

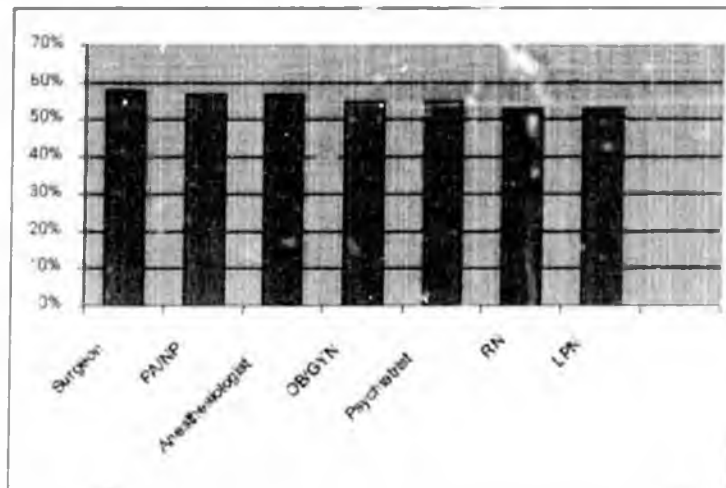
ALASKA LEGISLATURE COMMITTEE FILES, 2003-2000 0014

11743 SENATE HEALTH, EDUCATION & SOCIAL SERVICES

Healthcare Provider Shortages are Projected for Alaska



PERCENT OF PROVIDERS CURRENTLY MORE THAN 45 YEARS OF AGE



Source: AK Department of Labor

5/30/2005 4:00 PM

Heyman/Anderson, Draft 0 0

24

Shortage of doctors: 1/2 doctors in Alaska are over 50. Fewer doctors are practicing than are licensed. Compared to the rest of the U.S., Alaska has 17-30% fewer doctors per capita, partly because we have a relatively younger population. However Alaskans are aging, and the need will increase. Today Alaska needs 472 more doctors than it has. The shortage will increase in the future. Statewide Alaska has a 25-30% shortage of physicians. Physicians are practicing fewer hours and retiring younger than in past decades. As a result it may require more than one new physician to replace a retiring one. 70% of doctors in the lower 48 practice near where they did their residency. The rate of return on a medical education is diminishing compared to other professions. Medical students average \$100,000 of debt; specialties can be \$250,000 with an average of 8 years post-graduate education. Similarly, graduating dentists average nearly \$200,000 in debt. In contrast, graduating attorneys and MBA's begin earning money faster and with less debt.

Nurse Practitioners and Physician Assistants provide care to Alaskans in a wide variety of settings, including rural and urban primary care clinics, urban specialty practices, and remote critical access hospitals that were historically difficult to staff with other providers. There are over 200 physician assistants and 420 nurse practitioners working in Alaska. This gives Alaska one of the highest ratios of nurse practitioners per capita in the nation.

As in 25 other states nurse practitioners are licensed to practice autonomously. A recent Columbia University study (JAMA, 2000) and another from Yale University (1992), compared physician and nurse practitioner practice. They found that patients expressed a high degree of satisfaction with the care they received, that accuracy of diagnosis and health outcomes were equivalent, and that Nurse Practitioners provide quality, cost-effective care to their patients.

The role and extent of coverage of complementary and alternative medicine (chiropractic, acupuncture, etc.) in Alaska is undefined, but substantial. As of May 25, 2005, the Alaska Division of Occupational licensing listed the following numbers of active licenses for the following types of doctors:

Allopathic doctors (M.D.)	2,377
Chiropractic doctors (D.C.)	227
Osteopathic doctors (D.O.)	183
Podiatrist (D.P.M.)	20

SPECIFIC ALASKAN RECOMMENDATIONS FOR IMPROVEMENT

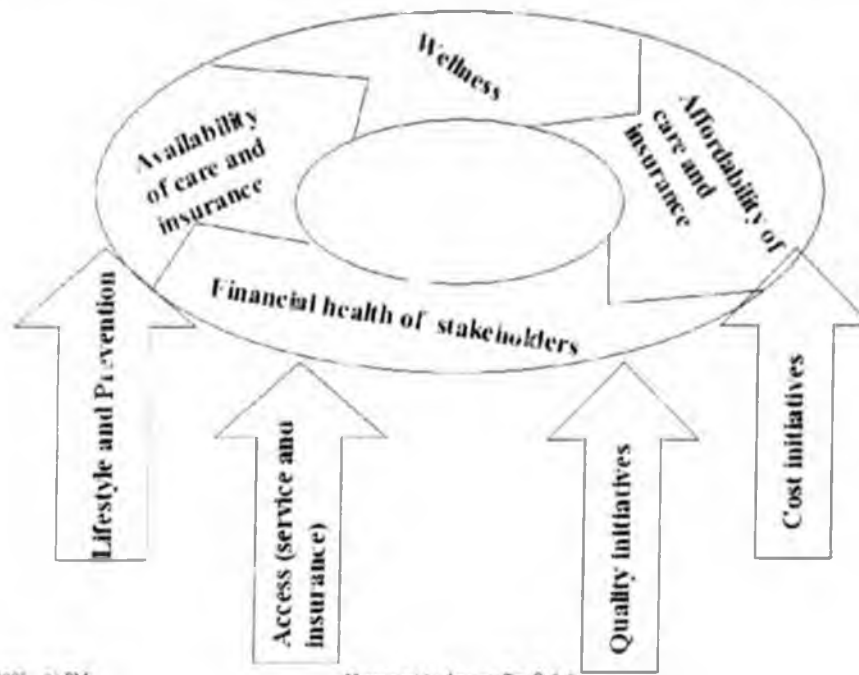
This Study Group has identified a continuum of challenges, many of which are interrelated to each other. While they may all be part of a whole, the Study Group identified discrete categories to more readily focus on how each recommendation may be best implemented. A chart below summarizes the recommendations and identifies which parties are affected by, or responsible for, each recommendation.

However, in the process of assessing health care in Alaska, and looking for improvements, the Study Group developed consensus on three overarching conclusions:

- 1. The Study Group process itself, which includes representatives of all key components of the health care system in Alaska, has been enlightening, educational and productive. For the first time in recent years, key players have been able to share experiences and ideas in a supportive and cooperative environment.**
- 2. Every aspect of health care is complex. Education, technology, funding, social and demographic factors, economics, federal and state laws and regulations all have many interrelated facets. Understanding the health care system, and improving it, are beyond the capacity of any one element within the system.**
- 3. Therefore, a fundamental recommendation of the Study Group is that an ongoing body be established to achieve multiple goals:**
 - a. Continue the communication process started by this Study Group among the key elements in the Alaska health care system and the broader Alaska community.**
 - b. Create a body that will have a long-term vested interest in understanding and improving the system. Some solutions are immediate, others will take generations. But without consistent advocacy, the system is unlikely to make needed fundamental changes.**
 - c. Through the quality of its participants, and the comprehensiveness and depth of its vision, the body will set a standard of credibility that will sustain its ongoing operations and facilitate implementation of its recommendations.**

In that spirit, this Study Group offers the "Yarmon Plan" as a starting point for structuring such a body.

The Roundtable Proposal (The Yarmon Plan)



5/10/2005 03:15 PM

Heyman/Anderson: Draft 8.0

44

The Alaska Health Care Roundtable

Goals: a, b, c on the previous page. Create a timely, actionable package that will gather bipartisan political support, get quick approval, and become a significant part of a long-term fiscal plan for Alaska.

Focus: Access, quality and cost. Function as both a sounding board and facilitator for ideas and recommendations.

Structure: Create the "Alaska Health Care Roundtable"

Membership in the Roundtable: Self-selecting. Must have a core of members who have a long-term compelling interest in improving access, quality and cost of health care in Alaska. Examples of potential members would be:

- a. Major employers
- b. Providers
- c. Foundations
- d. Other participants as invited by the Roundtable

Funding: Voluntary contributions by the participants.

Strategic relationships: Form a research relationship with the **University of Alaska/Institute of Social and Economic Research (ISER)**. The Roundtable itself could focus on strategic policy and political analysis. UA would provide in-depth research as needed on a contract basis.

Tactics: Secure the support of major employers and secure their interest in funding such a Roundtable. There is no point in CWN issuing a major recommendation that will fall flat on its face. Get seven or more CEOs of major employers to make a financial commitment to the project and be present at its unveiling.

Create a package of recommendations that will be dynamic, compelling and politically impossible not to accept. Create a "win-win" atmosphere so all participants can claim victory.

Local or regional Roundtables can address "nuts and bolts" issues of cooperation, implementation, sharing and efficiency.

Potential resources, ad hoc participants or additional members: Business leaders of large businesses, business leaders of small businesses, Alaska Natives, labor, non-profit (Foraker Group), education, military, insurance industry, state government (legislature, administration), health care providers, Medicare, Medicaid

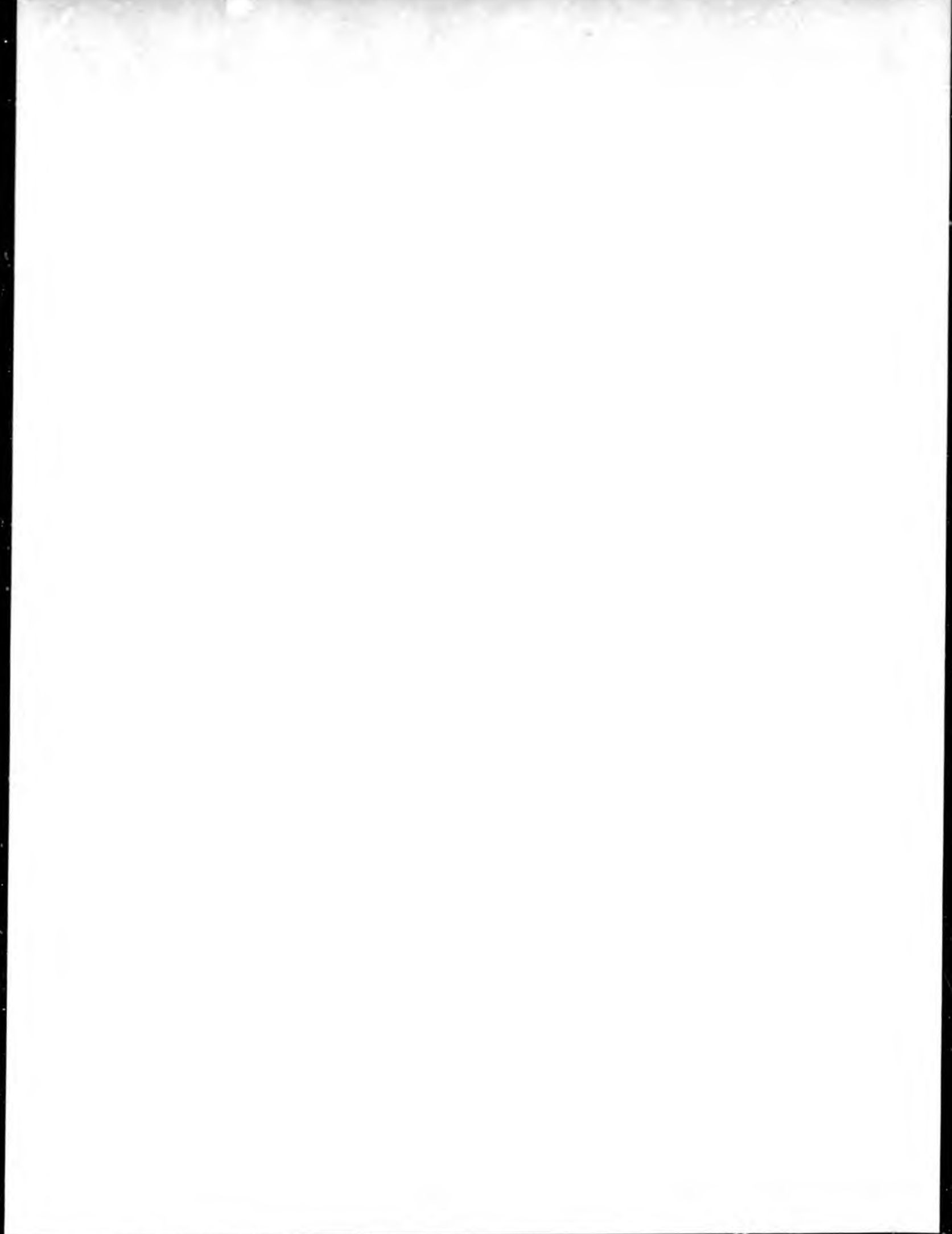
Summary table of recommendations with affected and responsible parties

The following chart summarizes various recommendations that were suggested in the course of our study. They are a starting point of menu items for the Roundtable to analyze and prioritize.

A = Parties affected by or benefiting from the listed Recommendation

R = Parties responsible for implementing the listed recommendation

Recommendation	Individuals	Legislature	Governor	Local Governments	Private Sector	Health Care Professionals & Institutions	Universities (or schools)	Insurance Companies
Lifestyle & Prevention								
1. Walkable community	AR			AR	AR	AR	AR	AR
2. Public Health role	A	R	R	AR	A	A	AR	A
3. School phys ed	A	R	R	AR	A	AR	R	A
4. Schools nix bad foods	AR	R	R	AR	A	AR	AR	A
5. Incentivize behaviors	AR	AR	AR	AR	AR	A	AR	AR
7. Rural dentistry	A	A	A	AR	A	AR	AR	AR
8. Drug psych facilities	A	AR	AR	AR	A	AR	A	AR
9. U.S. preventive health recommendations	AR	AR	AR	AR	AR	AR	AR	AR
10. Circumpolar health studies	A	AR	AR	AR	A	A	A	A



Access	Indiv.	Legis.	Gov.	Loc Gv	Private	HC	Univ/Sc	Ins. Cos
1a. Expand WWAMI	A	R	R	A	A	AR	AR	AR
1b. Market AK To MDs	A	R	R	AR	AR	AR	A	AR
2. Cut liability ins. Cost factors	A	R	R	A	A	AR		AR
3. Cover uninsured	AR	AR	AR	AR	AR	AR	AR	AR
4. Pool small cos.	A	R	R	AR	AR	A		AR
5. Promote lower cost centers	A	AR	AR	AR	AR	AR	A	A
6. Same day non FR alternatives	A	R	R	AR	A	AR	A	AR
7. Examine other state models e.g. UT, ME	A	R	R	A		R	R	AR
8. More GME \$ for family practice	A	R	R	A	A	AR	AR	A
9. Improve MD reimbursements	A	R	R	A	A	AR		AR
10. Medicare licensing requirement	A	R	R	A	A	A	A	A
11. Public insurance hearings	A	R	R	A	A	A	A	AR
Quality								
1. Evidence based prevention, Intervention	AR	AR	AR	AR	AR	AR	AR	AR
2. Use benchmarks	A	R	R	AR	AR	AR	AR	AR
3. Measure, disclose quality info	AR	AR	AR	AR	AR	AR	AR	AR
Costs								
1. Prevention education, intervention	AR	AR	AR	AR	AR	AR	AR	AR
2. Electronic medical records	A	AR	AR	AR	AR	AR	AR	AR
3. Drug formularies	AR	AR	AR	AR	AR	AR	A	AR
4. Health care <> State fiscal plan	A	AR	AR	AR	AR	AR	AR	AR
5. Disclose fees clearly	A	R	R	A	A	AR	A	AR
6. Community duplication dialogue	A			AR	AR	AR		AR
7. Joint purchasing	A			AR	AR	AR		A
8. Allocation & rationing	A	AR	AR	AR	A	AR	AR	AR
9. Fee transparency legislation	A	R	R	AR	A	AR	AR	AR
10. Legislative ins., reimbursement, tort solutions	A	R	R	AR	AR	AR	AR	AR

The Impact of lifestyle and prevention

First and foremost, this is an issue of individual responsibility. This means that each of us is ultimately responsible for our own health, how we eat, exercise and live. Nevertheless, many collective societal educational and social efforts can help further acceptance of this individual responsibility through application of sound health maintenance principles.

Our society is not used to facing the facts of collective issues. They are not part of the national or state non-Native psyche. Currently, the health care industry plugs holes in the dike that are the result of unhealthy lifestyles. We need to go way upstream and focus on prevention.

Fortunately, we can learn from the positive example of reduction of smoking in America. Much remains to be done. Today's limited but meaningful success is the result of a long-term effort that lasted over a generation. Extensive public education, warning labels, laws banning smoking in public places and a consistent message from the health care community ultimately resulted in societal changes that now appear to have gained a self-reinforcing life of their own.

1. **Plan a "walkable community."**
 - a. Land use designed to facilitate walking and biking can encourage cardiovascular health. Maintaining safe municipal trail systems, seasonal bike paths, and cleared wintertime walkways permit citizens to practice healthful life habits year around.
 - b. Enlightened city planning and architecture can promote a more active lifestyle.
 - c. As public demand for exercise opportunities grow, their inclusion in real estate development and city planning can improve property values.
2. **The role of public health as community educator and provider.** Municipal health departments need to serve many more people than those who seek care at the clinic. Promoting wellness and healthful living habits to the entire community is an essential part of the public health mission. This portion of the mission needs to be funded adequately in the budget.
3. **The importance of physical education in the schools— (not a "frill")** It is important to teach children about the relationship between health, diet and exercise. Not every child will want to join a sports team, but learning to be responsible for their own health by incorporating physical activity into their daily lives is an important health lesson that cannot be ignored.
4. **Eliminate internal inconsistencies and conflicts between programs and objectives.** For example, eliminate financial incentives in schools to promote unhealthy foods. Provide a financial alternative to schools that have come to rely upon income from selling junk foods in the schools.

5. **Incentivize healthy behaviors through workplace activities.** Convince the Top 49 Alaska businesses to educate their employees on healthy lifestyles and offer healthful workplace activities. The Top 49 businesses would represent a large percentage of the Alaska population not already covered by Federal or Alaska Native health care systems. Encourage a **Top 49 Health Summit** to facilitate understanding and participation of these large Alaska businesses.
6. Develop intervention programs for **promoting the traditional rural diet.**
7. **Reconsider rural access to dentistry as part of the study.** Many rural communities lack a sufficient population to support construction of a simple dental facility to house a full time dental practice. The investment required to maintain a facility for use by an itinerant dentist would likely need to be made by the community, possibly partnering with the state. Lack of roads prevents the use of mobile dental clinics that are used in other remote locations worldwide.
8. **Reduce the critical shortage of facilities for alcohol and drug detox, and psychiatric facilities. The lack of services these facilities provide can increase costs in the long run.** Persons affected by alcohol and drug use, and the accidents they cause, account for a significant portion of the population needing care in hospital emergency rooms and psychiatric facilities. Yet Alaska has too few beds to treat those in need of drug and alcohol recovery. As a result we are forced to tolerate that burden of higher healthcare costs. Detox beds make good economic and health policy sense.
9. Find ways to incorporate **U.S Task Force on Preventive Health** recommendations into medical practices, schools, work environments and homes.
10. **Continue the Institute of Circumpolar Health Studies** to analyze common problems and look for solutions that will work for all circumpolar peoples. Similar environments and cultures may result in shared knowledge that can benefit those in northern latitudes. Many health issues in Alaska relate to weather, the environment, subsistence food quantity and quality, potable water and sanitation issues. These are issues shared by other circumpolar peoples. Alliances with other circumpolar countries, and organizations like the Institute for Circumpolar Health Studies may provide new insights in resolving some of these issues.

Access improvement recommendations

1. **Workforce development issues**
 - a. **Expand the WWAMI program.** Improve the supply of primary care providers (family practice physicians, internists, nurse practitioners, physician's assistants), especially outside of Anchorage. Current or potential shortages can be identified in specific specialties.
 - b. **Market the Alaska lifestyle to Outside doctors.** JV with tourism, the State Medical Board, ASMA. Create a dog and pony show.

2. **Investigate and modify the factors that influence the cost of professional liability insurance**
3. **Reduce the number of uninsured Alaskans**— A non-government designed system is probably preferable to a government-operated system.
4. **Investigate pooling smaller companies a la the Foraker Group in an effort to reduce premium costs.**
5. **Promote lower cost models such as neighborhood health centers where appropriate**
6. **Educate the public and promote same day access to alternatives other than hospital emergency rooms.** This involves creation of more readily available and timely access to primary care. Alternatives could include increasing the number of primary care providers and clinics, establishing a variety of disincentives for visits for minor complaints, and establishing a system for care for the uninsured. Emergency rooms themselves may need to be reorganized and redesigned to separate life-threatening emergencies from routine medical needs.
7. **Examine uninsured models elsewhere; e.g. Utah, Maine and Florida.**
8. **Adjust the Medicare (GME) reimbursement formula for Family Practice Residency programs.**
9. **Ensure adequate government reimbursement to doctors, hospitals, community health centers, mid-level practitioners and community health aides without unreasonable bureaucratic burdens.**
10. **Consider making accepting Medicare patients a condition of licensure in Alaska.** This has been done in Massachusetts. Weigh the advantages of increased access for Medicare patients against the negative effect of attracting practitioners to Alaska.
11. **Consider public hearings for health care insurance and professional liability insurance rates** to facilitate price transparency. Currently insurance rates are largely negotiated between large institutional users and insurance carriers. As private contracts, the resulting rates are not disclosed. Individuals have little or no negotiating power and either have to accept or reject rates offered to them. The thought is that greater transparency could result in more favorable, or at least understandable, rates for individual consumers.

Quality improvement recommendations

1. **Promote and encourage primary prevention, early intervention, and evidence based practices by providers and payers of health care.**
2. **Use meaningful benchmarks; e.g. the Alaska 20/20 example.**
3. **Measure quality of service and make the information publicly available.**

Cost reduction recommendations

1. **Prevention through Public health education, and early intervention** Preventing illness will save more lives, more lost work time and more healthcare dollars than any other option available to us as a community. Consider the adage "the cheapest health insurance is healthcare you don't need." Measures include flu shots when they are recommended and vaccinations against common diseases. Encourage the following behaviors: weight control, regular exercise, avoiding cigarettes and excessive alcohol, fat, salt, and sugar, adequate water consumption, and controlling blood pressure.
2. Encourage and promote the establishment of an **Electronic Medical Record** with a common interface as a means to improved safety and efficiency of health care.
3. **Drug formularies**—utilize where appropriate and effective.
4. **Promote the strong interrelationship between cost of health care and a state fiscal plan** as a means of putting health and budget decisions in perspective
5. **Fee and billing transparency.** Mandatory disclosure of fees in advance of treatment and "understandability" standards for medical billing
6. Encourage **local cooperation and sharing of services and facilities.** Promote community by community dialogue on the cost of duplication
7. Analyze the possibility of saving money by **joint purchasing** by appropriate parties.
8. **Allocation and rationing** might be considered if other measures fail to stabilize health care costs.
9. **Suggest legislation to mandate fee transparency**
10. **Consider legislative solutions to tort and liability issues.** Quantify professional liability insurance, patient reimbursement and tort issues—are there legislative solutions? Look at tort reform experiences Outside, such as MICRA, for ideas that might apply to Alaska.

SUCCESS STORIES AND PROMISING PROGRAMS

Alaska has a number of programs that have proven to be successful:

Lifestyle and prevention

- The South Central Foundation Primary Care Clinics place great emphasis on prevention. This results in some of the best state data for immunization rates, colorectal screening, mammograms and other standard preventive health interventions.

Access

- Anchorage Neighborhood Health Center
- Other community health centers
- Health aides in rural Alaska
- South Central Foundation has programs that have established same day access. Utilization rates for emergency room use and specialty services have fallen dramatically. Utilization rates of primary care services have also had a modest decrease.

Quality

- Hospital quality control programs have been established in all the major hospitals in Alaska with excellent results. For example, Providence Hospital received national recognition for reducing surgical site infections after joining a national collaborative focus on this issue. Alaska Regional Hospital was recognized for reducing pneumonias after intubations. The Alaska Native Medical Center has developed a national reputation for quality improvement activities working in close association with the Institute for Health Care Improvement. All of our major hospitals have joined the national initiative known as the "100,000 Lives Campaign" to save this many lives in U.S. hospitals by June 2006.

Costs

- The Alaska Federal Health Care Partnership, consisting of the DOD, VA, Coast Guard and the Alaska Native Health System, have been able to reduce costs by bulk purchasing and the sharing of clinical resources.

Other programs show promise:

- The State of Alaska has developed benchmarks for population health improvement targets in a document called "Healthy Alaskans 2010."

Lifestyle and prevention

- The Anchorage Daily News and a growing number of businesses are discussing wellness incentives in an effort to reduce health care costs. Generally all of these approaches are similar. Employees who agree to join this effort receive personal health care improvement plans and personalized coaching on a regular basis. Some companies offer health care premium discounts as an incentive to participate.

Access

- Anchorage Project Access is a developing physician initiative in Anchorage (adopting a national model) to provide free care to uninsured individuals who meet certain low-income criteria. Almost all physicians and hospitals currently provide uncompensated care. By organizing this effort, other communities with this program have been able to efficiently provide more care to the uninsured.

Quality

- A new initiative in the U.S., public reporting of quality indicators in hospitals and nursing homes, is being required by the Center for Medicaid/Medicare Services (CMS). Hospital quality reports are now available on the Web under the title of "Hospital Compare." Both the federal government and insurance companies are instituting "pay for performance" programs to improve service quality by hospitals and doctors. Countries like Great Britain have already introduced these programs.

APPENDIX

Key ideas in the 1994 CWN study "Health Care: Finding an Alaskan Solution"

1. The health care reform debate is complex and controversial, with multiple players with competing interests.
2. There are significant factual disputes about the health care system.
3. Health care reform creates winners and losers.
4. The most important conclusion for Alaskans: Involvement of Alaskans in the health care debate is vital. Some type of reform is inevitable and Alaskans must work to ensure that reform is responsive to our unique Alaskan conditions.

Study Group Participants

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Eric Wohlforth	Attorney, Wohlforth, Vassar, Johnson and Brecht
James Yarmon	CEO, Yarmon Investments, Inc.
<hr/>	
Duane Heyman	Executive Director, Commonwealth North

The Charge

Alaska Primary Health Care – Opportunities & Challenges

Approved by the Commonwealth North Board on July 20, 2004

1. Questions to be addressed:

- a) How is primary health care currently being delivered to Alaskans?
- b) Are Alaskans receiving quality health care under the current scenario?
- c) What does the future hold for health care in Alaska?
- d) Are there ways to do a better job, such as by bridging the current multiple systems?

2. Scope of study:

The intention of this study is to focus on primary care – the need for Alaskans to receive basic health care. Recognizing there are a number of health care areas which merit similar attention such as long-term care, behavioral health, dental care, etc., the focus of this particular study is to address the past, present and future of primary health care in Alaska. The study will include an update/compilation of previous reports to provide a context.

- The study will briefly explore the historical delivery of health care and how that history impacts the present challenges Alaska faces. In providing this background, the study will also look at the health status of Alaskans – is it above/below that of other states or are we keeping pace?
- The study will explore the “drivers” behind the cost of health care in Alaska and will assess its impact, if any, upon economic development in the State. Access and quality of care/services are a critical determinant of cost within the various health systems in Alaska.
- This study will identify principal health care entities and look at the current multiple health systems – what are the benefits and challenges? Are they sustainable? What impact, if any, do these multiple systems have on the cost and quality of health care?
- There are a number of challenges facing health care providers and recipients. This study will identify those challenges and where possible, potential solutions.
- There are a number of examples where health care entities are collaborating. The study will highlight the best practices and identify additional areas of collaboration. The study will also take into account lessons learned from other states.

3. Nature of report to be issued (Technical, Analytical, or Opinion):

This report will analyze issues, identify a process for addressing them and suggest guiding principles. The report will provide background, current status and recommendations for change or further study. While the report will largely express opinions, it will address technical issues that are necessary aspects of the larger picture.

4. Conflict of interest standards:

The intent of the study is to represent a balance between the geographic, demographic, ethnic and economic interests in Alaska. It is expected that persons with interests in the outcome of the study will be members of the study group and will participate in its deliberations. Study group leaders should request that study group members identify their interests relative to specific points they advocate.

5. Measure of success:

This study will succeed by generating a greater understanding of and insight into health care issues in Alaska and areas in which health providers can work together for the mutual benefit of all Alaskans.

Resource People Interviewed

- 9.23.04 Ed Lamb, Al Parrish—Hospital perspectives
- 9.30.04 Barbara Russell—Premera
- 10.07.04 Alex Spector—VA, Lt. Col. Vic Rosenbaum—Elmendorf Hospital, Maj. Ward Hinger-
-TRICARE
- 10.14.04 Commissioner Joel Gilbertson
- 10.21.04 Paul Sherry—Alaska Native Tribal Health Consortium
- 10.28.04 Tessa Rinner—Denali Commission
- 10.28.04 The Maine Plan (Sergei Bogojavlensky, MD)
- 11.11.04 Norman Wilder MD, MBA (Regional), Roy Davis MD (Providence)—Quality and cost
control initiatives
- 11.18.04 Rod Betit—State Hospital & Nursing Home Association
- 12.02.04 Catherine Schumacher MD—Access to health care in Anchorage
- 12.09.04 Cathy Giessel, MS, FNP-CS—The role of nurse practitioners
- 12.09.04 Harold Johnston, MD—Program Director, Alaska family Practice Residency
- 1.06.05 Joan Fisher – Executive Director, Anchorage Neighborhood Health Center and Medical
Director, Dr. Tom Hunt and Beverly Wooley, Director, Anchorage Municipal Health
Department
- 1.27.05 Janet Trautwein – VP Government Affairs, National Assn of Health Underwriters
- 1.28.05 (Forum) panel discussion with Commissioner Joel Gilbertson, Al Parrish, Randall
Burns—Alaska Small Hospital Performance Improvement Network, Dr. David Snyder—
Alaska Native Medical Center
- 2.03.05 James Jordan, Executive Director, Alaska State Medical Association
- 3.10.05 Ann Conway, Maine Center for Public Health
- 3.25.05 Joseph Ditre, Executive Director, Consumers for Affordable Health Care Foundation
(Maine)

**Have health insurance?
Think you're well protected?
Think Again!**

You might think that debt and despair are problems only of the uninsured. If so, think again. Millions of Americans face enormous health care costs and risk financial ruin. You may see your friends, coworkers, or neighbors try to recover from a painful illness or a car accident. What you probably don't see is how little their health insurance covers or how costly their medical bills are. Millions of Americans suffer from devastating financial burdens at the same time they face serious illness or injury. The middle class, those with college degrees, decent jobs, health insurance—the group of people who feel secure and well-protected—are at high, and often highest, risk of being left penniless when serious illness hits.

Millions of insured Americans are spending their life savings on health care

- 51 million insured Americans spent more than one-tenth of their income on health care
- 10.7 million insured Americans spent more than a quarter of their paycheck on health care
- 6.8 million insured Americans spent more than one-third of their income on health care

People who can't afford out-of-pocket costs delay and skip needed health care

- Almost one in five Americans reported postponing seeking medical care
- Of these, more than one in three said the delay resulted in a temporary disability that included significant pain and suffering
- And more than one in ten said the delay caused a long-term disability

Those who do seek medical care are often ruined financially

- Every 30 seconds, an American files for bankruptcy after having a health problem
- About half of all personal bankruptcy cases are due to medical reasons
- Among those whose illness led to bankruptcy, more than three in four had insurance at the onset of the illness
- The majority of the medically bankrupt had been to college, had responsible jobs, and had been homeowners

Bankrupt families lose more than their assets

- One in five went without food
- A third had utilities shut off
- Nearly two-thirds skipped needed doctor or dentist visits

And it's likely to get worse ...

From 2000 to 2004, premiums paid by workers rose nearly three times faster than the average U.S. earnings

*Alaska Health Summit Post Forum
Thursday, December 4, 2003, Anchorage Sheraton Hotel*

Accessing Health Care

MISSION POSSIBLE!

Presented and Moderated by

Dr. Brian L. Saylor, Director, Institute for Circumpolar Health Studies, University of Alaska Anchorage and Dr. Lawrence D. Weiss, Research Professor of Public Health, Department of Health Sciences, University of Alaska Anchorage; MPH Program Coordinator.

Coordinated by

Sharon M. Cissna, M.S., Alaska State Representative, District 22

RECOMMENDATIONS

Prevention

Outpatient 330 Community Based Clinic
Construction and Support

Technology Solutions

Informed Consumers

A State Insurance Plan

Survey Shows Business Leaders Believe Employees Will Shoulder More of Their Health Care Costs

Sep 14, 2005 - Washington, D.C.

As employees pay 29% of monthly health insurance premiums, business owners worry that rising costs will force workers to join ranks of uninsured. Poll of business leaders released at Capitol Hill summit of lawmakers and CEOs.

Faced with rising health care costs, small, medium and large businesses say they must continue to pass a portion of the increased costs on to their employees by requiring them to pay a mounting share of the premiums, co-pays, or deductibles, a new survey of business leaders shows. Four in five business owners (79 percent) who anticipate increases in their health care costs say they are concerned about their employees' ability to shoulder the projected increases. The Robert Wood Johnson Foundation today released *"Attitudes of Business Leaders Regarding Health Care Coverage"* at a Capitol Hill briefing led by legislators, governors, and Fortune 500 executives. The survey of more than 600 business owners and benefits managers whose companies currently pay for at least some health insurance benefits shows that companies of all sizes expect health care costs to jump an additional 12 percent over the next year. Business owners surveyed say they will ask their employees to pay an average of 21 percent of the increase. Survey respondents estimate that their employees

Healthy policies =

Healthy children =

Healthy budgets



- *“Family-friendly” policies & incentives*
- *Mandated child care standards & quality control*
- *Support for education at all levels, including Pre-K*
- *Support for early preventative social service programs*
- *New & creative legislation*

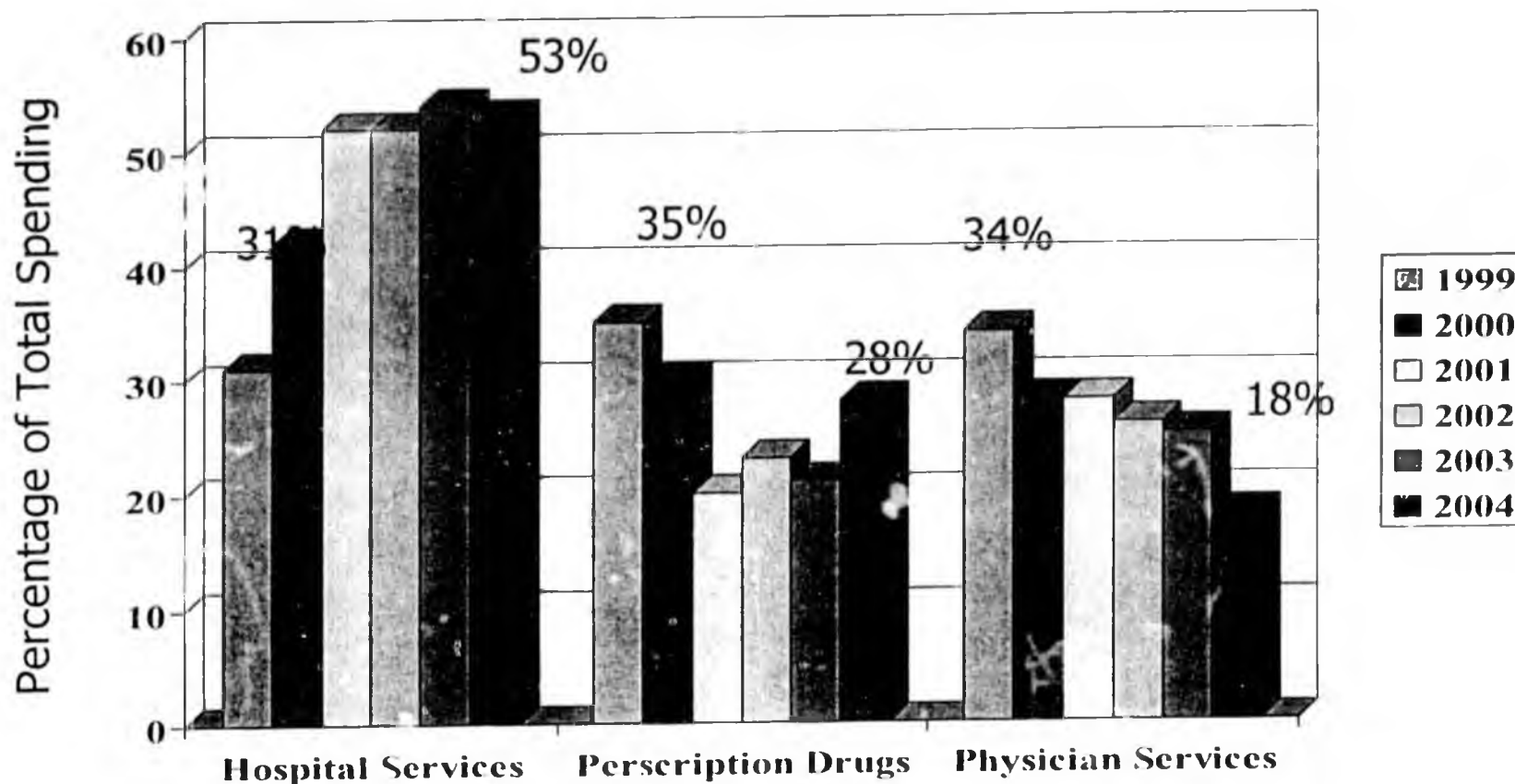
Alaska Department of Labor

- "Why are (workers compensation) rates rising so much? The main reason is higher medical expenses. The cost for a common knee reconstruction surgery, for example, knee has nearly doubled from \$5,225 in 1999 to \$10,967 in 2004."

Greg O'Claray Commissioner of Labor and Workforce Development in a 2005 editorial

Spending Growth Continues To Be Dominated by Hospital Services

Percentage of Yearly Medical Spending Increase



Employee Benefit Research Institute, Strunk, Gabel and Ginsburg, December 2004, Center for Studying Health System Change www.hschange.org

**Legislative
Health Caucus**

Table 3: Cost for Nursing Home, Assisted Living, and Personal Care Assistant Services for Current 2005 Personal Care Program Enrollees

Type of Care	Average Daily Cost (1)	Average Annual Cost (1)	Total Annual Cost for Current PCA Enrollees (2)
Private Nursing Home	\$561	\$204,765	\$702,343,950
Semi-Private Nursing Home	\$435	\$158,775	\$544,598,250
Assisted Living Home	\$125	\$45,625	\$156,493,750
Personal Care Assistant	\$65	\$23,725	\$81,376,750

NOTES and SOURCES:

(1) Personal Care Assistant costs were derived by dividing total expenditures for the program in the first seven months (218 days) of FY2005 by the approximate number of enrollees. It is possible that further billing for services provided over this time period will be submitted. As a result, this figure should be viewed as a rough estimate only. Nursing Home and Assisted Living costs are from the MetLife Insurance 2004 Market Survey on Nursing Home and Home Health Care Costs and Assisted Living Costs, available online at www.pvca.com/LTCcosts.html.

(2) These figures represent the estimated costs for the roughly 3,300 current enrollees in the PCA program for an entire year. The actual number of enrollees fluctuates over the course of a year. These calculations are, therefore, intended only for comparing costs among the different types of care for a constant population group and should not be considered estimates of actual annual expenditures.

Legislative Research Services, April 2005 Update of Report 0-1,155

February 2004, Legislative Research reported on the “Impacts on Expenditures from Terminating the Personal Care Program”.

Family support services, in combination with PCA and respite care at 60 hours per week is one way to hold cost down.

With an additional 15 hours a week of family support services, caregivers could go back to working full time...

**Adding 60 hrs/mo
Family Support Services** \$ **1260**/mo.

Total Cost at home \$ **4881**/mo.

Alzheimer Care (in Anchorage) \$ **6300**/mo.

Nursing home care (Anchorage) **\$11,000**/mo.

Savings to the State \$ **1419**/mo. to
\$ **6119**/mo.

Family Support Cost Comparison (2005)

Personal Care Attendant \$ 65/day

**Semi-Private
Nursing Home* \$ 435/day**

Savings to State \$ 370/day

*Private Nursing Homes (also available to Medicaid Waiver recipients should they choose: \$561/day)

A Traveling Provider

- A “Traveling Audiologist” has seen 593 patients at 24 remote clinics.
- Total cost: \$46,000.
- Travel savings: \$99,598 (for 271 patients)
- About 76% of the patients seen needed something done (meds, surgery, ongoing monitoring).
- About 24% were screened out.
- Now being implemented as a sustainable business.

“Having [the traveling audiologist] go out to the villages is a huge financial benefit.

[She] saw 20 patients a day in Selawik which saved us \$2400.00 in airfare alone, since those patients would have to be flown to Kotzebue for the same service. Since most of the patients she saw were minors, you can add on another \$2400.00 for a parent to accompany the child.

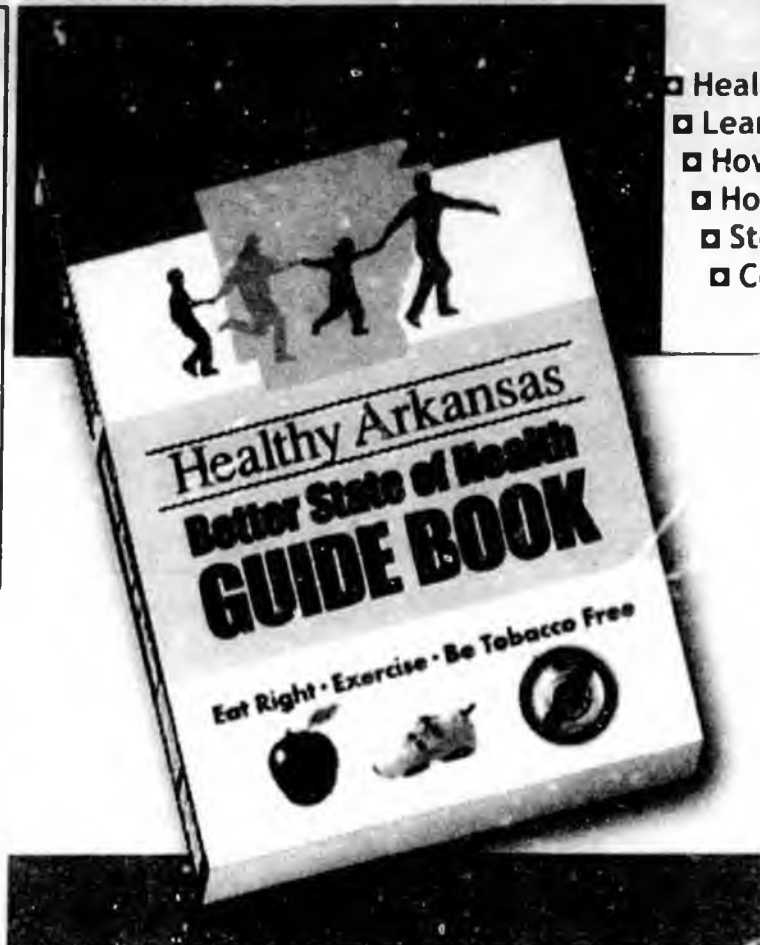
On top of that, the child misses a day of school, the parent misses a day of work, and there are usually other children in the family whose care must be arranged.”



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Healthy Arkansas is a comprehensive effort to clearly define specific areas where behavioral changes can lead to healthier citizens. The burden of chronic diseases, including diabetes, stroke, lung and heart diseases, and cancer, is higher in Arkansas than in the nation generally.

Tobacco use, obesity, and physical inactivity are the three primary causes of these and other serious chronic conditions. The Healthy Arkansas website provides strategies to reduce and/or eliminate the three primary behavior-related causes of these diseases with information on nutrition, physical activity and smoking cessation.

Call 1-800-235-0002, or check the links below for more information

Community Resources

F.A.Q.

Site Map



A Step in the Healthy Direction

The Happy Birthday
BABY BOOK



SOS
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1 866-NOW QUIT

**OVERVIEW
PERSONAL
CARE
ASSISTANTS
REGS.,
3/3/06**

DEPARTMENT OF HEALTH AND SOCIAL SERVICES



ADOPTED CHANGES TO REGULATIONS

7 AAC 43. MEDICAL ASSISTANCE. Personal Care Assistants



FILED REGULATIONS With Changes Made by the Department of Law

Effective April 1, 2006

The regulations reproduced here are provided by the Alaska Department of Health and Social Services as a public courtesy. While every effort has been made to assure the accuracy of the reproduced version, the department cannot guarantee its absolute accuracy. A paper copy of the regulations originally filed by the Lieutenant Governor is available from the department. For the official published version of the regulations, please refer to the Alaska Administrative Code, Register 177, April 2006.

Notes to reader:

1. Except as discussed in note 2, proposed new text that amends an existing regulation is **bolded and underlined**.
2. If the lead-in line above the text of the regulations states that a new section, subsection, paragraph, or subparagraph is being added, or that an existing section, subsection, etc. is being repealed and readopted (replaced), the new or replaced text is not bolded or underlined.
3. [ALL-CAPS TEXT WITHIN BRACKETS] indicates text that is proposed to be deleted.
4. When the word "including" is used, Alaska Statutes provide that it means "including, but not limited to."

Title 7. Health and Social Services.

7 AAC 43.750 is repealed and readopted to read:

7 AAC 43.750. Purpose and scope of personal care services. (a) The purpose of personal care services is to enable an individual, of any age, whose needs would otherwise result in placement in an acute care hospital or nursing facility or loss of that individual's employment solely related to activities of daily living (ADL) to remain at home or prevent job loss.

(b) Personal care services must be provided by either an agency-based or consumer-directed program and must

- (1) be provided to an enrolled Medicaid recipient;
- (2) be approved in the recipient's PCAT service plan as provided in

7 AAC 43.751;

- (3) receive prior authorization from the department before service is provided;

and

(4) be provided by an individual who is not an immediate family member of the recipient or a legal representative and who is a personal care assistant

(A) selected by the recipient and employed by a personal care agency enrolled in the consumer-directed program under 7 AAC 43.786; or

(B) employed by a personal care agency enrolled in the agency-based program under 7 AAC 43.787; and

(5) be supported by a form that

(A) is provided by the department;

(B) identifies the recipient's diagnosis; and

(C) is completed by a physician, a physician assistant, or an advanced nurse practitioner, who is licensed in this state or practicing or employed in a federally or tribally owned or leased health facility in this state.

(c) The department may authorize personal care services for up to a 12-month period.

Reauthorization by the department for personal care services will be done on an annual basis and based upon a PCAT. (Eff. 11/6/86, Register 100; am 6/27/92, Register 122; readopt 8/7/96, Register 139; am 10/21/98, Register 148; am 10/1/2001, Register 159; am 1/1/2002, Register 160; am 6/19/2004, Register 170; am 4/1/2006, Register 177)

Authority: AS 47.05.010 AS 47.07.030

Editor's note: The form referenced in 7 AAC 43.750(b)(5) may be obtained from the Department of Health and Social Services, Division of Senior and Disabilities Services, 3601 C Street, Suite 310, Anchorage, Alaska 99503.

Effective 8/7/96, register 139, the Department of Health and Social Services readopted 7 AAC 43.750 in its entirety, without change, under AS 47.05 and AS 47.07. Executive Order No. 72 transferred certain rate-setting authority to the department.

7 AAC 43 is amended by adding new sections to read:

7 AAC 43.751. Personal care assessment tool (PCAT). (a) All personal care services must be performed in accordance with a recipient's PCAT that is approved by the department under this section. The recipient's PCAT will be prepared using the department's document entitled *Personal Care Assessment Tool (PCAT) 2005*, adopted by reference, including the

- (1) consumer assessment tool;
- (2) personal care services supplemental tool; and
- (3) service plan, including changes made under (e) of this section.

(b) The department or its designee will develop the recipient's PCAT, which must include

- (1) supporting documentation

- (A) on a form provided by the department;
 - (B) that identifies the recipient's diagnosis; and
 - (C) that is completed by a physician, a physician assistant, or an advanced nurse practitioner, who is licensed in this state or practicing or employed in a federally or tribally owned or leased health facility in this state;
- (2) an assessment of the recipient's personal care needs, prepared in accordance with (d) of this section;
- (3) specific instructions regarding the type and frequency of tasks the personal care assistant is expected to perform;
- (4) a statement of the expected outcome of the recipient's PCAT service plan;
- (5) for the consumer-directed program only, identification of any legal representative of the recipient and specification of the requirements of 7 AAC 43.768 for which the legal representative will be responsible; and
- (6) for the agency-based program only, a backup plan that defines the agency's responsibility to
- (A) provide services if the recipient's regularly scheduled personal care assistant is unable to provide those services;
 - (B) develop a contingency plan to ensure the health and welfare of the recipient if the recipient is unable to receive personal care services from either the regularly scheduled personal care assistant or from another personal care assistant

provided through the backup plan; and

(C) educate the recipient about the contingency plan.

(c) For the consumer-directed program only, the agency and either the recipient or the legal representative shall develop a backup plan that

(1) identifies the extent to which the agency or recipient is responsible for obtaining personal care services if the recipient's regularly scheduled personal care assistant is unable to provide those services; and

(2) includes a contingency plan that

(A) defines the agency's and the recipient's responsibilities to work with and educate a recipient about a plan of action to ensure the health and welfare of the recipient if the recipient's regularly scheduled personal care assistant is unable to provide personal care services and other personal care services are not available through the backup plan; and

(B) informs the recipient of the risks involved.

(d) An assessment of a recipient's need for personal care services will be

(1) recorded on the recipient's PCAT;

(2) based upon personal observation of the recipient; and

(3) performed by the department staff or designee and conducted in the

recipient's residence.

(c) Any change in a recipient's PCAT before the end of the 12-month authorization period

(1) must be developed by the department or its designee and approved as provided in (g)(1) of this section;

(2) must include medical or other relevant documentation of the recipient's condition;

(3) must be recorded in the recipient's PCAT service plan records; and

(4) may be made outside the recipient's residence and without personal observation of the recipient by the department or its designee.

(f) The department will establish a renewal date for a recipient's PCAT that coincides with the renewal of a plan of care under 7 AAC 43.1030 so that services are coordinated and payments are not duplicated. A copy of a recipient's PCAT will be made part of the recipient's service record under 7 AAC 43.1000 – 7 AAC 43.1110 (Home and Community-Based Waiver Services Program), if applicable.

(g) A recipient's PCAT developed under (a) of this section does not take effect unless approved by the department. The department will approve a recipient's PCAT if the department determines that each service listed in the PCAT

(1) is of sufficient duration, amount, and scope to prevent

(A) placement in an acute care hospital or nursing facility; or

(B) loss of employment; and

(2) is supported by documentation required under (b) of this section.

(h) Reimbursement is not available under 7 AAC 43.750 – 7 AAC 43.795 for any service provided that is not identified in a recipient's PCAT. (Eff. 4/1/2006, Register 177)

Authority: AS 47.05.010 AS 47.07.030

Editor's note: The *Personal Care Assessment Tool (PCAT) 2005*, adopted by reference in 7 AAC 43.751, may be obtained from the Department of Health and Social Services, Division of Senior and Disabilities Services, 3601 C Street, Suite 310, Anchorage, Alaska 99503.

The form provided under 7 AAC 43.751(b)(1) may be obtained from the Department of Health and Social Services, Division of Senior and Disabilities Services, 3601 C Street, Suite 310, Anchorage, Alaska 99503.

7 AAC 43.752. Covered services. (a) If the requirements of 7 AAC 43.750 – 7 AAC 43.795 are met, the department will reimburse a personal care agency, whether it is enrolled in the consumer-directed or agency-based program, for services provided to a recipient in accordance with the recipient's PCAT for

(1) assistance with the recipient's activities of daily living (ADL), including

(A) physical assistance with basic personal hygiene and grooming,

including

(i) bathing;

(ii) dressing;

(iii) care of the mouth, hair, and skin; and

(iv) filing of toenails and both cutting and filing of fingernails,

excluding nail care for recipients who are diabetic or have poor circulation:

(B) physical assistance with bladder and bowel routines, including

(i) helping the recipient to and from the bathroom;

(ii) assisting the recipient with a bedpan or other toileting

procedures;

(iii) providing general hygiene care of a colostomy, an ileostomy,

or an external catheter;

(iv) giving suppositories that do not contain medication;

(v) providing digital stimulation; and

(vi) providing routine care of an incontinent recipient;

(C) assistance with eating;

(D) physical assistance with transferring the recipient in and out of a bed,

chair, or wheelchair and helping the recipient walk with support of a walker, cane,

gait belt, braces, or crutches; and

(E) physical assistance with positioning or turning a nonambulatory recipient in a bed or chair;

(2) assistance with a recipient's instrumental activities of daily living (IADL) essential to the recipient's health and specifically related to an approved task for an ADL need, including

- (A) light housekeeping tasks;
- (B) changing and laundering the recipient's bed linens;
- (C) laundering the recipient's clothing;
- (D) meal planning and preparation; and
- (E) shopping; and

(3) additional covered services, including

- (A) physical assistance taking and documenting the recipient's temperature, pulse, blood pressure, and respiration when medically necessary;
- (B) physical assistance with setup for diabetic testing and documentation;
- (C) physical assistance with
 - (i) care of nonsterile dressings for uninfected post-operative or chronic conditions;
 - (ii) prescribed foot care, excluding nail care for recipients who are diabetic or have poor circulation; and
 - (iii) the application of elastic bandages and support hose;
- (D) physical assistance with the use and minor maintenance of respiratory equipment and prescribed oxygen;

(E) physical assistance with putting on and removing a prosthetic device;

(F) assistance with self-administered routine oral medication, eye drops, and skin ointments; that assistance may include reminding the recipient and placing a medication within the recipient's reach;

(G) physical assistance with walking and simple exercises prescribed by a physician, a physician assistant, or an advanced nurse practitioner, who is licensed in this state or practicing or employed in a federally or tribally owned or leased health facility in this state; and

(H) assistance with

(i) travel to and from routine medical and dental appointments;

and

(ii) conferring with medical or dental staff for routine medical or dental appointments.

(b) The department will reimburse only a personal care agency enrolled in the agency-based program for physical assistance with range-of-motion and stretching exercises, if

(1) the physical assistance is provided to a recipient in accordance with the recipient's PCAT; and

(2) the exercises are prescribed by a physician, a physician assistant, or an advanced nurse practitioner, who is licensed in this state or practicing or employed in a federally or tribally owned or leased health facility in this state.

(c) The department will reimburse only a personal care agency enrolled in the consumer-directed program for physical assistance for services provided to a recipient in accordance with the recipient's PCAT, including health maintenance activities, urinary system management, bowel treatments, administration of medications, tube feeding, and wound care.

(d) The department will reimburse for IADL services that are

- (1) provided to a recipient 18 years of age or older; and
- (2) approved under 7 AAC 43.751 as part of a recipient's PCAT service plan.

(e) The department will reimburse under this section for meal preparation essential to meeting a recipient's health needs, if the meal preparation service is

- (1) not duplicated by another meal service approved under 7 AAC 43.1053 or 42 U.S.C. 3001 – 3058ee (Older Americans Act);
- (2) provided in the recipient's home; and
- (3) provided in accordance with 42 U.S.C. 3030e(1).

(f) The department will reimburse under this section for up to four hours a month of assistance with shopping in the vicinity of a recipient's residence for prescribed drugs, medical supplies, groceries, and other household items required specifically for the health and maintenance of the recipient, including items required by the recipient but also used by other occupants of the recipient's residence.

(g) If there is a second recipient in a residence, the department may authorize a personal care assistant to perform an IADL for both recipients residing in the same residence.

(h) The department will authorize limited assistance, in conjunction with another service listed in this section essential to a recipient's health and specifically related to an approved task for an ADL listed in (a)(1) of this section, if

(1) the recipient's PCAT service plan supports an ADL self-performance of two or three for the respective ADL, as scored in Section E of the PCAT; and

(2) the recipient has a medical history of falls with injury, documented by a physician, a physician assistant, or an advanced nurse practitioner, who is licensed in this state or practicing or employed in a federally or tribally owned or leased health facility in this state.

(Eff. 4/1/2006, Register 177)

Authority: AS 47.05.010 AS 47.07.030

The section heading of 7 AAC 43.755 is changed to read:

7 AAC 43.755. Excluded [CONSUMER-DIRECTED AND AGENCY-BASED PROGRAMS; EXCLUDED] services.

7 AAC 43.755(.(2)) is amended to read:

(2) invasive body procedures; for purposes of this paragraph, invasive body procedures include [, INCLUDING] injections of medications, [AND] insertion or removal of catheters,[:] tracheostomy care,[:] enemas, deep suctioning, tube or other enteral feedings,[:] medication administration, and[: OR] care and maintenance of intravenous equipment;

7 AAC 43.755(a)(3) is amended to read:

(3) chore services in the home, except for those tasks identified in

7 AAC 43.752(a)(2): for purposes of this paragraph, chore services in the home include[.]

[INCLUDING] cleaning of floors and furniture not used directly by the recipient, [;] laundry not incidental to the recipient's care, [;] and cutting firewood;

7 AAC 43.755(a)(4) is amended to read:

(4) a task that the [PERSONAL CARE AGENCY, SUPERVISING NURSE, OR] department determines could reasonably be performed by the recipient;

7 AAC 43.755(a)(6) is amended to read:

(6) a task that is not on the recipient's PCAT [APPROVED] service plan that has been approved under 7 AAC 43.751:

7 AAC 43.755(a)(11) is amended to read:

(11) supervision, monitoring, cueing, transportation provided under 7 AAC 43.502, babysitting, social visitation, general monitoring for equipment failure, services provided under 7 AAC 43.1000 – 7 AAC 43.1110 (Home and Community-Based Waiver Services Program), home maintenance, or pet care, except for a service animal; [AND]

7 AAC 43.755(a)(12) is repealed:

(12) repealed 4/1/2006:

7 AAC 43.755(a) is amended by adding new paragraphs to read:

(13) tasks that supplant or duplicate assistance offered by an individual or organization without charge or that is paid for by a third party;

(14) IADL under 7 AAC 43.752 if

(A) the recipient or anyone else in the household is capable to perform or financially provide the IADL for the recipient;

(B) another relative, caregiver of the recipient, community or volunteer agency, or third-party payer is capable of or responsible for the provision of the IADL services;

(C) IADL services, other than shopping, are greater than one-third of the total time authorized per week for personal care services;

(D) other recipients living in the same residence receive IADL services under 7 AAC 43.75 – 7 AAC 43.795 or under 7 AAC 43.1000 – 7 AAC 43.1110 (Home and Community-Based Waiver Services Program); or

(E) the IADL services are not specifically related to a qualifying ADL listed in 7 AAC 43.752(a)(1);

(15) tasks to provide necessary food, clothing, shelter, or medical attention for a minor recipient that are a parental responsibility and are considered neglect under AS 47.10.014 if not performed.

7 AAC 43.755 is amended by adding a new subsection to read:

(c) The department will not make separate payment for personal care assistants under 7 AAC 43.750 – 7 AAC 43.795 if the recipient receives in-home support services under 7 AAC 43.1046(b)(5). (Eff. 11/6/86, Register 100; am 6/27/92, Register 122; am 10/21/98, Register 148; am 10/1/2001, Register 159; am 1/1/2002, Register 160; am 6/19/2004, Register 170; am 4/1/2006, Register 177)

Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.760(a) is amended to read:

7 AAC 43.760. Place [CONSUMER-DIRECTED AGENCY-BASED PROGRAMS; PLACE] of service. (a) Personal care services may be provided only to a recipient who is living in the recipient's personal residence and [OTHERWISE] meets the requirements of this section.

7 AAC 43.760(b)(3) is amended to read:

(3) a foster home licensed under AS 47.32 [7 AAC 50], except for recipients in a licensed foster home who are receiving residential habilitation services under 7 AAC 43.1000 – 7 AAC 43.1110;

7 AAC 43.760(b)(4) is amended to read:

(4) an assisted living home licensed under AS 47.32 and AS 47.33; [7 AAC 75.]

7 AAC 43.760(b) is amended by adding new paragraphs to read:

(5) a residence where personal care services are already paid in a contractual agreement;

(6) an acute care hospital.

7 AAC 43.760(c) is repealed and readopted to read:

(c) The department will not pay for transportation, room, or board for a personal care assistant to travel with a recipient away from the recipient's municipality of residence. However, the department will pay for a recipient's approved services for up to two weeks annually while the recipient is away from the recipient's municipality of residence, unless additional time is required based on documented medical necessity or for education not available in this state, if

(1) the department authorizes the travel before it begins; and

(2) as specified in the recipient's PCAT, the need cannot be met during the travel period by any means other than by being accompanied by a personal care assistant.

7 AAC 43.760(d) is repealed:

(d) Repealed 4/1/2006.

7 AAC 43.760(e) is repealed:

(e) Repealed 4/1/2006.

(Eff. 11/6/86, Register 100; am 6/27/92, Register 122; am 7/1/95, Register 134; readopt 8/7/96, Register 139; am 3/1/98, Register 145; am 10/21/98, Register 148; am 10/1/2001, Register 159; am 1/1/2002, Register 160; am 6/19/2004, Register 170; am 4/1/2006, Register 177)

Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.765 is repealed:

7 AAC 43.765. Agency-based program; service plan. Repealed. (Eff. 11/6/86, Register 100; am 6/27/92, Register 122; readopt 8/7/96, Register 139; am 10/21/98, Register 148; am 10/1/2001, Register 159; am 1/1/2002, Register 160; am 6/19/2004, Register 170; repealed 4/1/2006, Register 177)

Publisher: {Delete the editor's note after 7 AAC 43.765.}

7 AAC 43.766 is repealed:

7 AAC 43.766. Consumer-directed program; service plan. Repealed. (Eff. 10/1/2001, Register 159; am 6/19/2004, Register 170; repealed 4/1/2006, Register 177)

7 AAC 43.768 is repealed and readopted to read:

7 AAC 43.768. Consumer-directed program; recipient requirements. (a) To qualify for personal care services from a consumer-directed program, a recipient must have a health-related condition that results in the need for personal care services, and either the recipient or the recipient's legal representative must be capable and willing to

- (1) supervise the personal care assistant;
- (2) demonstrate a capacity for making choices about ADL under 7 AAC 43.752, understand the impact of those choices, and assume the responsibility of those choices;
- (3) designate a consumer-directed personal care agency as responsible to fulfill the responsibilities of 7 AAC 43.786 on behalf of the recipient;
- (4) cooperate with the department staff or designee in the review of the recipient's PCAT;
- (5) cooperate with the department staff or designee, and with other state and federal oversight agencies, in conducting compliance reviews, investigations, or audits;
- (6) negotiate a recipient contract with the consumer-directed personal care agency;

(7) specify the training requirements of the personal care assistant and assure that the specified training has been received; and

(8) obtain a physician's, a physician assistant's, or an advanced nurse practitioner's prescription regarding the recipient's home exercise or range-of-motion program under 7 AAC 43.752(a)(3)(G) or (b).

(b) A recipient or the recipient's legal representative

(1) is primarily responsible for the scheduling, training, and supervising of the personal care assistant; and

(2) has the right to terminate the personal care assistant providing services to that recipient.

(c) A recipient's legal representative must be

(1) an unpaid care provider involved in the day-to-day care of the recipient; and

(2) managing the recipient's care, and capable of evaluating the care, as it occurs in the home.

(d) A recipient or a recipient's legal representative must notify the personal care agency within five days after the date that the service needs of the recipient change or the name or the address of the recipient or the recipient's legal representative changes. (Eff. 10/1/2001, Register 159; am 6/19/2004, Register 170; am 4/1/2006, Register 177)

Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.770 is repealed and readopted to read:

7 AAC 43.770. Employment of personal care assistants; qualifications. (a) To be enrolled as a personal care assistant and work for a personal care agency in either the consumer-directed program or the agency-based program, a personal care assistant

(1) must be at least 18 years of age;

(2) must meet all requirements for the position as set out in 7 AAC 43.750 –

7 AAC 43.795;

(3) must be individually enrolled with the department;

(4) may not be disqualified for the position due to a criminal conviction or a pending charge for a criminal offense set out in (e) of this section;

(5) may not have been denied a health care provider license or certification for a reason related to patient services described in this chapter, or ever had a license or certification revoked;

(6) must be able independently to assist the recipient with the specific ADL under 7 AAC 43.752 and services provided to a recipient.

(b) To be a personal care assistant working in the agency-based program, an individual must

(1) submit three letters of reference from individuals who

(A) are not employed by the same personal care agency;

(B) are not under the individual's supervision;

(C) have known the personal care assistant for at least three years; and

(D) attest to the personal care assistant's good character and ability to

meet the performance requirements of a personal care assistant; and

(2) submit evidence of having met the education and training requirements of

7 AAC 43.771.

(c) A personal care assistant must provide the employing agency all documentation, fingerprint cards, and fees necessary for requesting the personal care assistant's criminal history record information under AS 12.62.160. The agency shall submit a request for criminal history record information on a personal care assistant to the Department of Public Safety no later than 10 working days after the personal care assistant is hired. The agency shall contact the department within five days after the agency receives the Department of Public Safety's determination. The agency may employ a person as a personal care assistant on a conditional basis pending completion of review of the criminal history record information requested. The department will not pay for services provided by a personal care assistant for whom criminal history record information was not timely requested.

(d) An individual may not be employed as a personal care assistant by a personal care agency if criminal history record information shows that the individual has a conviction or a pending charge in any jurisdiction for one of the criminal offenses listed in (e) of this section. An individual may appeal denial of employment by an agency to the department if the individual

was denied employment with an agency on the basis of criminal history record information and is challenging the accuracy of the criminal history information.

(e) For the purposes of (a) and (d) of this section, the following are disqualifying criminal offenses, some of which disqualify a person for a limited period of time, as specified:

(1) an unclassified felony under AS 11, including murder in the first and second degree, attempted murder in the first degree, solicitation to commit murder in the first degree, conspiracy to commit murder in the first degree, sexual assault in the first degree, sexual abuse of a minor in the first degree, misconduct involving a controlled substance in the first degree, and kidnapping;

(2) a class A felony under AS 11 or AS 28, including manslaughter, assault in the first degree, misconduct involving weapons in the first degree, misconduct involving a controlled substance in the second degree, arson in the first degree, and robbery in the first degree;

(3) two or more class B felony offenses under AS 11 or AS 28;

(4) sexual abuse of a minor in the second degree, a class B felony under AS 11.41.436;

(5) sexual abuse of a minor in the third degree, a class C felony under AS 11.41.438;

(6) class A, B, and C felony assault under AS 11.41.200 - AS 11.41.220;

(7) endangering the welfare of a child in the first or second degree, as defined in AS 11.51.100 and 11.51.110, respectively;

(8) endangering the welfare of a vulnerable adult in the first degree, a class C felony under AS 11.51.200;

(9) endangering the welfare of a vulnerable adult in the second degree, a class A misdemeanor under AS 11.51.210;

(10) stalking in the first degree, a class C felony under AS 11.41.260;

(11) failure to register as a sex offender, a class A misdemeanor under AS 11.56.840;

(12) possession of child pornography, a class C felony under AS 11.61.127;

(13) misconduct involving a corpse, a class A misdemeanor under AS 11.61.130;

(14) a single class B felony under AS 11 or AS 28 not listed in (1) - (13) of this subsection, for a period of 10 years after the person was convicted of the crime;

(15) a class C felony under AS 11 or AS 28 not listed in (1) - (13) of this subsection, for a period of five years after the person was convicted of the crime, or until that person is no longer subject to probation or parole restrictions, whichever is longer;

(16) any crime that is not listed in (1) - (15) of this subsection, for a period of five years after the person was convicted of the crime, or until that person is no longer subject to probation or parole restrictions, whichever is longer, unless the person convicted of or charged with the crime

(A) reveals the conviction or charge at the time of employment; and

(B) provides evidence satisfactory to the agency that the person

does not pose a risk to recipients and will not adversely affect the safety or effective provision of services;

(17) unlawful exploitation of a minor under AS 11.41.455.

(f) This section does not require an agency to terminate employment of a personal care assistant convicted of an offense listed in (e) of this section if that person was an employee of the agency as a personal care assistant on June 19, 2004, unless the person did not respond truthfully to a question, asked before that date, about a felony conviction for an offense that would have been a disqualifying offense before that date.

(g) On or after February 1, 2007, a personal care assistant employed by a consumer-directed agency must provide proof to the employing agency of having and maintaining a valid certificate in

(1) first aid issued by the American Red Cross, American Heart Association, or other agency approved by the department; and

(2) cardiopulmonary resuscitation (CPR) issued by the American Red Cross, American Heart Association, or other agency approved by the department.

(h) The department may waive, for up to six months, the first aid or CPR requirements of 7 AAC 43.771(a) and, on or after February 1, 2007, the first aid or CPR requirements of (g) of this section, if a personal care assistant is unable to attend the first aid or CPR courses, or obtain the first aid or CPR certificates due to reasonable cause or excusable neglect. The personal care assistant must request a waiver in writing, to the department, and must include a statement

explaining the reasonable cause or excusable neglect. If the department grants a waiver, the department may prescribe an alternative method of compliance with the requirements.

(i) In this section, "reasonable cause or excusable neglect" includes

(1) medical emergency;

(2) weather; and

(3) unavailability of classes in the community. (Eff. 11/6/86, Register 100; am 6/27/92, Register 122; readopt 8/7/96, Register 139; am 10/21/98, Register 148; am 10/1/2001, Register 159; am 1/1/2002, Register 160; am 6/19/2004, Register 170; am 4/1/2006, Register 177)

Authority: AS 47.05.010 AS 47.05.310 AS 47.07.030
AS 47.05.017

Editor's note: Effective 8/7/96, Register 139, the Department of Health and Social Services readopted 7 AAC 43.770 in its entirety, without change, under AS 47.05 and AS 47.07. Executive Order No. 72 transferred certain rate-setting authority to the department.

[AS A RESULT OF THE 6/29/96 AMENDMENT OF 7 AAC 43.770, THE MATERIAL IN THE SECTION WAS DESIGNATED SUBSECTION (a), EVEN THOUGH THERE WERE NO OTHER SUBSECTIONS IN THE SECTION.

AS OF REGISTER 151 (OCTOBER 1999), THE REGULATIONS ATTORNEY MADE TECHNICAL REVISIONS UNDER AS 44.62.125(b)(6) TO REFLECT THE NAME CHANGE

OF THE DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT TO THE DEPARTMENT OF COMMUNITY AND ECONOMIC DEVELOPMENT MADE BY CH. 58, SLA 1999 AND THE CORRESPONDING TITLE CHANGE OF THE COMMISSIONER OF COMMERCE AND ECONOMIC DEVELOPMENT.]

7 AAC 43.771 is repealed and readopted to read:

7 AAC 43.771. Agency-based program; personal care assistant education and training requirements. (a) A personal care assistant in the agency-based program must have and maintain a valid certificate in first aid and cardiopulmonary resuscitation (CPR) issued by the American Red Cross, American Heart Association, or other agency approved by the department. A personal care assistant must also

- (1) hold a valid license as a nurse in this state under AS 08.68;
- (2) hold a valid certification as a certified nurse aide in this state under AS 08.68;
- (3) have satisfactorily completed training as specified in (b) of this section and passed a standardized competency test approved by the department; or
- (4) have had training or experience equivalent to the training specified in (b) of this section within the five years immediately preceding application to work in the program, and passed a standardized competency test approved by the department.

(b) Training referred to in (a)(3) or (4) of this section must be approved by the department, must be provided by a nurse licensed under AS 08.68, and must provide at least 40 hours of instruction in the following subject areas:

- (1) infection control in the home;
- (2) bowel and bladder care;
- (3) basic nutrition and food planning and preparation;
- (4) procedures for physical transfers, including emergency evacuation of physically disabled persons and nonambulatory persons;
- (5) assistance with self-administered medication;
- (6) procedures for taking blood pressure, temperature, pulse, and respiration;
- (7) understanding and working with children, the elderly, persons with physical or developmental disabilities, persons with communicable diseases, and persons with physical or mental illnesses;
- (8) practical knowledge of body systems, body mechanics, body disorders and diseases, and the observation of body functions;
- (9) death and dying;
- (10) practical skills and use of equipment necessary to perform tasks identified in 7 AAC 43.752(a)(1);
- (11) legal requirements affecting personal care assistants, including record keeping under 7 AAC 43.030, confidentiality, personal care assistant program responsibilities as

set out in this chapter, medical assistance fraud under AS 47.05.210, and reporting of harm under AS 47.17.020 – 47.17.022 and AS 47.24;

(12) universal precautions; for purposes of this paragraph, “universal precautions” means the infectious control precautions that are recommended by the United States Department of Health and Human Services, Centers of Disease Control and Prevention to be used to prevent the transmission of blood-borne germs such as human immunodeficiency virus and hepatitis B virus;

(13) infection control.

(c) The department may allow reimbursement for services provided by an individual who has performed duties similar to those of a personal care assistant under 7 AAC 43.750 – 7 AAC 43.795, has completed at least 16 hours of training in the areas listed in (b) of this section, and whose job performance has been found satisfactory by the appropriate personal care agency, based upon references or other verification, but whose training does not meet the requirements of this section, if that individual

(1) is otherwise qualified to act as a personal care assistant under 7 AAC 43.770;

(2) provides proof of enrollment in training that, within four months after beginning employment as a personal care assistant, will qualify the individual to meet the requirements of (b) of this section; and

(3) ensures that the personal care agency provides proof that the individual has successfully completed the 16 hours of training required under this subsection to enable that

individual to be eligible for reimbursement as a personal care assistant. (Eff. 6/27/92, Register 122; readopt 8/7/96, Register 139; am 10/1/2001, Register 159; am 1/1/2002, Register 160; am 6/19/2004, Register 170; am 4/1/2006, Register 177)

Authority: AS 47.05.010 AS 47.07.030

Editor's note: Effective 8/7/96, Register 139, the Department of Health and Social Services readopted 7 AAC 43 771 in its entirety, without change, under AS 47.05 and AS 47.07. Executive Order No. 72 transferred certain rate-setting authority to the department.

[AS OF REGISTER 151 (OCTOBER 1999), THE REGULATIONS ATTORNEY MADE TECHNICAL REVISIONS UNDER AS 44.62.125(b)(6) TO REFLECT THE NAME CHANGE OF THE DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT TO THE DEPARTMENT OF COMMUNITY AND ECONOMIC DEVELOPMENT MADE BY CH. 58, SLA 1999 AND THE CORRESPONDING TITLE CHANGE OF THE COMMISSIONER OF COMMERCE AND ECONOMIC DEVELOPMENT.]

7 AAC 43.775 is repealed and readopted to read:

7 AAC 43.775. Responsibilities of personal care assistant. (a) In the consumer-directed and the agency-based programs, a personal care assistant shall maintain a contemporaneous service record for Medicaid billing for each recipient for whom that assistant provides personal care services. The record must include

(1) documentation of tasks performed under the categories of the PCAT service plan, including case notes, frequency, scope, and duration;

(2) any changes in the recipient's PCAT service plan prepared under 7 AAC 43.751 and approved by the department;

(3) a copy of the PCAT service plan signed by, or bearing the legal mark of, the recipient or the recipient's legal representative and the department or its designee;

(4) a time sheet recording the date, time, and length of each visit and the services provided during each visit; and

(5) the signature or legal mark of the recipient or the recipient's legal representative on each time sheet, verifying that services were provided as reported by the personal care assistant.

(b) If a recipient changes personal care assistants or discontinues personal care services, the former personal care assistant shall deliver the record required by (a) of this section to the appropriate personal care agency within two days.

(c) If a personal care assistant terminates employment, the personal care assistant shall deliver the record required by (a) of this section to the appropriate personal care agency within two days.

(d) A personal care assistant may not

(1) accept payment in any form from a recipient for any Medicaid-reimbursable service; or

(2) solicit clients for personal care services.

(e) A personal care assistant shall keep all information concerning a recipient confidential in accordance with P.L. 104-191 (Health Insurance Portability and Accountability Act of 1996).

(f) A personal care assistant is subject to the reporting requirements of AS 47.17.020 and AS 47.24.010.

(g) A personal care assistant shall inform the personal care agency within 10 days after a change in the personal care assistant's

(1) name;

(2) license, certification, or registration status;

(3) mailing address, physical address, or telephone number; or

(4) record of any convictions or pending criminal charges from that disclosed by the criminal justice information obtained under 7 AAC 43.770(a).

(h) In this section, "case notes" means progress notes documented after services are provided that

(1) include how the recipient responded to care;

(2) identify any changes, improvement, or decline in the recipient's health, safety, or welfare, including changes in physical or mental conditions; and

(3) are dated, signed by a personal care assistant, and contained in the recipient's service record. (Eff. 11/6/86, Register 100; am 6/27/92, Register 122; readopt 8/7/96, Register 139; am 10/1/2001, Register 159; am 1/1/2002, Register 160; am 4/1/2006, Register 177)

Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.780 is repealed and readopted to read:

7 AAC 43.780. Agency-based program; supervising registered nurse. (a) A personal care agency in the agency-based program shall retain a supervising registered nurse, licensed under AS 08.68, to perform the following duties:

(1) obtain from the department prior authorization to implement the PCAT service plan for each recipient;

(2) at least once every six months perform, or supervise the performance of, a review of the recipient's services, including

(A) interviewing the recipient at the recipient's residence to assure services are provided and meeting the recipient's needs;

(B) evaluating the service records, including time sheets prepared by the recipient's personal care assistant;

(C) verifying in writing that the services provided are consistent with the recipient's PCAT service plan;

(D) determining whether progress is being made toward achieving the service goal; and

(E) notifying the department of any recommended changes in the number of personal care service hours and the reasons for the recommended changes;

(3) if the recipient resides in a community not accessible by road or air service, arrange for telephone, radio, or, if feasible, in-person contact with the recipient and the personal care assistant to the extent allowed by the recipient's PCAT service plan and the condition of the recipient, and request that the department waive the residence visitation requirements of this section if necessary; if the six-month, in-person visitation is waived, an in-person visitation must occur annually;

(4) put written provisions in the recipient's file for emergency situations that the personal care assistant may encounter;

(5) maintain communications with the recipient, the recipient's physician, if any, and the personal care assistant;

(6) maintain a service record for each recipient that includes a

(A) copy of each PCAT service plan, assessment, and evaluation made for the duration of care including changes made under 7 AAC 43.751;

(B) copy of the personal care assistant's time sheets; and

(C) record of all contacts with the recipient, the recipient's health care provider, if any, and the personal care assistant.

(b) A supervising registered nurse under (a) of this section is subject to the reporting requirements of AS 47.17.020 and AS 47.24.010.

(c) For purposes of this section, "supervising" means implementing and overseeing the PCAT service plan for a recipient in accordance with this section. A supervising nurse is not required to perform administrative or personnel functions such as hiring, disciplining, scheduling, or terminating a personal care assistant. (Eff. 11/6/86, Register 100; am 6/27/92, Register 122; readopt 8/7/96, Register 139; am 10/21/98, Register 148; am 10/1/2001, Register 159; am 1/1/2002, Register 160; am 6/19/2004, Register 170; am 4/1/2006, Register 177)

Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.786 is repealed and readopted to read:

7 AAC 43.786. Consumer-directed program; personal care agencies. (a) A consumer-directed personal care agency shall, in addition to meeting the requirements under 7 AAC 43.750 – 7 AAC 43.795, review a recipient's needs semiannually in the recipient's home. If the recipient resides in a community not accessible by road or air service, a consumer-directed personal care agency shall arrange for telephone, radio, or, if feasible, in-person contact with the recipient and the personal care assistant to the extent allowed by the recipient's PCAT service plan and the condition of the recipient, and request that the department waive the residence

visitation requirements of this section if necessary. If the semiannual in-person visitation is waived, an in-person visitation must occur annually.

(b) As an employer, an agency shall collect and verify consumer-directed personal care assistants' time sheets and submit claims to the department. Individual personal care assistants employed by an agency are not responsible for submitting their own claims.

(c) Before the agency submits the application materials required under 7 AAC 43.793, the administrator of a personal care agency in the consumer-directed program shall attend a department orientation.

(d) A newly employed administrator of an existing consumer-directed program shall attend a department orientation within six months after the date of hire by the personal care agency, if the department does not have documentation that any other current employee of the personal care agency has attended a mandatory department orientation.

(e) A recipient who, because of lack of capacity under 7 AAC 43.768(a), has been terminated from the consumer-directed program by the consumer-directed agency that has been providing services to the recipient is eligible to transfer to, and to receive personal care services through, an approved personal care agency in the agency-based program. Except as provided in 7 AAC 43.789, and at least 30 days before the date of termination, the agency terminating services to a recipient shall give the recipient written notice of the termination and of the recipient's eligibility to apply to the department for inclusion in the agency-based program. (Eff. 10/1/2001, Register 159; am [READOPT] 6/19/2004, Register 170; am 4/1/2006, Register 177)

Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.787 is repealed and readopted to read:

7 AAC 43.787. Agency-based program; personal care agencies. (a) A personal care agency in the agency-based program may provide personal care services for a recipient who does not yet have a PCAT service plan approved by the department under 7 AAC 43.751, if the recipient

(1) is being or has been discharged from an acute care facility or a nursing facility;

(2) has a discharge plan or a physician's confirmation of diagnosis and request for personal care services to begin immediately upon discharge from an acute care facility or a nursing facility, and home health services are not available or indicated; and

(3) has a plan to have an assessment done by the department or its designee within three days after discharge from an acute care facility or nursing facility; the three-day period may be extended if the department or its designee is not available to conduct the assessment within three days.

(b) A personal care agency in the agency-based program may provide personal care services for a recipient who does not yet have a PCAT service plan approved by the department under 7 AAC 43.751, if the recipient's primary caregiver is absent due to an emergency and lack of personal care services will result in immediate hospitalization or placement in a nursing

facility. The recipient must have an assessment done by the department or its designee within three days after the emergency caregiver absence occurs. The three-day period may be extended if the department or its designee is not available to conduct the assessment within three days.

(c) A personal care agency in the agency-based program may deny an application for employment of a personal care assistant for any reason subject to sanction under 7 AAC 43.950.

(d) Before the agency submits the application materials required under 7 AAC 43.793, the administrator of a personal care agency in the agency-based program shall

(1) attend a department orientation;

(2) establish the agency's policy on termination of services to be provided to recipients; and

(3) establish a grievance procedure for employees.

(e) A newly employed administrator of an existing agency-based program shall attend a department orientation within six months after the date of hire by the personal care agency, if the department does not have documentation that any other current employee of the personal care agency has attended a mandatory department orientation. (Eff. 6/27/92, Register 122; readopt 8/7/96, Register 139; am 10/1/2001, Register 159; am 1/1/2002, Register 160; am 6/19/2004, Register 170; am 4/1/2006, Register 177)

Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.788 is amended to read:

7 AAC 43.788. Safety [CONSUMER-DIRECTED AND AGENCY-BASED PROGRAMS; SAFETY] of recipients. (a) An agency or an employee of an agency in either the consumer-directed or agency-based program who has reasonable cause to believe that a recipient of any service rendered under 7 AAC 43.750 - 7 AAC 43.795 is subject to [PHYSICAL, SEXUAL, ECONOMIC, OR MENTAL] abuse [,] or coercion of any kind, shall report that belief to the department immediately in accordance with AS 47.17.020 and AS 47.24.010 [7 AAC 37.050].

(b) If an immediate termination of services under 7 AAC 43.789 appears likely to put a recipient at risk of harm, the agency shall

(1) include a statement to that effect in its notice to the department for referral of the recipient to adult protective services or the office of children's services within the department; and

(2) [SHALL] promptly call the department's adult protective services hotline or the child abuse hotline. (Eff. 6/27/92, Register 122; readopt 8/7/96, Register 139; am 10/1/2001, Register 159; am 1/1/2002, Register 160; am 6/19/2004, Register 170; am 4/1/2006, Register 177)

Authority: AS 47.05.010 AS 47.07.030

Editor's note: Effective 8/7/96, Register 139, the Department of Health and Social Services readopted 7 AAC 43.788 in its entirety, without change, under AS 47.05 and AS 47.07. Executive Order No. 72 transferred certain rate-setting authority to the department.

The hotline number for the department's [DIVISION OF SENIOR SERVICES'] adult protective services is 1-800-478-9996. The child abuse hotline number for the department is 1-800-478-4444.

7 AAC 43.790 is repealed and readopted to read:

7 AAC 43.790. Payment for services. (a) The department will only provide Medicaid reimbursement for personal care services that are performed in accordance with 7 AAC 43.750 – 7 AAC 43.795 and applicable federal and state law.

(b) The department will base its reimbursement on the tasks specified in the recipient's approved PCAT service plan under 7 AAC 43.751 and the time authorized by the PCAT service plan for each task, to the extent that the tasks and times are consistent with the recipient's condition.

(c) In the agency-based and consumer-based programs, the total time per task for each week may not exceed the time authorized in the recipient's PCAT service plan. If the time-per-task activity is provided less than one time per week, the time may not exceed the authorized time per period.

(d) Reimbursement for an enrolled personal care agency's provision of personal care services may not exceed \$21 an hour. This rate includes reimbursement for all personal care and administrative services rendered, including travel and telephone expenses. At least 50 percent of the annual total reimbursement paid by the department to a personal care agency for personal care services must be spent on compensation for personal care assistants.

(e) On or after February 1, 2007, a personal care assistant's rendering provider identification number must be submitted with each claim that the personal care agency submits for Medicaid reimbursement from the department. (Eff. 11/6/86, Register 100; am 6/27/92, Register 122; am 7/1/95, Register 134; readopt 8/7/96, Register 139; am 3/1/98, Register 145; am 10/21/98, Register 148; am 10/1/2001, Register 159; am 1/1/2002, Register 160; am 6/19/2004, Register 170; am 4/1/2006, Register 177)

Authority: AS 47.05.010 AS 47.07.030

Editor's note: [COPIES OF THE DIVISION OF MEDICAL ASSISTANCE MANUAL FOR PERSONAL CARE SERVICES TIME PER TASK STANDARDS, AS REVISED IN FEBRUARY 1992, MAY BE OBTAINED FROM ANY ENROLLED PERSONAL CARE AGENCY OR BY WRITING OR CALLING THE DIVISION OF MEDICAL ASSISTANCE, 4501 BUSINESS PARK BOULEVARD, SUITE 24, ANCHORAGE, ALASKA 99503-7167.]

Effective 8/7/96, Register 139, the Department of Health and Social Services readopted

7 AAC 43.790 in its entirety, without change, under AS 47.05 and AS 47.07. Executive Order No. 72 transferred certain rate-setting authority to the department.

7 AAC 43 is amended by adding a new section to read:

7 AAC 43.791. Review and appeal rights. (a) A recipient who is terminated from a consumer-directed or agency-based program may challenge that termination through the agency's grievance procedure, as the agency documented that procedure in the application materials required under 7 AAC 43.793.

(b) If the PCAT shows that an individual is not capable of managing consumer-directed services because of a lack of capacity as provided in 7 AAC 43.768, or if a person is terminated from a consumer-directed program because the individual lacks capacity to manage personal care services, the individual may appeal that decision under 7 AAC 49.

(c) If a service authorized by the PCAT service plan is reduced, terminated, or denied, the recipient may appeal that decision under 7 AAC 49. (Eff. 4/1/2006, Register 177)

Authority: AS 47.05.010 AS 47.07.030

7 AAC 43 is amended by adding new sections to read:

7 AAC 43.793. Provider certification and enrollment. (a) To be certified and enrolled by the department as a provider of personal care assistant services, a personal care

agency must meet the applicable certification criteria, including provider qualifications and program standards, set out in the department's *Personal Care Assistance Agency Certification Application Packet*, dated 2005 and adopted by reference, which the agency must submit to the department. (Eff. 4/1/2006, Register 177)

Authority: AS 47.05.010 AS 47.07.030

An editor's note is added to read:

Editor's note: The *Personal Care Assistance Agency Certification Application Packet*, adopted by reference in 7 AAC 43.793, may be obtained from the Department of Health and Social Services, Division of Senior and Disabilities Services, 3601 C Street, Suite 310, Anchorage, Alaska 99503.

7 AAC 43.794. Provider decertification and disenrollment. (a) The department may deny enrollment or certification to, or disenroll or decertify, a personal care agency as a provider for the consumer-directed or agency-based program

(1) if the agency does not meet the requirements in the department's *Personal Care Assistance Agency Certification Application Packet*, adopted by reference in 7 AAC 43.793;

(2) for grounds and under procedures set out in 7 AAC 43.950 – 7 AAC 43.985;

or

(3) if the agency is no longer qualified for certification under this chapter.

(b) Providers that are disenrolled or decertified by the department under (a)(2) or (3) of this section may appeal that decision under 7 AAC 43.980. (Eff 4/1/2006, Register 177)

Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.795 is repealed and readopted to read:

7 AAC 43.795. Definitions. In 7 AAC 43.750 - 7 AAC 43.795, unless the context requires otherwise,

(1) "ADL" means activities of daily living;

(2) "acute care hospital" means a facility that provides inpatient hospitalization for medical and surgical care of acute illness or injury;

(3) "agency-based program" means a program to provide personal care services to a recipient who is unable to, or who chooses not to, take responsibility for managing those services;

(4) "consumer-directed program" means a program to provide personal care services to a recipient who takes, or whose legal representative takes, responsibility for managing those services;

(5) "CPR" means cardiopulmonary resuscitation;

(6) "health care professional" means a physician, a physician assistant, a nurse