



Alaska Department of Health and Social Services (DHSS)

Long Term Care Performance Review

October 1, 2015

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EXECUTIVE SUMMARY

The Alaska Division of Legislative Audit (DLA) engaged Public Consulting Group, Inc. (PCG) to conduct a performance review of the Alaska Department of Health and Social Services (“DHSS” or “the Department”) long-term care services. PCG has considerable experience conducting system studies and evaluations for government agencies across the country including financial and programmatic reviews of long term care and behavioral health programs. This performance review was authorized in accordance with Chapter 19 SLA 2013. Results of the analysis are to be included in a report to the Alaska Legislative Budget and Audit Committee (LBAC).

The Department is a complex organization with eight operating divisions and a FY 2015 budget of approximately \$2.6 billion, of which \$1.3 billion is funded by state general funds and \$1.3 billion in federal funds. Its long-term care programs are administered primarily by the Division of Alaska Pioneer Homes (AKPH), and the Division of Senior and Disabilities Services (SDS). The Division of Health Care Services’ (HCS) budget contains Medicaid long-term care funding appropriations, but the administration of programs appears to be heavily influenced by SDS.

PCG was tasked with 10 separate review objectives spanning all facets of the Department’s long term care programs. Work began in November 2014 and encompassed reviews of available reports and budget documents, requests for fiscal and utilization information on programs, visits to long-term care facilities, attendance to public forums, and interviews with approximately 65 persons, including state staff, long-term care providers, and interested parties and stakeholders.

This report represents the culmination of PCG’s work on this performance review. The report provides the results of PCG’s research, utilization and cost studies, and analysis which assisted in the creation of final recommendations.

In order to successfully complete this project, PCG worked closely with staff from the Division of Legislative Audit (DLA) and staff within The Department. PCG is indebted to the positive relationships and information supplied by these parties. Regardless of the collaboration that existed between the groups, the information, analysis, and recommendations in this report represent PCG’s independent opinion regarding the performance of the Department.

The phrase “long-term care” tends to be an older term and contemporary terminology tends to use the phrase “long-term services and supports.” This report follows the more contemporary usage to the extent possible. Regardless of the terminology used, PCG included the following programs in the scope of its review.

- Division of Alaska Pioneer Homes
- Division of Senior and Disabilities Services
- Personal Care Assistance (PCA)
- Alaskans Living Independently Waiver (ALI)
- People with Intellectual and Developmental Disabilities Waiver (IDD)
- Adults with Physical and Developmental Disabilities Waiver (APDD)
- Nursing Facilities

This executive summary provides an overview of PCG's findings and recommendations for each of the 10 review objectives. Following this summary, the main body of the report takes each review objective and its subparts in sequence as specified in the contract listing the purposes of the review.

REVIEW OBJECTIVE 01 - COMPREHENSIVE OVERVIEW

Develop a comprehensive overview of how long-term care services are delivered and funded in the State of Alaska and provide recommendations for how DHSS' annual budget can be constructed differently to provide the legislature a more easily understood format with sufficient detail to allow for a comprehensive review of services and funding needs by program. This should address the following:

- A. Identify and provide recommendations for how the number of individuals serviced, cost of services provided, and funding sources utilized can be organized and presented to provide a comprehensive yet easily understood annual review of long-term care services and funding needs.**
- B. Identify strengths and weaknesses of the current budget reporting format.**

Alaska has a national reputation for having an excellent long-term care program. In 2014, The American Association of Retired Persons (AARP) published a scorecard of state performance in long-term services and supports. The scorecard is the only large-scale, comprehensive comparison of state LTSS programs on performance measures. Alaska had an impressive overall rank of fifth highest in the nation.

Alaska's main strength is having a balanced program that provides in-home service alternatives, multiple residential choices, and institutional placement for those persons that meet the level of care. The state also has developed a significant consumer directed in-home program which is consistent with national best practices. In addition, the state has a deservedly high reputation because it is difficult to develop a broad range of in-home and residential programs and implement significant consumer direction in programs. Based on the experience and models of other leading states, Alaska is implementing a new automated service plan technology system which should result in significant efficiencies.

A review of program expenditures over a five-year period shows that program administrators have made considerable efforts to control program expenses. The review found no programs that were tangential or unessential to the mission of providing long-term care services and supports (LTSS). The mix of state and federally funded programs work together in an architecturally coherent manner. Currently in Alaska, state funds and federal Older Americans Act funding typically provide services to persons that delay or defer their spending down of excess income to Medicaid financial eligibility levels and become Medicaid eligible. The use of these state funds thus helps control Medicaid caseloads.

In general, program operations traditionally benefit from a systematic review of federal matching efforts. Although our review determined that Alaska has good programs, more can be done to maximize federal funds. One way to obtain additional funding would be to maximize the use of programs established by federal authorities in the Social Security Act such as sections 1915(c), 1915(i), and 1915(k). The use of these authorities has been discussed for years, but programs related to these federal authorities have not been implemented because of limited staff time and other pressing matters such as Medicaid Management Information System (MMIS) issues, and efforts to control Medicaid LTSS expenditures. In other words,

the state is currently in the position of not having enough staff to obtain increased federal funding or apply for federal grant programs to help prepare for changing federal policy.

While the state has commendably accomplished expenditure and caseload reductions in programs, the effect of these reductions on individuals losing services has not been studied and these effects need to be known and measured. A budget reduction per se cannot be determined to be programmatically effective absent an understanding of the impacts of the reduction on individuals no longer receiving services.

A significant problem affecting numerous Alaskans is the prevalence of Alzheimer's and related disorders. Alzheimer's disease is a physical process in which portions of the brain progressively atrophy. The state needs a sustained effort to diagnosis and treat persons with this brain disease.

In general, reviewers made recommendations about the frequency of Medicaid assessments, the assessment instruments used, and the use of other assessment approaches such as those of the National Core Indicator (NCI) project.

PCG was asked to comment on whether the Department acted in "in good faith" and was compliant with requests from the Legislature for a list of budget reductions totaling 10%. PCG concluded that the Department acted in good faith but was not compliant. These findings are discussed at length in the report.

Reviews of grants and contracting procedures and certificate of need (CON) practices yielded multiple recommendations to strengthen policies, procedures, and staff training.

In the presentation of budget information, reviewers made the observation that the format of the Governor's Amended Budget allowed Departments to insert program information and that more description and trend data could be added to take advantage of this capability. In reviewing Departmental performance reporting, the primary recommendation made by reviewers was that the performance measures lacked interpretative context that stated what constitutes good and bad performance. In other words, it is not sufficient to simply say "the percentage is X." What is needed is needed is an understanding or benchmark of whether "X" is the right percentage.

For PCG's recommendations, please refer to the table at the end of this Executive Summary or the body of the report.

REVIEW OBJECTIVE 02 – DELIVERY AND ADMINISTRATION

Using recognized standards for determining such, examine and evaluate all aspects of long-term care services provided by DHSS including the types, delivery, and funding, and determine the extent services are effectively and efficiently delivered and administered. The review team shall provide recommendations for improvement to any area identified as not effective or efficient. This should address the following:

- A. Do the department’s Long Term Care service goals, programs, and objectives tie directly to the department’s mission?**
- B. Are the department’s long-term care programs and services delivered and administered effectively?**
- C. Are the department’s long-term care programs and services delivered and administered efficiently?**
- D. Are there opportunities for the department to increase the quantity and/or quality of services provided to clients with the same level of funding?**
- E. Are there opportunities for the department to reduce the level of funding while maintaining the quantity and/or quality of services provided to clients?**
- F. Are there any long-term care programs or services that are not effective or efficient?**
- G. Can best practices be implemented to better position the department to effectively and efficiently manage the projected growth in demand for long-term care services?**
- H. Identify best practices and make recommendations to address projected growth in demand for services provided through Alaska Pioneer Homes.**
- I. Identify and recommend best practices that distinguish service needs between seniors and people with disabilities.**
- J. Identify and recommend best practices that allow the department to identify services that are producing quality outcomes for individuals served.**

Because of the complexity of its numerous components, the discussion of review objective two is lengthy and hard to easily summarize.

PCG believes that all of the long-term care services, goals, programs, and objectives tie directly to the Department’s mission. All expenditures can be tracked to Department priorities. PCG also found that, in general, the Department’s LTSS programs and services are delivered and administered effectively. Alaska has successfully implemented an LTSS program that provides three types of services: institutional, in-home, and residential. Additionally, the state provides modest general fund programs that delay or deter persons from spending down their resources and becoming Medicaid eligible. The programs emphasize more cost-

effective home and community care while providing multiple opportunities for persons to maximize their responsibility for their own care. PCG also found that there are ways in which the administration of programs could be improved. A significant issue raised by multiple persons interviewed involved the treatment of persons with dementia. Dementia is a serious physical illness in which portions of brain tissue die. PCG examined the eligibility requirements for Medicaid waiver services and concluded that the requirements create significant obstacles for persons with brain diseases that impede their access to Medicaid home and community based services. The Department should study how these requirements can be changed and change them.

PCG performed five-year trend analyses of each LTSS program. These analyses established that the program expenditures in the waivers and the personal care (PCA) program grew at significant rates of increase until the Department took multiple actions during 2013 and 2014 to gain control of the expenditure increases. These actions have resulted in more efficient program operations. While not restoring expenditure levels to 2010-2011 levels, there have been substantial reductions in program expenditure levels. These reductions had a differential impact on aged persons and aging advocates have expressed their concerns about these program reductions. The Department should study the impact of these budget reductions on individuals.

The Department placed a moratorium on conducting annual reassessments for the PCA program because of staff shortages. While such an action is understandable it is also inefficient since persons receiving LTSS services need to be assessed annually to ensure the right mix of services is still being provided.

By occupancy measures the Alaska Pioneer Homes are efficient. The Pioneer Home occupancy rate has maintained an over 90% average over the last five years. From the standpoint of expenditures and census data, the Pioneer Homes have the appearance of not operating efficiently since collective bargaining increases create yearly cost increases while census is fixed. Total fund expenditures have been increasing by about a million per year on average between 2010 and 2014 while overall resident census has been flat and Level III census, the most impaired level of residents, has been declining.¹ This is not a situation controllable by the Department since it does not have authority to set benefit levels of staff that work in the Pioneer Homes.

Revenue received by the Pioneer Homes does not cover the cost of private pay and Medicaid residents. For example, the homes receive the same Medicaid rate paid to other assisted living programs, but the rate does not cover the costs of taking care of Medicaid residents, and reviewers were told that the costs were not recouped in the Department's federal cost allocation plan.

PCG recommends the Department review its federal claiming for Pioneer Homes to clarify the possibility of additional federal funds for the homes. Changing the restrictive nursing facility eligibility assessment

¹ Persons interviewed generally expressed the view that the Level III census in the Pioneer Homes was increasing. This is true historically, but the data provided PCG shows that this is not true in recent years.

criteria for individuals suffering from Alzheimer's and Dementia Related Diseases could also benefit the Homes since a minimum of 25% of their residents have dementia or a related situation.²

The use of a 1915(i) federal program has been discussed for years in Alaska. In February 2015, the Department proposed a \$789,800 reduction to the program and expressed the hope that, by using a 1915(i) Medicaid waiver, some of the expenditures in the program could be made eligible for federal matching funds.³ Fiscal Note 6 to the 2015 Senate Bill 78 estimated that an additional \$ 4,494,300 in federal funds could be obtained if Alaska applied for a 1915(i) Medicaid waiver.⁴ If this estimate is correct, then the 1915(i) Medicaid waiver would add further efficiency towards cost savings by generating extra revenue.

Section 2401 of the Affordable Care Act of 2010, added a new section 1915(k) to the Social Security Act (the Act).⁵ This new section established what is called the Community First Choice (CFC) program which is a new Medicaid state plan option to provide home and community-based attendant services and supports at a six percentage point increase in the federal medical assistance percentage (FMAP). As a "state plan" benefit, the option is available to states without the need for special waiver authority. A 2012 study of the feasibility of a CFC program indicated substantive savings could be accomplished but the Department chose not to implement CFC because of a lack of staff. PCG recommends the state revisit its decision and fund the use of staff time since the program can bring an additional 6% federal match if implemented in a cost neutral manner.

As shown in the cost analysis of the waiver and PCA programs, the Department has already made significant funding reductions, and it is difficult to see how additional short-run reductions could be made without effecting the quality and quantity of services provided. However, there is a long-run option to help reduce funding while maintaining the quality and quantity of services. This option will not result in immediate funding reductions, but will create long-run changes. This option is the use of a long-term care insurance partnership program, and PCG recommends Alaska submit a Medicaid state plan amendment to obtain approval for implementing such a program.

In considering the demand for Pioneer Home services in future years, PCG observes that the leading edge of the baby boomers will not become 80 years of age and older until 2026-2027. There is still time to plan and consider options before this wave of persons has impairments that require 24-hour care such as that provided in a nursing home or Pioneer Home. Outside of nursing homes, other states tend not to own and operate large residential programs. Given the upfront construction costs and ongoing operational costs of an additional Pioneer Home, PCG finds that such a home should not be built at the present time.

In reviewing the methodology used to distinguish service needs between seniors and persons with disabilities, reviewers considered the assessment instruments currently used by the Department. Reviewers noted the continued use of multiple instruments is administratively inefficient. The Comprehensive

² Reviewers obtained various estimates of the percentage of persons with dementia who were residents of the Pioneer Homes. For example, one person estimated that 89% of the Homes' residents had dementia of some sort. Reviewers examined diagnostic information on residents and found approximately 25% of residents had the word dementia in their diagnosis.

³ See https://www.omb.alaska.gov/ombfiles/16_budget/HSS/Amend/comp2875.pdf.

⁴ See Fiscal Notes at <http://www.akleg.gov/basis/Bill/Detail/29?Root=SB%20%2078>.

⁵ For text of Affordable Care Act see <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf> and for CMS website for CFC see: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/community-first-choice-1915-k.html>.

Assessment Tool (CAT) used with the PCA and waiver programs is weak in areas that are stressed by contemporary health practices which focus on integrated and person-centered care. Moreover, contemporary scoring practices associated with the CAT assign fixed time limits to provide given services regardless of the individual's unique needs and are not person directed.

The Inventory for Client and Agency Planning (ICAP) used to determine the eligibility of persons for the Intermediate Care Facilities/Intellectual-Developmental disabilities (ICFs/ID-DD) level of care should be replaced with a modified CAT or other instrument such as the InterRAI Home Care tool.

Regarding assessment, PCG also recommends that Alaska enroll in the National Core Indicators (NCI) study. This study enables public agencies that provide developmental disabilities supports to track their progress data. The NCI data is valuable for obtaining experience of persons receiving services and this viewpoint supports person-centered planning.

For PCG's recommendations, please refer to the table at the end of this Executive Summary or the body of the report.

REVIEW OBJECTIVE 03 – GRANTS AND CONTRACTS

Evaluate DHSS' procurement of home and community-based long-term care services through the use of grants and contracts. Determine whether contracts and/or grants for the provision of long-term care services are being managed to ensure funds are expended effectively, efficiently, and in an appropriate ratio of direct service to administration. Evaluate DHSS' process of solicitation, review, and award of grants and contracts for home and community-based services. Determine whether the system is effective and efficient and whether there is a more effective means of procuring long-term care services for recipients. Recommend best practices to maximize the benefits received by clients and/or improve monitoring and oversight. This should address the following:

- A. Does the Department's grant and contract procurement process maximize the quantity and quality of long term care services delivered to recipients and minimize the administrative costs of such services.**
- B. Does the Department's grant and contract procurement process adequately leverage other funds such as fees, insurance, and matching funds?**
- C. Does the Department's grant and contract procurement process provide for maximum and fair competition, evaluation, and award?**
- D. Does the Department's grant and contract procurement process ensure adequate monitoring and oversight of the quality and quantity of long term care services?**
- E. Do grant and contract provisions promote the efficient and effective use of funds?**
- F. Does Department staff respond timely and appropriately to deficiencies when noted?**

The Department does well in maximizing the quantity and quality of long term care services through utilization of effective contracts and spending grant dollars appropriately. However, the Department is not as effective in minimizing the administrative costs of such services as the Divisions appear to vary in their efficiency. In regard to this, PCG's recommendations focus on establishing tighter controls over the administrative costs allowed in grants and contracts.

In general, PCG's review of fees found that Departmental fees are fairly consistent of typical programmatic fees that are collected in order to support program operations. Two recommendations were made in regard to CON and Pioneer Home fees.

A review of the insurance requirements of state contracts indicates that the Grants and Contracts unit appropriately leverages insurance resources.

PCG reviewed the use of federal matching funds and identified five grants where a review of the Medicaid eligibility of persons receiving services might show possibilities for additional match. In addition to reviewing the eligibility of persons receiving these grant services, bringing mental health related grant services under a 1915(i) federal authority might also produce some additional federal match.

In reviewing traumatic brain injury (TBI) funding, PCG recommends exploring the use of a Traumatic Brain Injury Waiver (TBI). The state currently provides state funding for traumatic brain injuries and related injuries through three grant programs: the Traumatic and Acquired Brain Injury (TABI) Grant totaling \$70,624, another \$300,000 in General Funds for TABI Case Management services, and \$200,000 in TABI Mini Grants. Rolling these funds into a Medicaid waiver program could produce approximately \$285,000 in savings to the state.

Overall in the Grants and Contracts procurement process, the Department has established a fair and effective process that leverages technology and ensures competition, proper evaluations, and awards. PCG presents five recommendations that may be of use to the Department in improving its procedures. Three of these relate to procurement procedures, and two of them concern the Grants Electronic Management System (GEMs).

Regarding monitoring and oversight, PCG presents two recommendations for modifying the oversight. The first recommendation is that the Department change the year-end report to focus further on outcomes and performance metrics as opposed to simply the dollar amounts spent or tasks accomplished. An annual report that focuses on the value driven by the contract and the outcomes that resulted will tell a much stronger story than simply reporting dollar amounts spent and whether timelines were met. The second recommendation is that additional training be provided to the Department contract managers.

The efficient and effective use of funds has been discussed throughout the entire section on grants and contracts. Overall, grant and contract provisions work in unison to ensure funds are used both efficiently and effectively and the Grants and Contracts Unit works well to ensure all grants and contracts are properly allocated and delivered to the most targeted recipients. PCG does recommend two changes to the manner in which performance measures associated with grants are tracked.

Regarding deficiencies, per interviews with Grants and Contracts staff, there are no formal policies and procedures on how and when to follow up on deficiencies. Historical precedence has given program

managers discretion in handling these issues. PCG found that it was not possible to empirically measure the timeliness of deficiency tracking and recommends stronger controls over the handling of deficiencies.

For PCG's recommendations, please refer to the table at the end of this Executive Summary or the body of the report.

REVIEW OBJECTIVE 04 – BUDGET REDUCTIONS

Determine if DHSS' proposed long-term care related budget reductions are supported by the performance review, including whether DHSS complied with AS 44.66.020(c)(2) when proposing cuts to long-term care services. Compare the agency's priorities submitted to the legislature under AS 37.07 with the list of long-term care programs identified for reduction. Identify any areas in which the reductions are not aligned with service priorities and include a rationale for conclusions. This should address the following:

- A. Do the proposed reductions represent a good faith effort by the department to identify long-term care related areas that can be reduced without compromising the department's ability to meet its mission in regard to long term care?**
- B. Are the reductions recommended by the department in response to AS 44.66.020(c)(2) consistent with results derived from the review of each applicable objective within this scope of work (SOW)?**
- C. Did work on any of the objectives within this SOW reveal other potential areas that could be subject to a budget reduction without inhibiting the ability of the department to fulfill its mission in regards to long term care?**

PCG's review of Alaska statutes and correspondence between the Legislature and the Department concluded with two observations: the Department did not comply with AS 44.66.020(c)(2) and the Department acted in good faith. Both the non-compliance and the good faith matters are discussed at length in the report.

The program reductions proposed by the Department are discussed at length in the review, and PCG concluded that the reductions are consistent with the results derived from the review of objectives done in this performance review.

PCG's work did not result in recommendations to make further budget reductions to the Department's LTSS programs. The data in Figure 2.3 show that there was a 20% reduction in services and an 18% plus reduction in expenditures between 2013 and 2014. Interviews with DHSS staff contained projections that 2015 spending would be around \$92 million. If accurate this would represent an additional 10% reduction. Interviews with providers of senior services expressed concern about the depth of these cuts which fall primarily on the aged and persons with physical disabilities. PCG's work did not find any public comments expressing the need for more large cuts to the services received by the aged and persons with physical disabilities.

PCG took PCA expenditure data from the 2000-2005 period and extrapolated it forward and found that a \$93 million spending level in 2010 was quite consistent with the trend. Given that the cuts took PCA spending back to this 2010 trend level, PCG concluded it was programmatically reasonable to study the effects of the significant cuts that have been made before suggesting further large reductions.

Performance reviewers have not suggested further budget reductions. However, this performance review has made recommendations which imply that further cost savings are possible. These savings suggestions are in the form of revenue maximization. For example, reviewers have commented upon the need to review revenue maximization in the Pioneer Homes, the use of provider taxes, the use of new federal authorities and grant programs, reviews of contracts, and tightening of fraud and abuse procedures.

For PCG's recommendations, please refer to the table at the end of this Executive Summary or the body of the report.

REVIEW OBJECTIVE 05 – CERTIFICATE OF NEED

Determine whether the (CON) process can be improved or better utilized to expand access to services in high need and underserved areas, and if so, identify best practices to revise the process to expand access to necessary services while maintaining the quality of services. This should address the following:

A. Does the CON Process effectively address the need for services?

B. Does the CON process efficiently address the need for services?

PCG concluded that the CON process is effective at reaching its desired goals of ensuring there is a required need before building new healthcare facilities, and the CON process is efficient in addressing the need for services. However, there is room for improvement. PCG made seven recommendations regarding the effectiveness of the CON process and five recommendations regarding the efficiency of the CON process. These 12 recommendations cover large issues such as: the need and oversight of the process, the fees used, and the methods of calculating program financial information.

For PCG's recommendations, please refer to the table at the end of this Executive Summary or the body of the report.

REVIEW OBJECTIVE 06 – COST COLLABORATION

Determine whether DHSS’ current service delivery structure maximizes available opportunities for collaboration and partnership with the Alaska Native Tribal Health Consortium and federal entities to ensure appropriate assignment and payment of costs are allocated to federal entities such as Veterans’ Affairs and Indian Health Services. This should address the following:

- A. Does the current structure maximize the collaboration and partnership opportunities with federal entities to ensure proper assignment and payment of costs?**
- B. Are there changes that can be made to increase the level of collaboration and partnership with federal entities?**
- C. What cost savings can be realized by increasing the level of collaboration and partnership with federal entities?**

With the exceptions noted in this review, overall, the Department’s’ current delivery structure is close to maximizing available opportunities with federal entities to ensure proper assignment and payment of costs. Regarding veterans, PCG recommends the Department consider adding a skilled nursing home level of care for veterans to the Palmer Pioneer Home. Currently the Palmer Pioneer Home receives the lower “domiciliary” rate from the Veterans Administration and conceivably might have veterans that qualify for nursing facility level of care. This recommendation would result in the home continuing with its assisted living facility designation but adding a skilled nursing facility designation as well.

Regarding opportunities for collaboration with the Alaska Native Tribal Health Consortium, performance reviewers decided that one clear main recommendation was more implementable than multiple secondary recommendations. Following this decision, PCG recommends implementing a comprehensive approach for Medicaid enrollment tailored to each specific tribe. Approximately 49% of the American Indian and Alaska Native population in Alaska are currently enrolled in Medicaid, and it is likely that others are Medicaid eligible but not enrolled in Medicaid. Ensuring the effectiveness of Medicaid would be a substantive cost collaboration activity. While direct in concept, implementation will need to use multiple strategies to be effective.

Provider assessment fees or taxes are mandated payments set by a state on health care providers. A state voluntarily decides whether to implement a fee and what the fee applies to. Health care services or items may have a fee assessed. The collected payments from the fees are matched by the federal government and are added into the state Medicaid funding pool. This practice allows states to increase revenue for their Medicaid program, which in turn allows the state to expand coverage to its residents, to prevent provider rate cuts, and to fill budget gaps in the Medicaid program. This is particularly significant when a state is experiencing an economic downturn. They generally may implement a new provider assessment or increase a fee.⁶

⁶ <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8193.pdf>

Currently, all states but Alaska impose at least one type of provider assessment.⁷ Each state varies in the number of assessments and amount imposed on providers. In FY 2013, the majority of states, 31 and the District of Columbia, had at least three assessments implemented.⁸ Alaska should consider implementing a provider assessment fee or tax. At least one published report states that the average nursing home in Alaska in 2013, had revenue of approximately \$22.13 million.⁹ Provider tax analyses are heavily dependent on what scope of revenue is included in assessment procedures: Medicaid, Medicare, and private pay. The maximum amount of federal revenue that could be raised would be 6% of a facilities revenue times a 50% federal match, or approximately \$650,000 per facility. Depending on the types of revenue included in the assessment the actual amount would be less than \$650,000. A full analysis would require knowing each facility's revenue and modeling the impact of including different type of revenue and excluding certain facilities.

For PCG's recommendations, please refer to the table at the end of this Executive Summary or the body of the report.

REVIEW OBJECTIVE 07 – RESULTS BASED MEASURES

Using a recognized standard or methodology for measurement, determine whether DHSS' long-term care results-based measures demonstrate the effectiveness and efficiency of the agency's core services, goals, programs and objectives, and recommend necessary improvements. This should address the following:

- A. Do DHSS' long-term care results-based measures demonstrate the effectiveness of related programs and services?**
- B. Do DHSS' long-term care results-based measures demonstrate the efficiency of related programs and services?**
- C. Are there alternative long-term care results-based measures that could better demonstrate the effectiveness and efficiency of related programs and services?**

Reviewers examined each performance measure used by the Department that related to LTSS.

The two effective effectiveness measures are as follows:

- Percent of facilities licensed by the Department that are free from reports of harm, and
- Percent of cases that enforcement action is taken within required timeframes.

The other four effectiveness measures that need a better contextual grounding or should be amended are:

- Percent of Alaskans who are receiving community-based LTSS;
- Number of residents who access the Medicaid waiver;

⁷ "Quick Take: Medicaid Provider Taxes and Federal Deficit Reduction Efforts | The Henry J. Kaiser Family Foundation." Accessed June 29, 2015. <http://kff.org/medicaid/fact-sheet/medicaid-provider-taxes-and-federal-deficit-reduction-efforts-2/>.

⁸ Ibid.

⁹ [Average Nursing Home Revenue in Top and Bottom Three States](#). Statista.

- Total Medicaid waiver receipts, and
- Percent of Alaska adults with substantiated reports of abuse or neglect.

The five effective efficiency measures are as follows:

- Number of months LTSS recipients are able to remain in their home before institutional placement;
- Average cost of LTSS per recipient;
- Average cost for waiver eligible Alaskans who are living in an Intermediate Care Facility for Individuals with Mental Retardation (ICF/MR) or nursing home versus those who are living independently;
- Average time to initiate an investigation, and
- Percent of safety assessments concluded within required time frames;

The remaining efficiency measure, cost for licensure functions and oversight, needs a better contextual grounding or should simply be changed.

PCG recommends that the following apply broadly to all measures:

- Discussion of each measure should include a description of what constitutes a “good” score on the measure. Only a few measures, such as time elapsed before an abuse investigation starts, are unambiguous.
- Performance measures need a fuller explanation of how to interpret them.
- The Department should be cognizant of the fact that measures are interrelated and need to be explained well lest readers understandably form a plausible but probably incorrect interpretation of the data.

In general, the most authoritative performance comparison of LTSS programs is that used by the American Association of Retired Persons (AARP). The Department should review these measures and see which might be useful to Alaska. PCG recommends that Alaska consider using the following measures:

- Percent of nursing home residents with low care needs;
- Percent of home health patients with a hospital admission;
- Percent of long-stay nursing home residents hospitalized within a six-month period;
- Percent of nursing home residents with moderate to severe dementia with one or more potentially burdensome transition of end of life;
- Percent of new nursing home stays lasting 100 days or more, and
- Percent of people with 90+ day nursing home stays successfully transitioning back to the community.

For PCG’s recommendations, please refer to the table at the end of this Executive Summary or the body of the report.

REVIEW OBJECTIVE 08 – INFORMATION TECHNOLOGY

Evaluate whether DHSS' use of information technology effectively and efficiently supports the various long-term care programs and services. The evaluation should include the extent DHSS can track and report on benefit recipients, including the extent recipients are receiving multiple benefits and whether recipients are Medicaid eligible. As applicable, the evaluation should recommend new types and uses of technology to improve efficiency and effectiveness in line with recognized best practices. Recommendations should include a justification that benefits outweigh costs. The review team will exclude the recently implemented Medicaid Information System. This should address the following:

- A. Does the Department utilize technology to effectively and efficiently deliver and administer long-term care services?**
- B. Does information technology allow the Department to track and report on benefit recipients, including the extent recipients are receiving multiple benefits and whether recipients are Medicaid eligible?**
- C. Are there areas where the Department could utilize technology best practices to improve the effectiveness or efficiency of such services? What are potential savings or costs to the department if it adopts a recommended technology or best practice? What is the net benefit to the department by adopting a recommended technology or best practice?**
- D. What are the estimated long-term maintenance costs for the technology or best practice identified?**

In approaching the analysis of information technology (IT) used in LTSS, PCG looked at the following indicators of effectiveness and efficiency.

- Does the existing IT structure support all long term care health programs and services provided?
 - To what extent and how easily in terms of automation can summary tracking reports be pulled? Determine if these reports appropriately help the service delivery team.
- Is IT use consistent across all services?
 - Are there deficiencies in the Division's use of IT that increase cost and/or decrease quality of care provided?
- Do the IT systems in place track the recipients of benefits across different services and programs?
- Does the IT system in place improve efficiency and reduce costs?

In looking at these indicators, PCG interviewed information technology staff, obtained descriptions of technology projects, reviewed IT Governance priority documents, reviewed Departmental IT Plans, and reviewed information produced by IT systems.

Generally, PCG found that the Department is implementing efficient technology to use in its LTSS programs, and, in theory, can adequately track the utilization of services.

The changes that the Department is now making should result in effective technology use in its LTSS programs. In recent years, state LTSS programs in Connecticut, Maryland, Mississippi, and Minnesota¹⁰ have implemented substantial improvements to their technology. SDS has implemented a new technology platform, the Automated Service Plan (ASP), which should substantially enhance its technological capabilities.

The existing IT structure appears to support all LTSS programs. From staff descriptions of information they use and a review of the information provided to PCG by the Department, it appears that current technology will produce basic information on which services are provided when, persons receiving the services, and payments for services. MMIS programs routinely contain edits that eliminate the payment of duplicate benefits and restrict payments for only those dates of service that the recipient was Medicaid eligible. Because of the current litigation between the state and Xerox, PCG did not contact Xerox to confirm the existence of particular MMIS edits.

There are areas where the Department could utilize technology best practices to improve the effectiveness or efficiency of its LTSS services. The report discusses the expansion of telehealth, electronic health records and health information technology. The four recommendations that PCG developed in response to technological considerations overlap with recommendations made in other parts of the report. Two of the recommendations are repeated in this section. These are the adoption of a single assessment process to determine eligibility for LTSS and joining the National Core Indicators (NCI) project.

In addition, PCG recommends that the Department consider the use of an electronic visit verification (EVV) system with the PCA and waiver programs and that the Department's IT Plan be made more relevant to the needs of LTSS programs. PCG believes an estimate of 1% to 2% in savings in PCA and waiver programs is potentially possible. PCA expenditures in 2014 were approximately \$100 million and even a half percent savings in 2014, would have equaled \$500,000.

The use of technology to improve LTSS would benefit from a rigorous plan at the Department level outlining how technology can be better used to support LTSS.

For PCG's recommendations, please refer to the table at the end of this Executive Summary or the body of the report.

¹⁰ In the last 12 months, PCG staff have reviewed LTSS technology changes in Connecticut, Maryland, Mississippi, and Minnesota.

REVIEW OBJECTIVE 09 – UTILIZATION TRACKING

Evaluate DHSS' current method of tracking utilization of long-term care services by clients, and, if determined necessary, recommend effective methods to improve DHSS' effectiveness in this area. This should address the following:

- A. Does the Department effectively track the utilization of services by clients who are receiving long-term care services?**
- B. Are there recommended best practices to improve the methods of tracking the utilization of services by clients that would improve the effectiveness or efficiency of long-term care service delivery?**

The Department has the capability of tracking service utilization by clients but does not always report the utilization on easily discovered Department websites. There are improvements that can be made in the analysis and reporting of information about LTSS programs.

The report considers the various LTSS programs and examines the utilization information available about them. The state will collect payment information on nursing homes, but clinical information on nursing homes is collected by federal authorities using the Minimum Data Set (MDS) System. Data for each nursing home is published on federal data sites.

The Pioneer Homes:

- Have strong occupancy utilization and patient demographic information;
- Do not have a system for reporting quality of care information across the homes, and
- Do not use population health management practices and the associated medical care utilization reporting such as Healthcare Effectiveness Data and Information Set (HEDIS) or Quality Rating System (QRS) measures.

PCA and waiver programs have the normal utilization data typically found in MMIS including the amount and kind of services used, cost of services and demographic data. For its major LTSS programs, the Department has basic utilization data. What is missing is the reporting of it on Departmental websites.

After reviewing best practices and peer states for similar systems, PCG has identified the following recommendations for the Department to consider.

- As soon as MMIS is properly functioning, correct data for 2013 and 2014 needs to be disseminated to Department staff that have put data-related activities on hold. The Department should develop a dissemination plan to be sure that those staff that believe they still lack correct data have an opportunity to obtain accurate data for 2013 and 2014.¹¹
- The Department should implement a MDS system in its Pioneer Homes to track quality of care notwithstanding their licensing as an assisted living program.

¹¹ PCG reviewers have been assured that the data PCG has received for 2013 and 2014 can be relied upon.

- The Department should consider aggregating its medical care information from each of the Pioneer Homes into one database and use that database to manage the health of the entire population of persons using Pioneer Home Services instead of operating each home separately.
- Quality of care information on LTSS programs should be reported on Departmental websites to ensure transparency of quality and operations to the public. Such reporting is a national trend as evidenced by the expanded reporting of the federal Medicaid agency.
- SDS should develop a “dashboard” permitting persons to query utilization data on LTSS programs by eligibility group, age and geography.¹²

For PCG’s recommendations, please refer to the table at the end of this Executive Summary or the body of the report.

REVIEW OBJECTIVE 10 – FRAUD, WASTE, AND MISUSE

Recommend improvements based on best practices to reduce, prevent, or detect fraud, waste, and misuse of services. This should address the following:

- A. Does the Department effectively reduce, prevent, or detect long-term care related fraud, waste and misuse? Are there recommended best practices that could be utilized by DHSS to prevent, detect, or reduce, waste, and misuse of long term care services?**
- B. Are there cost savings that will result from reducing, preventing, or detecting fraud, waste, and misuse of services?**

The Department has made substantive progress in the prevention and detection of fraud and can still make improvements. PCG reviewed Departmental activities and federal audit reports, to determine if reasonable measures were being taken to effectively prevent, detect, or reduce fraud, waste, and misuse of LTSS programs. After a review of these measures, PCG recommended that:

- Federal guidance in audit reports on strengthening provider enrollment activities be implemented, if not done so already;
- The Department contract with a handful of larger PCA agencies, perhaps only four to six, and build in contractual requirements for the larger provider agencies to control fraud and abuse;
- The Department build in financial incentives for the provider agencies to control fraud and abuse;
- The state routinely review services provided in assisted living programs to ensure that they are provided to recipients consistent with their plan of care;
- Criminal penalties be increased for Medicaid fraud;
- Penalties and interests be assessed when persons are convicted of Medicaid fraud. The state could benefit by having a Medicaid False Claims Act, and
- The state study the feasibility of offering a one-time amnesty program to HCBS providers.

Recent years have undoubtedly resulted in substantial cost avoidance savings given the repetitive nature of fraud. In 2014, Medicaid program integrity efforts resulted in \$2,000,000 of savings. It is likely that this

¹² See for example, Maryland’s Medicaid e-statistics dashboard at <http://www.chpdm-ehealth.org/>.

also represents the amount of losses that were avoided in the following year given the repetitive multi-year nature of fraud.

For PCG's recommendations, please refer to the table at the end of this Executive Summary or the body of the report.

RECOMMENDATIONS

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RECOMMENDATIONS

TABLE 01: COMPREHENSIVE OVERVIEW RECOMMENDATIONS

Number	Recommendation
1.1	<p>The Department should consider altering the Continuum of Care document to reflect a consistent top-to-bottom approach. The document could provide more information if it were done in a tabular format without the info-graphics. Each program could be shown in a row and the information could be placed in columns. With the extra data space, SDS may consider providing additional details in the budget document such as comparisons to previous years or future projected growth. This will enable the readers to see the document less as a single point in time and more as a living document that enables comparisons to past and future years. This will also let viewers easily make comparisons and see how the level of services provided has evolved over time. Additionally, SDS may consider adding additional program descriptions to the document. Legislative staff may not be familiar with “DD Grants” and a brief description may provide an increase in the level of understanding. Another consideration may be to add in the number of providers that provide services in each of the areas. This will help readers to properly gauge scope and size of each of the programs.</p>
1.2	<p>The Department should consider adding in historical budget data (beyond FY 2014 actuals) to each of the Results Delivery Units (RDUs). Again this will help the reader see trends across years and see how the program has either been growing or decreasing in size. Providing historical costs increases will also enable the readers to make relative comparisons across multiple years to see how the program has evolved. Finally, the Department may consider summarizing outcomes data as well in this section. Demonstrating results and outcomes is an important step in justifying programming and the associated dollars; however, this is not included in the budget document. Nor is historical information on LTSS programs readily available on the Department’s websites. Outcome data will help readers connect with where and how dollars are being spent. It is easier to justify dollars being spent when direct outcomes can be persuasively described.</p>
1.3	<p>The Department should consider adding additional program information in the discussion of the each of the RDUs. This section of the budget document is the only place the Department has the opportunity to present additional unstructured narrative and the Department should take advantage of this opportunity to present full and complete program descriptions.</p>

TABLE 02: DELIVERY AND ADMINISTRATION RECOMMENDATIONS

Number	Recommendation
2.1	The Department should hire a vendor and take a random sample of persons that were denied service or had services discontinued to identify the impact of these reductions.
2.2	The Department should implement a Medicaid 1915(i) waiver. This implementation will allow an estimated \$4,494,300 of Federal funds to be captured allowing a reduction in State General Funds expended.
2.3	Alaska should implement the Community First Choice (CFC), 1915(k) waiver. The Department should revisit the CFC program through the 1915(k) waiver and submit a Medicaid state plan amendment to CMS to operate a CFC program. Having staff implement new initiatives is always a problem. In the case of CFC, it is more cost effective to hire a staff person to supervise the implementation of the program, than put off implementation of a cost effective program because staff are not available.
2.4	Alaska should submit a Medicaid State Plan amendment to obtain approval for implementing an LTC Partnership Program.
2.5	Annual reassessments should be performed for persons that are receiving PCA services. Currently PCA reassessments have been suspended. Reassessments can be performed for everyone or individuals can be triaged by acuity or age. It is inefficient to continue to provide services to persons who may now need different or fewer services.
2.6	The State of Alaska should amend its policy to make waiver eligibility for Alzheimer’s disease and related dementia (ADRDs) less of an exclusionary process. The assessment tools used for Medicaid waiver eligibility make it difficult to allow an individual with an ADRD access to Medicaid funds. The state has the power to amend this policy, which will allow better care for individuals suffering from ADRDs. Furthermore, federal match on expenditures can be utilized by allowing more individuals access to waiver services.
2.7	A new Pioneer Home should not be constructed at this time. Over the next decade construction of a Pioneer Home should be considered with the Kenai Peninsula area as a candidate area. This home would not need to be constructed right away, as the population will not significantly increase until 2022.
2.8	The Department should expand the use of small privately owned residential programs to gradually add residential capacity for individuals who would meet the AKPH level of care.
2.9	The Department should implement a person-centered rate setting system that ties acuity to payment level, allowing higher acuity patients to receive a higher reimbursement.
2.10	An Alaska Pioneer Home should be devoted to become a center of excellence for Alzheimer’s disease related dementia (ADRD) services in the state. Since there is a need for AKPH higher level services (Level III) and ADRD services, Alaska would be able to provide better care to individuals with high acuity and issues with ADRDs.

2.11	The Department should modernize its assessment instruments to incorporate person-centered assessment data. This will be accomplished by adopting a single assessment process to determine eligibility for LTSS, allowing a collection of information that will flow into care plan development. The continued use of multiple instruments is administratively inefficient.
2.12	The Department should discontinue the use of the ICAP by replacing it with a tool that is not proprietary. The ICAP is a proprietary tool whose continued use creates ongoing inefficiencies for the Department.
2.13	The State of Alaska should enroll in the National Core Indicators (NCI) study. While the NCI program focuses on persons with intellectual and developmental disabilities, CMS is moving towards implementing similar surveys for use with older persons and persons with physical disabilities. Alaska apparently did not apply for a CMS Testing Experience and Functional Tools (TEFT) grant. The nine states that received such grants have the opportunity to develop consumer experience surveys before CMS mandates their use by state Medicaid programs. Surveys like this, which are currently not done in Alaska, support and help build the kind of person-centered programs that are required in federal health planning. This recommendation is further addressed under <i>Review Objective 08: Information Technology</i> .

TABLE 03: GRANTS AND CONTRACTS RECOMMENDATIONS

Number	Recommendation
3.1	The Department should increase their ability to monitor, track, and limit administrative costs for vendors.
3.2	The Department should consider limiting administrative costs during the contracting process. Percentage guidelines constituting a reasonable administrative cost should be considered.
3.3	The Department should further monitor grant and contract budgets to ensure costs are properly allocated across each of the major cost or functional areas. In reviewing bids and/or budget proposals, the Department may desire to directly compare projected costs to see which vendors potentially may be hiding their costs.
3.4	The Department should change the CON Application fee to a fee that covers the cost of processing the application. A maximum fee of \$75,000 generates more in revenue to the state than the state incurs in costs to process the application. Please see <i>Recommendation 5.4</i> for additional details.
3.5	PCG recommends the Department consider revising AKPH fee structure to further reflect person centered care so residents are more responsible for the level of services they actually use. Please refer to <i>Review Objective 02: Delivery and Administration</i> for additional information.
3.6	For the following grants, the Department should explore potential opportunities for additional matching funds: the SDS Community Developmental Disabilities Grant totaling \$11,555,795 in general funds; the Nursing Facility Transition Program grant totaling \$120,000 in General Funds; the Adult Day Services grant totaling \$1,757,011 in general funds; the Alaska Mental Health Trust Authority Developmental Disabilities mini-grants totaling \$285,975 in general funds, and the Senior In-Home Services grant totaling \$2,917,265 in general funds. (The total grant figures represent the current grant value, not the potential value.)
3.7	The Department should explore expanding the Traumatic and Acquired Brain Injury (TABI) Grant through a Traumatic Brain Injury (TBI) Medicaid waiver. This would allow expansion of the TABI Grant which currently totals \$70,624. This will present an opportunity to potentially expand this program. The Department could pay for the services through a waiver and receive federal match funds for the service provision. The increased federal funding could be used to expand services under the waiver. There is additional room to expand this program by providing case management services. The Department is currently paying \$300,000 in general funds for TABI case management services. Additionally, the TABI mini grants totaling \$200,000 could further be covered through a waiver service which would help increase match funds. These three services could be better covered through a new TBI Waiver. For additional information please see <i>Review Objective 06: Cost Collaboration</i> .
3.8	The Department should consider expanding the <i>Funded Human Services Community Matching Grant Program for FY 2014</i> to other municipalities that do not exceed 65,000 in population. This is a good way to meet the needs of additional citizens while receiving additional match funds.

3.9	The Department should take an active role and recommend changes to minimum requirements for job classes and collective bargaining agreements to permit longer training periods for contract managers. These changes should allow employees to have a complete first year of training prior to allowing them to be a program manager. Seeing the entire grant cycle through for an entire year will help new employees understand and visualize the complete cycle. This will help ensure new employees are properly trained and understand the entire process.
3.10	The Department should implement a stand-alone or carve-out policy for evaluations of proposals that are more subjective in nature. Some procurements are challenging to evaluate within the given constraints. These procurements typically involve work submitted around creativity or media creation. The Department may consider having respondents consider either judging respondents on past work of similar nature. Additionally, the Department may consider not scoring sections that are based purely on creativity as they are overly subjective and are hard to backup through reviewer scores and notes.
3.11	The Department should include a user manual to accompany training videos. A physical or web-based manual will help communities in rural areas who may have poor or limited internet bandwidth. A training guide similar to the <i>DHSS Grant Budget Preparation Guide</i> would be an improvement to the overall system use.
3.12	The Department should update the GEMs system to allow PEC members access to the proposals outside of the state network. To ensure proper security virtual private networks (VPN) solutions may be considered so all proposals remain private and secure.
3.13	The Department should fix the year-end report to focus further on outcomes and performance metrics as opposed to simply the dollar amounts spent or tasks accomplished. An annual report that focuses on the value driven by the contract and the outcomes that resulted will tell a much stronger story than simply reporting dollar amounts spent and whether timelines were met.
3.14	The Department should provide proper contract and vendor management training to all Department contract managers. This training should ensure managers are adequately and properly trained in contract management. While some training is in place, staff would benefit from a more intensive program. In addition, in all cases staff workloads should be considered and monitored to ensure all managers have appropriate bandwidth to handle additional contract management tasks.
3.15	The Department should consider adding in a simple dashboard into the process that visually demonstrates tracking of program goals and percent completion. Although it is often hard to track exact qualitative measures, simple graphics demonstrating percent completion are useful to ensure all grantees are on track. Grant measures and outcomes are often complicated and having a simple tracking measurement will go a long way in tracking progress.
3.16	The Department should consider additional performance measures to the overall reporting structure. This will help further ensure that funds are spent in the most appropriate manner.
3.17	The Department should develop formalized policies and procedures for handling deficiencies. These policies can be tailored based on grant size and / or provider numbers.
3.18	Formalized timeframes should be developed for the issuance of a deficiency notification.

TABLE 04: BUDGET REDUCTIONS RECOMMENDATIONS

Number	Recommendation
4.1	A provision of additional details surrounding the list of reductions should be made. Having half of all the suggested cutbacks come from two large unspecified areas is not fully responsive to the Legislature's request for a <i>list of programs or elements of programs</i> since program-level reductions were not specified.

TABLE 05: CERTIFICATE OF NEED RECOMMENDATIONS

Number	Recommendation
5.1	The Department should consider the overall need for the CON application. It is no longer a federal requirement, and currently 14 of 50 states do not operate a CON recommendation. The program is effective in rural areas at controlling healthcare costs, but it is not necessarily needed in urban areas.
5.2	The office of private physicians loophole in the CON regulation should be closed. Amend office of private physician’s provisions to close the loophole as it is not defined as a "healthcare facility." Language pertaining to “not otherwise a health care facility” will need to be revised. In the past, providers have registered as an office of private physicians and then proceeded to purchase other health care facilities under the guise of an office of private physicians. This license enables the providers to bypass the required CONs through this loophole. The Department should close this loophole by changing regulations surrounding office of private physicians and the acquisition of other healthcare facilities. Regardless of the license type of the purchaser, a CON should be required for all facility types.
5.3	The Department should amend the regulatory language surrounding the ambulatory surgery centers to not allow for the moving of a facility without a CON. This exception undermines the overall effectiveness of the CON program in that facilities can be moved without having to first demonstrate the community need within a given geographic area.
5.4	The \$1.5 million threshold for differing facilities should be adjusted. Thresholds should vary depending on their size and scope (raising the threshold for larger facilities, and lowering for smaller facilities). The \$1.5 million dollar CON application threshold should be adjusted annually to stay in line with the inflation of the dollar.
5.5	The CON application process should be limited to rural areas. The Department may consider limiting the application process to rural areas as the demonstration of need provides more value. Rural areas have significantly smaller population size in Alaska and an extra provider or facility will have significant impact on the community and the overall quantity of services provided. This will indirectly lead to increases in costs in that region for the State. Urban areas tend to regulate more through economic controls and have a reduced need for a formalized CON Application. The Department should consider ending the CON process in the urban areas.
5.6	The Department should update the Net present Value (NPV) calculation in application and regulations. It should be modified to a uniform and actuarially accepted standard. The current definition allows applicants to depreciate their entire lease in determining their NPV.
5.7	The Department should change the CON Application fee to a fee that covers the cost of processing the application. A maximum CON application fee of \$75,000 generates more in revenue to the state than the state incurs in costs to process the application.
5.8	The Department should update and reform the CON application process as the application is repetitive and inefficient. Several sections are duplicative including portions of Section II and Section III. For a complete breakdown of all sections, please see <i>Appendix 02: Certificate of Need Application (Summary of Sections)</i> . The application was last updated in 2005 and is a non-writeable PDF that still contains tracked changes in the final posted version. Additionally, The Department should consider an online based electronic submission process which will assist in further streamlining the application.

5.9	<p>The Department should have regulatory authority increased to enforce CON violations. Currently, the Department has limited enforcement ability to regulate providers who do not appropriately comply with the CON process. The Department's only option is to file injunctive relief with the Alaska Supreme Court. The Department should increase enforcement ability through statute to enforce regulations, especially in situations where a CON was not filed.</p>
5.10	<p>CON standards and methodologies should be updated and re-baselined. The Department should review and update assessment criteria as they have not been updated since 2005 to ensure metrics in alignment with current standards and population needs. For a more detailed breakdown of the standards and methodologies, please see <i>Appendix 03: Alaska Certificate of Need Review Standards and Methodologies</i>. A thorough review of the standards and methodologies will help ensure criteria are in alignment with best practices of today. Additionally, new types of facilities, scanners, and service trends may need to be added to the standards and methodologies as medicine has quickly evolved over the past decade.</p>
5.11	<p>The Department should increase public involvement in the application review process and should streamline public noticing. In order to increase public involvement in the application review process, an online email noticing system should be considered. This would encourage public participation and feedback on the overall review process. Currently applications are posted in newspapers, however as readership is slowly declining an online forum may also double as an effective medium of communication.</p>
5.12	<p>The Department should consider creating an exception or allowance to CON regulations regarding renovating a facility. Currently, renovating a room is possible, but renovating a facility (ex: changing the layout of a floor) requires a CON application, as it falls under: <i>construction of a healthcare facility</i>. This exception would allow facilities to make renovations which improve patient care through a physical restructuring of where, within the facility, the services are offered, especially if bed capacity and services rendered do not change. The focus of the CON should be placed toward meeting the needs and comforts of patients as opposed to strictly being concerned about renovation costs, or whether the layout of the facility has changed.</p>

TABLE 06: COST COLLABORATION RECOMMENDATIONS

Number	Recommendation
6.1	The Department should move with the CFC waiver program to receive the additional 6% federal match.
6.2	The Department should move forward with implementing a 1915(i) option. Please refer to PCG’s Behavioral Health Performance Review report for more details on the Medicaid 1915(i) option.
6.3	Adjustments to the calculation of cognition on the CAT should be made. Adjusting CAT scoring is something the state could do without going to the time and expense involved with a 1915(i).
6.4	The Department should review the Veterans Needs Assessment as published by the University of Alaska, Anchorage to review potential cost shifts that may have been identified by the study.
6.5	The Department should upgrade the AKPH in Palmer to provide both domiciliary and veteran skilled nursing home care. This will allow the Pioneer Home to receive a higher average per diem rate than the domiciliary-only rate currently received from the VA. Currently, the Palmer Pioneer and Veterans Home receives a domiciliary rate of \$44.19 per veteran resident per day. If the Pioneer Home expands services to offer nursing facility level of care, this Pioneer Home would receive \$102.38 per day for providing veterans this level of care. ¹³ Additionally, the Department may consider licensing only certain portions of the home as skilled nursing facility level of care while other portions can remain as an assisted living facility. This would help avoid potential problems such as what to do with current residents who do not meet skilled nursing level of care requirements, persons on the active wait list, and the Home could still meet the needs of non-veterans.
6.6	The Department should ensure as many providers as possible are enrolled as an Indian Health Service provider to receive a 100% federal match for all eligible recipients.
6.7	The Department should implement a comprehensive approach for Medicaid enrollment tailored to each specific tribe.
6.8	The State of Alaska should continue its work to consider the best approach to optional Medicaid expansion.
6.9	Alaska should implement an assessment fee to further capture federal dollars. To align with peer states and national trends, Alaska should explore a provider assessment imposed on either hospitals, nursing homes, and/or assisted living facilities including the AKPH. Projections would need to be calculated to determine possible revenue outcomes for each type of potential provider assessment at different tax amounts to gain a better understanding of the financial impact on the state’s Medicaid program.
6.10	Recommendations provided in the Grants and Contracts Section in order to further pursue additional federal dollars should be reviewed. See <i>Review Objective 03: Grants and Contracts</i> .
6.11	The Department should consider implementing a TBI waiver to enroll additional individuals in a waiver program and which, based on Medicaid eligibility, will help bring in additional federal dollars. This waiver would be granted under the authority of section 1915(c) of the Social Security Act. The waiver would be designed to help Medicaid-eligible individuals who might otherwise be admitted to a hospital or nursing facility to live independently in the community and to permit the state to provide services that are not typically covered under the state’s regular Medicaid program.

¹³ http://www.va.gov/PURCHASEDCARE/programs/veterans/nonvacare/statehome/SH_Payment_Rate.asp.

TABLE 07: RESULTS BASED MEASURES RECOMMENDATIONS

Number	Recommendation
7.1	The measure stating: “Increasing the number of Alaskans with disabilities who are living safely in the least restrictive environment” should be amended. Changes in the number of individuals receiving LTSS is a useful fact, but expressing this as a percentage of total Alaskans creates the need to understand what a reasonable percentage is. The Department should consider expressing this as a percentage of Alaskans with disabilities rather than the total number of Alaskans.
7.2	Discussions of the effectiveness measure titled “Number of Residents Who Access the Medicaid Waiver” and the efficiency measure titled “Total Medicaid Waiver Receipts” should be expanded to identify what constitutes a good performance. For example, are lower receipts better, or are higher receipts better?
7.3	The Department should consider an alternative effectiveness measure to the <i>percent of Alaska adults with substantiated reports of abuse or neglect</i> . Abuse and neglect are often repetitive. An effective adult protective service does not simply count the number of abusive situations, it stops the abuse from happening again. The Department should consider measuring recidivism of abuse.
7.4	The interpretation of the following measure should be more fully described: “Average cost for waiver eligible Alaskans living in ICFMR or nursing homes versus those living independently.” It is unclear what programs are included in the phrase “living independently”. For example, do large assisted living programs with more than 25 residents meet federal standards for being classified as a home and community-based program? If an individual is living in an assisted living program with 25 other persons is that individual classified as living independently?
7.5	A text discussion of what constitutes good performance should be added along with an explanation of current percentages would strengthen the use of safety assessments concluded within required time frames. Interviews with staff indicate that the population of individuals who are supposed to have safety assessments performed has varied over the years and fluctuations in the data could be due to changes in policies, as not everyone in past years was supposed to receive a safety assessment.
7.6	Discussion of each measure should include a description of what constitutes a “good” score on the measure. Only a few measures, such as time elapsed before an abuse investigation starts, are unambiguous. For example, increases in the number of individuals receiving services and expenditures are good to an extent but there are limits on the reasonability of such increases and the text needs to demarcate these limits clearly.
7.7	The Department should include a fuller explanation of how to interpret all performance measures. For example, the rate of identification of substantiated abuse has all of the familiar problems associated with crime reporting. Is the crime rate increasing or is crime reporting getting better? Textual discussions are needed to set a context for interpreting the statistics provided.
7.8	The Department must be cognizant of the fact that measures are interrelated and need to be explained well, lest readers understandably form a plausible but probably incorrect interpretation of the data. There is a tendency for the performance measures to be discussed in isolation.
7.9	The Department should add in metrics where outcomes are tied to reimbursements. Measuring outcomes to reimbursements will help compare the quality of care to dollars spent in determining the efficiency of service delivery.

7.10	The 26 indicators in the AARP Scorecard of LTSS programs should be reviewed with the intent of determining if any of them might be suitable for inclusion in its performance measures. The following performance measures are suggested for special attention: percent of nursing home residents with low care needs, percent of home health patients with a hospital admission, percent of long-stay nursing home residents hospitalized within a six-month period, Percent of nursing home residents with moderate to severe dementia with one or more potentially burdensome transitions at end of life, percent of new nursing home stays lasting 100 days or more, and percent of people with 90+ day nursing home stays successfully transitioning back to the community.
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TABLE 08: INFORMATION TECHNOLOGY RECOMMENDATIONS

Number	Recommendation
8.1	The telehealth pilot program is recommended for expansion. An increase in telehealth in reassessments is an effective and efficient use of technology that will be cost effective.
8.2	The Department should adopt a single assessment process to determine eligibility for LTSS services.
8.3	The State of Alaska should join the National Core Indicators (NCI) project.
8.4	The Department should consider the use of an electronic visit verification (EVV) system with the PCA and waiver programs.
8.5	The Department’s IT plan should be amended to contain substantive planning and analysis of what IT work needs to be done in order to improve the effectiveness and efficiency of Department operations.

TABLE 09: UTILIZATION TRACKING RECOMMENDATIONS

Number	Recommendation
9.1	The Department should consider providing and presenting more quality of care data.
9.2	The Department should consider implementing a Minimum Data Set (MDS) system in its AKPHs to track quality of care.
9.3	The Department should consider aggregating its medical care information from each of the AKPHs into one database and use that database to manage the health of the entire population of persons using AKPH Services instead of operating each home separately.
9.4	The Department should improve its reporting on LTSS programs by publicly reporting quality of care information on Department websites.
9.5	The Division of Seniors and Disability Services should develop a “dashboard” permitting persons to query utilization data on LTSS programs by eligibility group, age, and geography. ¹⁴ This dashboard database could be merged into the new Cube project, which is being developed for implementation with the Master Client Index (MCI).

¹⁴ See for example, Maryland’s Medicaid e statistics dashboard at <http://www.chpdm-ehealth.org/>.

TABLE 10: FRAUD WASTE AND ABUSE RECOMMENDATIONS

Number	Recommendation
10.1	Provider enrollment activities should be strengthened.
10.2	The Department should issue regulations specifying the responsibility of PCA agencies for monitoring fraud and abuse and build in contractual requirements for provider agencies to control fraud and abuse.
10.3	The Department should create financial incentives for the provider agencies to control fraud and abuse.
10.4	The state should routinely review services provided in assisted living programs to ensure that they are provided to recipients consistent with their plan of care.
10.5	The Department should establish an electronic visit verification (EVV) system for in-home services.
10.6	Criminal penalties for Medicaid fraud should be increased.
10.7	Penalties and interests should be assessed when persons are convicted of Medicaid fraud. The state could benefit by having a Medicaid False Claims Act.
10.8	The state should consider a one-time amnesty program for HCBS providers.

REVIEW OBJECTIVES

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REVIEW OBJECTIVE 01 – COMPREHENSIVE OVERVIEW

Develop a comprehensive overview of how long-term care services are delivered and funded in the State of Alaska and provide recommendations for how DHSS' annual budget can be constructed differently to provide the legislature a more easily understood format with sufficient detail to allow for a comprehensive review of services and funding needs by program. This should address the following:

- A. Identify and provide recommendations for how the number of individuals serviced, cost of services provided, and funding sources utilized can be organized and presented to provide a comprehensive yet easily understood annual review of long-term care services and funding needs.**
- B. Identify strengths and weaknesses of the current budget reporting format.**

A. Identify and provide recommendations for how the number of individuals serviced, cost of services provided, and funding sources utilized can be organized and presented to provide a comprehensive yet easily understood annual review of long-term care services and funding needs.

HOW ALASKA COMPARES WITH OTHER STATES

Before discussing individual programs, it is useful to present a big picture overview of Alaskan long-term services and supports (LTSS). Generally speaking, these services can be divided into three distinct categories: institutional care, in-home services, and residential programs. States that have good LTSS programs provide all three kinds of services, often providing multiple types of in-home and residential services. Alaska has been successful in developing these three types of services.

In 2014, The American Association of Retired Persons (AARP) published its scorecard of state performance with regard to LTSS.¹⁵ The scorecard is the only large-scale, comprehensive comparison of state LTSS programs on performance measures. Alaska had an impressive overall rank of 5th highest in the nation. The AARP scorecard used 26 indicators to measure the performance of states. Alaska scored in the top 10 states on 11 of the 26 indicators. These 11 eleven indicators are shown in the Figure below.

In general, the 11 indicators and Alaska's high rankings on them indicate Alaska has been successful in providing home and community-based services to persons instead of relying on institutional services. These measures can be found below in *Figure 1.1: Eleven LTSS Performance Indicators where Alaska ranked in the Top Ten States Nationwide*.

¹⁵ American Association of Retired Person, (June 19, 2014), *Raising Expectations, 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*, Washington D.C. See: <http://www.longtermscorecard.org/2014-scorecard#.VT-0O-9FB9A>.

Figure 1.1: Eleven LTSS Performance Indicators where Alaska ranked in the Top Ten States Nationwide¹⁶

Rank in Country	AARP LTSS Performance Indicator
4	Percent of adults age 21+ with activities of daily living (ADL) disability at or below 250% of poverty receiving Medicaid or other government assistance health insurance (2011-12)
8	Medicaid LTSS participant years per 100 adults age 21+ with ADL disability in nursing homes or at/below 250% poverty in the community (2009)
4	Percent of Medicaid and state LTSS spending going to HCBS for older people & adults w/ physical disabilities (2011)
1	Percent of new Medicaid aged/disabled LTSS users first receiving services in the community (2009)
3	Number of people participant-directing services per 1,000 adults age 18+ with disabilities (2013)
5	Home health and personal care aides per 1,000 population age 65+ (2010-12)
2	Percent of adults age 18+ with disabilities in the community satisfied or very satisfied with life (2010)
5	Rate of employment for adults with ADL disability ages 18–64 relative to rate of employment for adults without ADL disability ages 18–64 (2011-12)
2	Low percent of long-stay nursing home residents who are receiving an antipsychotic medication (2013) ¹⁷
1	Number of health maintenance tasks able to be delegated to LTSS workers (out of 16 tasks) (2013)
2	Percent of nursing home residents with moderate to severe dementia with one or more potentially burdensome transitions at end of life (2009)
8	Percent of people with 90+ day nursing home stays successfully transitioning back to the community (2009)

In addition to these 11 indicators, Alaska also ranked well on the six following additional services:

- Availability of home health and personal care aids;
- Satisfaction surveys of persons with disabilities;
- Employment rates of persons with disabilities;
- Quality of care in nursing facilities;

¹⁶ American Association of Retired Persons, Raising Expectations, 2014.

¹⁷ A rank of 2 means Alaska scored second best in the nation. They have a low number of residents receiving antipsychotic medications.

- Regulatory authority to permit delegation of nursing tasks to caregivers, and
- State transition efforts to prevent persons from permanently residing in nursing facilities.

With top 10 rankings on 11 separate performance measures as well as strong rankings on an additional six performance measures of the AARP scorecard, Alaska ranks well on a total of 17 of the 26 performance measures further strengthening why it ranks in the top five overall for LTSS nationwide.

THE BUDGET PICTURE

PCG identified that LTSS are administered by two DHSS Divisions: Alaska Pioneer Homes (AKPH) and Senior and Disabilities Services (SDS). While these two divisions administer LTSS programs, the budgets only contain the non-Medicaid portions of LTSS services. These portions are demonstrated in *Figure 1.2: Funds Expended in the Division of Pioneer Homes and SDS, 2014*. The Medicaid figures can be seen in *Figure 1.4 Expenditure for LTSS in 2014*. *Figure 1.2*: below shows funds expended during FY 2014.¹⁸ The two divisions spent approximately a total of \$121 million on LTSS related services.

Figure 1.2: Funds Expended in the Divisions of Pioneer Homes (AKPH) and SDS, 2014.¹⁹

Division	General Funds	Federal Funds	Other Funds	Total Funds
AKPH	\$52,059,800	\$686,100	\$7,078,900	\$59,824,800
SDS	\$41,996,200	\$16,980,800	\$2,555,000	\$61,532,000
Total of Both Divisions	\$94,056,000	\$17,666,900	\$9,633,900	\$121,356,800

Figure 1.3: Components of SDS by Source of Funding, Actuals, FY 2014 shows components of SDS and the detail of state, federal and other funds used to fund each component. The federal funds are a combination of Medicaid, Older Americans Act funding, and funding for developmental disabilities programs.

¹⁸ Data taken from the Governor’s Amended Budget for FY 2015 as released on February 5, 2015.

¹⁹ Governor’s Amended Budget for FY 2015 as released on February 5, 2015.

Figure 1.3: Components of SDS by Source of Funding, Actuals FY 2014²⁰

Components of Senior and Disabilities Services	General Funds	Federal Funds	Other Funds	Total Funds
SDS Administration	\$10,202,800	\$10,418,600	\$389,800	\$21,011,200
General Relief/Temporary Assisted Living	\$7,969,300			\$7,969,300
Senior Community Based Grants	\$9,642,800	\$5,797,700	\$125,000	\$15,565,500
Community Developmental Disability Grants (CDDG)	\$13,034,600		\$748,500	\$13,783,100
Senior Residential Services	\$814,900			\$814,900
Commission on Aging	\$77,000		\$448,600	\$525,600
Governor's Council on Disabilities and Special Education	\$254,800	\$764,500	\$843,100	\$1,862,400
Total	\$41,996,200	\$16,980,800	\$2,555,000	\$61,532,000

Figure 1.4 Expenditure for LTSS in 2014: below combines FY 2014 data from the AKPH and SDS and LTSS Medicaid expenditures to arrive at an estimate that approximately \$529.5 million was spent on LTSS services through state programs.²¹

Figure 1.4: Expenditures for LTSS in 2014²²

Long-Term Services and Supports Programs	Total Funds Expended
Pioneer Homes	\$59,824,800
SDS	\$61,532,000
Personal Care Assistance (PCA)	\$102,565,934
Alaskans Living Independently Waiver (ALI)	\$66,653,032
People with Intellectual and Developmental Disabilities Waiver (IDD)	\$137,469,178
Adults with Physical and Developmental Disabilities Waiver (APDD)	\$7,603,867
Nursing Facilities	\$93,825,914
Total Expended Funds all sources	\$529,474,725

²⁰ Governor's Amended Budget for FY 2015 as released on February 5, 2015.

²¹ There are other sources of spending on LTSS in Alaska including funding from tribal associations, Indian Health Service funds, family caregivers, and charitable organizations. The sources of funding used in the table are meant to reflect state activity.

²² DHSS and Governor's Amended Budget for FY 2015 as released on February 5, 2015 and Excel files provided by the Department.

A WELL- STUDIED PROGRAM

There have been numerous studies of Alaska’s LTSS programs in recent history. In 2006, Representative Wilson requested a review of recommendations from these studies. In response to the request, Legislative Research Services prepared a report reviewing recommendations from seven reports written between 1999 and 2006.²³ Since 2006, at least 10 more reports touching on LTSS programs have been published:

- 2007 Establishment of a Rate-Setting Methodology for Home and Community-Based Services in Alaska²⁴
- 2008 Tribal Long Term Care Service Development Plan;²⁵
- 2008 Recommendations for the Alaska Long Term Care Plan;²⁶
- 2009 KANA Elder Care Long Term Care Needs Assessment Report;²⁷
- 2009 Needs Assessment and Service Delivery Options for Bristol Bay;²⁸
- 2011 Mat-Su Regional Plan for Delivery of Senior Services²⁹;
- 2012 Proposed Plan for Implementing Community First Choice in Alaska;³⁰
- 2012 Reconceptualizing Long-Term Care in Rural Alaska;³¹
- 2013 An Analysis of the Impact of Medicaid Expansion in Alaska,³² and
- 2015 Conflict-Free Case Management System Design.³³

In addition to these reports, routine plans and reports are also prepared by the Advisory Board of the Pioneer Homes, the Commission on Aging, the divisions of DHSS, and Indian Health Service.³⁴ These reports show that the State of Alaska puts a high priority on understanding its responsibilities of offering effective and efficient programs to its citizens.

DESCRIPTION OF ALASKA LTSS PROGRAMS

Given the long history of reports on Alaskan LTSS programs, an-in-depth description of every program would appear to be duplicative of commonly understood information. The descriptive material below focuses on information relevant to the effectiveness and efficiency of programs. For purposes of this discussion, LTSS programs provided by the Department will be broadly overviewed and are discussed in five categories:

1. PCA;
2. Medicaid waivers;
3. Nursing facilities;
4. Pioneer Homes; and

²³ Burnham, C. (September 21, 2006). *Summary of Findings and Recommendations of Selected Studies of Alaska's Long-Term Care System, 1996-2006*. <http://archives2.legis.state.ak.us/PublicImageServer.cgi?lra/2007/07-010m.pdf>.

²⁴ Available at: http://dhss.alaska.gov/dsds/Documents/docs/AK_HCBS_initial.pdf.

²⁵ Available at: <http://www.anthc.org/chs/wp/elders/upload/ATHS-LTC-Plan.pdf>.

²⁶ Available at: <http://dhss.alaska.gov/dsds/Documents/01-External/AK%20Long%20Term%20Care%20Plan%20-%20Final%20Report%20-%20HCBS%20Strategies-10-23-08.pdf>.

²⁷ Available at: http://agnewbeck.com/pdf/kodiakaleutians/KANA_Report_forweb.pdf.

²⁸ Available at: <http://www.agnewbeck.com/pdf/bristolbay/SILC/SILC%20Implementation%20Toolkit.pdf>.

²⁹ Available at: <http://www.healthymatsu.org/health-resources/regional-plan-senior-services>.

³⁰ Available at: http://www.hcbsstrategies.com/download/AK_Proposed_CFC_Plan_7-5-12.pdf.

³¹ Available at: http://www.academia.edu/2015440/Reconceptualizing_long_term_care_in_rural_Alaska.

³² Available at: http://dhss.alaska.gov/Documents/Lewin_Final_Report.pdf.

³³ Available at: http://dhss.alaska.gov/dsds/Documents/docs/CFCM_Report-FINAL.pdf.

³⁴ For example, see the Indian Health Services detailed descriptions of services provided in rural areas. <http://www.ihs.gov/alaska/healthcarefacilities/>.

5. Home and community based grants and contracts.

1. PERSONAL CARE ASSISTANCE

Personal care is a service offered under Alaska's Medicaid State Plan, which means that all persons on Medicaid are eligible to receive these services.³⁵ The program is a familiar one to the Legislature and has been the subject of periodic efforts to impose tighter cost and utilization controls.³⁶ For example, in response to a lack of cost controls in the PCA program in the 2000-2004 period, House Bill 67, which took effect July 1, 2005, directed the Department to issue new PCA regulations implementing numerous reforms.

The PCA program provides home care services statewide to functionally disabled and handicapped citizens of all ages, as well as to the frail elderly, to enable these individuals to live in their own home or community as an alternative to individuals moving away from their home communities and cultural base.

The DHSS website describes it generally as:

PCA services provide support related to an individual's activities of daily living (i.e. bathing, dressing, eating) as well as instrumental activities of daily living (i.e. shopping, laundry, light housework). PCA is provided statewide in Alaska through private agencies. The administration of the PCA program is overseen by the PCA Unit of Senior and Disabilities Services, Department of Health and Social Services.

Eligibility for the PCA program is specified in Alaska regulations at 7 AAC 125.020. A review of the eligibility regulation shows that the PCA program has low requirements. The eligibility requirements are shown below:

- (a) *The Department will authorize an individual to receive personal care services only after an assessment is conducted in accordance with this section that establishes the individual's need for one of the following levels of assistance:*
- (1) *Limited assistance with at least one ADL; in this paragraph, "limited assistance" means a recipient, who is highly involved in the activity, receives direct physical help from another individual in the form of guided maneuvering of limbs, including help with weight-bearing when needed;*
 - (2) *Extensive assistance with at least one ADL; in this paragraph, "extensive assistance" means that the recipient is able to perform part of the activity, but periodically requires direct physical help from another individual for weight-bearing support or full performance of the activity;*

³⁵ Personal care is authorized at Attachment 3.1-A p. 10 of the State Plan. See Plan at: http://dhss.alaska.gov/Commissioner/Pages/MedicaidStatePlan/stateplan_sec_3.aspx.

³⁶ See Legislative Research report of February 15, 2004 on the fiscal impact of terminating the PCA program. See at: <http://archives2.legis.state.ak.us/PublicImageServer.cgi?lra/2004/04-155m.pdf>. See also the 2010 legislative study on the impacts of eliminating the PCA and Medicaid waiver programs: <http://archives2.legis.state.ak.us/PublicImageServer.cgi?lra/2010/10-153m.pdf>.

- (3) *Dependent with at least one ADL or dependent with at least one IADL; in this paragraph, "dependent" means the recipient cannot perform any part of the activity, but must rely entirely upon another individual to perform the activity;*
- (4) *Independent with difficulty for at least one IADL; in this paragraph, "independent with difficulty" means the recipient can perform the activity without the help of another individual, but does so with difficulty or takes a great amount of time to perform it;*
- (5) *Needing assistance with at least one IADL; in this paragraph, "needing assistance" means that the recipient is involved in the activity, but receives help from another individual to perform the activity.³⁷*

The program is implemented through agencies that act as an administrative function of the state in that they conduct assessments, report changes in the material condition of program participants, submit requests of criminal record checks, ensure the personal care assistant can perform the tasks required in the care plan, e.g. medication administration, and conduct other activities. The agencies bill for the PCA services and keep some of the funds received by the state to pay for their services and then reimburse the personal care assistant for the services provided recipients. The use of these agencies has been extensively discussed in previous studies of the program.³⁸

The PCA program only pays for two procedure codes: T1019 is for ‘Personal Care Agency’ and is paid on 15-minute unit of service in situations where the personal care assistant is an employee of the agency, and T1019 with a U3 modifier and is for consumer-directed services, which is also paid on a 15-minute unit of service. The *Figure 1.5: Units of Service and Expenditures by Procedure Code in PCA Program, 2014* below indicates that almost all expenditures in the PCA program, 98.91%, are made for consumer-directed services, not agency-provided personal care services.

Figure 1.5: Units of Service and Expenditures by Procedure Code in PCA Program, 2014³⁹

FY 2014	Units of Service	Expenditures	Percent Expenditures
T1019 Agency based	185,203	\$1,118,378	1.09%
T1019 U3 Consumer Directed	16,820,440	\$101,447,556	98.91%
Total	17,005,643	\$102,565,934	100.00%

The use of these billing codes for PCA services totaled \$102,565,934 in expenditures for FY 2014 supplying services to 5,592 individuals.⁴⁰

³⁷ See 7 AAC 125.020.

³⁸ See the 2006 Alaska Long Term Care Cost Study for example. Retrieved on 5-2-2015 from <http://dhss.alaska.gov/dsds/Documents/docs/alaskaLongTermCareCostStudy.pdf>.

³⁹ Excel files supplied by DHSS.

⁴⁰ Expenditures and person counts taken from Excel files supplied by the DHSS.

2. MEDICAID WAIVER PROGRAMS

In federal Medicaid terminology, a “waiver” is an exception or addition to a state’s Medicaid Plan. Home and community-based services (HCBS) were not part of the original list of mandatory and optional Medicaid services established in the Social Security Act (the Act) language that created the Medicaid program.⁴¹ HCBS services were authorized in the early 1980s, in section 1915 of the Act. The most common waivers are provided under the federal authority of 1915(c) and as of April 2015, there were 300 1915(c) waivers approved and currently being operated by states.⁴² States have considerable discretion in deciding what waivers they want, who will be served by them, what services are offered, and how many persons will be allowed to use waiver services.

The year 2012, was a transition period in Alaskan waivers. Older adults from the Older Alaskans Waiver (OA) and adults with physical disabilities from the Adults with Physical Disabilities (APD) waiver were transitioned into the ALI. The APD waiver was renamed the APDD, and now incorporates a small sub-group of physically disabled adults with developmental disabilities.

Currently, Alaska has four 1915(c) waivers used to offer services to Alaskans who meet the level of care requirements:

1. Alaskans living independently;
2. People with intellectual and developmental disabilities;
3. Adults with physical and developmental disabilities, and
4. Children with complex medical conditions.

The first three Medicaid waivers are the most relevant to LTSS services and the sections below provide an overview of each.

Alaskans Living Independently Waiver

The ALI Waiver was first approved in 1993 and provides adult day services, care coordination, respite, chore, environmental modifications, meals, residential supported living, specialized medical equipment and supplies, specialized private duty nursing, transportation for aged individuals 65 and older as well as persons who are physically disabled ages 21-64.

An examination of the procedure codes used with the ALI waiver provides a detailed description of the services that program participants use and the cost of the services. *Figure 1.6 ALI Waiver with Expenditures Ranked by the Ten Procedure Codes with the Highest Expenditures, 2014* below shows, ranked by expenditures, the top ten procedure codes paid for on behalf of participants in the ALI waiver. The largest single service paid for is residential supported living. Approximately 40% of all ALI expenditures help persons reside in assisted living programs. Other significant sums are spent on respite, chore services, home delivered meals, and adult day services which support persons living in their own homes. Case management of waiver participants comprises approximately five to six percent of all waiver expenditures.

⁴¹ See section 1905(a) the Act at http://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

⁴² See: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html for list of Medicaid waivers.

Figure 1.6: ALI Waiver with Expenditures Ranked by the Ten Procedure Codes with the Highest Expenditures, 2014⁴³

Procedure Code	Type of Service	Units of Service	Expenditures
T2031	Residential Supported Living	267,380	\$ 39,020,707
S5150	Respite per 15 Minutes	1,098,430	\$ 6,716,121
T2022	Case Management	22,361	\$ 5,211,487
S5120	Chore	610,835	\$ 4,035,875
S5170	Home Delivered Meals	141,038	\$ 2,916,649
S5101	Adult Day Services	35,682	\$ 2,872,304
T2003	Transportation	128,488	\$ 2,411,312
S5151	Respite per Day	2,068	\$ 595,384
T1003	15-minute LPN/LVN	23,362	\$ 451,971
T1002	15-minute Registered Nurse	19,707	\$ 444,608

The remaining procedure codes billed in FY 2014 equaled an additional \$1,380,491. The total expenditures for ALI waiver services in FY 2014 was \$66,653,032. These funds provided necessary in-home services to 2,886 individuals in Alaska.⁴⁴

People with Intellectual and Developmental Disabilities Waiver

The IDD waiver is the second largest waiver with regard to population served, but the largest with regard to expenditure in FY 2014. As the name of the IDD waiver indicates, it provides services for individuals with autism, and intellectual and/or developmental disabilities. There is no age restriction on the program. It provides care coordination, day habilitation, residential habilitation, respite, supported employment, chore, environmental modifications, intensive active treatment, meals, nursing oversight and care management, specialized medical equipment, specialized private duty nursing, and transportation. Participants on the IDD waiver are assessed using the Inventory for Client and Agency Planning (ICAP).⁴⁵

An examination of the procedure codes used with the IDD waiver provides a detailed description of the services that program participants use and the cost of the services. *Figure 1.7: IDD Waiver Expenditures Ranked by the ten Procedure Codes with the Highest Expenditures, 2014* below shows, ranked by expenditures, the top 10 procedure codes paid for on behalf of participants in the IDD waiver. The procedure

⁴³ Excel files supplied by DHSS.

⁴⁴ Expenditures and person counts taken from Excel files supplied by the DHSS.

⁴⁵ See <http://icaptool.com/>.

codes used in the IDD waiver are substantially different from the procedure codes used in the ALI reflecting the different service needs of the populations. Half the codes refer to habilitation.

Figure 1.7: IDD Waiver Expenditures Ranked by the Ten Procedure Codes with the Highest Expenditures, 2014⁴⁶

Procedure Code	Type of Service	Units of Service	Expenditures
T2016	Group Home Habilitation	153,296	\$52,413,275
T2021	Day Habilitation	3,304,773	\$33,741,427
T2017	Supported Living Habilitation	2,561,099	\$27,927,656
S5140	Residential Habilitation	48,690	\$7,267,102
T2019	Supported Employment	529,480	\$5,652,651
T2022	Case Management	17,733	\$4,324,196
S5150	Respite per 15 Minutes	510,774	\$3,135,754
S5145	Family Home Habilitation - Child	5,007	\$826,571
S5151	Respite per Day	2,109	\$614,563
T2024	Plan of Care Development	1,243	\$470,583

The following are basic explanations of the types of service provided from the top ten procedure codes billed under the IDD waiver:

- *Habilitation* is a specialized term used in the provision of services to persons with intellectual and developmental disabilities. For example, as defined in the IDD waiver application

Residential habilitation assists participants to reside in the most integrated setting appropriate to his or her needs by providing individually tailored supports that assist with the acquisition, retention or improvement in skills related to living in the community. Supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, and social and leisure skills development.⁴⁷

- Supported employment programs are employment subsidies that help persons obtain a modest wage doing activities that are generally routine tasks requiring low-skill levels. Two separate respite codes occur in the top ten procedure codes as do two administrative management codes.
- Unlike the ALI waiver, chore, home delivered meals, transportation, and nursing services are not in the top ten procedure codes. The top ten procedure codes from the IDD table on the previous page equaled \$136,373,778 which is 99% of total expenditures for the IDD waiver. Total IDD

⁴⁶ Excel files supplied by DHSS.

⁴⁷ Waiver applications can be found at the CMS website at: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html. Click the “Show More” button to see the application for a particular waiver.

expenditures for FY 2014 were \$137,469,178. These funds were used to serve the IDD population of 1,926 individuals.⁴⁸

Adults with Physical and Developmental Disabilities Waiver

This is the smallest of the three waivers with regard to population served. This waiver was formed in 2012 when adults with physical disabilities were transitioned from the APD waiver. The APD waiver was renamed the Adults with Physical and Developmental Disabilities Waiver (APDD), and now incorporates a small sub-group of physically disabled adults with developmental disabilities.

The waiver contains a mix of services, some more appropriate for persons with physical disabilities and some more appropriate for persons with developmental disabilities, but all are appropriate for someone with both types of disability. The APPD waiver services include adult day services, care coordination, day habilitation, residential habilitation, respite, supported employment, chore, environmental modifications, intensive active treatment, meals, residential supported living, specialized medical equipment, specialized private duty nursing, transportation for adults with autism, developmental disabilities, and intellectual disabilities.

Figure 1.8: APPD Waiver Expenditures Ranked by the ten Procedure Codes with the Highest Expenditures, 2014 provides a more granular look at what the APDD program paid for in 2014 by showing the ten largest procedure codes paid for. The services are a mix of services provided on the ALI and IDD waivers befitting the dual disabilities of program participants.

Figure 1.8: APDD Waiver Expenditures Ranked by the Ten Procedure Codes with the Highest Expenditures, 2014⁴⁹

Procedure Code	Type of Service	Units of Service	Expenditures
T2017	Supported Living Habilitation	274,690	\$3,002,543
T2021	Day Habilitation	141,609	\$1,465,025
T2016	Group Home Habilitation	3,468	\$1,196,748
T2031	Residential Supported Living	4,459	\$624,058
S5150	Respite per 15-Minutes	48,321	\$297,941
T2022	Case Management	1,252	\$274,255
S5140	Residential Habilitation	961	\$126,146
S5170	Home Delivered Meals	6,251	\$126,032
T2019	Supported Employment	7,958	\$92,338
T2003	Transportation	4,711	\$88,168

⁴⁸ Expenditures and person counts taken from Excel files supplied by the DHSS.

⁴⁹ Excel files supplied by DHSS.

Procedure codes for the top ten services billed under the APDD waiver equaled \$7,293,254 which is 95% of overall expenditures. In FY 2014, APDD Waiver overall expenditures totaled \$7,603,867. These funds were used to provide services for a total of 109 individuals.⁵⁰

Children with Complex Medical Conditions Waiver

This is a Medicaid waiver but it is not considered to be a LTSS service since the population is medically fragile children. Services provided under the waiver are care coordination, day habilitation, residential habilitation, respite, supported employment, chore, environmental modifications, intensive active treatment, meals, nursing oversight and care management, specialized medical equipment, and transportation. In 2014 the waiver had 276 participants and \$9,928,878 in expenditures.

Since this is not an LTSS service, detailed trend information on expenditures, units of service and number of participants will not be presented.

3. NURSING FACILITIES

In December 2014, the 18 facilities with nursing home licenses in Alaska had 692 beds and an 87.7% occupancy rate, compared to a national occupancy rate of 82.3%.⁵¹ State websites contain licensing information about each home.⁵² Only four of these facilities are not co-located with hospitals. In 1997, Alaska had 633 nursing home beds.⁵³ In the last 17 years Alaska has only added about 10% more nursing home beds indicating that the demand for LTSS services has been almost entirely met by expansions of home and community based services.

Total Department expenditures on Medicaid nursing facility residents increased from \$43,559,385 in FY 1997, to \$93,825,914 in FY 2014. In 2014 these funds were used to provide for a total of 762 individuals with an average annual cost of \$123,131 per Medicaid resident.⁵⁴

4. PIONEER HOMES

The Pioneer Homes are well known to Alaskans and have been frequently studied. The AKPH operates six Pioneer Homes, discussed in administrative regulations at 7 AAC 74.010 through 7 AAC 74.990. The first Pioneer Home was built in 1913 in Sitka as a residential facility for indigent prospectors and others, who spent their working years in Alaska and became dependent in retirement. Five additional homes were built in other areas of the state from the late 60s through 1988, when the last home was built in Juneau.

Over time, the AKPH redirected its focus from independent living to an environment appropriate for individuals with more severe functional, physical and emotional needs. In the mid-90s, the Homes opened

⁵⁰ Expenditures and person counts taken from Excel files supplied by the DHSS.

⁵¹ American Health Care Association, "Nursing Facilities' Operational Characteristics Report, December 2014. The website requires a log in and password to see the reports. See website at: http://www.ahcancal.org/research_data/oscar_data/Pages/default.aspx.

⁵² Alaska Legislative Research Report 04.155, Burnham, C. (February 15, 2004), Potential Impact on Expenditures of Terminating the Personal Care Program, <http://archives2.legis.state.ak.us/PublicImageServer.cgi?lra/2004/04-155m.pdf>, p. 4.

⁵³ Alaska Legislative Research Report 04.155, Burnham, C. (February 15, 2004) Potential Impact on Expenditures of Terminating the Personal Care Program, <http://archives2.legis.state.ak.us/PublicImageServer.cgi?lra/2010/10-153m.pdf>.

⁵⁴ Expenditures and person counts taken from Excel files supplied by the Department of Health and Social Services.

special care units with a focus on Alzheimer's disease and other forms of dementia. In 1994, the homes fully converted to an assisted living service definition and ceased being licensed as nursing homes.

In 2003, the Pioneer Home in Palmer received approval for conversion to a United States Veterans Administration (USVA) “domiciliary” after obtaining a specific license from the USVA and completing specific reconstruction. Alaska received a \$2.3 million dollar grant to construct/renovate the Pioneer Home, which opened for veterans’ services in late spring of 2006.⁵⁵

As currently operated, the Pioneer Homes are licensed as assisted living programs by the state but contain a mixture of services found in assisted living and nurse staffing typically found in nursing facilities. For example, the Pioneer Homes do not typically admit persons that require intravenous injections (IVs) or have feeding tubes, but do employ multiple registered nurses.

The AKPH assign their residents into one of three levels depending on the characteristics of the resident. These levels are shown in the following *Figure 1.9: Levels of Care Provided in Pioneer Homes*.

Figure 1.9: Levels of Care Provided in Alaska Pioneer Homes⁵⁶

Level of Care	Description
Level I	Services include the provision of housing, meals, emergency assistance, and opportunities for recreation; Level I services do not include staff assistance with activities of daily living, medication administration, or health-related services, although the Pioneer Home pharmacy may supply prescribed medications.
Level II	Services include the provision of housing, meals, and emergency assistance, and as stated in the resident’s assisted living plan, staff assistance, including assistance with activities of daily living, medication administration, recreation, and health-related services; assistance provided by a staff member includes supervision, reminders, and hands-on assistance, with the resident performing the majority of the effort. During the night shift, the resident is independent in performing activities of daily living and capable of self-supervision.
Level III	Services include the provision of housing, meals, and emergency assistance, and as stated in the resident’s assisted living plan, staff assistance, including extensive assistance with activities of daily living, medication administration, recreation, and health-related services; assistance provided by a staff member includes hands-on assistance, with the staff member performing the majority of the effort; the resident may receive assistance throughout a 24-hour day, including the provision of care in a transitional setting.

In FY 2014, total AKPH expenditures were \$59,824,800. These fees totaled Alaska state General Funds, Resident Fees, U.S. Veterans Administration, Medicaid, and other funds. In 2014, the AKPHs served 466

⁵⁵ See: <http://www.alaskajournal.com/Alaska-Journal-of-Commerce/July-2006/Alaska-Veterans-and-Pioneers-Home-project-completed/>.

⁵⁶ Division of Pioneer Homes, (Winter, 2010) Report to the Legislature http://dhss.alaska.gov/daph/Documents/pdfs/Final_Leg_report_1-26-2010.pdf.

residents: 64 in Level I, 138 in Level II, and 264 in Level III.⁵⁷ During 2014, the total unduplicated count of persons served was 539.

5. HOME AND COMMUNITY-BASED GRANTS AND CONTRACTS

5A. General Relief/Temporary Assisted Living

In 2014, the Department spent \$7,969,300 in unrestricted general fund (UGF) to provide assisted living accommodations to approximately 1,000 adults.⁵⁸ The program is consistent with the priorities of the Department because it protects vulnerable Alaskans. Regulated by 7 AAC 47.300 through 7 AAC 47.510, the program is intended to provide temporary housing to persons that are ineligible for other assistance but are in a financial or other crisis and need the housing. The aid is intended to be temporary and is paid at a rate set in AS 47.25.120(d) of \$70 per day.

5B. Senior Community Based Grants

The Senior Community Based Grant program is a large umbrella program. Containing the following seven notable grant services are:⁵⁹

1. Nutrition, Transportation, and Support Services;
2. Senior In-Home Services;
3. Adult Day Services;
4. National Family Caregiver Support Program (NFCSP);
5. Aging and Disability Resource Centers (ADRCs);
6. Alzheimer's disease and related dementia (ADRDs), and
7. Traumatic and Acquired Brain Injury (TABI) Case Management.

These seven grant services are addressed in further detail below:

1. Nutrition, Transportation and Support Services

The largest grant type by funding is the Nutrition, Transportation and Support Services Grant. The 2015 funding level for this grant equaled \$6,597,152.⁶⁰ The services under this grant are substantially supported through federal Older Americans Act funding and include:

- Congregate and home delivered meals;
- Assisted and unassisted transportation;
- Homemaker services;
- Outreach, information and assistance;
- Legal services;
- Media services (provides partial funding for the Senior Voice), and

⁵⁷ Excel book provided by Division of Alaska Pioneer Homes.

⁵⁸ Data provided by the DHSS.

⁵⁹ Smaller programs include Health Promotion, Disease Prevention and Nursing Facility Transition. Senior Residential Services are discussed below.

⁶⁰Spread sheet data provided by the Department of Health and Social Services

- Community services; senior companion, foster grandparent/elder mentor, and retired senior volunteer programs.

2. Senior In-Home Services

State-funded HCBS services are not reported by any federal agency. However, like Alaska's Senior In-Home Services Program, the majority of states operate state-funded programs.⁶¹ Despite the lack of federal match, states operate these programs because they believe the programs are cost effective in delaying admission to the Medicaid program. These programs typically focus on persons who have financial resources that make them ineligible for Medicaid. For example, persons with a small bank account fall under this classification. These financial resources inevitably diminish as they are used to pay for medical services. By providing care coordination and modest amounts of general fund-paid services to these persons, the state delays their admission to the Medicaid program.

In FY 2014, Senior In-Home Services served 1,422 persons at \$1,902 per recipient.⁶²

As described in DHSS documents:

*Senior In-Home Services provide care coordination and in-home services to eligible seniors who do not qualify for Medicaid waiver services and need assistance with activities of daily living. The goal of the program is to support Alaskan seniors so that they may remain in their homes and communities for as long as possible, thereby forestalling or eliminating more costly institutional care. Services include Care Coordination, Chore, Respite, Extended Respite and Supplemental Services (up to \$500 per household per year) for items or services that support the "low-income" senior in avoiding a crisis that would jeopardize their ability to remain independently in their home.*⁶³

3. Adult Day Services

The provision of adult day services is part of having a balanced set of long-term services and supports. The Department contracts with 13 programs that provide day care services at centers to persons aged 60 and older. Persons leave their home and go to the center to receive services. Program participants are typically assessed, have care plans and receive multiple services such as therapeutic activities to increase physical and mental functioning, medication management, physical health checks, and socialization. The day care services also provide respite to family caregivers.⁶⁴

State staff report that the contractors tend to be the same ones year after year. This continuity of providers in LTSS contracting is frequently found in states especially in the contracting of Older American Act programs through state Area Agencies on Aging (AAAs).

⁶¹ The last survey of state funded programs was done by AARP in 2007. It found that only three states, Alabama, Mississippi and Montana did not operate any state-funded programs. See Mollica, R. and Simms-Kastelein, K. (2007), *State Funded Home and Community Based Program for Older Adults*, American Association of Retired Persons. See http://assets.aarp.org/rgcenter/il/2009_06_hcbs.pdf.

⁶² See http://www.akleg.gov/basis/get_documents.asp?session=29&docid=112.

⁶³ See DHSS FY 2015 Operating Grants, <http://dhss.alaska.gov/fms/Documents/FY15GrantBook.pdf>.

⁶⁴ Utilization data on the Adult Day Services program is not readily available in DHSS budget materials or websites.

4. National Family Caregiver Support Program

The NFCSP is a Title III program of the Older Americans Act. Established in 2000, it provides grants to states, based on their share of the population aged 70 and over. As its name indicates, the funds are to support family caregivers. The Alaska Commission on Aging estimates there are approximately 33,000 family caregivers in Alaska. In 2013, family caregivers provided an estimated 37 million hours of care and provided 80% of all in-home care received by Alaskan seniors.⁶⁵

In 2013, the Family Caregiver Support Program contracted with nine providers that served 1,056 family caregivers of which 424 were caregivers of older people with dementia living at home and 46 were grandparents raising grandchildren.⁶⁶

5. Aging and Disability Resource Centers

The ADRCs program has been a major non-Medicaid initiative at the federal level for over a decade. The purpose of the centers is to provide unbiased information, counseling and referrals for LTSS choices. Most areas also have Medicare Counseling and Outreach (MCO) funding to provide coordination of Medicare outreach, counseling, and referral, consistent with the State Health Insurance Assistance Program (SHIP) and Senior Medicare Patrol (SMP) programs. The audience of the centers is seniors and persons with disabilities and their families. These are important programs because they improve access to services and do so in an unbiased manner.⁶⁷

In 2015, the Department funded five ADRCs serving the areas of Anchorage; Kenai/Valdez/Cordova; Southeast Alaska; Bristol Bay/Kodiak and the Matanuska-Susitna Borough which served 12,283 individuals in FY 2014.⁶⁸

6. Alzheimer's Disease and Related Dementia

In 2014, an estimated 6,100 Alaskans had Alzheimer's or a related disease.⁶⁹ The lack of services for persons with AD/DRDs was a frequently mentioned subject of conversation with reviewers. It is a major priority of the Commission on Aging. A January 2011 study of persons in Pioneer Homes found that 57% had dementia.⁷⁰ The December 2014 Alaska Roadmap to Address Alzheimer's presents a systematic and lengthy outline of steps public agencies can take to improve the treatment of Alzheimer's.⁷¹ The Roadmap's identification of the need for a 1915(i) Medicaid state plan amendment was cited by persons interviewed

⁶⁵ See Alaska Commission on Aging, (February 25, 2015), "National Family Caregiver Support Program." See <http://dhss.alaska.gov/acoa/Documents/legislative/2015/Family%20Caregiver%20Support%20Program%20FY16.pdf>.

⁶⁶ Ibid.

⁶⁷ There is a large literature on the operation of ADRC nationally. For example, see ADRC technical assistance site at <http://www.adrc-tae.acl.gov/tiki-index.php?page=HomePage>.

⁶⁸ 2016 Governor's Amended Budget, DHSS Component Senior community Based Grants, at https://www.omb.alaska.gov/ombfiles/16_budget/HSS/Amend/comp2787.pdf.

⁶⁹ March 3, 2014 Commission on Aging presentation. Retrieved from <http://dhss.alaska.gov/acoa/Documents/ADRDRoadmap-HouseHSScomm.pdf>.

⁷⁰ See State Plan on Aging Appendix F p. 14. Retrieved from: http://dhss.alaska.gov/acoa/Documents/documents/State_plan_2012-2015.pdf.

⁷¹ See Alaska Commission on Aging and other organizations, (2014, December 31), Alaska's Roadmap to Address Alzheimer's Disease and Related Dementias, Juneau, AK. Retrieved on 8-28-2014 from: http://act.alz.org/site/DocServer/Alaska_State_plan_2015.pdf?docID=42541.

as being an important encouragement to pursue this federal initiative. The Roadmap's policy recommendations are comprehensive and an elaboration upon them appears unnecessary.

As reported by persons interviewed, the Homes are one of the few community resources that will provide long-term housing to persons with dementia. Services for persons with dementia and behavioral health issues were said to be in short supply everywhere. More than one person interviewed referred to the Alaska Psychiatric Institute as a provider of last resort using its beds to serve persons who have nowhere else to go and are not maintainable in community programs.

The Senior Community Based Grant program funds one provider to provide education and support activities to family caregivers. The grantee had staff and offices in Anchorage, Fairbanks, the Matanuska-Susitna Valley, and Juneau.

7. Traumatic and Acquired Brain Injury Case Management

The Department has a grant to provide \$300,000 a year to provide case management for persons with traumatic brain injury (TBI) and acquired brain injury (ABI). The Department reports that there are approximately 10,000 to 12,500 persons with TBI or ABI in Alaska. As described by the Department, "Since Medicaid provides extremely limited options for sub-acute treatment and rehabilitation services for this population and no targeted case management under Medicaid is available, this grant-funded option is a critical service."

5C. Community Developmental Disabilities Grants

In FY 2015, the CDDG program contracted with 25 grantees to provide funding for services to individuals with developmental disabilities. At \$11,555,795, the grant program is the largest of SDS grant programs and it is all General Fund unlike the senior grants which have substantial federal Older Americans Act funding associated with them.⁷²

The Department applies a national prevalence factor of 1.8% for the occurrence of developmental disabilities in the Alaskan population to obtain an estimate that there are 12,000 to 13,000 Alaskans with developmental disabilities.

When individuals request services, the provider agencies assess the individuals and develop a case plan and arrange for services that will help them until more comprehensive services can be obtained. A major function of the program is to provide services to persons on the waiting list for the IDD waiver. These are individuals who meet Medicaid financial and functional eligibility for services, however, sufficient funds to provide them waiver services are not available.

As required by AS 47.80.130(d), the Department prepares an annual registry report. The 2014 IDD waiver registry report states that 43 months was the average time on the wait list for the 679 individuals who were on the wait list as of June 30, 2014.⁷³

⁷² Fiscal Year 2015, [DHSS Operating Grants Book](#).

⁷³ Individuals with Developmental Disabilities – [Registration and Review Report](#) – July 1, 2013 through June 30, 2014.

5D. Senior Residential Services

In 2015, the Department expended \$789,500 to fund three senior residential services located in Dillingham, Galena, and Tanana. These facilities are licensed as assisted living programs and funded to provide assisted living options in remote rural areas whose residents do not have access to Pioneer Homes or other assisted living opportunities in the region. Department documents acknowledge the high cost of services and say the “SRS grant provides consistent funding to support providers in sustaining the operation of the services and off-set the significant costs to provide services in rural remote communities.”⁷⁴

Utilization data is not readily available on senior residential programs. When visited by reviewers, staff at one site said they had 15 beds and usually had from 7 to 9 beds occupied. Utilization is an issue because the services are located in small rural areas. For example, the site visited by a performance reviewer required a plane ride and there were only 3,000 persons in the town. While residents met Medicaid financial eligibility requirements, they did not meet Medicaid nursing facility level of care requirements and their costs could not be federally matched.

B. Identify strengths and weaknesses of the current budget reporting format.

SDS presents two kinds of budget presentation material; brief handouts vs. a complete budget book. The SDS Continuum of Care document dated July 22, 2014, was provided to the Legislature during testimony by the Division Director and the Governor’s Amended budget provides substantial detail on the Department’s LTSS programs.

SDS CONTINUUM OF CARE – JULY 22, 2014

The majority of programs covered in this document are waivers or institutional care and all eligible persons must meet a nursing facility level of care. In addition there may be and probably are persons served on grants that meet a nursing facility level of care but are over income for Medicaid. This document is provided to the Legislature and details the overall budget and program descriptions for SDS.

In reviewing the SDS Continuum of Care document, it was found this document contains useful information but has a cluttered format.⁷⁵ The idea of a one-page summary is good; however, the format of the document limits the effectiveness of the information and detracts from the overall efficiency of the document. The budget format includes grants programs, Medicaid programs, waivers and institutional costs, providing a complete picture of the SDS. For each of the above categories the document details the following:

- Number of individuals served;
- Total spend;
 - a. Fund source;
 - i. State;
 - ii. Federal;
 - iii. Other;

⁷⁴ Fiscal Year 2015, [DHSS Operating Grants Book](#).

⁷⁵ SDS Continuum of Care – July 22nd, 2014 – Hardcopy http://www.akleg.gov/basis/Meeting/Detail?Meeting=HHSS%202015-01-27%2015:00:00#tab4_4.

- Average spend per individual, and
- Income eligibility for the program.

The Continuum of Care document is a supplemental handout used in budget hearings and is not part of the Governor’s Amended Budget. The document provides an excellent one-page description of expenditures and persons serviced by program. The idea of a one-page summary document is very useful; however, the format of the document loses effectiveness in that it is challenging to decipher the info-graphic. Time is spent interpreting the format as opposed to interpreting its budget information. The ovals contain limited information, and the squares, which contain only program names, are overly large given the information that is delivered.

Best practices for budget documents typically provide information spanning multiple years of a program so persons can visualize changes over time. Additionally, although great effort has gone into fitting all of the information onto a single page of paper, the clutter may be reduced by expanding to a two page format or a legal (11” by 17”) page size. *Please see Appendix 4 for the continuum of care.*

Recommendation 1.1: The Department should consider altering the Continuum of Care document to reflect a consistent top-to-bottom approach. The document could provide more information if it were done in a tabular format without the info-graphics. Each program could be shown in a row and the information could be placed in columns. With the extra data space, SDS may consider providing additional details to the budget document such as comparisons to previous years or future projected growth. This will enable the readers to see the document less as a single point in time and more as a living document that enables comparisons to past and future years. This will also let viewers easily make comparisons and see how the level of services provided has evolved over time. Additionally, SDS may consider adding additional program descriptions to the document. Legislative staff may not be familiar with “DD Grants” and a brief description may provide an increase in understanding. Another consideration maybe to add in the number of providers that provide services in each of the areas. This will help readers to properly gauge scope and size of each of the programs.

STATE OF ALASKA – FY 2016 GOVERNORS AMENDED BUDGET DEPARTMENT OF HEALTH AND SOCIAL SERVICES⁷⁶

In reviewing the Governors’ *Amended Budget Book* as posted by the Office of Management and Budget, PCG has concluded this budget provides the necessary baseline budget requirements while leaving small improvements to further increase effectiveness and efficiencies. Although this budget has room for improvement, it is effective in delivering its intended goal. The document is over 1,800 pages in length which may initially cause concerns of inefficiencies, but when considering the level of detail and breadth of material to be covered, 1,800 pages becomes a much more reasonable and manageable number.

Overall, the *Amended Budget Book* is laid out in a logical and progressive manner that builds upon itself as the additional divisions are reviewed. The document is set up that the entire Department is reviewed as a

⁷⁶ State of Alaska – FY 2016 Governors Amended Budget Department of Health and Social Services
https://www.omb.alaska.gov/ombfiles/16_budget/HSS/Amend/FY16_budget_book_hss.pdf

whole and then subsequent divisions or Results Delivery Units (RDUs) are reviewed. A brief outline of the document has been provided in Appendix: 01: DHSS FY 2016 Budget Book Format.

In the beginning stages of the budget book, the Department does a good job in displaying its overall mission and provides good detail relative to how changes have occurred over time in working toward these goals. Additionally a clear breakdown is provided of the core services and the level of expenditure based on Unrestricted General Fund (UGF), Designated General Funds (DGF), Other, Federal Funds, and Total. Included in this chart is a breakdown of the permanent full-time employees, permanent part time employees, and non-permanent employees.

The budget book also provides measures by core services and demonstrates progress towards these goals. Progress towards these services is clearly depicted over time through easy to read bar and line graphs. One potentially confusing aspect of comparing these metrics is that that graphs do not all extend to the same point in time. For example, #5 Strengthen Alaska Families begins demonstrating some data in 2007 for some charts while other charts do not begin plotting data until 2012. This creates a level of confusion in attempting to make apples to apples comparisons across years. Additionally, the years displayed vary across the core measures themselves further limiting the ability to make direct comparisons. The core services are as follows:

1. Protect and promote the health of Alaskans.
2. Provide quality of life in a safe living environment for Alaskans.
3. Manage health care coverage for Alaskans in need.
4. Facilitate access to affordable health care for Alaskans.
5. Strengthen Alaska families.
6. Protect vulnerable Alaskans.
7. Promote personal responsibility and accountable decisions by Alaskans.

Additionally, the budget book contains a section detailing “Major Department Accomplishments” in 2014. Although this is a useful page in terms of demonstrating what has been accomplished, it does not provide any detail as to what the original goals of the Department were in 2014, thus leaving readers wondering if the Department met and exceeded their goals or if it fell short. Being able to compare a series of goals and outcomes will add further value to this section as readers and legislative staff will be able to determine how well the Department has (or has not) met their goal over the previous years.

In the Section “Key Department Challenge,” the budget book focuses on major issues that the Department is continuing to work on. The major challenges include the following:

- Assuring intra-departmental and inter-departmental activities are planned and executed in a manner that considers both short and long-term results;
- Meeting the needs of the increasing senior population;
- Managing services for an aging population with an increasingly complicated and difficult health care needs and behaviors;
- Sustaining the Health Information Exchange:⁷⁷
- Addressing obesity as nearly three of every ten Alaska kids are overweight, and

⁷⁷ <http://www.ak-ehealth.org/for-patients/what-is-health-information-exchange/>.

- Developing quality local psychiatric Emergency Services throughout the state.

The Department is clear in expressing its challenges and difficulties. However in this section it does not provide any mitigating strategies. Providing solutions or prospective strategies would provide further confidence to the reader that the Department is capable of handling these challenges. The Department likely has mitigating strategies and is developing solutions to these problems, but it fails to demonstrate these solutions upfront potentially causing concern for the reader.

In the following section, “Significant Changes in Results to be Delivered in FY 2016”, The Department effectively presents any major changes that may be observed. Not only does this section identify potential changes in the budget and overall delivery of care, it effectively explains the reasons as to why these changes may occur. These explanations are important in that they foreshadow potential changes in future budgets and sweeping programmatic changes.

In the “Impacts of Key Proposed FY 2016 DHSS Operating Budget Reductions” section, the Department accurately and fairly describes potential impacts on Alaskans as the result of budget reductions. This is a vitally important section as it describes key impacts the Department may see as a result from budget cuts. The section is especially important as it relates issues directly back to the level of care delivered and the potential impacts. Being able to tie budgets cuts back to levels of service helps to ensure readers are aware of potential downfalls and are able to effectively deal with budget reductions. This section also contains potential solutions to the pitfalls that may be presented through budget cuts.

In reviewing each of the accompanying RDUs, all budgetary information is displayed in a logical manner. The budget sheets are easy to read and are effective tools in *understanding* the figures involved for each of the RDUs. At times, the RDU sheets lack adequate explanation. Each of the RDUs should be introduced by a brief introduction and program summary that sets up the overall program and its desired impact on Alaska’s residents. This will help set the stage and enable the general reader to understand where and why the dollars are being spent. Included in this general description, the Department may consider adding brief utilization data, information on the number of providers, and overall enrollee data. Again this information will help set the baseline for the budget and inform readers of the overall programs.

Recommendation 1.2: The Department should consider adding in historical budget data (beyond FY 2014 actuals) to each of the RDUs. Again, this will help the reader see trends across years and see how the program has either been growing or decreasing in size. Providing historical costs increases will also enable the readers to make relative comparisons across multiple years to see how the program has evolved. Finally, the Department may consider summarizing outcomes data as well in this section. Demonstrating results and outcomes is an important step in justifying programming and the associated dollars; however, this is not included in the budget document. Nor is historical information on LTSS programs readily available on the Department’s websites. Outcome data will help readers connect with where and how dollars are being spent. It is easier to justify dollars being spent when direct outcomes can be persuasively described.

Overall, the *FY 2016 Governors Amended Budget Department of Health and Social Services* is both an efficient and effective document. Although the document is over 1,800 pages that is a reasonable size given the breadth and scope of the document. The main deficiency in the budget format is that RDU information

does not routinely include program descriptions. Included in these descriptions should be a summary of applicable performance outcomes and the populations(s) served by each RDU. Included in these descriptions should be a summary of the outcomes and the population who is served by each of the RDUs.

Recommendation 1.3 The Department should consider adding additional program information in the discussion of each RDU. This section of the budget document is the only place the Department has the opportunity to present additional unstructured narrative and the Department should take advantage of this opportunity to present full and complete program description.

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REVIEW OBJECTIVE 02 – DELIVERY AND ADMINISTRATION

Using recognized standards for determining such, examine and evaluate all aspects of long-term care services provided by DHSS including the types, delivery, and funding, and determine the extent services are effectively and efficiently delivered and administered. The review team shall provide recommendations for improvement to any area identified as not effective or efficient. This should address the following:

- A. Do the Department’s Long Term Care service goals, programs, and objectives tie directly to the Department’s mission?**
- B. Are the Department’s long-term care programs and services delivered and administered effectively?**
- C. Are the Department’s long-term care programs and services delivered and administered efficiently?**
- D. Are there opportunities for the Department to increase the quantity and/or quality of services provided to clients with the same level of funding?**
- E. Are there opportunities for the Department to reduce the level of funding while maintaining the quantity and/or quality of services provided to clients?**
- F. Are there any long-term care programs or services that are not effective or efficient?**
- G. Can best practices be implemented to better position the Department to effectively and efficiently manage the projected growth in demand for long-term care services?**
- H. Identify best practices and make recommendations to address projected growth in demand for services provided through Alaska Pioneer Homes.**
- I. Identify and recommend best practices that distinguish service needs between seniors and people with disabilities.**
- J. Identify and recommend best practices that allow the Department to identify services that are producing quality outcomes for individuals served.**

Overview

The order of this review objective closely follows the description of the review objectives as laid out above. Each question will be addressed as clearly as possible. In Review Objective 01: Comprehensive Overview, Public Consulting Group (PCG) identified five main programs and services offered by the Department. These LTSS related programs are the following:

1. Personal Care Assistant (PCA) services;
2. Medicaid waiver services;
3. Nursing facility services;
4. Alaska Pioneer Homes (AKPH), and
5. Home and community-based grants and contracts.

These five main programs and the services for each applicable questions is what PCG will be reviewing in this section. It is important to note that these classifications serve as an umbrella, especially for Medicaid waiver services and home and community-based grants and contracts. The State of Alaska uses three different Medicaid waiver services relevant to long term care, which are the following:

1. Alaskans Living Independently (ALI) waiver;
2. Adults with Intellectual and Developmental Disabilities (APDD) waiver, and
3. Intellectual and Developmental Disabilities (IDD) waiver.

For home and community-based grants and contracts, PCG has identified the following long-term care programs and services offered by the State of Alaska to review:

1. General Relief/Temporary Assisted Living;
2. Senior Community-Based Grants;
3. Community Developmental Disabilities Grants, and
4. Senior Residential Services Grants.

In the following review objective, these classifications will be addressed to show the Department's performance with regard to the service delivery and administration of long-term care services.

A. Do the Department's Long Term Care service goals, programs, and objectives tie directly to the Department's mission?

PCG believes that the long-term care services, goals, programs, and objectives tie directly to the Department's mission.

“The mission of the Department of Health and Social Services is ‘to promote and protect the health and well-being of Alaskans.’”⁷⁸

PCG believes that the programs and services PCG is reviewing adequately accomplish this overarching mission.

To understand more fully how the Department is accomplishing the task of administering these services and programs to its citizens, PCG reviewed the Results Based Budgeting process as well as the Department's “2014 Priorities”.⁷⁹ Both of these practices show how the Department aligns its goals to complete its mission.

The “2014 Priorities” document communicates the top priorities for the Department. These priorities are as follows:

1. Health and wellness across the lifespan;
2. Health care access, delivery and value, and
3. Safe and responsible individuals, families, and communities.

This document is clearly organized stating the mission, vision, and service philosophy of the Department. Each priority is clearly stated, showing how specific objectives need to be completed in order to accomplish the provision of the core services. Furthermore, this priority list shows effectiveness and efficiency measures with supplied population health indicators for every objective on this list showing how progress to accomplishing the objective is tracked. This document shows the Department is cognizant of creating a process flow which will ensure the accomplishment of the Department's mission.

Through interviews with Department staff, PCG was able to identify the process of results-based budgeting, that the Department uses for its practice of core service alignment.⁸⁰ This document ensures that every division within the Department is able to track every service offered and how that service aligns with the overall mission of the Department. For Example, the *Core Service Alignment* Document shows on the first page shows the core service alignment of AKPH. AKPH identified five different core services provided for Alaskans receiving care in the AKPHs. These core services are the following:

1. Memory Care;
2. Personal Care and Assistance;
3. Activities;
4. Food Service, and
5. Provide a Home.

⁷⁸ Alaska Department of Health and Social Services Website. Retrieved May 2015.

⁷⁹ [2014 Priorities](#). State of Alaska DHSS.

⁸⁰ DHSS provided *FY 2015 Core Service Alignment* Document.

The document shows how each of the AKPH specific core service fits into the overall core services of the Department and what Department priority that core service addresses. This alignment has allowed the Department to ensure that they are continually serving its own mission through every service offered, and exactly how that service enables the Department to accomplish its mission.

B. Are the Department's long-term care programs and services delivered and administered effectively?

In general, the Department's long-term care programs and services are delivered and administered effectively. The State of Alaska faces many different challenges to providing LTSS services; therefore the tactics applied to provision of these services must be adapted to overcome these challenges. Although PCG believes the Department provides effective services, this section will cover actions the Department can take to create more robust programs.

The analysis of the effectiveness of programs includes understanding how Alaska's LTSS compare with other states, as well as the accessibility of the service for Alaska residents.

As stated in Review Objective 01, effective LTSS programs include three types of services:

1. Institutional care;
2. In-home services, and
3. Residential programs.

Alaska has been successful in developing all three types of these services. Therefore creating an effective LTSS programs.

In 2014, The American Association of Retired Persons (AARP) published its scorecard of state performance in long-term services and supports.⁸¹ Alaska had an impressive overall rank of fifth highest in the nation. The AARP Scorecard used 26 indicators to measure the performance of states. Alaska scored in the top ten states on 11 of the 26 indicators. In general, the 11 indicators and Alaska's high rankings on them indicate Alaska has been very successful in providing home and community-based services to persons instead of relying on institutional services. These high rankings from the AARP show that Alaska is performing well with regard to administering LTSS to its citizens.

The Department provides effective services to all Alaskans in need through the use of its five main programs:

1. PCA services;
2. Medicaid waiver services;
3. Nursing facility services;
4. AKPHs, and
5. Home and community-based grants and contracts.

⁸¹ American Association of Retired Person, (June 19, 2014), *Raising Expectations, 2014: A State Scorecard on Long-Term Services and Supports For Older Adults, People with Physical Disabilities, and Family Caregivers*, Washington D.C. See <http://www.longtermscorecard.org/2014-scorecard#VT-00-9FB9A>.

Each one of these services is designed to provide care needed by individuals in differing circumstances. The development of these programs allow the Department to overcome the unique geographical challenges it faces in order to provide the needed services to its constituents.

Eligibility for Nursing Facility Services

Although PCG believes that the LTSS programs are effective, the nursing facility eligibility requirements are a key area that should be improved.

A primary concern brought up by numerous interviewees lies with the number of persons with dementia and related disorders. This same concern was expressed in previous studies of Alaska LTSS programs.⁸² The Alaska Commission on Aging's (ACOA) 2012-2015 state plan for senior services clearly emphasizes the importance of strengthening state capability to deal with Alzheimer's and related dementia disorders.⁸³ Because of the depth and breadth of concern about the capability of the state's LTSS efforts to help persons with dementia, this section of the performance review report focuses on eligibility for nursing facility services and how dementia and related cognition conditions are taken into account in determining eligibility for nursing home services.

Eligibility for Medicaid nursing facility services is based on scores. The state uses a 32-page Consumer Assessment Tool, known as the CAT to determine nursing facility level of care eligibility. Depending on the answers to the questions in the assessment, persons are assigned scores and deemed to be eligible or not eligible based on the scores. There are two main ways to become nursing facility eligible. One must either meet one of the following conditions or obtain a score of three on other factors. If an individual meets any of the following conditions the individual is considered to be nursing facility eligible:

- a. In Section A, Nursing Services, items 1-8, did you code any of the responses with a 4 (i.e., services needed 7 days/wk)?*
- b. In Section A, items 9 (Ventilator/Respirator) did you code this response with a 2, 3 or 4 (treatment needed at least 3 days/wk)?*
- c. In Section A, item 10 (Uncontrolled seizure), did you code this response with a 1, 2, 3, or 4 (care needed at least once/wk)?*
- d. In Section A, item 11 (Therapies), was the total number of days of therapy 5 or more days/wk?*
- e. In Section E, (Physical Functioning/Structural Problems), were 3 or more shaded activities of daily living (ADLs) coded with a 3 (extensive assistance) or 4 (dependent) in self performance?⁸⁴*

⁸² See p. 52 <http://dhss.alaska.gov/dsds/Documents/01-External/AK%20Long%20Term%20Care%20Plan%20-%20Final%20Report%20-%20HCBS%20Strategies-10-23-08.pdf>. Also see: p. 15 <http://dhss.alaska.gov/dsds/Documents/docs/alaskaLongTermCareCostStudy.pdf>.

⁸³ See State Plan at http://dhss.alaska.gov/acoa/Documents/documents/State_plan_2012-2015.pdf.

⁸⁴ An ADL is an activity of daily living and usually refers to bathing, dressing, eating, grooming, mobility, toileting, and transferring location e.g. bed to chair. For example, see <http://careresponse.com/wp-content/uploads/2013/03/Ann-Arbor-ADL-IADL-Checklist.pdf>.

**If the answer to any of these questions is "Yes", then the person will be found medically eligible for nursing facility level of care and will be scored a 3 or presumed to have a score of 3 or more.⁸⁵*

If an individual does not meet the above conditions, then the individual will need a score of 3 on other factors. A review of the medical conditions and requirements around ADLs indicates the eligibility requirements are high, as compare to other states. Either significant medical problems have to be present or an individual has to require “extensive assistance” with at least three ADLs. These high requirements have multiple consequences:

- They control the number of persons admitted to nursing homes and Medicaid waivers thereby controlling costs;
- Persons with a brain disease such as Alzheimer’s and related disorders have a restrictive screening hurdle, and
- Some AKPH residents and residents of the SRS program are found not eligible for Medicaid waiver services when a change in the level of care standard that accounts for dementia would make them eligible.

Cognition is one of the other factors that contributes to a score of three. One may can get a score of one on cognition if one meets all of the following four conditions:

1. There has to be a short-term memory problem.
2. The person must be unable to remember two of the four following conditions:
 - Current season;
 - Location of own room;
 - Names/faces, and
 - Where he/she is.
3. In their *Cognitive Skills for Daily Decision-Making* a person must have one of the two conditions shown below.
 - Moderately impaired – decisions poor, cues/ supervision required, and
 - Severely impaired – never/rarely made decisions.
4. The person must be deemed to require the following: “professional nursing assessment, observation and management required at least 3 days/week to manage all the above cognitive patterns”, OR, the person must require at least limited assistance with bed mobility, transfer, locomotion, eating, or toilet use AND require either one or two-person assistance, AND, the person must score 13 out of a possible 16 points on a test of cognitive skills.

⁸⁵ Taken from p. 31 of the CAT. See: <http://www.alaskaccn.com/files/QuickSiteImages/BlankECAT.pdf> retrieved 4-30-2015.

The test of cognitive skills has five parts. If one has all of the following conditions, and achieves the second highest score as shown in the figure below, one would only get a score of 11 on for this portion instead of the 13 needed on this test.

Figure 2.1: Condition on Cognitive Test Section C4B of CAT

Condition on Cognitive Test in section C4B of CAT	Score on Cognitive Test if Condition Exists
Cannot recall entire events (e.g. recent outings, visits of relatives or friends) or names of close friends or relatives without prompting.	2
Has difficulty remembering and using information. Requires direction and reminding from others four or more times per day. Cannot follow written instructions;	3
Periodic confusion during daytime.	2
Gets lost when walking neighborhood.	2
Able to carry out only simple conversations.	2

Individuals must meet all of the above four conditions mentioned in one through four on the previous page, to get a score of one on cognition in the nursing facility eligibility process and a score of 3 is needed to be considered nursing facility eligible. The 2013 National Center for Health Statistics found that 48% of persons in nursing homes had dementia.⁸⁶ Approximately 13% of the persons on the ALI waiver in 2014 had the words dementia or Alzheimer’s in their diagnoses. This 13% proportion would likely be higher had the screening not been restrictive. The consequence is to minimize the proportion of persons with dementia and related disorders who can obtain access to assisted living, chore, respite and other services provided through Medicaid waivers.

C. Are the Department’s LTSS delivered and administered efficiently?

Although LTSS costs are significantly higher in Alaska due to unique cultural and geographical constraints, the LTSS programs generally operate efficiently, but with room for improvement. LTSS operations are determined to be efficient through examination of program expenditures where applicable, and the understanding of the necessity of the service. The findings that follow detail a trend of expenditure reduction for the services addressed between the year 2013 and 2014. This reduction in expenditures implies that the Department is efficient at outlining and addressing the needs of the population.

With regard to the five basic operations that the Department performs, as identified by PCG, it has been determined that they generally operate efficiently. The performance of these five services are addressed

⁸⁶ National Center for Health Statistics (2013), *Long-Term Care Services in the United States: 2013 Overview*, Washington D.C. See Figure 23. Retrieved on 5-17-2015. From: http://www.cdc.gov/nchs/data/nsltcp/long_term_care_services_2013.pdf.

below with regard to the efficiency of their service delivery. The main factor for understanding and addressing the efficiency of the program resided in the analysis of the costs versus persons served for each program. When available data provided by the Department is used to look at trend data with regards to cost and program population.

Program efficiency will be addressed in the following order:

1. Analysis of the efficiency of PCA services;
2. Analysis of the efficiency of Medicaid waiver services;
3. Analysis of the efficiency of nursing home services;
4. Analysis of the efficiency of the Alaska Pioneer Homes, and
5. Analysis of the efficiency of the home and community-based grants and contract services.

ANALYSIS OF THE EFFICIENCY OF PCA SERVICES

A significant methodology for analyzing the efficiency of the service delivery of PCA services in the State of Alaska is to look at budget expenditure trends. The Department provided PCG with historical cost and population data over the past five years.

Below PCG presents quantitative analyses to help describe the overall PCA program.

Figure 2.2: PCA Expenditures, Units of Service and Persons Using PCA Services, 2010-2014 below, shows five years of expenditures, units of service and the number of persons using PCA services.⁸⁷ The data show a substantial growth from 2010 to 2013 in expenditures, units of service, and persons with a leveling out in 2013 and a substantial reduction in 2014.⁸⁸ The decrease in expenditures and units of service from 2013 to 2014 was larger than the decrease in the number of persons served and the result was that the units of service per person decreased from 3,591 in 2013 to 3,041 in 2014 while the cost per unit of service went up slightly.⁸⁹ This reduction shows that expenditures, units of service, persons served, and units of services per person all declined almost proportionately from FY 2013 to FY 2014.

Figure 2.2: PCA Expenditures, Units of Service and Persons Using PCA Services, 2010-2014⁹⁰

Year	Expenditures	Units of Service	Persons	Cost per Unit of Service	Units of Service Per Person
FY 2010	\$94,276,628	16,936,491	4,314	\$5.57	3,926
FY 2011	\$81,906,116	14,641,062	5,254	\$5.59	2,787
FY 2012	\$121,192,628	21,031,415	5,776	\$5.76	3,641
FY 2013	\$125,786,076	21,288,825	5,928	\$5.91	3,591
FY 2014	\$102,565,934	17,005,643	5,592	\$6.03	3,041

⁸⁷ The units of service data is a composite count of all units of services across all procedure codes paid for by the program.

⁸⁸ The drop in PCA expenditures for 2011 in the information provided to performance reviewers is puzzling since data reported by the Office of Rate Review for 2011 shows expenditures of \$109,152,152. See: http://dhss.alaska.gov/dsds/Documents/pdfs/HCBW-PCA_trends.pdf. It is likely that the information provided to performance reviewers is incorrect.

⁸⁹ The person counts in this overview are based on annual unduplicated counts of persons that received at least one PCA or one waiver service during the year and will differ from average monthly counts that may also be reported in Department documents.

⁹⁰ Expenditures and person counts taken from Excel files supplied by DHSS.

Figure 2.3 Percentage Changes in PCA Expenditures, Units of Service and Persons using PCA Services, 2010 – 2014 shows the percentage change in PCA expenditures, units of service and persons using PCA services. The percentage data show a clear picture of large uncontrolled program increases over the 2010-2013 period. This increase was followed by a leveling off in 2013 and a substantial reduction of expenditures in 2014.

Figure 2.3: Percentage Changes in PCA Expenditures, Units of Service and Persons Using PCA Services, 2010-2014⁹¹

Year	Expenditures	Units of Service	Persons	% Change Expenditures	% Change Units of Service	% Change Persons
FY 2010	\$94,276,628	16,936,491	4,314			
FY 2011	\$81,906,116	14,641,062	5,254	-13.12%	-13.55%	21.79%
FY 2012	\$121,192,628	21,031,415	5,776	47.97%	43.65%	9.94%
FY 2013	\$125,786,076	21,288,825	5,928	3.79%	1.22%	2.63%
FY 2014	\$102,565,934	17,005,643	5,592	-18.46%	-20.12%	-5.67%

The data in the figures above suggests that conscious effort has been applied towards controlling PCA expenditures. As the above data demonstrates, PCA expenditures increased greatly between FY 2011 and FY 2013, where expenditures increased by nearly 50% but the PCA population receiving services only increased by approximately 13%. The reductions in services and expenditures from 2013 to 2014 show that the Department has applied controls to this program to avoid costs. This was primarily achieved by reducing the PCA population by 336 individuals in FY 2014. This was also followed by a 20% decrease in units of service provided to the PCA population. Together, these reductions were able to decrease overall expenditures by approximately 18.5% by limiting PCA services to those who were assessed to need them.

Waiver and PCA Reductions

The reductions in expenditures in the waiver and PCA programs had an impact and providers organized to better understand the depth and breadth of the reductions. A presentation by providers was developed, dated February 6, 2015, and shared with Departmental staff. The presentation contained the following points.

- The impact fell primarily on the elderly population as the reductions in the PCA and ALI waiver were larger than reductions in other programs;
- Persons that were being provided a higher than average number of hours prior to the reduction took the largest percentage of reductions;
- Of the participants in the PCA program, 82% had services reduced;
- Despite a 7% increase in Alaska’s senior population, there was a 250% increase in denied applications for first-time applicants;

⁹¹ Expenditures and person counts taken from Excel files supplied by DHSS.

- While there was an 8% decrease in served clients, there was a 226% increase in active clients being denied;
- There was a 29% average reduction in services;
- Of new recipients, 50% had lower services;
- In 2014, 781 waiver recipients lost nursing facility level of care eligibility, and
- A total of 3,361 persons had service cut or eliminated.

This presentation showed that actions taken by the reductions in the PCA program have serious program consequences. It is argued that these PCA and waiver program reduction practices will cause higher long-term healthcare costs because preventative care is not being performed as it was previously, before individuals' units of service were reduced or denied. Program recipients have also expressed that they felt the assessment process was not accurate, or they did not receive a fair assessment of their healthcare needs when they were evaluated by the assessor.

Recommendation 2.1: The Department should hire a vendor and take a random sample of persons that were denied service or had services discontinued to identify the impact of these reductions.

ANALYSIS OF THE EFFICIENCY OF WAIVER SERVICES

As described in section one of this report, four separate Medicaid waiver services are offered through the Department. These services are as follows:

1. Alaskans Living Independently waiver;
2. People with Intellectual and Developmental Disabilities waiver;
3. Adults with Physical and Developmental Disabilities waiver, and
4. Children with Complex Medical Conditions waiver.

PCG determined that the first three waivers listed above most closely offered long-term care type services to Alaskans.

ALI Waiver Efficiency

Figure 2.4: ALI Waiver Expenditures, Units of Service and Persons using ALI Services, 2010 - 2014 below contains five years of data, 2010 through 2014, on the ALI waiver. The Figure indicates that expenditures, units of service, and the number of persons served all increased from 2010 to 2013 and then decreased in 2014.⁹² Fewer units of service were provided in 2014, but the average unit cost more. These data imply the State is providing a more expensive mix of services for those individuals who retain waiver eligibility. The use of more expensive service mixes show, if reassessments were performed correctly, that reductions made between 2013 and 2014, were effective in distinguishing and supplementing those individuals who have higher needs with the appropriate waiver services. This implies that the 2013 reductions were effective in that persons remaining on the waiver were individuals with a higher need for services.

⁹² Unit of service data is a mixed variable. In 2014, not counting procedure code modifiers, the ALI program paid for 26 different procedure codes. The unit of services is summary count across all 26 procedure codes of how many times procedure codes were paid for.

Figure 2.4: ALI Waiver Expenditures, Units of Service and Persons Using ALI Services, 2010-2014⁹³

Year	Expenditures	Units of Service	Persons	Cost per Unit of Service	Units of Service Per Person
FY 2010	\$41,844,462	1,865,981	1,603	\$22.42	1,164
FY 2011	\$44,600,177	2,132,214	1,873	\$20.92	1,138
FY 2012	\$61,466,456	3,036,171	3,162	\$20.24	960
FY 2013	\$83,782,806	3,746,276	3,220	\$22.36	1,163
FY 2014	\$66,653,032	2,422,599	2,886	\$27.51	839

Figure 2.5: Percentage Changes in ALI Expenditures, Units of Service and Persons Using ALI Services, 2010 - 2014 expresses these differences as percentage changes. Consistent with the changes in the PCA program, the ALI Waiver percentage changes increased from 2010 to 2013 and then declined from 2013 to 2014. The shift of older adults (OA) from the OA waiver and adults with physical disabilities from the APD Waiver into ALI in 2012 is clearly shown in the percentage increase in persons on the ALI waiver in 2012.

Figure 2.5: Percentage Changes in ALI Expenditures, Units of Service and Persons Using ALI Services, 2010-2014⁹⁴

Year	Expenditures	Units of Service	Persons	% Change Expenditures	% Change Units of Service	% Change Persons
FY 2010	\$41,844,462	1,865,981	1,603			
FY 2011	\$44,600,177	2,132,214	1,873	6.59%	14.27%	16.84%
FY 2012	\$61,466,456	3,036,171	3,162	37.82%	42.40%	68.82%
FY 2013	\$83,782,806	3,746,276	3,220	36.31%	23.39%	1.83%
FY 2014	\$66,653,032	2,422,599	2,886	-20.45%	-35.33%	-10.37%

These figures show the increase in efficiency of ALI waiver services through reduction in expenditures and a drop in the units of service provided to persons. Expenditures and units of service are decreasing at a greater amount than the decrease in persons and this relative reduction shows that these services are becoming more efficient.

IDD Waiver Efficiency

Figure 2.6: IDD Waiver Expenditures, Units of Service and Persons Using IDD Services, 2010 - 2014 below contains five years of data, 2010 through 2014, on the IDD Waiver. The figure below indicates that

⁹³ Expenditures and person counts taken from Excel files supplied by DHSS.

⁹⁴ Expenditures and person counts taken from Excel files supplied by DHSS.

expenditures, units of service, and the number of persons served all increased from 2010 to 2013 and then decreased in 2014.

Figure 2.6: IDD Waiver Expenditures, Units of Service and Persons Using IDD Services, 2010-2014⁹⁵

Year	Expenditures	Units of Service	Persons	Cost per Unit of Service	Units of Service Per Person
FY 2010	\$100,554,597	6,153,598	1,464	\$16.34	4,203
FY 2011	\$111,062,247	6,901,420	1,551	\$16.09	4,450
FY 2012	\$128,838,695	7,533,179	1,671	\$17.10	4,508
FY 2013	\$145,331,255	8,220,085	1,820	\$17.68	4,517
FY 2014	\$137,469,178	7,181,141	1,926	\$19.14	3,729

Figure 2.7: Percentage Changes in IDD Expenditures, Units of Service and Persons Using IDD Services, 2010 – 2014 expresses these differences as percentage changes. Consistent with the changes in the PCA program and the ALI waiver, percentage changes in IDD expenditures and units of service increased from 2010 to 2013 and then declined from 2013 to 2014. The percentage decreases in the IDD 2014 data are lower than the percentage decreases in the ALI waiver indicating that more reductions were made in the ALI waiver. For example, ALI expenditures were cut by 20.45% from 2013 to 2014 but IDD expenditures were only cut 5.41%

Figure 2.7: Percentage Changes in IDD Expenditures, Units of Service and Persons Using IDD Services, 2010-2014⁹⁶

Year	Expenditures	Units of Service	Persons	% Change Expenditures	% Change Units of Service	% Change Persons
FY 2010	\$100,554,597	6,153,598	1,464			
FY 2011	\$111,062,247	6,901,420	1,551	10.45%	12.15%	5.94%
FY 2012	\$128,838,695	7,533,179	1,671	16.01%	9.15%	7.74%
FY 2013	\$145,331,255	8,220,085	1,820	12.80%	9.12%	8.92%
FY 2014	\$137,469,178	7,181,141	1,926	-5.41%	-12.64%	5.82%

Expenditure reductions from FY 2013 to FY 2014 were not as significant as the other Medicaid waiver services offered by the State of Alaska. Expenditures decreased at 5.41% while the IDD waiver population

⁹⁵ Expenditures and person counts taken from Excel files supplied by DHSS.

⁹⁶ Expenditures and person counts taken from Excel files supplied by DHSS.

grew by 5.82%. These changes in population and expenditures were coupled with a 12.64% decrease in units of service being charged to IDD waiver. The cost per unit of service went up indicating fewer units of service were provided in 2014, compared to changes in expenditures. The increase in the cost per unit of service in 2014, indicates a more expensive mix of services was provided. This pattern of changes shows that service evaluations have become more efficient and effective with providing the needed services to individuals on the IDD waiver.

APDD Waiver Efficiency

Figure 2.8: APDD Waiver Expenditures, Units of Service and Persons Using APDD Services, 2010 - 2014 below, contains five years of data, 2010 through 2014, on expenditures in the APD waiver. The expenditure pattern with the APDD waiver is quite similar to the ALI and IDD waivers. Expenditures, units of service paid for, and persons increased from 2010 through 2013 and then decreased substantially in 2014.⁹⁷

Figure 2.8: APDD Waiver Expenditures, Units of Service and Persons Using APDD Services, 2010-2014⁹⁸

Year	Expenditures	Units of Service	Persons	Cost per Unit of Service	Units of Service Per Person
FY 2010	\$28,943,737	1,986,996	1,127	\$14.57	1,763
FY 2011	\$33,936,156	2,460,369	1,286	\$13.79	1,913
FY 2012	\$28,377,970	1,998,262	90	\$14.20	22,203
FY 2013	\$13,724,066	963,490	104	\$14.24	9,264
FY 2014	\$7,603,867	509,813	109	\$14.92	4,677

Figure 2.8 Percentage Changes in APDD Expenditures, Units of Service and Persons Using APDD Services, 2012 - 2014 expresses these differences as percentage changes. Consistent with the changes in the PCA program and the ALI and IDD waivers, there were large percentage declines in the expenditures and units of service. The percentage declines from 2013 to 2014 were higher in the APDD waiver than the percentage declines in other waivers indicating deeper cuts were made to this program. The reported data for 2012 looks anomalous since over \$28 million in expenditures are reported but the case load is reported at 90 persons. This anomaly has been explained by SDS.⁹⁹

⁹⁷ The data provided to PCG by the Department for 2012 is likely incorrect since the person count is 90 and the reported expenditures are over \$28 million.

⁹⁸ Expenditures and person counts taken from Excel files supplied by DHSS.

⁹⁹ “Although the changes to individual’s eligibility was done retroactive to 7/1/2011 the change did not go into effect until 4/1/2012. As a result paid claims prior to 4/1/2012 were paid based on old waiver eligibility (OA and APD waivers), as of 4/1/2012 claims were paid using the new waiver eligibility (ALI and APDD). The already processed claims were not recorded with the updated eligibility, as a result when we conduct analysis or aggregate data for FY 2012, we identify the individuals whom SDS approved for APDD and/or ALI waivers and then retrieves claims just for those individuals regardless of what their eligibility was during that fiscal year. The reason that you have 90 individuals identified as APDD with \$28.377 mil in expenditures is because the 90 individuals are the actual APDD service recipients as identified by SDS, the expenditures are ALL paid claims that were coded with eligibility codes of 30, 31, and 34. Prior to 4/1/2012 this included all APD clients (1,399 individuals), after 4/1/2012 it included just the subgroup identified as APDD; however half of the individuals coded as APDD after 4/1/2012 were coded erroneously and clean-up efforts are ongoing.”

Figure 2.9: Percentage Changes in APDD Expenditures, Units of Service and Persons Using APDD Services, 2012-2014¹⁰⁰

Year	Expenditures	Units of Service	Persons	% Change Expenditures	% Change Units of Service	% Change Persons
FY 2010	\$28,943,737	1,986,996	1,127			
FY 2011	\$33,936,156	2,460,369	1,286	17.25%	23.82%	14.11%
FY 2012	\$28,377,970	1,998,262	90	-16.38%	-18.78%	-93.00%
FY 2013	\$13,724,066	963,490	104	-51.64%	-51.78%	15.56%
FY 2014	\$7,603,867	509,813	109	-44.59%	-47.09%	4.81%

These figures show the increase in efficiency of APDD waiver services through reduction in expenditures and concentration of services applied to users. As in the review of the two main waivers, the drop in the units of service was greater than the drop in the expenditures resulting in an increase in the average unit of service. The fact that the decrease in services was greater than the decrease in expenditures resulted in a smaller more expensive service mix as the cost per unit increased. When compared to the decreases in caseload in the PCA and ALI waiver programs, this waiver population has largely remained unchanged. This shows that the eligibility determination was effective since the right individuals were receiving needed services.

ANALYSIS OF THE EFFICIENCY OF NURSING HOME SERVICES

Alaska has high nursing home rates; the highest median costs in the country.¹⁰¹ Figure 2.10 below shows nursing facility residents, expenditures, and cost per resident for the period 2010-2014. The high costs are driven by the rural location of most nursing homes and their connections with hospitals.¹⁰² The high Medicaid rates paid for rural nursing facilities support essential rural hospital operations. Furthermore, the State of Alaska is able to receive a 100% federal match on expenditures paid to facilities associated with the Indian Health Services.

Figure 2.10: Nursing Facility Medicaid Residents, Expenditures, and Cost per Resident, 2010 - 2014 below shows expenditures and average cost per resident based on data provided by the Department for the Fiscal Years ranging from 2010 to 2014.

¹⁰⁰ Expenditures and person counts taken from Excel files supplied by DHSS.

¹⁰¹ See the 2014 Genworth Cost of Care Study p. 18.

https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_032514_CostofCare_FINAL_nonsecure.pdf

¹⁰² Three nursing facilities are in Anchorage, one is in Juneau and one is in Fairbanks. Approximately 14 of the 18 nursing facility licenses are associated with hospitals.

Figure 2.10: Nursing Facility Medicaid Residents, Expenditures, and Cost per Resident, 2010-2014¹⁰³

Year	Medicaid Nursing Facility Residents	Expenditures	Cost Per Resident
2010	868	\$ 86,118,745	\$99,215
2011	809	\$ 90,220,335	\$111,521
2012	809	\$ 97,589,660	\$120,630
2013	805	\$ 102,367,120	\$127,164
2014	762	\$ 93,825,914	\$123,131

Figure 2.10 above, shows the actual expenditures and cost per resident whereas, the figure below expresses these figures in percent change.

Figure 2.11: Percent Change in Nursing Facility Medicaid Residents, Expenditures, and Cost per Resident, 2010-2014¹⁰⁴

Year	Percent Change in Medicaid Nursing Facility Residents	Percent Change in Expenditures	Percent Change in Cost Per Resident
2010	N/A	N/A	N/A
2011	-6.8%	4.76%	12.4%
2012	0%	8.17%	8.17%
2013	-4.94%	4.9%	5.42%
2014	-5.34%	-8.34%	-3.17%

The information above provided by the Department shows the same trend in expenditures as PCA and Medicaid waiver services offered by the State of Alaska. However, the percent changes in these figures do not show drastic changes in expenditures as does the PCA and Medicaid waiver. These services show that the population of Medicaid nursing facility residents has gradually decreased over the past five years. Initially, expenditures increased but then decreased in 2014, and the average cost per resident decreased by 3.17% in 2014, after a consistent rise for the previous four years.

These changes in expenditures, residents, and especially cost per resident, can be an example of how the Department is making an effort to provide efficient services to Medicaid nursing facility residents. As stated earlier, nursing facility costs for Alaska are the highest in the country due to the unique geographic challenges the state faces. Nevertheless, PCG understands these costs are necessary toward providing a continuum of care to Alaskans residents in order for them to live healthy and productive lives.

¹⁰³ Resident data obtained from Budget staff in SDS, expenditure data for 2010-2014 obtained from Excel files provided to PCG.

¹⁰⁴ Resident data obtained from Budget staff in SDS, expenditure data for 2010-2014 obtained from Excel files provided to PCG.

ANALYSIS OF THE EFFICIENCY OF PIONEER HOME SERVICES

The Department provided PCG with census, employment, and expenditure data. PCG used this data, along with interviews with key Department staff to determine the efficiency of AKPH Services.

The comprehensive overview for **Review Objective 01: Comprehensive Overview** provides an overall picture of the AKPHs with acuity levels described. PCG was provided data per acuity level of residents since 2008 as well as total home census. The figure below shows the average monthly census at the six homes by level for the years 2008 to 2014.

The data indicate that the total monthly average declined until 2013 and then increased in 2014 with the net result that total census has been flat over the six-year period. Furthermore, the table shows that by acuity level, Level I increased, Level II was flat, and Level III has shown the most decrease. Level III residents are individuals with the highest acuity in the homes, needing the most services.

A strong metric for efficiency is to compare the occupancy rate of the AKPHs to other homes and peer states. The AKPH occupancy rate has maintained an over 90% average over the last five years. This average is higher than the occupancy rates recorded in 2012 by the CDC for the States of Alaska, Washington and Oregon.¹⁰⁵ From the standpoint of occupancy, the AKPHs are operating efficiently.

Figure 2.12: Average Monthly Census at the Six Homes by Level, 2008 to 2014¹⁰⁶

Year	Level I	Level II	Level III	Total
2008	52	137	279	468
2009	59	135	271	465
2010	56	140	261	457
2011	60	142	258	460
2012	57	148	254	459
2013	60	137	252	450
2014	64	138	264	466

The next figure shows the source of funds and the number of staff used to operate the homes.¹⁰⁷ The Figure shows a steady increase in the amount of total funds used to operate the Homes. Resident fees and general funds have gone up while Medicaid revenue declined especially between 2013 and 2014. Medicaid funding dropped substantially from 2013 to 2014 as residents lost waiver eligibility due to the tightening of waiver eligibility procedures. There was a substantial percentage increase in funds obtained from the U.S Veterans Administration for Palmer House operations but the amounts were small compared to overall expenditures.

¹⁰⁵ Table 110. Nursing homes, beds, residents, and occupancy rates, by state: United States, selected years 1995 – 2012. Nursing Home Care. FastStats. Centers for Disease Control and Prevention. <http://www.cdc.gov/nchs/data/abus/abus13.pdf#101>.

¹⁰⁶ Division of Alaska Pioneer Homes.

¹⁰⁷ These funds do not include management costs associated with operating the Division of Alaska Pioneer Homes.

The general picture is that total fund expenditures have been increasing by about a million per year on average between 2010 and 2014 while overall resident census has been flat and Level III census, the most impaired level of residents, has been declining. From the standpoint of expenditures and census data, the AKPHs do not appear to be operating efficiently since costs automatically increase without corresponding increases in benefits provided or persons served. This is not a situation controllable by DHSS since it does not have authority to set benefits levels of staff that work in the AKPHs.

Figure 2.13: Alaska Pioneer Homes Source of Funding and Staff Levels, 2010-2014¹⁰⁸

Funds and Staff	2014	2013	2012	2011	2010
General Fund	\$35,762,900	\$35,189,100	\$33,615,200	\$30,595,500	\$31,386,000
Resident Fees	\$16,296,900	15,616,300	\$15,775,400	15,540,100	\$15,083,500
U.S. Veterans Admin.	\$686,100	\$281,000	\$281,000	\$281,000	\$231,000
Medicaid	\$4,587,800	5,904,200	\$5,813,900	5,700,100	\$5,238,300
Other Funds	\$2,491,100	\$2,494,000	\$2,667,900	\$2,802,800	\$2,883,700
Total Funds	\$59,824,800	\$59,484,600	\$58,153,400	\$54,919,500	\$54,822,500
Permanent Full Time Staff	561	561	564	564	561
Permanent Part Time Staff	41	42	43	43	46
Non-Permanent Staff	32	32	32	32	31

According to Department staff, roughly half of all individuals at the AKPHs are private pay. Residents pay approximately 27% of cost to the AKPHs and other payment sourcing including the General Fund Account for the remaining 73%. Since 50% of individuals are private pay but only 27% of total funds come from private pay, it can be concluded private pay residents do not cover a complete portion of their costs. As shown in the cost analysis the average annual cost per resident is nearly \$130,000.

Furthermore, AKPH staff have expressed that they have not received a Medicaid reimbursement rate increase since 2009. The cost of living has increased approximately 8.9% since 2009. If the Medicaid reimbursement rate was increased by 8.9%, then the cost of living increase would equal an influx of nearly \$400,000 more dollars.¹⁰⁹ Since there has been no rate increase, there is a reimbursement inefficiency. Furthermore, the AKPHs are reimbursed on the assisted living rate. If the homes had their own Medicaid rate which fully reimburses their costs, Alaska would not be subsidizing the Medicaid program through the expenditure of general fund dollars.

¹⁰⁸ Governor's Amended budgets 2012-2016.

¹⁰⁹ [Social Security Cost-of-Living Adjustments](#). Social Security Administration.

ANALYSIS OF THE EFFICIENCY OF HOME AND COMMUNITY BASED GRANTS AND CONTRACT SERVICES

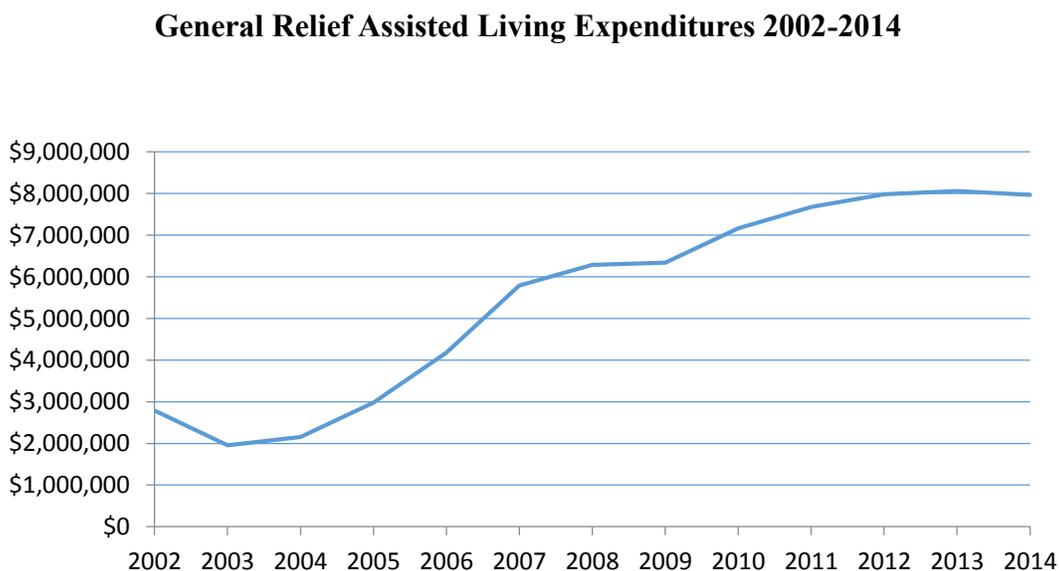
As stated before, the classification of the home and community based grants and contract services is an umbrella classification. Included under this umbrella are the following areas of service:

1. General Relief/Temporary Assisted Living,
2. Senior Community Based Grants.

General Relief/Temporary Assisted Living

The figure below graphs the growth in general relief expenditures from 2002 to 2014. After a period of rapid growth from 2003 to 2011, expenditure growth tapered off during the period 2012-2014. It is difficult to examine whether or not these programs are run efficiently, but it is necessary to note the importance of these programs. Without these LTSS programs in place, Alaska would not be able to have a robust LTSS system which is able to overcome the unique challenges the state faces when providing these services. This program is efficient because it provides a small amount of funds which deter homelessness and the attendant medical and social problems that happen to people who are homeless.

Figure 2.14: General Relief Expenditures, 2002 to 2014 ¹¹⁰



In February 2015, the Department proposed a \$789,800 reduction to the program and expressed the hope that by using a 1915(i) Medicaid waiver some of the expenditures in the program could be made eligible for federal matching funds. ¹¹¹ Fiscal note 6 to the 2015 bill S.B. 78 estimated that an additional \$ 4,494,300 in Federal Funds could be obtained if Alaska applied for a 1915(i) Medicaid waiver. ¹¹² If this estimate is

¹¹⁰ Governor's Amended Budgets 2004-2016.

¹¹¹ See https://www.omb.alaska.gov/ombfiles/16_budget/HSS/Amend/comp2875.pdf.

¹¹² See Fiscal Notes at <http://www.akleg.gov/basis/Bill/Detail/29?Root=SB%20%2078>.

correct, then the 1915(i) Medicaid waiver would add further efficiency towards cost savings by generating the extra revenue of nearly \$4.5 million.

SENIOR COMMUNITY BASED GRANTS

The figure below shows the seven types of programs covered under the senior community-based grants and their 2015 total fund expenditure levels. Historical data was not provided to PCG for analysis, therefore it was not possible to benchmark these figures. As a result, it is difficult to examine whether or not these programs are run efficiently, but it is necessary to note the importance of these programs. Much of this funding is federal funding and local match, these programs are widely recognized nationally as being essential non-Medicaid programs.

Figure 2.15: Senior Community Grants and Total Fund Expenditure Levels, 2015¹¹³

Senior Community Grant Program	2015 Funding Level
Nutrition, Transportation and Support Services	\$6,597,152
Senior In-Home Services	\$2,917,265
Adult Day Services	\$1,757,011
National Family Caregiver Support Program	\$1,026,575
Aging and Disability Resource Centers (ADRCs)	\$949,190
Alzheimer's Disease and Related Disorders	\$357,118
Traumatic and Acquired Brain Injury Case Management	\$300,000

D. Are there opportunities for the Department to increase the quantity and/or quality of services provided to clients with the same level of funding?

PCG has identified the two following options for increasing the quantity and quality of services provided with the same level of funding. These two options are the incorporation of the following:

1. Expansion into use of the 1915(i) Medicaid waiver, and
2. Expansion into the use of the 1915(k) Medicaid waiver.

1915(i) Medicaid Waiver

The 1915(i) is a section of the Social Security Act (the Act) authorized by Congress in Section 6086 of the Deficit Reduction Act of 2005, (DEFRA 2005).¹¹⁴ Effective January 2007, this act established an optional

¹¹³ DHSS, Fiscal Year 2015 Operating Grants.

¹¹⁴ For Social Security Act provisions impacted by Public Law 109-171 (DEFRA 2005). See http://www.ssa.gov/OP_Home/comp2/F109-171.html. There were problems with the definition of services used in the 2005 language. A technical error omitted a coma that would allow States to also cover “and other services approved by the Secretary.” This error was fixed in the Affordable Care Act with changes that became effective October 1, 2010.

Medicaid benefit giving states a new method with which to cover home- and community-based (HCBS) services, which prior to 2007 could only be authorized via a waiver of a state's Medicaid plan.¹¹⁵

The 1915(i) was the first time that HCBS services could be authorized without the use of a waiver. The 1915(i) authority had four features that were different from 1915(c) waivers. They were:

- No institutional level of care requirements;
- No option to limit number of participants;
- No option to limit state-wideness requirements, and
- No financial estimates required.

The package of services authorized under 1915(i) included both HCBS and mental health. The language in the Act specifically included "...day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness."¹¹⁶

Eligibility for 1915(i) services was also based on a definition of need selected by the state. It was widely recognized at the time that the legislative features of 1915(i) made it attractive for states to offer mental health services using this authority. For example, Iowa was the first state to use a 1915(i) and its definition of need centered on mental health services.¹¹⁷

Fifteen states now have approved 1915(i) programs and five others have pending amendments. A PCG review of state plan amendments shows that mental health is the most frequently used of the 1915(i) authority. PCG affirms that the state should actively consider implementing a 1915(i) waiver as the Mental Health Trust Authority is doing.

Recommendation 2.2: The Department should implement a Medicaid 1915(i) waiver. This implementation will allow an estimated \$4,494,300 of Federal funds to be captured allowing a reduction in State General Funds expended.¹¹⁸

1915(k) Medicaid Waiver - Community First Choice

Section 2401 of the Affordable Care Act of 2010, added a new section 1915(k) to the Social Security Act (the Act).¹¹⁹ This new section established what is called the Community First Choice (CFC) program which is a new Medicaid state plan option to provide home and community-based attendant services and supports at a six percentage point increase in the federal medical assistance percentage (FMAP). As a "state plan" benefit, the option is available to states without the need for special waiver authority. The purpose of CFC

¹¹⁵ Home and community based services (HCBS) were not included in the original list of optional and mandatory Medicaid services when Medicaid was first enacted. By the 1980's the need for HCBS services became apparent and Congress passed Social Security Act legislation in 1915(c) and 1915(d) authorizing waivers to state Medicaid plans permitting the use of HCBS.

¹¹⁶ SSA at 1915(i) and 1915(c)(4)(B).

¹¹⁷ See <http://dhs.iowa.gov/sites/default/files/Attachment3.1-C.PDF>.

¹¹⁸ See Fiscal Notes at <http://www.akleg.gov/basis/Bill/Detail/29?Root=SB%20%2078>.

¹¹⁹ For text of Affordable Care Act see <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf> and for CMS website for CFC see <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/community-first-choice-1915-k.html>.

is to encourage the use of home and community based services. This section of the Act was implemented in federal regulation in May of 2012.¹²⁰

States electing the CFC option must make hands-on assistance (actually performing a task for a person) or supervision and cueing available to eligible Medicaid beneficiaries so that they accomplish activities of daily living (ADLs) and instrumental activities of daily living (IADLs) for themselves.¹²¹ In addition to coverage of ADL and IADL services, the CFC program will also cover:

- Training on recruiting, hiring, managing, and dismissing personal care attendants;
- Back-up systems such as personal emergency electronic devices to ensure continuity of services and support;
- Transition costs associated with moving from an institution to home or a community-based setting, and
- “Expenditures relating to a need identified in an individual’s person-centered service plan that increases an individual’s independence or substitutes for human assistance.”¹²²

To be eligible for the CFC program, a person must be eligible for Medicaid and meet the criteria for an institutional level of care. The person must have needs that would make them eligible for admission to a nursing home or intermediate care facility for persons with intellectual or developmental disabilities. There are other eligibility rules which are discussed at length in the federal regulations, but the most basic one is the requirement that persons meet an institutional level of care.

Four states have received permission from the Centers for Medicare and Medicaid Services (CMS) to enact a CFC program: California, Maryland, Montana and Oregon.¹²³ Eight states currently have state plan amendments under review by CMS.¹²⁴

Recommendation 2.3: Alaska should implement the Community First Choice, 1915(k) waiver. The Department should revisit the CFC program through the 1915(k) waiver and submit a Medicaid state plan amendment to CMS to operate a CFC program. Having staff implement new initiatives is always a problem. In the case of CFC, it is more cost effective to hire a staff person to supervise the implementation of the program, than put off implementation of a cost effective program because staff are not available.

¹²⁰ For a copy of final CFC regulations see <http://www.gpo.gov/fdsys/pkg/FR-2012-05-07/pdf/2012-10294.pdf>.

¹²¹ “Activities of daily living” refer to dressing, grooming eating, toileting, bathing and mobility and “instrumental activities of daily living” refer to using a telephone, paying bills, preparing meals, shopping, and transportation.

¹²² See Code of Federal Regulations §441.520 Included services at <http://www.ecfr.gov/cgi-bin/text-idx?rgn=div6&node=42:4.0.1.1.10.11>.

¹²³ PCG staff obtained the CFC state plan amendments of these states and reviewed them.

¹²⁴ See June, 1, 2015 State Medicaid Integration Tracker at <http://www.nasuad.org/initiatives/tracking-state-activity/state-medicare-integration-tracker>.

E. Are there opportunities for the department to reduce the level of funding while maintaining the quantity and/or quality of services provided to clients?

As shown in the cost analysis above, the Department has already made significant funding reductions and it is difficult to see how additional reductions could be made without effecting the quality and quantity of services provided.

Long-Term Care Insurance Partnership Program

The Long-Term Care Insurance Partnership Program (LTC Partnership) is an option to help reduce funding while maintaining the quality and quantity of services. This option will not result in immediate funding reductions, but will create long-run changes. If individuals have insurance policies that cover long-term services and supports then there is less reliance on publically funded programs such as Medicaid.

Beginning in 1992, the LTC Partnership has been a public-private partnership between states and private insurance companies, designed to reduce Medicaid expenditures by delaying or eliminating the need for some people to rely on Medicaid to pay for long-term services and supports. To encourage the purchase of private partnership policies, qualified LTC insurance policyholders are allowed to retain an amount of assets equal to the monetary value of the insurance policy. For example, if an individual purchases a \$100,000 insurance policy that qualifies under the Partnership Program and exhausts that coverage after a stay in a nursing home, then this individual can protect \$100,000 in assets when applying for Medicaid.¹²⁵

The program had substantial federal restrictions on its operations and only four states participated in the program until these restrictions were lifted in 2005.¹²⁶ The program expanded rapidly after 2005 and as of March 2014, approximately 40 states participated in the LTC Partnership.¹²⁷

The 2014 long-term care services and supports (LTSS) report by the American Association of Retired Persons (AARP) found that Alaska ranked fifth in the nation on the overall quality of its LTSS programs.¹²⁸ However, Alaska ranked 49th in the nation on the number of private long-term care insurance policies in effect per 1,000 population Age 40+.¹²⁹ Alaska has an excellent overall program, but ranks poorly on its support of long term care insurance programs.

Other states have found such programs cost effective, which is why over 40 states have initiated these insurances programs.¹³⁰ CMS has approved all these initiatives and there is a standard preprint of the required State Plan Amendment that facilitates submission of the federal paperwork.

¹²⁵ For substantive information about this program see http://www.ahcancal.org/facility_operations/medicaid/Pages/ltcipp.aspx.

¹²⁶ Section 6021 of the Deficit Reduction Act allowed for "Qualified State LTC Partnerships." States with approved State plan amendments (SPAs) could now exclude from estate recovery the amount of LTC benefits paid under a qualified LTC insurance policy. For States that elect this option, the State plan must provide that, in determining eligibility for Medicaid, an amount equal to the benefits paid under a qualified LTC policy is disregarded. The State must also allow, in the determination of the amount to be recovered from a beneficiary's estate, for the same amount to be disregarded. See http://www.ssa.gov/OP_Home/comp2/F109-171.html.

¹²⁷ <http://www.aaltci.org/long-term-care-insurance/learning-center/long-term-care-insurance-partnership-plans.php>.

¹²⁸ See http://www.longtermcard.org/2014-scorecard#.VYQitu_bJ9A.

¹²⁹ Ibid, Exhibit A6, p. 69.

¹³⁰ For example, see the 2014 Connecticut Partnership report to the Connecticut state legislature. http://www.ct.gov/opm/lib/opm/hhs/ltc/annrpt-jan_2015.pdf.

Recommendation 2.4: Alaska should submit a Medicaid State Plan amendment to obtain approval for implementing an LTC Partnership Program.

F. Are there any long-term care programs or services that are not effective or efficient?

PCG has identified two separate programs that do not either (1) operate entirely efficiently, or (2) operate effectively. These programs were both addressed above and are the following:

5. Restrictive nursing facility eligibility assessment criteria for individuals suffering from Alzheimer's and Dementia Related Diseases, and
6. AKPHs unable to recuperate costs from patients at homes.

The restrictive nursing facility eligibility assessment criteria has been addressed at length above, where PCG made a clear recommendation that the state should study changes to the scoring of its assessment criteria. Changes to the scoring of the assessment criteria could potentially have an impact on AKPH reimbursement through impacting the number of AKPH residents found to be eligible for Medicaid waiver services.

This issue needs to be explored in more depth as discussions with state staff indicate that the state does not appear to be getting a full match on its Medicaid costs. The Medicaid rate does not cover the full costs of taking care of a Medicaid client. Either a new Medicaid rate should be established solely for the AKPHs, so a full match can be made on Medicaid costs, or the Department's cost allocation plan should capture the costs of taking care of Medicaid clients not reimbursed through the Medicaid rate. Additionally, PCG suggests the Department undertake a comprehensive revenue maximization review for the Alaska Pioneer Homes.

G. Can best practices be implemented to better position the Department to effectively and efficiently manage the projected growth in demand for long-term care services?

Recommendation 2.5: Annual reassessments should be performed for persons that are receiving PCA services. Currently PCA reassessments have been suspended. Reassessments can be performed for everyone or individuals can be triaged by acuity or age. It is inefficient to continue to provide services to persons who may now need different or fewer services.

In approximately October of 2014, the Department suspended reassessments of persons in the PCA program. This was done in response to difficulties the Department has had around issues of timely assessment. Federal waiver rules require an annual assessment of persons receiving Medicaid waiver services.¹³¹ Reassessment rates are reported to the Centers for Medicaid and Medicare Services (CMS) as part of waiver quality control. Since the use of annual assessments for personal care is not required by CMS,

¹³¹ See 1915(c) application at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/hcbs-waivers-application.pdf>. See section 5 Assurances item C.

the Department’s suspension focused resources on federally required Medicaid reassessments. If it has done so already, the Department should continue to reassess persons receiving personal care. Federal Medicaid had sound policy reasons for requiring annual reassessments. For example, one option could be the restoration of reassessments for selected groups such as persons receiving personal care that are also eligible for nursing facility services, persons with permanent medical conditions (quadriplegic), or persons over the age of 85.

Demand for long-term care services are projected to increase over the next twenty years. PCG was provided with demographic data from the Department for usage of PCA and Medicaid waiver services. The figures below have projected this demand for the next five, ten, and twenty years.

Figure 2.16: Projected Demand for PCA Services¹³²

Alaska PCA Service	2012	2017	2022	2032
Projected PCA Population (Prevalence of 0.73%)	5592	5656	5921	6380
Projected Percent Change in PCA Population	N/A	1%	4.7%	7.7%

Figure 2.17: Projected Demand for Medicaid Waiver Services¹³³

Alaska Medicaid Waiver	2012	2017	2022	2032
Projected ALI Waiver Population (Prevalence of 0.55%)	3162	3148	3285	3550
Projected Percent Change in ALI Population	N/A	-0.01%	4%	8%
Projected APDD Waiver Population (Prevalence of (0.02%)	90	90	94	101
Projected Percent Change in APDD Population	N/A	0%	4%	8%
Projected IDD Waiver Population (Prevalence of 0.22%)	1671	1690	1769	1906
Projected Percent Change in IDD Population	N/A	1%	4.7%	7.7%

Demand for these services was projected by calculating the prevalence of these needs within the population of Alaska. Baseline data was calculated from 2012, since that is the latest population projection released by the Alaska Department of Labor and Workforce Development.

The above figures show a slight increase in demand (prevalence) of individuals needing PCA and Medicaid Waiver Services. However, PCG is aware of the need for the state to provide more robust services for individuals with Alzheimer’s disease and related dementia (ADRD). If Medicaid waiver eligibility is changed to be less exclusionary for individuals with ADRDs, then this projected population would increase. This change in the eligibility could subsequently increase Medicaid nursing facility expenditures.

¹³² PCA demographics provided by the Department of Health and Social Services. PCA population data was compared with the Department of Labor and Workforce Development’s [Alaska Population Projections 2012 to 2042](#) to calculate projections.

¹³³ Medicaid Waiver demographics provided by the Department of Health and Social Services. The Medicaid population data was compared with the Department of Labor and Workforce Development’s [Alaska Population Projections 2012 to 2042](#) to calculate projections.

Recommendation 2.6: The State of Alaska should amend its policy to make waiver eligibility for Alzheimer’s disease and related dementia (ADRD) less of an exclusionary process. The assessment tools used for Medicaid waiver eligibility make it difficult to allow an individual with an ADRD access to Medicaid funds. The state has the power to amend this policy, which will allow better care for individuals suffering from ADRDs. Furthermore, Federal match on expenditures can be utilized by allowing more individuals access to waiver services.

H. Identify best practices and make recommendations to address projected growth in demand for services provided through Alaska Pioneer Homes.

The AKPHs serve an older population. Data obtained on 658 admissions to the AKPHs during the period 2008-2013 shows that the average age on admission was 84 years old.¹³⁴ A review of the total beds in the six homes and the total filled beds shows that the homes have had an occupancy rate greater than 90% since 2008.¹³⁵

The AKPHs have an active and inactive waitlist. Individuals on the active waitlist are ready to move into a home within 30 days of an offer of admission. Individuals on the inactive waitlist wish to move into an AKPH, but are not yet ready to move in within 30 days of an offer of admission. In March 2015, there were 4,729 individuals on the inactive list and 303 on the active list. The inactive waitlist has steadily grown over time. In 2009, there were 2,663 on the inactive list.¹³⁶ The March 2015 active list is approximately the same size it was in 2009.

When interviewed in March 2015, Palmer House officials said their active waitlist had approximately 100 persons on it and their annual turnover in residents averaged from 15 to 20 implying it would take approximately five years before everyone on the current active list would obtain access to the Pioneer Home.

Figure 2.18: Alaska Older Population Projections, 2012, 2022, 2032 below, shows estimates of Alaska population growth by age for coming decades. The population of seniors will expand rapidly especially between July 2022 and July 2032. The leading edge of the baby boomers will turn 75 in 2021-2022 and the following decade will see considerable growth in the populations that require increasing assistance with activities of daily living (ADLs).

¹³⁴ PCG was unable to identify the birth dates of every one entering an AKPH since homes varied in how information was captured and reported. Alaska Pioneer Home transitioned to an electronic health record system, Point Click Care in 2014. Prior to 2014, all data were stored in AccuCare which was not a centralized program. Each home had its own AccuCare program with home specific data.

¹³⁵ Data obtained from the Division of Alaska Pioneer Homes.

¹³⁶ See Alaska Pioneer Homes Advisory Board Report 2012, p. 6 at <http://dhss.alaska.gov/daph/Pages/advisoryboard.aspx>.

Figure 2.18: Alaska Older Population Projections, 2012, 2022, 2032 ¹³⁷

Ages	July 2012	July 2022	July 2032
65-74	71,300	76,355	73,377
74-84	16,427	29,816	56,180
85+	5,448	7,957	15,066
Total	21,875	37,773	71,246

Figure 2.19: Alaska Estimates of Persons Using Residential Services, 2012, 2022, 2032 below shows 2012 results from the National Center for Health Statistics Study of Long-Term Care Providers. ¹³⁸ The Figure projects forward the 2012 results to 2022 and 2032 assuming the 2012 utilization rates are constant and can be applied to 2022 and 2032.

Figure 2.19: Alaska Estimates of Persons Using Residential Services, 2012, 2022, 2032¹³⁹

Ages	Residential Population in 2012	Estimated Residential Population in 2022	Estimated Residential Population in 2032
65-74	191	204	196
74-84	510	926	1744
85+	645	942	1784
Total	1,346	2,072	3,724

The figures above show a population size which increases by 50% in the next ten years and more than doubles the current population by 2032. With a fixed bed count, the AKPHs will not be able to absorb any of this utilization increase. With this increase the state has a clear policy choice. If the state wishes to provide more residential opportunities it can either build an additional AKPH, incentivize the growth of other residential providers, or do both.

Recommendation 2.7: A new Pioneer Home should not be constructed at this time. Over the next decade construction of a Pioneer Home should be considered with the Kenai Peninsula area as candidate area. This home would not need to be constructed right away, as the population will not significantly increase until 2022.

There has been discussion that, because of its population growth, the Kenai area would be a logical place to build a new AKPH. Given the state’s current budget shortfalls this policy choice is not moving forward. The leading edge of the baby boomers will not become 80 years of age and older until 2026-2027. There is

¹³⁷ Population Projections Alaska Department of Employment and Workforce Development.

¹³⁸ See state table for Alaska, Table 2 at http://www.cdc.gov/nchs/data/nsltcp/2012_nsltcp_state_tables.pdf.

¹³⁹ From the National Center for Health Statistics, Study of Long-Term Care Providers.

still time to plan and consider options before this wave of persons has impairments that require 24-hour care such as that provided in a nursing home or AKPH. Outside of nursing homes, other states tend not to own and operate large residential programs. Given the upfront construction costs and ongoing operational costs of an additional AKPH, PCG finds that such a Home should not be built at the present time.

Recommendation 2.8: The Department should expand the use of small privately owned residential programs to gradually add residential capacity for individuals who would meet the AKPH level of care.

It would be fiscally efficient for the state to expand the use of small privately owned residential programs to gradually add residential capacity. An example of an incentive program is Washington's add-on payment to assisted living programs. Since 1995, programs with a high Medicaid occupancy have received an add-on to their Medicaid rate to encourage them to continue to accept Medicaid residents.¹⁴⁰ An increased level of education, recruitment, licensing, implementation support, and ongoing provider training are all useful in identifying and maintaining residential provider capacity. An increase in such activities is more cost effective than the state building a large capital project with large downstream funding commitments.

Recommendation 2.9: The Department should implement a person-centered rate setting system that ties acuity to payment level, allowing higher acuity patients to receive a higher reimbursement.

Recommendation 2.10: An Alaska Pioneer Home should be devoted to become a center of excellence for Alzheimer's disease related dementia (ADRD) services in the state. Since there is a need for AKPH higher level services (Level III) and ADRD services, Alaska would be able to provide better care to individuals with high acuity and issues with ADRDs.

Further efficiency could be achieved at the AKPHs through a more person-centered rate system. Currently, the reimbursement for assisted living homes is not acuity based. This assisted living reimbursement rate is tied to the number of beds in the facility and not related to the characteristics of persons receiving care. The creation of a person-centered rate setting system that ties acuity to payment level would provide the AKPHs higher reimbursement for Level III residents. Other states use acuity considerations in assisted living programs. For example, in Oregon the 2013 Legislative directed state agencies to develop a standardized rate methodology for mental health residential providers that would be person centered and incentivize providers to serve individuals with higher needs.¹⁴¹

I. Identify and recommend best practices that distinguish service needs between seniors and people with disabilities.

Service needs are identified through the use of assessment instruments. These instruments contain a battery of questions designed to obtain information about persons and their social, mental and physical condition.

¹⁴⁰ <https://www.dshs.wa.gov/sites/default/files/SESA/legislative/documents/Capital%20Add-On%20Rate%20and%20the%20Effectiveness%20in%20Incentivizing%20Assisted%20Living%20Facilities%20to%20Serve%20Medicaid%20Eligible.pdf>

¹⁴¹ <http://www.oregon.gov/oha/amh/rtt/Documents/Current%20FFS%20Methodology.pdf>

Answers to the questions on these instruments are used to determine eligibility for Medicaid-paid services such as nursing homes and Medicaid waivers. Tools such as these and other information provided in interviews with individuals and their families provide sufficient information to distinguish the service needs of seniors and persons with disabilities.

Alaska currently uses three assessment tools:

- The Consumer Assessment Tool (CAT) which is used with the ALI waiver;
- The Inventory for Client and Agency Planning (ICAP) is used with persons that have intellectual or developmental disabilities (ID/DD), and
- The CCMC waiver uses a third tool specialized for children.

While these tools have been used for years and are embedded in Departmental technology and practice standards, there is room for improvement in the assessment tools and assessment practices of the Department.

The Consumer Assessment Tool

The CAT is used in the determination of the nursing facility level of care. Persons who qualify for the nursing facility level of care are eligible to receive Medicaid waiver services as well as nursing home services. The CAT is also used to determine the eligibility of persons for services provided through Medicaid's Personal Care Assistance program.

A 2003 Departmental instruction guide states that regarding the CAT, "The language, definitions, and format of the CAT form are similar to that used in the MDS 2.0 (Minimum Data Set) system, which is used in most long-term care nursing facilities."¹⁴² Given its institutional origin, it is not surprising the CAT is weak in areas that are stressed by contemporary health practices which focus on integrated and person-centered care:

- The collection of information useful to screen and refer for substance abuse and mental health needs;
- The collection of family and caregiver information on the range and amount of supports available to the individual;
- The care preference and views of the individual, and
- Environmental conditions e.g. the type of heating used in the individual's home.

Person-centered care has been heavily stressed in contemporary federal legislation such as the Affordable Care Act.¹⁴³ The absence of a person-centered care philosophy is seen in the making of the service plan which is created by assigning uniform number of minutes for each activity of daily living and independent activity of daily living the individual needs help with.¹⁴⁴ For example, a person who is "independent with difficulty" can receive a maximum of 30 minutes a week of shopping help. What if a person lives 30 minutes away from where they can shop?

¹⁴² See "Alaska CAT Instructions" at <http://www.hcbs.org/hcbs/article/alaska-consumer-assessment-tool-cat>.

¹⁴³ See Section 2402(a) of the ACA. For example, see http://www.acl.gov/NewsRoom/blog/2014/2014_07_09.aspx.

¹⁴⁴ See the "PCA Service Level Computation" at <http://dhss.alaska.gov/dsds/Documents/pca/PCA%20Service%20Computation.pdf>.

The use of fixed times was useful in cutting budgets and eliminating variability in the assignment of services to individuals, but fixed time allotments run directly counter to contemporary health practices which emphasize a person-centered care policy. Under a policy that took into account individual needs, the number of minutes would be based on the actual time it took to go shopping.

The CAT will be incorporated into new Automated Service Plan and will be accessible by staff with role-based access privileges to the CAT. For example, care coordinators will be able to review an individual's CAT and update it as necessary.

Inventory for Client and Agency Planning

The ICAP is used to determine the eligibility of persons for the Intermediate Care Facilities/Intellectual-Developmental disabilities (ICFs/IDD) level of care. Persons eligible for this level of care can receive Medicaid waiver services when they are available.¹⁴⁵ The ICAP is not a home-grown instrument like the CAT. A 2006 Rutgers study found it was used in six states.¹⁴⁶

Developed in 1986, the ICAP is designed to be administered in 20 minutes and appears to contain about 100 items dealing with “adaptive” and “maladaptive” behavior, plus other demographic, special needs and supports-related items. One recent reviewer made the following comment about it. “The ICAP has probably been more frequently used as an indirect measure of support needs than as a true scale of adaptive behavior. Its usage has been in decline over the past years and that trend will not likely change unless a refreshed version with updated norms is released.”¹⁴⁷

The ICAP is proprietary and while the state has a copy of the completed ICAPs, the ICAP data cannot currently be queried and individual ICAPs will not be accessible in the new Automated Service Plan program. This is a significant inefficiency.

PCG's Recommendations for Distinguishing Service Needs between Seniors and People with Disabilities

Recommendation 2.11: The Department should modernize its assessment instruments to incorporate person-centered assessment data. This will be accomplished by adopting a single assessment process to determine eligibility for LTSS, allowing a collection of information that will flow into care plan development. The continued use of multiple instruments is administratively inefficient.

The purpose of a core standardized assessment is to improve the efficiency and economy of state LTSS programs. A single assessment process is seen as simplifying eligibility, improving access to services and resulting in a lower administrative burden on states. CMS is not requiring that states have one assessment instrument, rather there needs to be a single assessment document containing information about the person's

¹⁴⁵ There is a wait list for Medicaid ID/DD waiver services. The wait list is called a registry list and as of 6-30-2014 the list had 679 individuals and the average time on the list of the 679 persons was 43 months. See <http://dhss.alaska.gov/dsds/Pages/info/reports.aspx> for annual wait list information.

¹⁴⁶ See <http://www.nasdds.org/uploads/documents/NASDDDS-EligibilityReportFinal.pdf> p. 7.

¹⁴⁷ See Wehmeyer, M., (2013.) *The Oxford Handbook of Positive Psychology and Disability*, Oxford University Press, New York, NY p. 111.

abilities to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs), as well as information about their medical, cognitive and behavioral concerns.

For example, approximately 23 states use the InterRAI MDS Home Care and InterRAI ID instruments and assessment tools such as these could provide the base for a revamped Alaskan assessment tool.¹⁴⁸

Recommendation 2.12: The Department should discontinue the use of the ICAP by replacing it with a tool that is not proprietary. The ICAP is a proprietary tool whose continued use creates ongoing inefficiencies for the Department.

J. Identify and recommend best practices that allow the Department to identify services that are producing quality outcomes for individuals served.

The National Core Indicators (NCI) study enables public agencies who provide developmental disabilities supports to track their progress data. The results of the study are used to assess the outcomes of services provided to the individuals' families. Currently, Alaska is one of nine states not participating in this study. In the future, tracking of this data will be required by CMS. Therefore voluntary enrollment in this program before it becomes mandatory will enable the state to begin obtaining service outcomes data from its residents in order to compare against national benchmarks.

Recommendation 2.13: The State of Alaska should enroll in the National Core Indicators (NCI) study. While the NCI program focuses on persons with intellectual and developmental disabilities, CMS is moving towards implementing similar surveys for use with older persons and persons with physical disabilities. Alaska apparently did not apply for a CMS Testing Experience and Functional Tools (TEFT) grant.¹⁴⁹ The nine states that received such grants have the opportunity to develop consumer experience surveys before CMS mandates their use by state Medicaid programs. Surveys like this, which are currently not done in Alaska, support and help build the kind of person-centered programs that are required in federal health planning.¹⁵⁰ This recommendation is further addressed under *Review Objective 08: Information Technology*.

¹⁴⁸ See <http://www.interrai.org/home-care.html>.

¹⁴⁹ See CMS grant announcement at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/grant-programs/teft-program.html>.

¹⁵⁰ The heavy emphasis on person-directed concepts can be seen in the massive overhaul of New York's Medicaid program. See DSRIP program at https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/.

REVIEW OBJECTIVE 03 – GRANTS AND CONTRACTS

Evaluate DHSS' procurement of home and community-based long-term care services through the use of grants and contracts. Determine whether contracts and/or grants for the provision of long-term care services are being managed to ensure funds are expended effectively, efficiently, and in an appropriate ratio of direct service to administration. Evaluate DHSS' process of solicitation, review, and award of grants and contracts for home and community-based services. Determine whether the system is effective and efficient and whether there is a more effective means of procuring long-term care services for recipients. Recommend best practices to maximize the benefits received by clients and/or improve monitoring and oversight. This should address the following:

- A. Does the Department's grant and contract procurement process maximize the quantity and quality of long term care services delivered to recipients and minimize the administrative costs of such services.**
- B. Does the Department's grant and contract procurement process adequately leverage other funds such as fees, insurance, and matching funds?**
- C. Does the Department's grant and contract procurement process provide for maximum and fair competition, evaluation, and award?**
- D. Does the Department's grant and contract procurement process ensure adequate monitoring and oversight of the quality and quantity of long term care services?**
- E. Do grant and contract provisions promote the efficient and effective use of funds?**
- F. Does Department staff respond timely and appropriately to deficiencies when noted?**

A. Does the Department's grant and contract procurement process maximize the quantity and quality of long term care services delivered to recipients and minimize the administrative costs of such services.

QUANTITY AND QUALITY

Overall, the Department does well in maximizing the quantity and quality of long term services and supports (LTSS) through utilization of effective contracts and spending grant dollars appropriately. However, the Department is not as effective in minimizing the administrative costs of such services as the Divisions vary in their efficiency. All grants and contracts are planned, evaluated, and awarded in conjunction with their respective division(s). In certain cases, there are lapse funds which did not get allocated throughout the year; however the Grants and Contracts Section works to keep these at a minimum. In specific cases, funding requirements may be so strict on available dollars that they are not properly allocated. Certain divisions are better with lapse funds than others. Additionally, when scheduling conflicts arise, the distribution of funds may be hindered. The Division of Senior Disabilities and Services (SDS) is timely and accountable with adhering to requested timelines. This helps to ensure that all funds can be delivered in a timely and efficient manner. This is not the case for all Divisions across the Department.

The Alaska Commission on Aging (ACoA) is charged by statute (Section 47.45.230)¹⁵¹ to develop a four year comprehensive Alaska State Plan for Senior Services for the Department. The plan is a requirement by the US Administration on Community Living for states receiving funds for the Older Americans Act.¹⁵² This plan is developed in conjunction with the State Plan Steering Committee. This committee includes representation from state agencies including SDS, nonprofit senior providers, for profit senior providers, and senior consumers. The State Plan Steering Committee plays a role in defining the State Plan's vision statement; goals, strategies and performance measures, and the intrastate funding formula – which are among the components of state plans required by the U.S. Administration on Community Living.

The intrastate funding formula is used by SDS and the Grants and Contracts Section to determine the regional allocation of federal and state funds for the following senior grant funded programs based on the Department's nine regions. Funds are divided across the following categories:

1. Nutrition, Transportation & Support Services (funds senior home-delivered meals, congregate meals, transportation, and homemaker services);
2. Senior In-Home Grant Program, and
3. National Family Caregiver Support Grant Program.

The Older Americans Act requires state funding plans give preference to seniors with the greatest economic and social need. The funding formula in the draft Alaska State Plan for Senior Services, FY 2016-2019 has six factors including the following:

1. Senior population factor;
2. Poverty factor;
3. Frail factor;

¹⁵¹ <http://codes.lp.findlaw.com/akstatutes/47/47.45./02./47.45.230>.

¹⁵² http://www.aoa.gov/AoA_programs/OAA/.

4. Minority factor;
5. Rural factor, and
6. A cost of living factor.

Statewide grant fund allotments are determined in conjunction with the respective Division that operates under state plan approval. In determining grant amounts, the respective Division in conjunction with the Grants and Contracts Section considers the following factors in parsing out grant dollars:

Number of individual requiring services;

- Minority status;
- Medical frailness standards;
- Rural / urban locations, and
- Cost of Living challenges.

This is not an all-inclusive list and is instead a representative sample of typical and standard considerations.

In addition to the aforementioned considerations, the ACoA and the Grants and Contracts Section distributes funds based on the needs of the nine state regions and the tenth statewide region. The Department's service regions are divided as follows: ¹⁵³

- Region I: Yukon / Kuskokwim Region;
- Region II: Interior Region;
- Region III: Northern Region;
- Region IV: Anchorage;
- Region V: South-central Regional;
- Region VI: Kotzebue / Norton Sound Region;
- Region VII: Bristol Bay / Kodiak Region;
- Region VIII: Aleutian Islands Region;
- Region IX: Southeast Region, and
- Region X: Statewide.

The grants management process was administered separately by each division until about a decade ago when it was consolidated to a single section with the Office of the Finance and Management Services (FMS). The transformation helped to further streamline and create unity across the entire Grants and Contract process. The transformation also helped ensure all Grants and Contracts were procured in a consistent manner with minimal variations across the seven Divisions that are supported by the Grants and Contracts Section.

The ability to have a centralized Grants and Contract Section has reduced the silo effect that previously existed with the Grants and Contract process. Additionally, this process increased transparency across Divisions as they could leverage what worked well in other Divisions that may not have been previously known or privy to. Additionally, as a general trends across all of the Departments Grants and Contracts, the

¹⁵³ <http://dhss.alaska.gov/fms/grants/Pages/default.aspx>.

number of Grants and Contracts awarded has decreased while the total number of dollars has increased. This is largely the result of the consolidation of services from the provider side.

ADMINISTRATIVE COSTS

The Department has significant room for improvement in minimizing administrative costs of Grants and Contracts, as there are no set limits in place to help minimize overall administrative costs. There are currently no regulations that restrict administrative costs in operating grants. All operating grants in the Department follow grant regulations 7AAC 78.010 – 7AAC 78.950.¹⁵⁴ Specific guidelines for administrative and allowable costs payable by the grants are identified in 7AAC 78.160 Costs. These guidelines have been summarized below.¹⁵⁵

(d) A grantee may use grant money to pay the following costs for capital grants:

(1) General construction;

(2) Allowable administrative expenses, as provided in the grant agreement, and subject to (r) of this section;

(r) The Department will specify the amount of administrative and general costs the grantee may charge a capital grant project in the request for proposal, request for letters of interest, or other method of solicitation, and in the grant agreement.

Although this section does detail administrative costs, there are not specific levels defined. This regulation allows for the specification of administrative costs in specific grant agreements, however in conversations with the Grants and Contracts team, this option is rarely exercised. In lieu of itemizing administrative costs by link item, grantees are allowed to use their federally negotiated indirect rate.

Some states require vendors or grantees to limit their administrative costs in the overall budget totals. Administrative cost limits are typically either established as a set dollar limit (depending on a range of the contract size) or as a percentage of the total contract value. Typical administrative percentages range from 7 – 10% of the total contract value. Although this is a common and typical approach for limiting administrative costs, it is easy for vendors to “hide” their administrative costs. Every vendor or grantee may allocate and calculate administrative costs differently, so it is possible for vendors to shift their administrative costs to new areas or buckets. These costs can easily be hidden in labor or supplies costs. It is also possible that vendors may underreport travel costs and may in turn bury these costs again into either a labor or supply bucket.

¹⁵⁴ 7AAC 78.101 – 7AAC 78.950 - http://dhss.alaska.gov/fms/grants/Documents/7%20AAC%2078_10-16-12.pdf.

¹⁵⁵ 7AAC 78.160 - http://dhss.alaska.gov/fms/grants/Documents/7%20AAC%2078_10-16-12.pdf.

Recommendation 3.1: The Department should increase their ability to monitor, track and limit administrative costs for vendors.

Recommendation 3.2: The Department should consider limiting administrative costs during the contracting process. Percentage guidelines constituting a reasonable administrative cost should be considered.

Recommendation 3.3: The Department should further monitor grant and contract budgets to ensure costs are properly allocated across each of the major cost or functional areas. In reviewing bids / budget proposals, the Department may desire to directly compare projected costs to see which vendors potentially may be hiding their costs.

B. Does the Department's grant and contract procurement process adequately leverage other funds such as fees, insurance, and matching funds?

FEES

The Department has taken a widely accepted approach in incorporating fees, insurance and matching funds in the overall Grants and Contracts process.

The Grants and Contract procurement process is not involved with fees. In reviewing the DHSS Fee Book as provided by the Division of Legislative Audit (DLA), the following fees are collected by the Department. The following *Figure 3.1 DHSS Fees* provides additional information regarding applicable fees.

Figure 3.1: DHSS Fees¹⁵⁶

Program	Purpose of Fee	FY 2015 Fee	How are the fee revenues utilized?	FY 2014 fee revenues (in thousands)
AKPH	AKPH Services	Monthly Charges: Level #1 \$2,350.00 Level #2 \$4,260.00 Level #3 \$6,170 .00 Daily Charges: Day services \$70.00 Respite services \$100.00	The revenues from the fees are utilized for division operating costs.	\$ 16,296.9
Rate Review (CON) Process	CON Application Fee	1% of Total Project Cost, minimum of \$2,500 maximum of \$75,000	Fee revenues offset the program expenditures for the CON process.	\$120.8
Health Facilities Licensing and Certification	Biennial Health Facility Licensing Fees: Beginning with the implementation of 7 AAC 12.610(i)(j)(k)(l)(m), the entity or provider shall submit to the Department the fees as outlined in the regulation. An application for a provisional or standard license, or for renewal of a license must be accompanied by the appropriate fee.	No fees were implemented this year.	When implemented, fees were used to offset expenditures incurred by surveyor staff.	\$ -

¹⁵⁶ “Copy of 8 – Fees.” Provided by DLA Sharefile site.

The fees in *Table 3.1* are fairly consistent of typical programmatic fees that are collected in order to support program operations. AKPH fees are further discussed in **Review Objective 02: Delivery and Administration**, but overall these funds are collected and utilized to offset the costs of providing services to residents. The Fees applying to CON applications are further discussed in **Review Objective 05: Certificate of Need**.

Recommendation 3.4: The Department should change the CON application fee to a fee that covers the cost of processing the application. A maximum fee of \$75,000 generates more in revenue to the state than the state incurs in costs to process the application. Please see *Recommendation 5.4* for additional details.

Recommendation 3.5: The Department should consider revising AKPH fee structure to further reflect person centered care so residents are more responsible for the level of services they actually use. Please refer to *Review Objective 02: Delivery and Administration* for additional information.

MATCHING FUNDS

In reviewing the 2015 Grants and Contract Book¹⁵⁷, PCG notes a series of grants that require a matching fund or contribution from the local community or organization in addition to grants that do not require a matching fund. The majority of DHSS grants are funded solely through general funds. The second most common series of grants are funded by the general fund and federal funds. Other sources of grant funding include I/A receipts¹⁵⁸ and Mental Health Trust Authority funds.

Grants that include only General Funds represent the following:

- Adult Day Services - \$1,757,011
- Alzheimer's Disease Resource Agency of Alaska - \$357,118
- Community Developmental Disabilities - \$11,555,795
- Alyeska Vocational Services – \$135,000
- Nursing Facility Transition Program - \$120,000
- Disability Law Center of Alaska - \$150,000
- Senior in Home Services – \$2,917,265
- Senior Residential Services - \$789,500
- Short-Term Assistance and Referral - \$1,020,000
- Traumatic and Acquired Brain Injury Case Management - \$300,000
- Traumatic and Acquired Brain Injury Mini-Grant - \$200,000

Grants with federal receipts in addition to general funds and Mental Health Trust Authority (MHTAAR)

- Aging and Disability Resource Centers and Medicare Counseling and Outreach - \$949,190

Grants with only General Funds and Federal Funds include the following:

¹⁵⁷ <http://dhss.alaska.gov/fms/grants/Pages/default.aspx>.

¹⁵⁸ I/A receipts represent "Inter-Agency" receipts and are representative of funds received from other Departments including but not limited to the Department of Corrections and the Department of Educations. These enumerated amounts represent funds that have not been matched.

- Alaska Mental Health Trust Authority Developmental Disabilities Mini-Grants – \$285,975
- Health Promotion and Disease Prevention – \$150,000
- National Family Caregiver Support - \$1,026,575
- Nutrition, Transportation, and Support Services - \$6,597,152

Grants with General Funds / Inter Agency (I/A)¹⁵⁹ Funds

- Behavioral Risk Management - \$327,990

Grants with Only Inter Agency (I/A) Funds

- Student Living Center Services for the Deaf and Hard of Hearing - \$408,700

Grants with only Federal Funds

- Traumatic and Acquired Brain Injury - \$70,624

Recommendation 3.6: For the following grants, the Department should explore potential opportunities for additional matching funds: the SDS Community Developmental Disabilities grant totaling \$11,555,795 in general funds; the Nursing Facility Transition Program grant totaling \$120,000 in general funds; the Adult Day Services grant totaling \$1,757,011 in general funds; the Alaska Mental Health Trust Authority Developmental Disabilities mini-grants totaling \$285,975 in general funds, and the Senior In-Home Services grant totaling \$2,917,265 in General Funds.

(The total grant figures represent the current grant value, not the potential value.)

The *CDDG* program totaling \$11,555,795 provides funding for services to enhance the quality of life for consumers impacted by developmental disabilities. For all individuals receiving a CDDG, or currently on the waitlist, need to have their Medicaid eligibility checked to ensure all funds are matched to the highest degree possible. Individuals who are Medicaid eligible will help bring additional federal dollars to the program which will offset state general funds. Individuals who are Medicaid eligible, if submitted to Medicaid, will help bring in additional federal dollars to the program which will offset State General Funds.

For the *Nursing Facility Transition Program Grant* totaling \$120,000, there is an additional opportunity to receive additional funds through Medicaid eligibility. This program allows people with disabilities or the elderly to live in the least restrictive setting possible, and integrate into, and participate in their community. Alaska does not currently have a Money Follows the Person opportunity and this may present a good opportunity to operate such a program. The Money Follows the Person (MFP) Rebalancing Demonstration Grant is designed to help states rebalance their Medicaid LTSS systems. According to CMS, over 40,500 people with chronic conditions and disabilities have transitioned from institutions back into the community through MFP programs. The Affordable Care Act of 2010 (ACA 2010) strengthened and expanded the

¹⁵⁹ I/A receipts represent “Inter-Agency” receipts and are representative of funds received from other Departments including but not limited to the Department of Corrections and the Department of Educations. These enumerated amounts represent funds that have not been matched.

MFP program and allowed more states to apply. There are currently forty-four states and the District of Columbia participating in the demonstration.¹⁶⁰

The *Adult Day Services Grant* totaling \$1,757,011 the Department may consider covering additional individuals including the Adults Living Independently (ALI) and the Adults with physical and Development Disabilities (APDD) waiver to receive any additional match on Medicaid funds.

For the *Senior In-Home Services* totaling \$2,917,265 there may be additional match opportunities as well. All individuals receiving funds should be checked for Medicaid eligibility and not simply for Waiver Services. Any individuals who are eligible may result in additional Federal fund matching.

For *Senior Residential Services* totaling \$789,500 in General funds, the majority of residents do not qualify for Medicaid benefits as a result of not passing the Consumer Assessment Tool (CAT) which is used in the determination of the nursing facility level of care. Persons who qualify for the nursing facility level of care are eligible to receive Medicaid waiver services as well as nursing home services. If the CAT tools is adjusted as discussed in *Review Objective 02: Delivery and Administration*, the Department could bring in additional federal match dollars.

Recommendation 3.7: The Department should explore expanding Traumatic and Acquired Brain Injury (TABI) Grant through a Traumatic Brain Injury (TBI) Medicaid waiver. This would allow expansion of the TABI Grant which currently totals \$70,624. This will present an opportunity to potentially expand this program. The Department could pay for the services through a waiver and receive federal match funds for the service provision. The increased federal funding could be used to expand services under the waiver. There is additional room to expand this program by providing case management services. The Department is currently paying \$300,000 in general funds for TABI Case Management services. Additionally, the TABI Mini Grants totaling \$200,000 could further be covered through a waiver service which would help increase match funds. These three services could be better covered through a new TBI Waiver. For additional information please see *Review Objective 06: Cost Collaboration*.

In reviewing additional grant funds as provided by the Department of Health and Social Services include the following *Funded Human Services Community Matching Grant Program for FY 2014*.¹⁶¹ These grant programs are funded using general funds but also require a 30% match from each of the Municipalities / Boroughs (MB) with a population exceeding 65,000. Grants awarded include the following:

- Municipality of Anchorage - \$1,468,623
- Fairbanks North Star Borough - \$491,079
- Matanuska – Susitna Borough - \$343,755

¹⁶⁰ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Money-Follows-the-Person.html>.

¹⁶¹ <http://dhss.alaska.gov/fms/Community/Pages/HSCMG-2012-Funded-Programs.aspx>.

Recommendation 3.8: The Department should consider expanding the *Funded Human Services Community Matching Grant Program for FY 2014* to other municipalities that do not exceed 65,000 in population. This is a good way to meet the needs of additional citizens while receiving additional match funds.

INSURANCE REQUIREMENTS

A review of the insurance requirements of state contracts indicates that the Grants and Contracts unit appropriately leverages insurance resources. PCG received a wide sample of contracts including a large IT contract, a Provider Contract, and Community Supports Contract / Grant. The following contracts and grants were reviewed:

- EIS Replacement Project; Technical Services
 - Deloitte Consulting LLP
- Senior Residential Services
 - Tanana Tribal Council
- SDS Telehealth Reassessment Site Initiation Provider Agreement
 - Draft Contract

In reviewing a sample of contracts, PCG has determined the Insurance requirements in the grants and contracts examples to be both effective and efficient. Contractors are required to purchase at their own expense and maintain in force at all times during the performance of services under the agreement, all of the following policies.

- Workers Compensation Insurance;
 - Covering all employees engaged in work under a given contract;
- Commercial General Liability Insurance,
 - Covering all business premises and operations used by the provider in the performance of services under this Agreement with minimum coverage limits of \$300,000 combined single limit per occurrence;
- Commercial Automobile Liability Insurance;
 - Covering all vehicles used by the Contractor in the performance of services under this agreement with minimum coverage limits of \$300,000 combined single limit per occurrence, and
- Professional Liability Insurance.

Figure 3.2: Contract Professional Liability Insurance Levels

Contract Amount	Minimum Required Limits
Under \$100,000	\$300,000 per Claim / Annual Aggregate
\$100,000 - \$499,999	\$500,000 per Claim / Annual Aggregate
\$500,000 - \$999,999	\$1,000,000 per Claim / Annual Aggregate
\$1,000,000 or over	\$2,000,000 per Claim / Annual Aggregate

These policies were noted in the EIS Replacement Project and SDS Tele health Reassessment contracts. These levels of insurance were not noted in the Senior Residential Services Grant language, however the following language was provided under “Terms and Conditions:”¹⁶²

The Department of Health and Social Services (grantor) and the grantee agree to comply with all applicable laws, the terms and conditions pertaining to the grant and services identified herein and incorporated into this agreement by reference, including 7 AAC 78, the Request for Proposals, the approved grant application, and the items listed below:

- i. Special Conditions to this grant agreement,*
- ii. Privacy and Security Procedures for grantees,*
- iii. All other applicable items as required by the terms and conditions of the documents incorporated into this agreement, which may include but are not limited to: Federal Certifications, Waiver of Sovereign Immunity, and program specific reporting forms.*

In a separately provided Appendix B – Alaska Department of Health & Social Services Grant Assurances additional insurance language is provided. Language is provided below:

*An applicant awarded a grant shall maintain sufficient insurance to hold the State harmless and agrees to: the provision of workers' compensation insurance, for which the policy must waive subrogation against the State; the provision of comprehensive general liability insurance; the provision of liability insurance if automobiles are used for the purpose of this grant program, and the provision of professional liability insurance when applicable to the services performed under the grant.*¹⁶³

The Department is effectively ensuring all grantees are covered by proper insurance limits. Although they are not defined to the same extent of the contracts, the Department is still ensuring sufficient coverage for the State of Alaska through these grant provisions.

¹⁶² DHSS – Grants and Contract – Adult Day Services – 6/26/2014.

¹⁶³ Appendix B – Alaska Department of Health & Social Services – Grant Assurances.

C. Does the Department's grant and contract procurement process provide for maximum and fair competition, evaluation, and award?

The Department has established a fair and effective grants and contracts procurement process that leverages technology and ensures competition, proper evaluation, and award. Contracts are issued and awarded to provide additional labor and support for the Department in addition to procuring new services. Grants are offered in both competitive and non-competitive solicitations. Most Grants begin as competitive RFPs and non-competitive grants are procured using a waiver of competitive solicitation. Grants can be extended through a non-competitive process for an additional one to two years. Proposals with associated funds between \$10,000 and \$100,000 are posted for 10 days while proposals valued at over \$100,000 are posted for a total of 21 days. This delineation gives vendors additional time to write to and apply for the grants and contracts. This is a fair process to the vendors as more expensive proposals typically will require a more thorough and extensive proposal writing period. The Department is operating as a good and fair business partner by giving potential business partners ample time to respond to proposals.

All grants and contracts are planned, evaluated, and awarded in conjunction with the appropriate Division(s). Meetings are held with Division directors and Commissioners in the fall to plan out the overall grant cycle. Funds are delivered from the respective Division after programming is approved. The Division then plans out the ideal program length and dollar limiting conditions prior to receiving authority to release the grant. Following receipt of authority to release a grant, the Division releases the grant, facilitates the solicitation process, and evaluates proposals. Proposals are evaluated based on a pre-determined scoring rubric.

Approximately 90% of grantees received grants for multiple year cycles. Two factors appear to account for this. First, there is a lack of potential grantee organizations especially in rural areas. Second, the state has little reason to change long established relationships especially when providers are performing well.

APPROVAL PROCESS

The overall approval process is summarized below:

- The Commissioner and Grants and Contracts Team (GAC) meet to discuss upcoming grants;
- Through the Grant Award Recommendation and Approval and Evaluation process identifies dollar amounts, scores, ranks and provider locations;
- Recommendations extend from the GAC Team to the Division Director, and finally to the Commissioner for final approval;
- The availability of funds are confirmed, and
- Approved by Commissioner.

EVALUATION PROCESS

All proposals for grants and contracts are evaluated by a Proposal Evaluation Committee (PEC). A typical or standard PEC is composed of Program Managers and representatives from the respective agency or divisions. Program managers are typically selected based on having intimate knowledge of community and provider dynamics. Program Managers are typically more involved in PECs for contracts; however, they are less involved in the PEC for grants. Typically a "lead" Program Manager is assigned to each of the

evaluation processes and the lead manager then is allowed to select the remainder of the PEC in addition to members of the Grants and Contract (GAC) Section.

The PEC only reviews the technical proposals while cost proposals remains blinded. This means that the reviewers evaluate the proposals purely based on technical merit without considering the cost proposal. This eliminates any undue confusion from having opinions clouded as the result of a lower or higher price. Additionally, this process helps to ensure that the best technical proposal is selected and that the State of Alaska receives the best services available. The cost proposal portion of the proposal is revealed later on in the process and is additionally factored into the overall review. Costs are factored in the evaluation as described by the evaluation criteria set forth in each of the Requests for Proposals (RFPs). In converting the cost to point percentage, the Department has implemented an effective calculation that appropriately weighs the lowest cost proposal in comparisons with the submitted proposal. This calculation helps to ensure that the State of Alaska is receiving value with its grants and contracts in addition to receiving the best technical proposal. Combining the best weighted cost with the strongest technical score helps ensure the State of Alaska receives the most services for each dollar spent.

The cost proposal calculation can be found below.

$$\text{Total Points} = \frac{\text{Price of Lowest Cost Proposal} \times \text{Maximum Points for Cost}}{\text{Cost of each higher Priced Proposal}}$$

Recommendation 3.9: The Department should take an active role and recommend changes to minimum requirements for job classes and collective bargaining agreements to permit longer training periods for contract managers. These changes should allow employees to have a complete first year of training prior to allowing them to be a program manager. Seeing the entire grant cycle through for an entire year will help new employees understand and visualize the complete cycle. This will help ensure new employees are properly trained and understand the entire process.

Recommendation 3.10: The Department should implement a stand-alone or carve-out policy for evaluations of proposals that are more subjective in nature. Some procurements are challenging to evaluate within the given constraints. These procurements typically involve work submitted around creativity or media creation. The Department may consider having respondents consider either judging respondents on past work of similar nature. Additionally, the Department may consider not scoring sections based purely on creativity as they are overly subjective and are hard to backup through reviewer scores and notes.

GRANTS ELECTRONIC MANAGEMENT SYSTEM (GEMS)¹⁶⁴

The Grants Electronic Management System (GEMS) provides all-encompassing grant administrative support and is fully operational. The GEMS has been operational for approximately one year and has served as a major improvement to the management system. As expected, there were issues with validation controls

¹⁶⁴ Grants Electronic Management System – (GEMS) <https://gems.dhss.alaska.gov/>.

during the initial launch. Additionally, PCG heard minimal complaints surrounding account log-ins and password re-sets. These are typical issues when having multiple users and are not representative of sweeping system wide issues. GEMs has created a centralized system for grant monitoring and evaluation and has helped to present a streamlined signature and approval process of all employees involved. Commissioners and Directors are able to sign the document electronically which saves time and creates additional efficiencies for all parties involved.

In accordance with the release of GEMs, the Grants and Contracts Section created training and user videos which were widely distrusted prior to release. These videos were praised by the provider/grantee community as a useful resource. Complaints were received surrounding internet bandwidth in rural areas. Limited bandwidth and/or connectivity issues have been noted as presenting issues with the overall use and management of GEMs. These issues will continue to resolve themselves as connectivity continues to improve and become more stable in rural areas.

An additional complaint often noted with GEMs is that the system only runs when connected to a state network. This limits the ability to read a proposal outside of typical working hours. Proposals are typically long and require a high level of attention to detail when reading and reviewing. It would be ideal if readers were able to review and score proposals in other settings in addition to the workplace.

Accompanying the GEMs will be the Integrated Resource Information System (IRIS) system which will host procurement information and solicitations.¹⁶⁵ The IRIS system is set to go live in July of 2015 and trainings have already been offered to bring individuals up to speed prior to the official launch.¹⁶⁶

Recommendation 3.11: The Department should include a user manual to accompany training videos. A physical and web-based manual will help communities in rural areas who may have poor or limited internet bandwidth. A training guide similar to the *DHSS Grant Budget Preparation Guide* would be an improvement to the overall system use.¹⁶⁷

Recommendation 3.12: The Department should update the GEMs system to allow PEC members access to the proposals outside of the state network. To ensure proper security, virtual private networks (VPN) solutions may be considered so all proposals remain private and secure.

¹⁶⁵ Alaska Integrated Resource Information System (IRIS) <http://doa.alaska.gov/dof/iris/>.

¹⁶⁶ Alaska Integrated Resource Information System (IRIS) <http://doa.alaska.gov/dof/iris/schedule.html>.

¹⁶⁷ Grants Electronic Management System <https://gems.dhss.alaska.gov/Home/Documents>.

D. Does the Department's grant and contract procurement process ensure adequate monitoring and oversight of the quality and quantity of long term care services?

MONITORING AND OVERSIGHT

In monitoring ongoing grants and contracts the Department has established a firm structure for ensuring accountability of overall management of the grants. Audits are required at least every two years and in addition to audits, quarterly reports and end-of-year reports are conducted. The quarterly reports ensure that money is being spent according to the contract.

A year-end report is required that monitors the performance and total budget information from the entire year. Persons interviewed commented that the year-end report is currently flawed and does not effectively tell the entire story. Interviewees indicated that the report would benefit from more closely corresponding to the Results Based Budgeting programming in GEMS.

PCG reviewed the Logic Model Performance Measures, Biannual Report Narratives, Quarterly Reports, and Output forms for the following Department Grants:

- Senior In-Home Services (SIH);
- National Family Care Giver Support Program (NFCSP);
- Alzheimer's disease and related dementia (ADRDs);
- Adult-day services (ADS);
- Traumatic and Acquired Brain Injury Mini Grants (TABI);
- Aging and Disability Resource Center (ADRC);
- Senior Residential Services (SRS);
- Nutrition, Transportation & Support Services (NTS), and
- Health Promotion Disease Prevention (HPDP).

In reviewing the logic model, PCG noted that the Department is effectively tracking the proper measures across several grant programs. The logic model has places for "Outcomes/Results, Data Source, Efficiency, Effectiveness, and Goals. These are considered best practices to track for grant programs and are designed to demonstrate the outcomes of given dollars.

The bi-annual report covers major elements of the program and is limited to a pre-selected set of questions that are tailored to each of the grant programs. The questions cover the following topics:

- Did the program meet intended effects?
- Were there any unintended consequences?
- Did the program meet or exceed expectations?
- Did the program demonstrate benefits to consumers?
- Did the program solicit consumer input on services?
- Did the program have a waitlist?
- Was staff trained?
- Was the activity of the program briefly summarized?

These are all logical questions to track for the overall grant programs. The bi-annual report does not cover any funding updates and the Department may consider adding a budget line or question to this section of the bi-annual report. Data from GEMS could reflect this suggestion and need.

Recommendation 3.13: The Department should fix the year-end report to focus further on outcomes and performance metrics as opposed to simply the dollar amounts spent or tasks accomplished. An annual report that focuses on the value driven by the contract and the outcomes that resulted will tell a much stronger story than simply reporting dollar amounts spent and whether timelines were met.

Recommendation 3.14: The Department should provide proper contract and vendor management training to all Department contract managers. This training should ensure managers are adequately and properly trained in contract management. While some training is in place, staff would benefit from a more intensive program. In addition, in all cases staff workloads should be considered and monitored to ensure all managers have appropriate bandwidth to handle additional contract management tasks.

E. Do grant and contract provisions promote the efficient and effective use of funds?

Overall, the grants and contract provisions work in unison to ensure funds are used both efficiently and effectively. The Grants and Contracts teams work well in ensuring that all grants and contracts are properly allocated and delivered to the most ideal recipients. Additionally, the Grants and Contracts team works well in ensuring all grants are properly monitored. There are small areas where the Department can improve their overall provisions. These areas focus on administrative costs, increased use of performance measures, and additional areas for increased matching funds.

In reviewing performance measure framework, PCG noted the Department consistently tracks the following:

- Resources;
- Activities;
- Outputs;
- Outcomes/Results;
- Efficiencies, and
- Effectiveness.

In reviewing the outcomes / results and the corresponding efficiencies and effectiveness measures, it can be noted the Departments grants team is conducting a thorough review of the outcomes measure. The efficiency and effectiveness calculations are detailed to the extent that the measures can be effectively tracked without being overly burdensome.

As an example in reviewing the Logic Model and Performance Measure Frame Works for the Health Promotion Disease Prevention grants, the following is tracked:

- **Outcomes / Results**

“Increase the number of evidence-based Health Promotion Disease Prevention (HPDP) activities available to seniors.”

- **Efficiency**

Average cost to provide HPDP per activity (intervention) (Grants funds only)

Grant Award amount =

of activities

- **Effectiveness**

of evidence based HPDP activities (interventions) available for seniors (Total # from July 1st – June 30th)

Recommendation 3.15: The Department should consider adding in a simple dashboard into the process that visually demonstrates tracking of program goals and percent completion. Although it is often hard to track exact qualitative measures, simple graphics demonstrating percent completion are useful to ensure all grantees are on track. Grant measures and outcomes are often complicated and having a simple tracking measurement will go a long way in tracking progress.

Recommendation 3.16: The Department should consider additional performance measures to the overall reporting structure. This will help further ensure that funds are spent in the most appropriate manner.

F. Does Department staff respond timely and appropriately to deficiencies when noted?

DEFICIENCIES

Grants are monitored through a standardized template and timeline. The “check-ins” typically occurs on a quarterly basis. The Alaska Grants Electronic Management System (GEMS) is used to track and monitor grants. The system spans the entire life of the grant/contract period for initial to close out and all steps in between. GEMS can be and is typically used to both identify and track potential deficiencies.

Grantee are required to submit multiple tracking and monitoring reports through GEMS that are reviewed and approved by both the Grants Administrator (GA) and Program Manager (PM). Reporting requirements vary on a program by program basis, but quarterly reports generally include the following:

- Consolidated Fiscal Report
 - Reporting of expenditures
- Program Narrative – Description of ongoing activities and any issues that have occurred during the past quarter
- Service Utilization data

- Numbers served and units of service,
- Consumer demographics
- Other Data Points

Once reports are approved by both the Grants Administrator (GA) and Program Manager, they are either approved or denied and sent back to the grantee. When a report is not approved, grantees do not receive their advance. For grantees in which a deficiency is noted, they are typically contacted by either the GA or PM and typical deficiencies are resolved with simple clarification. Common deficiencies include not spending or allocating all funds or not submitting reports. For persistent deficiencies or grantees, the grantee will not receive their upcoming payment and will instead receive a notice of correction from the Program Manager. All reporting requirements are listed in the original grant agreement which is the system of record throughout the grant process.

At least one time per grant cycle (typically every three to four years), the Project Manager will evaluate the program through an on-site visit (as funding allows). The PM typically evaluates the program and provides feedback through the SDS Site Review format. If any deficiencies are noted, the PM indicates them in a plan of correction and submits it to the grantee. Of the 140 grants typically managed each year, there are generally 10 grantees who have an ongoing resolution with deficiencies.¹⁶⁸ There have been instances where the Grants and Contracts Section has recouped funds previously delivered.

Per interviews with Grants and Contracts staff, there are no formal Policies and Procedures on how and when to follow up on deficiencies. Historical precedence has given Program Managers discretion in handling these issues. The wide differences between the grantees in their staff size and experience implies each deficiency must be considered separately. This also means that each situation must be assessed differently and an assessment must be made before a Plan of Action can be issued.

Recommendation 3.17: The Department should develop formalized policies and procedures for handling deficiencies. These policies can be tailored based on grant size and / or provider numbers.

Recommendation 3.18: Formalized timeframes should be developed for the issuance of deficiencies.

¹⁶⁸ Grant deficiency is when an organization is not fully complying with the terms of the grant.

REVIEW OBJECTIVE 04 – BUDGET REDUCTIONS

Determine if DHSS' proposed long-term care related budget reductions are supported by the performance review, including whether DHSS complied with AS 44.66.020(c)(2) when proposing cuts to long-term care services. Compare the agency's priorities submitted to the legislature under AS 37.07 with the list of long-term care programs identified for reduction. Identify any areas in which the reductions are not aligned with service priorities and include a rationale for conclusions. This should address the following:

- A. Do the proposed reductions represent a good faith effort by the Department to identify long-term care related areas that can be reduced without compromising the Department's ability to meet its mission in regard to long term care?**
- B. Are the reductions recommended by the Department in response to AS 44.66.020(c)(2) consistent with results derived from the review of each applicable objective within this Scope of Work?**
- C. Did work on any of the objectives within this SOW reveal other potential areas that could be subject to a budget reduction without inhibiting the ability of the Department to fulfill its mission in regards to long term care?**

DHSS compliance with AS 44.66.020(c)(2)

To review the questions the legislature asked us to address, PCG reviewers first examined the Department's compliance with budget reduction requests. As described by persons interviewed, under the authority of AS 44.66.020(c)(2), the legislature repeatedly requested a list of budget reductions that would total 10 percent of the Department of Health and Social Services (DHSS) unrestricted general fund (UGF) budget.

AS 44.66.020(c) states, the agency being reviewed that year will, prior to November 1, provide:

(2) a list of programs or elements of programs that compose at least 10% of the general funds in the agency's budget appropriated from the general fund that could be reduced or eliminated; the agency shall consider first those programs or elements of programs that

- 1. Do not serve a current need;*
- 2. Are not authorized by the Constitution of the State of Alaska or the Alaska Statutes; or*
- 3. Are not essential to the agency mission or delivery of the agency's core services;*

In early November 2014, the Department responded to the initial legislative request saying:

The DHSS human service programs and associated elements funded by general funds through the appropriation process are supported through the State Constitution under Article 7; Sections 7.4 Public Health and 7.5 Public Welfare, in addition to being delineated by numerous Alaska State Statutes. Therefore, the Department would not identify reductions or eliminations of programs or elements of programs. Such proposed changes would need to be identified through the legislative process with the Department implementing those changes.

After additional requests on January 7, 2015 and then again on February 11, 2015, the Department provided a list of approximately \$50 million in UGF reduction suggestions. The Governor's amended budget for FY 2016 indicates that in FY 2014, the Department expended approximately \$1.175 billion in UGF.¹⁶⁹

PCG believes that the Department was not in compliance with 44.66.020(c)(2) in three respects:

1. The 10% suggested reductions in UGF were not made timely despite the fact that the Department had ample time to prepare them before November 1, 2014.
2. The Department was incorrect in its assertion that "...proposed changes would need to be identified through the legislative process..." since the plain language of AS 44.66.020(c) explicitly authorizes the legislature to request the information from the Department.
3. When the list of requested reductions was presented to the Legislature, the list did not contain suggestions adding up to 10% of the Department's UGF.

¹⁶⁹ See OMB's Department summary at https://www.omb.alaska.gov/ombfiles/16_budget/HSS/Amend/16depttotals_hss.pdf.

A. Do the proposed reductions represent a good faith effort by the Department to identify long-term care related areas that can be reduced without compromising the Department’s ability to meet its mission in regard to long term care?

GOOD FAITH EFFORT

With qualifications, the reductions eventually received by the Legislature in February represent a good faith effort despite not being in compliance as previously mentioned. In keeping with AS 44.66.020(c)(2)(C), the proposed reductions represented a *good faith* effort because the Department identified long-term service and supports that could be reduced without compromising the Department’s ability to meet its mission in regards to long-term care. The Department proposed reductions that did the least damage to its major programs.

Alaska state statutes contain 530 references to *good faith* and at least four definitions of *good faith*.¹⁷⁰ These definitions are:

1. AS 34.03.360. Definitions.

Good faith means honesty in fact in the conduct of the transaction concerned;

2. Sec. 09.65.160.

“For purposes of this section, the presumption of *good faith* is rebutted upon a showing that the employer or former employer

(1) recklessly, knowingly, or with a malicious purpose disclosed false or deliberately misleading information”;

3. Sec. 23.10.699.

(6) *Good faith* means reasonable reliance on fact, or that which is held out to be factual, without the intent to deceive or be deceived and without reckless or malicious disregard for the truth;

4. Sec 45.25.990¹⁷¹

Good faith means honesty in fact and the observation of reasonable commercial standards of fair dealing in the trade;

These three definitions imply that *good faith* is the presentation of information believed to be true and offered in a way that is not intended to deceive the entity receiving the information. The initial November 2014 response of the Department, while not compliant with statute, was a clear, non-deceptive statement that the Department would not cooperate with the Legislature. The February 25, 2015 letter accompanying

¹⁷⁰ See search results at <http://www.legis.state.ak.us/basis/Search.asp?session=29&search=good+faith>.

¹⁷¹ <http://www.touchngo.com/1glcntr/akstats/Statutes/Title45/Chapter25/Section990.htm>.

the reductions clearly stated they were taken from the Governor's 2016 amended budget and no claim was made that they added up to 10%.

The qualifications that PCG makes to its observations are that:

- The Department never created a list of 10 per cent reductions for the Legislature. The proposed reductions appear to have been prepared in response to the new Governor's request for 5% and 8% program reductions and then recycled to the Legislature in response to its request for a 10% reduction list;¹⁷²
- The total amount of proposed reductions is well below the 10% required in statute;
- Half of the proposed reductions are unspecified, and
- The DHSS intent is to cover AKPH staffing reductions by an 8.5% increase in resident fees. This increase in fees will offset the requested reduction amount.

B. Are the reductions recommended by the Department in response to AS 44.66.020(c)(2) consistent with results derived from the review of each applicable objective within this Scope of Work?

THE REDUCTIONS

Figure 4.1: Direct Impact on LTSS of February 2014 Proposed Reductions on the following page indicates that approximately \$4,200,000 in budget reductions has a direct effect on seniors and persons with disabilities. A review of each proposed impact shows that the cumulative consequence is not strong enough to compromise the Department's ability to meet its mission in regards to LTSS programs, although the reductions would have a proportionate impact on some programs. A crosswalk of these reductions to the priorities of the Department indicates that all of these are linked to priorities.

¹⁷² See <http://gov.alaska.gov/Walker/press-room/full-press-release.html?pr=7049>.

Figure 4.1: Direct Impact on LTSS of February 2015 Proposed Reductions¹⁷³

Program	Component	Type of Reduction	Amount of Reduction
Alaska Pioneer Homes	Management staff reductions	2 positions	\$240,700
Alaska Pioneer Homes	Staffing reductions	17 positions	\$1,673,400
Public Health	Health Planning & Systems	Provider loan repayments and Senior Center grants	\$136,600
Public Health	Community Health Grants	Reduction of community health aide training grants	\$82,700
SDS	SDS Administration	Savings from Automated Service Plan (ASP) program	\$579,600
SDS	General Relief/Temporary Assistance	Reduction of benefits	\$789,800
SDS	Senior Community Based Grants	Reduce grants for multiple programs	\$33,600
SDS	Community Developmental Disabilities Grants	Reduce habilitation funding	\$506,700
SDS	Senior Residential Services	Planning grant reduction	\$200,000
Total Direct Impact on LTSS Services			\$4,243,100

Major reductions the Department proposed included the following:

Staffing reductions – Alaska Pioneer Homes

Because 80% of AKPH general fund expenditures are related to personnel, any significant AKPH reductions would have to come from personnel. Finding large amounts of savings from contracts or commodity purchases is not reasonable. After presenting its reduction concepts in February, the Department is seeking to restore the \$1,673,400 in staffing reductions by raising the amount that AKPH residents are charged for their services. The 8.5% fee increase proposed is detailed in the March 19, 2015, *DHSS Change Record Detail*.¹⁷⁴ If Legislative intent is to make a permanent reduction in total fund base expenditures, then the series of budget actions around the \$1,673,400 staffing reduction is not consistent with that intent

¹⁷³ Proposed reductions provided by DHSS.

¹⁷⁴ See page 4 of March 19, 2015 DHSS Change Record Detail.

since base total fund expenditures would remain level. If Legislative intent was to make a reduction in UGF, the series of budget actions is consistent with that intent since UGF would be reduced.

General Relief Assistance Reductions

General Relief Assistance expenditures currently total approximately \$8.1 million general fund dollars. A reduction of \$789,000 is close to ten percent of the program. Currently approximately 565 persons receive assisted living services through the program which pays \$70 a day for assisted living services. This reduction would mean the loss of a full-year of services for about 30 persons.¹⁷⁵

Community and Development Disabilities Grant Reductions

SDS annual expenditures are close to \$14 million for Community and Developmental Disabilities Grants. A reduction of \$506,700 will affect services and might reduce the number of persons served. This amount was chosen because it represents the discretionary funds in the Grant program. The Department’s documents indicate the reduction might also impact the Short Term Assistance and Referral (STAR) program which provided funding for 12 STAR coordinators throughout the state who assist individuals and families access necessary services.¹⁷⁶

Senior Residential Services Program Reductions

The Senior Residential Services program currently supports three rural assisted living programs in Tanana, Galena, and Dillingham. The reduction of \$200,000 is the elimination of planning grant funding for expanding the program. It is not a cut to current support levels for the three programs.

Figure 4.2: Potential Impact on LTSS of February 2015 Proposed Reductions

Program	Component	Type of Reduction	Amount of Reduction
Medicaid	Health Care Medicaid Services	Cost containment initiatives	\$20,000,000
DHSS	Agency Wide	Unallocated cuts	\$4,800,000

There are also approximately \$20 million in unspecified reductions which could have a potential impact on LTSS services. *Figure 4.2: Potential Impact on LTSS of February 2015 Proposed Reductions* above outlines these reductions. In its legislative response of February 25, 2015, the Department did not provide detail on what the initiatives are or how the unallocated reductions would be assigned to components of the Department. Presenting a list of reductions, but having half of all the suggested cutbacks come from two large unspecified areas is not fully responsive to the Legislature’s request for a “list of programs or elements of programs” since program-level reductions were not specified.

¹⁷⁵ See page 162 of March 19, 2015 DHSS Change Record Detail.

¹⁷⁶ See page 167 of March 19, 2015 DHSS Change Record Detail.

The Department also proposed \$4.8 million in reductions to the Senior Benefits Payment Program. This program provides cash payments of \$125, \$175, or \$250 each month depending on the individual's income. While not an LTSS service, these reductions will have a direct effect on seniors with lower income. The savings come from an approximate 20% reduction to the two lower pay levels of the Senior Benefits Program which is based on an overall caseload of 5,932 participants receiving \$125 monthly with an additional 3,890 participants receiving \$175 per month.¹⁷⁷

The full list of \$50 million had other reductions that may not have an impact on LTSS programs

It appears the Department's strategy was to protect its major LTSS programs by:

- Protecting services to persons who are most impaired i.e. those who meet a nursing facility level of care;
- By not making reductions to nursing facility reimbursement;
- Not closing any AKPHs;
- Leaving waiver and personal care in-home services intact;
- Making only minor cuts to residential services;
- Making as many administrative reductions as it could;
- Using reductions based on anticipated savings;
- Cutting a large cash payment public assistance benefit;
- Making cuts to as few programs as it could, and
- Promising that \$25 million or 50% of the reductions would come from unspecified cost containment initiatives.

Recommendation 4.1: A provision of additional details surrounding the list of reductions should be made. Having half of all the suggested cutbacks come from two large unspecified areas is not fully responsive to the Legislature's request for a *list of programs or elements of programs* since program-level reductions were not specified.

C. Did work on any of the objectives within this SOW reveal other potential areas that could be subject to a budget reduction without inhibiting the ability of the Department to fulfill its mission in regards to long term care?

The list of reductions presented is consistent with the information learned in the performance review. The need for more federal matching funds is apparent in considering ways to minimize general fund expenses. Two of the proposed budget reductions are to programs that could obtain more federal funds using the 1915(i) state plan authority. Both the Community Developmental Disabilities Grant Program (CDDG) and the General Relief/Temporary Assistance program need to be thoroughly scrutinized for their applicability to a 1915(i) Medicaid state plan amendment.

¹⁷⁷ Average age in the program is 75 years of age. See March 19, 2015 DHSS Change Record Detail. pp. 104-105.
https://www.omb.alaska.gov/ombfiles/16_budget/HSS/Amend/16crdetail_hss.pdf

The promise of unspecified cost containment initiatives is an understandable action given the uncertainty of realizing savings in FY 2016. While not compliant with Legislative requests, promising unspecified cost containment efforts is consistent with the information collected during the performance review. As stated in this performance review, the Department has in recent years operated its LTSS programs more efficiently.

Figure 4.3 Comparison of Long Term Service and Supports Expenditures in FY 2013 and FY 2014 to FY 2010 Expenditures shows expenditures for 2010, 2013 and 2014 in the personal care assistance and waiver programs and the change from 2013 to 2014 after the reforms initiated in 2012 and 2013.¹⁷⁸ Combining these totals indicated a far greater reduction than the requested 10%.

Figure 4.3: Comparison of LTSS Expenditures in FY 2013 and FY 2014 to FY 2010 Expenditures¹⁷⁹

Program	FY 2010	FY 2013	FY 2014	Percent Change from 2013 to 2014
Persons with Intellectual and Developmental Disabilities	\$100,554,597	\$145,331,255	\$137,469,178	-5.41%
Adults with Physical Disabilities	\$28,943,737	\$13,724,066	\$7,603,867	-44.59%
Alaskans Living Independently	\$41,844,462	\$83,782,806	\$66,653,032	-20.45%
Personal Care Assistance	\$94,276,628	\$125,786,076	\$102,565,934	-18.46%
Total	\$265,619,424	\$368,624,203	\$314,292,011	-14.74%

Since FY 2015 data are not available yet, the extent of reductions from FY 2014 to FY 2015 is not known. Department staff has an estimate that PCA spending will drop from \$102 million in FY 2014 to \$92 or \$93 million in FY 2014, approximately a 10% decrease.

Given that the spend rate for LTSS-related waivers and PCA in FY 2010 prior to the administrative reforms was \$265.6 million, it is conceivable that additional savings could be found in FY 2016.¹⁸⁰ However, an anticipated spending of \$93 million by PCA in FY 2015 would restore spending levels to FY 2010 levels. Moreover, these additional savings would have to come from reductions in the number of persons using services since the increase in the units of service provided is flat from 2010 to 2014 at approximately 27 million units. The large increases in the number of units of service provided in 2012 and 2013 were “walked back” by 2014 to FY 2010 levels.

Because two years of savings have already been realized there are difficulties in making further reductions in FY 2016. Current expenditures are now substantively lower than they were in FY 2013. Given the

¹⁷⁸ When interviewed, various DHSS staff expressed difficulties in relying upon MMIS claims data. PCG has been reassured by the Director of SDS that the data PCG has been given can be relied upon.

¹⁷⁹ Expenditure data provided by DHSS.

¹⁸⁰ Data for the Children with Complex Medical Conditions waiver is not included in these totals.

uncertainty of additional LTSS savings in FY 2016, is it understandable that the Department choose to put unspecified cost containment measures on the reductions list.

Performance reviewers have not suggested further budget reductions. However, this performance review has made recommendations which imply that further cost savings are possible. These savings suggestions are in form of revenue maximization. For example, reviewers have commented upon the use of provider taxes, the use of new federal authorities and grant programs, reviews of contracts, and tightening of fraud and abuse procedures.

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REVIEW OBJECTIVE 05 – CERTIFICATE OF NEED

Determine whether the Certificate of Need (CON) process can be improved or better utilized to expand access to services in high need and underserved areas, and if so, identify best practices to revise the process to expand access to necessary services while maintaining the quality of services. This should address the following:

- A. Does the CON Process effectively address the need for services?**
- B. Does the CON process efficiently address the need for services?**

A. Does the CON Process effectively address the need for services?

B. Does the CON process efficiently address the need for services?

CON PROGRAM SUMMARY

The Alaska Department of Health and Human Services (DHSS), Division of Health Care Services (HCS) administers a CON designed to address demands for growth and expanded access to lower-cost services in hard to serve areas of Alaska. The state of Alaska exhibits significant geographic and cultural diversity which presents additional challenges in delivering responsible and cost effective health care to all citizens. Alaska's CON program is designed to promote responsive health facility and service development, rational health planning, quality health care, and access to care.

The CON process is designed to help contain unnecessary healthcare expenditures through the use of a certificate that demonstrates the need for additional healthcare services. The application is designed to prevent excessive, unnecessary, or duplicative development of facilities or services. Additionally, the CON process ensures that the public is able to comment on the project and that it fits the required continuum of care needs. The review process involves a review of plan narratives, all relevant utilization data, and architectural designs to expand or remodel facilities. A key component of the CON process is that public comments are incorporated into the development and approval of a facility. Ongoing population growth and increasing services needs mandate that new and expanded services be planned properly to get the highest quality and most appropriate services at the lowest cost.

There has been a long standing debate over CON programs in the US. After a 1974 federal law requiring all states to have certificate-of-need programs was repealed in 1986, 14 states removed these programs; however, Alaska in addition to 35 other states still operates a CON program.¹⁸¹ CONs were originally designed as a cost control device in order to eliminate unnecessary duplication of services that can increase costs. Roemer's Law states "a built bed, is a filled bed, is a billed bed."¹⁸² This law is based on a study by the UCLA School of Public Health. This study proved Roemer's Law by finding a positive correlation between the number of short term hospital beds available per 1,000 population and the number of hospital days used per 1,000 population. This implies that if healthcare facilities were constructed in a free marketplace, they could run less efficiently by allowing individuals to stay, increasing census to generate revenue.

CON opponents typically argue that facilities developed in the free market will increase competition, keeping prices low. Additionally, CON opponents tend to argue there is limited direct proof that CON programs actually control health care costs. From an economic standpoint, reduction in supply may reduce competition between facilities and will instead drive costs up.¹⁸³

The Department's Office of Rate Review sets rates using a cost based approach as opposed to using a Diagnostic Related Group (DRG) formula which means that the Department and the overall Medicaid program is more subject to increased facility costs and these costs will ultimately be included in the cost

¹⁸¹ See National Conference of State Legislatures <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>.

¹⁸² See Governing.com <http://www.governing.com/topics/health-human-services/The-Pros-of-Cons.html>.

¹⁸³ See National Conference of State Legislatures <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>.

reports. Because the Office of Rate Review does not rely on fixed payments for defined services, overall Medicaid rates are more affected by the increased costs resulting from new facilities.

CON PROGRAM FINDINGS

Effectiveness

Overall, Alaska is in greater need of operating a CON program compared to other states due to the unique geographic challenges the state faces. Thus the CON is a necessary tool in the State of Alaska, especially in areas where economic competition is limited. From a holistic sense, the CON process is effective in addressing the need for services in rural areas. The CON process is effective at reaching its desired goals of ensuring there is a required need before building new or renovating existing healthcare facilities. The CON process is effective in addressing the need for services in rural areas; however the effectiveness is more limited in urban areas as economic competition plays a larger role. Additionally, the CON process adequately allows for public input into the process and has built in a letter of intent process for individuals who may want to submit an application proposing an activity that is similar to the activity proposed by the application in the geographic area. Alaska has a minimum CON expenditure limit of \$1 million which has currently capped out at \$1.5 million due to annual increments. There are no additional regulations allowing for additional increases to allow for inflation.

Additionally, because CON are designed to determine whether additional healthcare services are needed. This need is based on submitted utilization data, and this data must be properly vetted. Due to limitations resulting from Medicaid Management Information System (MMIS) technology issues, utilization data is regularly called into questions. Although PCG is not tasked with reviewing this data, it must be stated that inconsistent utilization data limits the CON's ability to effectively determine additional need for services. In determining how well the program works as a whole, the program can only be as efficient as the data it captures and how this data is regulated. CON application review criteria contains loopholes which may require adjustments and when closed will help increase overall application efficiency. Overall the CON process works well in promoting responsible health facility and service development despite significant geographic and cultural diversity across the state of Alaska.

Efficiency

From an overarching efficiency standpoint, the CON process is efficient in addressing the need for services; however there is room for improvement. The application itself is a major cause of inefficiencies in the overall process. There are multiple areas of redundancies built into the application, which could be removed to streamline the application process. Additionally the application itself is 37 pages long, is not web based, and was last updated in 2005. If the application were to be reviewed and the redundancies removed, it would be easier for an applicant to complete the CON, and for the reviewer to review it. For additional details on the format of the application itself, please see *Appendix 02: Certificate of Need Application (Summary of Sections)*.

In a typical year, the CON team housed in the HCS received three to five applications annually. Compared with peer states with smaller populations, this is a relatively similar number of applications. Additionally, in looking at the overall application and review period, the process can take an extended period of time. In

reviewing a new application, HCS has up to 30 days to certify the application as complete. Next, HCS has 60 days to review the application and may extend the period an additional 60 days to allow for receipt of additional applications based on public notice. Finally, after the review process is complete, a recommendation is passed along to the commissioner who then has an additional 45 days to make an announcement. The total period may extend up to 195 days.

Overall the CON process is efficiently operated but has room for improvements in the application and review process.

CON PROGRAM GOALS

The CON review process is designed to ensure that all applications fit well within the continuum of care, and that the project will meet the public need while preventing excessive, unnecessary, or duplicative development of facilities or services. The CON is used to promote responsive health facility and service development, rational health planning, healthcare quality, access to health care, and healthcare cost containment.

Program Elements

The CON process includes an application packet, a formal review process, a public comment period, and a reward period. The application review process involves an evaluation of plan narratives, relevant data, and architectural designs to remodel, expand or build health care facilities and/or add new services. For each application review period, a time period is assigned for public comments and if requested, a public hearing. Public comment periods and hearings are designed to give local consumers a chance to present their perspective and to help determine need of the requested services.

CON Application Packet

The CON process currently has an application packet that was last updated in December of 2005. The packet includes all information, instruction and forms necessary to prepare an application. If requested, applicants may also schedule a pre-application conference in preparation for completing the application. Please see *Appendix 02: Certificate of Need Application (Summary of Sections)* for a more detailed breakdown of the application.¹⁸⁴ Additionally, please see *Appendix 03: Alaska Certificate of Need Review Standards and Methodologies* for a detailed breakdown of the formal review standards.¹⁸⁵

CON REGULATIONS AND STATUTE

The regulations governing the CON process 7 AAC 7 were last updated in August of 2010. The Regulations effectively define which facilities are required to submit a CON application. The regulations also define an office of private physicians and state it cannot be “otherwise a health care facility.”¹⁸⁶ The language of the regulations is porous and allows wiggle room creating the opportunity for offices of private physicians to acquire facility-like services such as lab and x-ray, while retaining certification as an office of private

¹⁸⁴ <http://DHSS.alaska.gov/dhcs/Pages/CertificateOfNeed/CON-Application-and-Standards.aspx>.

¹⁸⁵ <http://DHSS.alaska.gov/dhcs/Pages/CertificateOfNeed/CON-Application-and-Standards.aspx>.

¹⁸⁶ <http://www.DHSS.alaska.gov/dhcs/Pages/CertificateOfNeed/CON-Statutes-and-Regulations.aspx>.

physicians. This language could be further strengthened in the regulations to help close the loophole the offices of private physicians may exploit in not wanting to complete a CON application.

The regulations pertaining to the section of determining the value of space that is covered by a lease appears to have an incorrect or outdated definition of *net present value*¹⁸⁷ (NPV). This definition improperly factors in the age of the asset and allows providers to take advantage of another loophole in the depreciating of their entire asset. Additionally the regulations permit individuals who are considering whether to undertake an activity involving the construction or modification of a healthcare facility to submit a written request for a determination as to whether a CON application may be required. The Department will send a written notice of determination to the interested individual stating whether:

- A CON application must be submitted and approved before the proposed activity may begin, and
- The requester may seek reconsideration under 7 AAC 07.033 of the Department's determination.

If the department determines that a CON is not required, the requester may proceed with the proposed activity. Before an applicant for a CON need submits an application, the Department will, if requested by the applicant, or on its own initiative, schedule a pre-application conference to provide guidance and technical assistance regarding the application process.

Per AS 18.07.031 the minimum expenditure was set at \$1,000,000 or more for having to complete a CON application. Beginning in July of 2005, the threshold increased annually by \$50,000 until July 2014. This annual increase in the threshold limit has halted at \$1,500,000 for perpetuity per statute.

The CON program both captures public input and notices the public of new receipts of applications. When the Department receives an application for a certificate of need under 7 AAC 07.040 the Department will publish notice in at least one newspaper of general circulation in the state and on the Alaska Online Public Notice System established under AS 44.62.175. The notice states that any person planning to submit an application for a similar activity in the same proposed areas must submit an application so the Department is able to conduct concurrent reviews of both applications.

In reviewing applications, the Department will review each complete application using the standards of AS 18.07.041 or AS 18.07.043 and the standards and methodologies adopted by reference in 7 AAC 07.025. When the Department's review is completed, the Department submits its analysis and recommendation to the Commissioner within the time standards allowed under AS 18.07.045, including any of the following:

- Deferment under AS 18.07.045; or
- Extension granted under AS 18.07.045.

After an application has been certified as complete (which must occur within 30 days of application receipt, the Department has an additional 60 days to submit an analysis and recommendation to the Commissioner. Additionally, the Department may defer commencement of the review process for a period of up to 60 days after certification of a complete application in order to receive and consider concurrent applications from each person who has submitted a letter of intent to submit an application proposing an activity that is similar

¹⁸⁷ Net Present Value (NPV) is an accounting calculation that compares the amount invested today to the present value of future cash receipts from the investment. [Accounting Coach](#). 2015.

to the activity proposed by the application in the geographic area.¹⁸⁸ Additionally, the Commissioner may extend the time periods set out in this section for not more than 30 days for any of the following reasons:¹⁸⁹

- The applicant amends the application under this chapter;
- The Department requests an extension of time within which to prepare its findings and recommendations on the application; the Commissioner may grant only one extension under this paragraph

If a comparative review is conducted, the Department will issue a single analysis and single recommendation to the commissioner regarding all applications in the comparative group. If the Department determines each applicant is equally capable of providing the health services in a manner that meets the purposes of this chapter, the Department will give preference to the originating application.

The commissioner must make a decision within 45 days after receiving the Departmental analysis and recommendations unless the Commissioner requires additional information from either the applicant or Department staff. In making a decision, the Commissioner must state the following:

- Maximum expenditure that may be obligated for the proposed activity;
- Bed capacity;
- Approved capacity of other services that are expanded or added, and
- Completion date for the proposed activity.

In making a decision, the Commissioner must consider the following:

- The Department's records, including the application under consideration;
- The Department's analysis and recommendations submitted under 7 AAC 07.060;
- Written public comments received before the deadline set in the notice published under 7AAC 07.052;
- Comments received at the public meeting held under 7 AAC 07.052;
- The applicable provisions of AS 18.07, AS 18.20.150 , this chapter, 7 AAC 12, and 7 AAC 105 - 7 AAC 160;
- Relevant health planning documents on file with the Department;
- Any other special or extraordinary circumstances related to:
 - Community access to health care, including the provision of a continuum of care in close proximity to family and community; or
 - The feasibility of the proposed activity;
- Whether, based on the Department's analysis and recommendations, conditions should be added to the CON, including specifying a minimum period during which an activity described in the certificate must be available in the proposed service area.

For applications that are denied a CON, respondents may appeal that decision by requesting a hearing under this section. A request for a hearing must:

¹⁸⁸ AS 18.07.045.

¹⁸⁹ AS 18.07.045.

- Be filed no later than 30 days after the date of publication of the notice under 7 AAC 07.072, and
- Clearly state, in writing, the basis for the hearing.

The Department, a member of the public who is substantially affected by activities authorized by a CON, or another applicant for a CON may initiate an administrative hearing under this section for purposes of seeking review on a modification, suspension, or revocation of an existing CON, by filing an accusation in accordance with (b) - (d) of this section of 7AAC 07.070. The accusation must be filed with the Department no later than 30 days of the date of publication of the notice under 7 AAC 07.072 if the accusation is seeking a review of a decision made under 7 AAC 07.070.

- A hearing to seek modification of an existing certificate of need must conform to the requirements of AS 18.07.081 (b) and AS 44.62.360.
- A hearing to request a suspension of an existing certificate of need must conform to the requirements of AS 18.07.081 (c) and AS 44.62.360.

A hearing to request a revocation of an existing CON must conform to the requirements of AS 18.07.081(d) and AS 44.62.360.

PEER AND ILLUSTRATIVE STATE REVIEW

The following illustration shows a selection of peer states. The states which operate a CON program are: Connecticut, New Jersey, New York, Oregon, Washington, and Wisconsin. Of the selected peer states, the following states do not operate a CON program: Colorado, Minnesota, and Wisconsin.

Figure 5.1: Peer States with Certificate of Need (CON) Programs

State	Application Minimum Threshold	Fee	Application Format	Application Review Length (Maximum)	Other
Alaska	\$1,000,000 Effectively \$1,500,000	For an activity value at \$2,500,000 or less, \$2,500; For an activity value at more than \$2,500,000, a fee equal to .1% of the estimated cost up to \$75,000 ¹⁹⁰	Paper	195 Days	
Connecticut ¹⁹¹	Not available	\$500	Paper	240 Days	
New Jersey ¹⁹²	No Minimum	For Long Term Care Beds: If \$1,000,000 or less than \$7,500, if > \$1,000,000 than \$7,500 + 2.5% of TPC	Paper	210 days ¹⁹³	Has separate applications for general long term care vs. hospital related projects vs. perinatal facilities The Commissioner publishes a yearly schedule outlining the receipt of applications
New York ¹⁹⁴	Not available	For Hospitals, Nursing Homes and D&TCs, \$2,000 + .55% of construction costs	Electronic	Not available	
Oregon ¹⁹⁵	No Minimum	Dependent upon project costs			
Washington ¹⁹⁶	A capital expenditure made by a nursing home exceeding \$1 million dollars (adjusted for inflation). The 2012 minimum is set at \$2,403,990.	Application fee is dependent on facility type. Nursing homes: \$46, 253 Hospice care center: \$12, 874 Hospital: \$40, 470	Paper		Application requirements differ for each review process.

¹⁹⁰ http://www.legis.state.ak.us/basis/folioiproxy.asp?url=http://www.legis.state.ak.us/cgi-bin/folioisadll/aac/query=*/doc/%7B@38040%7D?nexthit.

¹⁹¹ <http://www.ct.gov/dph/cwp/view.asp?a=3902&q=459510&dphNav=>.

¹⁹² http://www.nj.gov/health/healthfacilities/about_us.shtml.

¹⁹³ After application is deemed complete during an unspecified timeframe.

¹⁹⁴ <https://www.health.ny.gov/facilities/cons/>.

¹⁹⁵ <https://public.health.oregon.gov/ProviderPartnerResources/HealthcareProvidersFacilities/CertificateNeed/Pages/index.aspx>.

¹⁹⁶ <http://www.doh.wa.gov/LicensesPermitsandCertificates/FacilitiesNewReneworUpdate/CertificateofNeed>.

EFFECTIVENESS RECOMMENDATIONS

Almost all the recommendations listed below will probably require changes in state statutes or regulations. The Department and the Governor's office can take the opportunity that this report provides and propose a legislative agenda to change statutes impacted by these recommendations.

Recommendation 5.1: The Department should consider the overall need for the CON application. It is no longer a federal requirement, and currently 14 of 50 states do not operate a CON process. The program is effective in rural areas at controlling healthcare costs, but it is not necessarily needed in urban areas.¹⁹⁷

Recommendation 5.2: The office of private physicians loophole in the CON regulation should be closed. Amend office of private physician's provisions to close the loophole as it is not defined as a "healthcare facility." Language pertaining to "not otherwise a health care facility" will need to be revised. In the past, providers have registered as an office of private physicians and then proceeded to purchase other health care facilities under the guise of an office of private physicians. This license enables the providers to bypass the required CON through this loophole. The Department should close this loophole by changing regulations surrounding office of private physicians and the acquisition of other healthcare facilities. Regardless of the license type of the purchaser, a CON should be required for all facility types.

Recommendation 5.3: The Department should amend the regulatory language surrounding the ambulatory surgery centers to not allow for the moving of a facility without a CON. This exception undermines the overall effectiveness of the CON Program in that facilities can be moved without having to first demonstrate the community need within a given geographic area.

Recommendation 5.4: The \$1.5 million threshold for differing facilities should be adjusted. Thresholds should vary depending on their size and scope (raising the threshold for larger facilities, and lowering for smaller facilities). The \$1.5 million dollar CON application threshold should be adjusted annually to stay in line with the inflation of the dollar.

Although there is no defined best practice minimum threshold or recommended minimum level, the \$1.5 million threshold is the starting point for multiple peer states. Other states allow for minimum thresholds to adjust with inflation. For example, Washington has a capital expenditure for nursing homes set at \$1 million; however due to inflation, the minimum expenditure in 2012 was set at \$2,403,990.¹⁹⁸ The State of Montana Department of Public Health and Human Services operates a CON process with minimum capital expenditures of \$1,500,000 or for the addition of health services associated with annual operating expenses of \$150,000 or more. The State of New York Department of Health CON process has a minimum threshold of \$25 million (\$50 million for hospitals). The CON process in Oregon only looks at new hospitals and some skilled nursing facilities; however, there is no dollar limit threshold.¹⁹⁹

¹⁹⁷ <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>.

¹⁹⁸ <http://www.doh.wa.gov/LicensesPermitsandCertificates/FacilitiesNewReneworUpdate/CertificateofNeed>.

¹⁹⁹ <https://public.health.oregon.gov/ProviderPartnerResources/HealthcareProvidersFacilities/CertificateNeed/Pages/index.aspx>.

Based on the elevated costs of care in Alaska, the Department should adjust the \$1.5 million threshold depending on the facilities size and scope (raising the threshold for larger facilities, and lowering for smaller facilities). In general, the point of view from this performance review is that the state should only charge fees to the extent necessary to cover the cost of the processing activity that the state needs to conduct for the CON Application. It is especially difficult for regulated entities to complain about excessive charges given that regulators have control over their business operations for which government approval is required.

Recommendation 5.5: The CON application process should be limited to rural areas. The Department may consider limiting the application process to rural areas as the demonstration of need provides more value. Rural areas have significantly smaller population size in Alaska and an extra provider or facility will have significant impact on the community and the overall quantity of services provided. This will indirectly lead to increases in costs in that region for the State. Urban areas tend to regulate more through economic controls and have a reduced need for a formalized CON Application. The Department should consider ending the CON process in the urban areas.

Recommendation 5.6: The Department should update the Net Present Value (NPV) calculation in application and regulations. It should be modified to a uniform and actuarially accepted standard. The current definition allows applicants to depreciate their entire lease in determining their NPV.

Recommendation 5.7: The Department should change the CON application fee to a fee that only covers the cost of processing the application. A maximum CON application fee of \$75,000 generates more in revenue to the state than the state incurs in costs to process the application.

EFFICIENCY RECOMMENDATIONS

Recommendation 5.8: The Department should update and reform the CON application process, as the application is repetitive and inefficient. Several sections are duplicative including portions of Section II and Section III. For a complete breakdown of all sections, please see *Appendix 02: Certificate of Need Application (Summary of Sections)*. The application was last updated in 2005 and is a non-writeable PDF that still contains tracked changes in the final posted version. Additionally, the Department should consider an online based electronic submission process which would assist in further streamlining the application.

Recommendation 5.9: The Department should have regulatory authority increased to enforce CON violations. Currently, the Department has limited enforcement ability to regulate providers who do not appropriately comply with the CON process. The Department's only option is to file injunctive relief with the Alaska Supreme Court. The Department should increase enforcement ability through statute to enforce regulations, especially in situations where a CON was not filed.

Recommendation 5.10: CON standards and methodologies should be updated and re-baselined. The Department should review and update assessment criteria as they have not been updated since 2005 to ensure metrics in alignment with current standards and population needs. For a more detailed breakdown of the Standards and Methodologies, please see *Appendix 03: Alaska Certificate of Need Review Standards and Methodologies*. A thorough review of the standards and methodologies would help ensure criteria are in alignment with best practices of today. Additionally, new types of facilities, scanners, and service trends may need to be added to the standards and methodologies as medicine has quickly evolved over the past decade.

Recommendation 5.11: The Department should increase public involvement in the application review process and should streamline public noticing. In order to increase public involvement in the application review process, an online email noticing system should be considered. This would encourage public participation and feedback on the overall review process. Currently applications are posted in newspapers, however as readership is slowly declining an online forum may also double as an effective medium of communication.

Recommendation 5.12: The Department should consider creating an exception or allowance to CON regulations regarding renovating a facility. Currently, renovating a room is possible, but renovating a facility (ex: changing the layout of a floor) requires a CON application, as it falls under: *construction of a healthcare facility*. This exception would allow facilities to make renovations which improve patient care through a physical restructuring of where the services are offered, especially if bed capacity and services rendered do not change. The focus of the CON should be placed toward meeting the needs and comforts of patients as opposed to strictly being concerned about renovation costs, or whether the layout of the facility has changed.

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REVIEW OBJECTIVE 06 – COST COLLABORATION

Determine whether DHSS' current service delivery structure maximizes available opportunities for collaboration and partnership with the Alaska Native Tribal Health Consortium and federal entities to ensure appropriate assignment and payment of costs are allocated to federal entities such as Veterans' Affairs and Indian Health Services. This should address the following:

- A. Does the current structure maximize the collaboration and partnership opportunities with federal entities to ensure proper assignment and payment of costs?**
- B. Are there changes that can be made to increase the level of collaboration and partnership with federal entities?**
- C. What cost savings can be realized by increasing the level of collaboration and partnership with federal entities?**

A. Does the current structure maximize the collaboration and partnership opportunities with federal entities to ensure proper assignment and payment of costs?

Overall, The Department’s current delivery structure is close to maximizing available opportunities with federal entities to ensure proper assignment and payment of costs. The Department has done a good job at maximizing most opportunities and is considering the correct next steps by looking at a 1915(i) and 1915(k) waiver. Other opportunities exist to receive additional funds through Medicaid eligibility, new waiver programs, the Department of Veterans Affairs, and the Indian Health Services. In reviewing 2014 LTSS spending by the AKPHs and SDS Divisions, PCG noted for the AKPHs, approximately 1.1% of its total budget ties to Federal dollars. For SDS, approximately 27.6% of the total budget ties to Federal dollars. As a whole, Federal dollars account for 14.5% of total Long Term Care dollars spent. There appears to be a large disparity in the level of Federal dollars brought into each of the Divisions as the AKPHs may have additional opportunity for revenue maximization ideas. The exact figures can be found below in *Figure 6.1: Funds Expended in the Divisions of Pioneer Homes and Senior Disabilities Services, 2014*. This is not inclusive of Medicaid expenditures as well. Including Medicaid funds, the total LTSS expenditures is approximately \$529,474,725 and can be seen in *Figure 1.4: Expenditures for Long-term Services and Supports (LTSS) in 2014*.²⁰⁰

Figure 6.1: Funds Expended in the Divisions of Pioneer Homes and Senior Disabilities Services, 2014.

Division	General Funds	Federal Funds	Other Funds	Total Funds
Pioneer Homes	\$52,059,800	\$686,100	\$7,078,900	\$59,824,800
Senior and Disabilities Services	\$41,996,200	\$16,980,800	\$2,555,000	\$61,532,000
Total of Both Divisions	\$94,056,000	\$17,666,900	\$9,633,900	\$121,356,800

As with all Departments, DHSS has opportunities to bring additional funding. Key areas of focus include the following:

- 1915(k) Medicaid waiver;
- 1915(i) Medicaid waivers;
- 1115 Medicaid waiver;
- Consumer Assessment Tool (CAT) Realignment;
- Veterans Affairs;
- Indian Health Services;
- Medicaid Expansion;
- Provider Assessment Fees;
- Grants and Contracts alignment with Federal Programs, and
- Traumatic Brain Injury waiver.

Per discussions with Department staff, a comprehensive revenue maximization study has not been conducted in “the past decade.” The Department should consider updating such a study to help yield

²⁰⁰ DHSS and Governor’s Amended Budget for FY 2015 as released on February 5, 2015 and Excel files provided by Department.

additional areas of collaboration that may exist. These areas will likely extend beyond the reach of the LTSS area.

B. Are there changes that can be made to increase the level of collaboration and partnership with federal entities?

As mentioned above, there remains additional opportunities to receive increased contribution from federal entities.

1915 K WAIVER – COMMUNITY FIRST CHOICE (CFC) WAIVER PROGRAM

For additional information about the Community First Choice (CFC)²⁰¹ waiver program please see Review Objective 02: Delivery and Administration. The Community First Choice program allows state to provide home and community-based attendant services and supports to eligible Medicaid enrollees under the State Plan. This option first became available in October of 2011 and offers a 6% point increase in Federal Matching payment to states for service expenditures related to this option.

Alaska has studied the implementation of a Community First Choice at length.²⁰² A 2012 154-page study contained the finding that approximately \$2.5 million in state funds could be saved by implementing this program.²⁰³ The major savings come from shifting persons on the Personal Care Assistance (PCA) program that meet an institutional level of care to the new CFC program. State staff provided the estimate to PCG that approximately 23% of the persons receiving personal care assistance met nursing facility level of care requirements. There are also potential savings from moving services provided on waivers to CFC. For example,

- California covers chore services on its CFC program;
- Oregon and Maryland cover a range of ADL and IADL services;
- Oregon covers also covers respite and behavioral health supports, and
- Maryland, Oregon and Montana cover assessment and care planning activities.

When interviewed, Department staff reported the lack of available staff to work on the CFC program was the reason the CFC program was not implemented in 2012.

Recommendation 6.1: The Department should move forward with the CFC waiver program to receive the additional 6% Federal match.

²⁰¹ <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/community-first-choice-1915-k.html>.

²⁰² See <http://www.hcbsstrategies.com/resources.php> for copy of Proposed Plan for Implementing Community First Choice in Alaska.

²⁰³ Ibid. Exhibit 15.

1915 I WAIVER

The 1915(i) is a section of the Social Security Act (SSA) that established an optional federal Medicaid benefit which gives states a new method to cover home and community-based services (HCBS).²⁰⁴ The services authorized under the 1915(i) specifically include "...day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness." Importantly, states can take advantage of the 1915(i) through a state plan amendment rather than a waiver, avoiding the additional administrative burden and cost normally associated with Medicaid waivers.

The 1915(i) Medicaid option can be administered through a state plan amendment rather than a waiver. With these options, the potential for increased administrative burden and cost is low, the benefits afforded to consumers in terms of access to needed services is high, and the financial contribution from the federal government is high.

Recommendation 6.2: The Department should move forward with implementing a 1915(i) option. Please refer to PCG's Behavioral Health Performance Review report for more details on the Medicaid 1915(i) waiver option.

1115 WAIVER

Under SB 78 – Fiscal Note 7, the Department is directed to apply for an 1115 Demonstration waiver used to innovate service delivery models to improve Medicaid use of tribal health provides. This waiver is projected to go live in 2017.²⁰⁵ The first phase of the waiver program would consolidate medical transportation management of travel of Medicaid eligible, IHS beneficiaries through tribal facilities. In the second phase, the Department would seek to transition the provision of most, if not all, tribal services to Medicaid eligible, IHS beneficiaries through the demonstration waiver, consolidating the management and delivery medically necessary services provided directly through tribal facilities.

Under federal rules, Medicaid services provided at or through tribal health facilities to Medicaid eligible, IHS beneficiaries are funded at a 100% federal match rate. The Department anticipates that this waiver will substantially increase the percentage of Medicaid services provided to Medicaid eligible, IHS beneficiaries at the 100% federal match rate.

PCG agrees with the Departments desire to pursue the 1115 Demonstration Waiver as it will ultimately yield additional general fund savings.

CONSUMER ASSESSMENT TOOL (CAT) REALIGNMENT

The Consumer Assessment Tool (CAT) is used to assess an individual's ability to take care of him or herself. Applicants take the assessment to determine if they are eligible for personal care services or an Older Alaskans/Adults with Physical Disabilities waiver. The CAT is designed for immediate eligibility

²⁰⁴ [Social Security Administration](#).

²⁰⁵ State of Alaska 2015 Legislative Session – 3/18/2015 – SB 78 Fiscal Note Number 7.

determination. Eligibility for waiver services allows Medicaid to be used to provide a nursing home level of care to those who live outside of a nursing home. For Personal Care Assistance, services are provided to support daily living activities and are administered through private agencies throughout Alaska.

PCG provides an extensive review of the CAT, and particularly analyzes the cognitive test section. Please refer to *Eligibility for Nursing Facility Services* on pages 63-65.

Recommendation 6.3: Adjustments to the calculation of cognition on the CAT should be made. Adjusting the CAT scoring is something the state could do without going through the time and expense involved with a 1915(i).

VETERANS AFFAIRS

Veterans Home

The Palmer Pioneer and Veterans home is the only State Veterans home in the State of Alaska. There are approximately 142 Veterans Homes across the US. The Palmer Pioneer Home received Veteran Affairs (VA) certification in 2006, and is regarded as a domiciliary care unit which lies in the continuum of care as an Assisted Living Facility.

Currently the Facility receives \$44.19 as a per diem Veteran rate²⁰⁶. The VA per diem rate does not cover the monthly AKPH rate of \$2,100. The Palmer Home currently handles their own VA filling rates and is required to maintain 75% veteran occupancy. The home has a capacity of 79 residents and on March 30, 2015, had 47 veteran residents as approximately 59% of the facility capacity. Currently on the priority wait list there are additional Veterans who could move into the home. In the state of Alaska, there are approximately 15,000 Veterans who could be eligible to use the home.²⁰⁷

Recommendation 6.4: The Department should review the veterans needs assessment as published by the University of Alaska Anchorage to review potential cost shifts that may have been identified by the study.

²⁰⁶ http://www.va.gov/PURCHASEDCARE/programs/veterans/nonvacare/statehome/SH_Payment_Rate.asp.

²⁰⁷ Number of 15,000 veterans obtained during interview with DHSS staff.

Recommendation 6.5: The Department should upgrade the AKPH in Palmer to provide both domiciliary and veteran skilled nursing home care. This will allow the Home to receive a higher average per diem rate than the domiciliary-only rate currently received from the VA. Currently, the Palmer Pioneer and Veterans Home receives a domiciliary rate of \$44.19 per Veteran resident per day. If the Pioneer Home expands services to offer nursing facility level of care, this Home would receive \$102.38 per day for providing Veterans this level of care.²⁰⁸ Additionally, the Department may consider licensing only certain portions of the home as skilled Nursing Facility Level of Care while other portions can remain as an Assisted Living Facility. This would help avoid potential problems such as what to do with current residents who do not meet skilled nursing level of care requirements, persons on the active wait list, and the Home could still meet the needs of non-veterans.

INDIAN HEALTH SERVICES

The Indian Health Services (IHS) offers enrollees who use the Indian Health System no cost sharing or Medicaid premiums that the state imposes on traditional Medicaid beneficiaries. Furthermore, the state receives 100% federal match for Medicaid services received through an IHS or Tribal facility.²⁰⁹

Alaska is particularly unique in delivering services to the American Indian and Alaska Native (AI/AN) community as the population is spread across Alaska's vast and challenging geographic landscape. In a review of 12 states with a large AI/AN population, comparatively, Alaska had high costs in delivering care.²¹⁰ In 2007, the level of expenditures was at least 50% higher in Alaska than in Indian Health Programs in the lower 48. The isolated and dispersed villages not only result in higher costs in care, but also causes difficulty in the recruiting and retention of qualified health care professionals and staff. Even with a comparatively high level of funding, Alaska's Indian Health Programs are still considered underfunded.

Because Alaska has a large population of AI/AN, it is important to have them enroll in services they qualify for, such as the IHS, as to maximize federal funds. According to 2010 US Census Data, the (AI/AN) population in Alaska totaled 121,795 representing 16.86% of the total state population.²¹¹ Of the total AI/AN population, 60,257 (49.47% of total AI/AN population) were Medicaid eligible- this number represents those who requested and were determined to be eligible for Medicaid.²¹² While the federal government offers grants to spur IHA enrollment, ongoing efforts should be made to strengthen government relationship with Alaska Native tribes/governments to address barriers to enrollment. Alaska's Indian Health System staff are proactive in registering individuals for the Certificate of Indian Blood (CID) that come into tribal clinics. The certificate is required for the individual to be eligible for IHS. For individuals who do not get go into tribal centers, outreach efforts for enrollment can be difficult. The elderly, those who most commonly use Long Term Care services, can be particularly hard to reach if they live far from an IHS designated facility. Common barriers for the AI/AN may include lack of knowledge about IHS,

²⁰⁸ http://www.va.gov/PURCHASEDCARE/programs/veterans/nonvacare/statehome/SH_Payment_Rate.asp.

²⁰⁹ <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/indian-health-and-medicaid/indian-health-medicaid.html>.

²¹⁰ http://www.edfoxphd.com/Medicaid_and_Indian_Health_Programs_Western_Paper_b_March_19_2009_Verne_Boerner_and_Ed_Fox_copy.pd.

²¹¹ <http://dhss.alaska.gov/Commissioner/Documents/mrag/FFY%202012%20Tribal%20Medicaid%20Activity%20Report%2005-30-13.pdf>.

²¹² <http://dhss.alaska.gov/Commissioner/Documents/mrag/FFY%202012%20Tribal%20Medicaid%20Activity%20Report%2005-30-13.pdf>.

distrust in the government, difficulty with the enrollment process, language and literacy challenges, and geographic or transportation barriers.

Recommendation 6.6: The Department should ensure as many providers as possible are enrolled as an Indian Health Service provider to receive a 100% federal match for all eligible recipients.

Recommendation 6.7: The Department should implement a comprehensive approach for Medicaid enrollment tailored to each specific tribe.

In a review of best practices in outreach and enrollment for American Indian and Alaska Natives in the Children's Health Insurance Program (CHIP), it was emphasized that multiple strategies to overcome enrollment strategies are most effective.²¹³ A comprehensive enrollment approach would be to utilize community-based activities, person-to-person outreach, public awareness campaign, training local eligibility workers, and develop convenient, approachable recruitment settings. As Alaska has tribes spread throughout the state, each strategy would require tailoring to be effective for that particular tribe. This is why it is key to have strong relationships with Alaska Native tribes/governments, so culturally appropriate materials and approaches can be developed and implemented. A collaborative effort will ensure a targeted outreach that will resonate with the intended audience.

MEDICAID EXPANSION

The Affordable Care Act (ACA) allows states to expand Medicaid coverage to adults under the age of 65 up to 133% of the federal poverty level (FPL). This population set includes children, pregnant women, parents, and adults without dependent children. All newly eligible individuals will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges.²¹⁴ In June of 2012, the United States Supreme Court ruled that the Affordable Care Act requirement that states expand their Medicaid programs to an entirely new population group was unconstitutional. Thus states were allowed to keep their current federal Medicaid funding regardless of whether or not they choose to expand Medicaid. In reviewing peer states reports, it can be noted that Medicaid Expansion has demonstrated increased federal revenue to peer states.²¹⁵

PCG has found that expanding Medicaid has been modeled to have an increased general fund cost to the state. This cost increases over time as the Federal Financial Participation (FFP) declines from covering 100% of the expansion population beginning in 2014 to federal coverage of 90% of the costs in perpetuity. The effect of the reduction of the federal cost sharing can be seen as increased state share. In February 2015, Evergreen Economics projected that starting in 2017, Alaska would spend \$3.8 million on Medicaid expansion services and by 2021, spending would be \$19.6 million. In contrast, federal spending would be \$170.6 million in 2017 and \$204.9 million in 2021.²¹⁶

²¹³ http://www.edfoxphd.com/Outreach_and_Enrollment_KAI_Report_on_41_CHIPRA_Grants-1_3_.pdf

²¹⁴ <http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/>

²¹⁵ <http://www.health.utah.gov/documents/PCGUtahMedicaidExpansionAnalysis.pdf>

²¹⁶ http://dhss.alaska.gov/HealthyAlaska/Documents/Evergreen_Medicaid_Expansion_Analysis-020615.pdf

States that have completed the adoption of Medicaid expansion have seen state savings and revenues exceed increased state costs for the program.²¹⁷ In a study of three states (Connecticut, New Mexico, and Washington) of the 29 that have implemented Medicaid expansion, all study states showed savings within and outside of Medicaid budgets. Savings outside the budget were generally used for state general funds or reinvested.

In a study commissioned from the US Department of Health & Human Services Office of the Assistant Secretary for Planning and Evaluation titled “The Economic Impacts of Medicaid Expansion, Uncompensated Care Costs and the Affordable Care Act”²¹⁸ an estimated economic impact of \$2.33 billion is projected over the time period of 2014 – 2019 for the State of Alaska. Savings would be significantly seen in uncompensated care costs and in expenditures related to behavioral health costs. Additionally, 3,700 jobs have been projected for growth. In the Lewin Group report published in April of 2013, it was estimated the cost to Alaska for not expanding Medicaid would be \$39.9 million over the 2014 to 2020 period.²¹⁹

It has also been found that some Medicaid expansion states also experienced increased revenue through their imposed tax on health insurance claims.²²⁰ With more Medicaid enrollees after expansion, Medicaid managed care plans paid more fees to the state. Washington saw a yearly increase in revenue of \$34 million, while Arkansas and New Mexico both have had about \$30 million in yearly increases.

Projections for Medicaid expansion enrollment varies across a few studies. Looking at a 2016 expansion, studies have shown a range of 20,066 to 41,286 newly eligible enrollment.²²¹ These figures represent projections for those who will enroll, not the actual total population that will be eligible.

Recommendation 6.8: The State of Alaska should continue its work to consider the best approach to optional Medicaid expansion.

PROVIDER ASSESSMENT FEES

Provider assessment fees or taxes are mandated payments set by a state on health care providers. A state voluntarily decides whether to implement a fee and what the fee applies to. Health care services or items may have a fee assessed. The collected payments from the fees are matched by the federal government and are added into the state Medicaid funding pool. States are allowed to use the collected and matched money to increase reimbursement to Medicaid providers or to support the Medicaid program in other ways. This practice allows states to increase revenue for their Medicaid program, which in turn allows the state to expand coverage to its residents, to prevent provider rate cuts, and to fill budget gaps in the Medicaid program. This is particularly significant when a state is experiencing an economic downturn. They generally may implement a new provider assessment or increase a fee.²²²

²¹⁷ <http://kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states/>.

²¹⁸ http://aspe.hhs.gov/health/reports/2015/MedicaidExpansion/ib_MedicaidExpansion.cfm.

²¹⁹ http://dhss.alaska.gov/Documents/Lewin_Final_Report.pdf.

²²⁰ <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/4/29/states-find-savings-through-medicaid-expansion>.

²²¹ http://dhss.alaska.gov/HealthyAlaska/Documents/Evergreen_Medicaid_Expansion_Analysis-020615.pdf.

²²² <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8193.pdf>.

Currently, all states but Alaska impose at least one type of provider assessment.²²³ Each state varies in the number of assessments and amount imposed on providers. In FY 2013, the majority of states, 31 and the District of Columbia, had at least three assessments implemented.²²⁴ The provider class that is most commonly imposed with a tax are nursing homes (44 states), inpatient hospitals (39 states), followed by intermediate care facilities (36 states). Forty-two states and the District of Columbia impose at least one provider assessment fee at 3.5% or greater of net patient revenue.

There are rules and limitations on provider assessments.²²⁵ The Federal government sets requirements, and the Center for Medicare and Medicaid Services (CMS) is responsible for determining whether a state's assessment has met these requirements. The Federal government rules require that state provider taxes must:

- Be broad based- there are 19 classes of health care providers and an assessment must be imposed on all providers within a specific class of provider;
- Be uniform- the same assessment rate must be imposed on all providers within a specific class of providers;
- Not hold providers harmless- a state cannot guarantee that providers will be reimbursed the total amount which they were assessed;
- Not be greater than six percent of patient revenue, and
- Not exceed 25% of the state share of Medicaid expenditures.

Prior to imposing a provider assessment, an approval process must be followed.²²⁶ At the state level, the state government works with health care facilities to establish an agreed upon provider assessment and subsequent Medicaid reimbursement amounts. Then, the assessment is generally enacted through the legislature and a state plan amendment is submitted by the state's Medicaid agency to the State Medicaid Plan for federal approval. At the federal level, CMS works with the state to ensure all requirements are met and in the process the state may waive uniform and broad-based requirements for specific assessments.

According to the Congressional Research Service, the actual amount of provider tax revenues used by states to assist in their share of Medicaid costs is unknown. The provider tax revenues does fall under the category of "other state funds", which the National Association of State Budget Officers (NASBO) tracks through data collected from the CMS-64 form.²²⁷ During the recent recession, overall states' use of "other state funds" to assist in Medicaid expenditures increased from 20% to nearly 26%. This indicates the value of provider assessments during economic downturns.

Figure 6.2 Provider Assessment Fees in Illustrative and Peer States provides additional information about Provider Assessment Fees in illustrative and peer states.⁵ Each of these states has at least one fee that is at least 3.5% of net patient revenues:

²²³ "Quick Take: Medicaid Provider Taxes and Federal Deficit Reduction Efforts | The Henry J. Kaiser Family Foundation." Accessed June 29, 2015. <http://kff.org/medicaid/fact-sheet/medicaid-provider-taxes-and-federal-deficit-reduction-efforts-2/>.

²²⁴ Ibid.

²²⁵ "Medicaid Provider Fees Explained | Insights | American Action Forum." Accessed June 29, 2015. http://americanactionforum.org/insights/medicaid-provider-fees-explained#_ednref2.

²²⁶ http://www.communitycatalyst.org/resources/publications/document/ProviderAssessmentsforCTG_06.10.15.pdf.

²²⁷ <http://www.strategichealthcare.net/pdfs/45121463d.pdf>.

Figure 6.2: Provider Assessment Fees in Illustrative and Peer States

State	Number of Provider Assessments Imposed	Types of Provider Assessments
Connecticut	3	Hospital; Nursing Home; ICF/MR-DD (Intermediate Care Facilities for individuals with mental retardation or developmental disabilities)
New Jersey	5	Hospital; Nursing Home; ICF/MR-DD; Managed Care Organization; Other
New York	4	Hospital; Nursing Home; ICF/MR-DD; Other
Oregon	2	Hospital; Nursing Home
Washington	3	Hospital; Nursing Home; ICF/MR-DD

In 2011, Connecticut imposed a new tax on hospital net revenue and a new resident day user fee for particular intermediate care facilities. This was expected to generate almost \$400 million for the state.²²⁸ In the peer state of Oregon, a provider tax set in 2010 was expected to add \$700 million to the state’s revenue that was to be used to cover nearly all of Oregon’s uninsured children as well as add 35,000 uninsured. In 2013, the Nursing Facility Provider Tax was reauthorized as the provider assessments were viewed as successful. The funds continue to provide critical services to vulnerable populations in Oregon.

In 2013, Alaska had a net revenue of approximately \$22.13 million for its nursing homes.²²⁹ Provider tax analyses are heavily dependent on what scope of revenue is included in assessment procedures: Medicaid, Medicare, and private pay. The maximum amount of federal revenue that could be raised would be 6% of a facilities revenue times a 50% federal match, or approximately \$650,000 per facility. Depending on the types of revenue included in the assessment the actual amount would be less than \$650,000. A full analysis would require knowing each facility’s revenue and modeling the impact of including different type of revenue and excluding certain facilities.

Recommendation 6.9: Alaska should implement an assessment fee to further capture federal dollars. To align with peer states and national trends, Alaska should explore a provider assessment imposed on either hospitals, nursing homes, and/or assisted living facilities including the AKPH. Projections would need to be calculated to determine possible revenue outcomes for each type of potential provider assessment at different tax amounts to gain a better understanding of the financial impact on the state’s Medicaid program

²²⁸ <http://www.ohca.com/files/2014/11/2013-LEG-REPORT-8-6-13.pdf>.

²²⁹ [Average Nursing Home Revenue in Top and Bottom Three States](#). Statista.

GRANTS AND CONTRACTS RE-ALIGNMENT

See the Grants and Contracts section for recommendations surrounding additional match areas.

Recommendation 6.10: Recommendations provided in the Grants and Contracts Section in order to further pursue additional federal dollars should be reviewed. See *Review Objective 03: Grants and Contracts*.

TRAUMATIC BRAIN INJURY WAIVER

Disabilities resulting from Traumatic Brain Injuries (TBIs) depend upon the severity and location of the injury, as well as the age and general health of the individual. Some common disabilities include problems with cognition, sensory processing, communication, and behavioral health. The Department of Defense (DOD) posted the number of TBIs since 2000 from all service members of the U.S. Military which equates to roughly 1.218% of the veteran Population.²³⁰ In a report release by the DOD, roughly 80% of TBIs were diagnosed as mild.²³¹ Extrapolating data will mean Alaska can reasonably expect to have approximately 900 Veterans with a Traumatic Brain Injury.

With a veteran population of nearly 10% of the total state population (71,004)²³², the State of Alaska has the population to support a TBI program. Additionally, Traumatic Brain Injuries are becoming a more prevalent injury in the civilian population and there is an additional opportunity to serve more individuals with a potential increased federal match. With the Veteran population with TBI's there is an even greater opportunity for cost collaboration with the Federal government as Traumatic Brain Injuries are associated with full disability status.

For example, Tennessee operates a Traumatic Brain Injury program that was established by the Tennessee General Assembly to address the needs of those individuals who have sustained a brain injury, as well as their family members and primary caregivers.²³³ Based on summary data available from 2008, 23 states operate a Medicaid waiver targeted to individual with brain injuries.²³⁴

In implementing a waiver in the state of Alaska, the state must:²³⁵

- Provide assurances that the waiver will protect the health and welfare of participants.
- Specify how many people will be served during each year of the waiver's operation. Unlike its regular Medicaid program, a state can limit the number of individuals it will serve. This allows a state to control the costs of a waiver and have a waiting list when that number is reached.
- Identify what services are in the waiver. A waiver allows a state to cover services that are not permitted in the regular Medicaid program and provides a waiver participant with "optional" Medicaid services that a state has chosen not to include in its regular Medicaid program. A state

²³⁰ [DOD: Worldwide Numbers for TBI.](#)

²³¹ [DOD: Worldwide Numbers for TBI.](#)

²³² <http://quickfacts.census.gov/qfd/states/02000.html>.

²³³ <http://tn.gov/health/topic/tbi>.

²³⁴ 2008 Hendrickson, L. & Blume, R., A Survey of Medicaid Brain Injury Programs, Rutgers University, Rutgers Center for State Health Policy. New Brunswick, N.J <http://nasuad.org/hcbs/article/issue-brief-survey-medicaid-brain-injury-programs>.

²³⁵ 2008 Hendrickson, L. & Blume, R., A Survey of Medicaid Brain Injury Programs, Rutgers University, Rutgers Center for State Health Policy. New Brunswick, N.J <http://nasuad.org/hcbs/article/issue-brief-survey-medicaid-brain-injury-programs>.

may also provide a waiver participant with more of a service than it will provide to an individual through its regular Medicaid program.

- Finally, the state must show that the cost of waiver services will not exceed what the state would have spent in the absence of the waiver; this is also referred to as cost neutrality.

Recommendation 6.11: The Department should consider implementing a TBI waiver to enroll additional individuals in a waiver program and which, based on Medicaid eligibility, will help bring in additional federal dollars. This waiver would be granted under the authority of section 1915(c) of the Social Security Act. The waiver would be designed to help Medicaid-eligible individuals who might otherwise be admitted to a hospital or nursing facility to live independently in the community and to permit a state to provide services that are not typically covered under the state's regular Medicaid program.

C. What cost savings can be realized by increasing the level of collaboration and partnership with federal entities?

The various recommendations of this report have mentioned numerous opportunities for increasing Federal funding. An aggregate sum for these figures cannot be accurately calculated with any level of certainty. Too many factors are at play including legislative changes and demands that will ultimately have too large of an impact in order to accurately project likely findings.

REVIEW OBJECTIVE 07 – RESULTS BASED MEASURES

Using a recognized standard or methodology for measurement, determine whether DHSS' long-term care results-based measures demonstrate the effectiveness and efficiency of the agency's core services, goals, programs and objectives, and recommend necessary improvements. This should address the following:

- A. Do DHSS' long-term care results-based measures demonstrate the effectiveness of related programs and services?**
- B. Do DHSS' long-term care results-based measures demonstrate the efficiency of related programs and services?**
- C. Are there alternative long-term care results-based measures that could better demonstrate the effectiveness and efficiency of related programs and services?**

Introduction

To research this objective, PCG began by collecting performance measures used in specific long-term services and supports (LTSS) programs. For example, Medicaid waiver operations must comply with quality assurance measures mandated by the Centers for Medicare and Medicaid Services (CMS). PCG requested the federal forms, the CMS 372 forms, used to report on these quality measures.

PCG also examined CMS Nursing Home Compare information on quality measures in nursing homes and collected information on quality assurance programs in site visits to programs. For example, in its visit to the Alaska Veterans and Pioneer Home in Palmer, PCG found that staff had developed an outstanding quality assurance process and collected appropriate performance measures.

PCG also interviewed persons whose work is relevant to performance and quality such as the Ombudsman and waiver staff, and collected five years of utilization and payment information on LTSS programs.

Although program specific performance measures were identified, since the review objective focused on Departmental-level reporting of results-based measures, PCG focused on identifying Department budget-related documents from FY 2014 and FY 2015 that contained discussions of results-based measures. The most complete discussion of results-based measures appears to be in FY 2015 material, and PCG identified 12 LTSS-related measures. Seven of the twelve measures identified are reasonable as is and five need a better contextual grounding or should simply be changed.

To determine if a results-based measure demonstrated the effectiveness and efficiency of an LTSS program, PCG defined effectiveness as demonstrating whether program goals were attained and efficiency as demonstrating whether program costs were minimized.

In general, there are two types of measures:

- *Percentages*: For example, “Percent of safety assessments concluded within required time frames”, and those that are single numbers such as “Total Medicaid Waiver receipts”. For percentages, the conceptual relevance of selecting the numerator and denominator of the percentage was examined.
- *Single numbers*: The relevance of the measure to program goals and operations was examined.

In general, PCG focused on the logic of the measure. What exactly did its components measure and how are its results to be interpreted?

Overview

Measurement is an essential component of program performance. To judge the effectiveness and efficiency of programs, clear measurements of what a program is intended to do and how well it performs are necessary. In 2013, the Department implemented a results-based management framework in which its priorities were standardized across its Divisions into specific performance measures.²³⁶

The Department's selected priorities were:

1. Health and Wellness across the Lifespan;
2. Health Care Access, Delivery and Value, and
3. Safe and Responsible Individuals, Families, and Communities.

Priorities for 2014 were established that further detailed the priorities into specific objectives, and performance measures were developed for each objective. Each performance measure was further specified into effectiveness and efficiency measures. The three priorities, 24 objectives and their 99 effectiveness and efficiency performance measures were listed in the Department's 2015 Fiscal Year 2015 Performance and Budget Summary Book.²³⁷ This Book appears to be the single most extensive discussion of performance measures and is relied upon by PCG to describe what the Department presented in regard to its performance measures.

In the discussion below, we review each LTSS performance-related measure used by the Department. The performance objective is stated and then measure(s) are discussed. Excluding health measures that affect all age groups, a review of the measures indicates that the twelve following measures are directly related to long-term services and supports (LTSS).

A. Do DHSS' long-term care results-based measures demonstrate the effectiveness of related programs and services?

Objective 1.2.3: Increase the number of Alaskans with disabilities who are living safely in the least restrictive environment

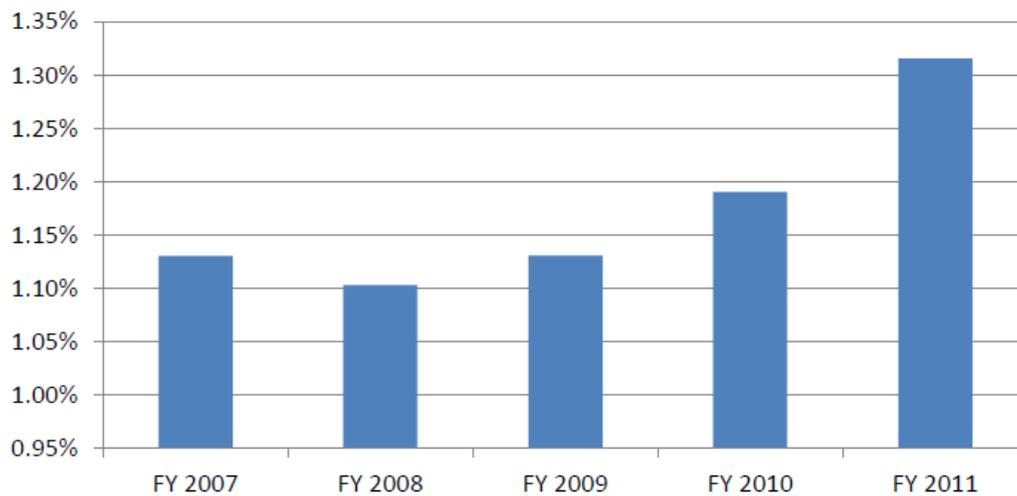
1. Percent of Alaskans who are receiving community-based long term services and supports

As shown in *Figure 7.1: Percent of Alaskans who are Receiving Community Based Long Term Services and Supports*, the data presented for this effectiveness measure indicate that the percentage has increased from roughly 1.13% in FY 2007 to 1.31% in FY 2011. PCG believes this is not a useful measurement, per se. Changes in the number of individuals receiving LTSS is a useful fact, but expressing this as a percentage of total Alaskans creates the need to define a "reasonable" percentage. For example, how is the percentage of 1.31 to be interpreted? Is this a high percentage, a low percentage?

²³⁶ See: <http://dhss.alaska.gov/Documents/Publications/priorities.PDF>. Retrieved on 4-6-2015.

²³⁷ See: <http://dhss.alaska.gov/Documents/Pdfs/PABS.pdf>. Retrieved on 4-6-2015.

Figure 7.1 Percent of Alaskans Who Are Receiving Community-Based Long Term Services and Supports²³⁸



The logic of the measure assumes that higher percentages are better. This is not a straightforward measure since the text accompanying the percentages does not identify what constitutes good performance. It is desirable to have the greater percentage of the individuals currently receiving LTSS to receive community-based services instead of institutional services. However it is also desirable to minimize the total number of individuals that receive public assistance altogether by emphasizing support for family caregivers, in addition to the employment, housing, and preventive medical care that keep individuals off of Medicaid LTSS. For example, would more affordable housing in Anchorage keep individuals out of general relief or Medicaid assisted living programs?

Measuring the intensity of LTSS community-based services is appropriate but comparing the percentage against total Alaskan population should be rethought. Alternative measures might be the more accepted gauge of comparing the percent of total LTSS expenditures spent on home and community-based services (HCBS) or the percentage of LTSS recipients that receive HCBS services. This measure is reported for all states and Alaskan percentages can be compared to national averages and peer states.

Recommendation 7.1: The measure stating: “Increasing the number of Alaskans with disabilities who are living safely in the least restrictive environment” should be amended. Changes in the number of individuals receiving LTSS is a useful fact, but expressing this as a percentage of total Alaskans creates the need to understand what a reasonable percentage is. The Department might consider expressing this as a percentage of Alaskans with disabilities rather than the total number of Alaskans.

²³⁸ Department of Health and Social Services Fiscal Year 2015 Performance and Budget Summary Book, p. 246.

Objective 2.2.1 Improve access to health care

2. Number of residents who access the Medicaid waiver

Although listed as a results-based measure in the beginning of the FY 2015 Book, it is difficult to identify either a discussion of this effectiveness measure or its associated data in the Department's 2015 Fiscal Year 2015 Performance and Budget Summary Book. Conceptually this measure is close to the previously discussed, the "Percent of Alaskans who are receiving community-based Long Term Services and Supports." The text of future discussions needs to explain what constitutes good performance on this measure. The logic of the measure implies that the more individuals receiving waiver services the better. However, there is a limit to this logic at some percentage. Is 5% good performance? What about 10%? If 10% of the total population is good, then what about 15%? At some point, the percentage becomes too big because it is not desirable to have large percentages of the population on public assistance. The Department needs to describe what good performance is. What is an optimal percentage?

3. Total Medicaid waiver receipts

As with the previous measure, it is difficult to identify either a discussion of this efficiency measure or its associated data in the Department's 2015 Fiscal Year 2015 Performance and Budget Summary Book. In addition, this measure also needs a discussion of what constitutes good performance. Are lower receipts better or are higher receipts better? Without a conceptual context, a reader could plausibly assume the Department thinks the more money it spends on Medicaid waivers, the better the Department is performing.

For example, five years of Personal Care Assistance (PCA) program expenditure data were reviewed. The data show that PCA expenditures increased from FY 2009 to FY 2012 and then dropped substantially in FY 2013. When interviewed, staff at the Division of Seniors and Disabilities Services said that better cost controls reduced expenditures in the PCA Program.²³⁹ These data are an example of where expenditure increases from FY 2009 to FY 2012 could be interpreted as efficient because more persons are using home and community based services (HCBS) instead of more expensive institutional services. But the drop in expenditures from FY 2012 to FY 2013 could also be interpreted as efficient because better regulations and more appropriate plans of care reduced inappropriate utilization.

The discussion of this efficiency measure would benefit from an explanation of what constitutes an efficient expenditure. What are the circumstances under which more expenditures are efficient, and what are the circumstances under which less expenditures are efficient?

²³⁹ The PCA expenditure data provided PCG reviewers shows a drop in PCA expenditures from \$121.2 million in FY 2012 to \$102.6 million in FY 2014.

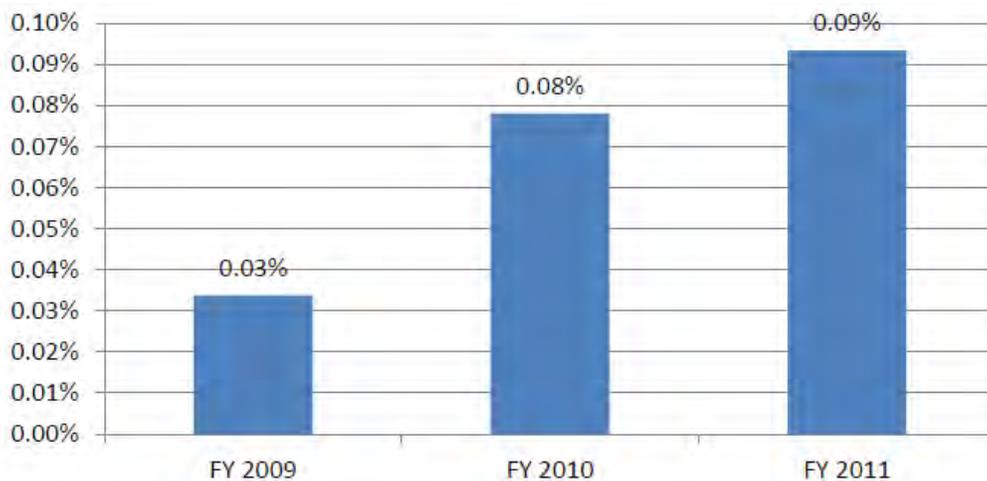
Recommendation 7.2: Discussions of the effectiveness measure titled “Number of Residents Who Access the Medicaid Waiver” and the efficiency measure titled “Total Medicaid Waiver Receipts” should be expanded to identify what constitutes a good performance. For example, are lower receipts better, or are higher receipts better?

Objective 3.2.2 Decrease the rate of maltreatment in vulnerable populations

4. Percent of Alaska adults with substantiated reports of abuse or neglect

As shown in *Figure 7.2 Percent of Alaska Adults with Substantiated Reports of Abuse or Neglect*, the data presented for this effectiveness measure shows the percentage has increased from 0.03% in FY 2009 to 0.09% in FY 2011.²⁴⁰ As mentioned in an earlier measure, it is not clear what constitutes good performance. Are higher rates better assuming that more work and effort has resulted in finding more substantiated cases? Are lower rates better assuming more work and effort is resulting in less abuse or neglect? The analysis of abuse is difficult since the reported rate depends on the underlying rate in the population, the frequency with which it is reported, and the vigor and thoroughness of the efforts to substantiate the occurrence of the abuse or neglect.

Figure 7.2 Percent of Alaska Adults with Substantiated Reports of Abuse or Neglect²⁴¹



²⁴⁰ Ibid. p. 10. SDS Business Plan. p. 251 in the PDF document.

²⁴¹ Department of Health and Social Services Fiscal Year 2015 Performance and Budget Summary Book, p. 251.

Recommendation 7.3: The Department should consider an alternative effectiveness measure to the *percent of Alaska adults with substantiated reports of abuse or neglect*. Abuse and neglect are often repetitive. An effective adult protective service does not simply count the number of abusive situations, it stops the abuse from happening again. The Department should consider measuring recidivism of abuse.

Objective 3.2.3 Improve Client Safety within Department and provider operated facilities

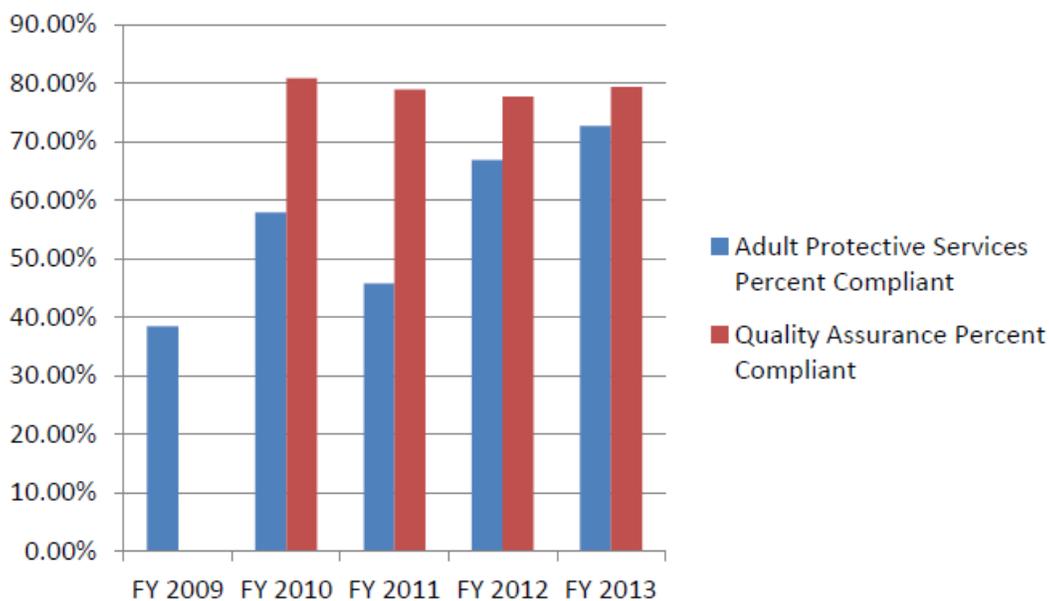
5. Percent of facilities licensed by the Department that are free from reports of harm

Assuming that reports of harm are accurate, this is a straightforward effectiveness measure.

6. Percent of cases that enforcement action is taken within required timeframes

This is a straightforward efficiency measure. The accompanying *Figure 7.3: Percent of Cases that Enforcement Action is taken within Required Timeframes* indicates that percentages are below 80%. The text comment indicates that this is because of staff shortages.

Figure 7.3: Percent of Cases that Enforcement Action is Taken within Required Timeframes²⁴²



7. Number of months long term services and supports recipients are able to remain in their home before institutional placement

This is a straightforward and reasonable effectiveness measure. It is an “outcome” measure rather than a “process” measure and is calculated by measuring the age of individuals before they enter an institutional placement. Data for the period FY 2009-FY 2012 shows the metric is increasing, implying that individuals

²⁴² Department of Health and Social Services Fiscal Year 2015 Performance and Budget Summary Book, p. 254.

are entering institutional care at older ages.²⁴³ Though the use of home and community based services (HCBS) is not directly measured, the implication is that these individuals are entering institutions later in life because of receiving more HCBS.

B. Do DHSS' long-term care results-based measures demonstrate the efficiency of related programs and services?

Objective 1.2.2 Increase the number of older Alaskans who live safely in their communities

8. Average cost of long term services and supports per recipient

This is a straightforward efficiency measure. Looking at the average cost of LTSS services per recipient is a reasonable efficiency measure assuming the individuals have similar acuity levels. The text interpreting the measure needs to provide contextual information as to whether or not increases in the cost of recipient care are reasonable. For example, if the program population has approximately similar acuity levels, then a cost per recipient that is stable or declining is a reasonable measure. If the acuity levels in the program population are increasing then it would be reasonable to expect that the average cost per recipient would increase proportionately. Text interpreting this measure's results needs to mention factors like acuity which affect the value of the measure.

9. Average cost for waiver eligible Alaskans who are living in (intermediate care facility for individuals with mental retardation (ICFMR) or nursing home versus those who are living independently

This is a reasonable measure of efficiency. Data supporting this measure indicate that the average cost of community services is lower than the average cost of institutional services for individuals with Intellectual and Developmental Disabilities. Community costs for other Medicaid eligibility groups are also presented although data on their nursing home costs is not. It is reasonable to assume that their nursing home costs would be higher.

The data seem to contain all non-institutional costs, possibly including assisted living. However, the wording of the measure refers to "living independently." Perhaps the data are aligned, but it is not clear from the discussion that the cost data reported in the Performance and Budget Summary Book are aligned with the concepts of the efficiency measure.

²⁴³ See: <http://dhss.alaska.gov/Documents/Pdfs/PABS.pdf>, pg., 3 SDS Business Plan. p. 244 in PDF file.

Recommendation 7.4: The interpretation of the following measure should be more fully described: “Average cost for waiver eligible Alaskans living in ICFMR or nursing homes versus those living independently.” It is unclear what programs are included in the phrase “living independently”. For example, do large assisted living programs with more than 25 residents meet federal standards for being classified as a home and community-based program? If an individual is living in an assisted living program with 25 other persons is that individual classified as living independently?

10. Average time to initiate an investigation

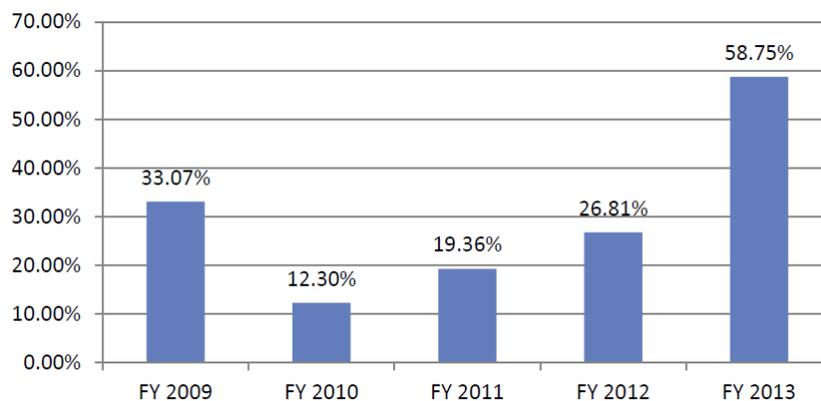
The data presented for this efficiency measure shows the number of days has dropped from 12 in FY 2009 to 4 in FY 2013.²⁴⁴ This is a straightforward measure and the drop is a clear improvement.

11. Percent of safety assessments concluded within required time frames

The data presented for this efficiency measure shows a wide fluctuation in the percentage by year as can be seen in *Figure 7.4: Percent of Safety Assessments Conclude within Required Timeframes*.²⁴⁵ For example, in FY 2009 the percentage was 33.07%, dropping to 12.30% in FY 2010. In FY 2013 the percentage was 58.75%. While 58.75% concluded within time frames sounds better than 12.30%, is 58.75% good? Are the timelines unrealistic considering workload and staffing levels?

Recommendation 7.5: A text discussion of what constitutes good performance should be added along with an explanation of current percentages would strengthen the use of safety assessments concluded within required time frames. Interviews with staff indicate that the population of individuals who are supposed to have safety assessments performed has varied over the years and fluctuations in the data could be due to changes in policies as not everyone in past years was supposed to receive a safety assessment.

Figure 7.4: Percent of Safety Assessments Concluded within Required Timeframes²⁴⁶



²⁴⁴ Ibid.

²⁴⁵ Ibid. p, 11 SDS Business Plan p. 252 in the PDF document.

²⁴⁶ Department of Health and Social Services Fiscal Year 2015 Performance and Budget Summary Book, p. 252.

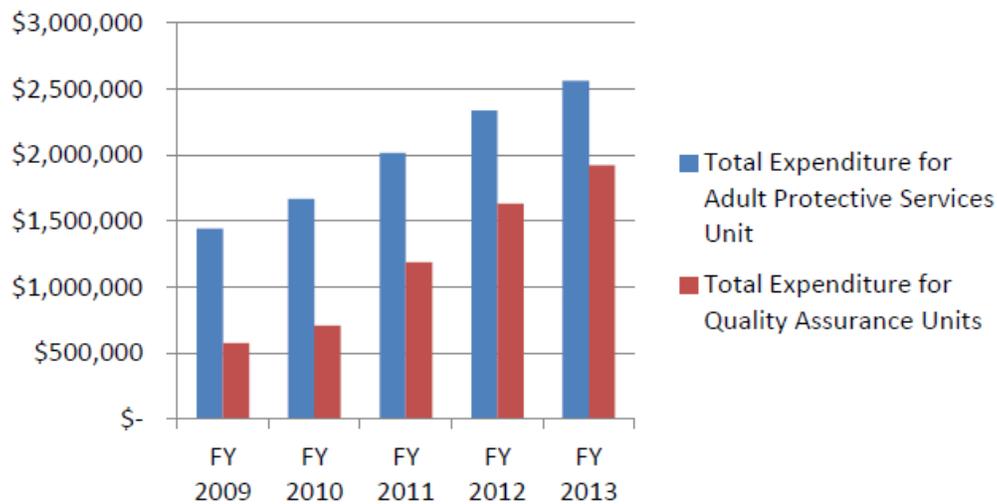
Staff interviewed told PCG that in 2013 a decision was made to perform a safety assessment on all referrals and in the future the percentages should be 100%. This revised efficiency measure should be reliable going forward since a 100% assessment is a clear standard of what constitutes acceptable performance and differences from it can be measured.

12. Cost for licensure functions and oversight

The cost of an administrative operation per se is not a good efficiency measure. *Efficiency* is what you do with the money you have. The text accompanying this performance measure contains no discussion of program costs. The text does not indicate that more costs mean better performance or worse performance. If a reader examines the data of this measure and compares it to the data shown for the next measure, the result is the observation that increasing administrative cost led to better performance for adult protective services but not for quality assurance activities.

Figure 7.5: Cost for Licensure Functions and Oversight further demonstrates total funds expended on licenses for both the Adults Protective Services (APS) Unit and the Quality Assurance (QA) Unit.

Figure 7.5: Cost for licensure functions and oversight²⁴⁷



²⁴⁷ Department of Health and Social Services Fiscal Year 2015 Performance and Budget Summary Book, p. 253.

C. Are there alternative long-term care results-based measures that could better demonstrate the effectiveness and efficiency of related programs and services?

In addition to the alternative measures suggested in the examination of specific measures above, PCG also recommends:

Recommendation 7.6: Discussion of each measure should include a description of what constitutes a “good” score on the measure. Only a few measures, such as time elapsed before an abuse investigation starts, are unambiguous. For example, increases in the number of individuals receiving services and expenditures are good to an extent but there are limits on the reasonability of such increases and the text needs to demarcate these limits clearly.

Recommendation 7.7: The Department should include a fuller explanation of how to interpret all performance measures. For example, the rate of identification of substantiated abuse has all of the familiar problems associated with crime reporting. Is the crime rate increasing or is crime reporting getting better? Textual discussions are needed to set a context for interpreting the statistics provided.

Recommendation 7.8: The Department must be cognizant of the fact that measures are interrelated and need to be explained well, lest readers understandably form a plausible but probably incorrect interpretation of the data. There is a tendency for the performance measures to be discussed in isolation.

For example, the data for the efficiency measure “Average time to initiate an investigation” shows a drop from 12 to 4 days, but the next measure “Percent of safety assessments concluded within required time frames” states that 58.75% of the safety assessments were done. A reader could plausibly be led to the observation that it is easy to initiate new assessments faster if Department staff only complete 58.75% of them.

Another example is the administrative cost for quality assurance which went up from about \$500,000 in FY 2009 to a little less than \$2,000,000 in FY 2013, but the percent of time that enforcement action was taken in a required time was flat at a little less than 80%. Without further explanation such as a discussion of changes in workload, a reader could be left with the impression that quadrupling the administrative cost of the program had no impact on its performance.

Recommendation 7.9: The Department should add in metrics where outcomes are tied to reimbursements. Measuring outcomes to reimbursements will help compare the quality of care to dollars spent in determining the efficiency of service delivery.

In the Performance and Budget Summary Book, there needs to be an easier way of finding out which Business Plans discuss which measure. For example, it is hard to find where the measures, the “Number of residents who access the Medicaid Waiver” and “Total Medicaid Waiver receipts” are located. Neither of these measures is discussed in the business plans of Health Care Services and Senior and Disabled Services.

Recommendation 7.10: The 26 indicators in the AARP Scorecard of LTSS programs should be reviewed with the intent of determining if any of them might be suitable for inclusion in its performance measures. The following performance measures are suggested for special attention: percent of nursing home residents with low care needs, percent of home health patients with a hospital admission, percent of long-stay nursing home residents hospitalized within a six-month period, Percent of nursing home residents with moderate to severe dementia with one or more potentially burdensome transitions at end of life, percent of new nursing home stays lasting 100 days or more, and percent of people with 90+ day nursing home stays successfully transitioning back to the community.

The scorecard ranking is based on how states score on 26 indicators measuring five dimensions of effective LTSS programs:

- Access and affordability;
- Choice of setting and provider;
- Quality of life and quality of care;
- Support for family caregivers, and
- Effective transitions.

Ranking fifth is a significant accomplishment. Not only did Alaska rank high on the LTSS Scorecard, but an analysis of changes revealed it improved its program over previous time periods. Baseline data, typically two to three years prior, were available for 19 of the 26 indicators. Alaska improved on seven of the 19 indicators.²⁴⁸ In general, Alaska scores well on these indicators and the use of some of them might convey the quality of Alaska's LTSS efforts.

PCG considered whether or not the average travel time needed to access selected services or the percent of persons by geographical region that access services would be desirable results-based measures. They are good measures but the administrative burden of correctly measuring them is considerable especially if done annually.

²⁴⁸ Ibid. Exhibit A4, p. 67.

REVIEW OBJECTIVE 08 – INFORMATION TECHNOLOGY

Evaluate whether DHSS' use of information technology effectively and efficiently supports the various long-term care programs and services. The evaluation should include the extent DHSS can track and report on benefit recipients, including the extent recipients are receiving multiple benefits and whether recipients are Medicaid eligible. As applicable, the evaluation should recommend new types and uses of technology to improve efficiency and effectiveness in line with recognized best practices. Recommendations should include a justification that benefits outweigh costs. The review team will exclude the recently implemented Medicaid Information System. This should address the following:

- A. Does the Department utilize technology to effectively and efficiently deliver and administer long-term care services?**
- B. Does information technology allow the Department to track and report on benefit recipients, including the extent recipients are receiving multiple benefits and whether recipients are Medicaid eligible?**
- C. Are there areas where the Department could utilize technology best practices to improve the effectiveness or efficiency of such services? What are potential savings or costs to the Department if it adopts a recommended technology or best practice? What is the net benefit to the Department by adopting a recommended technology or best practice?**
- D. What are the estimated long-term maintenance costs for the technology or best practice identified?**

Overview

In approaching the analysis of information technology used in long term services and supports (LTSS), PCG looked at the following indicators of effectiveness and efficiency.

- Does the existing information technology structure support all long term care health programs and services provided?
 - To what extent and how easily in terms of automation can summary tracking reports be pulled? Determine if these reports appropriately help the service delivery team.
- Is the use of information technology consistent across all services?
 - Are there deficiencies in the Division's use of information technology that increase cost and/or decrease quality of care provided?
- Do the IT systems in place track the recipients of benefits across different services and programs?
- Does the IT system in place improve efficiency and reduce costs?

In looking at these indicators, PCG staff interviewed information technology staff, obtained descriptions of technology projects, reviewed IT Governance priority documents, reviewed Departmental IT Plans, and reviewed information produced by IT systems.

This work has resulting in the summary findings that the Department is implementing efficient technology to use in its Long Term Service and Supports (LTSS) programs and can adequately track the utilization of services.

A. Does the Department utilize technology to effectively and efficiently deliver and administer long-term care services?

The changes that the Department is now making should result in effective technology use in its LTSS programs. In recent years, state LTSS programs have implemented substantial improvements to their technology. For example, these states include Connecticut, Maryland, Mississippi, and Minnesota.²⁴⁹ In addition to the work of particular states, the Center for Medicare and Medicaid Services (CMS) has funded 18 states via the Balancing Incentives Payment Program (BIP). BIP is designed to help states move to a more "balanced" program in which HCBS expenditures are the same as or greater than institutional expenditures.²⁵⁰ States e.g. Mississippi, have funded technology innovations using the CMS BIP funding.

In addition, CMS has awarded nine states funding under the Testing Experience and Functional Tools (TEFT) program. This funding will develop survey instruments for collecting information about the Medicaid participant's experience of care and build personal health records for participants.²⁵¹

Along with other states, Alaska is also implementing significant changes to its LTSS technology platform. It is developing an Automated Service Plan (ASP) program which will build a case management system for all persons that use LTSS services. This is a \$14 million dollar project funded by 90-10 Federal matching

²⁴⁹ In the last 12 months, PCG staff have reviewed LTSS technology changes in Connecticut, Maryland, Mississippi, and Minnesota.

²⁵⁰ See CMS BIP website at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Balancing-Incentive-Program.html>.

²⁵¹ See CMS TEFT website at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/grant-programs/teft-program.html>.

funds.²⁵² When operational, the technology will include the 1915(c) waivers, the PCA program, the nursing home transition program, and general relief services.²⁵³

The system is being implemented in stages. The first stage, which went live in December 2014, was a centralized reporting function encompassing adult protective services, quality assurance and licensing. The second stage, which will be rolled out between June and October 2015, contains tools to manage participants and providers:

- Developing a case management system that can be shared by about 5,000 users;
- Enabling the use of an automated service plan for PCA and waiver program participants;
- Transmitting service authorizations and plan approvals from SDS;
- Helping providers apply to be part of the program;
- Tracking how many clients are with each provider;
- Tracking which rendering provider is associated with a plan of care, and
- Sending automated licensing renewal notifications to providers.

While these technology changes improve the storage and transmission of information, the changes also have a substantive impact on how work is organized. They establish new methods of communicating information, change work routines, standardize business processes, and create multiple efficiencies in how tasks are processed.

B. Does information technology allow the Department to track and report on benefit recipients, including the extent recipients are receiving multiple benefits and whether recipients are Medicaid eligible?

The existing information technology structure appears to support all LTSS programs. Interviews with Department staff and documents reviewed indicate that current technology will produce basic information on which services are provided when, the number of persons receiving the services, and payment amounts for services. PCG had no difficulty obtaining these data and it appears they are readily available to Departmental staff.

The information technology used by the Department can identify the extent to which recipients are receiving multiple benefits and whether recipients are Medicaid eligible. MMIS programs routinely contain edits that eliminate the payment of duplicate benefits and restrict payments for only those dates of service that the recipient was Medicaid eligible. Because of the current litigation between the state and Xerox, PCG did not contact Xerox to confirm the existence of particular MMIS edits.

²⁵² See Department of Health and Social Services FY 16 Information Technology Plan for brief details on project.

²⁵³ The new system will not include persons served under grants and contracts. For grants per se, the procurement, award, and fiscal reporting will continue to be managed in the Grants Electronic Management System (GEMS).

C. Are there areas where the Department could utilize technology best practices to improve the effectiveness or efficiency of such services? What are potential savings or costs to the Department if it adopts a recommended technology or best practice? What is the net benefit to the Department by adopting a recommended technology or best practice?

There are areas where the Department could utilize technology best practices to improve the effectiveness or efficiency of its LTSS services.

PCG estimates that the 2014 allocated cost of the Department's information technology to LTSS support was approximately \$3.8 million.²⁵⁴ The 2014 contract for the SDS Automated Service Plan (ASP) was \$2,036,009 of which 90% was paid for through federal funds.²⁵⁵ These two sources account for approximately \$5.8 million in technology support costs. Another significant cost incurred by LTSS services is through the states' Medicaid Management Information System (MMIS). Usually, the use of MMIS services are estimated by counting the transactions associated with LTSS-related transactions. However, because of the litigation around the MMIS program it was deemed advisable that PCG's review not touch upon MMIS activities.

As mentioned above, the Department is undertaking a fundamental change in the technology platform it uses to link LTSS providers and state government processes. Ninety percent of the cost of this new program was paid by Federal Medicaid funds under the auspices of an Advanced Planning Documents (APD).²⁵⁶

TELEHEALTH

The next technology priority for LTSS programs is the expansion of telehealth capability to conduct reassessments of persons. Persons receiving Medicaid LTSS services are required to have their nursing facility level of care reassessed each year. A pilot program using telehealth technology for reassessments has been established and its forms and provider agreement can be accessed at Department websites.²⁵⁷ Approximately 50 persons have been reassessed using telehealth and the program is in the process of moving from a pilot status to a broader, more established program.

SDS staff have estimated the travel savings from the first 50 persons assessed to be approximately \$2,000 per person, based on the travel costs to remote locations. Fixed cost for the telehealth program are \$20,000 for equipment and \$1,000 a month for the telehealth room. The program is demonstratively cost effective.

The expansion of the reassessment program is supported by Medicaid reimbursement policies encouraging the use of telehealth. Alaska is one of three states whose Medicaid program reimburses for live video, "store

²⁵⁴ Calculated by taking the estimated costs of LTSS as a percentage of the Department's 2014 budget and applying that percentage to the 2014 costs of Information Technology.

²⁵⁵ Information obtained file titled "3 Copy of Active EN" provided to PCG.

²⁵⁶ For information regarding APDs see <http://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-Implementation/Downloads/FAQs-by-Topic-75-25-Eligibility-Systems.pdf> and <http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MMIS/downloads/mectchapter2.pdf>. See also <https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=93163>.

²⁵⁷ See Center for Connected Health Policy at <http://cchpca.org/jurisdiction/Alaska>.

and forward”, and remote monitoring. In addition, AS 08.64.364 permit on-line dispensing of medications.²⁵⁸

An SDS related telehealth project is listed on Department’s “Master IT Governance Project Initiative Prioritization.” The project is simply described as a “Beta project to use polycom video conferencing services for SDS telehealth to complete plans of care sessions” and the project list states the project is in a planning stage.²⁵⁹

Recommendation 8.1: The telehealth pilot program is recommended for expansion. An increase in telehealth in reassessments is an effective and efficient use of technology that will be cost effective.

ELECTRONIC HEALTH RECORDS

The use of electronic health records in LTSS is embryonic now. However, a new eLTSS initiative is coming. This new initiative is driven by the requirements of the CMS Testing Experience and Functional Tools (TEFT) program created in the Affordable Care Act (ACA).²⁶⁰ The protocols of this initiative are creating an electronic record format that is designed for eLTSS services. The system that is evolving will have states create electronic health records for persons in their Medicaid program and allow these persons a web-based access to their records.

An eLTSS EHR will be created and both the individual and entities that provide services to the individual will have access to the eLTSS EHR.

PCG does not recommend that Alaska develop web-based EHRs for use in its LTSS programs. Alaska lacks the LTSS administrative and program resources as well as Federal support to build or participate in eLTSS EHR initiatives, but these technology innovations should be tracked, understood, and considered when the time is appropriate.

HEALTH INFORMATION TECHNOLOGY

PCG reviewed the 2012-2014 State Medicaid HIT Plans and except for one reference to the Division of Seniors and Disabilities Services (SDS) providers using the provider portal, the plan did not appear to have other direct relevance to LTSS. Over the long run, LTSS beneficiaries will benefit from the sharing of physician and hospital records among their providers but this benefit is not an immediate one. Federal HIT efforts excluded nursing facilities from the “meaningful use” and incentive programs and this has had a fragmenting effect on efforts to include LTSS providers in EHR projects.

A review of the *2012 DHSS Enterprise Technology Roadmap* indicates the majority of references to SDS in it relate to the integration of the Automated Service Plan (ASP) with other Department enterprise functions. The Roadmap does not identify or prioritize LTSS automation needs and priorities.

²⁵⁸ See <http://www.legis.state.ak.us/basis/statutes.asp#08.64.364>.

²⁵⁹ Information obtained from the undated DHSS supplied file “Master IT Gov_Project Initiative Prioritization v1.0”.

²⁶⁰ [http://wiki.siframework.org/electronic+Long-Term+Services+and+Supports+\(eLTSS\)](http://wiki.siframework.org/electronic+Long-Term+Services+and+Supports+(eLTSS)).

In addition to the expansion of telehealth, PCG has four LTSS technology related recommendations which would improve Alaska's LTSS programs.

Recommendation 8.2: The Department should adopt a single assessment process to determine eligibility for LTSS services.

Alaska currently uses three assessment tools:

- The Consumer Assessment Tool which is used with the Alaskans Living Independently (ALI) waiver.
- The Inventory for Client and Agency Planning (ICAP) is used with persons that have intellectual or developmental disabilities (ID/DD), and
- The Children w/Complex Medical Conditions (CCMC) waiver uses a third tool specialized for children.
- Contemporary federal thinking is stressing the need for a single assessment process to cover the various population groups. This thinking is exemplified in the requirements of the Balancing Incentive Payment Program (BIP).
- As part of their participation in the BIP application, states agreed to make the following three structural changes:
 - A No Wrong Door–Single Entry Point system (NWD/SEP);²⁶¹
 - Conflict-free case management services, and
 - A core standardized assessment.

The purpose of a core standardized assessment is to improve the efficiency and economy of state LTSS programs. A single assessment process is seen as simplifying eligibility, improving access to services and resulting in a lower administrative burden on states. CMS is not requiring that states have one assessment instrument, rather their needs to be a single assessment document containing information about the person's abilities to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs), as well as information about their medical, cognitive and behavioral concerns.²⁶² Information from currently used assessment tools are inputted into the standardized assessment document.

While CMS has not mandated the use of a single assessment tool, some states are modifying existing assessment instruments to create a single tool e.g. New York is doing this with the InterRAI assessment system.²⁶³ Overtime, a continued federal push on states is likely. The federal position is clear.

A well-designed universal assessment can offer several benefits to a State, such as promoting choice for consumers, reducing administrative burdens, promoting equity, capturing standardized data, and automating data systems to indicate programs for which an individual is likely eligible... Universal

²⁶¹ LTSS policy stresses that information about LTSS option needs to be made available to persons in a convenient accessible manner. The development of "no wrong door" and "single entry points" was accelerated with the establishment of Aging and Disability Resource Centers (ADRCs). Between 2003 and 2005 CMS and the other federal agencies funded 43 states.

²⁶² See BIP manual at <http://www.balancingincentiveprogram.org/resources/revised-balancing-incentive-program-implementation-manual>.

²⁶³ See InterRAI website at <http://www.interrai.org/>.

assessment information and data systems can also support State efforts to project future service, support and budget needs and prioritize individuals for services when waitlists are present or budgets are limited.

The costs and savings of implementing this uniform assessment are hard to quantify since much of the cost is in the staff time to discuss and create the process and the savings are also in staff time and efficiency. There are some programming costs. These costs are potentially fundable under 90-10 federal funding. Some states such as Maryland and Mississippi have folded uniform assessment into their equivalent of the Automated Service Plan (APS) project and other states such as New York simply funded it as a standalone vendor contract.²⁶⁴

Recommendation 8.3: The State of Alaska should join the National Core Indicators (NCI) project.

Approximately 42 states participate in the NCI program. The essential characteristic of the project is that annual surveys are done each year of a random sample of persons with intellectual and developmental disabilities. The survey data focus on the individual's experience of care. These are not opinion surveys, rather the questions focus on the experience of the individual, asking for example, if they can see their family and friends when they want, do they engage in moderate physical activity, and do they have adequate transportation when they want to go somewhere.

Medicaid policy is emphasizing the use of such surveys and in March 2014 CMS funded nine states to participate in the Testing Experience and Functional Tools (TEFT) effort to build such tools. Experience surveys like this are valuable quality management tools for state program staff especially when answers can be compared across states. These are not opinion surveys of participants and are not the opinions of state staff about the quality of state programs. Rather they are an essential quality of care tool that Alaska should implement.

A coalition of national organizations has developed the online data entry system and other technology to compile and disseminate answers from all the states. The data provide states an understanding of how persons in their state experience their life and how well their state does compared to others. This national effort is unique among the populations served by Medicaid programs. Usually a third party, not the state, conducts the interviews. For example, in South Carolina the quality improvement organization (QIO) does the interviewing.

The primary expense to the state is the cost of the interviewing and the secondary expense is the \$13,380 annual participation fee.²⁶⁵

²⁶⁴ See https://www.health.ny.gov/facilities/long_term_care/uniform_assessment_system/.

²⁶⁵ See memo of agreement at <http://www.nationalcoreindicators.org/about/join-nci/>.

Recommendation 8.4: The Department should consider the use of an electronic visit verification (EVV) system with the PCA and waiver programs.

These systems use an electronic device of to confirm that a visit is occurring at a particular time and location.²⁶⁶ Numerous states including Texas²⁶⁷, Illinois²⁶⁸, and Oklahoma²⁶⁹ use electronic verification systems.²⁷⁰ These systems can be as simple as using an app on a smartphone, and increase healthcare provider accountability.²⁷¹

The Office of the Inspector General of the U.S. Department of Health and Human services has identified personal care services as a significant area for Medicaid scrutiny.²⁷² EVV systems are one of the technology tools that can minimize unnecessary state expenditures. In initiating authorization for electronic visit verification programs, states have made estimates of the potential savings.²⁷³ In 2013, based on pilot studies the state of Texas estimated a 3% savings in its personal care services program and a 2% savings in private duty nursing.²⁷⁴ The fiscal impact of Louisiana HB 668 which was passed in the 2014 session envisioned a 4% reduction in decrease in payments to Louisiana’s Long Care Personal Care Services providers and Community Choices waiver providers.²⁷⁵ In 2014, Rhode Island estimated savings of one million dollars on a personal care and home maker services program that had \$82 million in expenditures.²⁷⁶ PCG believes an estimate of 1% to 2% in savings is potentially possible.

An EVV pilot project is listed on the Department’s Master IT Governance Project Initiative Prioritization and has an estimated cost of approximately \$1 million.²⁷⁷ The project list indicates that IT Governance approval has not been given to the project.

Recommendation 8.5: The Department’s IT plan should be amended to contain substantive planning and analysis of what IT work needs to be done in order to improve the effectiveness and efficiency of Department operations.

PCG reviewed the Department’s *FY 16 Information Technology Plan*. The 13-page document consists of general vision statements, budget information, a DHSS table of organization, and lists of current projects. This Plan lacks a detailed plan of action. The use of technology to improve LTSS services would benefit

²⁶⁶ For example, see New Mexico description at <http://www.hsd.state.nm.us/uploads/files/Public%20Information/Centennial%20Care/Quarterly%20Reports/NM%20CC%20quarterly%20report%20053014final.pdf>.

²⁶⁷ See <https://www.dads.state.tx.us/evv/>.

²⁶⁸ See <https://www.dhs.state.il.us/page.aspx?item=68869>.

²⁶⁹ See <http://www.okdhs.org/programsandservices/aging/adw/evv/electronic+visit+verification.htm>.

²⁷⁰ Other states with EVV include Florida, New Mexico, New York, Ohio, Pennsylvania, South Carolina, Tennessee, and Washington.

²⁷¹ See example of app of <http://www.axxess.com/evv>.

²⁷² See <http://www.drnpa.org/wp-content/uploads/2014/03/Protecting-Personal-Care-Services-from-Fraud-and-Abuse.pdf>.

²⁷³ In 2014, legislative staff in the state of Nevada declined to make a fiscal on SB 198, an EVV bill. See

<http://www.leg.state.nv.us/Session/78th2015/FiscalNotes/2893.pdf>.

²⁷⁴ See <http://www.hhsc.state.tx.us/news/meetings/past/2013/mcac/110813/13.pdf>.

²⁷⁵ See fiscal note to HB 668 at <http://www.legis.la.gov/legis/ViewDocument.aspx?d=906018>.

²⁷⁶ See p. 23 of fiscal summary at

http://websserver.rilin.state.ri.us/SenateFinance/budget_analyses/FY2015/FY2015%20Budget%20as%20Passed%20by%20HFC.pdf.

²⁷⁷ Information obtained from the undated DHSS supplied file “Master IT Gov_Project Initiative Prioritization v1.0”.

from a rigorous plan at the Department level outlining how technology can be better used to support LTSS services. The Department operates in a complex environment and currently has approximately 500 servers, 4,000 workstations and 75 current projects. If the Department is going to publish an annual IT Plan, then it should contain substantive discussions.

D. What are the estimated long-term maintenance costs for the technology or best practice identified?

The long-term maintenance cost of a single assessment instrument and the ASP above base expenditure levels are not known. Both of these IT initiatives involve considerable startup costs but both are permissible IT expenditures and eligible for 90-10 federal match which is how the ASP was funded.

The 90-10 federal funding allows for considerable flexibility in avoiding downstream module repair and replacement. It is likely that maintenance expenditures for these two initiatives would not be above maintenance costs now in the Department's budget base.

Participation in the NCI quality program would require approximately \$14,000 a year and the cost of interviewing approximately 400 persons. The work would have to be bid and could conceivably run \$200 to \$300 per interview.

PCG spent considerable time establishing the potential savings of an EVV system. A review of state studies shows that net savings are reported but not maintenance costs. Equipment replacement and repair would be the major maintenance cost and can be covered from program savings. Exact costs are probably dependent on the make of device but it is highly likely they can be covered from program savings.

Telehealth maintenance would entail \$1,000 a month for the telehealth center and equipment would have to be replaced or updated periodically. The original equipment cost is \$20,000.

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REVIEW OBJECTIVE 09 – UTILIZATION TRACKING

Evaluate DHSS' current method of tracking utilization of long-term care services by clients, and, if determined necessary, recommend effective methods to improve DHSS' effectiveness in this area. This should address the following:

- A. Does the Department effectively track the utilization of services by clients who are receiving long-term care services?**

- B. Are there recommended best practices to improve the methods of tracking the utilization of services by clients that would improve the effectiveness or efficiency of long-term care service delivery?**

A. Does the Department effectively track the utilization of services by clients who are receiving long-term care services?

B. Are there recommended best practices to improve the methods of tracking the utilization of services by clients that would improve the effectiveness or efficiency of long-term care service delivery?

OVERVIEW

The Department has the capability of tracking service utilization by clients but does not always report the utilization on easily discovered Department websites. There are improvements that can be made in the analysis and reporting of information about LTSS programs.

In states that do not use Medicaid managed care organizations, any Medicaid Management Information Systems (MMIS) claims payment system has all of the information needed to fully track the units of service paid for and payment by program participant and provider.

In this section of the performance review, PCG uses the word “utilization” broadly to refer to units of service provided, payments for those services, and any quality-related information about the services provided.

This review of utilization tracking will list the major LTSS provided by the Department and describe utilization information available about these programs. Where applicable, recommendations will be provided tailored toward improving the effectiveness and efficiency of tracking the utilization of LTSS delivery.

NURSING HOMES

The Health Care Facilities Licensing and Certifications section of the Department is responsible for licensing Alaska’s 18 nursing homes. In December 2014, these homes had 693 beds and an 87.7% occupancy rate compared to a national occupancy rate of 82.3%.²⁷⁸ State websites contain licensing information about each home.²⁷⁹ Service utilization is captured by the Alaska Medicaid program which maintains claims payment files on the amount of payment made each day for each Medicaid-supported nursing home resident. A properly functioning claims payment system should have only normal delays in aggregating utilization data.²⁸⁰

The Centers for Medicare and Medicaid Services (CMS) has mandated the use of the Minimum Data Set (MDS) in all nursing homes. The MDS is a 41-page questionnaire containing 20 sections and has a 357-page manual to help nursing home staff fill out the questionnaire.²⁸¹ In addition to the MDS data, nursing

²⁷⁸ American Health Care Association, “Nursing Facilities’ Operational Characteristics Report, December 2014. See: http://www.ahcancal.org/research_data/oscar_data/Pages/default.aspx. *The website requires a log-in and password to see the reports.

²⁷⁹ See <http://dhss.alaska.gov/dhcs/pages/hflc/default.aspx>. Retrieved 4-14-2015.

²⁸⁰ For example, data processing requests are filtered up to the DHSS IT Governance group that decides what projects get worked on. They meet once a month and this introduces delay in the processing of requests.

²⁸¹ See <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html> Retrieved 4-14-2015.

homes also maintain medical and pharmaceutical histories on their residents with varying electronic retrieval and data query capabilities.

MDS information on quality of care in nursing homes is published by CMS and any resident of Alaska can examine how well a home they are considering using compares to other nursing homes both in Alaska and in the lower 48 states.²⁸²

In addition to linking to the CMS quality of care data, Department websites also provide access to the CMS 2567 reports which list deficiencies found by state survey staff when they inspected the nursing home.²⁸³

The CMS quality of care data continues to be published and CMS is also placing increased emphasis on nursing home staffing data.

Recommendation 9.1: The Department should consider providing and presenting more quality of care data.

Recommendation 9.2: The Department should consider implementing a Minimum Data Set (MDS) system in its AKPHs to track quality of care.

ALASKA PIONEER HOMES (AKPH) – ASSISTED LIVING FACILITIES

In its review of AKPH utilization information, PCG developed the summary observations that the AKPHs:

- Have strong occupancy utilization and patient demographic information;
- Do not have a system for reporting quality of care information across the homes, and
- Do not use population health management practices and their associated medical care utilization reporting such as Healthcare Effectiveness Data and Information Set (HEDIS) or Quality Rating System (QRS) measures.

AKPH staff told PCG that they track utilization and can provide the following types of information relevant to utilization:

- Demographic Data;
 - Occupancy tracking per level of care for each home (yearly averages and monthly data);
- Resident Data;
 - Entity name: AKPH the individual resides;
 - Last name: last name of resident;
 - First name: first name of resident;
 - Birth date: resident's birthday;
 - Current age: resident's current age (regardless if the resident has passed);

²⁸² See the CMS Nursing Home Compare website at <https://www.medicare.gov/nursinghomecompare/?AspxAutoDetectCookieSupport=1> Retrieved 4-14-2015.

²⁸³ See Statement of Deficiencies and Plan of Correction Form CMS 2567 at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms2567.pdf> Retrieved 4-14-2015.

- Stay type age: age when Stay Type has been documented;
- Stay type²: resident stay type (admission, discharge, therapeutic leave, etc...);
- Stay date: date of status change/documentation;
- SSN: social security number of resident;
- Veteran: veteran status;
- Care plan name: resident's level of care (Level I, Level II, Level II, Respite, Missing);
- Previous address 1: address prior to admission;
- Previous address 2: address prior to admission;
- Previous city: address prior to admission;
- Previous state: address prior to admission;
- Previous zip: address prior to admission;
- ICD 9 code: international statistical classification of diseases and related health problems, and
- Description: the description of the ICD 9 Code.

For example, Alaska's six AKPHs are licensed to provide assisted living and pharmaceutical services. The Homes tier the eligibility for services into three Levels.

Level I: includes household help with meals and emergency assistance. It does not provide assistance for activities of daily living (ADLs).

Level II: includes care provided by Level I, and additionally provides medication administration and assistance with ADLs.

Level III: includes care provided by Level I and II, and additionally provides 24 hour hands-on assistance, with staff performing a majority of the effort for an individual's activity.

The levels reflect differences in the amount and kind of services that persons require and AKPHs tend to co-locate persons in the same level. For example, a Home may set aside a certain number of beds for Level II residents and these beds will be located in a wing or other distinct part of the Home. Each month the homes report the number of residents by their Level and this monthly utilization information is available for a multi-year period. If the AKPH wished to analyze the data, it could study its Pioneer Home population to see which specific medical services its Medicaid residents are receiving. It could use procedure codes paid for through the MMIS system to identify these services.

For example, *Figure 9.1: Monthly Average Residents in Alaska Pioneer Homes by Tier Level, 2008 – 2013* summarizes utilization data by year by Level for the six homes.

Figure 9.1 Monthly Average Residents in Alaska Pioneer Homes by Tier Level, 2008-2013²⁸⁴

Year	Level I	Level II	Level III	Total
2008	52	137	279	468
2009	59	135	271	465
2010	56	140	261	457
2011	60	142	258	460
2012	57	148	254	459
2013	60	137	252	449

The figure indicates the total monthly average population in AKPHs has been almost flat, declining modestly from 468 in 2008, to 450 in 2013. The Level III population has shown the largest change of the three levels, declining from 279 to 252. The information in the figure above contradicts information provided in the interviews. When interviewed, more than one person told PCG reviewers that Level III persons were increasing. However, an examination of multi-year data indicates that this comment was true for the period prior to 2004, but is not true for recent years.

PCG was also told that AKPH may differ in their assignment of persons to levels e.g. a person could be assigned to be in Level II at one home but be deemed to be a Level III at another home. The analysis of variances in utilization classifications is beyond the scope of this review, however, any systematic biases in classification would impact utilization reporting.

In general, AKPH appears to collect and track utilization data on a monthly basis and can readily provide the information. What is missing in the operation of the AKPHs is comparable reported data on quality of care. While individual homes collect good quality of care data, there is no system of quality reporting that results in transparent published metrics of quality of care summarized across all homes.²⁸⁵ The AKPH Advisory Board has published annual reports containing quality metrics, but the last such report was published in 2012.²⁸⁶ For example, AKPHs do not appear to report on HEDIS or QRS measures for all AKPH residents.²⁸⁷

In 2014, AKPHs transitioned from AccuCare to Point Click Care, an electronic health record (EHR) system. Records stored in Point Click Care are different than historical records which are stored in AccuCare. AccuCare stores home specific data and it must be accessed through a remote connection to each home. From staff descriptions, it is not clear that medical information can be summarized across homes to aid in

²⁸⁴ DHSS.

²⁸⁵ The Pioneer Home in Palmer visited by PCG reviewers had an excellent quality assurance program.

²⁸⁶ See webpage of Advisory Board at <http://dhss.alaska.gov/daph/Pages/advisoryboard.aspx> Retrieved on 4-15-2015.

²⁸⁷ For HEDIS population measures see <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx>.

And for QRS quality measures see CMS website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html>.

the management of population health. In this respect the AKPH appear to be operated as single homes rather than being managed as a single population that happens to live in six locations.

The management of population health is increasingly stressed in contemporary health policy as systems of care move away from fee for service arrangements to value based payments. Treating the population of persons that live in the AKPHs as a single population and reporting quality measures on their health characteristics would be a fundamental perspective change. A much different perspective from thinking of the Homes as six different places each with their own population.

Recommendation 9.3: The Department should consider aggregating its medical care information from each of the AKPHs into one database and use that database to manage the health of the entire population of persons using AKPH Services instead of operating each home separately.

PERSONAL CARE ASSISTANCE (PCA)

Personal Care is offered as a state plan service at Attachment 3.1-A.²⁸⁸ The state's personal care program is further defined in Alaska Administrative Code at 7AAC 125.010-7AAC 125.199.²⁸⁹ Department staff indicated that the same claims and demographic data items that were available about the AKPHs were also available for PCA and waiver programs.

At PCG's request, the Department provided five years of PCA service utilization participant demographic data. Two data files for each year were provided: one with claims data and one with demographic information. The files contain considerable information and presumably other files of utilization information could be provided. The Department should be able to provide a wide range of basic utilization information.

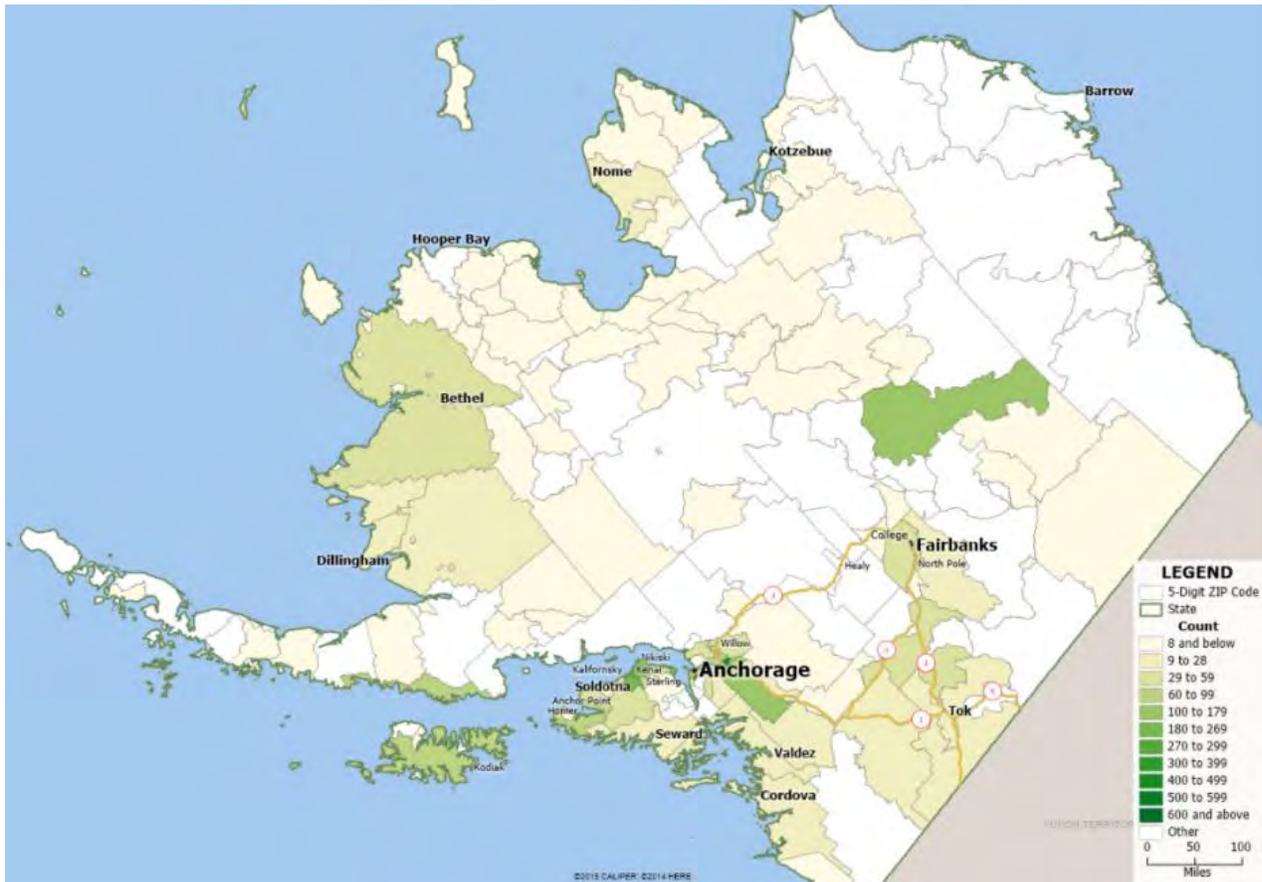
The Department was able to answer requests for utilization data and reviewers believe the Department has the capability of tracking utilization effectively. For example, on the following pages are two maps demonstrating PCA participants by zip code. The first figure shows the main part of the state and the second shows the southeast portion of the state. State utilization data show that there was 14% increase in the number of persons receiving PCA services in rural areas from 2010 to 2014 and a 10% increase in the number of persons receiving PCA services in urban areas.²⁹⁰

²⁸⁸ See Alaska Medicaid State Plan at http://dhss.alaska.gov/Commissioner/Documents/medicaidstateplan/PDF_SP/SP_pgs/SP_att3.1a.pdf.

²⁸⁹ See ACC at [http://www.legis.state.ak.us/basis/folioiproxy.asp?url=http://www.jnu01.legis.state.ak.us/cgi-bin/folioisa.dll/aac/query=\[JUMP:'Title7Chap125'\]/doc/{@1}?firsthit](http://www.legis.state.ak.us/basis/folioiproxy.asp?url=http://www.jnu01.legis.state.ak.us/cgi-bin/folioisa.dll/aac/query=[JUMP:'Title7Chap125']/doc/{@1}?firsthit).

²⁹⁰ In this data analysis an "urban" area is defined to include Anchorage Municipality, Fairbanks North Star Borough, Juneau Borough, and the Matanuska Susitna Borough.

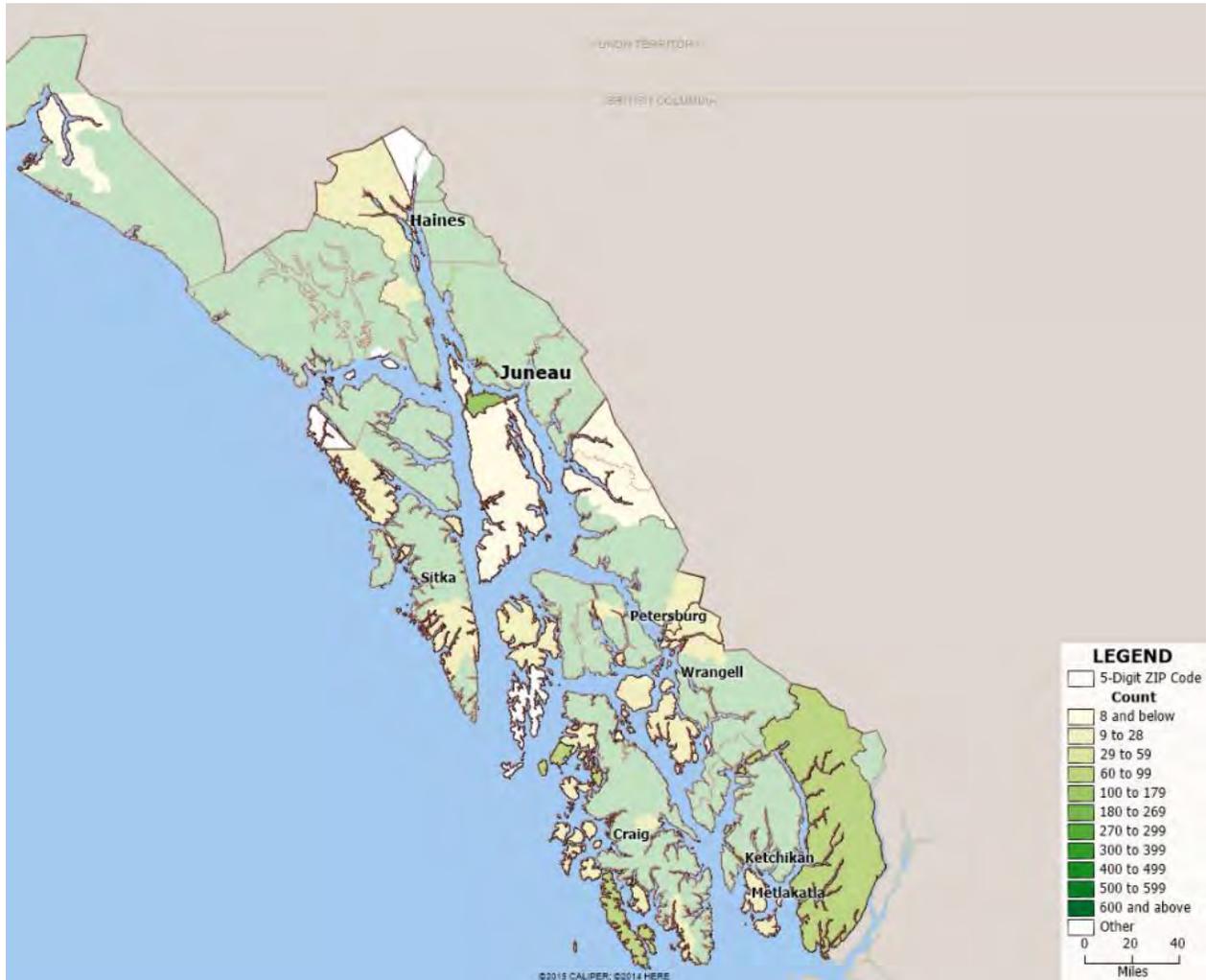
Figure 9.2: Personal Care Assistance Program Participants by Zip Code, 2015 ²⁹¹



²⁹¹ DHSS.

Figure 9.3: Personal Care Assistance Program Participants in Southeast Alaska by Zip Code, 2015

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MEDICAID WAIVERS

The waiver programs include the following:

- Children with Complex Medical Conditions (CCMC);
- Adults with Physical and Developmental Disabilities (APDD);
- Adults Living Independently (ALI), and
- People with Intellectual and Developmental Disabilities.

The ALI and APDD waivers were implemented on July 1, 2011. These waivers were the result of combining the Older Alaskans (OA) and Adults with Physical Disabilities (APD) waivers to create the ALI, then creating a separate waiver, the APDD, to serve adults with physical and developmental disabilities.

²⁹² DHSS.

At PCG's request, the Department provided five years of PCA service utilization and demographic data on program participants. These files also contain considerable information and presumably other files of utilization information could be provided. While the Department can provide a range of basic utilization information such information does not appear to be routinely reported. For example, the last Tribal Medicaid Activity report on was done in FY 2012.

SUMMARY COMMENTS

In states that do not use Medicaid managed care organizations, any Medicaid Management Information System (MMIS) claims payment system has all of the information needed to fully track utilization. During PCG's interviews with staff, multiple references were made to the fact that 2013 and 2014 MMIS data is unreliable, which has prevented them from using that data. However, this should be cleared up over time.

The summary finding of this section is that the Department can effectively track utilization. What is missing in Departmental websites is more expansive reporting of utilization data. There is a substantial public value when an agency transparently describes its programs and provides access to its information.

Currently, it is not possible for members of the legislature and members of the public to go to the Department's websites and find information on how many persons are served in each program and what the costs of the services are. Nor is it possible to find information on how well the Department manages its programs. What are the quality outcomes of the Department's work? For example, data on quality of care in AKHPs and waiver programs are not reported on the Department's website.

Recommendation 9.4: The Department should improve its reporting on LTSS programs by publicly reporting quality of care information on Department websites.

Recommendation 9.5: The Division of Seniors and Disabilities Services should develop a "dashboard" permitting persons to query utilization data on LTSS programs by eligibility group, age, and geography.²⁹³ This dashboard database could be merged into the new Cube project, which is being developed for implementation with the Master Client Index (MCI).

²⁹³ See for example, Maryland's Medicaid e statistics dashboard at <http://www.chpdm-ehealth.org/>.

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REVIEW OBJECTIVE 10 – FRAUD, WASTE, AND MISUSE

Recommend improvements based on best practices to reduce, prevent, or detect fraud, waste, and misuse of services. This should address the following:

- A. Does the Department effectively reduce, prevent, or detect long-term care related fraud, waste and misuse?**
- B. Are there recommended best practices that could be utilized by DHSS to prevent, detect, or reduce, waste, and misuse of long term care services?**
- C. Are there cost savings that will result from reducing, preventing, or detecting fraud, waste, and misuse of services?**

Overview

The Department has taken effective steps in the prevention and detection of fraud and can still make improvements. PCG reviewed Departmental activities to determine if reasonable measures were being taken to effectively prevent, detect, or reduce fraud, waste, and misuse of LTSS programs. The most significant improvement made has been to track the hours and days of work of individual providers. This is a national best practice which is not done by most states.²⁹⁴

The Office of Program Integrity (OPI) within the Division of Health Care Services is the Medicaid unit responsible for controlling fraud and abuse in Medicaid programs. OPI does not prosecute Medicaid fraud. Responsibility for prosecution rests with the Medicaid Fraud Control Unit (MFCU) in the Department of Law. The role of OPI is to develop the factual basis of the case and present that information to MFCU. Department staff interviewed indicated that relations with MFCU had dramatically improved in recent years and the Departments developed a close working relationship.

Major pre-payment and post-payment activities that OPI undertakes or cooperates with are prescribed in state law and federal Medicaid regulations, and include:

- A contracted review of selected providers done under the auspices of Alaska Statutes at AS 47.05.200;
- Medicaid Integrity Program (MIP) audits that are contracted by the Centers for Medicare and Medicaid Services;
- The Recovery Audit Contractor (RAC) program is a contracted review of claims;
- The Surveillance and Utilization Review Subsystem (SURS) is a routine claims activity performed by the vendor operating the Medicaid claims payment system, and
- The Payment Error Rate Measurement (PERM) program is a federally contracted review of state claims payments to detect and measure their error rate.

PCG was not authorized to review the activities of the Medicaid fiscal agent's SURS activity because of the ongoing litigation between the state and fiscal agent. Accordingly, PCG offers no opinion about the effectiveness of its activities.

²⁹⁴ U.S. Department of Health and Social Services, Office of the Inspector General. [Protecting Personal Care Services from Fraud and Abuse](#). 2013.

A. Does the Department effectively reduce, prevent, or detect long-term care related fraud, waste and misuse?

LTSS programs are provided through Medicaid and state grants. Medicaid programs include:

- Personal Care Assistance;
- Medicaid waivers;
 - Alaskans Living Independently;
 - Adults w/Physical and Developmental Disabilities;
 - Children w/Complex Medical Conditions;
 - People w/Intellectual and DD, and
- Nursing Homes.

Non-Medicaid Programs include:

- Community Developmental Disabilities Grant;
- General Relief/Temporary Assistance (GR);
- Senior Community Based Grant Programs (adult day and in-home), and
- Senior Residential Services Grants.

PERSONAL CARE ASSISTANCE

Personal Care Assistance (PCA) is a Medicaid State Plan service defined at 7 AAC 125.010.

(a) “The purpose of personal care services is to provide to a recipient physical assistance with activities of daily living (ADL), physical assistance with instrumental activities of daily living (IADL), and other services based on the physical condition of the recipient, as determined through a functional assessment of self-performance and physical supports.”²⁹⁵

PCA services can be received in one of two ways.

1. The agency-Based PCA program is where recipients receive services through an agency that oversees, manages and supervises their care.
2. The consumer-Directed PCA program is where recipients may manage his or her own care by selecting, hiring, firing and supervising their own personal care assistant. A PCA agency provides administrative support to the recipient and the personal care assistant.²⁹⁶

PCA services are billed on 15-minute increments and the state reimburses approximately \$6.00 per claim. PCG’s analysis of claims for the period FY 2014 found that of the approximately 17,000,000 claims submitted in FY 2014, 99% were for consumer directed services. Approximately \$103 million was paid during FY 2014 for these 17,000,000 claims. The claims data also indicate that approximately 5,600

²⁹⁵ See <http://dhss.alaska.gov/dsds/Documents/pca/pca-regulations.pdf>. Retrieved on 4-7-2015.

²⁹⁶ Description taken from DHSS website at <http://dhss.alaska.gov/dsds/Pages/pca/default.aspx>.

individuals received a PCA service during FY 2014. The agencies received the claim payments from the state and then compensate the personal care assistants.

Unfortunately, due to the size of the program, it has also attracted fraud and abuse.²⁹⁷ There are numerous national estimates as to the amount of fraud in the Medicaid program. For example the U.S. Health and Human Services estimated that in 2010 Medicaid lost 9.4% or \$22.5 billion in Federal Funds because of improper payments.²⁹⁸ It is inappropriate to speculate that a similar 9.4% of Alaska expenditures could be improper. However, there is fraud and abuse in the Alaskan LTSS program. For example, in July 2013, the Medicaid Fraud Control Unit (MFCU) in the Alaska Department of Law announced the filing of criminal charges against 27 Anchorage-based personal care attendants (PCA) and Medicaid recipients as part of an ongoing state and federal investigation into medical assistance fraud by employees of Good Faith Services.²⁹⁹

State staff interviewed indicated they undertook numerous efforts to control fraud and abuse in the PCA program. These efforts included:

- Requiring claims data to contain the provider name of individual personal care assistants that rendered the service;
- Aggregating claims by rendering provider to review billings for unreasonably large amounts;
- Checking vital statistics records to ensure that payments are not made for care provided to deceased recipients;
- Using data from the Department of Homeland Security to check out-of-country travel against dates on rendering provider claims;
- Matching employment data to see if and how many other jobs a rendering provider has;
- Matching corrections data to see if a rendering provider or recipient was in jail during a period when a PCA service was billed, and
- Matching hospital reports to see if a rendering provider was in a hospital during a period when a PCA service was billed.

State staff made comments that these efforts are necessary because agencies have no incentive to review the work of the personal care assistants. Under current policy, the agency gets paid regardless of whether or not the personal care assistant actually provides the service.

²⁹⁷ An excellent overview of fraud and abuse in PCA programs nationally is found in Jason Weinstock, November 5, 2013, "Protecting Personal Care Services from Fraud and Abuse: OIG's Concerns Regarding Vulnerabilities in Medicaid Personal Care Services." Presentation to the National Financial Management Services Conference, See <http://www.dnmpa.org/wp-content/uploads/2014/03/Protecting-Personal-Care-Services-from-Fraud-and-Abuse.pdf>.

²⁹⁸ In its Fiscal Year 2010 Agency Financial Report, HHS calculated and reported the 3-year (2008, 2009, and 2010) weighted average national payment error rate for Medicaid of 9.4%. See Department of Health and Human Services FY 2010 Agency Financial Report (Washington, D.C.: Nov. 15, 2010). At <https://oig.hhs.gov/publications/docs/hcfac/hcfacreport2010.pdf>.

²⁹⁹ See <http://www.adn.com/article/20130709/alaska-charges-29-medicaid-fraud-sets-new-state-record> and <http://www.adn.com/article/20140430/former-good-faith-services-owners-employee-charged-medicaid-fraud>.

MEDICAID WAIVERS

Chore and other services provided under the Medicaid waivers have the same potential for fraud and abuse because they involve a rendering provider visiting a recipient and providing a service to that person.³⁰⁰

Residential services under the waivers are paid on a per diem basis. For example, PCG's claims analysis indicates that in FY 2014 under the ALI waiver, approximately \$39 million was paid for residential services.³⁰¹ Another \$52.4 million was spent on group home habilitation services under the ID/DD waiver.³⁰² While the per diem cannot be gamed, assisted living fraud and abuse issues center on the difficulty of ensuring that services are provided to persons living in the residential setting. Descriptions of the licensing process did not include a confirmation that services were in fact being provided to residents of the assisted living homes.

NURSING HOMES

Alaska has a small number of nursing homes and the risk of fraud and abuse is minimal. Data from the American Health Care Association show that in December 2014, Alaska had 18 nursing homes with 608 residents. Approximately 39% of the 18 homes were publically owned.³⁰³ Twelve to 13 of these homes are collocated with hospitals and homes are reimbursed on a per diem basis. Cost reports are reviewed by state staff in the Office of Rate Review.

The risk of fraud and abuse in this situation seems minimal and PCG makes no recommendations regarding this provider type.

GRANTS AND CONTRACTS

The Department's grant and contracting staff were interviewed and they explained the oversight activities used with contractors and grant recipients.

Grantees are required to have either a State Single Audit or Federal Single Audit conducted if they meet the corresponding thresholds for those funding sources. The Department's Financial Management Section does not have the resources to conduct a full financial audit of all grantees; however, it does perform site visits, desk reviews, and limited reviews of specific expenditures of a grantee, should they come into question.

The Audit Section performs a monthly grantee risk analysis which takes into consideration the following:

- Grantees that are late and/or non-compliant in submitting audits;
- Grantees with issues such as going concern, bankruptcy, material weaknesses, questioned costs, or qualified, adverse or disclaimed audit, and

³⁰⁰ In 2014, under the ALI waiver alone, approximately \$4,000,000 was spent on chore services. These claims were billed using procedure code S5120 and paid at a rate of \$6.15 per 15 minutes.

³⁰¹ These claims were billed using procedure code T2031 and the July 1, 2013 rate schedule indicates per diem rates varying from \$141.08 to \$155.01.

³⁰² These claims were billed using procedure code T2016 and the July 1, 2013 rate schedule indicates a per diem rate of \$309.43 although actual rates paid can be higher.

³⁰³ See http://www.ahcancal.org/research_data/oscar_data/Pages/default.aspx. *This is a proprietary site and requires a log-in to access the data.

- Dollar amount of funding issued to the grantee.

The Audit Section focuses solely on financial factors. It does not look at performance factors. Performance and programmatic factors are overseen by Departmental program managers. The Audit section is relatively new and does not have a long history of performing audits or evaluating if there are recurrent patterns of problems with contracts generally or with specific providers. Staff did report that in recent years the Department has become more proactive in identifying and addressing grantees with issues. For example, in 2014, the Department withheld grant funds for a particular grantee until they brought their single audits up to date and in 2015 they withheld funding altogether for another long time grantee that was not in compliance with the single audit requirement in the required timely manner.

The practices of the Financial Management Unit are normal actions that would customarily be found in state contracting operations.³⁰⁴

B. Are there recommended best practices that could be utilized by DHSS to prevent, detect, or reduce, waste, and misuse of long term care services?

After reviewing the operations of the OPI and the comments of state staff, PCG believes there are recommended best practices that could be used by the Department to prevent, detect, or reduce fraud, waste, and misuse of long-term services and supports. PCG has recommendations for improving the efforts to deter and detect fraud and abuse in the PCA program. One theme of the recommendations is to rework the architecture of programs to create a shared responsibility for the prevention and remediation of fraud and abuse.

Recommendation 10.1: Provider enrollment activities should be strengthened.

CMS conducts reviews of state Medicaid Program Integrity efforts. The January 2014 review of Alaska's efforts was critical of provider enrollment procedures saying:

*Ineffective provider enrollment practices and reporting, including but not limited to, failing to properly search for excluded providers, properly capture necessary information for enrollment, properly implement new provider enrollment and screening regulations, and properly handle the reporting and notification requirements for adverse actions taken against providers who are denied enrollment or removed from the program.*³⁰⁵

³⁰⁴ PCG bases this opinion on its considerable experience reviewing state contracting procedures. For example, in 2009 PCG conducted a Cost Analysis of Community-based Rehabilitation Programs for the Florida Department of Education, and in 2010 PCG conducted the "Early Childhood Intervention Services Contract and Funding Infrastructure Review Project" for the Texas Department of Assistive and Rehabilitative Services. Neither of these reports is available on a state website.

³⁰⁵ See CMS report of January 2014, Alaska Comprehensive Program Integrity Review. CMS program integrity review reports are available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Program-Integrity-Review-Reports-List.html>.

The CMS report went on to point out that some of these same problems found in its 2010 review of Alaska’s work were still not resolved. Provider enrollment control is a best practice preventive measure employed by multiple states. In 2014, seven states took actions to improve their provider enrollment controls.

For example, Alabama reported requiring DME and home health providers to re-enroll annually (instead of once every three and five years, respectively); Arizona’s Office of Inspector General (OIG) is automating the provider registration process to increase its efficiency and effectiveness and has also prioritized the development of the automated Excluded Provider Screening process and the expansion of this initiative to include provider employees. California will launch the Provider Application and Validation for Enrollment (PAVE) system in FY 2015; Nebraska will contract with a vendor in FY 2015 to implement ACA compliant provider screening and enrollment services...³⁰⁶

Provider enrollment is not the responsibility of the OPI. Rather responsibility for provider enrollment is with the Division of Health Care Services which has folded provider enrollment into its contract with Xerox. The Department provided copies of its Corrective Action Plan (CAP) and updates to it to show the progress in fixing the provider enrollment problems that CMS auditors identified. While problems appear to have been addressed at least one significant problem appears to be addressed using a cumbersome manual “work around.” To identify individuals with an ownership interest, providers are required to submit letters, almost 4,000, with names and addresses that will be manually processed. The Department would benefit by ensuring its fraud prevention practices are as automated as possible.

Recommendation 10.2: The Department should issue regulations specifying the responsibility of PCA agencies for monitoring fraud and abuse and build in contractual requirements for provider agencies to control fraud and abuse.

Currently, the responsibility for controlling fraud and abuse falls solely upon state staff whose agencies are facing potential cuts of 25% in their budgets. The Department is in a situation usually referred to as “pay and chase.” The Department pays the money and then has to “chase” the money to recoup it from providers if the payment is found to be inappropriate.

The current program architecture contains no role for the provider agencies in control of fraud and abuse. Currently, agencies benefit whether the rendering providers provide the services or do not provide the services. The agencies take their administration fee off the top and pass the rest along to the rendering providers.

PCG recommends the Department should issue regulations specifying the responsibility of PCA agencies for monitoring fraud and abuse and build in contractual requirements for provider agencies to control fraud and abuse. The regulations could require:

³⁰⁶ Smith, V., et al. (2014) Medicaid in an Era of Health & Delivery System Reform, A Report prepared for the Kaiser Foundation and the National Association of Medicaid Directors pp. 59-60. See <http://files.kff.org/attachment/medicaid-in-an-era-of-health-delivery-system-reform-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2014-and-2015-report> Retrieved on 4-10-2014.

- The development of an agency plan to monitor fraud and abuse;
- The agency's verification of employee qualifications;
- The periodic examination of rendering claim statistics provided by the state to the agency;
- The establishment of agency procedures to confirm that scheduled services were provided consistent with the services and duration of services identified in the care plan;
- Routine surveys of recipients to determine their experience of care, and³⁰⁷
- Annual or semi-annual reports on the activities undertaken by the agency to control fraud and abuse and the results of those activities.

Recommendation 10.3: The Department should create financial incentives for the provider agencies to control fraud and abuse.

In addition to better contractual requirements, the Department could incentivize provider agencies to monitor fraud and abuse internally by automatically recouping funds from agencies whose rendering providers are not providing appropriate services and rewarding agencies whose providers consistently provide problem-free services.

These recommendations should extend to all Medicaid services provided on an in-home service basis including chore and respite whose rendering providers are supervised by agencies.

Recommendation 10.4: The state should routinely review services provided in assisted living programs to ensure that they are provided to recipients consistent with their plan of care.

Given the millions of dollars spent on the assisted living program, a heightened oversight of these expenditures is reasonable. The state lacks a system of impartial, conflict-free, care coordinators that is characteristic of other state HCBS programs. For example, in Oregon and Washington, Area Agency on Aging (AAA) and state staff provide care coordination management to recipients and monitor whether appropriate care is rendered.

One possibility for a stepped up review is to contract with a quality improvement organization (QIO), or a similar organization to perform quality audits of assisted living programs. Such an effort could be done modestly on a pilot basis perhaps sampling 5% of the assisted living programs to obtain an understanding of what is programmatically taking place within the assisted living programs. For example, are the services identified in the individual's service plan being provided in the scope and duration specified in their plan?

Quality improvement work could be potentially funded through a provider tax. Maine and Vermont have a provider tax on residential habilitation programs and the procedure would need to be researched and then discussed with the CMS Region 10 office in Seattle. Another payment alternative would be to lower the

³⁰⁷ The use of experience of care surveys in Medicaid home and community-based services are currently in a pilot phase but in five years it is likely that their use will be mandated. See the CMS Testing Experience and Functional Tools (TEFT) program at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/grant-programs/teft-program.html>.

rate slightly and pay for the quality contract out of the reduction. Setting aside \$100,000 from a \$100 million program would amount to less than 1%.

Recommendation 10.5: The Department should establish an electronic visit verification (EVV) system for in-home services.

Numerous states including Texas³⁰⁸, Illinois³⁰⁹, and Oklahoma³¹⁰ use electronic verification systems.³¹¹ Given Alaska's experience with fraud in its long-term care in-home programs, an EVV system is a recommended best practice that Alaska should consider. Many vendors provide such a system and PCG makes no recommendation as to which specific system would be most appropriate. However, the use of EVV is recommended.

Interviews with state staff indicate that perceived lack of staff or resources are the primary reasons why EVV has not been implemented. The use of EVV would directly address the billing problems identified with rendering PCA providers and would likely be cost effective. It is to the state's financial advantage to authorize staff and funds to implement an EVV system.

Recommendation 10.6: Criminal penalties for Medicaid fraud should be increased.

A July 10, 2014 press release from the Anchorage FBI office states that a man who robbed an Anchorage bank of \$2,078 was sentenced to 60 months in jail.³¹² An April 8, 2015 press release of Medicaid Fraud Control Unit announced that a woman who stole \$1.6 million from the Medicaid program received four months in jail.³¹³ Light penalties of Medicaid fraud are not unusual. MFCU press releases of January 14, 2014 and September 12, 2014 document similar penalties.³¹⁴ The March 20, 2014 edition of the Alaskan Dispatch News contains a story about a woman who stole \$90,000 from Medicaid and received no jail time at all.³¹⁵

PCG does not offer recommendations as to how penalties should be increased believing this is a matter best determined by local culture and judicial history.

³⁰⁸ See <https://www.dads.state.tx.us/evv/>.

³⁰⁹ See <https://www.dhs.state.il.us/page.aspx?item=68869>.

³¹⁰ See <http://www.okdhs.org/programsandservices/aging/adw/evv/electronic+visit+verification.htm>.

³¹¹ Other states with EVV include Florida, New York, Ohio, South Carolina, Tennessee, and Washington.

³¹² See <http://www.fbi.gov/anchorage/press-releases/2014/anchorage-man-sentenced-to-60-months-for-bank-robbery>.

³¹³ See <http://law.alaska.gov/press/releases/2015/040814-MFCU.html>.

³¹⁴ See http://law.alaska.gov/press/news_2014.html.

³¹⁵ See <http://www.adn.com/article/20140320/anchorage-woman-sentenced-90k-medicaid-fraud>.

Recommendation 10.7: Penalties and interests should be assessed when persons are convicted of Medicaid fraud. The state could benefit by having a Medicaid False Claims Act.

A review of press releases and newspaper stories does not indicate that penalties or interest are routinely levied on persons convicted of Medicaid fraud.³¹⁶ Both penalties and interest should be collected in situations where the Medicaid program has been defrauded. Penalties and interest are routinely levied in other situations where the state has been denied use of the money such as in tax collection situations.

The recommendation that penalties and interests be assessed has been proposed in other performance reviews of state Medicaid programs.³¹⁷ As of 2012, Alaska was one of 11 states that did not have a false claims act. As described by the ethics unit of the Hospital Corporation of America:

Under the federal False Claims Act, any person or entity that knowingly submits a false or fraudulent claim for payment of United States Government funds is liable for significant penalties and fines. The fines include a penalty of up to three times the Government's damages, civil penalties ranging from \$5,500 to \$11,000 per false claim, and the costs of the civil action against the entity that submitted the false claims. Generally, the federal False Claims Act applies to any federally funded program. The False Claims Act applies, for example, to claims submitted by healthcare providers to Medicare or Medicaid.³¹⁸

While Alaska statutes have provisions for recoupment of funds and disbarment from the Medicaid program, increased sanctions along federal lines would provide state staff, prosecutors and judiciary more latitude and support in controlling fraud.

Recommendation 10.8: The state should consider a one-time amnesty program for HCBS providers.

Two types of amnesty programs have been frequently offered. States have offered tax amnesty programs to persons who have not fully declared their income and states have offered gun buyback programs in which persons can bring guns in and be paid money for them with no questions asked regardless of whether or not the gun is illegal. A one-time amnesty program targeting persons who may have committed misdemeanor fraud is worth studying. Such a program would presumably work by notifying providers their state was going to be implementing stepped up enforcement with serious jail time for persons that were found to have overbilled Medicaid. However, if persons that made incorrect billings to Medicaid came in and offered to pay what they owed, then no charges would be filed against them. Given the repetitive nature of Medicaid fraud, even an offer that only attracted a handful of respondents would be worth the paper and time used to make the announcement.

³¹⁶ PCG researched the websites of Alaskan papers, MFCU and the FBI to obtain information on penalties associated with Medicaid fraud convictions. The Alaskan Dispatch News website is at <http://www.adn.com/>.

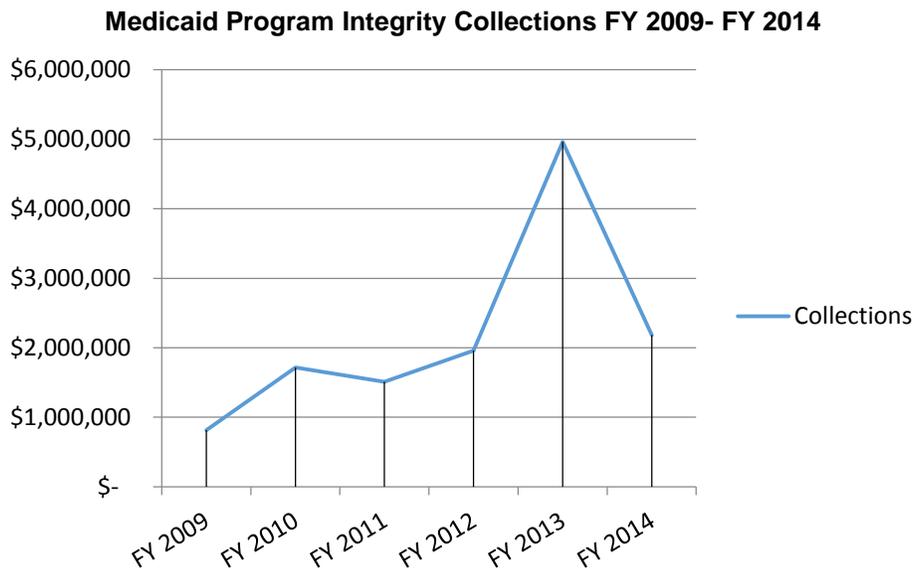
³¹⁷ See Iowa performance review at http://publications.iowa.gov/9046/1/Iowa_Efficiency_Review_Report_Final_for_Print.pdf p. 69.

³¹⁸ See: heaethics.com/policies/LLAK001.DOC.

C. Are there cost savings that will result from reducing, preventing, or detecting fraud, waste, and misuse of services?

There are definite cost saving that accrue from implementing good fraud and abuse controls. There are two types of savings. The first is the actual recoupment of paid funds. *Figure 10.1: Medicaid Program Integrity Collections, FY 2009 – FY 2014* below shows, across all of Medicaid programs, the amounts collected by the Office of Program Integrity. The figure does not show the additional amounts collected in the first six months of FY 2015, which were \$1,739,801.

Figure 10.1 Medicaid Program Integrity Collections, FY 2009 – FY 2014³¹⁹



The second type of cost savings is cost avoidance. A single case of fraud can cost the state a considerable amount of money. Putting a stop to the fraud can save the state substantial future funds. For example, on April 8, 2015 the Medicaid Fraud Control Unit announced that the owner of the Mat-Su Activity and Respite Center (MARC) in Palmer was convicted of Medicaid fraud. The press release announcing this conviction identified \$287,000 in costs that had been cost avoided because of the audit.

A full review of the agency’s medical records revealed that the changes primarily consisted of an increase in the amount of services the agency claimed to provide. The alterations, if undetected by auditors, would have resulted in the MARC avoiding over \$287,000 in extrapolated overpayment findings against the agency by the Alaska Medicaid Program. Myers and Stauffer extrapolated the results of the 2009 and 2010 audits conducted and estimated that the MARC improperly billed Medicaid \$1,628,023.00 for services without proper documentation to support the claims.

³¹⁹ DHSS.

This is an excellent example of an expensive multi-year fraud that would likely have continued into future years had the auditors not uncovered the altered records. The owner of the respite company was fraudulently billing close to \$300,000 a year and had been doing so for years resulting in a cumulative fraudulent billing of \$1.6 million. It is highly likely that this person would have continued their fraud had they not been caught. Approximately \$300,000 per year in future state expenditures were cost avoided by the detection of this fraud.

There are definite cost savings that accrue from implementing good fraud and abuse controls. There are two types of savings. The first is the actual recoupment of paid funds whose amounts are shown in the review. There is also cost avoidance. The stepped up Medicaid fraud detection that has occurred in recent years has undoubtedly resulted in substantial cost avoidance savings given the repetitive nature of fraud. In 2014, Medicaid program integrity efforts resulted in \$2,000,000 of savings. It is likely that this also represents the amount of losses that were avoided in the following year given the repetitive multi-year nature of fraud. The increase in Medicaid recoveries reflects the increasing effectiveness of state efforts to detect fraud.

APPENDICIES

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APPENDIX 01: DHSS FY 2016 BUDGET BOOK FORMAT

- Department of Health and Social Services
 - Mission
 - Major Accomplishments
 - Key Challenges
 - Significant Changes
 - Contact Information
 - Department Budget Summary by RDU
 - Funding Source Summary
 - Position Summary
 - FY 2016 Capital Budget Request
 - Summary of Department Budget Changes by RDU
- Alaska Pioneer Homes Results Delivery Unit
 - RDU Financial Summary by Component
 - Summary of RDU Budget Changes by Component
 - Component: Alaska Pioneer Homes Management
 - Component Alaska Pioneer Homes
- Behavioral Health Results Delivery Unit (Not in Long Term Care Scope)
- Children’s Services Results Delivery Unit (Not in Long Term Care Scope)
- Health Care Services Results Delivery Unit
 - RDU Financial Summary by Component
 - Summary of RDU Budget Changes by Component
 - Component: Catastrophic and Chronic Illness Assistance
 - Component: Health Facilities licensing and Certification
 - Component: Residential Licensing
 - Component: Medical Assistance Administration
 - Component: Rate Review
- Juvenile Justice Results Delivery Unit (Not in Long Term Care Scope)
- Public Assistance Results Delivery Unit
 - RDU Financial Summary by Component
 - Summary of RDU Budget Changes by Component
 - Component: Alaska Temporary Assistance Program
 - Component: Adults Public Assistance
 - Component: Child Care Benefits
 - Component: General Relief Assistance
 - Component: Tribal Assistance Programs
 - Component: Senior Benefits Payment Program
 - Component: Permanent Fund Dividend Hold Harmless
 - Component: Energy Assistance Program
 - Component: Public Assistance Administration
 - Component: Public Assistance Field Services
 - Component: Fraud Investigation
 - Component: Quality Control

- Component: Work Services
 - Component: Women, Infants and Children
- Public Health Results Delivery Unit (Not in Long Term Care Scope)
- Senior Disabilities Services Results Delivery Unit
 - RDU Financial Summary by Component
 - Summary of RDU Budget Changes by Component
 - Component: Senior and Disabilities Services Administration
 - Component: General Relief / Temporary Assisted Living
 - Component: Senior Community Based Grants
 - Component: Community Developmental Disabilities Grants
 - Component: Senior Residential Services
 - Component: Commission on Aging
 - Component: Governor’s Council on Disabilities and Special Education
- Departmental Support Services Results Delivery Unit
 - RDU Financial Summary by Component
 - Summary of RDU Budget Changes by Component
 - Component: Performance Bonuses
 - Component: Public Affairs
 - Component: Quality Assurance and Audit
 - Component: Agency – Wide unallocated Reduction
 - Component: Commissioner’s Office
 - Component: Assessment and Planning
 - Component: Administrative Support Services
 - Component: Facilities Management
 - Component: Information Technology Services
 - Component: Facilities Maintenance
 - Component: Alaska Pioneer Homes Facilities Maintenance
 - Component: HSS State Facilities Rent
- RDU / Component: Human Services Community Matching Grant (Not in Long Term Care Scope)
- RDU / Component: Community Initiative Matching Grants (non-statutory grants) (Not in Long Term Care Scope)
- Medicaid Services Results Delivery Unit
 - RDU Financial Summary by Component
 - Summary of RDU Budget Changes by Component
 - Component: Behavioral Health Medicaid Services
 - Component: Children’s Medicaid Services
 - Component: Adult Preventative Dental Medicaid Services
 - Component: Health Care Medicaid Services
 - Component: Senior Disabilities Medicaid Services

APPENDIX 02: CERTIFICATE OF NEED APPLICATION (SUMMARY OF SECTIONS)

- I. Section I. General Applicant Information
 - a. Complete the attached form
 - b. Part 2B – Ownership Information
 - c. Part 2C – Accreditation Standards
- II. Section II. Summary Project Description
 - a. Brief description of proposed services
 - b. Square footage
 - c. Number and type of beds / surgery suites
 - d. Services to be expanded, added, replaced, or reduced
 - e. Total cost of project
 - f. How will project be financed
 - g. Estimated completion date
- III. Section III – Detailed Description of Facilities and Capacity Indicators
 - a. Proposed Changes in services capacity
 - b. Detailed narrative description of each service
 - c. Equipment to be purchased
 - d. Equipment to be retired
 - e. Describe replacement or upgrading of utilities
 - f. Describe structural framing, floor system
 - g. Total square footage in current facility
 - h. Total square footage of proposed facility
 - i. Area per bed
 - j. Percentage of total floor area used for direct service
 - k. Additional volume of service
 - l. Brief History of Expansion
- IV. Section IV. Narrative Review Questions
 - a. Relationship to Applicable Plans and National Trends
 - b. Demonstration of Need
 - c. Availability of less costly or more effective Alternatives
 - d. Relationship of proposed project to existing health care system and to ancillary or support services
 - e. Financial Feasibility
 - f. Access to service by the general population and underserved groups
- V. Section V – Consideration of Quality, Effectiveness, Efficiency, and Benefits of the Applicants’ Services
 - a. Accreditation and Licensure
 - b. Quality Control
 - c. Personnel
 - d. Appropriate Utilization
 - e. New Technology and Treatment Modes
 - f. Labor Saving Devices and Efficiency
 - g. Program Evaluation

- h. Organizational Structure
 - i. Staff Skills
 - j. Economies of Scale
- VI. Section VI – Narrative Description of How Project Meets Applicable Review Standards
- VII. Section VII – Construction Data
 - a. Construction Type
 - b. Project Development Schedule
 - c. Facility Site Data
 - d. Plan for Completion
- VIII. Section VIII A. Financial Data – Acquisitions
 - a. Acquisition Type
 - b. Cost Data
 - c. Financing
- IX. Section VIII B. Financial Data – Construction Only
 - a. Construction Method
 - b. Construction Cost
- X. Section IX. Financial Data – All Proposed Activities
 - a. Facility Income Statement
 - b. Facility Balance Sheet
 - c. Average Patient Cost Per Day
 - d. Operating Budget
 - e. Debt Service Summary and New Project Debt Service Summary
 - f. Reimbursement Sources
 - g. Depreciation Schedule
- XI. Schedule VI – Reimbursement Sources
- XII. Fair Market Value – How to Calculate
- XIII. Application Fee
- XIV. Request for Modification to a Certificate of Need
 - a. Reason for Modification
 - b. Certification
- XV. Periodic Progress Report

APPENDIX 03: ALASKA CERTIFICATE OF NEED REVIEW STANDARDS AND METHODOLOGIES

- I. General Review Standards Applicable to all Certificate of Need Applications
 - a. Documents needs for the project by the population service or to be served
 - b. Applicant demonstrates that the project augments and integrates with relevant community, regional, state and federal health planning and incorporates or reflects evidence based planning and service delivery
 - c. Stakeholder participation in planning for project
 - d. Demonstrates they have assessed alternative methods of providing proposed services
 - e. Applicant describes anticipate impact on existing health care systems within projects service area
 - f. Applicant demonstrates that the projects location is accessible to patients and clients
- II. Additional Considerations for Concurrent review of More than One Application
 - a. Commitment to quality
 - b. Demonstrates pattern of licensure and accreditation surveys
 - c. Demonstrates application has consistently provided or has a policy to provide high levels of care
- III. Acute Care Hospital Services – Review Standards and Methodology
 - a. Beds for acute care hospital services for state or service area will be within the limits included in calculation
 - b. Applicant serving patients from a community with a pop. Of 10,000 or less demonstrates that the transport of patients to or from those areas for medical care or services will be facilitated
- IV. Hospital Laboratory and Emergency Department Services – Review Standards and Methodology
 - a. Hospital Lab Services
 - i. Population retains reasonable access to services
 - ii. Improved operational efficiencies
 - iii. Justify Redundant Equipment
 - iv. Accreditation reports show a defined need to add space
 - b. Hospital Emergency Department Services
 - i. Maintenance of stable and efficient emergency system
 - ii. Minimum of 1,500 annual visits
 - iii. Fast Track requirements
 - iv. Size by Functional need survey and analysis
- V. Behavioral Healthcare Services: Review Standards and Methodology
 - a. Acute Inpatient Psychiatric Treatment Services
 - i. Minimum of 25 beds for new freestanding facility, 12 beds for existing acute care community hospital
 - ii. Inpatient psychiatric treatment services must have an annual average occupancy of 80%
 - iii. Demonstrate that project augments the existing community system of care
 - b. Residential Psychiatric Treatment Centers (RPTC)

- i. Application identifies probably impact on cost to local consumers and cost to Medicaid
 - ii. Immediate and long term financial feasibility of project
 - iii. An RPTC facility must be accredited by JCAHO
 - iv. Projects larger than 29 beds have specific requirements
 - v. Applicant demonstrates project augments the existing community system of care
- VI. Long Term Care Acute Care Hospital Services (LTCACH): Review Standards and Methodology
 - a. Located in community where cardiologists, pulmonologists, nephrologists and infectious disease specialists are full time
 - b. Minimum of 25 beds for new facility for freestanding, a new LTCACH facility within an existing short term acute care hospitals must have a minimum of 15 beds
 - c. Annual occupancy of at least 85% annual occupancy
 - d. All facilities in area of at least 85% annual occupancy
 - e. Additional justification for an application that exceeds a rate of one bed per 10,000 persons
- VII. Long Term Nursing Care: Review Standards and Methodology
 - a. New free standing long-term facility will not be approved unless the application has demonstrated a need for a minimum of 40 beds
 - b. New long-term care nursing units co-located with hospitals will not be approved unless the applicant has demonstrated a need for a minimum of 15 beds
 - c. A freestanding long-term nursing care facility must have an average annual occupancy of at least 90% and co-located long term nursing care units must have an average annual occupancy rate of at least 80%
 - d. In a service areas with more than one long term nursing care facility, all facilities must have had an average annual occupancy of at least 90% in the preceding three years
 - e. There must be a combination of at least one assisted living bed or adult day care slot for each existing and proposed new long term nursing care bed
- I. Diagnostic Imaging Services: Review Standards and Methodology
 - a. Magnetic Resonance Imaging
 - i. Demonstrate ability to provide a minimum of 3,000 MRI scan per year by end of third operational year
 - ii. If community with a population of 10,000 or less, demonstrate ability to provide a minimum of 1,000 MRI scan per year
 - iii. No MRI service will be approved at a location that is less than 30 minutes access time of an existing MRI service performing fewer than 3,000 scans per year, or of a CON-approved, but not yet operational, MRI service.
 - b. Positron Emission Tomography (PET/PET-CT)
 - i. An applicant who seeks to establish a new PET service demonstrates the ability to provide a minimum of 750 PET scans per year by the end of the third operational year, dating from the initiation of the service.
 - ii. No new PET scanner will be approved at a location that is less than one hour travel time of an existing PET scanner performing fewer than 750 scans per year, or of a CON-approved, but not yet operational, PET scanner.

- iii. In a community that produces isotopes locally, no new PET scanner will be approved in the service area unless average use of each existing PET scanner exceeds 1,300 scans per year.
 - iv. In a community that is dependent upon shipped isotopes, no new PET scanner will be approved in the service area unless average use of each existing PET scanner exceeds 1,000 scans per year.
 - v. An applicant who seeks to expand a PET service demonstrates an average service volume of at least 1,300 PET scans annually for each PET scanner at the service site.
 - vi. PET services must be located in the same community as, or co-located with, facilities offering comprehensive oncology, cardiovascular, and neurology services.
- c. Computed Tomography
- i. An applicant who seeks to establish a new CT service in an urban area (population of 70,000 or more) demonstrates the ability to provide a minimum of 3,000 CT scans per year by the end of the third operational year, dating from the initiation of the service.
 - ii. An applicant who seeks to establish a new CT service in a rural area demonstrates the ability to provide a minimum of 1,000 CT scans per year by the end of the third operational year, dating from the initiation of the service.
 - iii. No new CT service will be approved in a service area or at a location that is less than 30 minutes travel time of an existing CT service performing fewer than 3,000 scans per year, or of a CON-approved but not yet operational, CT service.
 - iv. An applicant who seeks to expand an existing CT service must demonstrate an average service volume of at least 4,000 CT scans annually for each existing CT scanner at the service site.
- d. Cardiac Catheterization Services
- i. No new cardiac catheterization laboratories will be approved in a community with existing cardiac catheterization services unless all existing adult laboratories are operating at an average of at least 75% of capacity or an average of at least 750 procedures per year.
 - ii. The applicant for a facility that will offer pediatric cardiac catheterization demonstrates that at least 250 procedures per year will be performed.
 - iii. The applicant for a facility that will offer primary angioplasty without onsite cardiac surgery capability must have a proven and tested plan for rapid access (within 90 minutes from declaration of emergency to the patient being in a cardiac surgical operating room). Appropriate hemodynamic support capability for such a transfer must exist as well as a team of appropriately trained individuals. The ability to place an intraaortic balloon pump (IABP) and temporary transvenous pacemaker for stabilization before transport must also exist.
 - iv. A facility requesting authorization to perform elective coronary interventions must be located within a hospital or in a laboratory attached to a hospital with onsite cardiac surgery capability.

- v. An applicant who seeks to establish new cardiac catheterization services in a community without existing services demonstrates that the facility is likely to perform a minimum of 500 cardiac catheterizations per year by the third year after program implementation.
- vi. The applicant demonstrates that the facility has the capability of providing immediate transvenous pacemakers in case of cardiac arrest.

II. Surgical Care – Review Standards and Methodology

a. General Surgery Services

- i. Documents needs for the project by the population service or to be served
- ii. Applicant demonstrates that the project augments and integrates with relevant community, regional, state and federal health planning and incorporates or reflects evidence based planning and service delivery
- iii. Stakeholder participation in planning for project
- iv. Demonstrates they have assessed alternative methods of providing proposed services
- v. Applicant describes anticipate impact on existing health care systems within projects service area
- vi. Applicant demonstrates that the projects location is accessible to patients and clients

b. Open-Heart Surgery

- i. An applicant who seeks to establish a new open-heart surgery program demonstrates that they are likely to perform a minimum of 100 surgery cases within the first year of operation and at least 250 cases annually within the fifth year after initiating the service.
- ii. An applicant who seeks to establish new open-heart surgery services demonstrates that the hospital provides at least 500 cardiac catheterizations annually.
- iii. An applicant who seeks to establish new open-heart surgery services demonstrates that each physician performing open-heart surgery performs a minimum of 50 open-heart surgeries per year, as the attending surgeon, in any hospital or combination of hospitals.
- iv. An applicant who seeks to provide pediatric open-heart surgery services demonstrates that the hospital maintains a pediatric intensive care unit and a Level III neonatal intensive care unit, and will perform a minimum of 100 pediatric open-heart surgical procedures annually within three years of initiating the service.
- v. An applicant who seeks to expand open-heart surgery services demonstrates that each existing open-heart surgery operating room performed an average of at least 300 open-heart surgical procedures per year during the preceding three years.

III. Therapeutic Care: Review Standards and Methodology

a. Radiation Therapy

- i. Stereotactic Radiosurgery Services: An applicant who seeks to establish stereotactic radiosurgery services demonstrates a need for at least 250 stereotactic

treatments annually without reducing demand at any existing service to less than 250 treatments per year.

ii. Linear Accelerator Services:

1. No new radiation therapy service will be approved unless existing radiation therapy services located in the service area in which the proposed new service is to be located have provided an average of at least 6,000 radiation therapy treatments per year over the last three years.
2. No new radiation therapy service will be approved unless the applicant demonstrates that the new service will be used for at least 250 cancer patients and will perform at least 4,000 treatments by the third year of operation without reducing the average use of existing radiation therapy machines in the service area below 6,000 treatments per year.
3. No proposal to expand an existing radiation service will be approved unless the linear accelerators operated by the applicant provided an average of at least 6,000 treatments per year over the preceding three years.

iii. Radiation therapy services must be located in the same community as a facility providing comprehensive oncology and support services.

iv. An applicant proposing to establish or expand radiation therapy services must agree to participate fully in the Alaska cancer registry program.

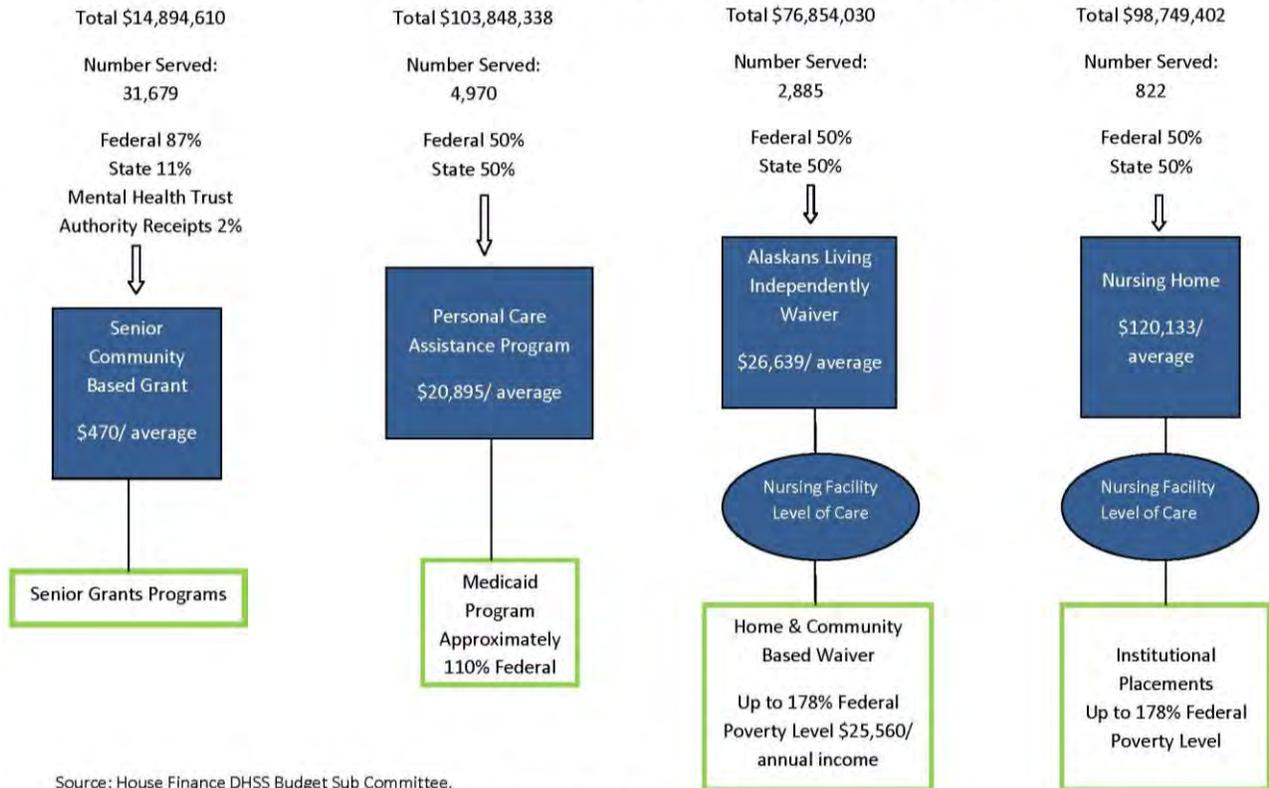
b. Renal Dialysis

- i. Dialysis facilities must contain a minimum of six dialysis stations.
- ii. No new dialysis services will be approved unless existing services located in the service area in which the proposed new service is to be located operated at an average annual use rate of at least 80% of capacity over the last three years.
- iii. No proposal to expand an existing dialysis service will be approved unless each station operated by the applicant provided at least 12 treatments per week over the preceding year.
- iv. The applicant demonstrates that the dialysis center will provide education and services for home and peritoneal dialysis patients, as well as in-center patients.

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APPENDIX 04: DSDS CONTINUUM OF CARE

Continuum of Care for Alaskans Age 60+ Served by Senior and Disabilities Services



Source: House Finance DHSS Budget Sub Committee, Division of Senior and Disabilities Services Overview, FY2016 Division Overview As of January 30, 2015

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of ALASKA
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October 30, 2015

Ms. Kris Curtis, CPA, CISA
Legislative Auditor
Legislative Budget and Audit Committee
Division of Legislative Audit
P.O. Box 113300
Juneau, Alaska 99811-3300

Dear Ms. Curtis:

RE: Department of Health and Social Services (DHSS) response to the legislative audit confidential preliminary report titled: Performance Review of the Alaska Department of Health and Social Services Long Term Care Services received October 8, 2015.

We appreciate the opportunity to review and evaluate preliminary report pertaining to the performance review on DHSS long term care services. DHSS has the following responses to share on the recommendations. Additionally, it is worthwhile to note that while the department and its divisions may agree with the recommendations as shared in this report, the agency is facing cost constraints that may limit the necessary resources available for implementation.

COMPREHENSIVE OVERVIEW (P. 37-60)

Recommendations 1.1, 1.2, and 1.3 (p. 56-59): DHSS concurs with the recommendations. Delivery of clear and concise budget information is in the best interest of the department. However, it is important to note that the budget documents are a product of collaboration between DHSS and our legislative house and senate finance committees.

DELIVERY AND ADMINISTRATION (P. 61-90)

Recommendation 2.1 (p. 70): DHSS partially concurs with the recommendation. Quality improvement is a priority of both DSDS and the Center for Medicaid and Medicare (CMS). DSDS is also providing additional information (DHSS Attachments 1 and 2) in response to this recommendation. Additional fiscal analysis is required as to whether the department has the available resources for implementation.

Recommendation 2.2 (p. 80): DHSS concurs with the recommendation. This option would allow DSDS to continue to provide services to vulnerable Alaskans and at the same time decrease use of state general fund dollars by accessing Federal reimbursement.

Recommendation 2.3 (p. 81): DHSS concurs with the recommendation. The department has also hired a contractor to evaluate potential implementation of both 1915(i) and 1915(k).

Recommendation 2.4 (p.83): DHSS partially concurs with the recommendation. DSDS agrees that in order to deliver Long-Term services and supports in a cost effective manner the State must use a multi-pronged approach by submitting a State Plan amendment to obtain approval for implementation of a LTC partnership. An analysis is also needed to assess why the state has such a low rate of long-term insurance given the large percentage of retired public employees in the state of Alaska who have access to long term care insurance through their retirement benefits.

Recommendation 2.5 (p.83): DHSS does not concur with the recommendation. The department is evaluating some form of targeted approach to reassess people who are most likely to have some significant change of condition. Also, the department never suspended PCA reassessment of people who have established the need for Nursing Facility level of care by qualifying for a waiver; this is not clear in the report.

Recommendation 2.6 (p. 85): DHSS does not concur with the recommendation. The department is currently evaluating potential implementation of 1915(i) and may expand coverage without risking expanding NF expenditures. Following this decision, cost benefit analysis of expanding the NF LOC criteria will be needed.

Recommendation 2.7 (p. 86): DHSS partially concurs with this recommendation. AKPH agrees the senior population is growing and previous studies have found that expansion of current resident facilities could help address the needs of seniors in Alaska. A feasibility study will need to be performed to determine whether it is the best use of state resources to expand existing services or pursue viable alternatives.

Recommendation 2.8 (p. 87): DHSS partially concurs with the recommendation. DHSS is in the process of developing acuity-based rates for licensed Medicaid assisted living facilities. However, additional fiscal analysis is required as to determine whether private facilities would take higher needs individuals who are served by the Pioneer Homes recommendation at a cost effective rate.

Recommendation 2.9 (p. 87): DHSS concurs with the recommendation. DSDS is currently engaged in an acuity project designed at setting Person Centered Assisted Living Home rates to ensure that the provider would receive a rate of reimbursement that reflected the level of care the recipient required. The Department is also in the process of designing and implementing a person-centered rate setting system that ties acuity to payment level, which will allow higher acuity recipient services to receive higher reimbursement and lower acuity recipient services to receive lower reimbursement. The Department is hopeful that proposed regulations will be

introduced next year to update the rate-setting system for home and community-based Waiver services and PCA services. These regulations should include a person-centered, acuity-based system for residential supported living services (i.e. assisted living homes). If this approach is successful, the Department may look to expand this concept to other services.

Recommendation 2.10 (p. 87): DHSS concurs with the recommendation. AKPH welcomes an opportunity to becoming a center of excellence for ADRD services in the state. Alaska Pioneer Homes prides itself on the care currently given to residents with a diagnosis of ADRD and would welcome moving further towards specializing in this type of care.

Recommendations 2.11 and 2.12 (p. 89-90): DHSS concurs with the recommendations. DSDS has reviewed InterRAI MDS Home Care and InterRAI ID instruments and assessment tools. With support from the Alaska Mental Health Trust Authority, DSDS will work with a contractor to evaluate various assessment tools and make a recommendation of a quality tool or tools that could replace the Divisions current assessment tools. Also, DSDS anticipates that if the departments implements the 1915(i) and 1915(k) state plan options, there will be a necessity to modernize the assessment tools.

Recommendation 2.13 (p. 90): DHSS concurs with the recommendation. DSDS with support from the Alaska Mental Health Trust authority is in negotiation to sign a contract with NCI to implement quality of life survey interviewing a percentage of HCBS Waiver recipients.

GRANTS AND CONTRACTS (P. 91-108)

Recommendation 3.1, 3.2, and 3.3 (p. 95): DHSS partially concurs with the recommendations. However, it is important to note the difference between administrative costs claimed as direct expenses, and those claimed as indirect costs. For grantees with a federally negotiated indirect cost rate in accordance with 2 CFR 200.414, pass-through entities are required by 2 CFR 200.331(a)(4) to include this rate in the grant award. Current department regulations at 7 AAC 78.160(p) require DHSS to honor a grantee's federally negotiated indirect cost rate. While potential departmental regulatory changes are within the control of the department, federal requirements per 2 CFR 200 are not. Consequently, the department does not have the ability to set a unilateral limit on these costs.

Recommendation 3.4 (p. 97): Please reference DHSS response to recommendation 5.4.

Recommendation 3.5 (p 97): DHSS partially concurs with the recommendation. The department supports processes to encourage personal responsibility for services being used, however, it must also weigh any changes to fees with the potential negative impacts to the population being served. Additional analysis of the existing fee schedule and further assessment of services provided including specialized care for high acuity individuals is needed to determine whether this recommendation would result in long term cost benefits.

Recommendation 3.6 (p. 98): DHSS concurs with the recommendation. DSDS is exploring the 1915(i) State Plan option; this option will utilize federal dollars to pay for Home and Community Based Services that are now being provided under the State General Fund Grant dollars. The State of Alaska has reviewed the Money Follows the Person (MFP) initiative; at the time of the review the Department was engaged in several initiatives, such as the conversion of the MMIS system. DSDS is interested in applying for MFP program, in doing so DSDS would request an additional staff person to manage the program. In addition to matching grant funds with Medicaid dollars, DSDS concurs with the recommendation to require a match for all grant programs, similar to the 10% match required for the Senior Community Based Grants. Currently not all grant programs have a required match.

Recommendation 3.7 (p. 99): DHSS concurs with the recommendation. Persons with Brain Injury are a potential target population for the 1915(i) option. The Department is evaluating the 1915(i) option for potential implementation.

Recommendation 3.8 (p. 100): DHSS concurs with the recommendation. The department expanded the community matching grant to include populations that are less than 65,000 several years ago.

Recommendation 3.9 (p. 103): DHSS partially concurs with the recommendation. While DHSS may make the recommendation it still must comply with minimum requirements established for each job class and collective bargaining agreements, both outside the control of this agency.

Recommendation 3.10 (p. 103): DHSS concurs with the recommendation. The departments Grant Electronic Management System (GEMS) has assisted in standardization of grant proposals, including limiting the ability to submit elaborate media creations.

Recommendation 3.11 (p. 104): DHSS concurs with the recommendation. FMS has recently completed a user manual.

Recommendation 3.12 (p. 104): DHSS concurs with the recommendation. FMS has purchased CITRIX allowing access to GEMS outside state network

Recommendation 3.13 (p. 106): DHSS concurs with the recommendation. FMS has added Results Based Budgeting (RBB) to GEMS. DSDS also agrees to amend the year-end report to include outcomes and performance metrics.

Recommendation 3.14 (p. 106): DHSS concurs with the recommendation. FMS has provided on site grant and contract training in both Anchorage and Juneau.

Recommendation 3.15 (p. 107): DHSS concurs with the recommendation. FMS has developed reports that reference RBB and they are available in GEMS.

Recommendation 3.16 (p. 107): DHSS concurs with the recommendation. FMS has implemented RBB.

Recommendation 3.17 and 3.18 (p. 108): DHSS concurs with the recommendations. This is currently addressed through departmental policy #352.II.B and handled on a case by case basis as there are several variables to be considered.

BUDGET REDUCTIONS (P. 109-118)

Recommendation 4.1 (p. 115): DHSS does not concur with the recommendation. Please reference the department's response as an additional comment for page 110. Approximately 80% of the DHSS budget is distributed in direct benefits and services to vulnerable populations statewide. The department is being asked to prioritize which vulnerable populations will be provided the basic essentials to survive, for example – whether families will be provided assistance purchasing food or heat versus providing protective services to children and elders. Currently the Alaska Constitution and Statutes require the department to comply with providing these necessary services. However, DHSS is evaluating impacts to our vulnerable populations while trying to meet a 25% reduction over next few years.

CERTIFICATE OF NEED (P. 119-130)

Recommendation 5.1 (p. 127): DHSS partially concurs with the recommendation. The Department agrees that the Certificate of Need (CON) program is effective in rural areas at controlling health care costs, and may not necessarily be needed in urban areas such as Anchorage. The Department will consider the overall need for the CON program. However, the Department can only partially concur with this recommendation because the CON program is a statutorily mandated program, so any substantive modifications, including partial repeal, would require a change in statute by the legislature. Additionally, a fiscal analysis is needed to evaluate whether there is a cost impact associated with these proposed changes, especially with eliminating CON for nursing facilities.

Recommendation 5.2 (p. 127): DHSS partially concurs with the recommendation. The Department agrees that the regulatory definition of “office of private physicians” can create a loophole for certain health care facilities attempting to evade CON review. Recommendation 5.5 recommends that the Department close this loophole by changing regulations surrounding the office of private physicians, and that regardless of license type of the purchaser, a CON should be required for all facility types. While the Department can modify the “office of private physicians” definition in regulation, it cannot require all purchasers of health care facilities or equipment to be subject to CON, regardless of facility license or facility type, because the type of health care facilities subject to or excluded from CON are defined in statute. Any substantive modifications would require a change in statute by the legislature.

Recommendation 5.3 (p. 127): DHSS partially concurs with the recommendation. The Department agrees that the exception concerning the relocation of ambulatory surgery centers undermines the effectiveness of the CON program. However, this exception exists in statute, not regulation. Any substantive modification would require a change in statute by the legislature.

Recommendation 5.4 (p. 127): DHSS partially concurs with the recommendation. The Department agrees that the \$1.5 million threshold may be more effective if it varied based on size and scope. The Department is open to feedback on how to best analyze the feasibility of a tiered threshold. Recommendation 5.4 also recommends that the \$1.5 million dollar CON threshold should be adjusted annually to stay in line with the inflation of the dollar. The Department is not opposed to annual inflation adjustments; however, the \$1.5 million threshold is specified in statute, not regulation. Any substantive modification would require a change in statute by the legislature.

Recommendation 5.5 (p. 128): Please reference DHSS response to recommendation 5.1.

Recommendation 5.6 (p. 128): DHSS concurs with the recommendation. The Department agrees that the language in regulation defining the NPV calculation is confusing. The Department also agrees that modifying the calculation to a uniform, actuarially accepted standard is preferable for purposes of preventing facilities from depreciating entire leases for purposes of evading CON review. Depending on the timing of legislative action for the aforementioned recommendations, the Department should update the CON definition for NPV through proposed regulations.

Recommendation 5.7 (p. 128): DHSS does not concur with the recommendation. The Department has not received any complaints from providers that the application fee is too high or is a barrier to entry. For projects valued at \$2.5 million or less, the fee is \$2,500. For projects valued over \$2.5 million, the fee is equal to 0.1% of the estimated cost, up to a maximum fee of \$75,000. The Department is open to feedback on a more suitable approach for setting a maximum fee, but without concerns from health care facilities or the general public, there is no feedback to consider.

Recommendation 5.8 (p. 128): DHSS concurs with the recommendation. The Department agrees that the CON application is repetitive and inefficient. Depending on the timing of legislative action for the aforementioned recommendations, the Department should update the CON application and eliminate the inefficiencies through proposed regulations.

Recommendation 5.9 (p. 128): DHSS partially concurs with the recommendation. The Department agrees that the CON program lacks basic tools to enforce CON violations. Currently, the CON program's only option is seeking injunctive relief in court. This is inefficient and costly for all parties involved, including the State. Enforcement authority, including injunctive relief, penalties, and right of action, exists in statute, not regulation. Any substantive modification would require a change in statute by the legislature.

Recommendation 5.10 (p. 129): DHSS concurs with the recommendation. The Department agrees that the CON standards and methodologies should be updated and re-baselined. This would likely require a contractor to review the current system and recommend changes to the standards and methodologies. Depending on the timing of legislative action for the aforementioned recommendations, the Department should update the CON standards and methodologies through proposed regulations with the assistance of a contractor.

Recommendation 5.11 (p. 129): DHSS concurs with the recommendation. The Department agrees that public notice requirements specified in regulation should only require use of the State's Online Public Notice System for public notice, rather than costly legal advertisements in newspapers of general circulation. This would be a more efficient process and save money by avoiding costs associated with newspaper fees. The Department currently uses an online email noticing system (i.e. the State's Online Public Notice System), and believes that the additional requirement of publishing the notice in a newspaper is unnecessary. Depending on the timing of legislative action for the aforementioned recommendations, the Department should incorporate this recommended change through proposed regulations.

Recommendation 5.12 (p. 129): DHSS partially concurs with the recommendation. The Department agrees that renovating a health care facility may require CON review based on the statutory definition of "construction" and the regulatory definition of "routine maintenance." Given that statutory and regulatory definitions may impair a facility's ability to make renovations without undergoing CON review, both a change in regulation by the department and a change in statute by the legislature would be required. Depending on the timing of legislative action for the aforementioned recommendations, the Department should update the regulatory definition through proposed regulations.

COST COLLABORATION (P. 131-142)

Recommendation 6.1 (p. 133): DHSS concurs with the recommendation. The department has awarded a contract to plan for the implementation of the 1915(k) State Plan Option.

Recommendation 6.2 (p. 134): DHSS concurs with the recommendation and the Medicaid 1915(i) option is included in the state's Medicaid reform package. The department has awarded a contract to explore the implementation of the 1915(i) State Plan Option and if it is determined that the resources exist the recommendation will be implemented.

Recommendation 6.3 (p. 135): DHSS partially concurs with the recommendation. Additional fiscal analysis is required as to whether this recommendation would be cost effective and determine whether resources are available to implement.

Recommendation 6.4 (p. 135): DHSS concurs with the recommendation.

Recommendation 6.5 (p. 136): DHSS partially concurs with the recommendation. Additional fiscal analysis is required as to whether this recommendation would be cost effective and determine whether resources are available to implement.

Recommendation 6.6 (p. 137): DHSS concurs with the recommendation. The department already has all tribal regional health consortia and local health programs enrolled as Medicaid providers, as well as the facilities included on the IHS facility list. This encompasses each region's tribal hospital, inpatient and outpatient, clinics, sub regionals, village clinics, and all appropriate providers within these facilities at the tribal health organization. The Department is not aware of any tribal health organization eligible to provide Medicaid services that is not already enrolled. The department has dedicated resources specific to this mission and additional information is available at the following link:

<http://dhss.alaska.gov/Commissioner/Pages/TribalHealth/Tribal-Health-Consultation.aspx>.

Recommendation 6.7 (p. 137): DHSS concurs with the recommendation. The Department works with tribal health organizations statewide to increase enrollment and assist with re-enrollment efforts. The department offers several programs in order to assist with this effort. The Tribal Medicaid Activity Claiming project allows for reimbursement of outreach activities, DHSS also offers training for Eligibility Information Systems read only access. This assists tribal health organizations with the ability to look up Medicaid status when they are present at patient registration for a clinic or hospital based service. The tribes also have access to a Medicaid download that specifies eligibility status of beneficiaries in their respective regions. Each of these tasks assists tribal health organizations with planning enrollment and reenrollment activities in their respective regions across the age range of their beneficiaries so they can prioritize where to focus efforts.

Recommendation 6.8 (p. 138): DHSS concurs with the recommendation. Additional information on the department's efforts pertaining to Medicaid Expansion is available at the following link: <http://dhss.alaska.gov/HealthyAlaska/Pages/enrollment.aspx>.

Recommendation 6.9 (p. 140): DHSS concurs with the recommendation. The department is currently evaluating taxes and fees with a contractor. DSDS also recommends that the establishment of fees take into consideration how fees may negatively impact providers; acknowledging current provider shortages for long term care services even in the Anchorage area, with severe shortages in rural Alaska. Additional costs to providers may become a barrier to providing services or developing new agencies.

Recommendation 6.10 (p. 141): DHSS concurs that it is necessary to pursue additional federal dollars for services that are currently provided through state general fund grant dollars.

Recommendation 6.11 (p. 142): DHSS partially concurs with the recommendation. Persons with Brain Injury are a potential target population for the 1915(i) state plan option. Further analysis is required to determine whether this group is best served through the option, modifications to existing 1915(c) waivers, or a separate waiver.

RESULTS BASED MEASURES (P. 143-154)

Recommendation 7.1 (p. 146): DHSS is unable to assess this recommendation. Access to reliable data on number of Alaskan's with disabilities is a barrier for the Divisions ability to report at this level.

Recommendation 7.2 (p. 148): DHSS concurs with this recommendation. The department agrees that providing clear and concise data is in its best interest. DSDS will evaluate what data it has available and how to present it to ensure that the reader understands the utilization of the services by Disabled Alaskans.

Recommendation 7.3 (p. 149): DHSS partially concurs with this recommendation. The data provided on substantiated findings of abuse provide the reader the historical trend that is necessary in order to ensure adult maltreatment remains relevant in policy making. However, adding additional measures such as recidivism would enhance the value and understanding of Adult Protective Services.

Recommendation 7.4 (p. 151): DHSS does not concur with this recommendation. A person residing in an Assisted Living Home (ALH) is considered to be living independently. The definition of Institutions would include ICF/IIDs or nursing facilities not ALH.

Recommendation 7.5 (p. 151): DHSS concurs with the recommendation. Implementation of the Harmony system for DSDS provides a better tracking tool for data collection related to the safety assessment. Establishment of standard that would constitute good performance is a recommendation that DSDS will support implementing.

Recommendations 7.6, 7.7 and 7.8 (p. 153): DHSS concurs with the recommendations. Additionally adding an explanation of how to interpret the data would result in increased understanding of the information as it is presented and how those data elements are interrelated. The department values the presentation of useful, clear and concise data/measures.

Recommendation 7.9 (p. 153): DHSS partially concurs with the recommendation. DSDS may support this recommendation but would require an additional staff person (or professional services contract) to provide the level of expertise required (e.g. economist, actuary). Additional fiscal analysis is required as to whether the department has the available resources for a complete implementation.

Recommendation 7.10 (p. 154): DHSS partially concurs with the recommendation. Additional fiscal analysis is required as to whether this recommendation would be cost effective and determine whether resources are available to implement.

INFORMATION TECHNOLOGY (P. 155-164)

Recommendation 8.1 (p. 159): DHSS concurs with the recommendation. After analysis of the current program, DSDS recognized that they must provide technical support and training to Senior and Disabilities Services (SDS) assessors. DSDS with support from the Mental Health Trust is hiring a staff person to support the SDS assessors in coordination and implementation of telehealth Assessments.

Recommendation 8.2 (p. 160): DHSS concurs with the recommendation. DSDS has reviewed InterRAI MDS Home Care and InterRAI ID instruments and assessment tools. With support from the Alaska Mental Health Trust Authority, DSDS will work with a contractor to evaluate various assessment tools and make a recommendation of a quality tool or tools that could replace the Divisions current assessment tools. Also, DSDS anticipates that with the implementation of the 1915(i) and 1915(k) state plan options there will be a necessity to modernize the assessment tool.

Recommendation 8.3 (p. 161): DHSS concurs with the recommendation. DSDS with support from the Alaska Mental Health Trust authority is in negotiation to sign a contract with NCI to implement quality of life survey interviewing a percentage of HCBS Waiver recipients.

Recommendation 8.4 (p. 162): DHSS concurs with the recommendation. DSDS has sought approval from IT Governance to move forward with this project.

Recommendation 8.5 (p. 162): DHSS partially concurs with this recommendation. The DHSS IT plan has been developed for statewide projects exceeding \$100,000 and it is recognized that ensuring internal department IT plans should capture effectiveness and efficiency opportunities. This is in contrast to the statewide IT plan, which is intended to inform large project requests for all state agencies.

UTILIZATION TRACKING (P. 165-174)

Recommendation 9.1 (p. 167): DHSS partially concurs with the recommendation. Additional fiscal analysis is required as to whether this recommendation would be cost effective and determine whether resources are available to implement. An alternate source of this information may be through the Centers for Medicare and Medicaid Services (CMS.gov at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research-Statistics-Data-and-Systems.html>).

Recommendation 9.2 (p. 167): DHSS partially concurs with the recommendation. Additional fiscal analysis is required as to whether this recommendation would be cost effective and determine whether resources are available to implement.

Recommendation 9.3 (p. 170): DHSS concurs with the recommendation. Alaska Pioneer Homes is standardizing data collection in each home allowing for aggregate, division wide data to be presented and analyzed. However, it should be noted that it is essential that the differences in resident populations should be taken into account when analyzing division-wide data.

Recommendation 9.4 (p. 173): DHSS partially concurs with the recommendation. Additional reporting requirements do require additional staff time. Additional fiscal analysis is required as to whether the department has the available resources for a complete implementation.

Recommendation 9.5 (p. 173): DHSS partially concurs with the recommendation. Due to cost constraints DSDS may not have the staff to develop and maintain the recommended dashboard. Additional fiscal analysis is required as to whether the department has the available resources for a complete implementation.

FRAUD, WASTE, AND MISUSE (P. 175-186)

Recommendation 10.1 (p. 180): DHSS concurs with the recommendation. The department is currently strengthening its policies and procedures which include utilizing two national databases prior to enrolling new providers.

Recommendation 10.2 (p. 181): DHSS partially concurs with the recommendation. DSDS does not agree with the recommendation to contract with large PCA agencies to control fraud. Most PCA services are provided under a consumer directed model. This model gives control of the PCA to the consumer, with limited oversight provided by the agency. Both the consumer directed agency model and the agency based model receive the same rate. The department recognizes the limited agency oversight in the consumer directed model and is working to strengthen requirements in regulation to ensure providers train on identification and reporting of fraud, waste and abuse; execute policy and procedures; continue to conduct at least biennial review of services for each recipient; and continue to conduct satisfaction surveys. DSDS does agree with the recommendation to require annual or semi-annual reports on the activities undertaken by the agency to control fraud and abuse.

Recommendation 10.3 (p. 182): DHSS partially concurs with the recommendation. Additional fiscal analysis is required as to whether this recommendation would be cost effective and determine whether resources are available to implement.

Recommendation 10.4 (p. 182): DHSS partially concurs with the recommendation. DSDS, with support from the Mental Health Trust, is establishing acuity for individuals receiving services in an ALH. Through this project the Division anticipates to have the capacity to determine if services are provided to the person in the ALH based upon POC and Acuity set through the assessment tool. Additional staff may be required to monitor the review of these services in the ALH. Additional fiscal analysis is required as to whether the department has the available fiscal resources for a complete implementation.

Recommendation 10.5 (p. 183): DHSS partially concurs with the recommendation. Additional fiscal analysis is required as to whether this recommendation would be cost effective and determine whether resources are available to implement.

Recommendation 10.6 (p. 183): DHSS partially concurs with the recommendation. Both the Program Integrity and DSDS believe that enforcement of such penalties has a sentinel effect in the community and would reduce Medicaid fraud. However, the department has no control over criminal penalties for fraud convictions.

Recommendation 10.7 (p. 184): DHSS partially concurs with the recommendation. Additional assessment is needed as this may require a change in state statute, which requires additional action outside the control of the department.

Recommendation 10.8 (p. 184): DHSS partially concurs with the recommendation. While DHSS agrees this is an interesting concept, it would require a review of the state's legal and federal reporting requirements. It would also require a cost analysis to determine whether resources are available to implement.

ADDITIONAL COMMENTS, CLARIFICATIONS, AND TECHNICAL CORRECTIONS

Additional Comment (p. 5; 83): It is unclear as to what federal cost allocation plan is being referenced because the federal public assistance cost allocation plan is applicable to administrative expenditures and not direct Medicaid services.

Additional Comment (p. 65-66): AKPH residents with ADRD may qualify for Medicaid waiver services if the changes to LOC levels include ADRD. A corresponding increase may also be anticipated in federal revenues collected. However, changing the nursing facility level of care could also increase Medicaid nursing facility expenditures.

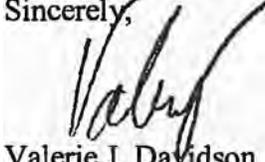
Additional Comment, Section D (p. 79): DHSS agrees with the report; however, grant funding would still be needed to care for people who do not meet Medicaid eligibility.

Additional Comment (p. 110): DHSS does not agree with the report's findings the department was not in compliance with Alaska Statute 44.66.020(c)(2). The department is required to comply with multiple statutes that are all determined by the legislature and it does not have the authority to decide which statute is more important than another as implied by the report. It is still the department's position that the elimination of assistance programs or elements of assistance programs would be identified through the state budget process with the department implementing those changes.

Additional Comment (p. 111-112): DHSS agrees with the report's findings that the department made good faith efforts.

Additional Comment (p. 115): DHSS agrees with the report's paragraph pertaining to the department's strategy as stated.

Please contact Sana P Efird or Linnea Osborne if you have any questions or require additional information. Thank you for the opportunity to evaluate and share additional insight.

Sincerely,

Valerie J. Davidson
Commissioner

Cc: Sana P. Efird, Assistant Commissioner
Jon Sherwood, Deputy Commissioner
Karen Forrest, Deputy Commissioner
Margaret Brodie, Director of HCS
Vickie Wilson, Acting Director of AKPH
Duane Mayes, Director of DSDD
Jared Kosin, Executive Director of ORR
Doug Jones, Program Integrity
Darla Madden, Grants & Contracts Manager
Tim Banaszak, Information Technology Manager
Torrey Jacobson, Internal Auditor
Linnea Osborne, Accountant V

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Public Focus. Proven Results.™

November 7, 2015

Legislative Budget and Audit Committee
Division of Legislative Audit
P.O. Box 113300
Juneau, Alaska 99811-3300

RE: Public Consulting Group (PCG) response to the *Performance Review of the Alaska Department of Health and Social Services Long Term Care Services.*

Dear Members of the Legislative Budget and Audit Committee,

PCG appreciates the opportunity to respond to comments made by the Alaska Department of Health and Social Services (DHSS) during its review of our report on the Long-Term Care Services Performance Review. Via this letter, PCG provides a summary of the comments received from DHSS and responds to selected comments. In addition to responding to comments from DHSS, PCG is including two appendices in response to requests from the Legislative Budget and Audit Committee. Appendix A, the *Cost Savings Summary* demonstrates potential cost savings that may result from PCG's recommendations. Appendix B, the *Glossary of Acronyms* provides a reference for all acronyms used within the report.

Overall, DHSS submitted a total of 84 comments in response to PCG's Performance Review. A majority of these comments exhibited a stance by DHSS of either "concurring" or "partially concurring" with PCG's findings and recommendations. For those recommendations in which DHSS partially concurred, further comment was provided. In most cases, these comments noted either that (1) DHSS believes there is a need for further fiscal analysis to understand the feasibility of the recommendation, or (2) DHSS does not have the personnel to incorporate the recommendation.

On the following pages PCG has chosen to respond specifically to ten DHSS comments that either express a lack of concurrence with PCG's recommendation or a need for further explanation. Once again, thank you for the opportunity to provide feedback.

Sincerely,

A handwritten signature in dark ink, appearing to read "James W. Waldinger". The signature is fluid and cursive, written over a light blue horizontal line.

James Waldinger
Associate Manager
Public Consulting Group, Inc.

DELIVERY AND ADMINISTRATION

Recommendation 2.5 on page 83

DHSS's comment: DHSS does not concur with the recommendation. The department is evaluating some form of targeted approach to reassess people who are most likely to have some significant change of condition. Also, the department never suspended PCA reassessment of people who have established the need for Nursing Facility Level of Care by qualifying for a waiver; this is not clear in the report.

PCG Response: PCG wishes to clarify its statements regarding PCA reassessments. The scope of comments in the report refer to the suspension of PCA reassessments for persons who do not meet Medicaid's nursing facility level of care requirements. According to PCG's interviews with DHSS staff, this suspension occurred in order to prioritize reassessments of persons receiving Medicaid waiver services in order to comply with federal waiver rules regarding annual assessments. PCG stands by the recommendation that annual reassessments should occur for the entire PCA population.

Recommendation 2.6 on page 85

DHSS comment: DHSS does not concur with the recommendation. The department is currently evaluating potential implementation of 1915(i) and may expand coverage without risking expanding NF expenditures. Following this decision, cost benefit analysis of expanding the NF LOC criteria will be needed.

PCG Response: PCG stands by its recommendation.

GRANTS AND CONTRACTS

Recommendations 3.1, 3.2, and 3.3 on page 95

DHSS comment: DHSS partially concurs with the recommendations. However, it is important to note the difference between administrative costs claimed as direct expenses, and those claimed as indirect costs. For grantees with a federally negotiated indirect cost rate in accordance with 2CFR 200.414, pass-through entities are required by 2 CFR 200.331(a)(4) to include this rate in the grant award. Current department regulations at 7 AAC 78.160(p) require DHSS to honor a grantee's federally negotiated indirect cost rate. While potential departmental regulatory changes are within the control of the department, federal requirements per 2 CFR 200 are not. Consequently, the department does not have the ability to set a unilateral limit on these costs.

PCG Response: While we understand that not all is within departmental control, PCG stands by its recommendations to more closely monitor administrative costs of its vendors.

BUDGET REDUCTIONS

Recommendations 4.1 on page 115

DHSS Comment: DHSS does not concur with the recommendation. Please reference the department's response as an additional comment for page 110. Approximately 80% of the DHSS budget is distributed in direct benefits and services to vulnerable populations statewide. The department is being asked to prioritize which vulnerable populations will be provided the basic essentials to survive, for example – whether families will be provided assistance purchasing food or heat versus providing protective services to children and elders. Currently the Alaska Constitution and Statutes require the department to comply with providing these necessary services. However, DHSS is evaluating impacts to our vulnerable populations while trying to meet a 25% reduction over the next few years.

PCG Response: PCG appreciates the difficulties in administering programs for vulnerable populations while trying to meet significant reductions in costs, but we stand by our recommendation.

CERTIFICATION OF NEED

Recommendations 5.7 on page 128

DHSS Comment: DHSS does not concur with the recommendations. The Department has not received any complaints from providers that the application fee is too high or is a barrier to entry. For projects valued at \$2.5 million or less, the fee is \$2,500. For projects valued over \$2.5 million, the fee is equal to 0.1% of the estimated cost, up to a maximum fee of \$75,000. The Department is open to feedback on a more suitable approach for setting a maximum fee, but without concerns from health care facilities or the general public, there is no feedback to consider.

PCG Response: PCG's task was to determine whether the Certificate of Need process can be improved or better utilized to expand access to services in high need and underserved areas. While PCG recognizes the lack of complaints may indicate no major objections to the current fee process, we stand by our recommendation as it relates to fees as a way to improve access to services for underserved areas.

RESULTS BASED MEASURES

Recommendations 7.1 on page 146

DHSS Comment: DHSS is unable to assess this recommendation. Access to reliable data on the number of Alaskan's with disabilities is a barrier for the Division's ability to report at this level.

PCG Response: PCG stands by its recommendation.

Recommendations 7.4 on page 151

DHSS comment: DHSS does not concur with this recommendation. A person residing in an Assisted Living Home (ALH) is considered to be living independently. The definition of Institutions would include ICF/IIDs or nursing facilities not ALH.

PCG Response: PCG understands that the Department's position is that only persons in ICF/MR and nursing homes are not living independently. Recent federal policies (see Federal Register of January 16, 2014) have altered the definition of living independently. As the Department constructs its performance measure, the Department may wish to take these changing federal views into account. Under these new federal rules, it is possible for persons living in an assisted living facility to be considered as not living independently.

Recommendations 10.2 on page 181

DHSS comment: DHSS partially concurs with the recommendation. DSDS does not agree with the recommendation to contract with large PCA agencies to control fraud. Most PCA services are provided under a consumer directed model. This model gives control of the PCA to the consumer, with limited oversight provided by the agency. Both the consumer directed agency model and the agency based model receive the same rate. The department recognizes the limited agency oversight in the consumer directed model and is working to strengthen requirements in regulation to ensure providers train on identification and reporting of fraud, waste and abuse; execute policy and procedures; continue to conduct at least biennial review of services for each recipient; and continue to conduct satisfaction surveys. DSDS does agree with the recommendation to require annual or semi-annual reports on the activities undertaken by the agency to control fraud and abuse.

PCG Response: PCG and DHSS are in substantial agreement that the PCA agencies need to strengthen their oversight of PCA activities.

ADDITIONAL COMMENTS, CLARIFICATIONS, AND TECHNICAL CORRECTIONS**Additional Comment page 5; 83**

DHSS comment: It is unclear as to what federal cost allocation plan is being referenced because the federal public assistance cost allocation plan is applicable to administrative expenditures and not direct Medicaid services.

PCG Response: PCG did not intend to reference Medicaid “cost allocation plan” in this context. PCG’s main point is that Medicaid costs exceed the Medicaid reimbursement rate and this should be reviewed.

DHSS Comment on page 110

DHSS does not agree with the report's findings the department was not in compliance with Alaska Statute 44.66.02(c)(2). The department is required to comply with multiple statutes that are all determined by the legislature and it does not have the authority to decide which statute is more important than another as implied by the report. It is still the department's position that the elimination of assistance programs or elements of assistance programs would be identified through the state budget process with the department implementing those changes.

PCG Response: Review Objective 4 tasked PCG with determining whether or not DHSS's proposed long-term care related budget reductions complied with Alaska Statute 44.66.02(c)(2). Since no budget reductions were submitted, PCG stands by its finding.

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APPENDIX A: COST SAVINGS SUMMARY

Review Objective	Description	Potential Annual Savings	Methodology
Review Objective 2	AKPH Medicaid Reimbursement Increase	\$4.5-\$5.0 million	The assisted living rate covers only half of the cost of covering services at AKPHs. DHSS should review the SWICAP to determine if all Medicaid costs for Pioneer Home residents are claimed.
Review Objective 2	1915(i) State Plan Amendment	\$4.5 million	Fiscal Note 6 to the 2015 Senate Bill 78 estimated that an additional \$ 4,494,300 in federal funds could be obtained if Alaska applied for a 1915(i) Medicaid waiver.
Review Objective 2	1915(k) State Plan Amendment	\$2.5 million	Based on estimates from a 2012 study by HCBS strategies on implementing a Community First Choice option in the state.
Review Objective 3	Traumatic Brain Injury Waiver	\$285,000	Calculated by assuming implementation of a waiver that allows a 50% federal match on operational TBI programs currently funded by state general funds.
Review Objective 6	Medicaid Expansion	\$975,845,000 from 2017 to 2021	This figure is the sum of the annual projected federal spending for 2017 - 2021. (http://dhss.alaska.gov/HealthyAlaska/Documents/Evergreen_Medicaid_Expansion_Analysis-020615.pdf)
Review Objective 6	Provider Assessment Fees	Maximum of \$650,000 per facility assessed	The figure comes from 2013 Alaska revenue on the maximum provider tax allowable of 6%. Actual savings is dependent on type, rate, and number of assessment imposed. Estimate from State data.
Review Objective 6	Grants and Contracts alignment with Federal Programs	More work needs to be completed	PCG identified five (5) grants that are currently funded only through General Fund monies. Through Medicaid eligibility checks PCG believes federal match could be identified for some portion of these grants. Further eligibility analysis is needed.
Review Objective 8	Electronic Visit Verification system for PCA and Waiver programs	\$1 million -\$2 million	An estimated 1%-2% in savings from the 2014 PCA expenditure of \$100 million.

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APPENDIX B: GLOSSARY OF ACRONYMS

AAAs – Area Agencies on Aging

AARP – The American Association of Retired Persons

ABI – Acquired brain injury

ACA 2010 – Affordable Care Act of 2010

ACOA – Alaska Commission on Aging

ADL – Activities of daily living

ADRCs – Aging and Disability Resource Centers

ADRDS – Alzheimer’s disease and related dementia

ADS – Adult-day services

AI/AN – American Indian and Alaska Native

AKPH – Division of Alaska Pioneer Homes

ALI – Alaskans Living Independently Waiver

APD – Adults with Physical Disabilities Waiver

APDD – Adults with Physical and Developmental Disabilities Waiver

APS – Adult Protective Services

ASP – Automated Service Plan

BIP – Balancing Incentives Payment Program

CAP – Corrective Action Plan

CAT – Comprehensive Assessment Tool

CCMC – Children with Complex Medical Conditions Waiver

CDDG – Community Developmental Disability Grants

CFC – Community First Choice

CHIP – Children’s Health Insurance Program

CDIB – Certificate of Degree of Indian Blood

CMS – Centers for Medicare and Medicaid Services

CON – Certificate of Need

DEFRA 2005 – Deficit Reduction Act of 2005

DGF – Designated general funds

DHSS or The Department – Alaska Department of Health and Social Services

DLA – Alaska Division of Legislative Audit

DOD – Department of Defense

DRG – Diagnosis-related group

EHR – Electronic health record

EVV – Electronic visit verification

FFP – Federal Financial Participation

FMAP – Federal Medical Assistance Percentage

FMS – Office of the Finance and Management Services

FPL – Federal poverty level

GA – Grants Administrator

GAC – Grants and Contracts Team

GEMs – Grants Electronic Management System

HCBS – Home and community-based services

HCS – Division of Health Care Services

HEDIS – Healthcare Effectiveness Data and Information Set

HPDP – Health Promotion Disease Prevention

I/A – Interagency

IABP – Intraaortic balloon pump

IADL – Instrumental Activities of Daily Living

ICAP – Inventory for Client and Agency Planning

ICF/MR – Intermediate Care Facility for Individuals with Mental Retardation

ICFs/ID-DD – Intermediate Care Facilities/Intellectual-Developmental disabilities

ID/DD – Intellectual or developmental disabilities

IDD – People with Intellectual and Developmental Disabilities Waiver

IRIS – Integrated Resource Information System

IT – Information technology

IVs – Intravenous injections

LTC Partnership – Long-Term Care Insurance Partnership Program

LTCACH – Long-Term Care Acute Care Hospital Services

LTSS – Long-term care services and supports

MARC – Mat-Su Activity and Respite Center

MB – Municipalities / Boroughs

MCI – Master Client Index

MCO – Medicare Counseling and Outreach

MDS – Minimum Data Set

MFCU – Medicaid Fraud Control Unit

MFP – Money Follows the Person

MHTAAR – Mental Health Trust Authority

MIP – Medicaid Integrity Program

MMIS – Medicaid Management Information System

NASBO – National Association of State Budget Officers

NCI – National Core Indicator

NFCSP – National Family Caregiver Support Program

NPV – Net present value

NTS – Nutrition, Transportation & Support Services

NWD/SEP – No Wrong Door–Single Entry Point system

OA – Older Alaskans Waiver

OIG – Office of Inspector General

OPI – Office of Program Integrity

PAVE – Provider Application and Validation for Enrollment

PCA – Personal Care Assistance

PCG – Public Consulting Group, Inc.

PEC – Proposal Evaluation Committee

PERM – Payment Error Rate Measurement

PET/PET-CT – Positron Emission Tomography

PM – Program Manager

QA – Quality Assurance

QIO – Quality Improvement Organization

QRS – Quality Rating System

RAC – Recovery Audit Contractor

RDUs – Results Delivery Units

RFPs – Requests for Proposals

RPTC – Residential Psychiatric Treatment Centers

SDS – Division of Senior and Disabilities Services

SHIP – State Health Insurance Assistance Program

SIH – Senior In-Home Services

SMP – Senior Medicare Patrol

SOW – Scope of work

SRS – Senior Residential Services

SSA or The Act – Social Security Act

STAR – Short Term Assistance and Referral

SURS – Surveillance and Utilization Review Subsystem

SWICAP – Statewide Indirect Cost Allocation Plan

TABI – Traumatic and Acquired Brain Injury

TBI – Traumatic brain injury

TEFT – Testing Experience and Functional Tools

UGF – Unrestricted general fund

VA – Veteran Affairs

VPN – Virtual private networks

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