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the temporary relief provided to the family caregivers is not enough to adequately address the pressing long-term care needs of an ADRD individual.

However, modifying the Medicaid eligibility requirement for ADRD-only patients may have budget implications for the state.[34] Approximately 40 percent of the cost for qualified Medicaid patients is paid from the state's General Fund. Some states have reduced the budget impacts by requiring that all long-term care patients receive universal care plan counseling. (Please see recommendation 20) The effect of this requirement has been to place residents in the least restrictive long-term care setting, which often is also the lowest-cost setting. The effect has been to prolong the time that residents can pay for their own care, and therefore, reduce the potential cost to the Medicaid program.[35]

"Persons with ADRD may have great difficulty living without assistance."

In addition to the budget concerns, the Division of Senior Services may not have the capacity to serve the additional clientele who may apply for home and community-based waiver services if ADRD is included as an eligible diagnosis.

Even though changing the Medicaid eligibility requirement to include ADRD-only patients raises serious concerns, 48 other states offer Medicaid programs to patients suffering from only Alzheimer's Disease. Alaska should too.

The Task Force requests the Department of Administration and the Department of 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. Also, the Task Force requests that a preliminary report outlining the departments' findings be submitted to the President of the Senate and Speaker of the House by April 30, 1999. ❖

INCREASE MEDICARE ACCESS

RECOMMENDATION 15

The Task Force requests the Department of Health and Social Services conduct a review of Medicare patients' access to medical services within the state and, if warranted, explore options to increase their access to health care.

The Task Force heard testimony regarding individuals covered by Medicare who were having difficulty accessing health care services. General concerns were ex-

pressed that some medical providers may refuse to accept new clients covered by Medicare, may drop patients as they approach age 65, or may elect not to become Medicare certified.

"Lack of access to adequate care under Medicare may have adverse consequences for the health of elderly Alaskans."

Lack of access to adequate care under Medicare may have adverse consequences for the health of elderly Alaskans and, as such, impact the long-term care needs of that population. If our seniors cannot get adequate primary care, their health may deteriorate. Because Medicare does not pay for most long-term care services, the lack of access to primary care has the effect of shifting the cost of care from Medicare to Medicaid, out-of-pocket expenses, and other local resources.

The Task Force is concerned about the possible limited access to Medicare services. The Task Force requests the Department of Health and Social Services conduct a review of Medicare-eligible Alaskans' access to medical services within the state and, if warranted, explore options to increase their access to health care. The Task Force recommends that a comparison be made of allowable Medicare rate reimbursements to the actual cost of providing the service and a summary of the findings be included in the review. ❖

INCREASE RATE FOR GENERAL RELIEF PATIENT CARE

The Task Force supports an increase in the rate paid to assisted living home providers under the general relief assistance program and requests the recommendations of the *Alaska Rate Study Report* be considered in determining the new rate structure.

The Department of Administration has the responsibility to provide a vulnerable adult with protective services when necessary. (AS 47.24.017) Often, the needed protective service includes placement of the vulnerable adult in an assisted living home at the state's expense.

"The rate...for the typical general relief client was established in 1983 at $34.50 per day."

The general relief payment made by the state is the amount needed to make up the difference between what the clients can pay, and the predetermined cost of provided services. The rate of payment for assisted living services for the typical general relief client in Alaska was established in 1983 at approximately $34.50 per day. The Division of Senior Services noted on a 1998 fiscal note accompanying legislation under consideration, "(T)he current base rate is not adequate to meet rising costs of providing assisted living care. A rate increase is overdue."[36]

It was also noted in a recent study that over 95 percent of the residents living in smaller assisted living homes (15 beds or less) are being provided help with activities of daily living. While the vast majority of these residents are private pay, the general relief residents were being provided most of these services as part of the base rate. "It should be noted that these services are much more difficult to provide in the smaller homes without the appropriate staff-to-resident ratio."[37] Without adequate reimbursement for general relief clients, it is difficult to maintain the appropriate staff-to-resident ratio.

"The lack of cost-of-care adjustments to the Assisted Living Home fee structure jeopardizes the future of Assisted Living Homes," wrote the Division of Mental Health and Developmental Disabilities, February 25, 1998.[38] Subsequently, the Assisted Living Training Institute, LLC, was hired as a consultant by the Department of Administration to review the current rate structure for general relief clients, and recommend a new rate plan that fairly represents the cost to provide the needed long-term care services.

"The lack of adjustments to the fee structure jeopardizes the future of Assisted Living Homes."

The Institute stated, "(M)inimal support of Activities of Daily Living (ADL) should and must be provided within any rate agreed upon. All facilities surveyed indicated that ADL services are now being provided without compensation."[39]

The Task Force recognizes that the current daily rate for general relief patients is unacceptable and supports an increase to the basic rate. The *Alaska Rate Study Report* should be considered in determining the final rate structure increase. ❖

SENIOR HOUSING OFFICE

The Task Force urges continued support for Alaska Housing Finance Corporation's Senior Housing Office and its state planning grant program.

In 1990 the Legislature established the Senior Housing Office (SHO) to " . . . promote a comprehensive response to the needs of senior citizens for adequate, accessible, secure, and affordable housing in the state." (AS 18.56.700) Initially the Senior Housing Office was operated within the Department of Community and Regional Affairs. On July 1, 1992 the SHO, other DCRA housing activities

and the Alaska State Housing Authority were merged with the Alaska Housing Finance Corporation.

Before the creation of the Senior Housing Office, senior housing development was almost nonexistent. Since its inception, AHFC programs have helped to create 25 new senior housing facilities with total development costs approaching $85 million. According to testimony presented to the Task Force, all senior housing has been designed with the "aging in place" concept, which helps facilitate both the current and future needs of older Alaskans.

"AHFC programs have helped to create 25 new senior housing facilities with total development costs approaching $85 million."

Recently the Senior Housing Office has been expanding its efforts to encourage the construction of assisted living facilities. Within the past couple of years, the SHO has helped in the development of approximately 135 new units of assisted living, thereby providing increased capacity to seniors who need long-term care services.

In addition to the loan program available under AHFC, the Senior Citizen's Housing Development Fund (AS 18.56.800) provides grants to qualified recipients to develop and plan various types of senior housing facilities. Funds from this program cover professional expertise (preliminary architectural drawings, construction and operating estimates, legal fees, and other services) necessary to develop and plan a senior housing unit. Testimony indicated that this program is vital to the future growth of senior housing in Alaska.

The Task Force recognizes the past efforts of AHFC's Senior Housing Office and applauds its success in assisting in the construction of 25 senior housing facilities. The Task Force urges continued support of the Senior Housing Office and its vital state planning grant program. ❖

LONG-TERM CARE DELIVERY SYSTEM

The *Legislative Working Group on Long-Term Care* stated its goal was to "advocate for long-term care that is responsive to the individual circumstances of Alaska's senior citizens and those with physical disabilities."[40] The *Working Group* recommended making the fullest use of the state's long-term care funding through expanding health care choices that are cost-effective and provide the long-term care as close to home as feasible.

"The Working Group recommended making fullest use of the state's long-term care funding through expanding health care choices."

The system of delivering long-term care has changed over the past few years. The current and projected population growth have encouraged new and creative long-term care programs. Alaskans are now able to receive the care they need in their homes or as close to their homes as is possible.

As the delivery system continues to evolve, issues that are of mutual interest to long-term care consumers and their families and private and public long-term care providers will be identified and resolved. It is a never-ending evolution of ideas and solutions. ❖

LONG-TERM CARE SERVICES AVAILABLE

The Task Force requests the Alaska Commission on Aging coordinate and strengthen efforts to inform and educate all Alaskans on long-term care services available in Alaska.

Alaska's home and community-based long-term care services enable a limited number of Alaskans to receive long-term care in their homes and communities, rather than in institutions. Under this program, Alaska offers a wide variety of services to seniors and adults with physical disabilities.

Home and community-based care services are partially funded through Alaska Commission on Aging grants to non-profit corporations across Alaska. In most instances, the state grants cover from 45 percent to 60 percent of the actual cost of services. The non-profit corporations generate a mix of local funding to cover the actual costs of services. Clients pay for services on a sliding scale according to their income. The services provided are as follows:

"The care coordinator identifies appropriate services based on (an) assessment."

- *Care Coordination* is a service through which a trained professional assesses a frail consumer's needs. The care coordinator identifies and arranges appropriate services based on this assessment and in consultation with the consumer's family. Care coordination incorporates outreach, intake screening, initial assessment, care planning, service arrangement, ongoing monitoring and formalized assessment.

- *Adult Day Centers* provide supervised group care and therapeutic activity in a social setting for seniors needing assistance with daily living tasks. Care is provided at a central site during the weekdays. Recently some centers have begun providing limited weekend care as well.

- *Respite Care* is provided by trained caregivers who provide periodic care in a senior's home. This means family caregivers can take a break from their work as full-time caregivers. While this care is usually provided in the elder's own home, respite care can also be provided in facilities such as assisting living homes, nursing homes, and adult day centers.

- *Hot nutritious meals* are prepared and served in group settings to seniors at central locations or delivered to homebound seniors.

"Medicaid provides funds for two long-term care home and community-based waiver programs, through the CHOICES program."

- *Escorted transportation services* are available in many communities and allow consumers access to community services.

Medicaid provides funds for two long-term care home and community-based waiver programs, through the CHOICES program. These programs, administered by the Division of Senior Services, Department of Administration, cover the costs of care necessary for individuals to continue living within their home or community. The cost of these waiver services must not exceed the cost of nursing home services the person would otherwise receive.

In addition to care coordination, adult day services, and respite care, the CHOICES program may cover the following, as necessary:

- *At-Home Skilled Nursing Care* provides skilled nursing care by licensed professionals.

- *Assisted Living Care* services, other than room and board, are provided for seniors or adults with physical disabilities who need assistance with activities of daily living.

- *Personal Care* provides in-home assistance with activities of daily living such as bathing, dressing, toileting, eating and moving from one place to another. These services can enable a person with non-technical medical care needs to remain at home rather than live in an acute or long-term care facility. (A person does not need to elect a waiver program to receive personal care services.)

"Over the last several years, home and community-based alternatives have increased dramatically."

Over the last several years, home and community-based alternatives to institutional long-term care in Alaska have increased dramatically, in part because of the expansion of Medicaid coverage of these services.[41] However, it still is difficult for the consumer to negotiate the confusing array of long-term care service alternatives.[42] Concise, relevant information on services available to seniors and individuals with disabilities must be readily and easily accessible to all.

The Task Force requests the Alaska Commission on Aging coordinate and strengthen efforts to inform and educate all Alaskans on the various long-term care services available. In addition, the Task Force requests the Alaska Commission on Aging to provide semi-annual updates on its efforts to the members of the Senate and House Health, Education and Social Services Committee. ❖

SCREENING AND ASSESSMENT TOOL

RECOMMENDATION 19

The Task Force requests the Department of Administration establish a uniform and comprehensive screening and assessment tool to be used by all program administrators when an individual enters a nursing home or selects a Medicaid waiver program.

In April 1996 the United States General Accounting Office examined the assessment instruments utilized in long-term care planning for all 50 states. Their findings indicated that very few states use a comprehensive assessment tool. Questions were raised as to whether sufficient information was being collected in the

less comprehensive assessments to develop an appropriate plan of care across settings.

Alaska is no exception. Alaska does not utilize an assessment process that supports a smooth transition between places of care.[43] At this time, several divisions within the Department of Health and Social Services and the Department of Administration administer programs for seniors and adults with disabilities. These agencies not only bring different perspectives to long-term care assessment, but also use different assessment tools for a variety of different purposes. This fragmented assessment process makes it difficult for a patient to move along the long-term care continuum of services.

"An accurate assessment is a valuable cornerstone to any program that provides for the long-term needs of Alaskans."

An accurate assessment is a valuable cornerstone to any program that provides for the long-term needs of Alaskans. Such assessment is especially relevant in Alaska, where there are multi-service long-term care programs offered. A uniform screening and assessment tool will assist patients to receive the right level of care, at the right time, and in the most cost-effective manner possible.

A comprehensive assessment tool will assist extended care providers in Alaska in planning for a person's health care needs at the first point of service along the continuum of care. This information will 1) ensure that the patient receives the right level of care, at the right time, and in the most cost-effective manner; 2) provide a centralized data base for the efficient and effective planning for extended care services in Alaska; and 3) contribute to developing a seamless planning process as the patient moves between settings along the continuum of care.[44]

"The use of consistent definitions...will provide health caregivers a common understanding of long-term needs in Alaska."

The Task Force recognizes that a genuine effort has been made to reach the goal of having a uniform, comprehensive screening and assessment tool, but unfortunately this goal has not yet been met. The Division of Senior Services is poised to tackle this challenge and plans to involve all the key health care industry stakeholders to help design the assessment tool, as well as determine the necessary health care definitions. The use of consistent definitions that are recognized and understood statewide will provide health caregivers a common understanding of long-term care needs in Alaska.

The Task Force requests the Department of Administration establish a uniform and comprehensive screening and assessment tool to be used when an individual enters a nursing home or selects a Medicaid waiver program and develop a pilot program to assess its validity and reliability by July 1, 2000. ❖

UNIVERSAL CARE PLAN COUNSELING

RECOMMENDATION 20

The Task Force requests the Department of Administration evaluate a phased-in universal care plan counseling requirement for all Alaskans entering the long-term care system, regardless of their ability to pay.

The purpose of universal long-term care plan counseling (or pre-admission assessment) is to educate consumers about their long-term care options. Long-term care counseling helps individuals find an appropriate long-term setting of their choice. Currently long-term care counseling is not available to all Alaskans entering the long-term care system.

"The purpose of universal long-term care plan counseling is to educate consumers about their long-term options."

Medicaid eligible patients are now more likely to receive information about their long-term options than are non-Medicaid eligible individuals. "(N)on-Medicaid eligible Alaskans who are being discharged from hospitals are not receiving adequate and consistent information, and as a result, some have been placed in nursing homes without understanding their choices. Others are not necessarily receiving the services of their choice, or in the location of their choice."[45]

Under a pilot project in Anchorage, long-term care planning is available in hospitals and long-term care facilities. Professional staff from the Division of Senior Services, Department of Administration, work directly with long-term care providers to identify Medicaid-eligible Alaskans for whom the waiver program might be appropriate. A care coordinator is assigned to the patient and the patient's needs are screened and assessed. The seniors and the adults with physical disabilities are active participants in the planning process and determine the best health care plan for them. Based on the information provided to them, many adults opted for the waiver services.

"Medicaid eligible patients are now more likely to receive information about their long-term options than are non-Medicaid eligible individuals."

Both Medicaid-eligible and non-Medicaid-eligible individuals will benefit from long-term care planning. The Task Force recognizes how important appropriate and timely long-term care planning and care coordination is for the long-term health of both seniors and adults with disabilities. Therefore, the Task Force requests the Department of Administration evaluate a phased-in universal care plan counseling requirement for all Alaskans entering the long-term care system, regardless of their ability to pay. ❖

CERTIFICATE OF NEED

RECOMMENDATION 21

The Task Force recommends that legislation be drafted and introduced to adopt the nursing home certificate of need recommendations developed by the *Legislative Working Group on Long-Term Care* (1997).

Under AS 18.07, the Department of Health and Social Services administers the Certificate of Need Program. This program was created as a tool to control health care costs and prevent unnecessary or duplicative facilities or services. A certificate of need is required of any health facility planning to spend one million or more for construction, expansion or remodeling.

"The certificate of need review process is required of any health facility planning to spend a million dollars or more for construction."

The certificate of need review is initiated when a health care facility submits a letter of intent to the Department of Health and Social Services. This letter of intent provides the project description, estimated cost, and starting and completion dates for the project. Based on the letter of intent, the department determines whether a detailed certificate of need application is needed. Once the application is received and declared complete, department staff analyzes the request and makes a recommendation to the Commissioner of Health and Social Services, who decides to approve or deny the application. The decision to grant or deny a certificate of need may be appealed.

In June 1996, HB 528 was signed into law (Chapter 84, SLA 96). This placed a two-year moratorium on the issuance of certificates of need or licenses for any new nursing home beds in Alaska effectively preventing any nursing home beds from being added until the moratorium expired. This two-year moratorium expired May 1, 1998. The law was passed due to concerns over the potential rapid growth of nursing home beds that became imminent as the result of the planned addition of 147 new nursing beds costing $11 million annually. The moratorium allowed time to develop alternatives to nursing home beds and assess what could be done to promote cost containment.[46]

The six-member working group established under HB 528 thoroughly analyzed the current procedure to grant certificates of need to long-term care health facilities and determined several weakness in existing law. As currently written, AS 18.07.041 requires the Department of Health and Social Services to grant a certificate of need if "the availability and quality of existing health care resources or the

accessibility to those resources is less than the current or projected requirement for health services to maintain the good health of citizens of this state." In other words, the Department must grant a certificate of need for new construction, expansion or remodeling of a nursing home facility if the service is not available or sufficiently accessible, and the applicant can demonstrate that th. proposed service will be provided in a quality manner.

"The Legislative Working Group states that the certificate of need program requires more explicit statutory definition."

In its report the *Legislative Working Group* stated the following:

> While availability, accessibility and quality are important, they are insufficient for assessing a current or projected requirement for health services. Meeting a current requirement does not mean that there is a long-term need for the service or facility or there will be the resources necessary to sustain the service or facility throughout its life cycle. Similarly, meeting a current or projected need does not mean that it is the most cost-effective method for doing so; nor does it mean that the State, facing declining resources, should encourage and support a low priority service in the face of more pressing priorities. The certificate of need program requires more explicit statutory and regulatory definition in these areas to better control costs and better target the health care priorities of Alaskans.[47]

Currently there is a potential in Alaska for many new nursing beds to be built and, if built, these beds will cost the state a great deal. Using a medium growth projection, it is estimated that the senior population in Alaska will grow from 31,398 in 1997 to 80,927 by 2015.[48] In FY97, the Alaska Medicaid program spent $43.8 million for 720 licensed nursing home beds. If the need for beds remains constant in the future, the number of beds could grow to 1,861 by 2015, a 250 percent growth at the annual cost to Medicaid of an additional $109.5 million. "Proposed projects need to be compared against feasible alternatives to determine if the proposal is the most cost effective way of achieving comparable results."[49]

"Under the legislation, new nursing home projects will need to demonstrate cost effectiveness."

Under the legislation proposed by the *Legislative Working Group on Long-Term Care,* new nursing home projects will need to demonstrate the cost-effectiveness of each request. Proposed projects will be compared against feasible alternatives to determine if the proposal is the most effective way to achieve comparable results. The Task Force recognizes that this issue needs more discussion and recommends that legislation be introduced for further consideration. (Please see Appendix B, page 69, for further detail. ❖

CONSOLIDATION OF SERVICES

The Task Force requests the Departments of Health and Social Services and Administration monitor the success of long-term care programs offered by states which have consolidated their efforts and determine if consolidation would benefit the people of Alaska in the future.

In 1995, the Division of Senior Services, Department of Administration, contracted with Ladd & Associates to review the long-term care system in Alaska, compare it with other state systems, and evaluate its effectiveness.

In its analysis of Alaska's long-term care system, Ladd & Associates said, "The state organizational structure that administers long-term care is one of the most fragmented in the nation. Each of these units of state government has different missions and different methods of conducting business. Many of these agencies serve other populations besides those requiring long-term care, and they also administer other health and social programs. It is difficult to make long-term care a priority in this current state structure."[50]

"It makes little sense, from a management point of view, to have this program separated from the other components of long-term care."

Based on its findings, Ladd & Associates recommended that the Division of Senior Services, Department of Administration, be transferred intact to the Department of Health and Social Services. "It makes little sense, from a management point of view, to have this program separated from the other components of long-term care, and the other supportive health and social services that seniors require."[51]

The Alaska State Hospital and Nursing Home Association (ASHNHA) also echoed ideas expressed by Ladd & Associates. In August 1996 ASHNHA hired Health Dimensions, a consulting firm specializing in health care issues, to identify common themes regarding long-term care services in Alaska and propose solutions to the identified problem areas. As the result of this review, ASHNHA recommended the reorganization of the Pioneer Homes under the authority of the Department of Health and Social Services. "The Pioneer Homes and the community nursing homes are under separate administrative offices yet they are a significant financial component to providing long-term care services to seniors."[52]

"Keeping these homes under separate funding sources supports the continuation of a fragmented continuum of care."[53] Under their proposal, the Department of

Health and Social Services would become a central point for identifying and monitoring statewide efforts to provide increased services to the increasing senior population with limited state dollars.[54]

"Other states in general have found that through consolidation, they reduce the time and energy spent managing these programs and concentrate their resources on the people that the programs serve."[55]

"A major organizational restructure occurred with the creation of the Division of Senior Services."

The Task Force wrestled with these recommendations from two respected, yet distinctly different, consultants. The Task Force noted the fact that both long-term care advisors arrived at the same conclusion. However, it also recognized that in 1993, a major organizational restructure occurred with the creation of the Division of Senior Services within the Department of Administration. As noted in Administrative Order No. 139, the purpose of the reogranization was to provide better access to services and promote dignity and independence for seniors. In addition to this major reorganization, in 1996 and 1997, several other programs were transferred from the Department of Health and Social Services to the Department of Administration.

The Task Force recognizes that the various programs responsible for the delivery of long-term care services have undergone significant management restructuring over the past few years and, possibly, the time is not right to consider yet another move: a move towards consolidating all long-term care programs within one department.

"At some point, the time may be right for Alaska to consider the value of consolidation of services."

However, at some point the time may be right for Alaska to consider the value of consolidation of services. The Task Force recommends the Department of Health and Social Services, Department of Administration, and the Legislature monitor the success of the various long-term care programs offered by states that have consolidated their efforts into one agency and determine if consolidation would benefit the people of Alaska in the future.

In addition, the Task Force received testimony that the Office of the Long-Term Care Ombudsman may be more effective if placed in a department or agency that is independent of the administrative functions that administer long-term care services, funding or licensing. The Task Force requests the Department of Administration survey other states to determine whether the Office of the Long-Term Care Ombudsman is located in a neutral agency and recommend any necessary changes.

GOVERNMENT FUNDING FOR LONG-TERM CARE

States beware – Medicaid long-term expenditures for the elderly could double in inflation-adjusted dollars between 1993 and 2018. That was the opening message of Dr. Joshua M. Wiener, principal research associate at the Urban Institute, who addressed participants from 46 states during the April 2, 1998, *Health Policy Monitor Teleconference.*

Wiener also added that the "current long-term care for the elderly accounts for 14 percent of state and local health expenditures and 25 percent of all Medicaid expenditures. Medicaid long-term care takes on a broader function than it does for the population as a whole and thus, states will face unprecedented pressures in the years ahead. Considering these facts and the onset of an aging population, long-term care for the elderly is clearly an important issue for states."[56]

"Because of the high cost of nursing home care, Medicaid serves as a safety net for both the middle class and the poor."

Medicaid expenditures in Alaska mirror what is happening elsewhere. Because of the high cost of nursing home care, Medicaid serves as a safety net for both the middle class and the poor. The percentage of long-term care Medicaid payments far exceeds the percentage of eligible beneficiaries. The elderly and individuals with disabilities compose only 16 percent of the people eligible for Medicaid, while their Medicaid expenditures total 52 percent.

The Task Force recognized this looming problem, but a quick fix was elusive and not available. Alaska, like all other states, must continue to confront these issues and make small, incremental improvements until a national solution is implemented. ❖

COORDINATION BETWEEN MEDICAID AND MEDICARE

The Task Force requests the Department of Health and Social Services seek out new opportunities for improved program coordination between Medicare and Medicaid and consider this relationship when developing state Medicaid policy.

Medicare, administered by the federal government, is a major source of health care coverage for people over age 65 and for many younger people with substantial disabilities. While Medicare provides coverage for most primary and acute care services, it covers very little long-term care services.

"Medicaid is the primary payer of long-term care services in Alaska."

On the other hand, Medicaid, administered by state government, is the primary third-party payer of long-term care services in Alaska. Yet the management of long-term care cannot truly be separated from primary and acute care. Good primary care can reduce long-term care needs by keeping people healthy and more active longer. Good long-term care support services can reduce the need for acute care services by keeping people from the medical crises associated with inadequate long-term care.

Coordination of these two programs is important to the management and delivery of effective long-term care. In 1997, Congress established the Program for All-inclusive Care for the Elderly (PACE), a cooperative arrangement between Medicare and Medicaid. Under the PACE model, people who are 55 years of age and older and need a nursing-home level of care can receive their care from a PACE provider. This provider is responsible for providing all Medicaid and Medicare services for the PACE recipient.

"Less comprehensive means of coordinating the Medicaid program with Medicare may be available."

PACE offers a way to make integrated health policy decisions and to capture the cost savings associated with better care management; however, the decision to pursue this option cannot be made lightly. A substantial, multi-year planning effort would be necessary to assure the success of the program in Alaska.

In the meantime, less comprehensive means of coordinating the Medicaid program with Medicare may be available to the Department of Health and Social Services. The Task Force requests the Department of Health and Social Services seek out new opportunities (including PACE, if practical) for improved program

coordination and consider the relationship of these two programs when developing state Medicaid policy. ❖

MEDICAID AND MEDICARE ELIGIBLE

RECOMMENDATION 24

The Task Force requests the Department of Health and Social Services identify the necessary changes, either in regulation or in statute, to assure the Medicare program funds health care services provided to dual eligible patients.

Medicare is the federal health insurance program for Americans age 65 or older and certain Americans with disabilities. Eligible Americans are automatically covered by Medicare Part A (hospital insurance) if they receive Social Security benefits. If the individual is not eligible for Social Security, a premium may be required.

Medicare is completely funded by federal dollars; no state money is necessary. Unfortunately Medicare doesn't pay for all of the medical expenses for the people it is meant to serve. In fact, Medicare now pays for less than half of the total health care bill of older people.[57] But for those services that Medicare will reimburse, it is to Alaska's advantage to bill the federal government for payment.

"If nursing homes billed Medicare for services...an estimated General Fund savings to the Medicaid program could be as high as $400,000."

Currently the Alaska Medicaid program pays Medicare premiums, deductibles, and coinsurance on behalf of Medicaid recipients eligible for Medicare benefits. However, not all Alaska nursing homes bill Medicare when appropriate, but, instead rely on Medicaid to reimburse the facilities for the health care costs incurred. (Medicaid is a federal and state health care program; 40 percent of the cost is paid from the state's General Fund.) If nursing homes billed Medicare for Medicare services provided to patients eligible for both Medicaid and Medicare, the Department of Health and Social Services estimates that the annual General Fund savings to the Medicaid program could be as high as $400,000.[58]

In recent years, the Department of Health and Social Services has encouraged nursing facilities to bill Medicare for services provided to patients who qualify for both Medicare and Medicaid (dual eligible). This urging has achieved limited results.[59] In some instances, nursing homes bill Medicare for inpatient hospital care (Medicare Part A), but do not request payment from Medicare for ancillary

services covered under Medicare Part B (physician services, laboratory tests, occupational therapy and physical therapy).

"DHSS has several options on how to build a plan that will assure Alaska receives the maximum benefit from the federal government."

The Department has several options on how to build a plan that will assure Alaska receives the maximum benefit from the federal government for dual eligible patients. One alternative under consideration is to remove Medicare-eligible services from the Medicaid payment rates structure.[60] This action would force nursing facilities to either bill Medicare for the services, or discontinue the service, or absorb the cost of service.

As the state is currently paying Medicare premiums for Medicaid patients so that those clients will be eligible for Medicare health benefits, it is important that the federal government pay for all health services covered under Medicare. But it is equally important that health care providers and the Department of Health and Social Services cooperatively decide on the solution to recover federal dollars under Medicare.

The Task Force requests the Department of Health and Social Services identify the necessary changes, either in regulation or statute, to assure the Medicare program funds health care services provided to dual eligible patients. In addition, the Task Force requests that the department report to the President of the Senate and the Speaker of the House by March 31, 1999 on its efforts to comply with this recommendation.

MILLER TRUST

The Task Force requests the Department of Health and Social Services review the regulations that govern the Miller Trust program and propose recommended changes, if necessary.

In determining eligibility for Medicaid assistance for long term care services, Alaska is considered an "income-cap" state. The financial eligibility criteria for Medicaid assistance for nursing home or home and community-based services per individual is a monthly income limit of $1,482 with a resource limit of $2,000.[61] As a result of this income level cap, many individuals are disqualified due to excess income,

even though they still do not have enough income or resources available to cover their long-term medical needs.[62]

The "Miller Income Trust" authorized by the Omnibus Budget Reconciliation Act of 1993 lifted the lid on income caps altogether for most people.[63] Under federal law, an individual may establish an irrevocable trust, known as a "Miller Trust." The trust is a mechanism that allows people who do not qualify for Medicaid coverage, based solely on income, to qualify by assigning their income to a trust. Approximately 70 Alaskans established Miller Trusts in 1997 thereby qualifying for long-term care services through Medicaid. Although all medical needs are covered under Medicaid, people who establish a Miller Trust will permanently lose all their disposable income. "It is a big step, and should not be entered into lightly."[64]

"Many individuals are disqualified even though they still do not have enough income to cover their long-term medical needs."

The Miller Trust allows individuals who need long-term care services and earn slightly more than the established allowable monthly maximum to qualify for Medicaid. "However, one difficulty that we (Alaska Legal Services Corporation) have observed is that trustee fees are not among the items for which the Trust must pay. For needy Alaskans with disabilities or the elderly who have no friends or family to serve as trustees, this can create an extreme hardship."[65] In response to this recognized concern, Ms. Marcia Rom, director of the Senior Law Project, and private attorney Ms. Una Gandbhir conducted a policy study on how Miller Trusts were administered nationwide. This study was supported by a grant from the Alaska Mental Health Trust Authority.

Upon completion of the nationwide review, it was concluded that two options were available to help relieve this financial burden assumed by some individuals who establish a Miller Trust. Two possible solutions are: 1) that the cost of administering the trust be considered an allowed expense covered by the Miller Trust; or 2) that an independent funding source be identified and established to pay a fixed fee for trust administration. The Task Force agrees that this issue should be explored further and requests the Department of Health and Social Services revisit the regulations governing the Miller Trust in response to this recent study.

"The Task Force agrees that this issue should be explored further."

SECURECARE CONGRESSIONAL PROPOSAL

The Task Force acknowledges and supports the four guiding principles of the American Health Care Association's *SecureCare* congressional proposal.

"The elderly and Americans with disabilities deserve quality long-term care."

The American Health Care Association (AHCA), formed in 1949, is a federation of 50 affiliated health care associations, together representing more than 11,000 non-profit and for-profit assisted living, nursing facility, and subacute care providers. AHCA is concerned about the "graying" of America and the looming health care crisis. "Our nation is not prepared to care for its aging population. We must replace the existing long-term care system with a new system that is designed to meet the long-term care needs of our grandparents, our parents and ourselves before the current system collapses. The elderly and Americans with disabilities deserve quality long-term care. It is what each of us wants for our loved ones and ourselves. If we are to ensure that quality long-term care is available to all that need it, the nation must work together for change. *SecureCare* is that change."[7,1]

SecureCare, a proposal before Congress, is built on four principles designed to solve the nation's long-term care crisis while preserving the safety net for America's poor elderly and persons with disabilities. The guiding principles are to: 1) transform long-term care from welfare to health care; 2) coordinate long-term care private resources with Medicare and Social Security; 3) encourage personal and family responsibility for long-term care; and 4) maximize quality and control costs through market competition and consumer choice.

The Task Force recognizes that the long-term crisis is not limited to Alaska, but is a problem facing the entire nation.

- Across the nation, Medicare does not address the long-term care and nursing home needs of our nation's elderly. Medicare covers only those nursing facility services provided to help a resident recover from an acute illness or injury. In most cases, Medicare provides for, at a maximum, the first 100 days of care and only if certain conditions are met.[66]

- Nationwide, two out of every three nursing home residents rely on Medicaid to pay for their care.[67] (However, in Alaska four out of every five nursing home residents are Medicaid patients.)

- Every eight seconds in America, a baby boomer turns 50.[68]

"Every eight seconds in America, a baby boomer turns fifty."

- Americans aged 85 and older are the fastest-growing segment of population and the heaviest users of long-term health care services. From 1960-1994, the 85 and older age group increased by more than 274 percent. Longevity is expected to rise for all ages.[69]

- Two out of five Americans will need long-term care at some point in their lives.[70]

- In 1996, the nationwide average cost of a stay in a nursing facility was $51,000 per year. Only one in four Americans can afford private nursing home care for one year – yet the average length of stay in 1995 for a nursing facility resident was 2.3 years.[71] (In Alaska, the current average cost of a stay in a nursing home facility is $98,000 per year for a Medicaid patient and $117,500 per year for a private pay patient.)

"In Alaska, the current average cost of a stay in a nursing facility home is $98,000 per year for a Medicaid patient and $117,500 per year for a private pay patient."

- Three out of four nursing facility residents are women.[72]

These statistics are daunting and the problem, overwhelming. The creative minds of all Americans will be required to find a solution. One option under consideration is the American Health Care Association's proposal *SecureCare*. AHCA's goal is "to work together with other organizations and legislative bodies to develop solutions. For us, *SecureCare* is not an end product but rather the beginning of a process to stimulate discussion."[74]

The four guiding principles of *SecureCare* set the framework for this discussion and will lead toward a workable resolution of the long-term care uncertainty. The Task Force acknowledges and supports these four guiding principles. ❖

ALASKA MENTAL HEALTH TRUST AUTHORITY

The Task Force supports the continued partnership with the Alaska Mental Health Trust Authority to help meet the long-term care needs of Alaskans.

In 1994, the Alaska Mental Health Trust Authority was created to ensure an integrated, comprehensive mental health program (AS 47.30.011). The Authority administers the Mental Health Trust, reconstituted by the Legislature in 1994, and preserves and protects the trust assets.

"Through a collaborative partnership...the lives of many have significantly improved."

Through a collaborative partnership between the Trust Authority, the Governor, and the Legislature, the lives of many Trust beneficiaries, who are heavy users of Alaska's long-term care system, have significantly improved. The Trust's beneficiary groups include Alaskans experiencing mental illness, developmental disabilities, Alzheimer's Disease and Related Dementia, and chronic alcoholism with psychosis.

"The Trust allocated between $6.6 million to $11.5 million each year for three years..for people needing long-term care."

Beginning in FY97, the Trust allocated between $6.6 – $11.5 million each year for three years to provide direct services or home and community-based services for people needing long-term care. Trust income, increases in General Fund/mental health dollars and other receipts have funded new projects for community living support services, treatment and emergency services, and planned closing or size reduction of institutions to return residents to community-based settings where appropriate. The projects and proposals funded through the Trust created new efficiencies and innovative ways to deliver long-term care services.

The FY00 Trust funding recommendations include critical funding for increased rates for general relief clients residing in assisted living homes. In addition, the Trustees have expressed support for the "one-stop shop" concept for long-term care services, recommended using savings from the Alaska Longevity Bonus program to increase services to senior Alaskans, and explored ways to improve the guardianship system in Alaska.

The current partnership between the Trust Authority, the Governor, and the Legislature, is necessary to assure these improvements continue. The Task Force recognizes the partnership formed with the Alaska Mental Health Trust Authority and supports the continued working relationship. ❖

PRIVATE FUNDING FOR LONG-TERM CARE

In a recent interview, U.S. Sen. Charles Grassley, Chairman of the Senate Special Committee on Aging, stated the following:

"The role of private long-term care insurance is critical."

> Longer and healthier lives are a blessing and a testament to the progress and advances made by our society. However, all Americans must be alert and prepared for long-term care needs. The role of private long-term care insurance is critical in meeting this challenge. Because increasing numbers of Americans are likely to need long-term care services, it is especially important to encourage planning today.
>
> Earlier this year, the Special Committee on Aging, which I chair, held a hearing to explore the challenges of providing long-term care for the baby boomer generation. A key message from that hearing was that policy makers need to encourage personal responsibility for financing long-term care. Most families are not financially prepared when a loved one needs long-term care.
>
> So, with the impending retirement of the baby boomers, it is imperative that Congress takes steps now to encourage all Americans to plan ahead for potential long-term care needs. The bill I introduced, S.2492, The *Long-Term Care and Retirement Security Act*, will do this. It will allow Americans who do not currently have access to employer subsidized long-term care plans to deduct the amount of such a plan from their taxable income. This bill will encourage planning and personal responsibility while helping to make long-term care insurance more affordable for middle class taxpayers and encourage Americans to be pro-active and prepare for their own long-term care needs by making insurance more widely available and affordable.

"The Task Force applauds the fact that members of Congress recognize the severity of the long-term care financing problem."

The Task Force applauds the fact that members of Congress recognize the severity of the long-term care financing problem facing America, as well as Alaska, and that possible solutions are being proposed and discussed. ❖

ALASKA'S LONG-TERM CARE PLAN FOR RETIREES

RECOMMENDATION 28

The Task Force recognizes and applauds the Public Employees' Retirement Board and the Teachers' Retirement Board effort to update the State of Alaska's Long-Term Care Plan and encourages consideration to expand the LTC Plan to include active employees.

In 1987 Alaska was the first state government employer to offer long-term care coverage to retiring state employees.[75] Employees covered under the Public Employees' Retirement System or the Teachers' Retirement System may select a voluntary Long-Term Care (LTC) Plan for themselves and their spouses upon retirement. This LTC Plan provides a range of health and social services for people who, because of a chronic condition, might need help with the basic activities of daily living.[76] The plan's premiums are paid entirely by the retirees.

"Alaska was the first state government employer to offer long-term care coverage."

Since the first Long-Term Care Plan was offered to retiring employees, it has been a popular option. Currently, approximately 45 percent of retirees select the LTC Plan. Of the 18,839 state retirees covered by medical insurance as of June 1998, 8,309 had signed up for LTC insurance. Almost half of those, or 3,479, had also enrolled their spouses.[77] The premium is based on the individual's age on the date of enrollment: a person under the age of 50 years pays a monthly premium of $16.10, while an employee retiring at the age of 65 years will pay $80.45 per month.

The employees of the State of Alaska are very fortunate that this Long-Term Care Plan is available to them. According to the 1994 Employee Benefits Survey by the Bureau of Labor Statistics, only 4 percent of state and local government employees in the United States were eligible for long term-care insurance.[78]

"The employees of the State of Alaska are very fortunate that this Long-Term Care Plan is available to them."

In order to assure the best plan possible is offered, the Public Employees' Retirement Board and the Teachers' Retirement Board met in a joint meeting, October 27, 1998 and considered a presentation by Deloitte & Touche LLP on the existing Long-Term Care Plan and several options for improvement. Deloitte & Touche LLP discussed possible plan modifications to allow flexibility in choosing the Daily Maximum Benefit, as well as a Lifetime Maximum. The presentation discussed the potential expansion of the "benefit triggers" to include cognitive impairment, e.g. Alzheimer's Disease and Related Diseases, and explained the possible components covered under home and community-based services. Both re-

tirement boards expressed interest in adjusting its current Long-Term Care Plan and asked Deloitte & Touche LLP to refine the various options presented to the boards and report back in another joint meeting on March 23, 1999.

Deloitte & Touche LLP brought to the two boards' attention the possibility of including active state employees under the Long-Term Care Plan. According to Deloitte & Touche LLP, Alaska is unique in limiting eligibility for long-term care insurance to retirees only.[79] Any proposal that increases the number of individuals covered under a private long-term care insurance plan will decrease the potential future burden to the Medicaid program and ultimately reduce the state's General Fund obligation. The "true promise" of long-term care insurance is in the employer-sponsored market, where people can buy policies when they are young enough to ensure affordability.[80]

"Any proposal that increases the number of individuals covered under a private long-term care insurance plan will decrease the potential future burden to the Medicaid program."

The Task Force applauds the Alaska Retirements Boards' foresight in exploring ways to expand the Long Term Care Plan to include active employees and encourages serious consideration of this proposal. ❖

INFORMATION ON PRIVATE LONG-TERM CARE INSURANCE

The Task Force requests the Division of Insurance compile relevant information on the need for and availability of long-term care insurance in Alaska and disseminate the information to the general public.

On March 9, 1998 Mr. Paul Willging, Ph.D., executive vice-president of the American Health Care Association, testified before the U.S. Senate Special Committee on Aging. "Most Americans (76 percent) do not believe they will ever need long-term care, but the facts are that two out of five will at some point in their lives, and that one in five over the age of 50 is at risk of needing long-term care within 12 months. None-the-less, few take any steps to plan for the possibility, believing Medicare will provide for their needs. Medicare, of course, will not. It only provides limited long-term care, so government help for most Americans comes only when they have exhausted their personal savings and are forced onto welfare."[81]

"Most Americans (76%) do not believe they will ever need long-term care, but the facts are that two out of five will at some point in their lives."

Private long-term care insurance coverage, must be considered as another option. Although the market is still small – the American Association of Retired Persons

estimates 6 percent of older people have private polices – interest is growing. The Health Insurance Association of America (HIAA) data revealed that in 1986, fewer then 125,000 policies were in effect. Eleven years later, roughly 5 million policies had been written.[82]

"In Alaska in 1997, approximately 80 percent of nursing home costs were paid by the Medicaid program."

Private long-term care insurance usually pays for skilled, intermediate, or custodial care in a nursing home. It can also cover a variety of home and community-based care services. Typically, long-term care polices pay up to a specific dollar amount for covered services per day, reimbursing policy owners for expenses they incur. Annual premiums for long-term care insurance policies can range from $250 to over $2,500 depending on age, waiting periods, and the duration and amount of benefits.[83]

According to the Health Care Financing Administration, approximately 80 percent of nursing home costs were paid by the Medicaid program in Alaska in 1997, while only 10 percent were paid by either private long-term care insurance or out-of pocket. This federal-state welfare system cannot continue to exist unless a change is made. The private sector must begin to shoulder a greater portion of the financial burden. As shown, private long-term care insurance is affordable if purchased early in life. Unfortunately, many people believe that long-term care insurance is unnecessary and display a basic unwillingness to face up to their own future frailty.[84]

"Alaskans should be encouraged to examine the options available through private long-term care insurance."

However, this does not mean that the issue should be dropped. Indeed, Alaskans should be encouraged to examine the options available through private long-term care insurance and ultimately, if appropriate, purchase policies that meet their individual needs. Accurate, concise, and unbiased information about long-term care insurance and the alternatives available is invaluable in this decision-making process. State government, especially through its annual publications, mailings, and mass media campaigns, has the ability to inform all residents about this issue.

The Task Force requests the Division of Insurance compile relevant information on the need for and availability of long-term care insurance in Alaska and disseminate the information to the general public by January 1, 2000. ❖

CENTER FOR LONG-TERM CARE FINANCING

RECOMMENDATION 30

The Task Force recognizes the value of the information compiled and distributed by the Center for Long-Term Care Financing and encourages the continued association with the Center.

Mr. Stephen Moses and Mr. David Rosenfeld established The Center for Long-Term Care Financing in April 1998. The Center's mission is to promote universal access to top-quality long-term care by encouraging private financing and discouraging welfare financing of long-term care for most Americans.

The Center for Long-Term Care Financing advocates public policy that targets scarce public resources to the neediest, while encouraging people who are young, healthy and affluent enough, to take responsibility for themselves. The Center publishes, free of charge, a periodic on-line news service called "LTC Bullets" which covers the latest information and trends in long-term care financing.

"The Center for Long-Term Care Financing's mission is to promote universal access to top-quality long-term care by encouraging private financing and discouraging welfare financing."

Mr. Stephen Moses was formerly Director of Research for LTC, Incorporated and a senior analyst for the Health Care Financing Administration and the Office of Inspector General of the U.S. Department of Health and Human Resources. On November 19, 1998 Mr. Moses addressed a National Press Club Forum in Washington, D.C. on the topic of long-term care financing reform.

The Task Force reviewed the Center's first policy paper, *LTC Choice - A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle*, and found the material very informative and practical. As the issue of long-term care financing is discussed at the national level, as well as in Alaska, the current and accurate information available through this organization will be invaluable. The Task Force recognizes the value of the information compiled and distributed by the Center for Long-Term Care Financing and encourages the continued association with the Center. ❖

CONCLUSIONS

The major driving force in the Alaska long-term care system for the next few decades will be the extremely high growth rate of the elderly population. At the current high growth rate the 65 to 74 age population will double every 14 years, the 75 to 84 age population will double every 12 years, and the 85 and over population will double every 10 years. These growth rates will have lasting consequences in Alaska. [85]

These high growth rates are coupled with the high cost of providing long-term care in Alaska. Medicaid nursing home costs per day are the highest in the nation, $223.61.[86] For a private pay patient the average cost of a stay in a nursing home facility is $117,500 per year.[87] Long-term health care in Alaska is expensive.

We must remember that neither private health insurance nor Medicare covers long-term care to any significant extent, and few older adults have private long-term care insurance. Because of the high cost of long-term care, Medicaid coverage for long-term care provides a safety net for the middle class as well as the poor. In Alaska, 80 percent of nursing home residents were dependent on Medicaid to finance at least some of their care. Medicaid long-term care expenditures for the elderly are projected to more than double in inflation-adjusted dollars between 1993 and 2018.[88] If this projection is tied to Alaska's high growth rate of the elderly population, the potential financial burden facing our state is tremendous.

"The ideas are a beginning; this problem will be solved one step at a time."

The recommendations presented by the Long-Term Care Task Force are certainly not the total answer to this huge problem. But the ideas are a beginning; this problem will be solved one step at a time. With the steps set forth in this report, the quality of long-term care will improve, the access to long-term care will expand, and the delivery of long-term care will be enhanced. These steps will slow the growth of state expenditures and begin the shift from public spending to private responsibility.

The Task Force recommended creative approaches to one of our state's most pressing health concerns. Our recommendations are grounded in real-work experience and the realization that all Alaskans have a personal stake in ensuring quality long-term care is available for all residents. The Task Force trusts the 21st Legislature will give serious consideration to these recommendations. ❖

CREATION OF A NEW TASK FORCE

RECOMMENDATION 31

The Task Force requests the Senate and House Health, Education and Social Services Committees, in consultation with the legislative leadership, strongly consider the creation of a new task force to continue the review and monitoring of long-term care in Alaska.

Senate Concurrent Resolution 11 created the Long-Term Care Task Force, but also terminated the task force upon the convening of the First Regular Session of the Twenty-First Alaska State Legislature, January 19, 1999.

As acknowledged throughout this report, the study and review conducted by this Task Force is only the first step in meeting its ultimate goal in developing a suitable and equitable plan for providing access to long-term care for all Alaskans. Additional work needs to be done; current long-term care options must be further analyzed and new options explored.

"Oversight by a group of legislators, state officials, and the public interested in long-term health care is important."

The Task Force recognizes that oversight by a group of legislators, state officials, and the public interested in long-term health care is important. Such a commission, if appointed, would be in a position to monitor the state's long-term care programs as they evolve to meet the needs of all Alaskans. This group would provide the necessary leadership and guidance to ensure success of the Task Force's suggestions and recommendations.

The representatives of the public may include people who are receiving long-term care, have relatives who are receiving long-term care, are from an organization that represents the interests of people in need of long-term care, are health care providers whose services include long-term care, or have had experience with an Alaska Native organization that delivers long-term care services in a rural area of the state.

The Task Force requests the Senate and House Health, Education and Social Services Committees, in consultation with the legislative leadership, strongly consider the creation of a new task force to continue the review and monitoring of long-term care in Alaska.

GLOSSARY OF COMMONLY USED TERMS

ADRD - Alzheimer's Disease and Related Disorders.

Activities of Daily Living - This term includes activities such as: eating, bathing, dressing, using the toilet, communication, and moving from one place to another.

Assisted Living Homes - Formerly called adult foster homes, assisted living homes are facilities that provide a homelike environment for seniors and people who have a disability and need assistance with everyday living activities.

Care Coordination or Case Management -The assessment of needs, coordination and monitoring of services required by an individual experiencing a short-term medical crisis or long-term chronic care. These services, offered by trained providers, will ensure that long-term care resources are used strategically.

Certificate of Need (CON) - A certificate issued by the State of Alaska to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment, modify a health facility, or offer a new or different health service. CON is intended to control expansion of facilities and services by preventing excessive or duplicative development of facilities and services.

CHOICES - The CHOICES Program provides home and community-based services for seniors 65 or older and adults with physical disabilities who require a nursing facility level of care and who are eligible for Medicaid. With the assistance of a care coordinator, each senior or adult with physical disabilities who qualifies and elects home care instead of care in a nursing facility will have services described in a plan of care paid for from state Medicaid funds.

Chronic Care - Care and treatment provided to individuals whose health problems are long-term and continuing in nature.

Health Care Financing Administration (HCFA) - The federal government agency within the U.S. Department of Health and Human Services which directs the Medicare and Medicaid programs and conducts research to support those programs.

Home and Community-Based Care - Long-term care services delivered outside of a nursing home. These services include transportation, home delivered meals, home care, home alterations and maintenance, personal care, adult day services, assisted living facilities, respite care, and care coordination.

Long-Term Care - A combination of health care, personal care, and social services required by people who have some degree of diminished capacity on a long-term basis.

Medicaid - A federally-aided, state-operated and administered program that provides medical benefits for certain indigent or low-income persons in need of health and medical care. Authorized under Title XIX of the Social Security Act, it requires people to meet specified eligibility criteria. Subject to broad federal guidelines, states determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.

Medicare - A U.S. health insurance program for people aged 65 and over, for individuals eligible for Social Security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis. Monies from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B).

Personal Care Attendant - A trained health care paraprofessional who has received 75 hours of classroom training and who provides services under the clinical supervision of a nurse. Personal care attendants provide hands-on assistance to help clients perform activities of daily living.

Skilled Nursing Facility - A nursing facility participating in the Medicaid and Medicare programs which meets specified requirements for services, staffing, and safety.

Spend-Down - The amount of expenditure for health care services, relative to income, that qualifies an individual for Medicaid in states that cover categorically eligible, medically indigent individuals. Eligibility is determined on a case-by-case basis.

Underinsured - People with public or private insurance policies that do not cover all necessary medical services, resulting in out-of-pocket expenses in excess of their ability to pay.

Wellness - A dynamic state of physical, mental, and social well-being; a way of life which equips the individual to realize the full potential of his or her capabilities and to overcome and compensate for weaknesses; a life-style which recognizes the importance of nutrition, physical fitness, stress reduction, and self responsibility.

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Long-Term Care in Alaska: Recommendations for Reform – A copy may be obtained from Ms. Kay Burrows, Director of the Division of Senior Services, Department of Administration.

Moving Toward the Development of a Balanced Long-Term Care Delivery System in Alaska – A copy may be obtained from the Alaska State Hospital and Nursing Home Association.

APPENDIX A

SCR 11

CS FOR SENATE CONCURRENT RESOLUTION NO. 11(FIN)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE SENATE FINANCE COMMITTEE

Offered: 3/19/98
Referred: Rules

Sponsor(s): SENATORS SHARP, Duncan, Ward, Adams, Ellis, Hoffman, Kelly, Taylor, Wilken, Torgerson, Mackie, Green

REPRESENTATIVES Hudson, Brice, Croft

A RESOLUTION

Creating the Long-Term Care Task Force.

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

WHEREAS the establishment of a system to meet the long-term care needs of aging Alaskans is an important issue not only for elderly persons but also for young and middle-aged Alaskans as they attempt to meet the needs of their parents at the same time that they are facing their own and their children's needs; and

WHEREAS the cost of long-term care, whether in a home setting or in an institution, often exceeds an individual's ability to pay for the care either immediately or after a short period of time, causing extreme economic and social stress and hardship for many people who have worked hard for many years and still do not have sufficient assets or income to bear the costs of their care; and

WHEREAS residents in a Pioneers' Home have been asked to pay the full cost of their long-term care within seven years, resulting in as much as a 30 percent increase this year in some rates for care in the system; and

WHEREAS 80 percent of the cost of care for persons now receiving long-term care in privately operated long-term care facilities is paid through state and federal funds under the Medicaid program; and

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
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CS FOR SENATE CONCURRENT RESOLUTION NO. 11(FIN)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE SENATE FINANCE COMMITTEE

Offered: 3/19/98
Referred: Rules

Sponsor(s): SENATORS SHARP, Duncan, Ward, Adams, Ellis, Hoffman, Kelly, Taylor, Wilken, Torgerson, Mackie, Green

REPRESENTATIVES Hudson, Brice, Croft

A RESOLUTION

Creating the Long-Term Care Task Force.

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

WHEREAS the establishment of a system to meet the long-term care needs of aging Alaskans is an important issue not only for elderly persons but also for young and middle-aged Alaskans as they attempt to meet the needs of their parents at the same time that they are facing their own and their children's needs; and

WHEREAS the cost of long-term care, whether in a home setting or in an institution, often exceeds an individual's ability to pay for the care either immediately or after a short period of time, causing extreme economic and social stress and hardship for many people who have worked hard for many years and still do not have sufficient assets or income to bear the costs of their care; and

WHEREAS residents in a Pioneers' Home have been asked to pay the full cost of their long-term care within seven years, resulting in as much as a 30 percent increase this year in some rates for care in the system; and

WHEREAS 80 percent of the cost of care for persons now receiving long-term care in privately operated long-term care facilities is paid through state and federal funds under the Medicaid program; and

WHEREAS current federal and state long-term care policies of the state have resulted in large subsidies from the state's general fund that will increase in the future, competing with funding for other state programs; and

WHEREAS the legislature established a working group in 1996 to analyze issues regarding long-term care services in the state, including projected costs to the state of various alternative methods of providing long-term care;

BE IT RESOLVED that the Alaska State Legislature establishes the Long-Term Care Task Force to develop an equitable plan for providing long-term care for all Alaskans; and be it

FURTHER RESOLVED that the task force shall consist of the following nine voting members:

(1) three members of the House of Representatives appointed by the Speaker of the House of Representatives; at least one member shall be a member of the majority and at least one a member of the minority;

(2) three members of the Senate appointed by the President of the Senate; at least one member shall be a member of the majority and at least one a member of the minority;

(3) three members of the public, one each chosen by the Governor, the Speaker of the House of Representatives, and the President of the Senate, from among people who are receiving long-term care, have relatives who are receiving long-term care, are from an organization that represents the interests of people in need of long-term care, are health care providers whose services include long-term care, or have had experience with an Alaska Native organization that delivers long-term care services in a rural area of the state; and be it

FURTHER RESOLVED that the following persons may serve on the task force as nonvoting members:

(1) the commissioner of health and social services or the commissioner's designee;

(2) the commissioner of commerce and economic development or the commissioner's designee; and

(3) the commissioner of administration or the commissioner's designee; and

be it

FURTHER RESOLVED that the public members of the task force shall serve without compensation but are entitled to per diem and travel expenses authorized for boards and commissions under AS 39.20.180; and be it

FURTHER RESOLVED that the task force shall select a chair and vice-chair from among its voting members, shall meet as frequently as the task force determines necessary to perform its work, may meet during the interim, and may meet and vote by teleconference; and be it

FURTHER RESOLVED that the task force shall

(1) review the work done and the recommendations made by the long-term care working group established under sec. 3, ch. 84, SLA 1996, if available;

(2) review existing elder care services in Alaska, including rural Alaska, including the current types of delivered care and the projected future care demands;

(3) review the existing Pioneers' Home system, its current types of delivered care, and its projected future care demands, and craft a mission statement for the Pioneers' Home system to set goals to meet long-term senior care needs;

(4) prepare a plan, including drafts of legislation that might be necessary to implement the plan, for establishment of an actuarially sound system of long-term care and propose funding options, including options that would allow prepayments by persons desiring coverage for long-term care and require reasonable copayments by the recipients of the care;

(5) hold public hearings on the plan, legislation, and funding proposals developed under (4) of this clause;

(6) redraft the plan, legislation, and funding proposals based on the comments received at the public hearings and other information that becomes available to the task force; the final plan, with proposed legislation and funding options, shall be available for public review at least 30 days before the convening of the First Regular Session of the Twenty-First Alaska State Legislature; and

(7) submit the plan, proposed legislation, and funding options to the Governor and the legislature by the convening of the First Regular Session of the Twenty-First Alaska State Legislature; and be it

FURTHER RESOLVED that the task force may begin work immediately upon the

appointment of its full voting membership and is terminated upon the convening of the First Regular Session of the Twenty-First Alaska State Legislature.

APPENDIX B

PROPOSED LEGISLATION

1-LS0139\A
Lauterbach
11/6/98

_____ BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - FIRST SESSION

BY

Introduced:
Referred:

A BILL

FOR AN ACT ENTITLED

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

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

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

Sec. 18.20.090. Disclosure of information. (a) The department shall make reports concerning annual inspections and investigations of the facilities or entities it licenses in this chapter, including statements of deficiencies and approved plans of correction, available to the public within 14 calendar days after the information is made available to the facility or entity being reviewed.

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

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

Article 2. Home Health Agencies.

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

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

Sec. 18.28.120. Powers of department. The department may

(1) license and supervise home health agencies;

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

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

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

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

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

Sec. 18.28.140. Application for license. Application for a license to operate

a home health agency shall be made to the department on a form provided by the department and shall be accompanied by applicable fees established by the department under AS 18.28.120.

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

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

(c) The department shall establish the standards for license renewal and determine the renewal period by regulation.

(d) A license is not renewable if it has been suspended or revoked under AS 18.28.160.

Sec. 18.28.160. Denial, suspension, or revocation of license. (a) The department may deny, change to a provisional license, or revoke a home health agency application or license if the department finds that the agency

(1) has endangered or would endanger the health, safety, or welfare of a patient;

(2) has a history of deficiencies in quality of care;

(3) has had a license to operate a home health agency revoked in any licensing jurisdiction;

(4) has been convicted of operating a home health agency without a license in any licensing jurisdiction;

(5) lacks a sufficient number of personnel who have the training, experience, or judgment to provide adequate patient care;

(6) has committed fraud, deceit, misrepresentation, or dishonesty associated with the application for or operation of a home health agency in any licensing jurisdiction; or

(7) has violated regulations adopted under AS 18.28.110 - 18.28.190.

(b) The department may, without a hearing, summarily suspend a home health agency license if it finds that the actions or deficiencies of the agency cause an immediate and serious threat to the public health, safety, or welfare. A summary suspension remains in effect until the department finds that the actions or deficiencies are corrected or the license is revoked.

(c) The department may, without a hearing, change a home health agency license to a provisional license for a period of time established by the department if the department finds that an agency is temporarily unable to comply with AS 18.28.110 - 18.28.190 or is in the Medicare decertification process, but is taking the appropriate steps necessary to bring the agency into compliance. An agency holding a provisional license may not accept new patients. If the agency fails to correct its deficiencies within the provisional license period, the department shall revoke that agency's license.

(d) Application denial and revocation actions by the department shall be conducted under AS 44.62 (Administrative Procedure Act).

Sec. 18.28.190. Definitions. In AS 18.28.110 - 18.28.190,

(1) "branch" means an office location from which a home health agency provides service within a portion of the total geographic area served by the parent home health agency and that is sufficiently close in geographic proximity to the parent home health agency that it shares administration, supervision, and services on a daily basis;

(2) "department" means the Department of Health and Social Services;

(3) "geographic area" means the location, site, or address of the clients served by the parent home health agency or its parents or subunits;

(4) "home health agency" is a public agency or private organization, or a subdivision of such an agency or organization, that primarily engages in providing skilled nursing services in combination with medical social services, occupational therapy, speech therapy, and other home health aide services to individuals in the individual's home, an assisted living home, or another residential setting;

(5) "parent home health agency" means a licensed home health agency,

which may have branches or subunits;

(6) "subdivision" means a component of a multi-function home health agency, such as the home care division of a hospital or the nursing division of a health agency, that independentiy meets the requirements for a licensure as a home health agency;

(7) "subunit" means a home health agency that provides services beyond the geographic area served by the parent home health agency and is unable to share administration, supervision, and services on a daily basis with the parent home health agency.

* **Sec. 3.** TRANSITION. A department affected by this Act may proceed to adopt regulations necessary to implement this Act. Regulations to implement a provision of this Act take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of sec. 2 of this Act.

* **Sec. 4.** REVISOR'S INSTRUCTION. In AS 18.28.040, 18.28.050, and 18.28.100, the revisor shall substitute "AS 18.28.010 - 18.28.100" for "this chapter."

* **Sec. 5.** Section 3 of this Act takes effect immediately under AS 01.10.070(c).

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

TONY KNOWLES, GOVERNOR

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MEMORANDUM

DATE: January 11, 1999

TO: Sheila Peterson
Staff Assistant
Long-Term Care Task Force

FROM: Elmer A. Lindstrom
Special Assistant to the Commissioner

SUBJ: Licensing Home Health Agencies and Disclosure of Licensing Reports Bill

The Department of Health and Social Services and Department of Administration have reviewed the above named bill under consideration by the Long-Term Care Task Force. We support this bill, both for the Disclosure of Licensing Reports and Licensing Home Health Agencies sections. We have included an analysis of each section and recommendations we feel are essential to the bill.

Section 1
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. 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.

Recommendations:
If this language is included only in AS18.20, it would not allow for the disclosure of licensure reports for hospice organizations licensed under AS18.18 or for disclosure of reports of home health agencies licensed under statute proposed in this bill. It is recommended the bill include similar language in AS18.18 and in the home health licensure section to allow for disclosure of reports in these facilities/agencies as well. Recommended language would be:

- ***Section _. AS 18.18. is amended by adding a new section to read:**
  Sec. 18.18.350. Disclosure of information. (a) The department shall make reports concerning inspections and investigations of the hospice programs it licenses in this chapter, including statements of deficiencies and approved plans of correction, available to the public within 14 calendar days after the information is made available to the hospice organization or entity being reviewed.

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

- Similar language is included in recommendations for home health agencies below.

Note: There is no FY2000 fiscal impact to this section of the bill.

Section 2
Home Health 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 and specific 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.

Recommendations:

- I am not sure why the bill suggests putting this statute under AS 18.28. Chapter 28 relates to "State Assistance for Community Health Aide Programs." Home health agencies have no relationship to the Community Health Aid Programs. I would suggest the bill place the statute in a separate chapter the same as the hospice program licensure was (AS 18.18), such as AS 18.17 or AS 18.19.

- **Section 18.28.120(1) should be revised to read:**
  Sec. 18.28.120. Powers of department. The department may
  (1) license[AND SUPERVISE] home health agencies;

Note: The words "and supervise" should be removed because it is not a function of the licensing agency to supervise a home health agency. As a regulator, we enforce regulation and statute and provide oversight to ensure compliance. This would be different than supervision

- Section 18.28.130(a) should be revised to read:
  Sec. 18.28.130. License required. (a) An entity that establishes, conducts, or represents itself to the public as a home health agency, or otherwise meets the definition found at AS 18.28.190(4) [OR AN ORGANIZATION THAT PROVIDES COORDINATED HOME HEALTH SERVICES FOR COMPENSATION] must have a license from the department authorizing it to be a home health agency under AS 18.110 - 18.28.190.

  Note: The language "or an organization that provides coordinated home health services for compensation" should be stricken because there are other types of services provided in the

  home by other types of organizations that should not be considered home health agencies under this proposed statute. These include but are not limited to: entities providing in home respiratory care; and in home intravenous therapies provided by pharmacies. Entities such as these may coordinate care in the home and not meet the definition of a home health agency.

The current language is too broad and would lead to confusion and challenge. Rationale for requiring licensing of entities that meet the home health agency definition is to ensure compliance with minimum standards for entities effectively operating as home health agencies, but may not be calling themselves such.

- **Section 18.28.190(4) should be revised to read:**
  Sec. 18.28.190. Definitions

...

(4) "Home health agency" is a public agency or private organization, or a subdivision of such an agency, or organization, that primarily engages in providing skilled nursing services in combination with [MEDICAL SOCIAL SERVICES,] physical therapy, occupational therapy, speech therapy, or [AND OTHER] home health aide services to individuals in the individual's home, an assisted living home, or another residential setting;

Note: A home health agency is only required to provide at a minimum skilled nursing service in combination with one other therapy of those listed above. Acceptable therapies are physical therapy, occupational therapy, speech therapy or home health aide services. Medical social services MUST NOT be included as a qualifying service. This is consistent with the federal standards for Medicare certification. Additionally, the current language would require home health agencies provide all the above therapies, which would create undue hardship on most home health agencies and would result in many to go out of business. Therefore, it is highly recommended that "medical social services" be deleted, "physical therapy" be inserted, "or" be inserted, and "and other" be deleted as shown above. Again. physical therapy qualifies as one of the therapies that may be used along with skilled nursing, and must be included, while medical social services does not qualify as one of the required therapies that may be used. Medical social services may be provided by a home health agency, however the agency must also have skilled
nursing service and one of the other qualifying therapies as well

- Disclosure of licensure reports for home health agencies licensed under the statute proposed in this bill is recommended. Recommended language to be inserted would be:

Sec. 18.28.170. Disclosure of information. (a) The department shall make reports concerning inspections and investigations of the home health agency it licenses in this chapter, including statements of deficiencies and approved plans of correction, available to the public within 14 calendar days after the information is made available to the home health organization or entity being reviewed.

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

Note: Because the Department is currently surveying home health agencies, there would be no increased funding necessary for this bill anticipated for FY2000.

Sec. 3 TRANSITION
Sec. 4 REVISOR'S INSTRUCTION
Sec. 5

No concerns or comments.

cc: Pat Pourchot, Legislative Director
Office of the Governor
Karen Perdue, Commissioner
Department of Health and Social Services
Alison Elgee, Deputy Commissioner
Department of Administration

1-LS0135\A
Lauterbach
11/5/98

_____ BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - FIRST SESSION

BY

Introduced:
Referred:

A BILL

FOR AN ACT ENTITLED

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

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

*** Section 1.** AS 47.24.015(c) is amended to read:

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

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

or

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

*** Sec. 2.** AS 47.24.019(a) is amended to read:

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

*** Sec. 3.** AS 47.24.019(c) is amended to read:

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

*** Sec. 4.** AS 47.24.050(b) is amended to read:

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

*** Sec. 5.** TRANSITION. A department affected by this Act may proceed to adopt regulations necessary to implement this Act. Regulations to implement a provision of this Act take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of sec. 1 of this Act.

*** Sec. 6.** Section 5 of this Act takes effect immediately under AS 01.10.070(c).

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

TONY KNOWLES, GOVERNOR

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MEMORANDUM

DATE: January 11, 1999

TO: Sheila Peterson
Staff Assistant
Long-Term Care Task Force

FROM: Elmer A. Lindstrom
Special Assistant to the Commissioner

SUBJECT: Draft legislation relating to vulnerable adults

The Department of Health and Social Services and Department of Administration have revised the draft legislation relating to vulnerable adults and support it's introduction as drafted.

This bill will increase the State's ability to provide protective services to a vulnerable adult in circumstances when the vulnerable adult's guardian, attorney in fact, or surrogate decision-makers the alleged perpetrator of abuse.

We appreciate the Task Force's endorsement of these changes.

cc: Pat Pourchot, Legislative Director
Office of the Governor
Karen Perdue, Commissioner
Department of Health and Social Services
Alison Elgee, Deputy Director
Department of Administration

I-LS0138\A
Lauterbach
11/6/98

_____ BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - FIRST SESSION

BY

Introduced:
Referred:

A BILL

FOR AN ACT ENTITLED

"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."

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

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

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

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

(3) expanding the availability of in-home or community-based services would allow adults to maintain their independence longer, maximize the adult's or family's resources to provide essential care and perhaps avoid or reduce state expenditures for care, and avoid

potential emotional and social problems that can result from an adult having to relocate to an institution hundreds of miles away from family or friends;

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

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

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

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

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

(3) encourage a variety of agencies, facilities, and individuals to provide in-home and community-based services in the state.

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

Article 2. In-Home and Community-Based Services Program for Medically, Physically, or Cognitively Impaired Adults.

Sec. 47.24.200. In-home and community-based services program for medically, physically, or cognitively impaired adults. (a) There is created in the department a program to administer, coordinate, and deliver or to award grants or contracts for the delivery of in-home and community-based services for adults eligible for services under AS 47.24.200 - 47.24.290.

(b) The program may serve only the adults who are eligible for the program. The program may not replace or augment state-administered programs for in-home and community-based services for adults described in AS 47.24.205(b). The expenditures of this program may not exceed the appropriations available for it.

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

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

(1) the adult is not described in (b) of this section;

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

(3) the adult's need for services is because of medical, physical, or cognitively functional impairment;

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

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

(b) The department may not consider an adult with any of the following illnesses, impairments, or disorders as eligible for the program even if the adult also has other illnesses, impairments, or disorders that would otherwise make the adult eligible for the program:

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

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

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

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

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

(1) is at risk of being or already has been placed in a setting providing

services more restrictive than is necessary to meet the adult's needs or more restrictive than the adult would choose;

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

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

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

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

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

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

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

purposes of the program.

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

(d) The department may use demonstration projects to test new approaches to in-home and community-based services in limited areas in the state.

Sec. 47.24.225. Responsibilities. (a) An adult receiving services under the program shall contribute a copayment towards the cost of care and apply for, cooperate with, and seek payment from other sources as required by the department for which the adult is eligible for the same services.

(b) The department shall establish in regulation a schedule for copayments under this section. The schedule must vary on a sliding scale based on

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

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

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

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

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

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

Sec. 47.24.235. Comprehensive data system. The department shall develop and implement a comprehensive data system that tracks in-home and community-based

services, expenditures, services, consumer profiles, and consumer preferences. The department shall seek to coordinate and to share data with other state and local agencies or organizations.

Sec. 47.24.240. Assessment and care coordination services. The department may implement a system of long-term care assessment and care coordination to minimize administrative costs, improve access to appropriate services, and minimize obstacles to the delivery of in-home and community-based services to adults eligible for services under the program.

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

Sec. 47.24.290. Definitions. In AS 47.24.200 - 47.24.290,

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

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

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

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

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

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

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

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

(b) The department shall adopt regulations identifying actions that it will take, in addition to those otherwise required under AS 47.17 and **AS 47.24.010 - 47.24.130**

[AS 47.24], when a report of harm is made under AS 47.17 or AS 47.24.010 [AS 47.24] that might relate to harm caused by actions or inactions of a public home care provider. The regulations must

(1) address circumstances under which the department will, or will require a contractor or grantee to, reassign, suspend, or terminate a person alleged to have perpetrated harm;

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

(3) if the home care provider is a certified nurse aide, include procedures under which the department shall notify the Board of Nursing if the nurse aide is suspected of abuse, neglect, or misappropriation of property.

* **Sec. 5.** AS 47.24.011 is amended to read:

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

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

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

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

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

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

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

services;

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

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

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

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

* **Sec. 7.** AS 47.24.070 is amended to read:

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

* **Sec. 8.** AS 47.24.130 is amended to read:

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

AS 05.15.210.

* Sec. 9. This Act takes effect immediately under AS 01.10.070(c).

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

TONY KNOWLES, GOVERNOR

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MEMORANDUM

DATE: January 8, 1999

TO: Sheila Peterson
Staff Assistant
Long-Term Care Task Force

FROM: Elmer A. Lindstrom
Special Assistant to the Commissioner

SUBJ: Proposed Amendments to draft legislation establishing an in-home and community-based services program for certain adults with long-term care needs

Funding for home-based services under the new program established under the bill was never intended to supplant other funding available to clients through existing state programs. The original draft of the bill addressed this potential issue by deeming certain classes of persons, e.g., the developmentally disabled, ineligible for the new program since developmentally disabled persons are already eligible for home-based services through existing programs.

The proposed amendments attempt to accomplish the same objective by making it clear that the Department of Administration may not authorize payment for services under the new program if the applicant is eligible for these services through another state program. We believe this is a cleaner approach to resolving the issue than making persons with specific illnesses, impairments, or disorders categorically ineligible for the program.

Based on this analysis, the Department of Health and Social Services and Department of Administration recommend the following amendments:

AS 47.24.200 (b)

Line 30 - Strike "described in AS 47.24.205(b)"

AS 47.24.205 (a)

Line 10 - Strike (1), and renumber.
Lines 18-28 - Strike all of (b)

AS 47.24.215 (b) is amended to read:

The department may not authorize payment for the following services:

(1) intermediate or skilled care provided by a nursing facility or hospital licensed under AS 18.20;

(2) services provided in the Alaska Pioneers' Home under AS 47.55;

(3) home and community based services normally provided through another state program.

The department may adopt regulations to grant waivers from the provisions of this subsection if the department finds that these services are necessary on a short-term basis to allow the adult to remain at home or in a less restrictive care setting than that described in (1) or (2) of this subsection.

Please feel free to contact my office if you or Legislative Legal Services have any questions about the proposed amendment.

cc: Pat Pourchot, Legislative Director
Office of the Governor
Karen Perdue, Commissioner
Department of Health and Social Services
Alison Elgee, Deputy Commissioner
Department of Administration

1-LS0137\A
Lauterbach
11/9/98

_____ **BILL NO.**

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - FIRST SESSION

BY

Introduced:
Referred:

A BILL

FOR AN ACT ENTITLED

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

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

*** Section 1.** FINDINGS. The legislature finds that

(1) ch. 84, SLA 1996, placed a two-year moratorium on the issuance or modification of certificates of need under AS 18.07 for nursing beds and created a working group to analyze issues relating to long-term care and the certificate of need program;

(2) it is anticipated that the long-term care system in Alaska will face a crisis in its ability to provide services to a growing and increasingly aging population by the twenty-first century unless the system can provide services in a more efficient and appropriate manner;

(3) in 1996, the state spent $120,000,000 in long-term care services for approximately 5,000 Alaskans; approximately two-thirds of these expenditures, $80,000,000, were made from the state general fund;

(4) moderate assumptions about population and inflation would project that more than $545,000,000 will be needed to pay for long-term care services in Alaska by the year 2015;

(5) a shift from the current significant reliance on costly institutional care to a more balanced continuum of home-based and community-based services is needed;

(6) a two-year moratorium on the issuance or modification of a certificate of need for the addition of nursing home beds was enacted in law in 1996 to

(A) encourage the development of home-based and community-based services;

(B) direct the state's resources toward the services that can best meet the needs of the clients; and

(C) facilitate actions to provide a more balanced system of care and more appropriate placement of clients, enlarge client choice, and avoid unnecessary new long-term care costs;

(7) appropriate planning is necessary to ensure that a certificate of need for new or replacement nursing home beds is not approved without a

(A) demonstrated long-term need for those beds on a regional basis;

(B) demonstration that the project is financially feasible and fosters the least reliance on the state general fund for provision of the most appropriate service;

(C) demonstration of public participation in the planning process and support by affected groups; and

(D) showing that the approval or modification of the certificate of need is consistent with existing state plans for delivery of care in Alaska; and

(8) this Act provides a minimum framework to ensure that the approval of new or replacement nursing home beds enhances access to the appropriate level of care to meet the needs of Alaskans and does not foster reliance on the state general fund to finance the operating and capital costs.

*** Sec. 2.** AS 18.07.021 is amended to read:

Sec. 18.07.021. <u>Administration</u> [OFFICE OF PLANNING AND RESEARCH]. The [OFFICE OF PLANNING AND RESEARCH IN THE] department shall administer the certificate of need program under this chapter and

perform other functions prescribed in this chapter.

* **Sec. 3.** AS 18.07.031 is amended to read:

Sec. 18.07.031. Certificate of need required. (a) A person may not make an expenditure of $1,000,000 or more for any of the following unless authorized under the terms of a certificate of need issued by the **department** [OFFICE]:

(1) construction of a health care facility;

(2) alteration of the bed capacity of a health care facility; or

(3) addition [OR ELIMINATION] of a category of health services provided by a health care facility.

(b) Notwithstanding the expenditure threshold in (a) of this section, a person may not convert a building or part of a building [THAT IS LICENSED AS AN ASSISTED LIVING FACILITY UNDER AS 47.33] to a nursing home that requires licensure under AS 18.20.020 unless authorized under the terms of a certificate of need issued by the **department** [OFFICE].

* **Sec. 4.** AS 18.07.041 is amended to read:

Sec. 18.07.041. Standard of review for applications for certificates of need relating to non-nursing home beds. The **department** [OFFICE] shall grant a sponsor a certificate of need or modify a certificate of need **that authorizes beds other than nursing home beds or that is for a health care facility other than a nursing home** if the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services required to maintain the good health of citizens of this state.

* **Sec. 5.** AS 18.07 is amended by adding a new section to read:

Sec. 18.07.043. Standard of review for applications for certificates of need relating to nursing homes and nursing home beds. (a) The department shall develop criteria and standards for reviewing an application for a certificate of need, or for a modification of a certificate of need, issued under this chapter for a health care facility that is a nursing home or has nursing home beds.

(b) In developing the criteria and standards under (a) of this section, the department shall consider

(1) whether the sponsor recognized statewide, regional, and community

needs in planning for the project;

(2) whether the sponsor has included a public process in planning and designing for the nursing home or nursing home beds;

(3) whether the sponsor has designed the proposed project to provide the services in the most efficient and cost-effective manner;

(4) whether there are adequate home-based and community-based services in the community or region of the state where the nursing home or nursing home beds are proposed to be located;

(5) whether an additional nursing home is or additional nursing home beds are an effective way of providing appropriate services for consumers in the community or the region of the state where the nursing home or nursing home beds are proposed to be located;

(6) whether there is a demonstrated need for a nursing home or nursing home beds in the community or region of the state where the nursing home or nursing home beds are proposed to be located;

(7) whether the addition of the nursing home or nursing home beds will result in increased costs to the state;

(8) whether the sponsor has access to the resources necessary to sustain the financial viability of the proposed services or nursing home on a long-term basis without increasing dependency on the state treasury;

(9) whether the proposed services are to be provided in a manner that maintains quality of care and professional competence of staff; and

(10) other factors that the department determines are necessary to evaluate the application for the certificate of need or modification of a certificate of need according to the standards set out in this chapter.

(c) The department shall grant a sponsor a certificate of need or modify a certificate of need that authorizes nursing home beds or that is for a health care facility that is a nursing home if the department finds that the sponsor meets the criteria established in or under this chapter.

* **Sec. 6.** AS 18.07.061 is amended to read:

Sec. 18.07.061. Modification and termination of activities. The certificate

holder shall apply to the **department** [OFFICE] for a modification of the certificate before terminating part of the activities authorized by the terms of issuance, but the certificate holder is not required to obtain the acquiescence of the **department** [OFFICE] before terminating all the activities authorized by the certificate. If a certificate holder terminates all of the activities authorized by a certificate, the certificate holder is required to notify the **department** [OFFICE] 60 days before termination and to surrender the certificate to the **department** [OFFICE] within 30 days of termination.

* **Sec. 7.** AS 18.07.071 is amended to read:

Sec. 18.07.071. Temporary and emergency certificates. (a) The **department** [OFFICE] shall grant a sponsor an emergency certificate for the construction of a health care facility for which a certificate is required under AS 18.07.031 if the sponsor shows, by affidavit or formal hearing, that the act of construction consists of effecting emergency repairs.

(b) The **department** [OFFICE] may grant a sponsor a temporary certificate for the temporary operation of a category of health service [,] if the sponsor shows by affidavit or formal hearing

(1) the necessity for early, immediate, or temporary relief; [,] and

(2) adverse effect to the public interest by reason of delay occasioned by compliance with the requirements of AS 18.07.041, **18.07.043,** and application procedures prescribed by regulations under this chapter.

(c) A temporary certificate granted under (b) of this section does not confer vested rights on behalf of the applicant. The **department** [OFFICE] shall impose those special limitations and restrictions concerning duration and right of extension that the **department** [OFFICE] considers appropriate. A temporary certificate may not be granted for a period longer than necessary for the sponsor to obtain review of the action certified by the temporary certificate under AS 18.07.051. Application for a certificate of need under AS 18.07.041 **or 18.07.043** must commence within 60 days of the date of issuance of the temporary certificate.

* **Sec. 8.** AS 18.07.081(a) is amended to read:

(a) The **department** [OFFICE], a member of the public who is substantially

affected by activities authorized by the certificate, or another applicant for a certificate of need may initiate a hearing to obtain modification, suspension, or revocation of an existing certificate of need by filing an accusation with the commissioner as prescribed under AS 44.62.360. A revocation, modification, or suspension of an outstanding certificate may not be undertaken unless it is in accordance with AS 44.62.330 - 44.62.630.

* **Sec. 9.** AS 18.07.081(c) is amended to read:

(c) A certificate of need shall be suspended if an accusation is filed before the commencement of activities authorized under AS 18.07.041 **or 18.07.043** that charges that factors upon which the certificate of need was issued have changed [,] or new factors have been discovered that significantly alter the need for the activity authorized. A suspension of a certificate may not exceed 60 days. At the end of this period or sooner, the **department** [OFFICE] shall revoke or reinstate the certificate.

* **Sec. 10.** AS 18.07.081(d) is amended to read:

(d) A certificate of need may be revoked if

(1) the sponsor has not shown continuing progress toward commencement of the activities authorized under AS 18.07.041 **or 18.07.043** after six months of issuance;

(2) the applicant fails, without good cause, to complete activities authorized by the certificate;

(3) the sponsor fails to comply with the provisions of this chapter or regulations adopted under this chapter;

(4) the sponsor knowingly misrepresents a material fact in obtaining the certificate;

(5) the facts charged in an accusation filed under (c) of this section are established; or

(6) the sponsor fails to provide services authorized by the terms of the certificate.

* **Sec. 11.** AS 18.07.101 is amended to read:

Sec. 18.07.101. Regulations. The commissioner shall adopt, in accordance with AS 44.62 (Administrative Procedure Act), regulations that establish procedures

under which sponsors may make application for certificates of need required by this chapter and that govern the review of those applications by the **department** [OFFICE], establish requirements for a uniform statewide system of reporting financial and other operating data, and otherwise carry out the purposes of this chapter.

*** Sec. 12.** AS 18.07.111(2) is amended to read:

(2) "certificate" means a certificate of need issued by the **department** [OFFICE] under AS 18.07.041**, 18.07.043,** or **18.07.071** [AS 18.07.071];

*** Sec. 13.** AS 18.07.111 is amended by adding a new paragraph to read:

(13) "nursing home bed" means a bed not used for acute care in which nursing care and related medical services are provided over a period of 24 hours a day to individuals admitted to the health care facility because of illness, disease, or physical infirmity.

*** Sec. 14.** AS 18.07.111(11) is repealed.

*** Sec. 15.** TRANSITION. (a) A matter described in former AS 18.07.031 that is authorized under a certificate of need issued before the effective date of this Act shall be reviewed and completed in accordance with the applicable statutes and regulations as they existed on the day before the effective date of this Act.

(b) Except as provided in (a) of this section, pending applications and any other matters described in former AS 18.07.031 or in AS 18.07.031, as amended by this Act, shall be reviewed and completed in accordance with the provisions of this Act.

*** Sec. 16.** This Act takes effect immediately under AS 01.10.070(c).

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

TONY KNOWLES, GOVERNOR

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MEMORANDUM

DATE: January 11, 1999

TO: Sheila Peterson
Staff Assistant
Long-Term Care Task Force

FROM: Elmer A. Lindstrom
Special Assistant to the Commissioner

SUBJECT: Proposed amendments to Certificate of Need draft legislation

The Department of Health and Social Services and Department of Administration have reviewed and support the proposed certificate of need draft legislation because it will provide an additional tool to control rising nursing home bed costs. Following is an analysis of each section of the bill along with several suggested amendments:

Sec. 18.07.031: Certificate of Need Required: Currently the Department of Health and Social Services reviews all nursing bed projects that cost over $1 million. LS 137 adds the requirement that all conversions of acute care or other beds to nursing beds must have a CON review. The department supports this change. It should be noted that a loophole remains for a facility to add new nursing beds if they can be built for under $1 million.

Sec. 18.07.043: Standard of Need for non-nursing beds: This section allows the standard of need to remain the same for non-nursing beds and other services. Non-nursing beds are primarily acute care beds, but also includes other services such as ambulatory surgery and kidney dialysis. **Recommendation:** The title on this section should be changed to read "Standard of Need for non-nursing home services."

Sec. 18.07.043: Standard of Need for applications: This is a new section that allows broader review analysis for nursing homes and nursing home beds. Decisions are currently limited to accessibility and quality. This new section allows decisions to be made based on additional standards such as need, financial feasibility, and availability of alternatives.

The list of criteria and standards to be developed in AS 18.07.043 (b), need to be changed to be more specific and better reflect the recommendations of the Legislative Working Group on Long-Term Care. Standard number (10) may be worded too broadly to be passed into law because it allows "any other factor" that the department determines "is necessary" in the analysis of a CON application. Also, (7) is insignificant because all new nursing beds will cost the state additional money. Following is a revised list of standards proposed by the department:
* Sec. 5. AS 18.07 is amended by adding a new section to read:

Sec. 18.07.043. **Standard of review for applications for certificates of need relating to nursing homes and nursing home beds.** (a) The department shall develop review standards for an application for a certificate of need or for an application to modify a certificate of need, issued under this chapter for a health care facility that is a nursing home or has nursing home beds.

(b) In developing review standards under (a) of this section, the department shall consider

(1) whether a public process and existing appropriate statewide, regional and local plans were included in planning and designing the project;

(2) whether the project meets minimum required utilization rates for new nursing beds and the impact on utilization rates for existing nursing home beds;

(4) whether the project demonstrates consideration of community, regional and statewide the needs for new nursing home beds;

(5) whether the project meets the minimum number of new nursing beds that should be required in a facility to ensure efficiency and economies of scale;

(6) whether the project demonstrates the proposed service will provide a quality of care equivalent to existing community, regional or statewide services .

(7) whether the project demonstrates financial feasibility, including long-term viability, and what the financial impact will be on consumers and the state; and

(8) whether the sponsor has demonstrated cost effectiveness through considering the availability of appropriate, less costly alternatives of providing the services planned.

(c) The department shall grant a sponsor a certificate of need or modify a certificate of need that authorizes nursing home beds or that is for a health care facility that is a nursing home if the department finds that the sponsor meets the criteria and standards under (a) and (b) of this chapter.

Other Changes: All other changes included in LS 137 are cosmetic and are meant to clean up the law. Examples include changing the reference to the program from the "State Health Planning and Development Agency" to the "Department."

cc: Pat Pourchot, Legislative Director
Office of the Governor
Karen Perdue, Commissioner
Department of Health and Social Services
Alison Elgee, Deputy Commissioner
Department of Administration

APPENDIX C

LETTER ON THE ANCHORAGE PIONEERS' HOME