

ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672 34

10189 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

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

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. ❖

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

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.

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

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.

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.

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

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.

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

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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.

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

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

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

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

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

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

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 Gandhir 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.

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

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

SECURECARE CONGRESSIONAL PROPOSAL

RECOMMENDATION

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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."⁷³

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
- ❖ 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 \$41,000 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.)
- ❖ Three out of four nursing facility residents are women.⁷²

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

“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.”

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:

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 facing America, as well as Alaska, and that possible solutions are being proposed and discussed. ♦

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ALASKA'S LONG-TERM CARE PLAN FOR RETIREES



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.

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

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.

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."

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

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-

irement 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

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. ❖

"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."

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

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

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

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

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 policies 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



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.

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. ♦

"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."

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 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. ❖

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

CREATION OF A NEW TASK FORCE



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.

FOOTNOTES

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4. Ibid, page 27
5. Layzell, Anne, C.: "The Aging of America." *The Council of State Governments*, August, 1998.
6. Ibid.
7. American Health Care Association: "Facts and Trends – The Nursing Facility Sourcebook." 1998, page iiiii
8. "Legislative Working Group on Long-Term Care - Report." 1997, page 11
9. Letter to "Alaskans" on the Personal Care Attendant Summit, October 29, 1998
10. Ladd & Associates, "Long-Term Care in Alaska: Recommendations for Reform." page 33
11. Alaska Board of Nursing, "Position Statement - Activities of Unlicensed Assistive Personnel." November 1993
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The following sources were used extensively by the Task Force:

Legislative Working Group on Long-Term Care Report to Governor Tony Knowles – A copy may be obtained from Mr. David Pearce, Division of Administrative Services, Department of Health and Social Services.

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

1 Creating the Long-Term Care Task Force.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 be it

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

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

9 **FURTHER RESOLVED** that the task force shall

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

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

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

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

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

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

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

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

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

APPENDIX B

PROPOSED LEGISLATION

1-LS0139A
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

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

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

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

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

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

14 * 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 which may have branches or subunits;

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

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

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

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

16 * 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

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

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.

January 11, 1998

Page 4

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-LS0135A
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

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

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

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

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

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

1 or

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

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

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

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

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

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

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

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

5 * 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

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

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

1-LS0138VA
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

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

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

4 * Section 1. FINDINGS AND POLICY RELATED TO SECTION 2. (a) Regarding sec.
5 2 of this Act, the legislature finds that

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 (b) The department shall solicit proposals from providers to provide services
26 under AS 47.24.205 - 47.24.240. An interested provider shall submit its proposal in
27 a form and manner as required by the department. An entity, an agency, a facility, a
28 local government, or an individual intending to offer services under AS 47.24.200 -
29 47.24.290 is eligible to submit a proposal to the department to provide eligible
30 services. The department may enter into an agreement or award a contract or grant
31 if the proposal meets the requirement of AS 47.24.200 - 47.24.290 and furthers the

1 purposes of the program.

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

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

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

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

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

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

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

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

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

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

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

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION



Central Microfilm Services
Department of Education & Early Development
State of Alaska

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3 department may provide services through individual agreements, grants, or contracts
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12 under this section). The schedule must vary on a sliding scale based on

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23 recover the payments on behalf of the adult to offset program expenditures. An adult
24 receiving services or assistance under the program is considered to have assigned to
25 the state, through the department, all rights to accrued and continuing payment
26 obligations that the adult may have from the third-party payors.

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

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

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

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

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

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

16 (1) "program" means the in-home and community-based services
17 program for medically, physically, or cognitively impaired adults under AS 47.24.200 -
18 47.24.290;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 services;

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

3 and

4 (8) adopt regulations to carry out the purposes of AS 47.24.010 -
5 47.24.130 [THIS CHAPTER].

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

7 (a) Investigation reports and reports of the abandonment, exploitation, abuse,
8 neglect, or self-neglect of a vulnerable adult filed under AS 47.24.010 - 47.24.130
9 [THIS CHAPTER] are confidential and are not subject to public inspection and
10 copying under AS 09.25.110 - 09.25.125. However, in accordance with AS 47.24.010
11 - 47.24.130 [THIS CHAPTER] and regulations adopted under AS 47.24.010 -
12 47.24.130 [THIS CHAPTER], investigation reports may be used by appropriate
13 agencies or individuals inside and outside the state, in connection with investigations
14 or judicial proceedings involving the abandonment, exploitation, abuse, neglect, or self-
15 neglect of a vulnerable adult.

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

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

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

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

1 AS 05.15.210.

2 * 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

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

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:

January 8, 1998

Page 2

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-LS0137A
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

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

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

4 * Section 1. FINDINGS. The legislature finds that

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

29 **Sec. 18.07.021. Administration [OFFICE OF PLANNING AND**
30 **RESEARCH].** The [OFFICE OF PLANNING AND RESEARCH IN THE]
31 department shall administer the certificate of need program under this chapter and

1 perform other functions prescribed in this chapter.

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

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

6 (1) construction of a health care facility;

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

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

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

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

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

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

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

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

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

1 needs in planning for the project;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 affected by activities authorized by the certificate, or another applicant for a certificate
2 of need may initiate a hearing to obtain modification, suspension, or revocation of an
3 existing certificate of need by filing an accusation with the commissioner as prescribed
4 under AS 44.62.360. A revocation, modification, or suspension of an outstanding
5 certificate may not be undertaken unless it is in accordance with AS 44.62.330 -
6 44.62.630.

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

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

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

15 (d) A certificate of need may be revoked if

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 * 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

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

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.

January 11, 1999

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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

Alaska State Legislature



State Capitol
Juneau AK
99801-1182

Official Business

Long-Term Care Task Force

January 15, 1999

Mr. Bob Poe, Commissioner
Department of Administration
PO Box 110200
Juneau, AK 99811-0200

Dear Commissioner Poe,

As you know, the Long-Term Care Task Force was created last year with the passage of SCR 11 to develop a suitable and equitable plan for providing access to long-term care for all Alaskans. We have served as co-chairmen of this 12-member task force composed of legislators, state officials, and private citizens. On January 6, 1999 the task force conducted its last public meeting in Anchorage. Approximately 100 individuals participated in the hearing either in Anchorage or other communities via teleconference. Public comment was offered on the draft report of the findings and recommendations of the Long-Term Care Task Force as well as other issues impacting long-term care available in Alaska.

The level of long-term care offered in the Anchorage Pioneers' Home and the current administrative practices at the Home were topics of significant discussion by those appearing before the committee. Relatives of individuals residing in the Home recounted personal observations that put into question the safety and care of some residents. Their narratives highlighted the problems caused by insufficient staffing levels, the injuries that resulted from the lack of safety precautions, and the negative impact that limited social activities has on residents. Unfortunately this is not the first time these problems have been voiced. The family members expressed frustration that their concerns and experiences are not taken seriously and there is no apparent avenue available to them to affect positive change.

Deputy Commissioner Alison Elgee announced a public hearing in Anchorage to review these various complaints and concerns before the end of January. The Task Force is sensitive to the issues raised regarding the Anchorage Pioneers' Home and would like to

Commissioner Bob Poe

Page 2

January 15, 1999

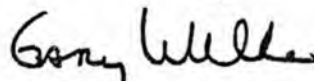
be informed of the time and location of this public meeting. In addition, the Task Force requests that the co-chairmen of the Senate and House Health, Education and Social Services Committees receive a summary of this public hearing and any corrective actions taken by the Department of Administration to address the identified issues by February 28, 1999.

Thank you for your assistance in this very serious matter. The quality of long-term care given to our Pioneers' Home residents must be beyond reproach.

Sincerely,



Representative Con Bunde
Co-chairman



Senator Gary Wilken
Co-chairman

Cc: Long-Term Care Task Force Members
Deputy Commissioner Alison Elgee
Mr. Jim Kohn

APPENDIX D

TIME TABLE

FOR

SPECIFIC REQUESTS

LONG-TERM CARE TASK FORCE TIME TABLE FOR SPECIFIC REQUESTS

Request	Who	What	To Whom	When	Comment
No. 3 *		Introduce legislation relating to the disclosure of licensing reports and licensing of home health agencies.			
No. 6	Department of Administration	Consider the formal recommendations outlined in <i>The Alaska Guardianship Report</i> and recommend necessary statutory changes.	Senate President and House Speaker	March 31, 1999	
No. 7 *		Introduce legislation relating to the protection of a vulnerable adult from a guardian, attorney-in fact or surrogate decision-maker who may harm the vulnerable adult.			
No. 8	Alaska State Hospital and Nursing Home Association	Prepare a full report on the actions required to be taken as a result of the conclusion reached at the statewide <i>Work Force Development Summit</i> to be held April 9-10, 1999	Senate President and House Speaker	No Date Specified	
No. 10	Alaska Commission on Aging	Implement a plan to increase the awareness of Alaskans to advance directives and prepare a report on the Commission's efforts to do so.	Senate and House HESS Committees	Beginning of the Second Session of the 21 st Legislature	
No. 12	Department of Health and Social Services	Aggressively pursue the rebuttal of the federal Health Care Financing Administration's interpretation of the Social Security Act as it relates to the Indian Health Service.	Legislature	Semi-annually	

TIME TABLE FOR SPECIFIC REQUESTS

Request	Who	What	To Whom	When	Comment
No. 13 *		Introduce legislation relating to the establishment of a home and community-based services program for certain adults with long-term care needs.			
No. 14	Departments of Administration and Health and Social Services.	Review all options available to support the long-term care needs of patients whose sole diagnosis is Alzheimer's Disease and prepare a preliminary report outlining findings and recommendations	Senate President and House Speaker	April 30, 1999	
No. 18	Alaska Commission on Aging	Coordinate efforts to inform and educate all Alaskans on the various long-term care services available and provide updates on its efforts.	Senate and House HESS Committees	Semi-annually	
No. 19	Department of Administration	Establish a uniform and comprehensive screening and assessment tool and develop a pilot to assess its validity and reliability.	Not Specified	July 1, 2000	
No. 21 *		Introduce legislation relating to the adoption of the nursing home certificate of need recommendations developed by the <i>Legislative Working Group on Long-Term Care</i> .			
No. 24	Department of Health and Social Services	Identify necessary changes to assure the Medicare program funds health care services provided to dual eligible patients. Prepare a report on its efforts and make recommended changes.	Senate President and House Speaker	March 31, 1999	

TIME TABLE FOR SPECIFIC REQUESTS

Request	Who	What	To Whom	When	Comment
No. 29	Department of Commerce	Compile relevant information on the need for and availability of long-term care insurance in Alaska and disseminate the information to the general public.	All Alaskans	January 1, 2000	
No. 31 *	Senate and House HESS Committees, in consultation with legislative leadership	Consider the creation of a new task force to continue the review and monitoring of long-term care in Alaska.			
Letter to Commissioner Bob Poe	Department of Administration	Prepare a summary of a public hearing regarding the administrative practices of the Anchorage Pioneers' Home and corrective actions either taken or proposed to be taken, by the department.	Senate and House HESS Committees	February 28, 1999	

* Requires legislation

APPENDIX E

AFN RESOLUTION

ALASKA FEDERATION OF NATIVES, INC.

1998 ANNUAL CONVENTION

RESOLUTION NO. 98-59

TITLE: IN SUPPORT OF ELDER CARE FACILITIES IN RURAL ALASKA

WHEREAS: The elders are a much respected group of people within the family unit and community for the Yup'ak people and all Alaskan Natives alike; and,

WHEREAS: Most villages in rural Alaska do not have the proper facilities for the care of elders; and,

WHEREAS: The only elder care facility for many regions is in the city of Anchorage, which is too far away from the family unit and communities; and,

WHEREAS: Being away from familiar surroundings, culture, foods, and activities, would be detrimental to the health and welfare of the elders; and,

WHEREAS: There is a growing and significant need for proper elder facilities throughout rural Alaska;

NOW THEREFORE BE IT RESOLVED by the Delegates to the 1998 Annual Convention of the Alaska Federation of Natives, Inc., that AFN politically supports the efforts of rural organizations in seeking, acquiring, and administering the required funding, facilities, personnel, and technical and professional support for elder care facilities.

SUBMITTED BY: St. Mary's Native Corporation

COMMITTEE RECOMMENDATION: DO PASS

CONVENTION ACTION:

Passed

APPENDIX F

MISSIONS AND MEASURES

Alaska State Legislature



Official Business

State Capitol
Juneau AK
99801-1182

Long-Term Care Task Force

MEMORANDUM

To: Representative Eldon Mulder, Co-chairman
Representative Gene Therriault, Co-chairman
House Finance Committee

Senator Sean Parnell, Co-chairman
Senator John Torgerson, Co-chairman
Senate Finance Committee

From: Representative Con Bunde, Co-chairman
Senator Gary Wilken, Co-chairman
Long-Term Care Task Force

C Bunde
Gary Wilken

Date: January 15, 1999

Re: Mission and Measures for Long-Term Care programs

As you know, the Long-Term Care Task Force was created last year with the passage of SCR 11 to develop a suitable and equitable plan for providing access to long-term care for all Alaskans. We have served as co-chairmen of this 12-member task force composed of legislators, state officials, and private citizens.

As part of the Task Force's review, legislative staff and directors of the divisions of Alaska Longevity Programs and Senior Services met and prepared draft mission statements and performance measures for these two divisions. The draft mission and measures are attached for your review.

The Task Force recommends that these documents be critiqued and refined during the next legislative budget cycle with input from both the legislature and administration. The divisions' mission and measures statements will help direct long-term programs offered in the state.

Missions & Measures

Draft as of January 6, 1999

Program: Senior Services – Commission on Aging

Statutory reference: § 47.65

Mission.

Assist and advocate for older Alaskans to lead dignified, independent and useful lives through partnering with state, local and private agencies.

Measures.

- At least 5 communities will have coordinated transportation systems by 6/30/03. (current systems: Anchorage, Ketchikan, Kodiak and Juneau)
- Percentage of annual change in number of persons served with home based meals.
- Percentage of annual change in number of persons served with community based meals.
- Number of public requests for information.
- Number of presentations made by Commission staff.
- Percentage of total resources spent on targeted seniors in ___% of communities. (Targeted seniors = over 75 years, low income, minority and/or rural)