FY 2011 Capital Budget TPS Report 53971v1

Agency: Commerce, Community and Economic Development

Grants to Named Recipients (AS 37.05.316)

Grant Recipient: Maniilaq Association **Federal Tax ID:** 92-0041461

Project Title: **Project Type:** New Construction and Land Acquisition

Maniilaq Association - Elder Care Facility

State Funding Requested: $10,200,000 **House District:** 40 / T
One-Time Need

Brief Project Description:

The Elder Care Addition project is the construction of an 18 bed long term nursing care wing co-located with the Maniilaq Health Center in Kotzebue, Alaska.

Funding Plan:

Total Cost of Project: $17,700,000

	Funding Secured		Other Pending Requests		Anticipated Future Need	
	Amount	*FY*	*Amount*	*FY*	*Amount*	*FY*
Federal Funds	$500,000	2009				
State Funds	$7,000,000	2008				
Total	$7,500,000					

Detailed Project Description and Justification:

The Elder Care Addition project is the construction of an 18 bed long term nursing care wing co-located with the Maniilaq Health Center in Kotzebue, Alaska. The project is a 15,000 square foot addition to the Maniilaq Health Center. The facility will be operated under an Eden Alternative model of care. A feasibility study has shown that it will be financially sustainable with a break even occupancy level of 75%. Medicaid will be the primary source of revenue for the projected $2.8 million dollar annual operational budget.

Design of the project was completed in November 2008 and a contractor was selected through an RFP process in December 2008. Phase I of construction began in spring 2009 utilizing $7 million in funding from the State of Alaska and $500,000 in funding from a federal appropriation. Maniilaq is seeking Phase II funding of $10.2 million to complete the project.

This facility will provide skilled nursing care to elders in a region that is geographically isolated from the rest of Alaska. Currently there are no other options for elders and their families to receive these services within the region. It will greatly expand care to Alaska Natives and all residents of Northwest Alaska. The 2007 study by the Pacific Health Policy Group, commissioned by the Alaska Legislature, indicated that a statewide shift of long term care services from the private sector to the tribal healthcare system would result in a savings of $36 million over ten years. Maniilaq Association is a non-profit, tribally-owned health corporation incorporated in the State of Alaska. It is also the only health care provider in the area.

Project Timeline:

Over the course of the next year.

Contact Name: Christine Hess
Contact Number: 465-4833

For use by Co-chair Staff Only:

$10,200,000 Approved

5:53 PM 5/4/2010

Entity Responsible for the Ongoing Operation and Maintenance of this Project:

Maniilaq Association

Grant Recipient Contact Information:

Name:	Ian Erlich
Address:	P.O. Box 256
	Kotzebue, AK 99752
Phone Number:	442-3311
Email:	ierlich@maniilaq.org

Has this project been through a public review process at the local level and is it a community priority? [X] Yes [ ] No

For use by Co-chair Staff Only:

5:53 PM 5/4/2010

Contact Name: Christine Hess
Contact Number: 465-4833

By DOWL Engineers

ELDER CARE ADDITION
MASTER PROJECT BUDGET

Confidential
28-OCT-09

Line	Phase and Item	Firm / Org	Current Budgeted Amount	Source / Basis	% or Unit Cost	Obligated To Date	Invoiced As of 28-OCT-09	Notes
		a	b	c	d	e	f	g
A	**Planning and Design Services**				**% of Const.**			
A1	Design, Planning, Environmental, Early CA	DOWL	825,000	T&M / LS	5.5%	825,000	825,000	Bid Docs Complete, RFP & Addendum included
A2	Survey	McClintock		LS / T&M				Complete
A3		**Subtotal**	**$825,000**		**5.5%**	**$825,000**	**$825,000**	
B	**Construction**				**$/gsf**			
B1	Purchase Piles	Maniilaq	948,159	LS	$53.10	948,159	948,159	FOB Anchorage; complete
B2	Purchase Pad Insulation	Maniilaq	79,500	LS	$4.45	79,500	79,500	FOB Kotzebue; complete
B3	Site-Work	KIC	270,000	LS + Unit	$15.12	271,500	271,500	Complete
B4	LS General Construction Contract	SKW	13,176,000	4-FEB-09 Contract	$737.94	5,846,295	2,023,555	Ph. I NTP, PH. II Submittals NTP, AHU NTP, GYP NTP
B5	Estim Phase II Cost Increase (Mtls & Shipping)	SKW	375,000	4-FEB-09 Contract	$21.00	383,786		Estimate based on econ/market conditions
B6	* Asphalt Paving Option	SKW	130,000	11-DEC Bid	$7.28			Assumes paving equipment is in town
B7		**Total**	**$14,978,659**		**$838.91**	**$7,529,240**	**$3,706,500**	
C	**Other Construction Related Costs**				**$/gsf**			
C1	FF&E	Maniilaq	750,000	$50/SF for new space	$42.01			Purchase, Transport, & Install
C2	Art	Maniilaq	100,000		$5.60			
C3		**Subtotal**	**$850,000**		**$47.61**	**$0**	**$0**	
D	**Construction Administration**				**% of Const.**			
D1	Design Team CA	DOWL/AA	256,850	CA Proposal	1.7%	308,993	112,459	CA Agreement with DOWL HKM. (Invoices through Sep-09)
D2	*Special Testing and Inspections	ATL	52,151					
D3								
D4	Contingency	Maniilaq	748,933	Estimations Inc. 4-Nov-08 Estimate	5.0%			
D5		**Subtotal**	**$1,057,934**		**7.1%**	**$308,993**	**$112,459**	
E	**Misc. Reimburseables**				**% of Const.**			
E1								
E2	Printing & Other Reimburseable Costs	Maniilaq	10,000	T&M Allowance	0.1%			
E3		**Subtotal**	**$10,000**		0.1%	**$0**	**$0**	
F	**Hard Cost Totals**							
F1		**Total**	**$17,721,593**			**$8,663,233**	**$4,643,959**	Includes, Piles Purchase, Planning
F2		**$ per gsf =**	**$993**					

1. Planning and Design costs do not include 2006 MHC Master Planning or previous

Total project gsf = **17,855**

Maniilaq Association Elder Care Addition

The Elder Care Addition project is the construction of an 18 bed long term nursing care wing co-located with the Maniilaq Health Center in Kotzebue, Alaska. The project is a 15,000 square foot addition to the Maniilaq Health Center. The facility will be operated under an Eden Alternative model of care. A feasibility study has shown that it will be financially sustainable with a break even occupancy level of 75%. Medicaid will be the primary source of revenue for the projected $2.8M annual operational budget.

Design of the project was completed in November 2008 and a contractor was selected through an RFP process in December 2008. Phase I of construction began in spring 2009 utilizing $7M in funding from the State of Alaska and $500k in funding from a federal appropriation. Maniilaq is seeking Phase II funding of $10.2M to complete the project.

This facility will provide skilled nursing care to elders in a region that is geographically isolated from the rest of Alaska. Currently there are no other options for elders and their families to receive these services within the region. This project would serve as demonstration of co-location of an elders care wing onto an IHS supported, tribally-owned health facility. It will greatly expand care to Alaska Natives and all residents of Northwest Alaska. The 2007 study by the Pacific Health Policy Group, commissioned by the Alaska legislature, indicated that a statewide shift of long term care services from the private sector to the tribal healthcare system would result in a savings of $36M over ten years.

Maniilaq Association is a non-profit, tribally-owned health corporation incorporated in the State of Alaska. Maniilaq is the sole provider of health and social services in Northwest Alaska.

Elder Care Addition Project Costs	
Planning and Design	$825,000
Construction	$16,025,000
FFE & Art	$850,000
TOTAL Project Cost	$17,700,000
Elder Care Addition Project Funding	
FY2009 State of Alaska Funding	$7,000,000
FY2010 Federal Appropriation	$500,000
TOTAL Funding	$7,500,000
TOTAL FY2011 Request	$10,200,000

Financial feasibility and Sustainability of the Proposed Elder Care Addition and related modifications to the Maniilaq Health Center

Kotzebue, Alaska
March 2004

Maniilaq
Association, Inc

Mather and Associates

Financial feasibility and Sustainability of the Proposed Elder Care Addition and related modifications to the Maniilaq Health Center

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ACKNOWLEDGMENTS

The author thanks the Board of Directors of the Maniilaq Association who are committed to providing the region's elders a system of health care, which will keep them in the region and preserve their culture and traditions in the most independent setting.

The author is grateful for the time and assistance provided by Jay Farmwald at NANA/DOWL. Also, thanks to Maniilaq executive staff and the many health and human service professionals at the Maniilaq Association. These people include: Helen Bolen, Chief Executive Officer, Jimmy Johnson, Director of Community Health Services, Annie Livingston, Senior Center Director, Barbara Janacheck, the former Medical Center Director, Paul Hansen, Medical Center Deputy Director, Dr. Ruth Zent, Staff Physician, Sandy Hook and Rhonda Eunice of the Home Care Program, and many other Maniilaq staff who gave freely of their expertise to assist the authors with the development of this report. Their assistance was crucial in developing the senior survey, and formulating the final recommendations found in this report.

The author recognizes that not all of the recommendations in this report may be accepted. To the extent that information has been overlooked or misinterpreted, Mather and Associates takes sole responsibility for any errors or omissions that may be contained in this report.

David Mather, Dr. P.H.
Mather and Associates

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CHAPTER 1 - EXECUTIVE SUMMARY

The goal of Maniilaq elders is to remain at home and stay out of nursing homes and institutional long-term care as long as possible. Currently fewer elders from the Maniilaq Region live in nursing homes and assisted living homes than would be expected from the size and age structure of the regional population. Caring for elders from the Maniilaq region in their homes with home and community based supportive services is also by far the most cost effective and desired means of meeting the needs of the Maniilaq Elders into the next decade. As recommended in the 1997 Needs Assessment and Service Options for Elders of the Maniilaq Region.

Elder Facility Concept Design

In 2003 the board requested a concept design for a co-located nursing home from NANA/DOWL to meet a need for this type of service which had been identified as a priority by the board for some time. This report was commissioned to provide an assessment of the financial and operational feasibility of developing and sustaining the proposed Elder Care Addition and Related Modifications to the Maniilaq Medical Center which was developed by NANA/DOWL. This facility is conceived of as an addition to the Maniilaq Health Center and includes space for a nursing home, assisted living home and some needed additional acute care space. In total the proposed addition includes over 26,000 square feet of additional space at an estimated cost of over 15.7 million dollars.

Table 1.1
Program Elements of Elder Care Addition

Activity	*Skilled Nursing*	*Assisted Living*	*Non-Elder Acute Space*	*Total Project*
New Space	10,515 s.f.	12,930 s.f.	2,685 s.f.	26,125 s.f.
Renovated Space			3,750 s.f.	3,760 s.f.
Total Cost	$7,364,000	$5,948,000	$2,401,000	$15,713,000

Source: NANA/DOWL, Elder Care Addition and Related Modifications, Maniilaq Health Center, July 2003

This concept design provides for 10 double occupancy rooms for the nursing home unit (20 licensed beds), 10 double occupancy rooms for assisted living (20 licensed beds) and additional acute clinical space primarily to provide for more efficient outpatient and specialty clinic workflow.

This review includes the issues of need or demand, operational capacity and financial sustainability for both nursing home and assisted living services. In addition some of the legal, financial and operational issues involved in implementing the proposed project will be reviewed. The proposed additional space for acute medical care is outside the scope of this review.

Need or Demand from Elders for Care

The elder population of Maniilaq is not growing as fast as the rest of the state. The eldest age group, over 85 years old actually declined in numbers

between the 1990 and 2000 census (see table 4.1). In addition the use of nursing homes by elders in Alaska as a whole has declined by almost 22% in the past 5 years (see figure 4.1) In the Maniilaq region the use of both nursing home and assisted living by regional elders has declined since 1997.

Table 1.2
Occupancies for Maniilaq Elders in Nursing Homes and Assisted Living in 1997 and 2003

Type of Care	*1997*	*2003*	*Change*
Nursing Home Residents	10	6	-40%
All assisted Living Home Residents	16-19	6-10	-55%
Sub-set of assisted living residents on CHOICE waivers	1-5	0	-100%

Source: Mather and Associates, Needs Assessment and Service Options for Elders of the Maniilaq Region, Cross sectional telephone survey of Alaska nursing homes.

These declines are substantial and will have an impact on number of nursing home and assisted living beds that can be supported in the region.

Demand and Need for assisted living and nursing home services are not independent of each other. An elder can often times be appropriately placed in either a nursing home or assisted living home. In fact, the elders living in assisted living on Medicaid CHOICE waivers have to be eligible for placement in a nursing home by definition

Table 1.3 below, shows the projected number of elders in the Maniilaq regions that would be expected to live in nursing homes and assisted living facilities based on the statewide Alaska utilization rates for each type of care. Using 2005 for an example, based on the elder population of the region, it predicts that there would be 8 individuals that would be best served in a nursing home, 5 individuals that could be served in either a nursing home or assisted living home on a CHOICE waiver and 4 individuals that would need care in assisted living, but would not be eligible for nursing home care.

Table 1.3
Projected Utilization by Maniilaq Elders of Nursing Homes and Assisted Living Services - 2005 to 2020

Type of care	2005 Projected Need	2010 Projected Need	2015 Projected Need	2020 Projected Need
Elder Population	470	561	683	816
Projected Nursing Home Demand	8	10	11	13
Assisted Living or CHOICE waivers	5	6	7	8
Assisted Living non waiver	4	10	11	13

Source: Projections based on DOL census projections corrected to 2000 census and current AK utilization rates for nursing home and assisted living care.

Elders who are in the CHOICE waiver category could be served in either assisted living homes or in a nursing home. The least restrictive setting and the lowest cost (to the Medicaid program) setting to provide care for these elders would be in an assisted living home, however, financial feasibility considerations, including the potential for generating adequate revenue to cover operational costs, also must be considered and Maniilaq will receive substantially higher revenue if the elders are supported in a nursing home.

Other rural regions in Western Alaska have demonstrated that it is very difficult to operate both assisted living and nursing home facilities in small regions (see table 4.6). Norton Sound region has 40% more elders(over 65 years old) that the Maniilaq region, The Norton Sound Hospital has successfully operated a nursing home, Quyanna Care, in Nome for over 20 years. This is a 15 bed facility that is attached to the hospital and has consistently had occupancy levels approaching 100%. There is no assisted living facility in Nome or in the region.

Dillingham which serves the Bristol Bay region, has almost exactly the same number of elder in the service area as Maniilaq. It has no nursing home and has recently established an assisted living facility in a stand alone facility operated by a sole purpose non profit established specifically for that purpose. This facility has only been marginally successful financially. It lost money the first two years of operation and hopes to break even this year, its third year. It is concerned that the establishment of a new assisted living facility may reduce occupancy levels to

The Maniilaq has made it clear that eventually they would like to support elders in there own villages in assisted living facilities if possible. The models for providing assisted living in small villages remain undeveloped however and are very high risk financially. The lack of consistent demand for services, the lack of more sophisticated health care facilities in the community to support the elder clients and the very small facilities with out economies of scale all make development assisted living in villages hard to achieve successfully.

As table 1.2 above demonstrates Maniilaq will not need in the foreseeable future 40 licensed beds for nursing home and assisted living as described in the Final Concept Design.

Assisted Living Addition

Maniilaq has operated an assisted living home for over 15 years in the senior center. Maniilaq has relied on a direct grant from the Division of Senior and Disabilities Services to support this program. Last year, the Maniilaq was notified that this grant, which had been recurring at a static level for some years, was going to be reduced next year and eventually phased out. This will require Maniilaq to generate all operational revenue from resident fees and Medicaid payments like other assisted living facilities in the state. The state has urged Maniilaq to quality residents in the assisted living program for CHOICE waivers to obtain income to replace the phase out of the direct grant. To date, despite increased training the in the waiver process by the state and active outreach programs to the regions elders, Maniilaq has been unsuccessful admitting seniors that qualify for Medicaid CHOICE waivers. It is not fully understood why the levels of CHOICE eligible elders are so low in the Maniilaq region.

Loss of the State grant and the resulting deficits may well force the closure of the existing assisted living facility if the State grant is withdrawn. Moving the program into a proposed new facility co-located with the Maniilaq Medical Center[1] will not change this economic reality. Moving the program will not reduce the operational budget, and it will substantially increase the operational budget if the non-grant capital costs of construction of the new assisted living facility are fully amortized in the cost structure. The cost of depreciation and interest on the assisted living home which was 50% funded (maximum allowable level) by a grant from the Denali Commission would be about $361,000 per year. Thus, the construction of new facility would add over $50 dollars per day to the cost of providing care for each resident (Appendix A) in the new facility just for capital cost.

Given this situation, it is unwise to make a large capital investment in a new assisted living facility, which would be attached to the Maniilaq Health Center. Rather than construct a new assisted living facility, Maniilaq should focus on trying to achieve continuing costs savings and revenue enhancements in the operations of the current program in the existing facility.

In conjunction with these efforts, the Maniilaq may explore other avenues to insure continued provision of assisted living in the Maniilaq region after the current grant funding is eliminated, if the current facility is forced to close due to lack of revenue.

Nursing Home Addition

Maniilaq may be able to operate a 15 bed nursing home attached to the Maniilaq Medical Center on a long term “breakeven” basis. Even with the current Medicaid rates for nursing home care, however Maniilaq must

[1] Although nursing homes co-located with small rural hospitals are a common model across the state the benefits of attaching an assisted livening home to a hospital are much less clear. There are no assisted living homes currently attached to a hospital or operated by a hospital.

achieve occupancy of 11 to 12 residents to operate a nursing home on a break-even basis. This occupancy level will require higher levels of utilization of nursing home services by elders than currently (6 Maniilaq elders were living in Nursing Homes in December 2003) or statewide levels expected based on the elder population and age structure (this would predict 8 elders from the region in nursing homes).

As discussed previously however the occupancy of a Maniilaq nursing facility would also depend on the availability of assisted living services in the community and the use of those services by CHOICE waiver patients that qualify for nursing home admission. If the Maniilaq nursing home experienced utilization rates similar to the nursing home in Nome (where there is no assisted living facility), which is the most comparable region in the state with a nursing home, it would have 11-12 residents in 2007.

Establishing a nursing home, however, will require a substantial investment of cash (about 4 million dollars) for start up and for capital financing. Maniilaq will experience start up deficits for the first two years due to low intial occupancy levels and the Medicaid reimbursement rate in the first two years. In addition since the Denali Commission does not provide funding for nursing homes at this time, Maniilaq will also have to finance the facility with a commercial loan and this will require a cash investment of a further 2.0 million dollars.

In addition despite the analysis provided in this report the Maniilaq will have some risks to the financial health of the nursing home in the future. If occupancy levels of 11-12 residents cannot be maintained due to changes in admission guidelines or operational difficulties or if the State of Alaska changes the rate setting structure for rural nursing homes it could result in reductions in revenue and operational losses for the new facility.

Table 1.4
Recommended Project Reserves

Type of Cost	*Budget*
Capital Project Reserves	$2,000,000
Operational Reserves	$1,900,000
Start Up/System Development Costs	$100,000
TOTAL RESERVES	$4,000,000

Maniilaq must evaluate the risks involved in the construction of a nursing home and the benefit of utilizing cash reserves and debt capacity for this purpose instead of funding an endowment or other priority projects, which may benefit a broader range of elder or other Maniilaq members.

Locating a nursing home (or assisted living) facility attached to the Maniilaq Medical Center raises several issues regarding ownership, capital financing and the Medicaid rate of the facility. These issues which will involve the Indian Health Service, Department of Health and Human Services, the State Division of Medical Assistance and potentially the Alaska Congressional Delegation will require significant addition time to resolve.

Summary

It would not be prudent to construct both a 20 bed assisted living home and a 20 bed nursing home as envisioned in the NANA/DOWL concept design.

The need and feasibility of the proposed additions for acute medical services are not evaluated in this report.

The proposed addition for assisted living should not be developed. The current assisted living facility is threatened with loss of the state grant; this will cause ongoing substantial losses in this program. Relocation to a new facility will add operational costs and not resolve the current crisis. Maniilaq should concentrate on developing alternative smaller assisted living program which can replace the current program if funding is lost.

Operation of a nursing may be feasible as conceived in the concept design. However several preliminary planning issues must be resolved and Maniilaq must carefully consider the tradeoffs involved in using a large proportion of the unrestricted fund balance to develop this facility. Development of a new nursing facility is also not without some long term risk. Unforeseen changes in the state of Alaska Medicaid program could reduce the revenue potential from a new nursing home.

CHAPTER 2 - INTRODUCTION

This report was commissioned to provide an assessment of the financial and operational feasibility of developing and sustaining the proposed *Elder Care Addition and Related Modifications to the Maniilaq Medical Center*. The review will include:

- Recommendation regarding the sustainability of the assisted living and nursing home units described in the NANA/DOWL concept design.
- A review and update of the findings, and recommendations, identified in the *Needs Assessment and Service Options for Elders of the Maniilaq Region* report by Mather and Associates dated November 1997.
- New estimates of the demand for nursing home services in the Maniilaq Region, and a review of current demand for Assisted Living in Maniilaq area and projections for future demand.
- An estimate of the amounts of operational revenue, which might be generated by and available to support the proposed facility including both the nursing home and the assisted living home in the Maniilaq Region.
- An estimate of the operational costs of the nursing home and any changes in the costs of the assisted living home proposed for the new addition from the current expenditures for this program.
- Discussion of capital investment needed to construct the facility within the overall debt and resource capacity of Maniilaq.
- Certificate of Need (CON), licensing, facility ownership, rate setting and cost reporting issues involved in the construction and operation of a new nursing home and/or assisted living facility.
- The study will also review the operation of the Quyanna Care Center the nursing home in Nome that is located in the Norton Sound Health Corporation Hospital and provide any lessons to be learned from the successful operation of this facility.

The review will include the issues of operational capacity and financial sustainability for both nursing home and assisted living services. In addition, the legal, financial and operational issues involved in implementing the proposed project will be reviewed.

Background

Alaska now has the smallest, but one of the fastest, growing proportions of seniors in the population of any state in the nation. Alaska's senior population of age 65 and over is expected to more than triple in the 25 years[2] from 2000 to 2025. The senior population of the Northwest Arctic Borough,

[2] Alaska Economic Trends, Seniors in Alaska, December 2001

which is increasing more slowly, is projected[3] to more than double in the next 20 years from 359 in 2000 to a projected 752 in 2020. This growing senior population will offer challenges for Maniilaq and the other human service providers in the region. Despite this substantial increase in elder population, the number of elders in nursing homes and other institutional care is not expected to increase at the same rate as the population, as more elders are supported in their homes by home and community-based services.

Maniilaq is a leader among Native Regional Health Corporations in the provision of Elder care services. From 1989 to 1993, Maniilaq was one of only two regional native health corporations that operated a nursing home in Alaska. In 1993, Maniilaq was forced to close this nursing home due to large and consistent financial losses and inability to provide for stable nursing staffing in the facility. Currently, Maniilaq is the only regional native health organization to operate an assisted living home for elders. Maniilaq also offers home care services that provide personal care attendants and chore service providers to elderly and disabled residents of the region. This program enables individuals, whose medical needs would otherwise require placement in an acute or long-term facility, to remain safely and comfortably in their own home.

Since the closure of the nursing facility, however, Maniilaq has recognized that there is a gap in the continuum of care for the most fragile elders in the region, and has been committed to developing expanded services in the region that will reduce, or eliminate, the need for these elders to travel far from home to obtain the needed nursing or supported living services.

In 1997, Maniilaq commissioned an analysis of needs and service options for the elders living in the region from *Mather and Associates*. This study, which examined the feasibility of establishing a nursing home in the region, also included a survey that completed face-to-face interviews with over 50% of the elders in the region. The primary message from these interviews with Maniilaq elders was that they *do not want to live in long term care institutions, they want to live at home and have family and friends visit them*. Despite this, however, these same elders indicated that if they did have to go to a nursing home they did not want to leave the region.

In 2003, Maniilaq determined that capital funding may be available through the Denali Commission and other grant sources to develop nursing home care within the region. To determine how much capital funding would be needed to construct a nursing home, Maniilaq commissioned a concept design from NANA/DOWL for a nursing home wing, which would be attached to the Maniilaq Health Center. This study was completed in July of 2003, and, eventually, included a 40-bed addition to the Maniilaq Health Center that included a nursing home, assisted living beds and other capital improvements in the Health Center.

[3] 2000 census

Trends in Elder Care

The "Inupiat Ilitqusiat" promotes "respect for elders" as a central responsibility of all Maniilaq regional residents. The Maniilaq Board and staff have, for years, recognized the elders of the Maniilaq region as teachers of the traditional values and cultural spirit of the people of the region, and the Maniilaq strategic plan calls for "Elders, happy, well provided for and *living at home* in our service area".

A primary recommendation emerging from the earlier elder care needs assessment, done in 1997 by Mather and Associates, stated that the wishes of the elders was that *Maniilaq should continue to focus on the efforts of home and community portions of the elderly care continuum and should not channel resources away from these services to support a nursing home*. This recommendation remains valid and relevant today, and is consistent with the intent of state and national policy, which seeks to support elders in the most independent setting possible through the development of home and community based services to keep elders in their homes.

This "continuum of care for elders" relies on personnel care attendants, homemakers, respite care and home health services to come into the homes of elders and provide needed services to support families caring for their elders, and allow elders to continue in their homes as they wish. In cases where elders do not have the ability to remain in their homes, they are sometimes relocated to independent elderly housing, which are handicap accessible and where maintenance and meals may be provided. Elders that need additional assistance may choose assisted living homes that provide more extensive support in the activities of daily living, but still provide for greater independence than nursing home care.

Nationally, and in Alaska, the rate of utilization of nursing home care among the elderly has dropped over the past decade for every age group. Overall, the age-adjusted utilization rate for nursing home care for the Alaskan seniors has dropped by over 20% in the past 5 years. This is attributable to increased life expectancy, more married elders at any given age, more healthy seniors with fewer disabilities[4], and increased home and community options. Since 1998, elders who may qualify for nursing home care have had an additional option of receiving intensive, community-based support, or living in an assisted living home under the Medicaid CHOICE (Community and Home Options to Institutional Care for Everyone) program. For Medicaid eligible seniors, this program pays for more intensive home and community-based, or assisted living, services for persons who, otherwise, would have to be in nursing homes.

In the Maniilaq region, the decline in utilization of nursing homes by regional elders is also evident. The number of elders in nursing homes from the Kotzebue region has decreased from 10, which were enumerated in 1996 at the time of the earlier Mather and Associates study, to only 6 in late 2003 when all Alaska nursing homes were surveyed[5] for this report. Although a

[4] Alaska Commission on Aging, Issues Affecting the Economic Well-Being of Alaska Seniors, McDowell Group, December 2000.

[5] In addition to the 6 elders identified in the statewide nursing home survey, Maniilaq reported two long-term residents who could have been appropriately discharged to a regional nursing home.

decrease was predicted in the earlier report, due to a decline in the number of the "oldest old" (over 85 years old), the extent of the decrease was not anticipated.

Continuum of Care in Elder Services

The Alaska Commission on Aging has prepared several reports on long-term care in Alaska. In their 1993 review, "Long-Term Care Alternatives for Alaska's Elderly: A Report 1993 and Beyond," they proposed recommendations for long-term care services in Alaskan communities. They suggested that sub-regional centers should have locally available a continuum of home and community-based services, The Division of Senior and:

Table 2.1
Continuum of Care for Elders

Services	*Available in Maniilaq Region*
Home and community based services	
Personnel care/chore services	yes
Congregate and/or home delivered meals	yes
Home modifications	no
Senior transportation	yes
Case management	yes
Respite care	no
Adult day care	no
In home (visiting) nursing care	no
Independent Senior Living	yes
Assisted living services	yes
Nursing home services	no

Financial Sustainability and Investment Cost

New elder services that are developed by Maniilaq must represent a wise investment of limited resources. The investment should benefit the maximum number of elders and other Maniilaq residents and must also be financially self-supporting and sustainable over the long-term. Maniilaq has developed a long list of priorities for investment of the limited dollars that have been accumulated in the fund balance. Revenue growth has slowed recently as the IHS has been forced to limit operational increases due to homeland security, the war in Iraq and other federal priorities. Like every other hospital in the country, the Maniilaq Health Center is also facing changes in technology and increasing demand for medical services that require continuing investment of capital dollars to maintain quality and efficiency. In addition, a prudent operational reserve must be maintained to insure the stability in the provision of core health and medical services and the long-term success of the organization.

The initial investment cost of developing institutional care for elders is very large. Capital will be needed to contribute to the cost of construction, provide for the development of systems development and training of staff and to cover initial operational losses that will be sustained as the facility fills up with seniors and develops the rate structure and revenue streams needed to sustain the facility.

These long-term operational costs of providing institutional-based elderly care are substantial and far in excess of supporting elders in their own home. The table below shows the total and average cost of care to the State Medicaid program for *nursing home eligible* clients cared for in nursing homes and under the CHOICE program in home-based and assisted living homes. These costs are statewide averages and costs in rural areas similar to Maniilaq are often double or two and a half times these costs.

Table 2.2
Alaska 2003 Medicaid Expenditures

	Number clients	***Total cost***	***Cost per client***
Nursing homes	818	$57,600,000	$70,416
Assisted living homes	2254	$39,300,000	$17,436
Per. care attendant	2500	$38,000,000	$15,200

Source: DHSS, Senior and Disabilities Services, Coming Home Program, Recommended Priorities for Assisted Living, October 2003

Maniilaq must consider not only the operational costs of the program, but also the capacity of the program to generate enough revenue, "break even", to support the continued, successful operation of the program. In 1992, the Maniilaq was forced to close the previous nursing wing in the senior center because the facility could not generate enough money to pay for the staff needed to operate the home in a safe and satisfactory manner. A new nursing home must generate revenue to support itself. Nursing home care is not supported with grant revenue- it is supported by direct charges for each day of care provided to Medicaid- therefore, revenue that is obtained from a nursing home is a function of both the rate received from Medicaid and the number of elders living in the facility. Therefore, to break even, the Maniilaq must both achieve a satisfactory rate and there must be enough demand among regional seniors to keep the facility full.

Although the Maniilaq Assisted Living home has been supported in the past with a fixed grant that does not vary with the number of elders living in the facility, this is unlikely to continue in the future[6]. Maniilaq has been notified by the state that this grant will be reduced in the next fiscal year and may, eventually, be phased out entirely. The Maniilaq assisted living program is currently in the process of trying to refinance the program away from state grant funds to, instead, support from Medicaid and resident fees. This effort will require that costs be reduced significantly below current levels and

[6] Only 2 of 157 assisted living facilities in the state have received ongoing operational grants from the Division of Senior and Disabilities Services. Maniilaq and the other grantee have both been notified that this operational grant support is being reduced and phased out.

occupancy levels approach 100% in the existing assisted living program. In addition most if not all the residents of the program must be on CHOICE waivers if the program is to "break even" and generate enough revenue to support the continued operation of the program.

Development and Operational Challenges

Only one other tribally operated facility in the state has an attached nursing home, the Norton Sound Hospital in Nome. This hospital, however, was never a federally owned facility like the Maniilaq Health Center- it was constructed and is owned by the Norton Sound Health Corporation. This means that the Maniilaq Health Center would be the first federal IHS hospital in Alaska to have an attached nursing home[7]. This raises a multitude of property ownership and licensing issues, which will have to be considered and resolved prior to building the proposed facility.

In addition, the current rate-setting regulations call for Maniilaq to submit a full Medicare Cost report to determine the costs of providing care and the appropriate rate for a nursing home facility. Maniilaq, as a federal hospital, has not developed the capacity to implement this cost report and does not have the financial management software that would support this type of reporting.

The implementation of this financial reporting capacity will add significantly to the cost of implementing a nursing home, and may impact the ability of the financial management staff to develop other needed program support. The development of a special IHS rate for nursing home services, which is under consideration by the Division of Medical Assistance at the State, may reduce this somewhat if the rate can utilize the short form Medicare costs report which is currently produced in conjunction with the IHS. In addition, the development of a special IHS rate, which includes provision for rate setting of new facilities, could reduce the potential start-up losses for the new facility.

[7] Although there are over 14 tribally operated nursing homes across the US, there is one other tribally owned nursing home that is attached to a federal IHS hospital in Red Lake Minnesota. This facility is actually built on tribally owned land and title continues to rest with the tribe.

CHAPTER 3 - PROPOSED ELDER CARE ADDITION TO THE MANIILAQ HEALTH CENTER

In February 2003, Maniilaq began work with NANA/DOWL on a conceptual design for the development of an addition of a Nursing Home to the Maniilaq Medical Center in Kotzebue. During the development of the design, an assisted living unit was added to the second floor of the proposed additional along with the addition and renovation of some needed acute care clinical space. The final concept plan calls for an addition of 26,125 square feet and renovation of 3,750 square feet at an estimated cost of $15,710,000. The space and costs in the project is allocated between activities as follows:

Table 3.1
Program Elements of Elder Care Addition

Activity	*Skilled Nursing*	*Assisted Living*	*Non-Elder Acute Space*	*Total Project*
New Space	10,515 s.f.	12,930 s.f.	2,685 s.f.	26,125 s.f.
Renovated Space			3,750 s.f.	3,760 s.f.
Total Cost	$7,364,000	$5,948,000	$2,401,000	$15,713,000

Source: NANA/DOWL, Elder Care Addition and Related Modifications, Maniilaq Health Center, July 2003

The cost allocation relies on subsequent estimates provided by NANA/DOWL that allocated the costs of the entire facility to the functions in the facility. The allocation utilized was the most conservative (for nursing home space) and assumes a significantly higher cost per square foot for the nursing home (first floor), as most of the foundation and site work are required to complete this part of the structure. The cost estimate provides for construction completion in 2005 and will require additional costs for inflation, as the completion date of the project cannot be achieved by that date.

This concept design provides for 10 double occupancy rooms for the nursing unit (20 licensed beds), 10 double occupancy rooms for assisted living (20 licensed beds) and additional acute clinical space primarily to provide for more efficient outpatient and specialty clinic workflow.

Acute Care Space

During the initial concept design phase, the NANA/DOWL team was also asked to include in the concept planning needed acute care space, which the Medical Center management team had identified as currently needed, or, needed to support the provision of nursing home services.

- Enhancements currently needed to the Maniilaq Medical Center outpatient department. The total number of outpatient exam rooms will be increased from 12 to 18 exam rooms, and displaced services will be relocated on the first floor of the proposed addition.

- Expansion and reorganization of the admitting and billing areas in the health center.

- Alteration and/or expansion to other hospital support areas that may be impacted by the skilled nursing unit, including: pharmacy, physician therapy and other support areas

- Separate area for specialty clinics to include expanded pre/post recovery area, procedure area and support for these expansions.

These expansions and renovations are included in the proposed concept design and are estimated to cost approximately 2.4 million dollars. The need for the increased efficiency and additional revenues that will be generated with these modifications should be evaluated separately, as they are independent (for the most part) of the nursing home and assisted living programs. This cost/benefit analysis is not included in the scope of this report or project.

Nursing Home Services

The skilled nursing facility, located on the first floor of the planned addition, includes 10 rooms that can accept double occupancy for a total of 20 licensed beds. Although the proposed number of licensed beds is 33% higher the number of rooms provided in the schematic design, it is consistent with the recommendation the Long Term Care Needs Assessment prepared by Mather and Associates in 1997, which called for 15 licensed beds in 5 single and 5 double rooms. The proposed facility includes a separate entrance and a warm, home-like atmosphere. It provides ample space for cultural activities and common rooms for residents to gather.

The infrastructure and support space of the current hospital, including: heating, cooling, controls and support space for dietary, maintenance, admitting and housekeeping were determined to be adequate to support the proposed new space.

Assisted Living Services

During the development of the concept design, it became clear that a two story addition would significantly reduce the per square foot cost of the addition. Maniilaq indicated that the relocation of the Assisted Living units, currently provided from the senior center, would be a logical fit with the nursing unit. This addition in the concept plan doubled the space planned and added about 6 million dollars to the projected capital costs.

The concept design included 10 rooms with 20 licensed beds for assisted living located on the second floor of the nursing home addition. The facility would also utilize the dietary, housekeeping and other support functions of the hospital. Other care service staff providing services in the current facility would be transferred to the new facility. The proximity to the acute care services of the hospital would allow elders in need of more complex medical care to live in the facility, allowing the facility to care for individuals on Medicaid waivers.

The proposed facility would replace the current Maniilaq assisted living program. Maniilaq currently operates a licensed 20-bed assisted living facility in the Senior Center Facility. The 22,000 square foot senior center also houses several additional functions, including: transient quarters for elders in need of housing, pre-maternal housing, tribal doctors and traditional

foods and food preservation programs. Senior congregate meals and senior meals on wheels are also provided from the senior center. Currently, about 14,000 square feet of the senior center is devoted to the assisted living program.

CHAPTER 4 - DEMAND FOR NURSING HOME AND ASSISTED LIVING IN THE MANIILAQ REGION

A review of the literature indicates that the strongest predictors of utilization rates for nursing home beds within a particular region or system is the age structure of the population, and the number of beds which have been constructed and are available for use (Zedlewski 1992). Economic and social considerations, in addition to health status, are also strong predictors of individual demand for nursing home care. Most importantly, the need, and, to a lesser extent, the demand for nursing home beds is dependent on the availability of a continuum of effective alternatives to institutionalization, and on the cost of these alternatives to the elderly individual and/or their families.

The following factors will all influence the need and the demand for nursing home services in the Maniilaq region.

- The demographics of the elderly population- especially the growth in the "oldest old," or over 85 years old age cohort.
- The commitment of the state and federal payers to the development of a system that supports the maximum functional independence of the elderly.
- The continued availability and affordability of home and community-based care to the elders of the region as alternatives to nursing home placement.
- The availability of assisted living homes in the Maniilaq region and the use of CHOICE waivers by regional elders eligible for a nursing home placement.
- The reimbursement climate for nursing home services from the state Medicaid program.
- Cultural and social issues regarding the expectations, and abilities, of the elderly and their families to provide needed support in the elder's home and local community.
- The continued operation and availability of assisted living services in the Kotzebue Senior Center.
- The statewide bed supply for nursing home beds and placements available in other areas of the state (primarily Anchorage and Fairbanks).

In addition to these issues, estimating the number of beds needed in a long-term care system depends, to a great extent, on the philosophy of care practiced by the providers in the system.

Population Trends in the Maniilaq Region

The 2000 census reported there were 7,965 people living in the 12 villages and communities of the region. This includes 7,209 people in the Northwest Arctic Borough and 757 Point Hope. Approximately 90% of the region's population was Alaska Native. Even though the region has one of the highest birth rates in the state, population growth in general lags behind Alaska as a whole. This is because the region has a much lower in-migration rate than the state's more urbanized areas.

Between 1990 and 2000, the state's population grew by almost 14%, while the population of the NW Arctic Borough increased by only about 7%. The over 65 population in the NW Arctic Borough also increased at only about half the rate that it is increasing as a whole-- the over 85 year old age group shows the greatest departure from statewide trends. In the NW Arctic Borough, this population actually decreased by about 15% over the past decade while increasing by over 100% across the state.

The reasons for this decrease in the population of the "oldest old" in the Kotzebue region are because of the unusually low number in the age cohort of 75+ during the last decade. Although all the reasons for the small number in this age cohort are not fully understood, it is hypothesized that part of the reduced size of this age cohort can be attributable to the flu pandemic of 1919/1920 in western Alaska and the accompanying high death rates and out-migration of Alaska Natives. This is discussed more completely in the Needs Assessment and Service Options for Elders of the Maniilaq Region (Mather Associates 1997).

Table 4.1
Change in Age Group Population: 1990 – 2000
Alaska and the North West Arctic Borough

	1990		2000		Change
AGE GROUP	**#**	**%**	**#**	**%**	**1990-2000**
ALASKA	550,043	100.0%	626,932	100.0%	**13.98%**
Under 18 years old	172,870	31.4%	190,717	30.4%	**10.32%**
18 to 64 years old	355,078	64.6%	400,516	63.9%	**12.80%**
65 and older	22,095	4.0%	35,699	5.7%	**61.57%**
85 and older	1,200	0.2%	2,634	0.4%	**119.50%**
NW ARCTIC BOR.	6,113	100.0%	6,525	100.0%	**6.74%**
Under 18 years old	2,642	43.2%	2,990	45.8%	**13.17%**
18 to 64 years old	3,198	52.3%	3,859	59.1%	**20.67%**
65 and older	273	4.5%	354	5.4%	**29.67%**
85 and older	32	0.5%	27	0.4%	**-15.63%**

Source: 1990 census and 2000 census.

Impact of Population Growth on Demand for Nursing Home Services

The greatest determinant of the demand for nursing home services in the Maniilaq region is the number of elders within the region. Of particular importance is the number of "oldest old", who are individuals over 85 years old, because these individual live in nursing homes much more often than the "younger old". The table below shows rates of institutionalization for

elders in the US as a whole. This table also shows that for every 100 elders between 65 and 75 years of age, only about 1 individual lives in a nursing home, but this rate raises to 22 out of every 100 individuals over 85.

Table 4.2
Expected Nursing Home Utilization of Maniilaq Region
Based on Nation Age-Specific Utilization Rates

Age Group	USA Rate/100 individuals	Maniilaq Population	Expected Number
65 to 74 years old	1.3	266	3
75 to 84 years old	5.8	90	5
85 years or older	22	34	7
Total		390	15

Source: National Center for Health Care Statistics, National Nursing Home Survey, 1997.

Even though Alaska, as a whole, and the Maniilaq region, in particular, experience much lower rates of nursing home use than the rates shown above, the institutional rate for the 85+ age group of elders in the Maniilaq region[8] is still at least 10 times higher than in the younger age group of elders between 64 and 75 years old.

Recent Trends in Nursing Home Utilization by Maniilaq Elders

Since the Elder Care Needs assessment, completed by Mather and Associates in 1997, the demand and occupancy for both nursing home services and for assisted living services by Maniilaq Elders has decreased significantly. Table 4.3, below, shows occupancy levels in late 1997 when the earlier report was completed, compared to the occupancy levels in late 2003 when the nursing homes were re-surveyed. In both cases, nursing home occupancy was based on telephone surveys with every nursing home in the state, and would not have located residents in nursing homes out of the state. Assisted living occupancy levels below are based on reported occupancy at the Maniilaq Senior Center only, and do not include residents from the region that may be residing in other assisted living homes in Alaska[9]. This table shows a 40% reduction in nursing home residents and almost a 55% reduction in residents in assisted living in the Maniilaq region.

[8] Mather and Associates, *Needs Assessment and Service Options for Elders of the Maniilaq Region*, Kotzebue, November 1997.
[9] In both years, the Senior Center Assisted Living facility had unused capacity, so any Maniilaq residents living outside the facility in assisted living could be assumed to be there by choice.

Table 4.3
Occupancies for Maniilaq Elders in Nursing Homes and Assisted Living in 1997 and 2003

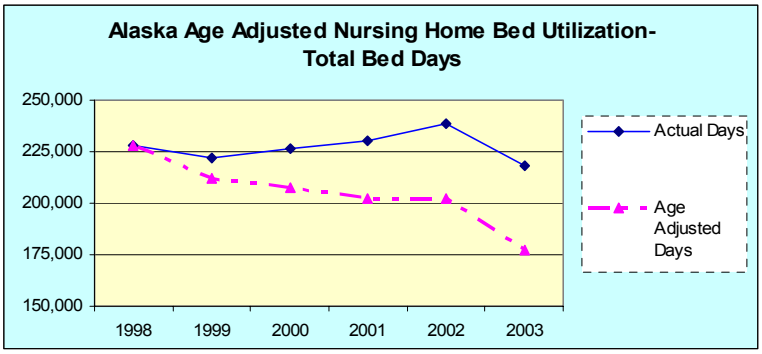
Type of Care	*1997*	*2003*	*Change*
Nursing Home Residents	10	6	-40%
All assisted Living Home Residents	16-19	6-10	-55%
Sub-set of assisted living residents on CHOICE waivers	1-5	0	-100%

Source: Mather and Associates, Needs Assessment and Service Options for Elders of the Maniilaq Region, Cross sectional telephone survey of Alaska nursing homes.

The change in nursing home utilization is partially attributable to decreases in the number of the "oldest old" (85 or older) in the region. This decrease was anticipated by the earlier Mather and Associates study, which predicted a declining population of the "oldest old" in the region, but the magnitude of the decline in nursing occupancy was not anticipated.

Several trends have evolved in nursing home services nationally, and in Alaska, that also impacts the projections of the number of beds needed to serve regions that were made in 1997. First, both nationally and in Alaska, the age-specific nursing home utilization rates have declined over the past decade. In Figure 4.1, below, data from the Alaska Medicaid Management Information System shows that despite significant growth in the elder population in Alaska, the total utilization of nursing home bed days has been relatively constant or dropped slightly over the past 5 years. The figure also demonstrates that the utilization rate of nursing home beds by Alaska elders has dropped over 22% in the time period from 1998 to 2003. This drop in utilization rates was not anticipated in the projections of nursing home bed needs for the Maniilaq Regional, completed in the Elders *Needs Assessment* done in 1997.

Figure 4.1
Nursing Home Utilization in Alaska



Source: MMIS Medicaid Management Information System.
Alaska Nursing Home Census 1998-2003. 2000 census.

Although all the causes of this are not known, there is an understanding of some of the factors causing this decline. The availability of Nursing Home bed days has not increased since 1998 despite the significant increase in the

elder population. This probably has some impact, however, statewide. Nursing home occupancy levels were only about 84% in 2003. Elders are remaining active and healthy longer, and there is a documented decline in disability among elders in Alaska and nationwide. In addition, a more important factor in Alaska in the decline in nursing home care has been the availability of substitute care in assisted living facilities and in their homes and communities, which are provided to Medicaid eligible seniors who are eligible for nursing home care through the Older Alaskan Medicaid CHOICE waiver program.

In September of FY2002, 347 Alaska elders were living in assisted living homes[10] under the Medicaid CHOICE waiver program. All of these individuals, by definition, were eligible for nursing home care. The same year, in any given month, there was an average of 409 elders living in nursing homes supported by Medicaid,[11] or about 45% of seniors eligible for Medicaid-supported care in a nursing home, were being cared for in assisted living homes.

Using statewide, age-specific nursing home utilization rates from 2003, the Maniilaq region could anticipate the following demand[12] for nursing home beds for Maniilaq elders through 2020. This projection for nursing care does not include care for younger individuals who normally require rehabilitative care, which would not be available at the Maniilaq Health Center. Statewide in 2003, individuals under age 65 were responsible for about 25% of all nursing home days.

This estimated demand for nursing home care, provided in Table 4.4, is based on current statewide rates of nursing home utilization by elders. It does not include the number of elders who are currently eligible for nursing home care, but rather those who live in assisted living homes or at home with a Medicaid CHOICE waiver.

[10] http://www.hss.state.ak.us/dsds/, Assisted Living Home Residents in Alaska, September 2002 statistics.
[11] MMIS data report based on LTC cover days in Alaska nursing LTC facilities. Another
[12] Maniilaq Medical, Home Health and Social Service staff has identified a much higher number of regional residents who might be in "need" of supported care outside their homes (i.e. Assisted Living or Nursing Home). This number, however, cannot be relied on in demand projections, as these individuals have chosen not to live in a nursing home or assisted living facility, despite their identified medical or social needs. Many Maniilaq elders prefer to remain home and will do so despite the urging of family or professional medical providers to consider placement in a nursing home or assisted living home. Many others, who may have social needs for a supported living situation, may not quality for nursing home care under Medicaid guidelines.

Table 4.4
Projected Nursing Home Utilization by Maniilaq Elders
2005 to 2020

Census Area	*2005 Projected Need*	*2010 Projected Need*	*2015 Projected Need*	*2020 Projected Need*
Northwest Arctic Borough	7.6	9.0	10.5	12.3
North Slope Borough (Point Hope)	0.7	0.8	0.9	1.1
Total Maniilaq Service Area	8.3	9.8	11.4	13.4

The demand prediction in Table 4.4 is based on the assumption that the age-specific utilization of nursing home bed days by the elderly will be flat at current rates for the time period of the projections. That means the projection relies on the assumption that the rate will not continue to decrease as it has over the past 5 years. If the trends established over the past 5 years continue, that is, if the age-specific utilization rates for elders continue, to decline, it would make it increasingly difficult for Maniilaq to keep the proposed nursing home full to capacity, and this could lead to reductions in revenue from the nursing home and operational losses.

Other issues could influence the occupancy as well. The projections above assume that all the elders living in the region will choose to obtain nursing care at a regional facility if it was available. This does not allow for elders who are referred outside the region for special medical or rehabilitative needs or those who choose to leave the region to be near an adult child other family member who lives in Anchorage, Fairbanks or other community.

Assisted Living Demand in the Maniilaq Region

Occupancy in the Maniilaq 20-bed assisted living facility is now significantly below capacity and below historical levels. Occupancy levels in the mid to late 1990s were between 16 and 19 individuals, but declined since 2000 to a low of only 6 residents in mid 2003, which has increased slightly to 11 residents in early 2004. In addition, the number of CHOICE-eligible residents has declined. Although, in 1997, up to 6 residents were CHOICE-qualified, no residents in the assisted living facility have been on Medicaid CHOICE waivers for the past two years. The reasons for the decrease in utilization of the assisted living home in the Maniilaq Senior Center, and the lack of eligible CHOICE waiver patients, are not entirely evident.

The decline in occupancy can be partially attributable to the development of independent elderly housing in Kotzebue, which has provide another alternative to elders who are capable of living in this less restrictive and less expensive setting. In addition, the drop in the number of elders on CHOICE waivers seems to indicate that the facility has selected elders who are not in need of a lot of supportive care due to the location and staff training levels. Although, recent efforts to actively recruit additional CHOICE waiver eligible elders have been unsuccessful. In addition, increased emphasis on collecting for room and board from elder residents has effectively raised the costs to the individual elders and has stimulated some elders to seek alternatives that are less expensive.

There is no accepted methodology for predicting demand for assisted living long-term from the Maniilaq region, but it is certain that demand, especially for elders who do not qualify for Medicaid CHOICE waivers, will be highly dependent on the cost of care to the elders who live in the facility, and, the ability of elders to obtain support services in their communities. Demand for assisted living care is changing rapidly, but in FY2002, about 1.85% of all Alaska's seniors lived in assisted living homes[13]. Of these residents, about half or 1% (of the total elder population) were supported by the Alaska Medicaid CHOICE program.

Relationship between Nursing Home Utilization and Assisted Living Utilization

Demand and Need for assisted living and nursing home services are not independent of each other. An elder can often times be appropriately placed in either a nursing home or assisted living home. In fact, the elders living in assisted living on Medicaid CHOICE waivers have to be eligible for placement in a nursing home by definition.

Table 4.5, below, shows the projected number of elders in the Maniilaq regions that would be expected to live in nursing homes based on the statewide Alaska utilization rates for each type of care. Using 2005 for an example, based on the elder population of the region, it predicts that there would be 8 individuals that would be best served in a nursing home, 5 individuals that could be served in either a nursing home or assisted living home on a CHOICE waiver and 4 individuals that would need care in assisted living, but would not be eligible for nursing home care.

Table 4.5
Projected Utilization by Maniilaq Elders of Nursing Homes and Assisted Living Services - 2005 to 2020

Type of care	2005 Projected Need	2010 Projected Need	2015 Projected Need	2020 Projected Need
Elder Population	470	561	683	816
Projected Nursing Home Demand	8	10	11	13
Assisted Living or CHOICE waivers	5	6	7	8
Assisted Living non waiver	4	10	11	13

Source: Projections based on DOL census projections corrected to 2000 census and current AK utilization rates for nursing home and assisted living care.

Elders who are in the CHOICE waiver category could be served in either assisted living homes or in a nursing home. The least restrictive setting and the lowest cost (to the Medicaid program) setting to provide care for these elders would be in an assisted living home, however, financial feasibility considerations, including the potential for generating adequate revenue to cover operational costs, also must be considered.

[13] http://www.hss.state.ak.us/dsds/rural/home.htm

Financial Feasibility of the Proposed 40-Bed Facility Expansion

It is clear from Table 4.5 that both the 20-bed assisted living home and the 20-bed nursing home envisioned in the concept design will not be needed and will not generate occupancy levels (and revenue) high enough to "break even" and insure continuing operational support. According to the predictions based on statewide utilization rates, the Maniilaq region can expect 17 elders to be in residential placements in nursing homes and assisted living care in 2005. This is consistent with the number of residential placements identified in the recent survey of nursing homes (6 residents) and currently living in assisted living in the senior center (11 residents). Both elder care and assisted living homes must maintain occupancy levels of 85% to 90% to break even with operational costs. This level of occupancy would be impossible to achieve in 40 licensed beds for elders, even with the projected growth of the elder population over the next 20 years.

The allocation of demand between assisted living and nursing care will depend on the type of facility available in the region. Elders who are in the CHOICE waiver category could be served in either assisted living homes or in a nursing home. The least restrictive setting and the lowest cost (to the Medicaid program) setting to provide care for these elders would be in an assisted living home. However, revenue consideration or costs of providing the needed care to Maniilaq may drive alternative considerations. For example based on current utilization of elders in the state, Table 4.5 would predict that 8 elders from the Maniilaq would require care in a nursing home and 4 would be cared for in an assisted living home, but 5 elders could be cared for in either an assisted living or nursing home. Clearly, caring for the 5 in a nursing home would allow occupancies levels that may allow a nursing home to be supported, while, without these individuals, it would be impossible to operate a nursing home successfully. In general, elders will generate significantly more revenue residing in a nursing home than in an assisted living facility, as per diem nursing home rates in some small rural facilities currently exceed $600 per day, when an assisted living home with a CHOICE waiver for the client would only be paid about $185 per day.

Other Alaska Rural Models for Care

In Table 7.1, below, the populations of elders in the regional health corporation areas of western Alaska are provided. All of these regions have cultural and demographic factors and health service systems, which have strong similarities to the Maniilaq region, and each of these regions has made elder care a priority for development. As the table demonstrates, there are assisted living facilities in Kotzebue, Barrow and Dillingham. The Barrow facility houses 7 seniors. It is operated by the NSB, and none of the seniors are eligible for Medicaid CHOICE waivers. This facility is supported with general revenue from the North Slope Borough and limited contributions from private funds of the elders residing in the facility. Faced with declining revenues, the NSB is actively working to try and refinance some costs of the facility away from general tax revenue. Bethel, with the largest population of elders, does not currently have either an assisted living or nursing home in the region, although, a multi-organization group of providers has been working to develop assisted living services. The YKHC, which will own and operate the assisted living home, is currently planning to start construction of a new 18-bed assisted living unit this spring.

Table 4.6
Elders in Western
Alaska in Assisted Living and
Nursing Home Care in Region*

Region	*Population >65 2000 census*	*Assisted Living in region***	*Nursing Home in region*
Maniilaq Region (Kotzebue)	390	10(0)	0
Bristol Bay Region	400	11(9)	0
NSB w/o Point Hope (Barrow)	277	7(0)	0
Yukon Kuskokwim Region (Bethel)	1264	0	0
Norton Sound Region (Nome)	540	0	15

*Census was taken in January 2004. ** Number of assisted living residents on CHOICE waivers is reported in parenthesis.

Maniilaq has a similar sized elder population to that of the Norton Sound and Bristol Bay Area, and these two areas take distinctly differing approaches to providing care for regional elders. Because of the similarities of the regions, both models offer some insights to what may be available to Maniilaq.

Norton Sound Region

The NSHC region is very similar to the Maniilaq region, although it has about 40% more elders living in the region. The NSHC has operated a nursing home in the Norton Sound region for over 20 years. It co-located with the Norton Sound Hospital and has 15 licensed beds. The nursing facility has consistently had high levels of occupancy and is usually fully occupied with one or two individuals on a waiting list. The facility has a much lower turnover among residents (a few short-stay, younger rehabilitation patients) than the average nursing home in the state. All residents of the NSHC home are elders, many over 80 years old, and most are permanent residents of the facility. Increasingly, the facility is faced with increased staffing demands to deal with dementia among the patients as the average age of the resident population continues to increase.

The revenue for the Norton Sound Nursing Home comes almost exclusively (98%+) from the Medicaid program. All residents are eligible for Medicaid and the facility is reimbursed at the approved per day rate, which is currently $631 per patient per day. Non-capital operational costs of the program are approximately 2.1 million per year. NSHC has consistently been able to operate the nursing home in the black and provide a safe and effective program on the revenue received from the Medicaid program with some funding remaining for depreciation and replacement of the capital plant.

There is no assisted living facility in Nome, although there is a current group of human services providers meeting to examine the need and feasibility of establishing one.

Bristol Bay Region

The Bristol Bay region is also very similar to the Maniilaq Region and has almost exactly the same size population of elders. Dillingham, the regional

center, also services the service hub for almost 32 regional villages. The Bristol Bay region has no nursing home facility and no plans to construct a nursing home, but it does have a newly constructed assisted living facility named Marrulut Enitt (Grandmother's house).

Marrulut Enitt opened in February of 2000 after almost 3 years of planning and development by Dillingham governments (both tribal and city) and regional health and human service providers. The facility is operated by a new non-profit organization, which was created expressly to own and operate the home, which is its only activity. The board of the non-profit draws membership from the regional housing authority, health corporation, native corporation, city government, Dillingham tribal government and elders from the community.

Although originally licensed for 10 beds, the number of licensed beds was increased in 2003 because the 10-bed facility did not create enough revenue to support the operation of the home. The capacity expansion was accomplished by increasing occupancy of the existing units and no capital expansion was necessary. The facility is a stand-alone facility located close to the senior center and independent senior housing in the community. It cost a total of $2,323,645 to build.

Marrulut Enitt was constructed with grant funds from Indian Community Development Block Grants, Alaska State Housing program and other small planning grants. It does not have a grant to support the facility however; revenue comes exclusively from charges to residents for room and board and Medicaid CHOICE waivers. The facility charges about $9,500 per resident per year for room and board. In addition, for each resident that has qualified for a CHOICE waiver under Medicaid, the home receives $49,275 per year based on the per diem Medicaid rate of $135 per day for these clients. The facility utilizes the cost reimbursement approach for negotiating the Medicaid CHOICE per diem rate. The facility strives to admit only CHOICE eligible seniors. Currently, the facility has an occupancy level of 11 residents of which 9 are qualified for Medicaid payments under CHOICE waivers.

The facility is staffed with a manager, assistant manager, 7 caregivers and two cooks. It has no mortgage or debt service and the annual operational budget is around $650,000 per year. It has operated with small operating losses ($40,000 to $70,000) for the first two years of operation. This loss was reimbursed by the sponsoring agencies. The facility director reports that they project that the facility needs 10 senior residents on the CHOICE program to break even. With the recent expansion of licensed capacity, the facility expects to break even in the current year of operation. Management is concerned with keeping occupancy levels at the break-even basis. However, 11 is the highest occupancy level that has been achieved since opening, and there is not an active waiting list. In addition, some of the residents now in the facility come from the YKHC service area, and the development of a new competitive facility in Bethel may impact the ability of the facility to achieve needed occupancy levels to break even.

Discussion

The differences in the approach to providing care for the regional elders in Norton Sound and Bristol Bay are an artifact of the time periods when the respective programs were developed. The Nome nursing home, Quyanna Care, opened over 20 years ago before the development of the current model of care of elders in the state, which relies heavily on assisted living facilities, and before the Medicaid program would support residents in assisted living facilities under "waivers". The Nome model has been successful financially due to the high levels of reimbursement for nursing home care in small rural facilities, but has undoubtedly resulted in some elders living in a nursing home who could do fine in a less restrictive setting of assisted living. The model may also leave a small segment of the elder population who need some assistance with the activities of daily living, but do not qualify for nursing home care un-served, due to the lack of an assisted living facility in the community.

The Dillingham model, in contrast, has provided care for elders in the least restrictive, most homelike setting. It has provided care for elders who, for the most part (9 of 11 residents), could be eligible for care in a nursing home, and at much lower cost (less than a third) than in a nursing facility. The model, although hopefully successful in the long-term, has been only marginally successful financially to this point, losing money in two out of three years since opening. The model relies on a sole purpose, non-profit agency to operate it, allowing it to operate at lower cost without the more extensive overhead of the local government or regional health and human service entities. This non-profit, however, was organized to insure the commitment of the larger health and human service organizations to provide funding when the facility operates at a deficit. For the first two years of operation these entities funded operating deficits from $40,000 to $60,000.

This model will also not serve the most fragile of the region's elders, who can only be supported in nursing homes due to their fragile condition and complex health care needs.

Other Models for Village Based Senior Care

Village-based senior care has relied on the provision of home and community-based support services. Although several smaller villages have engaged in planning and sometimes in design of assisted living facilities, assisted living has only been provided successfully in one level I village, Tanana. This facility was constructed by TCC in the old PHS hospital in Tanana when the hospital was closed. It was conceived and designed as a regional facility and has served elders from about half the TCC region, which is about 15 villages located primarily in the Fairbanks and Galena subregional areas. It has 12 licensed beds and has been the only other facility, besides the Maniilaq Senior Center, in the state supported with an operational grant from the State Division of Senior and Disabilities Services. Like the Maniilaq senior center, it currently has a declining occupancy, with only 6 residents, and is also threatened with the reduction and curtailment of the state grant supporting the facility. The director of this facility felt that continued operation after the elimination of state grant funding was unlikely, as they did not feel the facility could generate sufficient revenue from charges and Medicaid to support the cost of running the facility.

Galena, a small village of about 675 located on the middle Yukon river, is currently planning a 9 bed assisted living facility. As a sub-regional center however Galena hopes to serve the entire Yukon-Koyukuk sub-region which has 7 Alaska Native villages and about 1900 people. It has received the first phase of a capital construction grant from the Denali Commission.

Port Graham, a small level I village with 176 residents, is one of the smallest rural villages to try and develop senior housing. With assistance of the North Pacific Rim Housing Authority, which funded and will maintain the facility, Port Graham has constructed a multi-use senior housing. Because of the very small village size and variability of demand for senior housing, the facility is designed with three separate units to offer flexibility, which could include a live-in caretaker and senior independent living and/or assisted senior living. The facility opened in 2003, but, as of recently, there have not been any senior residents in the facility. Therefore, the success of this model cannot be evaluated at this point.

The models for providing assisted living in small villages remain undeveloped and very high risk. The lack of consistent demand for services, the lack of more sophisticated health care facilities in the community to support the elder clients and the very small facilities with out economies of scale all make development assisted living in villages difficult.

CHAPTER 5- OPERATIONAL COSTS, REVENUE AND FINANCIAL FEASIBILITY OF THE PROPOSED ASSISTED LIVING HOME

Maniilaq has operated an assisted living home for over 15 years in the senior center. Maniilaq has relied on a direct grant from the Division of Senior and Disabilities Services to support this program. Grant support for assisted living is a very unusual situation. Statewide, only 2 of 151 licensed assisted living homes have received an operational grant from state funds to support the facility. Last year, the Maniilaq was notified that this grant, which had been recurring at a static level for some years, was going to be reduced next year and eventually phased out. This will require Maniilaq to generate all operational revenue from resident fees and Medicaid payments like other assisted living facilities in the state. The state has urged Maniilaq to quality residents in the assisted living program for CHOICE waivers to obtain income to replace the phase out of the direct grant. To date, despite increased training the in the waiver process by the state and active outreach programs to the regions elders, Maniilaq has been unsuccessful admitting seniors that qualify for Medicaid CHOICE waivers.

Over the past 4 years, occupancy levels have fallen, while, at the same time, overall costs have increased. In addition, the census of Medicaid CHOICE resident has dropped from a high of 5 in 1997 to 0, currently.

Operational Costs

Costs incurred in operating the Senior Center/Assisted Living program have been increasing over the past 4 years despite the decline in the numbers of elders living in the facility. In FY2003, the total cost of operation of the Senior Center programs was very close to 1.9 million dollars. In early 2004, the assisted living program underwent a series of budget reductions to comply with the State of Alaska reduction plan for funding of the Senior Center. This process reduced staffing for assisted living by 9 individuals and reduced the total annual operational budget for assisted living to about 1.7 million dollars (1.36 direct costs and the required indirect cost allocation).

Even with these costs reductions, the per day costs for each elder in care is now over $450 per day- more than the cost of nursing home care in most Alaska nursing homes and facilities and more than two and a half times the highest daily rate in rural assisted living facilities providing care through the Older Alaskan Waivers program of Medicaid.

Revenue

Currently, the assisted living program relies on a grant from the State of Alaska ($863,000) for a substantial portion of operational support. The remaining revenue used to support the program included resident room and board charges (about $80,000 a year) and a collection of smaller grants for traditional foods, and caregiver services, etc. A substantial operational deficit is funded from miscellaneous, unrestricted revenue provided by the IHS to operate the Maniilaq Medical Center, or generated by other Maniilaq health programs (over $578,000). However, this is not revenue that is generated by the facility- this revenue will be received by Maniilaq whether or not the facility is operated. Even with the current reduced budget and the state grant to

support the assisted living program, the program is generating a $578,000 operational loss, or shortfall, in revenue to cover the operational costs of the facility.

Table 5.1
Sources of Revenue for Maniilaq Assisted Program – 2004

Type of Revenue	*Program Income*	*Maniilaq Discretionary Revenue*
State Senior Assisted Living Grant	$863,000	
Other State and Federal Grants	$197,000	
Medicaid CHOICE waivers	$0	
IHS Health Center discretionary funding*	$0	
Client rent and food payments	$80,000	
IHS and Admin revenue		$578,000
Subtotal	$1,140,000	$578,000
TOTAL REVENUE		$1,718,000

The State Senior Assisted Living grant, the largest source of revenue that is received to support the current program, is now threatened and will certainly not continue at current levels, and, probably, will be phased out all together. Maniilaq is one of only two tribal organizations that receive state grants funds to support assisted living, and the DHHS has informed Maniilaq that the state grant support for this program is likely to be phased out over the next few years due to declining state resources. The current state fiscal situation and the emphasis on refinancing "general fund" health services with Medicaid funding make it very unlikely that this decision by the state will be reversed, and that this grant funding will be available to support assisted living care into the future.

Table 5.2
Average Components of the Per Diem Rate In Assisted Living Facilities in Rural Alaska - 2004

Daily Rate Calculation	*Non-waiver*	*Waiver patients*
Food Component	$13	$13
Lodging Component (average)	$15	$15
Waiver Component	-	$150
Estimated Daily Rate	**$28**	**$178**

To replace the lost revenue from the direct grant, Maniilaq must rely on per diem payments from clients and from the State Medicaid Program when the residents can be qualified for a Medicaid waiver. The rates from this source

of revenue, however, are well below the current cost of caring for elders in Maniilaq assisted living, which is now over $450 per day. The State has been encouraging Maniilaq to reduce costs and admit elders who are eligible for Medicaid payments in the home under the Older Alaskan Medicaid Waiver (CHOICE) process. This program allows Medicaid to pay for lower cost, less restrictive care in an assisted living home for individuals that would otherwise have qualified for nursing home care. It allows the State to make Medicaid payments to assisted living homes for elders who are *eligible for care in nursing homes*. These elders normally require higher levels of care and the Maniilaq Assisted Living program has been unable to admit or qualify a significant number of residents for this payment source.

Table 5.2, below, shows the expected revenue that Maniilaq can expect to receive under the current assisted living payment rate structures if the existing state-assisted living grant of $863,000 is eliminated. The first row shows the revenue if no elders in a 20-bed facility are eligible for choice waivers, which is the current situation, at 50 % occupancy. The total revenue would be only $102,000, leaving large, un-funded deficits of almost 1.6 million for each year of operation.

In this scenario, Maniilaq would be using discretionary funding of 1.6 million dollars a year, or $160,000 for each elder in the assisted living home. That would mean the funds would not be available to provided the health care that they were intended to provide, or, in the worst case scenario, could threaten the financial health of the entire corporation. Larger numbers of CHOICE waiver patients would slightly improve the balance sheet, but not enough to take the program out of deficit-- even in the most optimistic scenarios. In a completely full facility (20 beds filled) in which 19 of the residents were qualified for CHOICE waivers, the facility would still only generate about 1.2 million in revenue– leaving a continuing annual deficit of almost half a million dollars under the most "rosy" revenue scenario.

Table 5.2
Expected Revenue from 20-Bed Assisted Living Facility with Various Levels of CHOICE Eligible Residents and Various Occupancy Levels

	Occupancy Levels			
Percentage CHOICE Waivers	***50%***	***75%***	***90%***	***100%***
No Choice Waivers	$102,200	$153,300	$183,960	$204,400
50% CHOICE waivers	$375,950	$563,925	$676,710	$751,900
95% CHOICE waivers	$622,325	$933,488	$1,120,185	$1,244,650

These deficits may well force the closure of the existing assisted living facility if the State grant is withdrawn. Moving the program into a proposed new facility co-located with the Maniilaq Medical Center[14] will not change this

[14] Although nursing homes collocated with small rural hospitals is a common model across the state the benefits of attaching an assisted living home to a hospital are much less clear. There are no assisted living homes currently attached to a hospital or operated by a hospital.

economic reality. Moving the program will not materially reduce the operational budget, and it will substantially increase the operational budget if the non-grant capital costs of construction of the new assisted living facility are fully amortized in the cost structure. If the Maniilaq received a 50% grant from the Denali Commission to support the construction of a new assisted living home attached to the hospital, the cost of depreciation and interest on the assisted living home would be about $361,000 per year. Thus, the construction of new facility would add over $50 dollars per day to the cost of providing care for each resident (Appendix A) in the new facility.

Table 4.5 illustrates that many elders could qualify under Medicaid for care in either an assisted living setting with CHOICE waivers or in a nursing home. The elder population in the Maniilaq region in combination with the cultural traditions and the wishes of the region's elders means that it is very unlikely that there will be enough elders in need of care to fill both an assisted living and nursing home of the proposed size. In this case, the qualification of nursing home residents for assisted living waivers, and the placement of these elders in the assisted living home, will reduce the occupancy of the nursing home below sustainable levels and the total revenue provided to Maniilaq to support senior residential services.

Given this situation, it is unwise to make a large capital investment in a new assisted living facility, which would be attached to the Maniilaq Health Center. Rather than construct a new assisted living facility, Maniilaq should focus on trying to achieve continuing costs savings and revenue enhancements in the operations of the current program in the existing facility.

In conjunction with these efforts, the Maniilaq may explore other avenues to insure continued provision of assisted living in the Maniilaq region after the current grant funding is eliminated

Alternative Models for Assisted Living

If Maniilaq develops a Nursing Home in the region, it will diminish the demand for assisted living for elders that qualify for nursing home care. On the other end of the care continuum, more independent senior housing may also reduce the need for assisted living services in the region, especially if supported with home care attendants and other home and community-based services. Even with additional development of these programs, however, it is possible that there would continue to be a demand for a small number of assisted living placements in the region, but it will be well below the 20 beds contemplated in the current facility or the concept design.

Two models appear to present themselves for some consideration. The first would be the type of program currently operated in Dillingham, which relies on a sole purpose; non-profit organized solely to provide assisted living care. This model has the advantage of not burdening the assisted living provider with the salary structure and more extensive overhead costs of the regional corporation, while, if appropriately organized, still provides some support from these entities. Dillingham has demonstrated, however, that the number of elders needed to support this type of facility is over 10, and a high proportion of resident need to be on Medicaid waivers. Table 4.5 indicates that this level of demand for assisted living care is unlikely to be attainable in

the next 15 years based on current utilization patterns and the projected growth of the elder population in the region.

The second potential model would be for Maniilaq to provide limited financial support to stimulate the development of small, privately owned assisted living homes in the region. Statewide, there are over 109 small (usually 6 beds or fewer) assisted living homes in operation, which are operated by private individuals for profit. This model, while common in urban and suburban areas of the state, has not become established in rural "bush" areas. Bush areas appear to have several barriers to developing this type of private response to demand for assisted living care. These include: the high cost of space in bush areas, lack of training in the business aspects of the industry and limited demand for the service in many areas because of public providers of service.

For a limited amount of funding and long-term assistance in training and quality management and support services, Maniilaq may be able to foster the establishment of private assisted living homes in Kotzebue, without incurring responsibility for ongoing operations of these homes. This may be a more cost-effective means of offering this service in the region and to completing the continuum of care for seniors, especially if a nursing home is established in Kotzebue for individuals in need of higher levels of care.

CHAPTER 6 - OPERATIONAL COSTS, REVENUE AND FINANCIAL FEASIBILITY OF A NURSING HOME

The following provides an updated analysis of the estimated operational budget and the projected Medicaid rate calculations for a 15-bed nursing home of the recommended size. Many of these estimates were provided in the "Needs Assessment and Service Options for Elders of the Maniilaq Region," by Mather and Associates in 1997. These earlier estimates have been updated to reflect the capital cost estimates in the NANA/DOWL design study, the revised projections for demand for nursing home care and the changes in the Medicaid rate setting regulations over the past 6 years.

The staffing plan was updated and based on current staffing levels of the 15-bed, co-located Quyanna Care Center in Nome. Recommended staffing levels were also reviewed to insure compliance with the State of Alaska licensing regulations. The staffing budget prepared was based on the existing salary structure of Maniilaq.

Assumptions regarding shared services and staffing supplements for existing hospital departments were developed, based on earlier recommendations and the assumptions in the Concept Design document.

Operational Costs

Staffing for the center includes: one director/administrator, additional nursing and nurse aide staffing, and part-time staffing for an activities director and social work associate. These positions can be shared with the Senior Center or employed on a part-time basis. Staff to provide the necessary support in dietary, housekeeping and maintenance will be integrated into existing hospital staffing for those services, with the additional costs allocated to the nursing home via the Medicare cost report. Table 8.1 summarizes the staffing requirement and other operational costs for a 15-bed, co-located facility.

The location of the nursing home with the Maniilaq Medical Center would allow existing hospital personnel and facilities to provide dietary support, housekeeping, maintenance, laundry and business office services. Co-location will also provide additional flexibility in nursing staffing, as the current pool of acute care nursing can be supplemented to deal with the addition demand for RN's. Management in a co-located facility could also utilize many of the existing systems for financial management, billing and preventative maintenance.

Co-location of the nursing home with the Maniilaq Medical Center provides many additional advantages, as a wide range of professional staff at the hospital will be available for consultation and support on a daily basis. Professional staff can be integrated into the training and professional development programs at the hospital, and the hospital staff will have a sense of "ownership" in the facility, due to the proximity and close association with the nursing home professional staff.

Table 6.1
Estimated Operating Costs
15-Bed Nursing Home

Budget Category	*Total Costs*	*Cost Allocation*
Salaries		
LTC Director (Assistant DON)	$70,000	$70,000
Nursing (4 FTE, RN's, LPN's)	$240,000	$240,000
CNA/Restorative Aides (14.5 FTE)	$440,000	$440,000
Social Work Associate (.5 FTE)	$33,000	$33,000
Activities Director (.5 FTE)	$24,000	$24,000
Support Staff (2. FTE)	$70,000	$70,000
Fringe @ 28%	$245,560	$245,560
Supplies		
Misc.	$45,600	$45,600
Food	$65,000	$65,000
HOSPITAL SERVICES- (allocation of costs)		
Housekeeping ($1.10/sq. ft/mo.)	$138,798	$138,798
Utilities ($1.45/sq ft/mo.)	$182,961	
Maintenance ($.60/sq. ft/mo.)	$75,708	$75,708
Dietary Services	$47,400	$47,400
Laundry Services	$22,000	$22,000
Bus. Office/Medical Records	$20,000	$20,000
Ancillary Services		
PT/OT Therapy Consultants	$50,000	$50,000
Speech Consultant	$15,000	$15,000
Dental/Medical/Pharmacy	$25,000	$25,000
General Corp. Admin. (Exec. Dir. finance, personnel, procurement)	$100,000	
Total expense without capital cost	$1,910,027	
Loan payment capital costs	$424,093	
IDC allocation		$667,097
Total expense	$2,334,120	$2,294,163

Start-Up Costs

The above budget is based on the projected recurring operational expenses of the facility. There will also be certain start up costs, which will have to be incurred within the first year of operation. Although capital costs estimated in the prior chapter include the costs of all capitalized equipment and fixtures, start-up costs will be also be incurred to establish inventories, as well as develop financial, management and other systems necessary to the successful operation of the facility. Maniilaq financial systems will have to be revised to support the preparation and development of a Medicare cost report on an annual basis, as this is necessary to support the Medicaid rate for services. In addition, there will be substantial start-up cost for training and

recruitment of personnel. The total amount of these costs is difficult to determine, as some may be incorporated in the operational budget for the first year. A total of $100,000, however, would be a prudent reserve for these costs.

Medicaid Rates for the Maniilaq Nursing Home

Without a doubt, the primary source of operational revenue for the Maniilaq nursing home will be the State Medicaid program. Currently, 85% of all nursing home residents in Alaska are supported by the Medicaid program. In Nome, which has a resident population that is economically and culturally similar to the Maniilaq region, and, in the Maniilaq nursing home operated earlier as part of the Senior Center, the Medicaid placement rate has been consistently even higher than the state average, usually accounting for well over 95% of the revenue from the facility.

Medicare, which provides 100 days of post-acute nursing home care as a lifetime benefit, is another potential option for limited revenues. There are significant operational difficulties that accompany Medicare certification. Currently, some small rural nursing home operators feel that the additional revenue generated by Medicare certification does not compensate for the burden imposed on the facility. Medicare only pays for skilled nursing care, so, Medicare eligible residents are usually more resource intensive. Medicare caps reimbursements substantially below the state Medicaid rate caps, and requires levels of care that exceed state standards, which are frequently not available in small rural facilities (such as daily OT and PT services).

Medicare certification also substantially slows collection of revenue for patients who are both Medicare and Medicaid eligible, as the nursing home is required by state regulation to make every effort to collect from Medicare (at a lower rate) prior to billing the state Medicaid program.

Because of the limited private resources and the difficulties in collecting for Medicare, these sources of revenue are not likely to be material to the overall revenue available to the facility.

Medicaid Rate Calculations

Medicaid rate calculations were developed for a 15-bed, co-located facility and projected over a 4-year period. Rates were calculated assuming debt financing (debt financing assumes a 25% down payment) of the facility's capital costs.

The Medicaid rate is broken down into three major components-set prospectively. These are based on actual costs in the nursing home and are subject to certain limitations.

The routine component, which is the largest component, covers all routine operational costs of the nursing home, including: dietary, nursing, housekeeping, administration and facility operating costs.

The ancillary component is for medical and therapy services provided to residents. These costs are fully reimbursed.

The capital costs are all depreciation, lease, rental, and interest costs for the facility and equipment. Interest costs are computed according to actual interest cost incurred. Depreciation is computed by straight-line method over the useful life of the equipment.

Rate calculations for start up facilities have several exceptions to these rules for the first two years of operations.

The statewide swing bed rate ($329 in 2004) is used less the capital component of the rate ($45 in 2004).

If the facility holds an approved certificate of need, the capital rate for the first year is computed according to the normal capital rate methodology, using the approved amount in the certificate of need as the capital basis. In the first three years of occupancy, however, the rate approved will be based on an occupancy rate of 80%, or the rate approved in the CON. The method is unclear if no Certificate of Need is required, but the calculations below rely on the capital cost estimates provided in the concept design.

In the Omnibus Budget Reconciliation Act of 1997, Congress repealed the Boren Amendment to title XIX. This amendment had required states to pay reasonable cost for nursing home care. This change in the federal law, coupled with the current state revenue shortfall and the escalating cost of small rural nursing home costs15, creates a very uncertain environment in which to estimate revenue from a new nursing home.

Maniilaq should be very cautious in proceeding with an investment in long-term care beds. If Maniilaq determines it does wish to proceed with the planning of a co-located nursing home facility, it should continue to monitor the Medicaid reimbursement environment and encourage the State to develop a special LTC rate for tribally-operated facilities during the planning of the facility to insure that changes in the rate setting regulations support the Maniilaq nursing home and do not radically reduce the revenue that may be available to support the facility.

Table 6.2 provides Medicaid rate projections over a four-year period for a 15-bed, co-located facility. The table estimates the year 3 and year 4 rates based on the average current rate for Nome, Cordova and Sitka, which are three small, long-term care facilities with similar cost characteristics.

[15] The Medicaid Rate Commission recently received a rate application requesting a per diem rate of $930 per day for a small rural facility. This compares to the nationwide average cost in 2000 of about $195 per day (http://www.nursinghomeresourcecenter.com/facts/).

Table 6.2
Medicaid Rate Projections for a 15 Bed Facility

Daily Rate Calculation	*Year 1*	*Year 2*	*Year 3*	*Year 4*
Swing Bed Rate	$329	$339	na	na
Capital Component SB rate	($45)	($47)	na	na
Allowable Depreciation and Interest	$129	$129	$129	$129
Estimated Daily Rate	**$413**	**$421**	**$614**	**$632**

Years 1 and 2 are based on current rate methodology. Years 3 and 4 are based on current averages of rate for Nome, Cordova, and Sitka facilities for year 3 and 2% growth for year 4.

As Table 6.2 demonstrates, the use of the swing bed rate, instead of true costs, for the first two years of operation will provide a severe financial penalty to Maniilaq, as the costs of operation will be substantially in excess of what will be recovered under this rate. Maniilaq could request "exceptional relief" from the Deputy Commissioner of Health and Social Services under the regulations based on demonstrated costs in excess of this reimbursement level. This relief may be granted, however, it is entirely optional with the commissioner whether to do so.

The proposed IHS/tribal-specific long-term care rate may also provide some relief from the start-up deficits calculated in table 6.2 above, depending on the methodology adopted by the state. The State is currently refinancing as much care as possible under Medicaid by encouraging tribal organizations to develop the capacity to provide more Medicaid reimbursed services in rural areas, therefore qualifying for 100% federal payment of the costs of this care.

Revenue and Expenses

Revenue and expenses for a 15-bed, licensed nursing home are projected in the table below. Revenue is dependent on the occupancy level of the facility. The revenue estimates below are based on occupancy levels of 60% for the first year (9 beds). This is above the current number of elders in nursing homes that were identified in the last survey and this may be hard to achieve, as it will require immediate transfer of all existing patients from the Maniilaq Area to the facility as well as the identification of additional patients in the hospital or from other regions. For the second year, the estimate is based on increasing the occupancy to 10 beds, or 66%, and for the 3rd and 4th years to 12 beds, or 80%.

In Table 8.3, the revenue and expenses for the proposed facility are projected for the first four years based on the assumptions defined above. An analysis of this table indicates that the nursing facility could expect a negative cash flow in the first two years of operation of about $1,841,000. This deficit is caused by the low routine rate in which the facility would be operating under, until it had adequate historical cost for a Medicare cost report. This projected deficit is also based on the relatively low occupancy of 60% to 66% for the first two years of operation.

It is likely that some minor savings could be achieved with less staffing required at lower occupancies, and or revenue could possibly be increased slightly with higher occupancy levels. However, these savings and increases in revenue would probably not be sufficient to materially reduce the expected deficit below.

Table 6.3
Estimated Revenue and Expenses
for a 15-Bed, Co-located Nursing Facility

	Year 1	*Year 2*	*Year 3*	*Year 4*
REVENUE (Medicaid Collections)	**$1,356,705**	**$1,536,650**	**$2,687,860**	**$2,768,496**
Operating Expenses	$1,910,000	$1,976,850	$2,046,040	$2,117,651
Capital Costs (loan pay't.)	$424,093	$424,093	$424,093	$424,093
Total - Operating Costs + Loan Amortization	**$2,334,093**	**$2,400,943**	**$2,470,133**	**$2,541,744**
CASH FLOW	***($977,388)***	***($864,293)***	***$217,727***	***$226,752***
Non Funded Depreciation	$129,582	$123,466	$117,013	$110,205

If Maniilaq was successful in achieving exceptional relief from the initial rate, or, if the state established an LTC rate that was specific to tribal facilities and did not impose the reimbursement penalty that the current new rate process imposes on small facilities and allowed for the capture of true costs of care in this period, the deficits in the first two years described above could be

reduced significantly, or, perhaps, even eliminated if 80%+ occupancy levels could be achieved quickly.

Capital Funding of Nursing Home

Maniilaq intended to pursue a Denali Commission grant to construct the nursing home. Denali Commission, by statute, is only allowed to fund capital projects up to 50% in non-distressed areas. So, if the application were awarded it would require Maniilaq to provide at least half the cost of the project as match from cash reserves or loans or other grant sources.

In addition, the Denali Commission, which has been working closely with the State of Alaska Rural Elder care program, has prioritized the construction of assisted living facilities and has not included nursing home construction as an eligible category for funding. The current round of financing in FY2004 does not include nursing homes as an eligible funding category.

This means Maniilaq will have to rely on cash and debt financing to construct the new facility. Financing the construction of a nursing home would also require that Maniilaq have the reserves necessary to cover the required down payment for the loan. Maniilaq can probably obtain loan/value ratios of about 75%. When financing cost and prudent reserves are added to the required down payment, a total of at least 2 million dollars of discretionary funds from the Maniilaq reserves will have to be budgeted for the project prior to beginning the capital planning.

The most economical method of financing for Maniilaq would be to utilize the non-profit status of the corporation to issue tax-exempt bonds. This was discussed thoroughly in the previous report and these findings remain applicable.

Summary

In summary, as was reported in the earlier report, it remains impossible for Maniilaq to start up a nursing home without significant operational reserves to fund anticipated operational losses, which will be incurred primarily in the first two years of operation. In the third year of operation, the nursing home should be able to generate adequate revenue to be self-sustaining over the remaining term of operation.

Anticipated operational reserves, which would be required to initiate nursing home services, would be approximately 1.9 million dollars under the current Medicaid rate setting environment. If Maniilaq was successful in pursuing higher Medicaid rate through an application to the Deputy Commissioner for exceptional relief, or, if the State provided for a special rate setting mechanism for tribally operated facilities, the anticipated reserve could possibly be reduced. However, it is highly unlikely that the initial operational deficit could be eliminated due to the risk in achieving the occupancy levels needed to break even in the first year or two of operations.

Table 6.4 provides a summary of the prudent financial reserves that Maniilaq should have available and dedicated to the nursing home project. The entire

amount of reserves may not be necessary. However, to enter into the project without prudent reserves would not be recommended.

Table 6.4
Recommended Project Reserves

Type of Cost	*Budget*
Capital Project Reserves	$2,000,000
Operational Reserves	$1,900,000
Start Up/System Development Costs	$100,000
TOTAL RESERVES	$4,000,000

Undertaking the construction of a nursing home without the necessary reserves would not be prudent. Maniilaq may be able, over time, to recover some of the capital and start-up costs, by capitalizing the costs and incorporating them into the rate base. However, recovery of these investments will take many years.

If Maniilaq determines it wishes to proceed with the construction of a nursing home, it needs to identify and commit approximately $4,000,000 in corporate reserves to this purpose. This could be reduced if capital grants were obtained to fund the down payment on the facility and if the State of Alaska developed a special rate for nursing homes in tribal facilities.

CHAPTER 7- PLANNING FOR A NURSING HOME

Locating a nursing home (or assisted living) facility attached to the Maniilaq Medical Center raises several issues regarding ownership, capital financing and the Medicaid rate of the facility. These issues were discussed in detail in the earlier report, "Needs Assessment and Service Options for Elders of the Maniilaq Region."

Maniilaq must resolve these issues in cooperation with the State of Alaska and the Indian Health Service to proceed with the collocation of the facility. This coordination will probably add significantly to the project development and planning time line.

The acute care facility in Kotzebue is a new 85,000 square foot, steel-framed building, which was recently constructed by the Indian Health Service. Although the facility is operated by the Maniilaq Association under a P.L. 93-638 Self-Governance compact, it is owned by the federal government. The Maniilaq P.L. 93-638 compact and the annual funding agreement contain provisions, which allow Maniilaq to utilize the hospital for the purposes defined in these documents. Title to the hospital physical plant, however, remains with the federal government and is subject to federal statutes and property regulations.

The federal ownership of the facility would require that the IHS be involved early in the planning process for an attached nursing home. It was the intent of Maniilaq to construct the facility on federal property and gift the facility to the federal government. The contracts would also require that the IHS review and approve the proposed alterations in the Medical Center prior to the renovations being completed.

If IHS provides permission to site the nursing home wing on federal property, when completed, the nursing home will have to be gifted to the Indian Health Service. Recently, the agency has been involved in updating the procedures for accepting gifts and the Office of General Council for the IHS has determined that the agency does not have authority to accept gifts with a value over 1 million dollars. Therefore, the agency would, under current statues, have the authority to approve the construction of a collocated facility– it would have to be negotiated with the Assistant Secretary for Health.

Despite the authorities provided in the Snyder Act and the Indian Health Care Improvement Act, the provision of nursing home care is significantly outside the scope of the services the IHS is providing to AI/AN. Because the agency may perceive the ownership of a nursing home as an expansion of responsibilities in an era of very restricted resources and increasing demand, it may be reluctant to accept the nursing home as a Federal IHS facility.

The most expeditious means of resolving the property issues raised by the attachment of the nursing home wing to a federal IHS hospital would be to engage the assistance of the Alaska Congressional Delegation, who could

provide statutory authority during the annual appropriation processes to the agency to permit the construction of the facility on federal property and for the agency to accept ownership of the addition once it is complete. This would significantly reduce planning time and allow the needed permissions to be obtained in a manner that would not seriously delay the development of the project.

The federal ownership of the facility also raises significant issues regarding the need for a Certificate of Need on the facility. Maniilaq has provided a letter indicating that they did not feel a CON was necessary because of the ownership and exemption of federal facilities from state control. Although the State did not concur with this totally, they permitted the facility to go forward while the question is under review (see Appendix B).

Several tribes and regional health corporations have constructed small facilities on PHS property and have given the facility to the Public Health Service. This approach is appropriate and may provide some advantages for small capital projects, such as a CAT or MRI scanner, when an organization has the capital resources necessary to construct the project, and does not have to finance it. It does, however, create difficulties on larger projects that require capital financing. Because Maniilaq is not likely16 to finance a nursing home wing from existing corporate cash reserves, in the near future it will probably have to be explored.

IHS ownership has one additional implication for financing the capital costs of the facility. If the facility were gifted to the federal government, the operating organization would be unable to utilize a deed of trust on the facility to secure debt financing. This would mean that tax-exempt financing for the facility would not be available without providing some other form of security for the loan, such as pledging the full faith and cash flow of the Maniilaq to obtain a loan.

Medicaid Reimbursement and Rate Setting Issues: IHS Facilities

A federally owned "facility of the service" would be authorized to accept Medicaid payment under the provisions of P.L. 94-437, thus qualifying for 100% federal funding (FMAP).

> Sec. 1911. (a) A facility of the Indian Health Service (including a hospital, nursing facility or any other type of facility which provides services of a type otherwise covered under the State plan), whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in Section 4 of the Indian Health Care Improvement Act), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as it meets all of the conditions and requirements which are applicable generally to such facilities under this title."

[16] Even if Maniilaq were able to finance a nursing home from capital reserves, it would financially disadvantage Maniilaq in the rate setting process.

In addition, under these provisions the payments for services in a "facility of the service" would not be subject to a matching requirement from the state, and would be 100% reimbursable by the federal government. The reimbursement process is governed by Section 1905 of the Social Security Act, which was amended by the original version of P.L. 94-437. This section states:

> Section 1905(b) . . . "Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 percent with respect to amounts expended as medical assistance for services which are received through an Indian Health Service Facility whether operated by the Indian Health Service or a tribal organization..."

The State of Alaska is actively supporting the development of tribal facilities to serve Alaska Natives in rural communities. It has recognized that the provision of care in a federally owned facility will provide benefits to the State as general fund revenues used to support the nursing home are replaced with federal revenue. In response to this, the State is considering the development of a special rate for care provided in tribally operated nursing homes.

Development of a unique rate for tribal nursing homes could also resolve the difficulties the Maniilaq could have completing the full Medicare cost report required under the current rate methodology. A tribal-specific rate could rely on the Method E report, currently completed by all IHS facilities, and avoid the necessity of implementing a hospital-specific chart of accounting system capable of supporting a full Medicare Cost report.

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APPENDIX A

Pro Forma For a 20 Bed Assisted Living Facility

Capital Costs of Proposed Assisted Living Addition -

Assumptions:			
	Price of building		$5,950,000
	site costs		$0
	Financing costs allow. @		$148,750
	Total Capitalized costs		$6,098,750
	Down payment/grant		$3,049,375
	Financed		$3,049,375
	Interest Rate (fixed)		5.5%
	Space		12930
	Number of beds		20
	Occupancy rate		85%
	Depreciation period		31.5
	Finance period		25
	Depreciation	100%	$6,098,750
	Property Tax		$0.00
	Operating cost annual increase		2.5%
	% down payment		50%

YR	Payment	Principle	Interest	Depreciation	Depreciation & Interest	Cost per room per day
1	$227,329	($59,613)	$167,716	$193,611	$361,327	$58.23
2	$227,329	($62,892)	$164,437	$193,611	$358,048	$57.70
3	$227,329	($66,351)	$160,978	$193,611	$354,589	$57.15
4	$227,329	($70,000)	$157,329	$193,611	$350,940	$56.56
5	$227,329	($73,850)	$153,478	$193,611	$347,090	$55.94
6	$227,329	($77,912)	$149,417	$193,611	$343,028	$55.28
7	$227,329	($82,197)	$145,132	$193,611	$338,743	$54.59
8	$227,329	($86,718)	$140,611	$193,611	$334,222	$53.86
9	$227,329	($91,488)	$135,841	$193,611	$329,452	$53.09
10	$227,329	($96,520)	$130,809	$193,611	$324,420	$52.28
11	$227,329	($101,828)	$125,501	$193,611	$319,112	$51.43
12	$227,329	($107,429)	$119,900	$193,611	$313,511	$50.53
13	$227,329	($113,337)	$113,992	$193,611	$307,603	$49.57
14	$227,329	($119,571)	$107,758	$193,611	$301,369	$48.57
15	$227,329	($126,147)	$101,182	$193,611	$294,793	$47.51
16	$227,329	($133,085)	$94,244	$193,611	$287,855	$46.39
17	$227,329	($140,405)	$86,924	$193,611	$280,535	$45.21
18	$227,329	($148,127)	$79,202	$193,611	$272,813	$43.97
19	$227,329	($156,274)	$71,055	$193,611	$264,666	$42.65
20	$227,329	($164,869)	$62,460	$193,611	$256,071	$41.27
21	$227,329	($173,937)	$53,392	$193,611	$247,003	$39.81
22	$227,329	($183,504)	$43,825	$193,611	$237,436	$38.27
23	$227,329	($193,596)	$33,733	$193,611	$227,344	$36.64
24	$227,329	($204,244)	$23,085	$193,611	$216,696	$34.92
25	$227,329	($215,478)	$11,851	$193,611	$205,462	$33.11
	$5,683,223	($3,049,375)	$2,633,848	$4,840,278	$7,474,126	

APPENDIX B

Certificate of Need Exemption

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

FRANK H. MURKOWSKI, GOVERNOR

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

October 8, 2003

Ms. Helen Bolen
Chief Executive Officer
Maniilaq Association
P.O. Box 256
Kotzebue, AK 99752

Dear Ms. Bolen,

On April 18, David Pierce, Certificate of Need Coordinator for the State of Alaska, received a letter of intent from Maniilaq association regarding the nursing home beds you propose to construct and operate in Kotzebue. As of this date it is my understanding that you have not submitted a Certificate of Need for this project.

Subsequently, we received copies of legal memoranda prepared by Myra Munson and R. Scott Taylor addressing the propriety of requiring a Certificate of Need for tribal health facilities. Although we appreciate the effort of your counsel, we doubt the legal conclusions drawn in those memoranda. Specifically, we do not concede that the State of Alaska is without legal authority to require tribal health facilities to obtain Certificates of Need. However, we are undertaking a review of that issue.

As you know, the State is actively looking at the development of tribal health facilities to better serve Alaska Natives in rural communities. In an effort to allow that development to continue, and because there is a legal question as to whether tribal health facilities must obtain a certificate of need, the Department has decided to allow this particular facility to go forward while we conduct our review.

We will advise you of the result of our legal review in due course.

Sincerely,

Joel Gilbertson
Commissioner

cc: David Pierce
Certificate of Need Coordinator

APPENDIX C

Pro Forma
For 15-Bed, Co-located Nursing Home

Capital Costs of Maniilaq Nursing Home Addition -

Assumptions:			
	Price of building		$7,400,000
	Site costs		$0
	Financing costs allow. @		$185,000
	Total Capitalized costs		$7,585,000
	Down payment/grant		$1,896,250
	Financed		$5,688,750
	Interest Rate (fixed)		5.5%
	Space		10515
	Number of beds		15
	Occupancy rate		87%
	Depreciation period		31.5
	Finance period		25
	Depreciation	100%	$7,585,000
	Operating costs/ month (estimated based on existing)		$0.00
	Property Tax		$0.00
	Operating cost annual increase		2.5%
	% down payment		25%

YR	Payment	Principle	Interest	Depreciation	Depreciation & Interest	per room per day
1	$424,093	($111,211)	$312,881	$240,794	$553,675	$116.69
2	$424,093	($117,328)	$306,765	$240,794	$547,558	$115.40
3	$424,093	($123,781)	$300,312	$240,794	$541,105	$114.04
4	$424,093	($130,589)	$293,504	$240,794	$534,297	$112.60
5	$424,093	($137,771)	$286,321	$240,794	$527,115	$111.09
6	$424,093	($145,349)	$278,744	$240,794	$519,537	$109.49
7	$424,093	($153,343)	$270,750	$240,794	$511,543	$107.81
8	$424,093	($161,777)	$262,316	$240,794	$503,109	$106.03
9	$424,093	($170,675)	$253,418	$240,794	$494,212	$104.15
10	$424,093	($180,062)	$244,031	$240,794	$484,825	$102.18
11	$424,093	($189,965)	$234,128	$240,794	$474,921	$100.09
12	$424,093	($200,413)	$223,679	$240,794	$464,473	$97.89
13	$424,093	($211,436)	$212,657	$240,794	$453,450	$95.56
14	$424,093	($223,065)	$201,028	$240,794	$441,821	$93.11
15	$424,093	($235,333)	$188,759	$240,794	$429,553	$90.53
16	$424,093	($248,277)	$175,816	$240,794	$416,609	$87.80
17	$424,093	($261,932)	$162,161	$240,794	$402,954	$84.92
18	$424,093	($276,338)	$147,754	$240,794	$388,548	$81.89
19	$424,093	($291,537)	$132,556	$240,794	$373,349	$78.68
20	$424,093	($307,571)	$116,521	$240,794	$357,315	$75.30
21	$424,093	($324,488)	$99,605	$240,794	$340,398	$71.74
22	$424,093	($342,335)	$81,758	$240,794	$322,552	$67.98
23	$424,093	($361,163)	$62,930	$240,794	$303,723	$64.01
24	$424,093	($381,027)	$43,066	$240,794	$283,859	$59.82
25	$424,093	($401,984)	$22,109	$240,794	$262,903	$55.41
	$10,602,316	($5,688,750)	$4,913,566	$6,019,841	$10,933,407	

APPENDIX D

Current Medical Assistance
Payment Rates

2004 Alaska Medicaid Program

FRANK H. MURKOWSKI, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF RATE REVIEW

4710 BUSINESS PARK BLVD.,
BUILDING F, SUITE 44
ANCHORAGE, AK 99503
PHONE: (907) 334-2463
FAX: (907) 563-7309

MEMORANDUM

TO: P.K. Wilson
Division of Health Care Services

FROM: Neal Kutchins
Rate Review

DATE: February 5, 2004

SUBJECT: Current Medicaid Payment Rates

Effective payment rates as of January 1, 2004, for Alaska Hospital, Nursing Facility, Rural Health Clinic, Ambulatory Surgical Center and Federally Qualified Health Centers Medicaid Providers.

Freestanding Nursing Facilities	Location	Rate	Time frame	
Temporary				
Heritage Place	Soldotna	$218.44	1/1/2004 - 12/31/2004	NO
Mary Conrad Care Center	Anchorage	$281.79	1/1/2004 - 12/31/2004	NO
Providence Ext. Care Ctr	Anchorage	$314.76	1/1/2004 - 12/31/2004	NO
Wildflower Court	Juneau	$421.87	1/1/2004 - 12/31/2004	NO

Combined Facilities		Location	Rate	Time frame	
Temporary					
Cordova Community	Inpatient	Cordova	$1,574.04	7/1/2003 - 6/30/2004	NO
	Outpatient		100.00%	7/1/2003 - 6/30/2004	NO
	(NF)		$642.46	7/1/2003 - 6/30/2004	NO
Fairbanks Memorial	Inpatient	Fairbanks	$1,646.91	1/1/2004 - 12/31/2004	NO
	Outpatient		55.88%	1/1/2004 - 12/31/2004	NO
	(NF)		$382.17	1/1/2004 - 12/31/2004	NO
Ketchikan General	Inpatient	Ketchikan	$1,800.68	7/1/2003 - 6/30/2004	NO
	Outpatient		100.00%	7/1/2003 - 6/30/2004	NO
	(NF)		$552.62	7/1/2003 - 6/30/2004	NO
Norton Sound Reg.	Inpatient	Nome	$2,112.34	10/1/2003 - 9/30/2004	NO
	Outpatient		89.99%	10/1/2003 - 9/30/2004	NO
	(NF)		$631.33	10/1/2003 - 9/30/2004	NO
Petersburg General	Inpatient	Petersburg	$1,890.47	7/1/2003 - 6/30/2004	NO
	Outpatient		100.00%	7/1/2003 - 6/30/2004	NO
	(NF)		$330.60	7/1/2003 - 6/30/2004	NO
Prov. Kodiak Island	Inpatient	Kodiak	$1,973.37	1/1/2004 - 6/30/2004	YES
	Outpatient		62.80%	1/1/2004 - 6/30/2004	YES
	(NF)		$329.07	1/1/2004 - 6/30/2004	YES
Prov. Seward General	Inpatient	Seward	$2,312.17	1/1/2004 - 12/31/2004	NO
	Outpatient		89.72%	1/1/2004 - 12/31/2004	NO
	(NF)		$436.70	1/1/2004 - 12/31/2004	NO
Sitka Community	Inpatient	Sitka	$3,138.33	7/1/2003 - 6/30/2004	NO
	Outpatient		93.66%	7/1/2003 - 6/30/2004	NO
	(NF)		$568.59	7/1/2003 - 6/30/2004	NO
South Peninsula	Inpatient	Homer	$2,185.72	7/1/2003 - 6/30/2004	NO
	Outpatient		80.62%	7/1/2003 - 6/30/2004	NO
	(NF)		$495.55	7/1/2003 - 6/30/2004	NO
Wrangell General	Inpatient	Wrangell	$2,536.90	7/1/2003 - 6/30/2004	NO
	Outpatient		100.00%	7/1/2003 - 6/30/2004	NO
	(NF)		$573.12	7/1/2003 - 6/30/2004	NO

PAGE TWO
Effective payment rates as of January 1, 2004, for Alaska Hospital, Nursing Facility, Rural Health Clinic, Ambulatory Surgical Center and Federally Qualified Health Centers Medicaid Providers

Acute Care Hospitals		Location	Rate	Time frame	
Temporary					
Alaska Psychiatric Inst (psych)		Anchorage	$757.46	7/1/2003 - 6/30/2004	NO
Alaska Reg. Hospital	Inpatient	Anchorage	$2,072.43	1/1/2004 - 6/30/2004	YES
	Outpatient		43.33%	1/1/2004 - 12/31/2004	YES
*Bartlett Memorial	Inpatient	Juneau	$1,636.04	7/1/2003 - 6/30/2004	NO
	Outpatient		81.87%	7/1/2003 - 6/30/2004	NO
Central Peninsula	Inpatient	Soldotna	$1,647.50	7/1/2003 - 6/30/2004	NO
	Outpatient		66.60%	7/1/2003 - 6/30/2004	NO
Charter North (sub.abuse/psych)		Anchorage	$598.10	1/1/2004 - 6/30/2004	YES
Providence AK Med Ctr	Inpatient	Anchorage	$1,699.79	1/1/2004 - 12/31/2004	NO
	Outpatient		45.28%	1/1/2004 - 12/31/2004	NO
*Valdez Community	Inpatient	Valdez	$3,267.00	1/1/2004 - 12/31/2004	NO
	Outpatient		76.58%	1/1/2004 - 12/31/2004	NO
Valley Hospital	Inpatient	Palmer	$2,113.40	1/1/2004 - 12/31/2004	NO
	Outpatient		66.56%	1/1/2004 - 12/31/2004	NO

* Limited per regulations

The Swing Bed Rate for the period 1/1/2004 - 12/31/2004 is $329.21.

Rural Health Clinics	Location	Rate	Time frame	
Temporary				
Iliuliuk Family & Health	Unalaska	$151.20	7/1/2003 - 6/30/2004	NO
Whittier Rural Health Center	Whittier	$113.84	7/1/2003 - 6/30/2004	NO
Yakutat Community Health Ctr	Yakutat	$298.61	7/1/2003 - 6/30/2004	NO

NOTE: Rural Health Clinic payment rates are on a per visit basis.
Long Term Care payment rates are on a per day basis.

Encounter Rate for Core Services: Federally Qualified Health Ctrs	Location	Rate	Time frame
Anchorage Neigh. Health Center	Anchorage	$195.24	7/1/2003 - 6/30/2004
Cottonwood Health Center	Soldotna	$188.75	7/1/2003 - 6/30/2004
Interior Neigh. Health Corp	Fairbanks	$141.76	7/1/2003 - 6/30/2004
Sunshine Community Health Ctr	Talkeena	$240.73	7/1/2003 - 6/30/2004

Alaskan Area Rate Ambulatory Surgical Centers	Location	Rate 1/1/2004-12/31/2004
Alaska Surgery Center	Anchorage	Group 1 - $ 457.08
Alaska Women's Health Services	Anchorage	Group 2 - $ 612.80
Geneva Woods Surgical Center	Anchorage	Group 3 - $ 700.77
Pacific Cataract & Laser Inst	Anchorage	Group 4 - $ 865.15
Anchorage Endoscopy Center	Anchorage	Group 5 - $ 984.82
		Group 6 - $ 928.58 + 150.00*
		Group 7 - $1,368.36
		Group 8 - $1,130.46 + 150.00*
		Group 9 - ***

NOTE: Ambulatory Surgical Center payment rates are on a per group basis.