



UNIVERSITY  
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*Many Traditions One Alaska*

**Challenges of Delivery of Academic-Based  
Certified Nurse's Aide/Assistant Programs in  
Rural Alaska, v.2**

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on behalf of the:

**University of Alaska CNA Faculty Advisory Group**

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**Introduction:**

The purpose of this white paper is to express concerns regarding challenges to delivering quality Certified Nurse's Aides/Assistant Training Programs in rural regions of Alaska, specifically those programs offered in academic settings within the University of Alaska system.

**Background and priority:**

Certified Nurse's Aides/Assistants (CNA's) work in a variety of health care related roles, but predominately in long-term care settings such as nursing homes, assisted living homes, and community-based care. In rural Alaska, it is common to find CNA's employed more commonly in clinical settings such as hospitals and health centers.

The CNA is trained to safely bathe, groom, dress and assist patients with their ADLs (activities of daily living). They are trained to safely assist with ambulation, transfers, and bed mobility. Additionally, the CNA training includes instruction in how to provide active and passive range of motion (ROM) exercises. They are also educated to provide patients with basic massage such as back rubs, and skin care to prevent breakdown, and learn about nutrition and basic anatomy and physiology.

The Alaska Health Workforce Coalition has designated this occupation as a high priority area of focus, given the increased needs for CNA's over the next decade. Alaska is aging, and currently holds the dubious honor of being the #1 state with the fastest growing senior (65+) population in the nation, per capita (US Census Bureau, 2011).

The population aged 65+ is largely composed of retirees. Very strong growth for this age group is expected through the year 2034. Currently, Alaska's population aged 65+ is estimated to be 52,263 people. The most likely picture for this group's population growth projects 124,857 people aged 65+ by 2034; this increase represents more than doubling in size over the 25-year period. Growth in this age group is fully attributable to the large cohort of baby boomers; "The massive change in the size of the population age 65+ will play a major role in shaping Alaska's future. The growth of the senior population will surely present new challenges to find funding and build infrastructure in support of more retirees." (Alaska Dept. of Labor and Workforce Development (AKDOLWD), 2011).

According to the AKDOLWD, there is a projected growth of **23% between openings in 2008 and openings in 2018** for Certified Nurse's Assistants. In 2010, there were 2,829 licensed CNA's, with a predicted 33% over the age of 45 (2011). CNA's, similar to registered nurses, face a shortage due to both population factors as well as occupational attrition factors primarily due to retirement within the occupation itself.

The 2009 Vacancy Study report shows Certified Nurse's Assistant had approximately 1,246 positions with 102 vacancies at the time of the survey, resulting in an 8.3% vacancy rate, which is defined by the study as moderately high rate. This rate puts the CNA occupation in the **top ten occupations with the highest vacancies as well as the top 10 most needed occupations in the next decade**. It is also

noted in the 2009 Vacancy Study that the Tribal Health Organizations had the highest vacancies for Certified Nurses Assistants at 23.7% (ACRH-AHEC/ISER, 2009)

CNA's are also reported in the 2009 Vacancy Study in the "Other Nursing Staff" category, which shows regional vacancies as considerably higher in rural areas. For example, the Gulf Coast region reported a 12.1% vacancy rate, and the Interior Region a 16.9% vacancy rate. The urban rate was much lower at 6.8% (ACRH-AHEC/ISER, 2009).

### Challenge #1, Lack of Qualified, Full-Time Nurse Aide Program Manager position within the State of Alaska Board of Nursing

The first and foremost challenge facing all CNA training programs in Alaska is the lack of a full-time, qualified Nurse Aide Program Manager position within the Board of Nursing. This position is integral to maintaining the Nurse Aide Registry and oversight and evaluation of all CNA training programs, and without adequate staff to meet the requirements of the Registry, this creates an **artificial barrier to training a nurse aide workforce in Alaska.**

According to the FY11 Board of Nursing Annual Report, a variety of details are indicated that support the critical need for the reinstatement of funding for this unfilled position:

- 627 new nursing assistants were certified in FY11, 495 by exam, 37 by endorsement, and 54 by reinstatement
  - On June 30, 2011 there were 3,161 active CNA's in Alaska
  - This is a 20% increase in workload from FY10
  - Based on population predictions for the need for future CNA's, it is anticipated this workload will only increase over the next decade
- The Board of Nursing oversees 15,200 licensed or certified individuals, with the number increasing each year.
  - The Nurse Aide Registry has the responsibility for approving programs, instructors, and proctors in addition to certifying qualified applicants.
  - Currently, these responsibilities are performed by either a contracted RN or the Executive Director, as they are a nursing function versus a license examiner function
  - The position of Nurse Aide Program Manager was defunded in 2002 by the Division Director, and although the position remains in the state system, no funding exists
  - The loss of this position has made it near impossible to meet federal mandates of program approval every two years
  - The continued lack of a full-time staff person in this position further creates a bottleneck in the program approval process, from initial new training applications to instructor qualification approval.

Rural communities rely on the University of Alaska CNA training programs to meet their localized needs in a timely fashion. Many rural CNA programs are specifically training the local workforce for open positions that have gone unfilled for long periods of time. It is by far more cost effective to train a cohort of students to fill those positions expediently, yet the bottleneck created in the Board of

Nursing due to the unfunded and unfilled Nurse Aide Program Manager position prevents timely review and approval of new training programs, instructors, and clinical sites. Communities are forced to wait for 6-12 months when many other states operate on a 90 day review and approval process.

This workgroup respectfully requests the State of Alaska, Department of Commerce, Community, and Economic Development reinstate the funding for the Nurse Aide Program Manager position within the Board of Nursing to unclog the bottleneck created by understaffing.

Challenge #2. Pool of Qualified Rural CNA instructors that meet Regulation Approval

The definition of long-term care services, per the Centers for Medicare and Medicaid, is as follows: Long-term care is a variety of services that includes medical and non-medical care to people who have a chronic illness or disability. Long-term care helps meet health or personal needs, i.e. most long-term care is to assist people with support services such as activities of daily living like dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, in assisted living or in nursing homes (CMS, 2011).

Long-term care can also be provided formally or informally. Facilities that offer formal LTC services typically provide living accommodation for people who require on-site delivery of around-the-clock supervised care, including professional health services, personal care and services such as meals, laundry and housekeeping. These facilities may go under various names, such as nursing home, personal care facility, residential continuing care facility, etc. (Centers for Medicare and Medicaid, 2011).

Long-term care provided formally in the home, also known as home health care, can incorporate a wide range of clinical services (e.g. nursing, drug therapy, physical therapy) and other activities such as physical construction (e.g. installing hydraulic lifts, renovating bathrooms and kitchens). These services are usually ordered by a physician or other professional. Informal long-term home care is care and support provided by family members, friends and other unpaid volunteers. (Centers for Medicare and Medicaid, 2011).

The Alaska statute for a CNA Instructor (12 AAC 44.840) states: *in a non-facility based program, a program instructor must be*

- (A) be either a registered nurse or practical nurse licensed under AS 08.68;*
- (B) have at least two years of nursing experience, of which at least one year is in the provision of long-term care facility services;*
- (C) have either*
  - (i) completed a course in teaching adults; or*
  - (ii) experience in teaching adults or supervising nurse aides; and*
- (D) be approved by the board as meeting the criteria for program instructors;*

This requirement imposes an **artificial barrier to training a workforce in rural Alaska**. According to current Board of Nursing interpretation, assisted living and/or community-based /LTC health service delivery experience doesn't meet that criteria, nor does hospital-based nursing experience.

In rural Alaska, this barrier is due to the lack of "long-term care facilities" in which to draw instructors from. There are 16 licensed "skilled" long-term care facilities in Alaska, under the literal interpretation. In comparison, there are, as of February 2011, 613 licensed assisted living facilities. In rural areas the LTC facilities are usually a primary access hospital in a hub community, but "LTC beds" are either very limited or swing beds.

By allowing for a more liberal interpretation of the state statutes, specifically the interpretation of "long-term care facility", non-facility based academic programs would be able to expand into rural and remote communities with a larger pool of qualified instructors and using a variety of teaching modalities to keep students in their home villages for training and future employment.

It is this advisory group's position that Registered Nurses who work in either hospital settings and/or community based health care services receive sufficient long-term care exposure in the course of their careers. Either setting provides opportunities to work with the elderly and could be considered loosely as a "facility". Registered Nurses also supervise CNA's in a variety of rural locations; therefore are in the perfect position to become faculty for rural-based CNA programs.

Suggested modification of 12 AAC 44.840 (a)(B) and (b)(1) could read " must have at least two years of nursing work experience in acute or chronic care inpatient facilities. One year may be substituted by 1 year of work experience in a community based agency (hospice, home health, public health nursing, school nursing etc.)"

**Challenge #3 Clinical Training Sites and Program Expense**

The perceived application and interpretation of Alaska Nursing Statutes and Regulations, specifically **12 AAC 44.830 – 12AAC 44.855**, has created a challenge to meeting rural workforce needs in Alaska.

12 AAC 44.835. states: (c) In addition to the requirements of (b) of this section, a certified nurse aide training program must consist of at least 140 hours of training that

(1) includes a minimum of 60 hours of didactic instruction that meets the requirements of 12 AAC 44.845;

(2) includes a minimum of 80 hours of supervised skills and clinical training that meets the requirements of 12 AAC 44.847, as follows:

- (A) 24 hours may be in
  - (i) an assisted living home licensed in this state that has a registered nurse or practical nurse on staff 24 hours a day and that provides an opportunity for the students to gain competencies required in 12 AAC 44.847; or
  - (ii) an acute care facility that provides an opportunity for the students to gain the competencies required in 12 AAC 44.847;
- (B) at least 32 hours must be in learning and practicing the skills under the direct supervision of an approved instructor under 12 AAC 44.840 or supplemental personnel with specialized training who have at least one year experience in their field;
- C) at least 24 hours must be in a long-term care facility

This requirement works well for programs in an urban location or a facility-based location, but for UA programs training rural students in their home communities, this requirement can be an expensive and cumbersome challenge. For example, in order to train CNAs in Bethel or throughout the YK Delta, students and /or employers are required to bear the expense and disruption of flying to Anchorage for a clinical experience at a long term care facility. As with all publically/federally funded institutions, funding to support the expense of this kind of training model is not sustainable or economically prudent.

Modifying section 12AAC 44.847 so that clinical training may be in a licensed assisted living home, an acute care facility, long term care facility or a combination of all three would uphold patient safety standards while expanding site opportunities in rural Alaska.

Restricting eligibility of assisted living homes to those who have LPNs or RNs on staff 24 hrs./day; statute 12AAC 44.847(A)(i) likewise imposes an artificial barrier. Clinical sites in general are inherently a barrier in many health occupations training programs. Simply put, Alaska doesn't have a large "clinical site pool" to begin with; restricting clinical sites even further exacerbates the problem.

Modifying the regulations so that all clinical experience requirements may be fulfilled at an acute care facility or at a licensed assisted living home during the hours that a staff RN or LPN are on the premises would greatly expand clinical sites and allow rural students to train in locations closer to their home community, while maintaining the integrity of the program by requiring clinicals only take place under the supervision of an RN or LPN.

This UA advisory group proposes a modification of this statute which could read: Eighty hours of clinical training **must** be in a licensed assisted living home with a staff RN or LPN on the premises, and/or at an acute care facility, and/or in a long-term care facility.

**Challenge #4 Training Program Expansion and Approval**

The fourth barrier is the issue of UA program approval and developing programs for distance delivery. It is this workgroup's request that programs approved at each UA major academic unit (MAU) should be portable and ready to meet industry demand in any community in Alaska at any time. However,

statue 12 AAC 44.855 (CHANGES IN TRAINING PROGRAM) states: *A change in curriculum or a substantive change in an approved certified nurse aide training program may not occur without board approval. The program provider must submit a description of the proposed change in curriculum or other substantive change to the board for review at least 60 days before the provider proposes to implement the changes. The board will base its approval on whether the proposed change meets the requirements of 12 AAC 44.835 – 12 AAC 44.847 and 12 AAC 44.852.*

This has been interpreted to include delivery of a distance program and arrangement of a clinical site in a community that has not hosted CNA trainings in the past but is affiliated and/or served by the MAU in the region. For example, if Yakutat or Hoonah wants to request the University of Alaska Southeast bring a CNA training to their community, the program is deemed a “new program” and must go through the official Board of Nursing approval process (with no guarantee of approval) even though the program itself has been approved at the campus.

It is not uncommon for the University of Alaska to offer flexible course delivery options to accommodate rural students, without making any significant changes in the program or curriculum to do so. And often, industry in particular regions/communities contacts the MAU in their region directly with workforce requests. Given the size of communities, it may not be feasible or necessary to establish a “new program” but to simply offer a one-time CNA training on location. This advisory group requests consideration of statue 12 AAC 44.855 to allow for flexibility in already-approved UA CNA training programs having portability around each respective region served.

In closing, the University of Alaska CNA faculty takes great pride in striving to meet the needs statewide in this high demand occupation. By periodically reviewing and reconsidering interpretations of the statutes that govern CNA non-facility based training programs, UA campuses can continue to deliver high quality and rigorous programs that maintain the high standards the State of Alaska expects, instead of being impeded by those standards.

#### **References:**

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United States Census Bureau. *US Census Quick Facts – Alaska*. Retrieved from <http://quickfacts.census.gov/qfd/states/02000.html>. January 3, 2012

United States Centers for Medicaid and Medicare. *Definition of Long-Term Care*. Retrieved from <http://www.medicare.gov/longtermcare/static/home.asp>. January 3, 2012

**Statutes cited for reference:**

**12 AAC 44.840. PROGRAM INSTRUCTORS.**

(a) In a non-facility based program,

(1) a program instructor must

- (A) be either a registered nurse or practical nurse licensed under AS 08.68;
- (B) have at least two years of nursing experience, of which at least one year is in the provision of long-term care facility services;
- (C) have either
  - (i) completed a course in teaching adults; or
  - (ii) experience in teaching adults or supervising nurse aides; and
- (D) be approved by the board as meeting the criteria for program instructors;

(2) the general supervisor must assume full responsibility and accountability for the program, including the quality of the program and performance of program instructors.

(b) In a facility-based program, the training may be performed under the general supervision of the director of nursing for the facility, who is prohibited from performing the actual training. The program instructor must be a registered nurse or practical nurse, licensed under AS 08.68, who has

(1) at least two years of nursing experience, of which at least one year is in a long-term care facility; and

(2) either

- (A) completed a course in teaching adults; or
- (B) experience in teaching adults or supervising nurse aides.
- (c) The primary instructor in a certified nurse aide training program offered in a nursing facility must be a registered nurse or a practical nurse, licensed under AS 08.68, who has at least two years of experience as a nurse in a nursing facility.
- (d) An approved program instructor, licensed under AS 08.68, must be on-site and provide direct supervision to a student during the student's clinical experience in any facility, including the required long-term care, assisted living, acute care, or ambulatory care setting.
- (e) Supplemental personnel may be used to meet the program objectives for specific topics in a certified nurse aide program. Supplemental personnel must have at least one year of experience in the field or specialty in which the training is to be provided.

Authority: AS 08.68.100 AS 08.68.331

**\*The Federal Nursing Home Reform Act or OBRA '87 creates a set of national minimum standards of care and rights for people living in certified nursing facilities:**

- § 483.152 Requirements for approval of a nurse aide training and competency evaluation program.
- (a) For a nurse aide training and competency evaluation program to be approved by the State, it must, at a minimum—
- (1) Consist of no less than 75 clock hours of training;
  - (2) Include at least the subjects specified in paragraph (b) of this section;
  - (3) Include at least 16 hours of supervised practical training. Supervised practical training means training in a laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or a licensed practical nurse;
  - (4) Ensure that—
    - (i) Students do not perform any services for which they have not trained and been found proficient by the instructor; and
    - (ii) Students who are providing services to residents are under the general supervision of a licensed nurse or a registered nurse;
  - (5) Meet the following requirements for instructors who train nurse aides;
    - (i) The training of nurse aides must be performed by or under the general supervision of a registered nurse who possesses a minimum of 2 years of nursing experience, at least 1 year of which must be in the provision of long term care facility services;
    - (ii) Instructors must have completed a course in teaching adults or have experience in teaching adults or supervising nurse aides;
    - (iii) In a facility-based program, the training of nurse aides may be performed under the general supervision of the director of nursing for the facility who is prohibited from performing the actual training; and
    - (iv) Other personnel from the health professions may supplement the instructor, including, but not limited to, registered nurses, licensed practical/vocational nurses, pharmacists, dietitians, social workers, sanitarians, fire safety experts, nursing home administrators, gerontologists, psychologists, physical and occupational therapists, activities specialists, speech/language/hearing therapists, and resident rights experts. Supplemental personnel must have at least 1 year of experience in their fields;
  - (6) Contain competency evaluation procedures specified in §483.154.
    - (b) The curriculum of the nurse aide training program must include—
      - (1) At least a total of 16 hours of training in the following areas prior to any direct contact with a resident:
        - (i) Communication and interpersonal skills;
        - (ii) Infection control;
        - (iii) Safety/emergency procedures, including the Heimlich maneuver;
        - (iv) Promoting residents' independence; and
        - (v) Respecting residents' rights.
      - (2) Basic nursing skills;
        - (i) Taking and recording vital signs;
        - (ii) Measuring and recording height and weight;
        - (iii) Caring for the residents' environment;

- (iv) Recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor; and
- (v) Caring for residents when death is imminent.
- (3) Personal care skills, including, but not limited to—
  - (i) Bathing;
  - (ii) Grooming, including mouth care;
  - (iii) Dressing;
  - (iv) Toileting;
  - (v) Assisting with eating and hydration;
  - (vi) Proper feeding techniques;
  - (vii) Skin care; and
  - (viii) Transfers, positioning, and turning.
- (4) Mental health and social service needs:
  - (i) Modifying aide's behavior in response to residents' behavior;
  - (ii) Awareness of developmental tasks associated with the aging process;
  - (iii) How to respond to resident behavior;
  - (iv) Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity; and
  - (v) Using the resident's family as a source of emotional support.
- (5) Care of cognitively impaired residents:
  - (i) Techniques for addressing the unique needs and behaviors of individual with dementia (Alzheimer's and others);
  - (ii) Communicating with cognitively impaired residents;
  - (iii) Understanding the behavior of cognitively impaired residents;
  - (iv) Appropriate responses to the behavior of cognitively impaired residents; and
  - (v) Methods of reducing the effects of cognitive impairments.
- (6) Basic restorative services:
  - (i) Training the resident in self care according to the resident's abilities;
  - (ii) Use of assistive devices in transferring, ambulation, eating, and dressing;
  - (iii) Maintenance of range of motion;
  - (iv) Proper turning and positioning in bed and chair;
  - (v) Bowel and bladder training; and
  - (vi) Care and use of prosthetic and orthotic devices.
- (7) Residents' Rights.
  - (i) Providing privacy and maintenance of confidentiality;
  - (ii) Promoting the residents' right to make personal choices to accommodate their needs;
  - (iii) Giving assistance in resolving grievances and disputes;
  - (iv) Providing needed assistance in getting to and participating in resident and family groups and other activities;
  - (v) Maintaining care and security of residents' personal possessions;
  - (vi) Promoting the resident's right to be free from abuse, mistreatment, and neglect and the need to report any instances of such treatment to appropriate facility staff;

(vii) Avoiding the need for restraints in accordance with current professional standards.

(c) Prohibition of charges. (1) No nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program may be charged for any portion of the program (including any fees for textbooks or other required course materials).

(2) If an individual who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility not later than 12 months after completing a nurse aide training and competency evaluation program, the State must provide for the reimbursement of costs incurred in completing the program on a pro rata basis during the period in which the individual is employed as a nurse aide.

**12 AAC 44.835. TRAINING PROGRAM STANDARDS.**

(a) A certified nurse aide training program must be conducted in a manner to assure that clients receive safe and competent care, and must train a certified nurse aide to

- (1) form a relationship, communicate, and interact competently with the client;
- (2) demonstrate sensitivity to the emotional, social, and mental health needs of a client through skillful and directed interactions;
- (3) assist a client in attaining and maintaining independence;
- (4) exhibit behavior that supports and promotes the rights of a client; and
- (5) demonstrate the skills of observing, caregiving, and reporting needed to document the health, physical condition, and well-being of a client.

(b) To be approved by the board, a certified nurse aide training program must provide the following:

- (1) curriculum that meets the requirements of 12 AAC 44.845 and 12 AAC 44.847;
- (2) instructors who meet the requirements of 12 AAC 44.840;
- (3) classroom and clinical facilities that meet the requirements of (f) of this section;
- (4) maintenance of records showing the disposition of complaints received against the program.

(c) In addition to the requirements of (b) of this section, a certified nurse aide training program must consist of

at least 140 hours of training that

- (1) includes a minimum of 60 hours of didactic instruction that meets the requirements of 12 AAC 44.845;
- (2) includes a minimum of 80 hours of supervised skills and clinical training that meets the requirements of 12 AAC 44.847, as follows:

(A) 24 hours may be in

- (i) an assisted living home licensed in this state that has a registered nurse or practical nurse on staff 24 hours a day and that provides an opportunity for the students to gain competencies required in 12 AAC 44.847; or
- (ii) an acute care facility that provides an opportunity for the students to gain the competencies required in 12 AAC 44.847;

(B) at least 32 hours must be in learning and practicing the skills under the direct supervision of an approved instructor under 12 AAC 44.840 or supplemental personnel with specialized training who have at least one year experience in their field;

(C) at least 24 hours must be in a long-term care facility; and

(3) documents each student's demonstration of skills by completion of the nurse aide skills checklist required under 12 AAC 44.852.

(d) During supervised skill and clinical training, a ratio of 10 students to one instructor may not be exceeded when the student is providing skills demonstration on an individual or clinical care to a client. Before having any direct contact with a client, a student must complete a minimum of 16 hours of classroom training and 16 hours of specific skill training that includes

- (1) communication and interpersonal skills;
- (2) infection control, including standard precautions;
- (3) safety and emergency procedures;
- (4) respecting and promoting the rights of the client;
- (5) observation, reporting, and documentation of patient status and the care or service furnished;
- (6) reading and recording temperature, pulse, and respiration;
- (7) basic elements of body functioning and changes in body function that must be reported to a nurse aide's supervisor; and
- (8) appropriate and safe techniques in personal hygiene and grooming that includes:
  - (A) bed bath;
  - (B) sponge, tub, or shower bath; .
  - (C) skin care;
  - (D) oral hygiene;
  - (E) toileting and elimination;
  - (F) safe transfer techniques and ambulation; and
  - (G) positioning.

(e) The training required under this section is in addition to a nursing facility's initial employee orientation requirements.

(f) Classroom and clinical facilities must provide space, comfort, safety, and equipment sufficient for conducting a professional certified nurse aide training program. When evaluating the sufficiency of classroom and clinical facilities, the board will consider whether

- (1) the facilities appear to be clean and in good repair;
- (2) a comfortable temperature is maintained;

(3) the lighting is bright enough to allow performance of classroom work, including reading and writing, and whether increased lighting is available as needed for specific clinical instruction;

(4) students have ready access to toilets and lavatories;

(5) space is sufficient to allow each student to be seated and take written notes during lectures, and to provide students with an unobstructed view during demonstrations of clinical skill tasks;

(6) the acoustics allow students to hear the instructor; and

(7) an aspect of the facilities likely could interfere with the effective presentation of a certified nurse aide training program;

(8) the clinical facility provides access to a sufficient number of clients to allow the student to provide care for more than one client at a time, and for the student to gain the competencies required in 12 AAC 44.847.

(g) Except as provided in (h) of this section, the board will not approve a certified nurse aide training program offered in or by a nursing facility that the state survey and certification agency or the Centers for Medicare and Medicaid Services, United States Department of Health and Human Services, has determined to be ineligible under federal Medicare or Medicaid regulations to offer a nurse aide training and competency evaluation program within the 24 months preceding the board's review of the nursing facility's program.

(h) The board will approve a certified nurse aide training program to be conducted in a nursing facility described under (g) of this section if a program provider other than that nursing facility offers the training program, and if the state survey and certification agency has

(1) determined that a similar program is not offered within a reasonable distance of the facility;

(2) determined that an environment exists that is adequate for the operation of the program in the facility; and

(3) provided notice of its determinations to the office of long term care ombudsman established under

AS 44.21.231.

(i) The board will maintain a current list of approved training programs. Those training programs approved by the board as of October 9, 1998 are determined to be in compliance with the requirements of 42 C.F.R. 483.152 and 42 C.F.R. 483.154. The board will review these programs as provided in 12 AAC 44.857.

(j) During classroom instruction, the ratio of students to the instructor may not exceed 20 students for each instructor.

Attachment B (B1)



ALASKA STATE HOSPITAL &  
NURSING HOME ASSOCIATION

Attachment 1

August 2, 2012

Dr. Ward Hurlburt  
Director and Chief Medical Officer  
3601 C Street, Suite 756  
Anchorage, AK 99503

Dear Dr. Hurlburt,

On behalf of the ASHNHA Board of Directors, I am writing to register a deep concern over the recent action by the Department and the Alaska Health Care Commission to undertake a Pricing and Reimbursement Study for Skilled Nursing Facility Care in Alaska.

We agree with the previous direction of the Commission, taken in December 2011, when they voted overwhelmingly to not spend public money to conduct such a study. We are confused about the action now being taken to reverse that decision and also to conduct the study in what we consider a very rushed fashion. We are particularly concerned the questions before Alaskans, as we grapple with a growing senior population and the cost burden associated with it, are inadequately framed.

More importantly, we believe much of the information you are seeking is readily available within the Department or from public sources. As you know, Medicaid is the predominant payer of SNF services. This is fundamentally different from acute care services. In accordance with the Alaska statutory and regulatory framework, facilities provide detailed information about their costs to Alaska DHSS which then sets the rates based on the documented cost of care. In other words, the State of Alaska DHSS determines what is paid for the major portion of SNF services. Please find attached the most current LTC rates being paid by the Department (Attachment 1).

Attached also find copious information on the selected states from readily available sources. If there are holes in the information they can be patched by a phone call or two. The source of the information on other states is the American Health Care Association (Attachment 2). There are dozens of other sources of information available.

The RFP references the hospital and physician study undertaken by the Commission and states the desire to "continue in 2012 the effort to better understand pricing, reimbursement and cost drivers for health care services by extending the same questions regarding variations in prices paid to those paid for skilled nursing care." Further the RFP requests, "an analysis of the range of billed and allowed charges, as well as the mean and the

50<sup>th</sup> and 80<sup>th</sup> percentile.” We do not understand this statement as it does not reflect the real and significant difference in LTC rates and payments versus hospital rates. We are concerned the RFP may be based on incorrect assumption and we would like to better understand how this is a relevant analysis in the SNF setting.

We also question the value of a unit cost analysis in and of itself. Several factors make us raise this question and others:

- Alaska SNF rates are very high as exhibited by the enclosed information. Virtually all rural SNF's, which are the most expensive, are attached to rural and critical access hospitals. This co-location allows rural hospitals to spread costs; to stay open; and maintain a vital health care community for small towns in Alaska. Medicare also recognizes this dynamic by designating most rural facilities as Critical Access Hospitals.
- We are concerned about why the Commission is taking an ad hoc and singular approach to examining a small element of the LTC system when the Commission already reviewed financial information on the LTC system in Alaska. That information, presented to the Commission in October 2011, documented that SNF care accounted for **20% of the State's LTC expenditures and 2% of the clients.** The presentation fully illustrated the per-unit cost of SNF services versus home and community based care (Attachment 3-selected pages).
- The number of nursing home beds has actually declined, while the senior population has tripled. (The State of Long Term Care in Alaska, Alaska Health Care Commission, October, 2011) Occupancy in SNF facilities in urban areas is very high (roughly 92%) which causes extra cost in the acute care system. The LTC Care expert study group asked the Commission how such pressures will be handled in the future as our senior population grows exponentially. How will a unit cost study reflect system issues and contribute to answering to this question?
- We know Alaska has high staffing per resident (see Attachment 2). While this can be reflected in a unit cost study, what is not addressed is the quality that staffing fosters. Alaska scores very high on numerous quality measures for its LTC system.
- Unit cost averaging used by the Commission in the previous study presents numerous methodology problems if you are seeking to understand the intricacies of the markets. States set SNF rates differently: some states base rates on acuity; others, such as Washington and Oregon are more urban and have larger facilities, which can achieve different economies of scale; and Alaska has a high use of co-located facilities, with cost-based reimbursement. Some rural states are converting their LTC beds to swing beds. Use of the simple averaging methodology which was

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employed in the previous study does not take into account facility size and the philosophy of maintaining rural access to care. Alaska's average rate would be roughly \$600 per day, yet some facilities are approximately half that and some are quite a bit more.

In conclusion, ASHNHA believes this study is unnecessary and poorly designed. We feel the solicitation was rushed with limited public notice. We do not support the study under these conditions and design.

If a study is to be done, we request the LTC expert group, already advising the Commission known as the Alaska Long Term Care Plan Steering Committee, be used to frame the questions. ASHNHA's LTC Committee also stands ready to assist.

Sincerely,

A handwritten signature in blue ink, appearing to read "Charles C. Franz".

Charles C. Franz, FACHE  
Chair, ASHNHA LTC Committee

Cc: Pat Branco, Health Care Commission  
Deborah Erickson, Director HCC  
ASHNHA Executive Committee  
ASHNHA LTC Committee

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### Attachment 1

Effective Alaska Medicaid payment rates as of July 1, 2012, for Alaska Nursing Facilities

	Rate	Time frame
Prestige Care & Rehabilitation Center (Ika Mary Conrad)	\$ 364.77	10/01/2011 - 9/30/2012
Providence Extended Care Center	\$ 443.94	1/01/2012 - 12/31/2012
Wildflower Court	\$ 524.08	1/01/2012 - 12/31/2012
Utuuqanaat Inaat (Maniilaq)	\$ 573.22	03/15/2012 - 9/30/2012
Central Peninsula <sup>1</sup> /Heritage Place	\$ 445.88	7/01/2012 - 6/30/2013
Cordova Community Medical Center	\$ 805.30	7/01/2012 - 6/30/2013
Fairbanks Memorial Hospital	\$ 622.75	1/01/2012 - 12/31/2012
Ketchikan General Hospital	\$ 724.42	7/01/2012 - 6/30/2013
Norton Sound Regional Hospital	\$ 888.74	10/01/2011 - 9/30/2012
Petersburg Medical Center	\$ 634.72	7/01/2012 - 6/30/2013
Providence Kodiak Island Medical Cntr	\$ 511.80	1/01/2012 - 12/31/2012
Providence Seward Medical Center	\$ 742.56	1/01/2012 - 12/31/2012
Sitka Community Hospital	\$ 859.05	7/01/2012 - 6/30/2013
South Peninsula Hospital	\$ 732.49	7/01/2012 - 6/30/2013
Providence Valdez Medical Center	\$ 603.62	1/01/2012 - 12/31/2012
Wrangell Medical Center	\$ 594.68	7/01/2012 - 6/30/2013

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Attachment 2

# **The State Long-Term Health Care Sector**

## **Characteristics, Utilization, and Government Funding: 2011 Update**

Reimbursement and Research Department  
American Health Care Association

September 6, 2011



## **The State Long-Term Health Care Sector Characteristics, Utilization, and Government Funding: 2011 Update**

### ***Overview***

The American Health Care Association is pleased to release *The State Long-Term Health Care Sector: Characteristics, Utilization and Government Funding: 2011 Update*, our 9<sup>th</sup> annual statistical report examining key aspects of the long-term health care sector by state. This statistical report contains general information on the characteristics of government Medicare and Medicaid expenditures, and the characteristics and utilization of nursing facilities and intermediate care facilities for the mentally retarded and developmental disabilities (ICFs/MRDD). This report also includes estimates of the direct and total economic impact of LTC facilities in terms of revenue, employment and labor income.

The report was prepared by the Reimbursement and Research Department of the American Health Care Association. The main report is available on the Trends and Statistics page under the Research and Data section of the AHCA web site ([http://www.ahcanca.org/research\\_data/trends\\_statistics/Pages/default.aspx](http://www.ahcanca.org/research_data/trends_statistics/Pages/default.aspx) ) for viewing and downloading. Detailed descriptions of data sources and methodologies used in calculating the various statistics reported in this report can be found in Appendix A.

We welcome your comments and suggestions as we seek to expand, and improve the content and the usefulness of the report to AHCA/NCAL members and the public. Please email comments and suggestions to [research@ahca.org](mailto:research@ahca.org).

## The State Long Term Health Care Sector Characteristics, Utilization, and Government Funding: 2011 Update

### WYOMING

#### FACILITY CHARACTERISTICS

##### Facility Characteristics (2010)

	# of Facilities	# of Units/Beds	# of Employees <sup>2</sup>
Nursing Facilities	38	2,965	3,043
ICFs/MRDD <sup>1</sup>	1	N/R	N/R
Assisted Living (2007)	35	1,436	N/A

##### Economic Impact of LTC Facilities (2009)

	Direct Impact	Total Impact
Total Revenue (in millions of dollars)	\$284.2	\$428.4
Employment (in thousands of jobs)	4.6	5.9
Wages (in millions of dollars)	\$155.8	\$192.7

#### DEMOGRAPHIC CHARACTERISTICS

##### Population Demographic Characteristics

	2010	2030
Total Population 65+	72,658	138,586
% of Overall Population	14.0%	26.5%
% under FPL <sup>8</sup> (2009)	6.4%	N/A
Total Population 85+	10,123	19,352
% of Overall Population	1.9%	3.7%

##### Facility Demographic Characteristics (2009)

	Total Number of Residents	Average Number of Residents	Average ADL <sup>9</sup> Dependence
Nursing Facilities	2,430	64	3.8
ICFs/MRDD <sup>1</sup>	N/R	N/R	N/A

#### MEDICAID

##### Medicaid Enrollees (2007)

	Number	% of Total
Total Medicaid Enrollees	69,178	100.0%
Aged Enrollees	4,285	6.2%
Blind & Disabled Enrollees	8,726	12.6%
HCBS <sup>3</sup> Waiver Enrollees	4,008	5.8%
Dual Enrollees	11,771	17.0%

##### Estimated Medicaid Federal & State MAP<sup>4</sup> Expenditure (2011) – (million \$)

	Est. Total Expenditure	% of Total MAP Exp.
Total Medicaid	\$536	100.0%
Total LTC <sup>5</sup> Related	\$228	42.6%
Nursing Facility	\$74	13.9%
ICFs/MRDD <sup>1</sup>	\$24	4.4%
HCBS <sup>3</sup>	\$130	24.3%

##### Estimated Medicaid NF<sup>7</sup> Reimbursement (2010)

Federal Matching Percentage (FY 2012) (FMAP) <sup>6</sup>	50.00%
Average Daily Nursing Facility Reimbursement	\$184.03
Average Daily NF <sup>7</sup> Reimbursement Shortfall	-\$23.67
Estimated Total Medicaid NF <sup>7</sup> Shortfall (mn \$)	-\$12.8

#### MEDICARE

##### Medicare Enrollees (2007)

	Number	% of Total
Total Enrollees	73,879	100.0%
Aged Enrollees	63,322	85.7%
Disabled Enrollees	10,557	14.3%
Enrollees below FPL <sup>8</sup>	10,023	13.6%
Dual Enrollees	11,771	15.9%

##### Estimated Medicare Expenditure (2011) – (million \$)

	Est. Total Expenditure	% of Total Expenditure
Total Medicare <sup>10</sup>	\$538	100.0%
Skilled Nursing Facilities	\$30	5.7%

##### Estimated Medicare SNF Reimbursement (2010)

	Total	Update Related <sup>11</sup>
Avg. Per Diem	\$389.19	\$11.88
% of Total Per Diem	100.0%	3.1%
Associated Funds (mn \$)	\$36.0	\$1.1

1. ICFs/MRDD – Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled
2. FTE – Full Time Equivalent
3. HCBS – Home and Community Based Services
4. MAP – Medical Assistance Payments
5. LTC – Long Term Care

6. FMAP – Federal Medical Assistance Percentage
7. NF – Nursing Facilities
8. FPL – Federal Poverty Level
9. ADL – Activities of Daily Living (i.e., dressing, bathing, transferring, toileting and eating)
10. Part D expenditure excluded
11. MBU – Market Basket Update and update related

## The State Long Term Health Care Sector Characteristics, Utilization, and Government Funding: 2011 Update

### UNITED STATES

#### FACILITY CHARACTERISTICS

##### Facility Characteristics (2010)

	# of Facilities	# of Units/Beds	# of Employees <sup>2</sup>
Nursing Facilities	15,682	1,706,087	1,808,570
ICFs/MRDD <sup>1</sup>	6,408	107,559	167,004
Assisted Living (2007)	38,412	972,579	N/A

##### Economic Impact of LTC Facilities (2009)

	Direct Impact	Total Impact
Total Revenue (in billions of dollars)	\$183.5	\$529.0
Employment (in thousands of jobs)	3,122.0	5,445.4
Wages (in billions of dollars)	\$102.5	\$205.2

#### DEMOGRAPHIC CHARACTERISTICS

##### Population Demographic Characteristics

	2010	2030
Total Population 65+	40,243,713	71,453,471
% of Overall Population	13.0%	19.7%
% under FPL <sup>8</sup> (2009)	9.5%	N/A
Total Population 85+	6,123,458	9,603,034
% of Overall Population	2.0%	2.6%

##### Facility Demographic Characteristics (2009)

	Total Number of Residents	Average Number of Residents	Average ADL <sup>9</sup> Dependence
Nursing Facilities	1,396,448	89	4.1
ICFs/MRDD <sup>1</sup>	88,421	14	N/A

### MEDICAID

##### Medicaid Enrollees (2007)

	Number	% of Total
Total Medicaid Enrollees	58,770,540	100.0%
Aged Enrollees	4,146,833	7.1%
Blind & Disabled Enrollees	8,693,801	14.8%
HCBS <sup>3</sup> Waiver Enrollees	1,268,458	2.2%
Dual Enrollees	12,379,310	21.1%

##### Estimated Medicaid Federal & State MAP<sup>4</sup> Expenditure (2011) – (million \$)

	Est. Total Expenditure	% of Total MAP Exp.
Total Medicaid	\$432,553	100.0%
Total LTC <sup>5</sup> Related	\$119,520	27.6%
Nursing Facility	\$50,525	11.7%
ICFs/MRDD <sup>1</sup>	\$12,576	2.9%
HCBS <sup>3</sup>	\$56,418	13.0%

##### Estimated Medicaid NF<sup>7</sup> Reimbursement (2010)

Federal Matching Percentage (FY 2012) (FMAP) <sup>6</sup>	N/A
Average Daily Nursing Facility Reimbursement	\$172.18
Average Daily NF <sup>7</sup> Reimbursement Shortfall	-\$17.33
Estimated Total Medicaid NF <sup>7</sup> Shortfall (mn \$)	-\$5,634.7

### MEDICARE

##### Medicare Enrollees (2007)

	Number	% of Total
Total Enrollees	43,131,635	100.0%
Aged Enrollees	35,953,992	83.4%
Disabled Enrollees	7,177,643	16.6%
Enrollees below FPL <sup>8</sup>	6,835,791	15.8%
Dual Enrollees	12,379,310	28.7%

##### Estimated Medicare Expenditure (2011) – (million \$)

	Est. Total Expenditure	% of Total Expenditure
Total Medicare <sup>10</sup>	\$477,162	100.0%
Skilled Nursing Facilities	\$30,654	6.4%

##### Estimated Medicare SNF Reimbursement (2010)

	Total	Update Related <sup>11</sup>
Avg. Per Diem	\$437.47	\$9.39
% of Total Per Diem	100.0%	2.1%
Associated Funds (mn \$)	\$29,487.7	\$632.7

1. ICFs/MRDD – Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled
2. FTE – Full Time Equivalent
3. HCBS – Home and Community Based Services
4. MAP – Medical Assistance Payments
5. LTC – Long Term Care

6. FMAP – Federal Medical Assistance Percentage
7. NF – Nursing Facilities
8. FPL – Federal Poverty Level
9. ADL – Activities of Daily Living (i.e., dressing, bathing, transferring, toileting and eating)
10. Part D expenditure excluded
11. MBU – Market Basket Update and update related

**UNITED STATES**

	Overall		Rural		Urban		Freestanding		Hospital-Based	
<b>NURSING FACILITIES (2010)</b>										
Overall	15,682	4,888	10,798		14,637	1,045				
# of Facilities	1,396,448	333,756	1,062,692		1,341,137	55,311				
# of Residents	198,328	40,188	158,138	14.9%	189,142	9,184	14.1%			16.8%
# Medicare	888,223	217,919	670,304	63.1%	854,688	33,557	63.7%			60.7%
# Medicaid	309,899	75,849	234,050	22.7%	297,329	12,570	22.2%			22.7%
# Other	1,706,087	426,740	1,279,347		1,635,184	70,903				
# of Beds	92,226	11,527	80,699	2.7%	85,478	8,748	5.2%			9.5%
# Medicare Certified	100,946	31,145	69,801	7.3%	92,185	8,761	5.6%			12.4%
# Medicaid Certified	1,478,408	376,190	1,102,218	86.2%	1,427,402	51,008	87.3%			71.9%
# Dual Certified	34,507	7,878	26,629	1.8%	30,119	4,388	1.8%			6.2%
# Other	1,808,570	424,607	1,383,964		1,722,494	86,220				
# Employees	677,220	164,217	512,986	37.1%	648,540	28,698	37.7%			33.3%
# Aides	108,289	22,387	85,896	5.3%	99,484	8,951	6.2%			10.3%
# RNs	230,042	52,882	177,153	12.5%	219,668	10,387	12.8%			12.0%
# LPNs/LVNs	793,019	185,121	607,880	43.6%	754,803	38,284	43.8%			44.4%
# Other										
Average per Facility	89	68	98		92	53				
# of Residents	4.1	4.0	4.1		4.1	3.9				
# ADL Dependence	109	87	119		112	68				
# of Beds	115	87	128		118	83				
# Employees	43	34	48		44	27				
# Aides	7	5	8		7	8				
# RNs	15	11	16		15	10				
# LPNs/LVNs	51	38	56		52	37				
# Other										
Hours per resident day										
# Direct Care Staff	3.6	3.6	3.6		3.6	4.3				
# Aides	2.4	2.5	2.4		2.4	2.6				
# RNs	0.4	0.3	0.4		0.4	0.8				
# LPNs/LVNs	0.8	0.8	0.8		0.8	0.9				

	Overall		Rural		Urban		Public		Private	
<b>ICFs/MR/DD (2010)</b>										
Overall	6,408	1,261	5,147		847	5,561				
# of Facilities	107,559	26,694	80,865		48,449	59,110				
# of Beds	88,421	21,719	66,702		33,955	54,466				
# of Clients	13,909	3,817	10,092	15.1%	4,212	9,697	12.4%			17.8%
# with Mild MR	16,466	4,255	12,211	18.3%	4,688	11,768	13.8%			21.6%
# with Moderate MR	19,017	4,596	14,421	21.2%	6,146	12,871	18.1%			23.6%
# with Severe MR	39,029	9,051	29,978	41.7%	18,899	20,130	55.7%			37.0%
# with Profound MR										
Total Employees	167,004	39,788	127,219		74,904	92,106				
# Direct Care Staff	117,847	28,522	89,327		48,758	68,184				
# RN	6,870	1,527	5,343		3,291	3,575				
Average per Facility	17	21	16		57	11				
# of Beds	14	17	13		40	10				
# of Clients										

## The State Long Term Health Care Sector Characteristics, Utilization, and Government Funding: 2011 Update

### ALASKA

#### FACILITY CHARACTERISTICS

##### Facility Characteristics (2010)

	# of Facilities	# of Units/Beds	# of Employees <sup>2</sup>
Nursing Facilities	15	682	1,154
ICFs/MRDD <sup>1</sup>	0	N/A	N/A
Assisted Living (2007)	229	1,912	N/A

##### Economic Impact of LTC Facilities (2009)

	Direct Impact	Total Impact
Total Revenue (in millions of dollars)	\$205.1	\$325.4
Employment (in thousands of jobs)	3.2	4.1
Wages (in millions of dollars)	\$114.6	\$149.3

#### DEMOGRAPHIC CHARACTERISTICS

##### Population Demographic Characteristics

	2010	2030
Total Population 65+	56,548	127,202
% of Overall Population	8.1%	14.7%
% under FPL <sup>8</sup> (2009)	3.2%	N/A
Total Population 85+	5,690	18,057
% of Overall Population	0.8%	2.1%

##### Facility Demographic Characteristics (2009)

	Total Number of Residents	Average Number of Residents	Average ADL <sup>9</sup> Dependence
Nursing Facilities	641	43	4.1
ICFs/MRDD <sup>1</sup>	N/A	N/A	N/A

#### MEDICAID

##### Medicaid Enrollees (2007)

	Number	% of Total
Total Medicaid Enrollees	119,340	100.0%
Aged Enrollees	6,733	5.6%
Blind & Disabled Enrollees	14,981	12.6%
HCBS <sup>3</sup> Waiver Enrollees	4,906	4.1%
Dual Enrollees	21,855	18.3%

##### Estimated Medicaid Federal & State MAP<sup>4</sup> Expenditure (2011) – (million \$)

	Est. Total Expenditure	% of Total MAP Exp.
Total Medicaid	\$1,280	100.0%
Total LTC <sup>5</sup> Related	\$436	34.1%
Nursing Facility	\$126	9.8%
ICFs/MRDD <sup>1</sup>	\$3	0.2%
HCBS <sup>3</sup>	\$307	24.0%

##### Estimated Medicaid NF<sup>7</sup> Reimbursement (2010)

Federal Matching Percentage (FY 2012) (FMAP) <sup>6</sup>	50.00%
Average Daily Nursing Facility Reimbursement	N/A
Average Daily NF <sup>7</sup> Reimbursement Shortfall	N/A
Estimated Total Medicaid NF <sup>7</sup> Shortfall (mn \$)	N/A

#### MEDICARE

##### Medicare Enrollees (2007)

	Number	% of Total
Total Enrollees	56,668	100.0%
Aged Enrollees	45,887	81.0%
Disabled Enrollees	10,781	19.0%
Enrollees below FPL <sup>8</sup>	N/A	N/A
Dual Enrollees	21,855	38.6%

##### Estimated Medicare Expenditure (2011) – (million \$)

	Est. Total Expenditure	% of Total Expenditure
Total Medicare <sup>10</sup>	\$511	100.0%
Skilled Nursing Facilities	\$5	1.1%

##### Estimated Medicare SNF Reimbursement (2010)

	Total	Update Related <sup>11</sup>
Avg. Per Diem	\$406.18	\$8.66
% of Total Per Diem	100.0%	2.1%
Associated Funds (mn \$)	\$7.6	\$0.2

1. ICFs/MRDD – Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled
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5. LTC – Long Term Care

6. FMAP – Federal Medical Assistance Percentage
7. NF – Nursing Facilities
8. FPL – Federal Poverty Level
9. ADL – Activities of Daily Living (i.e., dressing, bathing, transferring, toileting and eating)
10. Part D expenditure excluded
11. MBU – Market Basket Update and update related

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ALASKA NURSING FACILITIES (2010)	Overall		Rural		Urban		Freestanding		Hospital-Based	
Overall	15	12	3	3	3	3	3	3	12	12
# of Facilities	641	286	355	355	355	355	355	355	309	309
# of Residents	90	15	75	75	75	75	75	75	17	17
# Medicare	473	14.0%	244	5.2%	229	21.1%	216	22.0%	257	5.5%
# Medicaid	78	73.8%	27	85.3%	51	64.5%	43	65.1%	35	83.2%
# Other	682	12.2%	312	9.4%	370	14.4%	337	13.0%	345	11.3%
# of Beds	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
# Medicare Certified	121	17.7%	0	0.0%	121	32.7%	121	35.9%	0	0.0%
# Medicaid Certified	561	82.3%	312	100.0%	249	67.3%	216	64.1%	345	100.0%
# Other	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
# Employees	1,154		578		578		564		590	
# Aides	474	41.1%	246	42.6%	229	39.7%	220	39.0%	255	43.1%
# RNs	167	14.5%	96	16.5%	72	12.5%	69	12.5%	99	16.7%
# LPNs/LVNs	84	7.3%	28	4.9%	56	9.7%	49	8.6%	35	6.0%
# Other	429	37.1%	208	36.0%	221	38.2%	227	40.2%	201	34.1%
Average per Facility										
# of Residents	43	24	118	118	118	118	111	111	26	26
# ADL Dependence	4.1	4.1	4.3	4.3	4.3	4.3	4.3	4.3	4.1	4.1
# of Beds	45	26	112	112	112	112	188	188	29	29
# Employees	77	48	183	183	183	183	188	188	49	49
# Aides	32	21	76	76	76	76	73	73	21	21
# RNs	11	8	24	24	24	24	23	23	8	8
# LPNs/LVNs	6	2	19	19	19	19	16	16	3	3
# Other	29	17	74	74	74	74	76	76	17	17
Hours per resident day										
# Direct Care Staff	5.7	6.5	5.0	5.0	5.0	5.0	5.1	5.1	6.3	6.3
# Aides	3.7	4.3	3.2	3.2	3.2	3.2	3.3	3.3	4.1	4.1
# RNs	1.3	1.7	1.0	1.0	1.0	1.0	1.0	1.0	1.6	1.6
# LPNs/LVNs	0.7	0.5	0.8	0.8	0.8	0.8	0.7	0.7	0.8	0.8
ICFs/MR/DD (2010)										
Overall	0	0	0	0	0	0	0	0	0	0
# of Facilities	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
# of Beds	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
# of Clients	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
# with Mild MR	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
# with Moderate MR	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
# with Severe MR	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
# with Profound MR	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Employees	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
# Direct Care Staff	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
# RN	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Average per Facility										
# of Beds	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
# of Clients	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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## The State Long Term Health Care Sector Characteristics, Utilization, and Government Funding: 2011 Update

### IDAHO

#### FACILITY CHARACTERISTICS

##### Facility Characteristics (2010)

	# of Facilities	# of Units/Beds	# of Employees <sup>2</sup>
Nursing Facilities	78	6,123	6,602
ICFs/MRDD <sup>1</sup>	67	537	1,205
Assisted Living (2007)	278	6,819	N/A

##### Economic Impact of LTC Facilities (2009)

	Direct Impact	Total Impact
Total Revenue (in millions of dollars)	\$675.5	\$1,106.8
Employment (in thousands of jobs)	13.1	17.5
Wages (in millions of dollars)	\$352.8	\$479.6

#### DEMOGRAPHIC CHARACTERISTICS

##### Population Demographic Characteristics

	2010	2030
Total Population 65+	181,416	361,033
% of Overall Population	12.0%	18.3%
% under FPL <sup>6</sup> (2009)	8.3%	N/A
Total Population 85+	26,239	47,021
% of Overall Population	1.7%	2.4%

##### Facility Demographic Characteristics (2009)

	Total Number of Residents	Average Number of Residents	Average ADL <sup>9</sup> Dependence
Nursing Facilities	4,391	56	4.2
ICFs/MRDD <sup>1</sup>	489	7	N/A

#### MEDICAID

##### Medicaid Enrollees (2007)

	Number	% of Total
Total Medicaid Enrollees	233,056	100.0%
Aged Enrollees	13,300	5.7%
Blind & Disabled Enrollees	34,708	14.9%
HCBS <sup>3</sup> Waiver Enrollees	10,362	4.4%
Dual Enrollees	46,033	19.8%

##### Estimated Medicaid Federal & State MAP<sup>4</sup> Expenditure (2011) – (million \$)

	Est. Total Expenditure	% of Total MAP Exp.
Total Medicaid	\$1,701	100.0%
Total LTC <sup>5</sup> Related	\$517	30.4%
Nursing Facility	\$172	10.1%
ICFs/MRDD <sup>1</sup>	\$110	6.5%
HCBS <sup>3</sup>	\$235	13.8%

##### Estimated Medicaid NF<sup>7</sup> Reimbursement (2010)

Federal Matching Percentage (FY 2012) (FMAP) <sup>8</sup>	70.23%
Average Daily Nursing Facility Reimbursement	N/A
Average Daily NF <sup>7</sup> Reimbursement Shortfall	N/A
Estimated Total Medicaid NF <sup>7</sup> Shortfall (mn \$)	N/A

#### MEDICARE

##### Medicare Enrollees (2007)

	Number	% of Total
Total Enrollees	204,939	100.0%
Aged Enrollees	171,924	83.9%
Disabled Enrollees	33,015	16.1%
Enrollees below FPL <sup>6</sup>	N/A	N/A
Dual Enrollees	46,033	22.5%

##### Estimated Medicare Expenditure (2011) – (million \$)

	Est. Total Expenditure	% of Total Expenditure
Total Medicare <sup>10</sup>	\$1,507	100.0%
Skilled Nursing Facilities	\$106	7.0%

##### Estimated Medicare SNF Reimbursement (2010)

	Total	Update Related <sup>11</sup>
Avg. Per Diem	\$408.17	\$11.10
% of Total Per Diem	100.0%	2.7%
Associated Funds (mn \$)	\$99.6	\$2.7

1. ICFs/MRDD – Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled
2. FTE – Full Time Equivalent
3. HCBS – Home and Community Based Services
4. MAP – Medical Assistance Payments
5. LTC – Long Term Care

6. FMAP – Federal Medical Assistance Percentage
7. NF – Nursing Facilities
8. FPL – Federal Poverty Level
9. ADL – Activities of Daily Living (i.e., dressing, bathing, transferring, toileting and eating)
10. Part D expenditure excluded
11. MBU – Market Basket Update and update related

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IDAHONURSING FACILITIES (2010)	Overall		Rural		Urban		Freestanding		Hospital-Based	
Overall	78	34	44	62	18					
# of Facilities	4,391	1,808	2,783	3,912	479					
# of Residents	685	208	477	616	69					14.4%
# Medicare	2,692	1,075	1,617	2,357	335		15.7%			69.9%
# Other	1,014	325	689	939	75		24.0%			15.7%
# of Beds	6,123	2,227	3,896	5,514	609					
# Medicare Certified	146	0	146	84	62		1.5%			10.2%
# Medicaid Certified	5	0	0	5	0		0.1%			0.0%
# Dual Certified	5,972	2,222	3,750	5,425	547		98.4%			89.8%
# Other	0	0	0	0	0		0.0%			0.0%
# Employees	6,602	2,586	4,017	5,643	959					
# Aides	2,562	1,117	1,445	2,227	335		39.5%			34.9%
# RNs	458	181	278	385	74		6.9%			7.7%
# LPNs/L VNs	703	228	475	604	99		11.8%			10.3%
# Other	2,878	1,060	1,818	2,427	452		43.0%			47.1%
Average per Facility										
# of Residents	56	47	63	63	30					
# ADL Dependence	4.2	4.1	4.3	4.2	4.2					
# of Beds	79	66	89	89	38					
# Employees	85	76	91	91	60					
# Aides	33	33	33	36	21					
# RNs	6	5	6	6	5					
# LPNs/L VNs	9	7	11	10	6					
# Other	37	31	41	39	28					
Hours per resident day										
# Direct Care Staff	4.2	4.7	3.9	4.1	5.3					
# Aides	2.9	3.5	2.6	2.8	3.5					
# RNs	0.5	0.6	0.5	0.5	0.8					
# LPNs/L VNs	0.8	0.7	0.9	0.8	1.0					
ICFs/MR/DD (2010)										
Overall	67	12	55	1	66					
# of Facilities	537	98	439	N/R	473					
# of Beds	489	95	394	N/R	427					
# of Clients	87	12	75	N/R	68					15.9%
# with Mild MR	111	30	81	N/R	100					23.4%
# with Moderate MR	133	29	104	N/R	117					27.4%
# with Severe MR	158	24	134	N/R	142					33.3%
Total Employees	1,205	189	1,016	N/R	970					
# Direct Care Staff	1,106	182	924	N/R	929					
# RN	17	3	13	N/R	15					
Average per Facility										
# of Beds	8	8	8	N/R	7					
# of Clients	7	8	7	N/R	6					

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## The State Long Term Health Care Sector Characteristics, Utilization, and Government Funding: 2011 Update

### NORTH DAKOTA

#### FACILITY CHARACTERISTICS

##### Facility Characteristics (2010)

	# of Facilities	# of Units/Beds	# of Employees <sup>2</sup>
Nursing Facilities	85	6,438	8,711
ICFs/MRDD <sup>1</sup>	86	635	1,095
Assisted Living (2007)	111	3,472	N/A

##### Economic Impact of LTC Facilities (2009)

	Direct Impact	Total Impact
Total Revenue (in millions of dollars)	\$768.1	\$1,181.6
Employment (in thousands of jobs)	14.6	18.4
Wages (in millions of dollars)	\$408.2	\$528.1

#### DEMOGRAPHIC CHARACTERISTICS

##### Population Demographic Characteristics

	2010	2030
Total Population 65+	97,108	152,368
% of Overall Population	15.3%	25.1%
% under FPL <sup>3</sup> (2009)	11.5%	N/A
Total Population 85+	18,232	23,302
% of Overall Population	2.9%	3.8%

##### Facility Demographic Characteristics (2009)

	Total Number of Residents	Average Number of Residents	Average ADL <sup>4</sup> Dependence
Nursing Facilities	5,643	66	3.8
ICFs/MRDD <sup>1</sup>	573	8	N/A

#### MEDICAID

##### Medicaid Enrollees (2007)

	Number	% of Total
Total Medicaid Enrollees	74,017	100.0%
Aged Enrollees	7,523	10.2%
Blind & Disabled Enrollees	9,971	13.5%
HCBS <sup>3</sup> Waiver Enrollees	5,688	7.7%
Dual Enrollees	19,707	26.6%

##### Estimated Medicaid Federal & State MAP<sup>4</sup> Expenditure (2011) – (million \$)

	Est. Total Expenditure	% of Total MAP Exp.
Total Medicaid	\$759	100.0%
Total LTC <sup>5</sup> Related	\$459	60.6%
Nursing Facility	\$215	28.3%
ICFs/MRDD <sup>1</sup>	\$93	12.2%
HCBS <sup>3</sup>	\$152	20.0%

##### Estimated Medicaid NF<sup>7</sup> Reimbursement (2010)

Federal Matching Percentage (FY 2012) (FMAP) <sup>6</sup>	55.40%
Average Daily Nursing Facility Reimbursement	\$194.36
Average Daily NF <sup>7</sup> Reimbursement Shortfall	\$2.36
Estimated Total Medicaid NF <sup>7</sup> Shortfall (mn \$)	\$2.6

#### MEDICARE

##### Medicare Enrollees (2007)

	Number	% of Total
Total Enrollees	104,905	100.0%
Aged Enrollees	92,089	87.8%
Disabled Enrollees	12,816	12.2%
Enrollees below FPL <sup>3</sup>	10,555	10.1%
Dual Enrollees	19,707	18.8%

##### Estimated Medicare Expenditure (2011) – (million \$)

	Est. Total Expenditure	% of Total Expenditure
Total Medicare <sup>10</sup>	\$1,087	100.0%
Skilled Nursing Facilities	\$27	2.5%

##### Estimated Medicare SNF Reimbursement (2010)

	Total	Update Related <sup>11</sup>
Avg. Per Diem	\$323.97	\$17.68
% of Total Per Diem	100.0%	5.5%
Associated Funds (mn \$)	\$48.0	\$2.6

1. ICFs/MRDD – Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled
2. FTE – Full Time Equivalent
3. HCBS – Home and Community Based Services
4. MAP – Medical Assistance Payments
5. LTC – Long Term Care

6. FMAP – Federal Medical Assistance Percentage
7. NF – Nursing Facilities
8. FPL – Federal Poverty Level
9. ADL – Activities of Daily Living (i.e., dressing, bathing, transferring, toileting and eating)
10. Part D expenditure excluded
11. MBU – Market Basket Update and update related

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**NORTH DAKOTA**

NURSING FACILITIES (2010)	Overall		Rural		Urban		Freestanding		Hospital-Based	
Overall	85		61		24		71		14	
# of Facilities	5,643		3,752		1,891		4,852		791	
# of Residents	440	7.8%	228	6.1%	212	11.2%	385	7.9%	55	7.0%
# Medicare	3,003	53.2%	2,030	54.1%	973	51.5%	2,579	53.2%	424	53.6%
# Medicaid	2,200	39.0%	1,494	39.8%	706	37.3%	1,688	38.9%	312	39.4%
# Other	6,438		4,204		2,234		5,532		906	
# of Beds	41	0.6%	0	0.0%	41	1.6%	0	0.0%	41	4.5%
# Medicare Certified	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
# Medicaid Certified	6,397	99.4%	4,204	100.0%	2,193	98.2%	5,532	100.0%	865	95.5%
# Dual Certified	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
# Other	8,711		5,633		3,085		7,481		1,230	
# Employees	3,441	39.5%	2,109	37.4%	1,347	43.7%	2,969	39.7%	472	38.4%
# Aides	490	5.6%	283	5.0%	211	6.9%	387	6.9%	101	8.2%
# RNs	702	8.1%	444	7.9%	260	8.4%	606	8.1%	98	7.8%
# LPNs/LVNs	4,078	46.8%	2,796	49.6%	1,266	41.1%	3,518	47.0%	551	45.6%
# Other										
Average per Facility	66		62		79		68		57	
# of Residents	3.8		3.7		3.9		3.8		3.6	
# ADL Dependence	76		69		93		78		65	
# of Beds	102		92		129		105		88	
# Employees	40		35		56		42		34	
# Aides	8		5		9		5		7	
# RNs	8		7		11		9		7	
# LPNs/LVNs	48		46		53		50		40	
# Other										
Hours per resident day	4.0		3.8		4.3		3.9		4.2	
# Direct Care Staff	2.9		2.8		3.2		2.9		3.0	
# Aides	0.4		0.4		0.5		0.4		0.6	
# RNs	0.6		0.6		0.6		0.6		0.6	
# LPNs/LVNs										

ICFs/MR/DD (2010)	Overall		Rural		Urban		Public		Private	
Overall	66		42		24		3		63	
# of Facilities	635		471		164		175		460	
# of Beds	573		411		162		121		452	
# of Clients	111	19.4%	80	19.5%	31	19.1%	39	32.2%	72	15.9%
# with Mild MR	116	20.2%	80	19.5%	36	22.2%	17	14.0%	99	21.9%
# with Moderate MR	158	27.6%	109	26.5%	49	30.2%	22	18.2%	136	30.1%
# with Severe MR	188	32.8%	142	34.5%	46	28.4%	43	35.5%	145	32.1%
# with Profound MR										
Total Employees	1,095		803		291		271		824	
# Direct Care Staff	900		652		248		231		670	
# RN	53		48		4		14		39	
Average per Facility	10		11		7		58		7	
# of Beds	9		10		7		40		7	
# of Clients										

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## The State Long Term Health Care Sector Characteristics, Utilization, and Government Funding: 2011 Update

### OREGON

#### FACILITY CHARACTERISTICS

##### Facility Characteristics (2010)

	# of Facilities	# of Units/Beds	# of Employees <sup>2</sup>
Nursing Facilities	137	12,218	10,915
ICFs/MRDD <sup>1</sup>	1	N/R	N/R
Assisted Living (2007)	429	22,130	N/A

##### Economic Impact of LTC Facilities (2009)

	Direct Impact	Total Impact
Total Revenue (in billions of dollars)	\$2.5	\$4.6
Employment (in thousands of jobs)	44.0	62.1
Wages (in billions of dollars)	\$1.2	\$1.8

#### DEMOGRAPHIC CHARACTERISTICS

##### Population Demographic Characteristics

	2010	2030
Total Population 65+	494,328	881,857
% of Overall Population	13.0%	18.2%
% under FPL <sup>6</sup> (2009)	8.4%	N/A
Total Population 85+	80,959	121,741
% of Overall Population	2.1%	2.5%

##### Facility Demographic Characteristics (2009)

	Total Number of Residents	Average Number of Residents	Average ADL <sup>9</sup> Dependence
Nursing Facilities	7,559	55	4.2
ICFs/MRDD <sup>1</sup>	N/R	N/R	N/A

#### MEDICAID

##### Medicaid Enrollees (2007)

	Number	% of Total
Total Medicaid Enrollees	487,361	100.0%
Aged Enrollees	41,237	8.5%
Blind & Disabled Enrollees	78,371	16.1%
HCBS <sup>3</sup> Waiver Enrollees	34,332	7.0%
Dual Enrollees	84,962	17.4%

##### Estimated Medicaid Federal & State MAP<sup>4</sup> Expenditure (2011) - (million \$)

	Est. Total Expenditure	% of Total MAP Exp.
Total Medicaid	\$4,731	100.0%
Total LTC <sup>5</sup> Related	\$1,416	29.9%
Nursing Facility	\$346	7.3%
ICFs/MRDD <sup>1</sup>	-	-
HCBS <sup>3</sup>	\$1,070	22.6%

##### Estimated Medicaid NF<sup>7</sup> Reimbursement (2010)

Federal Matching Percentage (FY 2012) (FMAP) <sup>8</sup>	62.91%
Average Daily Nursing Facility Reimbursement	\$217.14
Average Daily NF <sup>7</sup> Reimbursement Shortfall	-\$3.76
Estimated Total Medicaid NF <sup>7</sup> Shortfall (mn \$)	-\$6.5

#### MEDICARE

##### Medicare Enrollees (2007)

	Number	% of Total
Total Enrollees	564,349	100.0%
Aged Enrollees	480,564	85.2%
Disabled Enrollees	83,785	14.8%
Enrollees below FPL <sup>6</sup>	66,311	11.7%
Dual Enrollees	84,962	15.1%

##### Estimated Medicare Expenditure (2011) - (million \$)

	Est. Total Expenditure	% of Total Expenditure
Total Medicare <sup>10</sup>	\$5,023	100.0%
Skilled Nursing Facilities	\$270	5.4%

##### Estimated Medicare SNF Reimbursement (2010)

	Total	Update Related <sup>11</sup>
Avg. Per Diem	\$470.63	\$10.76
% of Total Per Diem	100.0%	2.3%
Associated Funds (mn \$)	\$164.4	\$3.8

1. ICFs/MRDD - Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled
2. FTE - Full Time Equivalent
3. HCBS - Home and Community Based Services
4. MAP - Medical Assistance Payments
5. LTC - Long Term Care

6. FMAP - Federal Medical Assistance Percentage
7. NF - Nursing Facilities
8. FPL - Federal Poverty Level
9. ADL - Activities of Daily Living (i.e., dressing, bathing, transferring, toileting and eating)
10. Part D expenditure excluded
11. MBU - Market Basket Update and update related

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**OREGON**

**NURSING FACILITIES (2010)**

	Overall	Rural	Urban	Freestanding	Hospital-Based
Overall	137	40	97	133	4
# of Facilities	7,559	2,005	5,554	7,488	91
# of Residents	1,062	348	714	1,061	1
# Medicare	4,600	1,194	3,406	4,539	61
# Medicaid	1,897	463	1,434	1,868	29
# Other	12,218	3,556	8,662	11,997	221
# of Beds	248	36	212	248	0
# Medicare Certified	1,590	306	1,284	1,418	172
# Medicaid Certified	10,370	3,205	7,165	10,321	49
# Dual Certified	10	9	1	10	0
# Other	10,915	2,938	7,980	10,721	194
# Employees	4,630	1,236	3,395	4,574	57
# Aides	649	171	478	639	10
# RNs	883	238	644	872	11
# LPNs/LVNs	4,752	1,282	3,482	4,636	116
# Other					
Average per Facility					
# of Residents	55	50	57	56	23
# ADL Dependence	4.2	4.3	4.2	4.2	4.2
# of Beds	89	89	89	90	55
# Employees	80	73	82	81	48
# Aides	34	31	35	34	14
# RNs	5	4	5	5	3
# LPNs/LVNs	6	6	7	7	3
# Other	35	32	36	35	29
Hours per resident day					
# Direct Care Staff	4.1	4.1	4.1	4.1	4.3
# Aides	3.1	3.1	3.1	3.1	3.1
# RNs	0.4	0.4	0.4	0.4	0.6
# LPNs/LVNs	0.6	0.6	0.6	0.6	0.6

**ICFs/MRDD (2010)**

	Overall	Rural	Urban	Public	Private
Overall	1	1	0	1	0
# of Facilities	N/R	N/R	N/A	N/R	N/A
# of Beds	N/R	N/R	N/A	N/R	N/A
# of Clients	N/R	N/R	N/A	N/R	N/A
# with Mild MR	N/R	N/R	N/A	N/R	N/A
# with Moderate MR	N/R	N/R	N/A	N/R	N/A
# with Severe MR	N/R	N/R	N/A	N/R	N/A
# with Profound MR	N/R	N/R	N/A	N/R	N/A
Total Employees	N/R	N/R	N/A	N/R	N/A
# Direct Care Staff	N/R	N/R	N/A	N/R	N/A
# RN	N/R	N/R	N/A	N/R	N/A
Average per Facility					
# of Beds	N/R	N/R	N/A	N/R	N/A
# of Clients	N/R	N/R	N/A	N/R	N/A

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## The State Long Term Health Care Sector Characteristics, Utilization, and Government Funding: 2011 Update

### WASHINGTON

#### FACILITY CHARACTERISTICS

##### Facility Characteristics (2010)

	# of Facilities	# of Units/Beds	# of Employees <sup>2</sup>
Nursing Facilities	229	21,837	25,331
ICFs/MRDD <sup>1</sup>	14	855	1,541
Assisted Living (2007)	551	28,829	N/A

##### Economic Impact of LTC Facilities (2009)

	Direct Impact	Total Impact
Total Revenue (in billions of dollars)	\$3.8	\$6.5
Employment (in thousands of jobs)	61.1	82.8
Wages (in billions of dollars)	\$2.0	\$2.8

#### DEMOGRAPHIC CHARACTERISTICS

##### Population Demographic Characteristics

	2010	2030
Total Population 65+	795,528	1,563,901
% of Overall Population	12.2%	18.1%
% under FPL <sup>b</sup> (2009)	7.7%	N/A
Total Population 85+	126,063	215,899
% of Overall Population	1.9%	2.5%

##### Facility Demographic Characteristics (2009)

	Total Number of Residents	Average Number of Residents	Average ADL <sup>a</sup> Dependence
Nursing Facilities	18,082	79	4.2
ICFs/MRDD <sup>1</sup>	752	54	N/A

#### MEDICAID

##### Medicaid Enrollees (2007)

	Number	% of Total
Total Medicaid Enrollees	1,187,798	100.0%
Aged Enrollees	75,761	6.4%
Blind & Disabled Enrollees	168,569	14.2%
HCBS <sup>3</sup> Waiver Enrollees	45,832	3.9%
Dual Enrollees	245,100	20.6%

##### Estimated Medicaid Federal & State MAP<sup>4</sup> Expenditure (2011) – (million \$)

	Est. Total Expenditure	% of Total MAP Exp.
Total Medicaid	\$7,887	100.0%
Total LTC <sup>5</sup> Related	\$2,440	30.9%
Nursing Facility	\$674	8.5%
ICFs/MRDD <sup>1</sup>	\$159	2.0%
HCBS <sup>3</sup>	\$1,607	20.4%

##### Estimated Medicaid NF<sup>7</sup> Reimbursement (2010)

Federal Matching Percentage (FY 2012) (FMAP) <sup>6</sup>	50.00%
Average Daily Nursing Facility Reimbursement	\$181.03
Average Daily NF <sup>7</sup> Reimbursement Shortfall	-\$28.18
Estimated Total Medicaid NF <sup>7</sup> Shortfall (mn \$)	-\$111.8

#### MEDICARE

##### Medicare Enrollees (2007)

	Number	% of Total
Total Enrollees	869,583	100.0%
Aged Enrollees	730,329	84.0%
Disabled Enrollees	139,254	16.0%
Enrollees below FPL <sup>8</sup>	107,671	12.4%
Dual Enrollees	245,100	28.2%

##### Estimated Medicare Expenditure (2011) – (million \$)

	Est. Total Expenditure	% of Total Expenditure
Total Medicare <sup>10</sup>	\$7,822	100.0%
Skilled Nursing Facilities	\$543	6.9%

##### Estimated Medicare SNF Reimbursement (2010)

	Total	Update Related <sup>11</sup>
Avg. Per Diem	\$475.99	\$8.74
% of Total Per Diem	100.0%	1.8%
Associated Funds (mn \$)	\$503.7	\$9.3

1. ICFs/MRDD – Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled
2. FTE – Full Time Equivalent
3. HCBS – Home and Community Based Services
4. MAP – Medical Assistance Payments
5. LTC – Long Term Care

6. FMAP – Federal Medical Assistance Percentage
7. NF – Nursing Facilities
8. FPL – Federal Poverty Level
9. ADL – Activities of Daily Living (i.e., dressing, bathing, transferring, toileting and eating)
10. Part D expenditure excluded
11. MBU – Market Basket Update and update related

**WASHINGTON**

NURSING FACILITIES (2010)	Overall		Rural		Urban		Freestanding		Hospital-Based	
Overall	229	44	185	219	185	219	185	219	185	219
# of Facilities	18,062	2,498	15,564	17,775	15,564	17,775	15,564	17,775	15,564	17,775
# of Residents	3,056	425	2,631	3,019	2,631	3,019	2,631	3,019	2,631	3,019
# Medicare	10,901	1,616	9,285	10,698	9,285	10,698	9,285	10,698	9,285	10,698
# Medicaid	4,105	457	3,648	4,058	3,648	4,058	3,648	4,058	3,648	4,058
# Other	21,837	3,208	18,629	21,397	18,629	21,397	18,629	21,397	18,629	21,397
# of Beds	580	32	528	560	528	560	528	560	528	560
# Medicare Certified	1,592	138	1,454	1,522	1,454	1,522	1,454	1,522	1,454	1,522
# Medicaid Certified	19,601	3,019	16,582	19,231	16,582	19,231	16,582	19,231	16,582	19,231
# Dual Certified	84	19	65	84	65	84	65	84	65	84
# Other	25,331	3,245	22,089	24,812	22,089	24,812	22,089	24,812	22,089	24,812
# Employees	9,441	1,225	8,217	9,265	8,217	9,265	8,217	9,265	8,217	9,265
# Aides	1,934	302	1,632	1,878	1,632	1,878	1,632	1,878	1,632	1,878
# RNs	2,665	277	2,389	2,639	2,389	2,639	2,389	2,639	2,389	2,639
# LPNs/LVNs	11,292	1,442	9,651	11,030	9,651	11,030	9,651	11,030	9,651	11,030
# Other	79	57	84	81	84	81	84	81	84	81
Average per Facility	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2	4.2
# of Residents	95	73	101	98	101	98	101	98	101	98
# ADL Dependence	111	74	119	113	119	113	119	113	119	113
# of Beds	41	28	44	42	44	42	44	42	44	42
# Employees	8	7	9	9	9	9	9	9	9	9
# Aides	12	6	13	12	13	12	13	12	13	12
# RNs	49	33	53	50	53	50	53	50	53	50
# LPNs/LVNs	3.9	3.6	3.9	3.9	3.9	3.9	3.9	3.9	3.9	3.9
# Other	2.6	2.5	2.6	2.6	2.6	2.6	2.6	2.6	2.6	2.6
Hours per resident day	0.5	0.6	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
# Direct Care Staff	0.7	0.6	0.8	0.7	0.8	0.7	0.8	0.7	0.8	0.7
# Aides										
# RNs										
# LPNs/LVNs										
# Other										
Total Employees	1,541	1,541	1,541	1,437	1,541	1,437	1,541	1,437	1,541	1,437
# Direct Care Staff	1,120	1,120	1,120	1,039	1,120	1,039	1,120	1,039	1,120	1,039
# RN	78	78	78	76	78	76	78	76	78	76
Average per Facility	61	61	61	61	61	61	61	61	61	61
# of Beds	54	54	54	54	54	54	54	54	54	54
# of Clients										
# with Mild MR										
# with Moderate MR										
# with Severe MR										
# with Profound MR										
Total Employees	1,541	1,541	1,541	1,437	1,541	1,437	1,541	1,437	1,541	1,437
# Direct Care Staff	1,120	1,120	1,120	1,039	1,120	1,039	1,120	1,039	1,120	1,039
# RN	78	78	78	76	78	76	78	76	78	76
Average per Facility	61	61	61	61	61	61	61	61	61	61
# of Beds	54	54	54	54	54	54	54	54	54	54
# of Clients										
# with Mild MR										
# with Moderate MR										
# with Severe MR										
# with Profound MR										

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## The State Long Term Health Care Sector Characteristics, Utilization, and Government Funding: 2011 Update

### WYOMING

#### FACILITY CHARACTERISTICS

##### Facility Characteristics (2010)

	# of Facilities	# of Units/Beds	# of Employees <sup>2</sup>
Nursing Facilities	38	2,965	3,043
ICFs/MRDD <sup>1</sup>	1	N/R	N/R
Assisted Living (2007)	35	1,436	N/A

##### Economic impact of LTC Facilities (2009)

	Direct Impact	Total Impact
Total Revenue (in millions of dollars)	\$284.2	\$428.4
Employment (in thousands of jobs)	4.6	5.9
Wages (in millions of dollars)	\$155.8	\$192.7

#### DEMOGRAPHIC CHARACTERISTICS

##### Population Demographic Characteristics

	2010	2030
Total Population 65+	72,658	138,586
% of Overall Population	14.0%	26.5%
% under FPL <sup>6</sup> (2009)	6.4%	N/A
Total Population 85+	10,123	19,352
% of Overall Population	1.9%	3.7%

##### Facility Demographic Characteristics (2009)

	Total Number of Residents	Average Number of Residents	Average ADL <sup>10</sup> Dependence
Nursing Facilities	2,430	64	3.8
ICFs/MRDD <sup>1</sup>	N/R	N/R	N/A

#### MEDICAID

##### Medicaid Enrollees (2007)

	Number	% of Total
Total Medicaid Enrollees	69,178	100.0%
Aged Enrollees	4,285	6.2%
Blind & Disabled Enrollees	8,726	12.6%
HCBS <sup>3</sup> Waiver Enrollees	4,008	5.8%
Dual Enrollees	11,771	17.0%

##### Estimated Medicaid Federal & State MAP<sup>4</sup> Expenditure (2011) – (million \$)

	Est. Total Expenditure	% of Total MAP Exp.
Total Medicaid	\$536	100.0%
Total LTC <sup>5</sup> Related	\$228	42.6%
Nursing Facility	\$74	13.9%
ICFs/MRDD <sup>1</sup>	\$24	4.4%
HCBS <sup>3</sup>	\$130	24.3%

##### Estimated Medicaid NF<sup>7</sup> Reimbursement (2010)

Federal Matching Percentage (FY 2012) (FMAP) <sup>6</sup>	50.00%
Average Daily Nursing Facility Reimbursement	\$164.03
Average Daily NF <sup>7</sup> Reimbursement Shortfall	-\$23.87
Estimated Total Medicaid NF <sup>7</sup> Shortfall (mn \$)	-\$12.6

#### MEDICARE

##### Medicare Enrollees (2007)

	Number	% of Total
Total Enrollees	73,879	100.0%
Aged Enrollees	63,322	85.7%
Disabled Enrollees	10,557	14.3%
Enrollees below FPL <sup>6</sup>	10,023	13.6%
Dual Enrollees	11,771	15.9%

##### Estimated Medicare Expenditure (2011) – (million \$)

	Est. Total Expenditure	% of Total Expenditure
Total Medicare <sup>10</sup>	\$538	100.0%
Skilled Nursing Facilities	\$30	5.7%

##### Estimated Medicare SNF Reimbursement (2010)

	Total	Update Related <sup>11</sup>
Avg. Per Diem	\$389.19	\$11.88
% of Total Per Diem	100.0%	3.1%
Associated Funds (mn \$)	\$36.0	\$1.1

1. ICFs/MRDD – Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled
2. FTE – Full Time Equivalent
3. HCBS – Home and Community Based Services
4. MAP – Medical Assistance Payments
5. LTC – Long Term Care

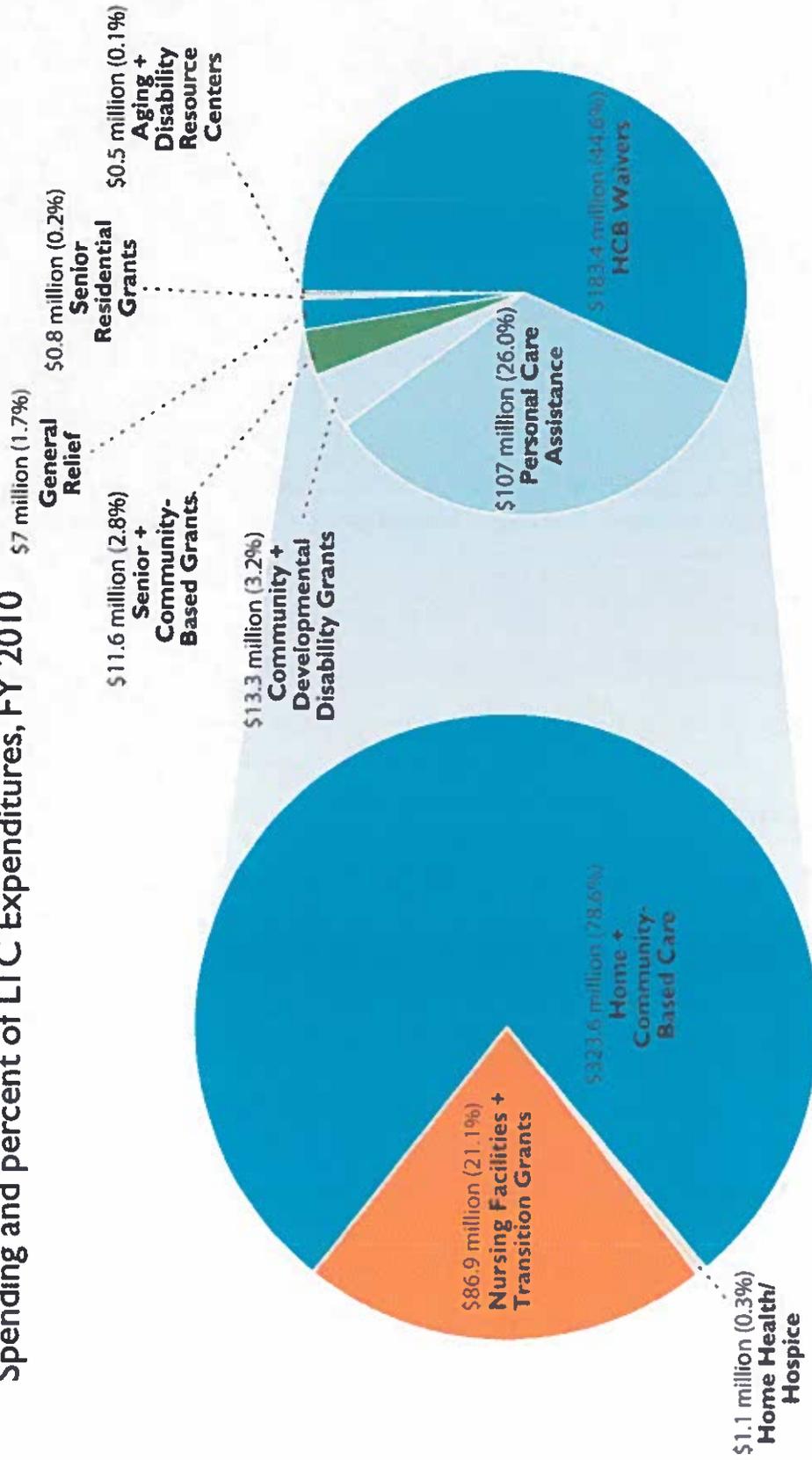
6. FMAP – Federal Medical Assistance Percentage
7. NF – Nursing Facilities
8. FPL – Federal Poverty Level
9. ADL – Activities of Daily Living (i.e., dressing, bathing, transferring, toileting and eating)
10. Part D expenditure excluded
11. MBU – Market Basket Update and update related



300

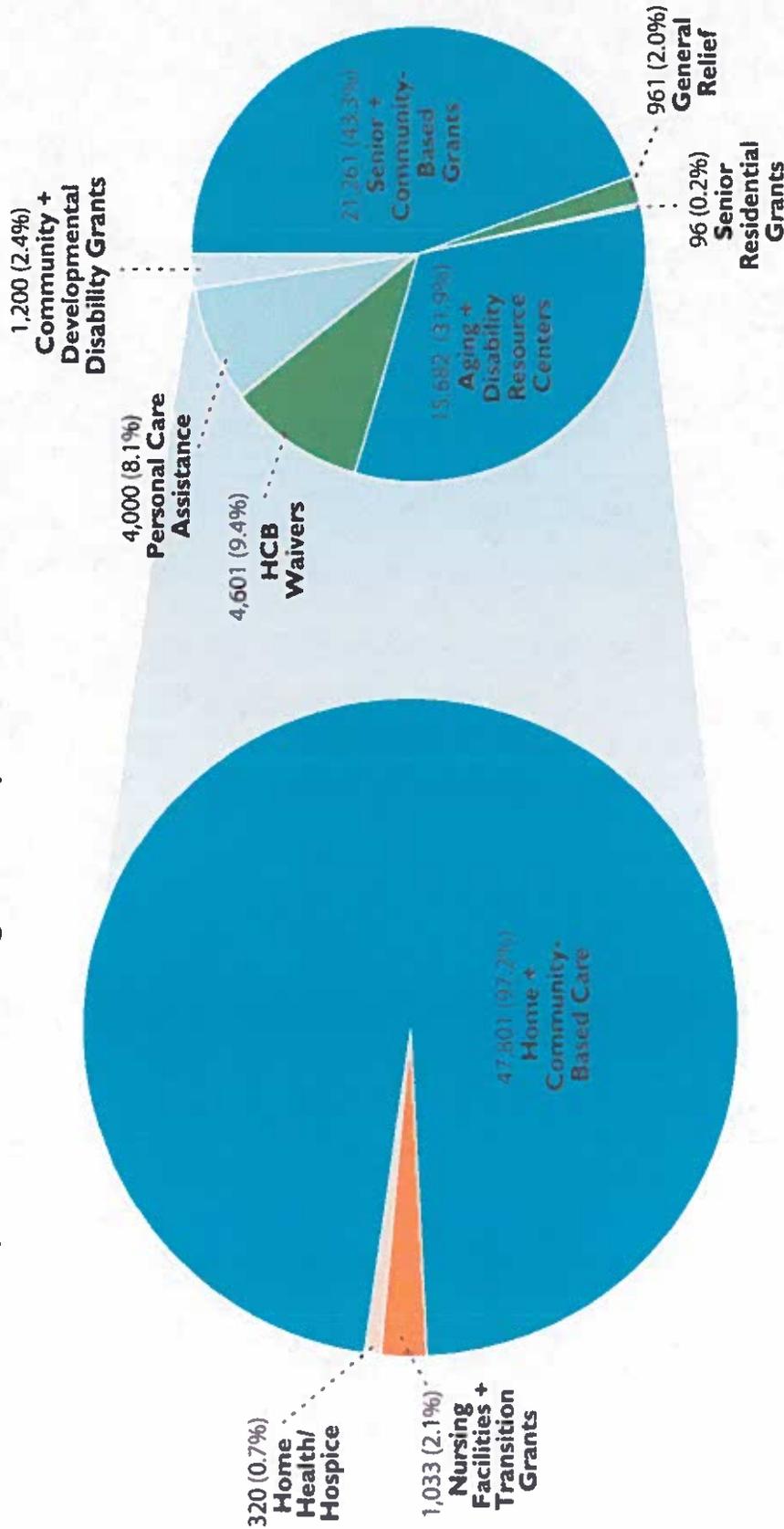
# State-Managed LTC Expenditures

Spending and percent of LTC Expenditures, FY 2010



# State-Managed LTC Program Recipients

Number and percent of LTC Program Recipients FY 2010.



\*Duplication exists between programs

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## Nursing Facilities

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- 15 nursing facilities with 708 nursing home beds.
- While senior population has tripled over last 20 years, number of nursing facility beds has actually gone down. Evidence of movement away from institution-based care.
- Alaska's nursing home occupancy rate is about 92% (650 beds) in 2011.
- In the last 5 years, roughly 100 nursing facility beds have been or will be eliminated.
- What role will nursing facilities play in the future of long term care?

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Source: State of Alaska. Department of Health and Social Services. Fiscal Year 2012 Budget Overview. and United States Department of Health and Human Services. *Health, United States, 2010*. Table 117. Nursing homes, beds, residents, and occupancy rates, by state: United States, selected years 1995–2009.

# Cost of Maintaining the Status Quo

Medicaid expenditures for Long Term Care Estimated to be 5 times Higher by 2030

Item	2010	2015	2020	2025	2030	Annual % Change (published)
HCB Waiver						
CCMC [1]	\$10,425,063	\$14,925,364	\$20,389,055	\$27,322,876	\$36,887,959	n/a
MRDD [1]	\$53,297,124	\$77,475,352	\$106,195,518	\$141,417,720	\$189,409,186	n/a
APD [1]	\$59,236,986	\$84,773,642	\$111,696,792	\$142,378,680	\$186,364,474	n/a
OA [1]	\$69,540,827	\$119,625,642	\$205,318,636	\$323,780,723	\$462,638,381	n/a
HCB Waiver Subtotal	\$192,500,000	\$296,800,000	\$443,600,000	\$634,900,000	\$875,300,000	7.9%
Home Health / Hospice	\$2,500,000	\$3,400,000	\$4,900,000	\$6,700,000	\$9,300,000	6.8%
Nursing Home	\$88,400,000	\$106,500,000	\$134,200,000	\$170,400,000	\$210,100,000	4.4%
Personal Care	\$99,600,000	\$190,500,000	\$338,900,000	\$542,000,000	\$791,200,000	10.9%
<b>Total Long Term Care</b>	<b>\$383,000,000</b>	<b>\$597,200,000</b>	<b>\$921,600,000</b>	<b>\$1,354,000,000</b>	<b>\$1,885,900,000</b>	<b>6.5%</b>

Source: Long-Term Forecast of Medicaid Enrollment + Spending in Alaska: Supplement 2010-2030 by DHSS

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**All Payer Claims Database Feasibility Study  
Alaska State Hospital and Nursing Home Association Comments  
October 5, 2012**

Alaska State Hospital and Nursing Home Association (ASHNHA) staff participated in the provider stakeholder focus group on Sept 18<sup>th</sup> and met individually with the Freeman Company consultants to provide input for the All Payer Claims Database (APCD) Feasibility Study. This is a summary of some of the issues we discussed.

- The feasibility study needs to clearly articulate the purpose and value of an APCD in Alaska. There are a variety of potential purposes behind developing an APCD such as cost reductions, quality improvement, consumer information on health care costs, etc. It is important to provide a clearly described vision and plan for the data. Be clear about intentions to use the data for cost or quality. Will the database be of value to the providers or is to regulate providers? What safeguards can be put into place to avoid punitive use? Related to this need is the question of what specific problem are we seeking to solve from the APCD in Alaska? Again, clearly articulate the problem the APCD seeks to address. This will help to gain support and understanding from stakeholders.
- One option for governance would have the State responsible for administering the APCD. We hope potential challenges with this structure will be identified as part of the feasibility study along with recommendations on structures to address anticipated governance issues. Some of the key governance issues we anticipate focus around the process of decision making on data accuracy, how the data is used and who gets access to the data.
- However the APCD is governed it needs to be guided by a Board that has strong authority to protect the data from political or poorly conceived uses. It cannot be just an advisory board, but must have authority over the data. The APCD would consolidate all the financial information of one industry in one place. This is a heavy responsibility which must have strong protections.
- Will an APCD be able to provide comprehensive data on all claims in Alaska or will certain groups get exclusions (such as tribal, federal, veterans) that result in a limited set of data? For ASHNHA, it will be essential that all payers and providers are included in the database. Another limitation of an APCD is the lack of data on uninsured, how will this be handled?
- We have gathered information from other State Hospital Associations on the status and progress of APCD in other states. The APCDs seem to be focused on different purposes in different states and no one seems to be able to do it all. Even states that have been working on this for a number of years still face many challenges and it does not yet seem

that an easily replicable model for an APCD has emerged. This needs to be acknowledged in the feasibility study.

- What is the payer response to a proposed APCD? Is there payer support? How will the APCD be financed? What are less expensive alternatives to an APCD? Without payer support, this could become another attempt at a “provider” database that will be fought by different stakeholder groups (ie: physicians).
- Hospitals are already participating in a voluntary database through the hospital discharge data system. The system is currently very poorly resourced. In order for the APCD to provide new benefit for public health purposes and quality improvement the database needs to include providers not currently in the existing hospital discharge data set.
- There could be significant benefits to hospitals/health systems if the APCD could be used for operational improvement efforts, especially to look at episodes of care or populations with chronic conditions. Availability of this type of data could be useful if/when Alaska moves towards ACOs. However, it is unclear at this point what data will be most useful for quality/operational improvement – claims data used in an APCD or patient medical record information from an electronic health record or a Health Information Exchange.
- An important issue to address is what mechanisms will be established to allow hospitals to verify the data being reported about them is accurate. There will also need to be a way to address variations in data quality from different payers.
- Although this is called a feasibility study, it seems likely there will be a recommendation that it will be useful to have an APCD at some point. So it seems this study needs to address issues such as; is this the right time to develop an APCD in Alaska and what factors in the environment indicate that this is the right time. From ASHNHA’s perspective we support the concept of an APCD, but given all the other efforts underway right now such as the Medicaid MIS, Alaska E Health Network Health Information Exchange, Health Insurance Exchange, etc. we are not sure if this is the right time to be able to successfully embark on an APCD effort.
- Cost of the APCD. As part of the feasibility study it is important to provide realistic cost estimates both for development and maintenance of the database. There is a wide range of costs among state. The study needs to address how Alaska can best estimate what it will cost to do an APCD in Alaska. If this estimate is a lowball or conservative estimate it could cause significant problems in the future.
- How does the concept of an APCD fit with the effort to develop the Health Information Exchange (HIE through AeHN)? How have other states managed the connection or lack of connection between an APCD and an HIE? This is especially an issue around “sustainability” as the expectation is that providers and/or insurers will be expected to financially sustain the HIE. If another statewide health information effort begins it will need to either be connected to the HIE or clearly explain how and why it is different and

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will be sustained financially. The State has invested significant funds in the HIE. Will seeking funding for an APCD detract or conflict with the HIE effort? Current agreements do not give the Exchange the ability to store and manipulate the data that moves through the exchange.