timeframe.

The second amendment will allow the board to excuse members from assessment, if the assessment amount is minimal. This will give the board the flexibility to determine the level of assessment at which it becomes cost prohibitive to assess a member.

Sec. 17. AS 21.55.330
The amendment to this section clarifies that monthly premium modes would be acceptable. Allowing a monthly premium mode is particularly important for the individuals in the CHIA plans, since premiums are relatively high.

Sec. 20. AS 21.55.500(6)
The amendment to this section corrects a minor error in the definition of a "federally defined eligible individual". The current law does not conform with federal law.

Sec. 21. AS 21.55.500(18)
The amendment to this section modifies the definition of "residents who are high risks" in order to simplify the eligibility requirements to allow an individual with only one declination to be eligible for coverage. Under current law individuals must wait to receive two formal declinations in order to prove eligibility under the plan. This often results in a long waiting period for the individual before they can be covered under the CHIA plan.

Sec. 23. AS 21.55.500(22)
This amendment defines the term "plan administrator".

Sec. 24.
This section repeals unnecessary provisions. AS 21.55.120(d) is no longer needed since reference to the consumer price index has been removed in AS 21.55.120(a) and (c). AS 21.55.120(e) is no longer needed since the provisions in AS 21.55.100(a) and (d) allow this flexibility. AS 21.55.500(21) is no longer needed since it is replaced with the more appropriate term "plan administrator".

Sec 5.
Sec. 8.
Sec. 12.
Sec. 15.
Sec. 16.
Sec. 18.
Sec. 19.
Sec. 22.
Amendments to these sections simply change the term "writing carrier" to "plan administrator" which is defined in AS 21.55.500(22). The term "writing carrier" is a misnomer as it implies that the administrator of the CHIA is insuring the plan when in fact the CHIA is the "insurer".

SLA 92

AN ACT

Relating to pooled health insurance for individuals who are uninsured or denied adequate coverage; and providing for an effective date.

• Section 1. PURPOSE. It is the purpose of this Act to provide access to health insurance to all residents of the state who are presently denied adequate health insurance or who are considered uninsurable.

• Sec. 2. AS 21 is amended by adding a new chapter to read:

CHAPTER 55. STATE HEALTH INSURANCE.

ARTICLE 1. COMPREHENSIVE HEALTH INSURANCE ASSOCIATION.

Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a nonprofit incorporated legal entity to be known as the Comprehensive Health Insurance Association. Membership consists of all licensed hospital or medical service corporations in the state that offer subscriber contracts for major medical coverage and all insurers licensed to transact health insurance in the state that offer policies for major medical coverage on an expense incurred basis.

Cross references. — For statement of legislative purpose in enacting this chapter, see § 1, ch. 126, SLA 1992 in the Temporary and Special Acts.

Article 1. Comprehensive Health Insurance Association.

Sec. 21.55.010. Creation; membership. There is established a nonprofit incorporated legal entity to be known as the Comprehensive Health Insurance Association. Membership consists of all licensed hospital or medical service corporations in the state that offer subscriber contracts for major medical coverage, all health maintenance organizations or other managed care arrangements approved by the director, and all insurers licensed to transact health insurance in the state that offer policies for major medical coverage on an expense incurred basis. All members shall maintain membership in the association as a condition of doing health insurance business, or being able to offer subscriber contracts or enrollment in a health maintenance organization or managed care arrangement, in the state. (§ 2 ch 126 SLA 1992; am § 2 ch 125 SLA 1994)

Effect of amendments. — The 1994 amendment, effective July 1, 1994, inserted ", all health maintenance organizations or other managed care arrangements approved by the director," in the second sentence and inserted "or enrollment in a health maintenance organization or managed care arrangement" in the last sentence.

Sec. 21.55.020. Board of directors; organization. (a) The board of directors of the association shall be made up of seven individuals. Five board members shall be selected by participating members, subject to approval by the director of the division of insurance, and two board members shall be consumers selected by the director of the division of insurance. The director or the director's designee shall serve as a nonvoting ex officio member of the board. In determining voting rights at members' meetings, a member is entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's premiums for health insurance for major medical coverage on an expense incurred basis, or the member's subscriber fees, derived from or on behalf of state residents in the previous calendar year, as determined by the director. In approving members of the board, the director shall consider, among other things, whether all types of participating members are fairly represented. Members of the board may be reimbursed from the association for expenses incurred by them as members, but may not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

(b) The board shall study and prepare a report at least once every three years on the effectiveness of this chapter. The report must include an analysis of the effectiveness of this chapter in promoting rate stability, product availability, and affordability of coverage. The report may contain recommendations for legislative or other regulatory action. The board shall notify the legislature that the report is available. (§ 2 ch 126 SLA 1992; am § 42 ch 21 SLA 1995)

Effect of amendments. — The 1995 amendment, effective August 8, 1995, in subsection (b), substituted "prepare a report" for "report to the legislature" in the first sentence and added the last sentence.

Sec. 21.55.030. General powers. The association may

(1) exercise the powers granted to insurers under the laws of the state;

(2) sue or be sued;

(3) enter into contra
other persons for the p

(4) establish admini
association; and

(5) receive funds fron
1992)

Sec. 21.55.040. Plar
a plan of operation and
and equitable administr
become effective upon
submit a suitable plan
association fails to subm
and hearing, adopt re
provisions of this chapte
director or superseded
director.

(b) All members of th

(c) The plan of operat

(1) establish procedu
this chapter will be per

(2) establish procedu

(3) establish the amo
under AS 21.55.020;

(4) establish regular

(5) establish procedu
association, its agents,

(6) provide that a m
association may appeal

(7) establish procedur
to the director;

(8) contain additional
and duties of the associ

Sec. 21.55.050. Adm
44.62 (Administrative P

Sec. 21.55.060. Tax
and taxes levied by the s
or personal property. (§

Articl

Sec. 21.55.100. Type
to residents who are hig
state plan of health insu
deductibles as described
tives.

(2) sue or be sued;
(3) enter into contracts with insurers, similar associations in other states, or with other persons for the performance of administrative functions;
(4) establish administrative and accounting procedures for the operation of the association; and
(5) receive funds from sources other than members of the association. (§ 2 ch 126 SLA 1992)

Sec. 21.55.040. Plan of operation. (a) The association shall submit to the director a plan of operation and amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and amendments become effective upon approval in writing by the director. If the association fails to submit a suitable plan of operation by December 22, 1992, or if at subsequent time the association fails to submit suitable amendments to the plan, the director may, after notice and hearing, adopt reasonable regulations necessary or advisable to effectuate the provisions of this chapter. These regulations shall continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director.
(b) All members of the association shall comply with the plan of operation.
(c) The plan of operation shall
(1) establish procedures whereby all the powers and duties of the association under this chapter will be performed;
(2) establish procedures for handling assets of the association;
(3) establish the amount and method of reimbursing members of the board of directors under AS 21.55.020;
(4) establish regular places and times for meetings of the board of directors;
(5) establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;
(6) provide that a member insurer aggrieved by a final action or decision of the association may appeal to the director within 30 days after the action or decision;
(7) establish procedures whereby selections for the board of directors will be submitted to the director;
(8) contain additional provisions necessary or proper for the execution of the powers and duties of the association. (§ 2 ch 126 SLA 1992)

Sec. 21.55.050. Administrative Procedure Act. The association is exempt from AS 44.62 (Administrative Procedure Act). (§ 2 ch 126 SLA 1992)

Sec. 21.55.060. Tax exemption. The association is exempt from the payment of fees and taxes levied by the state or any of its political subdivisions except taxes levied on real or personal property. (§ 2 ch 126 SLA 1992)

Article 2. State Health Insurance Plans.

Sec. 21.55.100. Types of insurance plans. (a) The association shall make available to residents who are high risks or to federally defined eligible individuals an individual state plan of health insurance. The association shall offer three alternatives related to deductibles as described in AS 21.55.120 and may offer additional deductible alternatives.

SB

56-59

Alaska State Legislature

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Long-Term Care Task Force

Senate Bill No. 59

An Act relating to the certificate of need program for nursing care facilities and other facilities; and providing for an effective date.

Alaska has had a Certificate of Need (CON) law since 1976. The purpose of this law is to insure the development of an accessible, cost-effective health care system with quality service. Currently the Department of Health and Social Services reviews all nursing home expansion projects that cost over $1 million. However, the review of each request is limited to the factors of *accessibility* and *quality*, that is whether the service is currently available and can be provided in a quality manner.

Under this proposed legislation, a new standard of need is adopted for nursing home certificate of need requests. The revised standard allows decisions to be made based on additional criteria such as need, financial feasibility and availability of alternatives. Under this change, a new nursing home project will need to demonstrate the cost-effectiveness of each request and the appropriateness of the service.

The Department of Health and Social Services estimates that on average, ten new nursing home beds increase the Medicaid budget by about $1 million annually. The decision to expand existing nursing home facilities has long-term implications to both the state treasury and our seniors and persons with disabilities. This legislation will give the Department of Health and Social Services the needed tools in which to make a more informed decision.

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. SB 59

Revision Date:
Title: An Act relating to certificates of need for nursing home beds and providing an effective date
Sponsor: HES Committee
Requestor: SENATE (HES)

Dept. Affected: Health and Social Services
BRU: Administrative Services
Component: Health Planning and Facilities Managemen
COMPONENT SERIAL NO. 2020
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY00	FY01	FY02	FY03	FY04	FY05
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	1.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	25.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.5	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS						
TOTAL OPERATING	**26.5**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGES IN REVENUES ( )	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	13.3	0.0	0.0	0.0	0.0	0.0
1003 GF Match	13.3	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health	0.0	0.0	0.0	0.0	0.0	0.0
Other (please specify)	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	**26.5**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

POSITIONS:

FULL-TIME	none	none	none	none	none	none
PART-TIME	none	none	none	none	none	none
TEMPORARY	none	none	none	none	none	none

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

ANALYSIS: (Attach a separate page if necessary)

This bill is a cost saving measure designed to avoid potential future costs to the state general fund of up to $9.8 million annually due to construction of up to 234 new nursing home beds in the next 5 to 15 years. Chapter 84, SLA 96 placed a moratorium on nursing home beds and established a working group on long-term care. The Legislative Working Group on Long-Term Care (established by Chapter 84, SLA 96) recommended development of a State long-term care facility plan that outlines the existing and future desired number of nursing home beds by region. Certificate of need applicants would be required to demonstrate that their proposals for new nursing home beds fit into these plans. This plan would also outline trends in nursing home use, senior population growth by community, define service areas, identify barriers to the use of home and community based services; develop nursing bed need projections, by service area and develop plans for better distribution of nursing home beds. The plan would ideally be an appendix to the Division of Senior Services annual plan.

Most of the plan can be written in house at no cost, however, a study needs to be completed to determine the amount of less costly and less restrictive, home and community based services and assisted living beds that need to be in place before new nursing beds are approved. Currently, there are no data available on the inter-relationship between these services. The $26,500 would go for contractual research, travel and supplies to develop a standard for construction of new nursing beds.

Prepared by: Janet Clarke
Division: Administrative Services
Phone: 465-1630
Date: 02/18/99

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 2/19/99

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Long-Term Care Task Force

Senate Bill No. 56

An Act allowing the disclosure of reports with regard to inspection and investigations of certain health care facilities, home health agencies, hospice programs, and assisted living homes; authorizing the Department of Health and Social Services to license home health agencies; and providing for an effective date.

Under current law, the Departments of Health and Social Services and Administration cannot make available to the public the annual inspection and investigation reports of hospitals, nursing homes, or assisted living homes licensed by the departments. Full public disclosure of licensing reports would benefit the public and help individuals make appropriate decisions regarding their health care needs.

This legislation will make the departments' licensing reports available to the public within 14 calendar days after the information is made available to the health care facility being reviewed. Public scrutiny encourages facilities to maintain a safe environment and provide a high quality of care. Any information that identifies patients or clients remains confidential.

This legislation also addresses the actual licensing process for home health agencies. A home health agency, either public or private, is an entity that provides primarily skilled nursing care and therapeutic services to people in their own homes, an assisted living home, or another residential setting.

The Department of Health and Social Services has, since the early 1980s, licensed home health agencies. Regulations (7AAC 12.500-12.590) were adopted under the department's broad regulatory authority. Recently the Department of Law questioned that authority. This legislation provides the Department of Health and Social Services the necessary and specific statutory authority to license and regulated the quality of care provided by home health agencies. The continued oversight of home health agencies will assure the public that the quality of care being provided to clients meets minimum standards.

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. SB 56

Revision Date/Time (Note if correction):
Dept. Affected: Health and Social Services
Title: Licensing Home Health Agencies and Disclosure of Licensing Reports
BRU: Medical Assistance Admin
Component: Certification & Licensing
Sponsor: Senate (HES)
COMPONENT SERIAL NO. 245
Requestor: Senate (HES)
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGES IN REVENUES	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY1999) cost: $0.0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary)

The Department supports this bill, both for the Disclosure of Licensing Reports and Licensing Home Health Agencies sections. **Section 1 - Disclosure of Licensing Reports (HOSPICE) - Analysis:** The disclosure of licensing reports would affect all hospice organizations licensed by the Department under AS18.18. It is in the interest of the public to have access to licensure reports to assist in making decisions about their health care needs. There is no FY2000 fiscal impact to this section of the bill. **Section 2 - Disclosure of Licensing Reports - Analysis:** The disclosure of licensing reports would affect all health facilities licensed by the Department under AS18.20. This would include hospitals, nursing homes, ambulatory surgical centers and free standing birth centers. It is in the interest of the public to have access to licensure reports to assist in making decisions about their health care needs. There is no FY2000 fiscal impact to this section of the bill. **Section 3 - Home Health**

Prepared by: Shelbert Larsen
Division: Medical Assistance
Phone: (907)561-8081
Date/Time: 2/11/99 1:47 PM

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 2/11/99

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ANALYSIS (cont.):

Agencies Analysis: The Department has, since the early 80s, licensed home health agencies. It was only recently that the Department of Law questioned the authority to do so. Currently the department has regulations (7 AAC 12.500-12.590) under the broad statutory authority of AS 18.05. for regulating home health agencies. This bill would provide unquestionable, clear andspecific statutory authority to license and regulate the quality of care provided by these agencies. It is felt this bill is justified in order for the Department to have statutory authority for oversight of home health agencies to assure minimum standards in quality of care are being provided to clients. Because the Department is currently surveying home health agencies, there would be no increased funding necessary for this bill anticipated for FY2000. **Section 4 - Disclosure of Assisted Living Home Licensing Reports - Analysis:** The disclosure of licensing reports would affect all assisted living homes licensed by the Department under AS 47.33. We believe it is in the interest of the public to have access to licensure reports to assist in making decisions about their health care needs. There is no FY2000 fiscal impact to this section of the bill. **Section 5 - TRANSITION - Analysis:** This section establishes authority for each department affected by the bill to adopt regulations necessaray to implement the act. Since regulations are currently used in licensure of home health agencies, revision would be minimal, requiring only to revise the regulations to include the authority. One or two sections will have to be added for the licensure of home health agencies. There is no FY2000 fiscal impact to this section of the bill. **Section 6 - REVISOR'S INSTRUCTION - Analysis:** This section provides instruction to the revisor. There is no FY2000 fiscal impact to this section of the bill. **Section 7 - EFFECTIVE DATE - Analysis:** This section establishes the effective date for the statute. There is no FY2000 fiscal impact to this section of the bill.

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Long-Term Care Task Force

Senate Bill No. 57

An Act relating to vulnerable adults; and providing for an effective date.

This bill will enhance the protective services afforded to vulnerable adults by reducing the possibility of exploitation or abuse by guardians, attorneys-in-fact, and surrogate decision-makers.

Under current law, the Department of Administration must immediately terminate an investigation of abuse upon the request of the vulnerable adult who is the subject of the report. Unfortunately, in some instances, the adult's guardian, attorney-in-fact, or surrogate decision-maker, who is the alleged perpetrator of the abuse and the subject under investigation, may make the request. As written, AS 47.24.015 (c) does not allow the department any option but to terminate the investigation. This proposed legislation allows the department to continue the investigation and protect the vulnerable adult.

In addition, this bill gives the Department of Administration the option to withhold investigative findings and reports of abandonment, exploitation, abuse, neglect or self-neglect filed with the department if the vulnerable adult's guardian is suspected of the abuse and currently under investigation. This flexibility will give the department the necessary information to effectively continue its inquiry.

The proposed statutory changes are necessary to adequately protect a vulnerable adult in the rare instance in which a guardian, attorney-in-fact, or surrogate decision-maker is the alleged perpetrator. These changes give the Department of Administration the needed leeway to conduct a thorough investigation.

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. SB 57

Revision Date:
Title: "An Act relating to vulnerable adults...."
Sponsor: Health, Education & Social Services
Requestor: (S) HES

Department Affected: Administration
BRU: Senior Services
Component: Protection, Community Services, Administration
COMPONENT SERIAL NO. 2083

Expenditures/Revenues: (Thousands of Dollars)
Note: Amounts do not include inflation unless otherwise noted below

OPERATING EXPENDITURES	FY 2000	FY 2001	FY2002	FY 2003	FY 2004	FY 2005
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
OTHER						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY 99) cost: $

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

This bill will have no fiscal impact on the Department of Administration.

SB 57 increases the department's legal authority to protect vulnerable adults from harm perpetrated by guardians, attorneys-in-fact, or surrogate decision makers by making changes and additions to AS 47.24.015 (c), .019 (a), .019 (c), and .050 (b). The amended language in these sections includes the additions of the terms "guardians, attorneys-in-fact, or surrogate decision makers" as possible perpetrators of harm. Additional amended language gives the department clear authority to petition for a "change of guardian." The amended language also gives the department authority to not disclose a report of harm to "guardians, attorneys-in-fact, or surrogate decision makers" who are alleged perpetrators who are being investigated as such.

Prepared by: Dwight Becker
Division: Senior Services
Phone: (907) 269-3674
Date

Approved by Commissioner: Robert Poe Jr. Alison M. Elgee
Agency: Department of Administration
Date: 3/2/99

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Long-Term Care Task Force

Senate Bill No. 58

An Act establishing an in-home and community-based services program for certain adults with long-term care needs; and providing for an effective date.

Currently only Medicaid-eligible adults can receive long-term health care services under the Department of Administration's home and community-based programs. Under this Medicaid option, individuals can receive the long-term health care they need in their homes and communities rather than institutions. Medicaid recipients have found this option very popular and almost twice as many Alaskans elected this waiver in FY97 than in FY96.

The proposed legislation will allow all Alaskans, with demonstrated long-term care needs, the opportunity to request services through the home and community-based care program. As noted, currently only Alaskans who are Medicaid-eligible receive this health care service. Under this bill, moderate-income adults who cannot pay the full cost of home care will be able to receive services under the home and community-based program. This program will not replace family care giving, but will support and augment the care given by families.

The adults receiving services will contribute through co-payment for services on a sliding scale. This bill does not create an entitlement program as the program is extended only to as many adults as the annual appropriation allows.

Under this legislation moderate-income seniors and adults with disabilities will have an opportunity to receive long-term health care at home or in their communities and therefore may avoid, or at least postpone, the need for more costly long-term care in an institution.

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. SB 58

Revision Date:
Title: Services for Adults With Long-Term Care Needs
Sponsor: Health, Education, And Social Services
Requestor: (S) HES

Department Affected: Administration
BRU: Senior Services
Component: Protection, Community Services, Administration
COMPONENT SERIAL NO. 2083

Expenditures/Revenues: (Thousands of Dollars)
Note: Amounts do not include inflation unless otherwise noted below

OPERATING EXPENDITURES	FY 2000	FY 2001	FY2002	FY 2003	FY 2004	FY 2005
PERSONAL SERVICES						
TRAVEL	10.0					
CONTRACTUAL	50.0					
SUPPLIES						
EQUIPMENT	15.0					
LAND & STRUCTURES						
GRANTS, CLAIMS	350.0	800.0	800.0	800.0	800.0	800.0
MISCELLANEOUS						
TOTAL OPERATING	425.0	800.0	800.0	800.0	800.0	800.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE: (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	425.0	800.0	800.0	800.0	800.0	800.0
1005 GF/Program Receipts						
1037 GF/Mental Health						
OTHER						
TOTAL	425.0	800.0	800.0	800.0	800.0	800.0

Estimate of any current year (FY 99) cost: $

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.) This fiscal note will provide funding for the development and implementation of SB 58 by providing increasing funds for in-home and community- based services and care coordination for eligible adults who otherwise could not afford to pay for the needed services and who do not qualify for the Medicaid waiver programs. Currently there are over 750 clients being served by the Medicaid waiver programs with an average cost per client of approximately 20.0. It is unknown as to how many clients would be eligible for this new program under SB 58. However, it is very likely that the eligible population will equal that of the Medicaid waiver population. The state's cost of care per client for this new program is projected to be 10.0, as these clients will have more income to contribute towards the cost of their care. This fiscal note would fund a developmental stage during the first year to include the writing of regulations and the design of a new care system with the potential consumers and providers. The 75.0 would fund regulation drafting, consumer and provider advisory meetings, and software purchases/development to start the client data system. The 350.0 would provide grants for the remainder of the year.

During the second year 800.0 in funding would be provided to begin services for an estimated 80 eligible clients at an estimated cost of 10.0 per client. This program is not an entitlement. Funding in future years will be limited to legislative appropriation.

Prepared by: Dwight Becker
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Date

Approved by Commissioner: Robert Poe dr. Alison M. Elgee
Agency: Department of Administration
Date: 3/2/99

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LTC TASK FORCE
Long-Term Care Task Force

FINAL REPORT
January 1999

Representative Con Bunde, Co-chairman
Senator Gary Wilken, Co-chairman

State Capitol Building
Juneau, Alaska 99801-1182

Long-Term Care Task Force Members

Representative Con Bunde - Co-chairman
Senator Gary Wilken - Co-chairman

Representative Al Kookesh
Representative Joe Ryan
Senator Lyman Hoffman
Senator Bert Sharp
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Mr. John Hanchett
Mr. Dennis Murray

Ms. Alison Elgee
Ms. Karen Perdue
Ms. Deborah Sedwick

The Long-Term Care Task Force recorded its meetings. The tape recordings may be obtained from the Alaska Legislative Reference Library, Goldstein Building, Room 400, Juneau, AK 99801.

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Alaska State Legislature

Official Business

State Capitol
Juneau, Alaska 99801-1182

Long-Term Care Task Force

January, 1999

To the reader;

The report you are now holding could not have been possible without the dedication and hard work of many people, in government and the private sector, who overcame significant limitations in time and resources to produce valuable recommendations on how Alaska can best provide long-term care for its citizens.

While we helped guide this process as co-chairs of the Long-Term Care Task Force, the credit for its achievement lies with them. We would therefore like to acknowledge our appreciation:

To the members of the Long-Term Care Task Force themselves, who absorbed vast amounts of data and produced creative approaches to one of our state's most pressing human concerns;

To the staffers at various state agencies, who generously shared their experience and expertise so that our recommended actions would have the best possible foundation in real-world experience;

And to the members of the public, who honored us with their time and attention, and whose personal testimony ever reminded us that all Alaskans have a personal stake in ensuring quality long-term care in the Last Frontier.

Thank you one and all.

Sincerely,

Representative Con Bunde
Co-Chair

Senator Gary Wilken
Co-Chair

TABLE OF CONTENTS

TABLE OF CONTENTS

INTRODUCTION TO LONG-TERM CARE

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

"Soon people 65 years old . . . will outnumber the young."

In 1900, there were 3.1 million people age 65 or older in the United States. By 2020, this population is expected to reach 54 million, representing about one out of every six Americans. In addition, a large portion will be over the age of 85 – a group that is most likely to need assistance with everyday activities.[1]

Alaska, too, is experiencing a rapid growth in our senior and disabled populations. Senator Bert Sharp, Fairbanks, and Senator Jim Duncan, Juneau, introduced Senate Concurrent Resolution 11 (SCR 11) in 1997 to address this critical issue and plan for the future. In his sponsor statement, Senator Sharp made the following comments regarding this resolution:

> As Alaska's senior community grows, it is necessary that we plan for the long-term care needs of these citizens. While it is the desirable goal of most families to provide home care for their elderly parents, the reality is that most will live in a long-term care facility. Either way, the costs of providing long-term care is becoming insurmountable to the state and to our private citizens.
>
> SCR 11 will create a long-term care task force. Their mission is to review the findings of the legislative working group and develop an equitable plan for providing actuarially sound and affordable long-term care options for all of the Alaska's senior citizens.[2]

"The Long-Term Care Task Force is created."

This resolution was adopted in 1998 and the 12-member Long-Term Care Task Force, composed of legislators, state officials and private citizens, was created.

The Task Force held meetings in Anchorage and many concerned Alaskans from around the state talked to the panel about the long-term care needs of seniors and adults with disabilities. Rural residents raised concerns about sparse services in rural Alaska. Many pointed to a shortage of workers to provide in-home personal care, the kind of help that can keep older people in their own homes. The exploding price tag associated with the cost of providing long-term care was frequently mentioned.

The task before this group was daunting, but all members of the task force were willing to devote their time and expertise to grapple with the challenge of accommodating and providing for adequate long-term care services for more and more Alaskans. The first step for the Task Force was to review the various reports and studies conducted over the past several years. These studies were invaluable in their work.

"Between the years of 1990-96, Alaska had a 42 percent increase in people age 65 years and older."

The *Legislative Working Group on Long-Term Care*, created in 1996, analyzed the state's population trends and noted that the number of Alaskans age 65 years and older is growing dramatically. The senior community is growing about 5 percent annually while the rest of the population is growing annually about 2 percent.

Alaska is second in the nation in the proportional growth of our senior population – with a 42 percent increase in people age 65 years and older in only six years (1990-96). Only Nevada had a greater rate (45 percent) in the same period of time.

Equally impressive is the anticipated long-term growth of Alaska's senior population. In 1980, there were 11,547 people over the age of 65 years. Using moderate growth projections, population experts agree this number may reach 80,927 by the year 2015. This is a 600 percent increase in only 35 years.[3]

The increased number of Alaskan seniors is the result of many factors, the three most mentioned being: 1) the state's more stable economy which makes it feasible for seniors to retire in Alaska; 2) successful public health care services; and 3) the many community-based programs which assist seniors to receive long-term care at home in their communities.

"Who should pay for long-term care?"

However, an increase in the number of elderly and adults with disabilities in Alaska means a dramatic increase in the number of people needing long-term care services. The *Legislative Working Group on Long-Term Care* noted that in FY96 the annual cost to provide long-term care services was $73 million, while in FY15 those same services would cost $372 million (assuming moderate population growth

and inflation). "The growth of the long-term care programs ... will be significant over time if costs or population grow at even a moderate rate."[4]

The question of who should pay for long-term care – the federal government, the state government, or private individuals themselves – was the focus of much discussion. Since Medicare and most private health insurance policies generally do not pay for long-term care, many people look to public financing to fund their nursing home or home health care needs.[5] In Alaska, Medicaid pays for the care of 80 percent of all nursing home residents. (The state pays 40 percent of all Medicaid costs.)

"The public is in denial about long-term care needs."

"The public is in denial about long-term care and routinely ignores the risk. Less than ten percent of seniors have purchased long-term care insurance and virtually none of the baby boomers have done so," stated Mr. Stephen Moses, Long-Term Care Center President, before a National Press Club Forum on November 19, 1998 in Washington, D.C. One out of three of us will need long-term care at some point in our lives. However, fewer than one in 20 Americans have purchased insurance to pay for it, forcing Medicaid to pick up the tab instead.[6]

Both at the state and federal level, policymakers are wrestling with this issue. *The Wall Street Journal* reported on December 7, 1998 that the Clinton administration was working on a proposal to provide tax credits to defray the cost of long-term care for the elderly and people with physical disabilities. Others are urging reform through the Social Security Act.

"The recommendations proposed by the Task Force will slow the growth of state expenditures."

The Task Force only scratched the surface in its discussion on how to adequately fund the increasing demand for long-term care for seniors and persons with disabilities living in Alaska. More in-depth and extensive research and analysis is necessary before a single funding plan, or a group of funding alternatives, can be structured. In the meantime, the recommendations proposed by the Task Force will slow the growth of state expenditures and begin the shift from public spending to private payers. ❖

QUALITY LONG-TERM CARE

As society has changed, so has the long-term care community. Long-term care now includes a broad spectrum of care including subacute medical care, ongoing skilled nursing care, care of the developmentally disabled and special populations, to adult day care, residential care, assisted living, and home and community-based care.[7]

A big change in home care for seniors and adults with disabilities was the development of the Medicaid waiver CHOICES program in December 1993. Indeed, a number of low-income seniors and adults with physical disabilities, who otherwise would need nursing home care, may now elect to receive long-term care services in their home or community. The plan of care is designed to meet the needs and preferences of each individual.

"The CHOICES alternataive is a popular option; the number of clients more than doubled between 1996 and 1998."

The CHOICES alternative is a popular option for qualifying Alaskans; the number of clients more than doubled between 1996 and 1998. Unfortunately not all seniors have this choice. The vast land area of our state, low population density, and our population distribution combine to create difficult hurdles to clear. But these unique problems can be solved, one step at a time.

The Task Force recognizes that long-term care is reinventing itself as providers strive to meet the diverse needs of Alaska's seniors and adults with physical disabilities. With each step, the quality of long-term care continues to improve. ❖

PERSONAL CARE ATTENDANT

RECOMMENDATION 1

The Task Force acknowledges and supports the effort of the Personal Care Attendant Design Team to redesign the personal care services delivery system and establish professional standards for personal care attendants.

Personal Care Attendant (PCA) services enable adults with physical and mental disabilities and elderly Alaskans to live in their own homes or communities. PCA services are typically provided in a consumer's home by trained health care para-

professionals and include assistance with activities of daily living such as eating, bathing, dressing, personal hygiene and medication needs. Ideally, these services are part of a continuous and coordinated system of social and medical support.[8]

In order to facilitate their integration with other home and community-based services, PCA services are administered through the Division of Senior Services, Department of Administration. Two models of personal care services are available in Alaska: the *independent model* and the *agency-based model.*

"Two models of personal care services are available in Alaska: the independent model and the agency-based model."

In the *independent model*, the consumer hires and manages the personal care attendant as an employee. In FY97, independent personal care attendants provided services to approximately 65 individuals. Independent care attendants who serve Medicaid clients contract directly with the Division of Medical Assistance for $12 per hour.

In the *agency-based model*, specific non-profit agencies provide personal care attendant services. In FY97, almost 950 individuals received personal care services through agency personal. The reimbursement rate for agencies to provide personal care services to Medicaid clients is $21 per hour. The attendant directly providing the services receives an average of $9-12 per hour, with or without benefits.

Personal care attendants are the cornerstone of home and community-based programs that allow Alaskans to receive health care support services in their home communities.

"Personal care attendants are the cornerstone of the waiver programs."

On November 14, 1998 a "Personal Care Attendant Services Summit" was held in Anchorage to develop clear objectives for improving Alaska's delivery of PCA services. The summit was directed by a steering committee composed of the key individuals and organizations, both public and private, actively involved in providing or directing long-term care services in the state.

Approximately 85 participants attended the statewide "Personal Care Attendant Services Summit." This conference was an instrumental step toward refining the way thousands of Alaskans with disabilities and seniors will receive long-term care in their homes and communities and continue to live independently in the future. To accomplish their goal, summit attendees 1) adopted guiding principles for a delivery system that provides service for all levels of care; 2) began the design of a PCA service program that fits Alaska; and 3) identified potential bar-

riers that must be addressed before a smooth transition to the new delivery system can occur.[9] (Please see Appendix G, page 79, for further detail.)

The Task Force recognizes that this summit represents a first step in a long, involved process that may include regulatory and statutory changes, as well as some possible change in funding sources. The Task Force applauds and encourages that beginning. As the Division of Senior Services and others continue and complete their work, the Task Force encourages the general public to get involved.

"The Task Force recommends that the Division of Senior Services review the possibility of establishing professional standards for PCAs."

In addition to reviewing the options for a new delivery system for personal care attendant services, the Task Force recommends that the Division of Senior Services and others review the possibility of establishing professional standards for personal care attendants. The adoption of standards developed through a public process will provide a reasonable framework to assure quality care. ❖

DELEGATION OF NURSING ACTIVITIES

The Task Force recognizes the efforts of the Alaska Board of Nursing to address the issue of "delegation of nursing activities" and challenges all interested parties to actively participate in the Alaska Board of Nursing public hearing process when this issue is addressed.

On September 21-23, 1998, approximately 100 community, agency and senior advocacy leaders from across Alaska met to identify and address opportunities and challenges affecting the growing number of older Alaskans. The focus of the conference, entitled *Alaskan Seniors: Finding the Common Ground*, was to unite the participants' efforts to better meet the needs and address the concerns of Alaskan seniors. (Please see Appendix H, page 81 for further detail.)

"Alaska is proud of its caregivers."

At this conference the participants stressed that the foundation of any long-term care service is the quality of the actual service provided through the public and private sector. A person who is elderly or experiences a disability must have assurance that the care provided is appropriate, provided in a timely manner, and performed by qualified personnel.

Likewise it is recognized that many long-term care recipients may wish to maximize their personal independence. To achieve this independence, they are willing to assume some personal risk.

The caregivers in Alaska are dedicated and well respected. "The degree of commitment to clients of those working in the Alaska long-term care systems seems higher than most states."[10] Alaska is proud of its caregivers.

"Delegation of some nursing activities is appropriate."

With the growth of Alaska's senior community and the expansion of the home and community-based programs and assisted living homes, the care of Alaskan seniors and people with disabilities may be provided by unlicensed assistive personnel. Unlicensed assistive personnel are individuals who are not authorized to perform nursing acts or tasks that are regulated by the Board of Nursing except pursuant to legal delegation by a nurse.[11]

Changes in the levels of health care provided in traditional and non-traditional settings have altered the scope of practice of nursing and its relationship to unlicensed assistive personnel. The unlicensed home care provider may now be involved in procedures such as assisting with medication, intermittent bladder catheterizations and gastrostomy feedings.[12]

Delegation of some nursing activities is appropriate and, in fact, a legally accepted part of the practice of nursing. However, at times, it can be difficult to define what is appropriate to delegate and in what circumstance. The Board of Nursing has the authority to regulate nursing practices, including the delegation of nursing tasks. In 1993 and 1995 the Board of Nursing wrote two position statements on how the practice of using unlicensed assistive personnel relates to the nursing practice.

"The Task Force applauds the continued effort of the Alaska Board of Nursing to establish guidelines."

Alaska is not alone in wrestling with this issue. At the national level, the issue of appropriate, safe nurse delegation is an ongoing topic among state boards of nursing and health care providers.

The question of delegation of responsibilities extends beyond the nursing staff. Other professionals such as pharmacists, social workers, physical therapists and occupational therapists provide input and directives regarding the care of clients. Unlicensed assistive personnel often carry out their directives.

The Task Force applauds the continued effort of the Alaska Board of Nursing to clarify the guidelines regarding the delegation of nursing tasks by nurses. In addition, the Task Force recognizes the importance of approaching this task with cre-

ativity and the active engagement of all interested individuals, agencies, long-term care providers and other professional boards. The Task Force challenges everyone to participate in the decision-making process. ❖

HOME HEALTH AGENCIES/LICENSING REPORTS

The Task Force recommends that legislation be drafted and introduced relating to the disclosure of licensing reports and licensing of home health agencies.

The Task Force was presented draft legislation that covered two specific areas of concern. The first subject dealt with the disclosure of licensing reports. Under current law, AS 18.20.090, the Department of Health and Social Services cannot make available to the public the annual inspection and investigation reports of the hospitals or nursing homes licensed by the department. As noted in testimony before the Task Force, full public disclosure of licensing reports would benefit the public and help individuals make appropriate decisions regarding their health care needs.

"Full public disclosure of licensing reports would benefit the public."

The proposed legislation under consideration will make the department's licensing reports available to the public within 14 calendar days after the information is made available to the health care facility being reviewed. Any information that identifies patients or clients remains confidential.

The second area of discussion centered on the actual licensing process for home health agencies. A home health agency, either public or private, is an entity that provides primarily skilled nursing care and therapeutic services to people in their own homes, an assisted living home, or another residential setting.

"A home health agency is an entity that provides primarily skilled nursing care."

The Department of Health and Social Services has, since the early 1980s, licensed home health agencies. Regulations (7AAC 12.500-12.590) were adopted under the department's broad regulatory authority. Only recently did the Department of Law question that authority. The draft legislation presented to the Task Force provides the Department of Health and Social Services with the necessary and specific statutory authority to license and regulate the quality of care provided by

these agencies. The continued oversight of home health agencies will assure the public that the quality of care being provided to clients meets minimum standards.

The Task Force acknowledges the importance of the concepts included in the proposed legislation and recommends the legislation be introduced for further consideration. (Please see Appendix B, page 69, for further detail.)

SMALL BUSINESS TRAINING

The Task Force supports an increased effort to train Assisted Living Home administrators in proven small business practices and urges collaboration between the Department of Administration and the University of Alaska to provide this education.

On January 14, 1994 Governor Wally Hickel introduced legislation that developed a system of long-term care "by encouraging the establishment of assisted living homes that provide a homelike environment for elderly persons and persons with a mental or physical disability who need assistance with the activities of daily living." (Chapter 130, SLA 1994) Assisted living homes promote and sustain the independence of Alaskans through a social model of community-based long-term care.[13]

"Eighty-five assisted living homes have been licensed by the Department of Administration."

Assisted living homes provide a home-like setting as well as certain health-related services or assistance with certain personal activities. Such services allow the elderly to age in place, rather than having to be transferred to a more institutionalized nursing-home setting, and allow adults with a physical or mental disability to become integrated into their community.[14] Eighty-five assisted living homes have been licensed by the Department of Administration to serve the elderly. In addition, the Department of Health and Social Services has licensed 134 assisted living homes to provide care primarily to individuals with a mental or developmental disability.

Assisted living homes have become a reality in many, but not all, areas of Alaska.[15] In some instances, it is difficult to establish an assisted living home and provide the necessary care. Interested care providers must first have an adequate, safe facility and then must obtain the required licensure, insurance coverage, and per-

sonnel before they can open their doors to clients. The start-up costs can be substantial and the risks great.

As was noted in the draft *Alaska Rate Study Report*, November 1998, many assisted living home owners/operators are not financially prepared or sufficiently trained in business operations to meet the needs of Alaska's aging population. The Division of Senior Services recognizes that more in-depth business education is necessary, and plans to expand its training options available to interested long-term care providers.

"The University ...is exploring the possibility of offering a three-credit college course in business practices for assisted living home administrators."

Currently assisted living home administrators and executive personnel are offered a one-day orientation seminar in which necessary fiscal practices are reviewed. The covered topics include general accounting practices, the state and federal reimbursement systems, availability of bank financing and various insurance requirements. In addition, the Division conducts a weeklong workshop and similar topics are reviewed in greater depth. At the completion of this course, the participants are recognized as "certified assisted living home administrators."

The Division of Senior Services and the University of Alaska are exploring the possibility of offering a three-credit college course in business practices for assisted living home administrators. The Task Force applauds this effort and encourages continued business training for owners and operators of assisted living homes. ❖

ASSISTED LIVING STANDARDS

The Task Force requests the Department of Administration review the current regulations governing assisted living homes and, through a public process, establish statewide standards for long-term care services provided in an assisted living home.

Recently the *Assisted Living Quality Coalition*, a coalition of six assisted living consumer and industry associations, issued a report that provides a framework for quality initiatives in assisted living facilities, as well as guidelines to help state policymakers set minimum quality standards.

The *Assisted Living Quality Coalition* consists of the American Health Care Association, the Alzheimer's Association, the American Association of Homes and Services for the Aging, the American Association of Retired Persons, the American Seniors Housing Association, and the Assisted Living Federation of America.[16]

"The guidelines will provide an excellent frame of reference to begin a discussion on statewide standards."

The issues addressed by this coalition are the same concerns regarding long-term care expressed by the Alaska Chapter Alzheimer's Association. It was noted in a letter to the Task Force that standardization of care in all facilities across the state is of utmost importance.[17] The quality initiative and the consensus guidelines as proposed by the *Assisted Living Quality Coalition* will provide an excellent frame of reference to begin a discussion on statewide standards for quality care in assisted living homes.

The Task Force requests the Department of Administration review the current regulations governing assisted living homes and, through a public process, establish statewide standards for long-term care services provided in an assisted living home. The standards may include a standard of care that takes into account each individual resident's needs and preferences, as well as whether the living arrangement is appropriate for a particular level of care.

In addition, the Task Force requests the Department of Administration determine if the current assisted living regulations are appropriate for any size facility. In certain instances, regulations that are appropriate for a small assisted living home may not be appropriate for a larger home. The Department is requested to promulgate the necessary changes, if needed. ❖

ALASKA GUARDIANSHIP SYSTEM

The Task Force urges the Department of Administration and the Division of Senior Services give serious consideration to the formal recommendations outlined in the report, *The Alaska Guardianship System*, and notify the Legislature of any statutory changes necessary.

Three guardianship systems exist in Alaska, each providing a different mix of services; public guardians, private professional guardians; and private unpaid (usually family) guardians. Under each system, the guardian is legally in charge of the affairs of a minor or incapacitated person.

In September 1998 the McDowell Group, Inc. reviewed and assessed the guardianship system in Alaska and issued a report entitled, *The Alaska Guardianship System*. This review was funded by the Mental Health Trust Authority and is the result of the Trustees' desire to look proactively at the future of guardianship services in Alaska. Most clients served within Alaska's guardianship system are Trust beneficiaries.

"The Alaska Guardianship System is reviewed."

The final product met two major objectives: 1) To describe and quantify the entire complex guardianship system; and 2) To identify and analyze major issues and provide clear recommendations for improving the quality of guardianship in Alaska.

This study included 70 in-depth interviews, a facilitated group discussion with the public guardian staff, and a sample telephone survey of 17 private guardians in Anchorage and Fairbanks. In addition, court data on open guardianship cases was analyzed and secondary research was conducted on other state's practices and standards.

The Alaska guardianship system was found to be complex, sophisticated, fragmented and confusing. Guardianship is a wide-ranging issue interconnecting Alaska courts, state agencies, the legislative branch, the legal profession, non-profit sector, many local, state and federal social service agencies, and private households.[18]

"The McDowell Group estimated that individuals suffering from Alzheimer's Disease account for approximately half of all guardianship cases."

As estimated by the McDowell Group, individuals suffering from Alzheimer's Disease and related dementia accounted for approximately half of all the guardianship cases and individuals experiencing developmental disabilities accounted for a quarter of all the cases. In other words, almost seventy-five percent of all clients receiving guidance and support from a guardian may also be receiving long-term care service.

The Task Force applauds the foresight of the Mental Health Trust Planning Board in initiating this review and urges serious consideration and discussion of the formal recommendations outlined in the report. In addition, the Task Force recommends that the President of the Senate and the Speaker of the House be notified by March 31, 1999 of any statutory changes necessary to implement the report's recommendations. ❖

LEGISLATION TO PROTECT VULNERABLE ADULTS

The Task Force recommends that legislation be drafted and introduced to protect a vulnerable adult from a guardian, attorney-in-fact or surrogate decision-maker who may harm the vulnerable adult.

AS 47.24.900 (16) defines a vulnerable adult as a person 18 years of age or older who, because of physical or mental impairment, is unable to meet his or her own needs or to seek help without assistance.

Under current law, if a person has reason to believe that a vulnerable adult suffers from abandonment, exploitation, abuse, neglect or self-neglect, the concerned individual must contact the Department of Administration which, in most instances, initiates an investigation. After the department conducts an investigation, a written report is prepared of the department's findings, recommendations, and determination of whether supportive or protective services are necessary.

"After the department conducts an investigation, a written report is prepared."

The department must immediately terminate an investigation upon the request of the vulnerable adult who is the subject of the report. Unfortunately, in some instances, the adult's guardian, attorney-in-fact, or surrogate decision-maker, who is the alleged perpetrator of the abuse and the subject under investigation, may make the request. Currently AS 47.24.015 (c) does not allow the Department of Administration any option in such a case but to terminate the investigation. A change to this statute is necessary to adequately protect the vulnerable adult.

The investigation findings and the reports of the abandonment, exploitation, abuse, neglect or self-neglect of a vulnerable adult filed with the department are considered confidential. However, the reports are disclosed if the vulnerable adult who is the subject of the report consents in writing. A problem arises when the vulnerable adult's guardian, attorney-in-fact or surrogate decision-maker is suspected of abuse and is under investigation. The disclosure of the complaint, in this case, would severely restrict the department's ability to effectively continue with its inquiry.

"A problem arises when the vulnerable adult's guardian is under investigation."

The Task Force recognizes that a situation may arise where a guardian, attorney-in-fact or surrogate decision-maker will abuse or harm a vulnerable adult and the statutes should reflect this possibility. The proposed legislation addresses this like-

lihood and gives the Department of Administration the needed leeway to conduct a thorough investigation in order to protect the vulnerable adult. (Appendix B)

Federal and state law provides for long-term care ombudsman services for vulnerable adults who are 60 years and older and reside in a nursing home or an assisted living facility. The Task Force recognizes that vulnerable persons under the age of 60 who reside in nursing homes or assisted living facilities also have a need for protective services. The Disability Law Center, the State Independent Living Council and its regional centers, the Division of Senior Services, and the Division of Mental Health and Developmental Disabilities offer protective and advocacy services to these individuals. Greater access and collaboration between these organizations will help strengthen their ability to meet the needs of these vulnerable persons under the age of 60 who are living in an institutional setting.

"The Task Force recognizes that vulnerable persons under the age of 60 who reside in nursing homes or assisted living facilities also have a need for protective services."

The Task Force recommends that these entities coordinate efforts: 1) to increase residents' awareness of the protection and advocacy services available within the state; 2) to facilitate the system's response to complaints and requests for assistance. ❖

WORK FORCE DEVELOPMENT SUMMIT

RECOMMENDATION 8

The Task Force endorses the efforts of the Alaska State Hospital and Nursing Home Association, in conjunction with the other training councils, to hold a statewide Work Force Development Summit.

On September 17, 1998 the Alaska Human Resource Investment Council (AHRIC) and the University of Alaska Statewide Vocational/Technical Education Advisory Council (UASVTEAC) held a joint meeting in Seward to discuss issues surrounding the demand and capacity of Alaska's health care industry.

"Low pay, lack of adequate training and frequent job turnover (are) problems."

The concerns expressed at this joint meeting parallel the testimony received by the Long-Term Care Task Force. Many long-term health caregivers testified in great detail about how fragile the job situation is for people who provide day-to-day health care for seniors and adults with disabilities. Low pay, lack of adequate training and frequent job turnover were some of the reoccurring problems mentioned.

"Alaska faces a crisis in meeting the demand for qualified workers within the health care industry."

Alaska faces a crisis in meeting the demand for qualified workers within the health care industry. The quality, affordability and availability of health care impacts every community and citizen in Alaska. The inability to meet the workforce demand translates into higher customer costs, limited service in the community, lower quality of service and added stress on the existing limited health care workers."

The Alaska State Hospital and Nursing Home Association (ASHNHA) plans to hold a statewide conference, in cooperation with AHRIC and UASVTEAC, on April 9 - 10, 1999 to address the five major areas of concern identified on September 17, 1998. The goal of the conference is to find ways to: 1) increase training opportunities for health-related occupations: 2) create career ladders for personal care attendants, certified nurse aides, licensed practical nurses, and individuals with an associate's degree in nursing; 3) design worker retention strategies for employers and existing workers; 4) recommend new workplace policies; and 5) increase the number of Alaska residents acquiring new jobs in the industry.[20]

The Task Force further recommends that a full report on the actions required to be taken as a result of the statewide summit be submitted to the President of the Senate and Speaker of the House for additional review and action. ❖

CAREER LADDER FOR HEALTH CARE PROVIDERS

The Task Force encourages the University of Alaska to explore further the development and expansion of its curriculum to facilitate a career ladder for health care providers.

On September 17, 1998 more than 70 people attended a statewide conference sponsored by the Alaska Human Resource Investment Council and the University of Alaska Statewide Vocational/Technical Education Advisory Council, focusing on *Alaska's Health Care Industry: Workforce Demand and Capacity* The Department of Labor outlined the workforce demand and occupational forecasts for the health-care industry. In addition, several industry representatives offered a unique view of the current workforce demand in health care and the corresponding training capacity.

During the facilitated roundtable discussions, the group was challenged to envision a more responsive workforce development system that produces a quality, skilled Alaska health care workforce. A common theme throughout the discussion was the lack of a formal, education career ladder that encourages an individual health caregiver to advance and grow within the health care field. As it was envisioned, a person could enter the health care profession at the entry level (personal care attendant) and through training and college education advance in the field. Through training, education and experience the caregiver could obtain certification at each level of expertise. This career ladder would enhance the training, education opportunities, and earnings for health care providers.

"It is projected that more than 1,500 new jobs in the health care profession will be created over the next five years."

As noted at the conference, it is projected that more than 1,500 new jobs in the health care profession will be created over the next five years. One half of these new jobs will require two-year associate's degrees, four-year baccalaureate degrees or master's degrees. An integrated training program that includes both vocational and college education will be necessary to meet this new job demand.

The Task Force is excited about the new job possibilities and expansion of the health care industry, but also recognizes the challenge before the University of Alaska and other training institutions. A well-qualified, trained workforce must be available. The Task Force applauds the University of Alaska's active involvement in addressing the needs of the health care industry and encourages the University to explore further the development and expansion of its curriculum to facilitate a career ladder for health care providers. ❖

ADVANCE DIRECTIVES

The Task Force encourages the Alaska Health Fair, Alaska Commission on Aging, AARP, and other related organizations to provide educational information on the importance of advance directives and encourage the use of advance directives in the provision of health care.

"Advance directives help all individuals maintain control over their health care decisions."

Advance directives are legal documents, prepared in advance of any incapacitating condition, stating the author's preference for health care. Advance directives help all individuals maintain control over their health care decisions even after the loss of decision-making capability. The Task Force heard testimony in support of

the concept of planning medical decisionmaking through the use of living wills and durable powers of attorney for health care.

In a *living will*, the applicant describes a specific preference for medical treatment if terminally ill or near death. With this document, even if the patient cannot communicate, he/she ensures that his/her desires have been conveyed to the doctors and family members. Alaska's living will has a checklist that helps describe the type of care desired.

"A person does not give up any control with an advance directive."

A *durable power of attorney* for health care is a legal document that expresses an individual's wishes about health care treatment and appoints someone to speak for the patient if the person becomes seriously ill or injured and cannot speak. Once signed and witnessed, this document becomes part of the individual's medical record.

A person does not give up any control with an advance directive. As long as the individual is able to make decisions, he/she is the decisionmaker. An advance directive only applies when one cannot speak or otherwise provide instruction to caregivers. The document can be changed or revoked at any time, as many times as wished.[21]

"AARP has established an education network to inform its membership on many issues facing us as we age."

The Alaska Health Fair plans and stages over 120 health fairs annually throughout Alaska, reaching approximately 40,000 people in both urban and rural settings. This outreach venue provides an excellent opportunity to inform many citizens on the various advance directives honored in Alaska.

In addition, the American Association of Retired Persons has established an education network to inform its membership on many issues. The Alaska Commission on Aging also regularly circulates information on resources available to all Alaskans as we age. Together their added voices will increase the education effort on the advance directives available.

The Task Force encourages the Alaska Health Fair, Alaska Commission on Aging, AARP, and other related organizations to provide educational and informational forums, as appropriate, on the importance of advance directives and encourage the use of advance directives in the provision of health care. In addition, the task force requests the Alaska Commission on Aging to coordinate these efforts, develop an implementation plan by December 31, 1999, and report to the Senate and House HESS Committees at the beginning of the Second Session of the 21st Legislature regarding the Commission's activities. ❖

ACCESS TO LONG-TERM CARE

One way, and possibly the best way, to ensure that Alaskan seniors and adults with disabilities remain as independent as possible for as long as possible is through a continuum of care. Under a continuum of care, individuals have available to them a broad spectrum of services that range from home and community-based services and preventive services at one end to 24-hour skilled nursing home care, notes the Alaska State Hospital and Nursing Home Association.

The Alaska long-term care system has many services available. However, it is not always the case that seniors are able to have a choice as to the type of service or the location of these services. This is especially true for services in the rural communities, as many Native elders need to leave their home communities and travel great distances to obtain services in unfamiliar urban settings.

"It is not always the case that seniors are able to have a choice."

The *Legislative Working Group on Long-Term Care* noted, "Access to the present long-term care system of direct services, payments for service, and grants to non-profits is very uneven across Alaska. In general, the range and quantity of available long-term care services increases with community size. Seniors in communities such as Kwethluk and Usibelli have no long-term services in their communities, while seniors in Fairbanks or Anchorage have limited access to a full range of services."

The Task Force recognizes that in some areas of the state access to appropriate health care services is a problem and recommends several changes to improve the availability of long-term care. ❖

AFN RESOLUTION

The Task Force recognizes and supports Resolution 98-59, *In Support of Elder Care Facilities in Rural Alaska*, as adopted at the Alaska Federation of Natives 1998 Annual Convention.

"The resolution supports elder care facilities."

At the recent Alaska Federation of Natives 1998 Annual Convention, Resolution No. 98-59, *In Support of Elder Care Facilities in Rural Alaska*, was submitted by the St. Mary's Native Corporation and formally approved by the whole convention. This resolution recognizes Alaskan elders as a respected group of people within the family unit and acknowledges the lack of proper facilities in rural areas that provide care for elders.

The resolution resolves that "(T)he Alaska Federation of Natives politically supports the efforts of rural organizations in seeking, acquiring, and administering the required funding, facilities, personnel, and technical and professional support for elder care facilities." The Task Force supports this effort to expand long-term care services in rural Alaska.

In FY99, the Division of Senior Services received funding to implement a rural long-term care development proposal that will focus on increasing home and community-based services in the rural regions of Alaska. The Alaska Mental Health Trust Authority is funding this two-year effort.

"By the end of FY00, more assisted living homes will be available in these five communities."

Five interested communities will receive assistance on ways to expand an existing home and community-based program or means to implement a new program. Local government, tribal authorities and federal and state agencies will be included in the planning and implementation process.

By the end of FY00, more assisted living homes will be available in these five communities. An appropriate workforce will also be created to meet the long-term care needs in those settings. ❖

INDIAN HEALTH SERVICE

RECOMMENDATION 12

The Task Force supports the Indian Health Service's role in providing long-term care services and encourages the Department of Health and Social Services to aggressively pursue its rebuttal of the Health Care Financing Administration's interpretation of the Social Security Act.

The Indian Health Service plays a pivotal role in the delivery of health care in rural areas of Alaska. "Designing a health care delivery system in rural Alaska, mostly populated by Alaskan Natives residing in communities of a few dozen to a couple thousand people, has been totally dependent upon the system developed by the Indian Health Service."[25]

"The Indian Health Service plays a pivotal role in the delivery of health care in rural areas of Alaska."

The Indian Self-determination and Education Assistance Act (PL 93-638) enabled Alaska Native people to become more actively involved in determining their destinies in health and educational affairs by allowing tribes to take over the operation of Indian Health Service programs and facilities. The Alaska Area Native Health Service encompasses nine service units distinguished by their cultural similarities and transportation patterns. Each service unit's field hospital or clinic serves as that service unit's headquarters and hub from which services radiate. In addition, personnel work at 22 health centers, and 167 village-built clinics.[26]

It has required ingenuity and determination to deliver community-based care to the dozens of villages scattered over thousands of square miles that each tribe serves without benefit of a road system.[27] The principal provider of health services at the village level is the community health aide, chosen by the village council. Planning for long-term care involves determining the level of patient care needed and providing home health services when possible. To date, with the exception of a nursing home wing in Nome, there are no nursing facilities in Alaskan villages and only two developing home health agencies. The establishment of home and community-based long-term care services has been difficult and has achieved limited success.

"The principal provider of health services at the village level is the community health aide."

New federal policy released during FY97 expanded 100 percent federal funding for Medicaid services to Alaska Natives to include tribal facilities and contract health services. Unfortunately the Health Care Financing Administration (HCFA) has determined that the actual health care must be provided "in" an Indian Health Service or tribal owned or leased facility in order to qualify for the 100 percent

federal funding. This ruling effectively eliminates any home and community-based care services from receiving the full federal reimbursement.

"The DHSS took exception to this ruling."

The Department of Health and Social Services took exception to this ruling and on June 9, 1997 wrote a position paper in support of an expansion of HCFA's interpretation to include community-based care. This letter states, "(It) is clear that the intent in adopting the 100 percent Medicaid Reimbursement Formula was to remedy the problem of access to Medicare and Medicaid supported services, and assure that states did not receive an unfair and inequitable burden of costs that normally would have been born by the Indian Health Service."[28]

The paper continued, "Home care services are under the control of the Indian Health Service or tribal health program, authorized under the Indian Health Care Determination Act, and covered as State Plan services under Medicaid, and should not be restricted from enhanced federal funding."[29]

The Indian Health Service is the prime provider of long-term care health service in rural Alaska. If the Health Care Financing Administration were to alter its opinion and recognize community-based services as being eligible for 100 percent federal reimbursement, the potential additional funding would have a definite beneficial impact on the level of services provided in rural Alaska.

"The Task Force recognizes and supports the Indian Health Service's role in providing long-term care."

The Task Force recognizes and supports the Indian Health Service's role in providing long-term care services. In addition, the Task Force encourages the Department of Health and Social Services to aggressively pursue its rebuttal of the Health Care Financing Administration's interpretation of 1905 (b) of the Social Security Act and provide the Legislature with semi-annual updates on the process of the Department's inquiry. ❖

HOME AND COMMUNITY-BASED LEGISLATION

RECOMMENDATION 13

The Task Force recommends that legislation be drafted and introduced to establish a home and community-based services program for certain adults with long-term care needs.

In 1995 Governor Knowles appointed a Long-Term Care Steering Committee, chaired by Department of Administration Commissioner Mark Boyer and Department of Health and Social Services Commissioner Karen Perdue, to develop and implement an interdepartmental Long-Term Care Strategic Plan. The Steering Committee developed legislation to create a comprehensive home and community-based services program that would not be limited to just Medicaid-eligible persons.

"Many seniors and adults with disabilities canot fully pay for all the long-term care services they need."

Many seniors and adults with disabilities cannot fully pay for all the long-term care services they need, but still cannot qualify to receive Medicaid benefits. When these moderate income seniors or adults with disabilities do not receive the necessary health care services, they can ultimately require more intensive services than would have been needed had they received earlier support to stabilize their situation.

The legislation proposed by the Steering Committee authorizes the Department of Administration to establish and administer a program of home and community-based support services for adults with long-term care needs. Under this proposed legislation, adults receiving services are expected to contribute through co-payments for services on a sliding scale and are required to apply for payment from other sources if available.

"The Task Force acknowledges the value of home and community-based long-term care services."

The long-term care home and community-based program offered under Medicaid is meeting great acceptance. When given an option, people often elect to receive the long-term health care they need in their home and community rathe. than an institution. Almost twice as many Alaskans elected this Medicaid waiver in FY97 as in FY96.

Passage of the proposed legislation will allow all Alaskans with demonstrated needs the opportunity to request services through the Department of Administration's home and community-based care program, not just those eli-

gible for Medicaid. The Task Force acknowledges the value of home and community-based long-term care services and recommends this legislation be introduced for further consideration. (Please see Appendix B, page 69, for further detail.) ❖

MEDICAID COVERAGE FOR ALZHEIMER'S PATIENTS

The Task Force requests the Departments of Administration and Health and Social Services review all options available to the state, including Medicaid, to support the long-term care needs of patients whose sole diagnosis is Alzheimer's Disease and Related Disorders.

Alzheimer's Disease and Related Disorders (ADRD) refers to cognitive impairments that are progressive and degenerative in nature. As a result of these impairments, effected adults require supervision and cueing from other individuals in order to adequately and routinely perform activities of daily living and instrumental activities of daily living.[30] People whose sole diagnosis is Alzheimer's Disease and Related Disorders do not typically require daily supervision by medical professionals.

"To be eligible for Alaska's Medicaid long-term care waiver programs, applicants must require skilled nursing services."

To be eligible for nursing home care and home and community-based services from Alaska's Medicaid program, applicants must be low-income and require skilled nursing or intermediate care. Persons whose sole diagnosis is ADRD typically do not meet the criteria for skilled nursing or intermediate care and consequently, the Alaska Medicaid program will not pay for nursing home placement or home and community-based services.

Alaska is only one of two states whose Medicaid eligibility standards for nursing home and home and community-based services require that the patient needs "professional-level medical supervision."[31] This requirement, as determined by the Department of Health and Social Services, effectively eliminates eligible Medicaid ADRD-only patients from the state's major long-term care services.

Persons with ADRD may have great difficulty living without assistance.[32] Currently for many people who suffer from ADRD, respite service for their families is the only long-term care service available.[33] The Task Force recognizes the desire for additional assistance for this particular group of Alaskans and understands that