HB
226
HB228

Feb 25, 1979
1835 Crescent Dr.
Anchorage, AK 99504

MEMORANDUM

To: HESS Committee, Alaska House of Representatives

From: Janette P. Adasiak, Public Member, State Medical Board JA

Re: HB 226 and 228

HB 226 - I am in favor of this bill.

HB 228 - The spirit in which it was written is commendable, but I am opposed to this bill because it is finding fault with the wrong parties. A recent article in the Anchorage Times reveals the reason why some Anchorage physicians (obstetricians in particular) are turning away medicaid patients is the length of time it takes to have claims processed--over a year in some circumstances. They also assert that the amount of compensation is inadequate. I cannot comment on that. However, if problems with the administration of the medicaid program could be worked out the problems addressed by HB 228 would cease to exist. A physician is a businessman like any other, and it would not be fair to force him by law into a practice that was not economical.

PHNP 1566 12.34 JN01 0032 13.02 02/26/79

BOOK OF TWO

Called 263030z #0800

(2541)

BYRON PERKINS PWA 7
OCCUPATIONAL LICENSING
JUNEAU

(3797)

THELMA BUCHOLDT PWA 3
CHAIRMAN OF HOUSE/H&SS
JUNEAU

Called 262044z #3100

HB 223 - PURPOSE OF LEGISLATION OR NEED RESOLVED IS NOT EXPRESSED. REDUNDANT. SEE SENATE BILL 356, 1978. INCLUDES NO LANGUAGE RELATING TO PATIENT INJURY FROM KNOWLEDGE OF DIAGNOSIS. RECOMMEND NO PASS.

HB 223 - UNWORKABLE IF PRACTICED. LEGALITY SHOULD BE REVIEWED. WILL AGGRAVATE THE PROBLEM IF IT PROPOSES TO SOLVE WITHOUT MODIFICATION OF THE PROBLEM. INTRODUCED IN RESPONSE TO UNDOCUMENTED ALLEGATIONS AND LANGUAGE AMBIGUOUS. SHOULD NOT PASS.

WINTHROP FISH M.D.
MEMBER AK STATE MEDICAL BOARD
ANCHORAGE 2/26/79 MS

2/26/79

Teletype message to Thelma Buchholz and Byron Perkins

HB 226 - Purpose of legislation or need resolved is not expressed. Redundant. See SB 356, 1978. Includes no language relating to patient injury from knowledge of diagnosis. Recommend no pass.

Winthrop Fish MD
Member Alaska State Medical Board

Teletype message to Thelma Buchholdt + Byron Perkins 2/26/79.

HB 228 - Unworkable if practiced. Legality should be reviewed. Will aggravate the problem if it proposes to without modification of the problem. Introduced in response to undocumented allegations and language ambiguous. Should not pass.

Winthrop Fish MD
Member Alaska State Medical Board.

POSITION PAPER / Department of Health and Social Services

POSITION PAPER
ON
HOUSE BILL NO. 226

"An Act amending the definition of unprofessional conduct in the practice of medicine."

This bill would redefine the definition of unprofessional or dishonorable conduct in the practice of medicine by the addition two paragraphs.

(I) requires physician to disclose to the patient the nature of the patient's illness, injury and disease; and

(J) to prevent the wilful misrepresentation by a physician to a patient of the nature of the patient's illness, injury, or disease.

(I) attempts to substitute a simplistic legal mandate to a judgmental physician/ patient relationship and ignores the sensitive paitent/physician relationship involving interface of scientific knowledge and the art of practicing medicine and in the interpretation of the patient's overall well being. An example, a potentially suicidal patient does not immediately need to know his diagnosis and imparting the knowledge is a decision of the physician and patient's family.

Paragraph (J) would already seem to be adequately covered in the principles of medical ethics of the American Medical Association and the Alaska State Medical Association.

Recommended by: Robert I. Fraser, M.D., Director
Division of Public Health

Approved by: Helen D. Beirne, Commissioner
Dept. of Health & Social Services

SEQUENCE OF CALCULATING THE ALLOWABLE CHARGE PAYABLE UNDER MEDICARE

A. ACTUAL CHARGE.

B. INDIVIDUAL FEE PROFILE.

1. PHYSICIAN'S CALCULATED CUSTOMARY CHARGE--MEDIAN OF CHARGES DURING THE PRECEDING CALENDAR YEAR.
2. PHYSICIAN'S CUSTOMARY CHARGE CONVERSION FACTOR FOR THE CATEGORY OF SERVICE MULTIPLIED BY THE RELATIVE VALUE UNITS FOR THE SERVICE.
3. THE 50TH PERCENTILE CHARGE LISTED ON THE PREVAILING CHARGE SCREEN.

C. PREVAILING CHARGE SCREEN.

1. PREVAILING CHARGE BY SPECIALTY (75TH PERCENTILE).
2. PREVAILING CHARGE WITHOUT REGARD TO SPECIALTY (75TH PERCENTILE).
3. PREVAILING CHARGE CONVERSION FACTOR FOR THE CATEGORY OF SERVICE MULTIPLIED BY THE RELATIVE VALUE UNITS FOR THE SERVICE.

INDIVIDUAL PRACTITIONERS

SECTION 447.34L INDIVIDUAL PRACTITIONERS: UPPER LIMITS OF PAYMENT.

(A) THIS SECTION APPLIES TO DOCTORS OF MEDICINE, DENTISTRY, OSTEOPATHY, PODIATRY, AND ANY OTHER INDIVIDUAL PRACTITIONER SERVICES THE AGENCY CHOOSES TO INCLUDE.

(B) THE AGENCY MUST NOT PAY THE INDIVIDUAL PRACTITIONER MORE THAN THE LOWEST OF --

(1) HIS ACTUAL CHARGE FOR SERVICE;

(2) HIS REASONABLE CHARGE FOR THE SAME SERVICE UNDER PART B, MEDICARE (PART 405, SUBPART D, OF THIS CHAPTER); OR

(3) HIS MEDIAN CHARGE FOR A GIVEN SERVICE.

(C) THE MEDIAN CHARGE FOR A GIVEN SERVICE IS DETERMINED FROM CLAIMS SUBMITTED DURING ALL OF THE CALENDAR YEAR PRECEDING THE FISCAL YEAR IN WHICH THE DETERMINATION IS MADE.

(D) THE AGENCY MUST NOT PAY MORE THAN THE HIGHEST OF --

(1) THE 75TH PERCENTILE OF THE RANGE OF WEIGHTED CUSTOMARY CHARGES IN THE SAME LOCALITY THAT ARE SET UNDER MEDICARE DURING THE CALENDAR YEAR PRECEDING THE FISCAL YEAR IN WHICH THE DETERMINATION IS MADE; OR

(2) THE PREVAILING REASONABLE CHARGE UNDER PART B, MEDICARE.

EXAMPLES:

THE PREVAILING CHARGE FOR A SPECIFIC MEDICAL PROCEDURE IS $100 IN A CERTAIN LOCALITY.

DOCTOR A'S BILL IS FOR $75 ALTHOUGH HE CUSTOMARILY CHARGES $80 FOR THE PROCEDURE.

DOCTOR B'S BILL IS FOR HIS CUSTOMARY CHARGE OF $85.

DOCTOR C'S BILL IS FOR HIS CUSTOMARY CHARGE OF $125.

DOCTOR D'S BILL IS FOR $100, ALTHOUGH HE CUSTOMARILY CHARGES $80 AND THERE ARE NO SPECIAL CIRCUMSTANCES IN THE CASE.

THE REASONABLE CHARGE FOR DOCTOR A WOULD BE LIMITED TO $75. THE REASONABLE CHARGE FOR A SERVICE CANNOT EXCEED THE ACTUAL CHARGE IF IT IS LOWER THAN THE PHYSICIAN'S CUSTOMARY CHARGE AND THE PREVAILING CHARGE FOR THE SERVICE IN THE LOCALITY.

THE REASONABLE CHARGE FOR DOCTOR B WOULD BE $85, BECAUSE IT IS HIS CUSTOMARY CHARGE AND IT DOES NOT EXCEED THE PREVAILING CHARGE FOR THE SERVICE IN THE LOCALITY.

THE REASONABLE CHARGE FOR DOCTOR C COULD NOT BE MORE THAN $100, I.E., THE PREVAILING CHARGE, IN THE ABSENCE OF ANY SPECIAL CIRCUMSTANCES WARRANTING A HIGHER CHARGE.

THE REASONABLE CHARGE FOR DOCTOR D WOULD BE $80, BECAUSE THAT IS HIS CUSTOMARY CHARGE. EVEN THOUGH HIS ACTUAL CHARGE OF $100 DOES NOT EXCEED THE PREVAILING CHARGE, THE REASONABLE CHARGE CANNOT EXCEED HIS CUSTOMARY CHARGE IN THE ABSENCE OF ANY SPECIAL CIR-

INDIVIDUAL PHYSICIAN FEE PROFILES COMPILED FROM CALENDAR YEAR CHARGES FOR USE DURING THE FOLLOWING YEAR.

MINIMUM OF THREE CHARGES FOR THE SAME SERVICE IS NEEDED TO CALCULATE A CUSTOMARY CHARGE FOR AN INDIVIDUAL PHYSICIAN.

PREVAILING CHARGE WITH ECONOMIC INDEX LIMITATION (FURNISHED BY THE MEDICAID BUREAU) IS SET AS THE UPPER LIMIT--THE 75TH PERCENTILE OF CHARGES.

FOUR CUSTOMARY CHARGES IS THE MINIMUM NUMBER OF SERVICES NEEDED TO CALCULATE THE PREVAILING CHARGE.

NEW PHYSICIANS ARE PAID BY THE 50TH PERCENTILE OF THE PREVAILING CHARGE WHERE IT DOES NOT EXCEED THE 75TH PERCENTILE.

CUSTOMARY CHARGE CONVERSION FACTOR FOR A CATEGORY OF SERVICE MAY ONLY BE CALCULATED WHERE AT LEAST SEVEN CUSTOMARY CHARGES FOR SERVICES HAVE BEEN MADE IN THE PARTICULAR CATEGORY OF SERVICE (MEDICINE, SURGERY, PATHOLOGY, X-RAY, ANETHESIA).

Medicaid Data

1978 OB/GYN Patient Days at Providence Hospital 4,406

Deliveries 1,809

Medicaid Deliveries (approx) 150

1978 Pediatric patient days 4,135

Pediatric patients (medicaid) (approx) 240
Pediatric patient days (medicaid) (approx) 1,200 (¼ of total)

Anchorage Pediatric Group -------- 4 pediatricians

% of business medicaid - 15% of all patients
# of physicians with medicaid patients - 4

# of hours spent on medicaid billings per month - 24 hours including forms, phone calls & coupons

Turnaround time for medicaid reimbursement payments:

small billings under $30 - 6 weeks
large billings - 6 months

Total money owed Anchorage Pediatric Group for medicaid - $13,150

CHILDREN'S CLINIC --------- 6 pediatricians (all see medicaid patients)

% of business in medicaid patients - 35% ---since 1/79 - 38.67%
# of hours per month processing medicaid paper work - 60 hours minimum ($450 to $500)

Total billings for medicaid from 7/1/78 to 3/5/79 ----$76,927.80

Total paid reimbursements from medicaid for same -----$11,699.85

15¢ on the dollar paid back on amount owed to Children's Clinic. Balance due -$65,288

Amount owed by medicaid prior to 7/1/78

Doctor A - $1,939; Doctor B - $6459.76; Doctor C - $2977.00
Doctor D - $5,373; Doctor E - $2145

Billed charges to medicaid vs. allowed charges by medicaid

Amount billed - $14,114 Amount Paid $11,699 (or 83¢ on the dollar)

CHAIRMAN
MARIAN T. WITT, M.D.
3300 PROVIDENCE DRIVE
ANCHORAGE, ALASKA 99504

ALASKA CHAPTER
American Academy of Pediatrics

Letter to the Editor: Anchorage Daily News

Dear Sir:

In the Saturday Forum of February 3rd regarding Medicaid, Jaime Love stated that only 2 pediatricians in Anchorage see medicaid children. This is not true. All of the pediatricians in private practice in the Anchorage-Palmer area see such children and we presently number 15.

The number of pediatricians has not increased in recent years in proportion to the population growth of the city, hence acceptance of a new family into pediatric care may be neither automatic nor easy whether one is a medicaid recipient, a merchant or a bank president. All of us accept many new families, but at times when a saturation point is reached, families are referred elsewhere. Family practitioners, as their name implies, take care of many children, medicaid included, and do so capably. The children of our community are not being denied medical care whether medicaid or not.

The Amercian Academy of Pediatrics believes that every child needs a "medical home"; for an office-based familiar, constant setting where he may receive comprehensive high quality preventive health care and specialized care during episodi illnesses or accidents. This requires 7-day, 24 hour coverage by small groups of pediatricians and cannot be provided by health department clinics or emergency rooms.

With these concepts in mind, the American Academy of Pediatrics, has initiated dialogue with HEW financing administrators to seek more effective methods of providing a "medical home" for the eleven million children enrolled in medicaid. The estimated cost is 4.5 billion dollars!

If there is a problem then, it is not that we have forgotten our role as child advocates, it is simply that there are not enough hours in the day. We are trying; and can be found at any hour of the night at any Anchorage hospital caring for sick babies or children, without concern or knowledge of "means of payment."

Marian T. Witt, M.D.
Alaska Chapter
American Academy of Pediatrics

ALASKA PUBLIC INTEREST RESEARCH GROUP

Post Office Box 1093/Anchorage, Alaska 99510/(907) 278-3661

Board of Directors: Hugh Fleischer, Chairperson; Julie Wroe, Vice Chairperson, Molly Crenshaw, Secretary; Don Clocksin, Treasurer, Eleanor Andrews; David Case; Judy Whitney Eckholm; Bob Goldberg, Terry Stimson; Phil Voland

Martha MacDermaid
Executive Director
Alaska State Medical
Association
1135 West 8th Avenue, Suite 6
Anchorage, Alaska 99501

January 23, 1979

Dear Ms. MacDermaid,

I am writing this letter to request an appearance before the Alaska State Medical Association at its April meeting to address the group on a very grave matter, that being the failure and refusal of many of our community's doctors to accept medicaid patients for treatment.

This request is made on behalf of the Alaska Public Interest Research Group, which is a citizens' organization whose membership numbers approximately six hundred Alaskans. Our main goal is to present the point of view of the consumer on various public concerns.

Although we are involved in a great number of issues, rarely has our organization confronted a problem as disturbing as the matter before us now. There is nothing so basic to our society, as physical health. In recent years the science of medicine has grown dramatically, conquering new diseases, inventing daring new methods of surgery, and implementing new technologies that bring undreamed of efficiencies to the healthcare system. In our country we have spent billions of dollars on medical research, the construction of hospitals, and the education of our physicians. Vast sums of this money come from the public sector. Hill-Burton funds and state revenue sharing dollars finance hospital construction. The federal government funds large and small research projects. The schools where our doctors are educated receive a number of subsidies. Some are direct, like the large government funding of research programs or the tuition itself. Medical schools are tax exempt so the private foundations, corporate donors, and individuals are able to write off contributions against income taxes. The students themselves benefit from a variety of government financial aid programs.

These expenditures are necessary -- necessary for our society to develop the new technology, to build the needed hospitals and health care facilities, and to train an adequate number of doctors. The expense of the undertaking is justified by our goal of bringing adequate medical treatment to the entire society. Without these subsidies few doctors could be trained. Hospitals would cost the consumer even more than they do today. Health care would be too expensive for the average citizen. Only the wealthiest of our society would be assured of proper medical care. This alternative is unacceptable.

So we have chosen to subsidize medical care at the public cost of billions of dollars. But we have stopped far short of a nationalized health care system. It is still firmly controlled by the private, for profit sector of our economy. Doctors are as much businessmen as healers. Of all the developed countries, only the United States and the government of South Africa have yet to provide its people with comprehensive national health insurance. The result is a patchwork system, financed through dozens of different medical insurance programs, health maintenance organizations, and public assistance for those who are indigent and have no medical insurance and no money to pay for health care.

The medicaid system is managed by a government bureaucracy. The State of Alaska runs the program within very detailed guidelines established by the federal government. Since its conception, medicaid has experienced administrative problems. The state has encountered significant delays in the payment of medical vouchers.

The response by individual physicians varies. Some continue to treat medicaid patients, others do not. Doctors with certain skills are more likely to reject medicaid patients than others. Obstetricians, gynecologists, and pediatricians are among those specialties which rarely accept medicaid patients today. For example, one young mother recently traveled to Anchorage from Kotzebue for an operation. A Public Health Service doctor had determined the existence of dysplasia on her cervix. He recommended a cone biopsy at the earliest possible date, to avoid a hysterectomy later.

She contacted the two doctors she had been referred to by the Kotzebue PHS doctor. They would not treat her, nor would six other Anchorage physicians. Some were not taking any new patients, but the majority refused treatment on the basis of her participation in the state medicaid program. Surely many of you can empathize with the distress this woman felt when she was refused treatment.

She and her husband were living in a rural area of the state, supporting themselves by seasonal construction work and living off the land the rest of the year. Their small cash income was enough to provide them with all their basic needs, but the operation was unexpected and they could not afford it. To be told you may have an early stage of cancer is unnerving enough. To

sign up for a public assistance program is a dehumanizing experience. But to beg doctors to treat you, simply because you are on welfare, and to be rejected by every doctor you contact, is more trauma than any Alaskan family should endure.

This woman, of course, is not alone. The present situation with the medicaid program can only be described as a crisis for poor people. It means that health care may not be obtainable if an individual or her/his loved ones get sick. It means being deprived of routine physicals and check-ups that other families have. It means that it is very difficult to find a pediatrician for your children - if you are poor. It means that you cannot get help from every doctor in the community, as the privately insured patient can. Your choices are limited to only those doctors who still treat medicaid patients. In short, it means that poor people have a second class health care system.

In defense of the medicaid program, it should be noted that the average turnaround time for billings is now less than 60 days. The reduction in payment of usual and customary fees, which may be the real underlying cause of physician disenchantment with the program, is mandated by the federal government. The paperwork is only that required by doctors in every other state.

Our organization is upset with the behavior of the medical community. It seems incredible that poor people who need medical treatment would be refused for any reason, let alone the stated grievances of the medical community. After all, physicians as a class are doing very well in Alaska. It is difficult to accept the judgment of those doctors who have turned their backs on medicaid patients, since it is the poor, and not the government bureaucracy, who suffer.

At one time the American Medical Association required each and every member to disregard the economic status of its patients in rendering its services. This standard was formally adopted by the AMA by its House of Delegates in 1934, in the mist of the great depression.

It stated:

> ABILITY OF PATIENT TO PAY.
>
> One of the strongest holds of the profession on public approbation and support has been the age-old professional ideal of medical service to all, whether able to pay or not. That ideal is basic in our ethics. The abandonment of the ideal and the adoption of a principal of service only when paid for would be the greatest step toward socialized medicine which the medical profession could take. All our arguments as to better service to the people, freedom of choice of doctors would be naught if such service were not available to a vast proportion of the people.

This ethic does not appear in more recent publications by the AMA. According to Bruce Nortell, of the AMA legal staff, the ability-to-pay ethic just "whithered away" in the late sixties after the medicaid and medicare programs were enacted.

But since the AMA ethics are only considered the minimum ethical standards for Alaskan doctors, the Alaska Medical Association should re-enact this ethic to address today's medicaid crisis. Certainly the sentiments expressed then are applicable today. For example, how can a medicaid patient have "free choice" when only few doctors in a certain specialty are treating medicaid clients?

While we live in a materialistic world today, with an economic system that encourages the relentless pursuit of self interest, it behooves us to reflect on this isolated activity of health care.

It is like no other commodity, in that no price can be placed on good health or the security of ones family. A profession that asks for the power of self government must consider the entire public responsibility it shoulders. For unless an internal remedy is forthcoming, people will look elswhere for relief. And such relief will be sought until poor people are accorded the same quality of health care as all others.

Sincerely,

ALASKA PUBLIC INTEREST
RESEARCH GROUP

Hugh Fleischer
Chairperson

Peninsula Medical Center, Inc.
P. O. BOX 569
SOLDOTNA, ALASKA 99669
(907) 262-4401

Family Practice
Paul G. Isaak, M.D., A.A.F.P.
Roy E. Benward, M.D., A.A.F.P.
Lavern R. Davidhizar, D.O., A.A.F.P.

General Surgery
Joseph A. Sangster, M.D., F.A.C.S.

[illegible]atrics
[illegible]xander B. Russell, M.D., F.A.A.P.

DEAR PATIENT:

EFFECTIVE JANUARY 15, 1979 PENINSULA MEDICAL CENTER, INC. WILL NO LONGER ACCEPT MEDICAID OR GRM COUPONS FOR SERVICES WE PROVIDE.

WE ARE RELUCTANT TO TAKE THIS STEP, HOWEVER, WE HAVE NOT BEEN PAID BY THE DEPARTMENT OF WELFARE FOR MANY SERVICES WE PROVIDED IN THE PAST. OUR CLINIC CANNOT CONTINUE TO OPERATE BY EXTENDING CREDIT TO THE STATE OF ALASKA.

WE WILL BE GLAD TO CONTINUE SERVICE TO ALL PATIENTS WHO ARE WILLING TO ADHERE TO OUR CREDIT POLICY. IF YOU CANNOT PAY FOR YOUR VISIT AT THE TIME OF THE SERVICE, FINANCIAL ARRANGEMENTS MUST BE MADE IN ADVANCE.

AS FAR AS WE KNOW, THE OTHER PHYSICIANS IN THE AREA ARE STILL ACCEPTING COUPONS FOR MEDICAL SERVICES.

RECEIVED
JAN 17 1979
Division of
Public Assistance

SINCERELY,

PENINSULA MEDICAL CENTER STAF

Dr
Martin Schlosstein
Mr. Muse
211 E-N L 279-6429

Peninsula Medical Center, Inc.
P. O. BOX 569
SOLDOTNA, ALASKA 99669
[907] 262-9341

Family Practice
Paul G. Isaak, M.D., A.A.F.P.
Roy E. Benward, M.D., A.A.F.P.
Lavern R. Davidhizar, D.O., A.A.F.P.
General Surgery
Joseph A. Sangster, M.D., F.A.C.S.
Pediatrics
Alexander B. Russell, M.D., F.A.A.P.

DEC 1978
RECEIVED
Office of the
Commissioner

December 4, 1978

Dr. Helen D. Beirne
Commissioner
Department of Health and Social Services
Pouch H-01
Juneau, AK 99811

Dear Commissioner Beirne:

This letter is giving formal notice that unless all past due accounts are paid by January 15, 1979, we will no longer provide medical service to Department of Welfare recipients. The current amount due us from the Department is in excess of $42,000 and some of these accounts are almost two years old. It is impossible for us to remain in business if we continue to provide service for any person or agency with such a poor payment record. We are far better off to provide service free to those people who cannot afford to pay. At least then we don't have all the hassle of repeated billings and record keeping which essentially reduces our return for your cliental to less than fifty cents (50¢) on the dollar of services. To begin with, practically all of our regular charges are discounted to a certain amount which amounts to an average of approximately thirty per cent. In addition, we have to wait excessively long for payment which increases the amount of staff time which is required to keep the records and keep sending statements. Thirdly, a number of charges are completely disallowed and for these we have no recourse. We will continue to provide service to those obstetrics patients that we have accepted to date, but will not accept new ones from 12/1/1978.

I am informed that the Department is out of funds and is in arrears of payment of their obligations to physicians in the State. If we had reasonable expectation that we could expect payment within a certain period of time and be paid for the amount of services rendered, we could conceivably borrow funds at approximately fourteen per cent interest until payment for services to DPW cliental is forthcoming. As it is now, our present financial position is such that we have to go to the local bank to borrow money to purchase new equipment which we feel is essential in providing quality medical care to the citizens of our community.

We regret having to take this step, but must do so in order to stay in business. It just isn't worth the time and trouble that we have to go through to serve DPW cliental which in the last two or three years has been a losing proposition financially.

Sincerely,

Paul G. Isaak

PAUL G. ISAAK, M.D.

cc: Representative Hugh Malone
Representative Leo Rhode
State Senator Clem V. Tillion

PGI/ns

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC ASSISTANCE

POUCH H 07 -- JUNEAU 99811

January 17, 1979

Paul G. Isaak, M.D.
Peninsula Medical Center
P.O. Box 569
Soldotna, Alaska 99669

Dear Dr. Isaak:

It has come to my attention that Peninsula Medical Center (PMC) has closed its doors to new Medicaid clients effective January 15, 1979.

The reasons for this closure appear to be as follows:

(1) Large unpaid accounts receivable from Medicaid for services prior to July 1, 1978 ("prior year bills").
(2) Excessive payment delays.
(3) Excessive costing down (adjudication) of PMC's billings.

I would like to clarify the current status of each of these problems compromising your participation in the Alaska Medicaid Program.

First, according to PMC records, we hold billings for services rendered prior to July 1, 1978, in the amount of $19,700. Based on PMC's average adjudication rate of 73% of amount billed, PMC can expect to receive approximately $14,400 once the Legislature approves supplemental funds to cover PMC's prior year bills and those of other provider's similarly situated. We regret the inconvenience this shortfall of Medicaid funds must have caused PMC; however, it occurred simply because there was a much greater demand for physician services than originally anticipated for FY78. To help relieve some of the cash flow difficulties which this shortfall caused PMC and other providers, Commissioner Helen Beirne sent written notification to each provider that our supplemental request to the Legislature would include "a sum for interest of one percent a month from the approximate date each billing would normally have been paid until the date it is actually paid". If a billing would normally have been paid in September 1978, but was not paid until February 1979, 5% interest would be due the provider for that billing in addition to the provider's normal rate of reimbursement.

Your second concern is promptness of billing. Although this agency did fall behind in processing billings during the first six months of 1978, payment timeframes were reduced to six weeks or less several months ago and have remained there since. For example, today we are processing physician

06-F51LH

billings received on December 26, 1978. PMC's billings received here in late December (for October and November services) are being processed at this time. (Note: We also have a small group of resubmitted invoices in the amount of $2700 to replace some July-September 1978 billings apparently lost in transit. We are processing these now and a check will be mailed to PMC around January 30, 1979.)

Your third concern is the rate of reduction applied against PMC's billings. You state that an average 30% reduction is taken against PMC charges, and that some charges are totally disallowed. Our records reflect generally a 27% reduction against PMC claims, quite close to your 30% claim. Unfortunately, the rate of reimbursement to PMC is governed by federal regulations which in turn are tied to Medicare limits. Although we cannot reimburse at a rate higher than Medicare we do reimburse for a broader range of services than Medicare does. This leads me to believe that PMC charges which were disallowed must have lacked required prior authorization, or appeared to be a duplicate bill. If you will provide specifics of these disallowances, I will see that the circumstances are carefully researched.

Again, I would like to emphasize that the Division of Public Assistance regrets the hardships imposed on PMC as a result of our previous slow payment timeframes, and the delay in our settling PMC's prior year claims. I am indeed sorry that this occurred and the Department is making every effort to rectify this situation. In addition, several major changes have been made to preclude reoccurrence of these same problems in the future. These include:

(1) Revision of our budgeting procedures to more accurately predict funding needs.
(2) A complete review of our Medicaid payment system by federal experts, at our request, to isolate problem areas and to recommend improvements.
(3) Development of an acknowledgement system which will notify each provider that their billings were received, and advise them of the approximate date payment can be expected.

We are determined to implement these and other improvements to make this agency more responsive to providers statewide. It is my hope that in view of this commitment, PMC will reconsider its decision and once again serve all Medicaid clients on the Kenai Peninsula in need of medical attention.

Sincerely,

Rod Betit

Rod Betit
Acting Director

RB:jf

cc: Helen Beirne
Catherine M. Lloyd

R. Betit
2/1/99

Jean:
Copies to
- Alistair
- David
- Tony McGinnis
-

Peninsula Medical Center, Inc.
P. O. BOX 569
SOLDOTNA, ALASKA 99669
[907] 262-4401

Family Practice
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Pediatrics
Alexander B. Russell, M.D., F.A.A.P.

January 19, 1979

Rod Betit, Acting Director
State of Alaska
Dept. of Health & Social Services
Div. of Public Assistance
Pouch 807
Juneau, Alaska 99811

RE: Taylor, Ola W.

Dear Mr. Betit:

Currently the Peninsula Medical Center, Incorporated of Soldotna is no longer accepting State Welfare patients because of poor compliance with contractural basis on the part of the State. However, the Clinic is continuing to provide health care for people who were previously under the program. It should be noted that in addition house calls are being made including one on Ola W. Taylor, a preterminal cancer patient, who is unable to come to the office. Of course, there has been no charge made to the patient or to the State.

Thank you.

Sincerely,

L Schlosstein MD

Lee Schlosstein, M.D.

LS:sar
cc. Helen Beirne, Commissioner

CHANNEL 2 TV - "FOCUS 2"
Saturday, January 27, 1979
10:10 PM
Suzie Arnell, Newsperson

TRANSCRIPT

ARNELL: Kristen Carnes lives with her husband and daughter outside a village on the Kobuk River outside of Kotzebue. They live the subsistence way mostly, which worked out fine until the couple learned Kristen had cancer and needed an operation.

KRISTEN CARNES: She came up to me on the street and said, "We've been looking for you." You see, we were camped out of town a ways so they couldn't find me. And she just said, "We've been looking for you. Your pap test showed some abnormal results and you may have cancer." At first I was really scared because they just kind of told me that I might have cancer. That was how I was told. I didn't feel any pain or hurt in my body, but I just felt panic that either I would have to have a hysterectomy, which would mean no more children and we very much want another child, or I had fears that I would die.

ARNELL: The Carnes immediately went on Medicaid and then found out that very few doctors would take it.

CARNES: We called about seven or eight doctors and a few of those were not accepting new patients, but I think we had four names altogether who just wouldn't take Medicaid patients at all. Doug said that when he called them, you know, he would mention at last, he would ask the doctor whether he would treat me and, you know, when and everything and then mention, do you take Medicaid, and there would be kind of a turnoff and they would say, no, we don't, sorry.

ARNELL: Meanwhile, she went to other doctors for second opinions. It always came back the same. The cancer was there and it seemed to be spreading. They all recommended a cone biopsy.

CARNES: Well, they just kind of go into the cervix like it's an apple and take a core out of it. And at first they stain it in order to know where to cut, then they cut out all the bad cells, hopefully. If they do have to take out a large cone, you may not be able to have children again because you could have a miscarriage; there's not enough cervix to hold the baby in. But usually, if they catch it quick enough, it's not a very serious operation and you're perfectly capable of having children. For a few months I've been thinking about it a lot and, yeah, worrying, sometimes trying not to worry because I hear that's bad. And, yeah, I was quite worried by this time. I really had made up my mind to have the surgery and wanted to get it as soon as possible.

ARNELL: Finally, they found a Palmer doctor who took Medicaid, Dr. Carolyn Brown.

DR. CAROLYN BROWN: No, I don't care whether they're Medicaid or not.

ARNELL: But apparently many local doctors do. In November, 56 Anchorage doctors were surveyed by the Anchorage Municipal Planning Department. All are OB/GYNs. The Gehler report is startling. Only six doctors said that they accept Medicaid patients and most of those qualified their answers, saying they only accepted a few a month or during certain months of pregnancy. Eighteen doctors said flatly no, they do not accept Medicaid patients. Three doctors said that they sometimes did. And the majority--29--just didn't answer the questions at all. Doctors interviewed listed a series of complaints, the main one being that Medicaid cost the doctors money. They only get reimbursed for part of the bill and doctors say that the payments from the State take way too long in coming.

BROWN: I can appreciate why some physicians would not take Medicaid patients because if they're only paid 60 percent worth of that piece of paper for what their fee is, or 70 or 80 percent, and the physician may have his or her own overhead, I can appreciate why they would be upset at getting a piece of paper that's only worth 60, 70 or 80 percent of what they're about to deliver.

In our office, we've never had a payment come in in less than three months. We have stopped taking Medicaids as of the first of January in '78, and we hadn't taken any more coupons for the entire year and we had a substantial amount that they owed us at that time and they still owe us at the beginning of '79, the same substantial amount. So, that'll tell you where we stand with them.

BROWN: I often wonder if Medicaid patients don't often feel like they're treated as second-class citizens. And you take a very good person who works, who does what they can do to make ends meet, who is responsible to pay their bills and then, bingo, a disaster hits. And they can't really pay for that. So, they have to seek some way to do it. Maybe they don't have insurance and they don't have enough money in the bank and they're making ends meet. So, anyway, they end up going and asking for some assistance from welfare, medical assistance. They're handed a coupon. My experience in talking to Medicaid patients is that nobody explains what that coupon is for. The patient thinks that coupon is money. They think it's 100% of money. It's like solid gold. Then the patient goes to the physician's office, passes over the coupon, for those doctors who will take a coupon, and then assumes that everything is cared for. The physician

BROWN:
(continued) then has got to wait six months, three months, six weeks--whatever it is--for the physician, before they're reimbursed and then only get between 60, 70 or 80 percent, if that much.

I would say it's pretty serious, you know, as far as our office is concerned. I know that they owe us quite a bit of money and the way I look at it is that we treat so many people on a credit basis that, in so many different groups and just like, the military with Champus and the Teamster organization, that it makes it very difficult during the month that no payments come in from any of the organizations and you got, you know, it makes it higher in health costs for doctors. They've got to cover that time somehow.

There is a longer time that goes by from the time the physician renders his service until the time they send the bill to us, then it takes us to get the money back to them once they send the bill to us.

BROWN: Obviously our expenses go on. We have staff, we have rents, we have bills, we have interests. These things have to be paid some way or another.

Say there are some months when not very much is coming in. I'm sure that a doctor, in order to cover his overhead, might have to take out a temporary loan on occasion which would again jack up the costs of the medical care to the other people.

That happens.

ARNELL: Hospitals get their fair share of Medicaid woes, too. Spokesman for Providence said some Medicaid patients never bring in their coupons. So the hospital never gets paid.

CHRIS BEARDSLEY,
PROVIDENCE HOSPITAL: We have to bill within six months in order to get reimbursed for the coupons. That's the deadline which the Legislature has put down through regulations through the Department. And last year a bill came through, as I remember correctly, where they tried to reduce that time that we could bill Medicaid recipients. It didn't pass, thank goodness, but that would have really put a crunch on us.

Our total losses for the budget year of 1979, which are based on past history and fact, and these are losses due to contractual adjustments because of the Medicare and Medicaid programs, bad debts, charity allowances which we give, will exceed $2,300,000.

ARNELL: From ten to fifteen thousand persons in Alaska are on Medicaid at any one time. Last year the State shelled out some 26 million dollars for Medicaid. This year the figure is set at 31 million, and next year's projection is 41. But last year, reimbursement money for the doctors ran out faster than the fiscal year, leaving many doctors with bad debts from the State and bad tastes in their mouths about Medicaid.

What does the State say about the whole thing? Well, we decided to talk to the man who wrote the Medicaid bill, Fred McGinnis. McGinnis told us that the Medicaid fund itself was solvent last year; they just couldn't transfer money to pay back the doctors.

FREDERICK McGINNIS
DEPUTY COMMISSIONER
DEPT. HEALTH AND
SOCIAL SERVICES: There are rules that change from time to time as to what we can do with funds in one budget review unit or component over against another one. It was a very technical budgeting detail that created the problem. But now, that is not true for the 1979 year. It isn't a problem for this year. We can use money back and forth in the 1979 year, but we could not in the 1978 year. And that was the essential problem. When all those bills are paid and hopefully the Legislature will very soon appropriate the additional money to pick up the services for I believe it was April, May, June--that period in there--there still will be after all those are paid totally, there will be a surplus of some $600,000 in the fund.

Several times we run into problems both in the delay area where we'll send a claim in and they'll send it back with something that should be obvious, like for instance an OB claim where we'll send it in and say, the bill won't be for a total, it'll be care or routine lab work related to prenatal visits, etc., etc., and they'll send it back and say, What's the diagnosis for this patient?

McGINNIS: It is an enormously big business. People don't tend to think of it that way because they tend to think of one hospital, one clinic, one doctor's office. But when it all focuses for that number of people in one set of offices, it is an enormous flow of processing. So there will be mistakes. But the last I heard, that's true with other forms of businesses, too; not just the medical profession.

ARNELL: The State Medical Association met with the State this fall trying to iron out any snags and the State plans to get a computer soon to speed up claims. But how does all this really effect Medicaid patients, and how serious is it really?

I t ink there's really no excuse for it. I think it's an outrage that doctors will pick on poor people, poor people who are sick...

...which will instill a certain level of incentive into the Medicaid program. Incentive to the recipient as well as to the provider and that is the large thing that is missing, as far as I'm concerned.

BROWN: And when a Medicaid patient sees a physician, it is the patient's encounter with the physician; not Medicaid or the Juneau office or the Anchorage office. Therefore, the patient is accountable for that care which was rendered by the physician. I fail to see why we should treat Medicaid patients any different than we treat private carrier insurance patients, in that we bill the patient, it becomes his or her bill, for the difference. I don't understand why this can't be. I'm worried that it's against the law to do this. But I fail to understand why.

I think they're more frustrated than angry, because it puts them in a bad situation with tle patients. You know, they feel bad because they can't understand why they can't get treatment and the doctors feel bad because they're not, they're working hard and they're doing a good job, but they're not getting paid for it and, you know, it's frustrating.

BROWN: We don't treat other people like that. Some of the private insurance companies don't treat people like that. They don't treat physicians like that There's a system worked out.

CARNES: I don't usually go around telling people that I'm on welfare, but that's because I'm afraid of their coldness, I think. It hasn't been a pleasant experience at all and I would avoid it if I could next time. I'd say that the doctors and the patients--they're both the losers in this.

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CHANNEL 13 TV NEWS
Saturday, January 27, 1979
6:30 PM
Beverley Michaelson, Newsperson TRANSCRIPT

MICHAELSON: (intro) Tonight on Channel 13, if you're a pregnant young woman looking for a doctor, you would have trouble finding one in Anchorage. If you're pregnant and on Medicaid, the problem would be even worse.

MICHAELSON: Kristy Carnes came to Anchorage from Ambler with her husband and daughter looking for help as a Medicaid patient. She had cancer of the cervix and needed a cone biopsy as soon as possible.

MRS. CARNES: If it isn't arrested now, it could become what they call evasive cancer, which would mean within a varying length of time, possibly a short time, I would have to have a hysterectomy and, if it got beyond the uterus, it could eventually kill me because it would get into other areas of the body.

MICHAELSON: What was your experience when you called? How many doctors did you call and what was the response and experience you had?

MR. CARNES: I think I called nine doctors in all and the experience I had varied. Some of them I think were just not taking new patients and others were very friendly and helpful, up to the point where I asked them whether they were accepting Medicaid patients, or whether they would accept Medicaid. At that point, they said, no, no sir, I'm sorry we're not. I had a feeling of coolness at that time.

MICHAELSON: Kristy Carnes was taken care of eventually in Palmer. But her situation raised the question in Anchorage-- Are other young women having this problem? Are they having problems getting medical help? Why is there a problem, and what is being done about it?

There are 16,000 people in the state who qualify for Medicaid, according to Rod Betit, Director of the Division of Public Assistance. Over 5,000 are in the Anchorage. None are Native because the Alaska Native Hospital cares for the Native population in the state. Among those who are on Medicaid include the disabled, blind, and many single mothers with dependent children. Is there a crisis in health care for these people on Medicaid?

DR. WINTHROP FISH: Not only is there not a health care crisis for the poor, but I believe it would be difficult to find a place in the United States where everybody--poor or well--is taken care of so well and with such good facilities and competent care.

MICHAELSON: Hugh Fleischer, Chairperson of the Board of the Alaska Public Interest Research Group, disagrees and he says there is evidence of a real health care problem for the poor in Anchorage.

HUGH FLEISCHER: We have a number of specific instances that we're familiar with in which patients who have reported to us about their own direct experience of having been refused any and all medical care based on the fact that they were Medicaid patients, and we know that is the policy of a number of physicians in the community. We've done a spot survey of a number of physicians and determined from their offices, from their own statements, that they were in fact not willing to provide medical care to Medicaid patients on the basis of that fact alone.

DR. JERRY LITTLE: I don't think there is a crisis as such. I think that there is a problem in certain areas in medicine in Anchorage and the Medicaid people being seen as soon as they'd like to be seen. But that is only part of the problem, in that there are a lot of people--Medicaid or non-Medicaid, insurance or non-insurance--who have trouble getting in to see certain physicians.

MICHAELSON: Those certain physicians--is there a particular area of them that is more pressed than others?

LITTLE: Offhand, I would have to think of the obstetrical field, gynecological field and the pediatrics. We need more of these doctors.

MICHAELSON: The crunch, as Dr. Little points out, is particularly bad for young women having babies and apparently even worse for Medicaid women having babies. Public Assistance personnel verify this, saying most of the complaints they get from Medicaid clients--and they do get complaints about not finding a doctor--are that, No. 1, doctors will not perform abortions on Medicaid patients and, second, they can't get prenatal care. Doctors and hospital personnel staunchly maintain, however, that if someone really needs medical care, he's going to get it.

If I were a Medicaid patient and I needed help, I needed to come for services right now, I thought, would I be able to walk into Providence Hospital and be seen?

CHRIS BEARDSLEY
PROVIDENCE HOSPITAL: Absolutely. We never turn away any patient. I don't think you would find an incident where anyone in an emergency or in an acute illness situation has been denied medical care.

MICHAELSON: That still doesn't help the woman who is having a baby and wants to be sure everything is okay. Medicaid patients, like everyone else, need care on something other than an emergency basis.

The next question is, Why aren't some doctors seeing Medicaid patients? There seems to be three major problems. One is payment that is too late and not enough. The second is paperwork and, last, federal regulations.

FISH: There is a problem of payment, of course. And that happens to be a matter of federal law and there's a very complicated payment rigamarole that is gone through in order to determine what percentage of what is billed will be actually eventually paid, and this varies from doctor to doctor depending on how long he's been here and what is known as a fee profile. More important recently has been the relative chaos in Juneau that has delayed the payments a great deal. So that we have a double problem. One is that the government asked, or desired, and planned to get into the practice--or at least the responsibility for providing care for the indigent or the poor. Then they set it out as a cut-rate system and then they delayed it. And then finally ran out of money altogether for a certain period of last year, so that they didn't pay at all.

MICHAELSON: Even though there was enough money in the Medicaid program for 1978 to pay the doctors those last few months of the fiscal year, the doctors did not get their money. I asked Mr. McGinnis, Deputy Commissioner of the Department of Health and Social Services, why that happened.

FREDERICK McGINNIS: It's simply because the Legislature appropriated the Medicaid in about six categories. One was nursing homes, one was hospitals, one was physician services, one was early periodic screening, and so forth. And we are limited to just those line items. We cannot change from one line item to the other. So, while the Medicaid fund has a surplus of $600,000 it's not on the right line item to be paid.

MICHAELSON: How then is there a shortfall at the end of the fiscal year? In other words, have you not been paid in previous years?

BEARDSLEY: Well, there have been...the last two or three years have been shortfalls in the General Relief Medical, Medicaid type funds and of course you're familiar with the different types of pools. So there is some tradition to this; it doesn't go back a long ways, but recently I would say...

MICHAELSON: Do you expect there to be a shortfall at the end of this fiscal year?

BEARDSLEY: If tradition follows, there will be.

MICHAELSON: According to the Department of Public Assistance in Juneau, the money for 1978 will be appropriated by the Legislature shortly and the doctors should receive payment within a few weeks. And, what is more, this shortfall problem should not occur this year because now the Medicaid money can be used where it is needed. Payment delay has been one problem; another problem, as Dr. Fish mentioned earlier, is that under Medicaid doctors, hospitals and other services don't get paid their entire fee.

Do you get paid for everything you bill?

BEARDSLEY: No. Medicaid and Medicare reimburse at a rate of somewhere in the neighborhood of 65 to 75 percent--occasionally 80 percent--of our costs. There are many bad debts. There is some charity care given. And the unreimburseable costs from both Medicare and Medicaid comes to a significant dollar amount here at the hospital and I'd say two million dollars a year that we lose. Contractual allowances, charity care and bad debts.

MICHAELSON: The doctors then are virtually guaranteed payment by Medicaid; not as quickly as they would like nor as much. But then, among other patients, similar situations must occur and these days uncollectable bad debts plague every businessman.

Do you find that there are other problems that you have besides the fact that you're not being paid on a timely basis?

BEARDSLEY: Well, on a timely basis, I would say you do run into the tradition where Medicaid patients, in order for us to get reimbursement, when they come for service, have to bring a coupon. And, if we don't get the coupon, we can't bill the State to reimburse us. And frequently--not all that frequently, but in a number of cases--the patient is getting free care and they don't take the liberty of bringing in the coupon, and we ask them to mail it back and sometimes they do, but many times they don't.

MICHAELSON: Which gets into the second and, in many doctors' opinions, the most severe of the problems--the hassle of additional paperwork with Medicaid patients.

LITTLE: If a private paying patient comes in and has an insurance form to fill out, we do not have an insurance clerk to assist. We have a routing slip that has all the information on it--the diagnostic code, the charge, the doctor's name, the patient's signature and so forth--and they just attach their copy of the routing slip to the insurance form and send it in. I think all but three insurance companies in the country accept these. If a Medicaid patient comes in, they have a complete separate form that we have to, one of our girls has to type up. We do not only have to put in the diagnostic code; you have to type out the diagnosis, the name of the diagnosis. Each one, each office, laboratory test that's done--all that has to be typed in. So there's an extra paperwork just in filling out the form.

MICHAELSON: There is one page to the Medicaid forms similar to most insurance claims. It takes one clerk one day to type all the Medicaid billing forms for six doctors for one month. But the doctors' business office says there's more time involved in dealing with returned forms, missing coupons and the like--all amounting to extra hassle.

Dr. McGinnis, who is the Deputy Commissioner of the Department of Health and Social Services, and others feel that the paperwork is not inordinate and represents a billing procedure that would be customary in any other type of business endeavor. What the doctors see is an increasing involvement in government in the way they're doing their business, and they don't like it.

FISH: Finally, more of a problem is the ever-increasing federal regulation that comes down because it's all tied to federal programs, and there are now a new set of regulations being fomented in Juneau and ready to go on...or ready to be actually implemented that will make the problem of taking care of somebody in the system. It's not the matter of the money but it's just that once you take on the system, why then you're involved with a great deal of paperwork, a great deal of hassle, rebilling...but more than that, even the threat of being prosecuted for criminal action under fraud and abuse laws that are becoming more and more strict. You've got to understand: we object to both Medicare and Medicaid at which time we customarily delivered if you want to call it charitable medicine. That was part of the tradition of medicine and we all did it. We objected politically and otherwise to the whole concept because we realized it would bring eventually tougher government regulations which bogs the system down and makes it difficult to deliver.

MICHAELSON: The Alaska Public Interest Research Group points out, however, that doctors and hospitals receive help from the federal government regularly in the form of research grants, subsidies to medical schools, and the financing of hospital construction. So they feel the doctors should take more responsibility for making federal programs like Medicaid work.

The next question: Are some of the problems between the medical community and the Medicaid program being solved?

FLEISCHER: The Department of Health and Social Services is working on the problem. The Governor recognizes that there is a problem. But still there is quite a time lag that can sometimes reach up into 90 to 120 days. That's awful hard to say, Bev, because there's a whole new ball game coming down and there's what is known as the State Health Plan, which is a big thick document superimposed on another big thick document called the State Medical Facilities Plan, which is terribly tough reading but seems to envision the State as going to set up in the next five years some sort of state health insurance where it's all under one lump program and so the whole thing is changing. If it's as bad as Medicaid when they get it, why then you will be a Medicaid patient along with the rest of us and will enjoy the benefits of it. I don't there there's any question about it. We understand that payments now are being made within 60 days of submission of billings to the State, and I don't think that's an unreasonable period of time for physicians to wait for a payment. It's certainly in accord with I think even private insurance coverage, or perhaps even better. So I don't really think that it even exists as a problem any more. There have been problems in the past, but we've been dealing with those problems. The fact of the matter is that the care is really owed to the community, to the poor people in this community, and the fact that there have been delays or hassles in payment should not be used as an excuse to refuse to treat poor people in Anchorage or in the state.

MICHAELSON: As the tugging and pushing goes on between the government and the doctors, the fact remains that there are many doctors in Anchorage who are not seeing Medicaid patients and, as a result, it is less likely that these people will receive the kind of medical care they may need.

And finally, and the most complex issue, is one that our nation is going to be dealing with for many years to come. That is, does the doctor have the right to refuse anyone who comes to him for help?

FLEISCHER: The doctors in our community really have an obligation to provide medical care to people who are so-called Medicaid patients, the poor people in Alaska. They're entitled to medical care along with all the other citizens in the state, and they're being denied it now because of the fact that they ar poor. I think that's wrong and we ask that it be changed.

FISH: I believe that we have an obligation to take-- I particularly feel I have an obligation to take care of a certain number of people who are not otherwise able to handle the situation. And a given number of these people are truly unfortunate and have no other access to medical care, and that happens to be my feeling. I do not believe, however, that it is, should ever be, a mandated thing that a person was forced to enter a system in which he didn't believe or didn't want.

* * * * *

South Central Health Planning and Development, Inc.
1135 West Eighth Avenue Suite 1 .
Anchorage, Alaska 99501

(907) 278-3631

OB Gyn

MEMORANDUM

FROM: Dennis DeGross

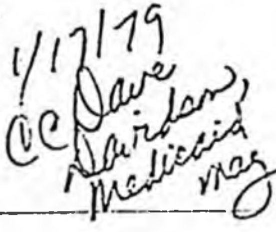
SUBJECT: Community Survey on Obstetrical Services

DATE: December 26, 1978

Enclosed you will find a . over letter and the Community Survey that was sent to all survey participants.

We would welcome your ideas and suggestions on any matters upon which you might wish to comment. Please call me at 278-3631.

Thank you.



1/17/79
cc Dave Davidson, Medicaid Mag

South Central Health Planning and Development, Inc.
1135 West Eighth Avenue Suite 1 Anchorage, Alaska 99501
(907) 278-3631

December 12, 1978

(This is a copy of the cover letter sent to all participants of the Childbirth survey.)

Dear:

On behalf of South Central Health Planning and Development, Inc., thank you for your willing participation in the enclosed community survey on Childbirth. I hope the information contained therein may be of some value to you and to your interest in childbirth.

As the interviews were being conducted, it became obvious that very few people are "neutral" about childbirth. It also became obvious that people who are involved in some way with childbirth want very much to communicate with others who are involved. The idea of a meeting of principal actors thus became almost inevitable. It was suggested that as a "disentangled" but not disinterested party, SCHPD Inc. might be an appropriate convener of such a meeting. Beyond saying that SCHPD, Inc. would be interested in a meeting or meetings which would attempt to deal with immediate, soluble problems, not much actual detail of possible agendas can be stated at this time.

Enclosed is an envelope addressed to SCHPD. If you are interested in participating in community meetings directed at some of the issues raised, please jot down your suggested agenda items--what subjects or problems on childbirth would you like to see addressed? You might also indicate best times for your participation (time of day, day(s) of week), and suggest other participants.

Again, thank you for your participation in this initial effort.

Very best regards,

Dennis P. DeGross
Health Planner

Encl.

CHILDBIRTH SURVEY: A LOOK AT OPINIONS ABOUT PRENATAL, DELIVERY, POSTNATAL CARE AND RELATED CONCERNS AS EXPRESSED BY VARIOUS REFERRAL AND SERVICE AGENCIES AND INDIVIDUALS IN ANCHORAGE.

Background:

In late October, medical staff from Anchorage Neighborhood Health Center, and staff from South Central Health Planning and Development, Inc. (the Health Systems Agency for South Central and Western Alaska) had discussions regarding reported claims that pregnant women (particularly women of lower economic means) were experiencing difficulty in obtaining necessary obstetrical services in Anchorage. These discussions raised the following questions:

1. Is there a shortage of obstetrical services (specialist and family practice)?

2. If there is a shortage, is it felt more in a particular economic segment of the population, such as among the poor?

3. Are Medicaid-eligible patients who are seeking OB services actually not able to obtain those services?

4. If enough prenatal work is not being performed in the community will that show up in the number and kind of unscheduled emergency deliveries being performed at the two hospitals or in any other form of "negative event" that can be documented?

5. Will a look at the volumn and quality of current home birth activities of the community reveal anything about who is not getting or who cannot afford prenatal care and delivery and hospital costs?

6. What new efforts are being put forth by physicians and hospitals, to meet the obstetrical needs of the community?

Summary of Results:

It was agreed that it would be an appropriate SCHPD, Inc. function to take a look at the community in the context of these questions, and attempt to establish some preliminary directions for future action.

The following statements are the results of interviews conducted by SCHPD Inc. staff. While they are anecdotal and hence, subjective, they would seem to confirm that some shortage of OB services does exist, and that the economically disadvantaged patients are those who are most likely to directly experience that shortage (Questions 1, 2, 3).

It is unclear from the interviews whether a scarcity of prenatal services is substantially manifesting itself in either an excessive number of unscheduled emergency room deliveries, or in other "negative event" results, such as toxemia of pregnancy, or stillbirth (question #4). That data may be retrievable with a concerted, well organized effort, and will be further explored with APRO and the two hospitals.

The interviews revealed a surprisingly substantial number of home births taking place in the Anchorage area (we estimate from 10 to 20 per month), but since many couples who choose home birth claim to do so for reasons other than finance, it is difficult to determine who has turned in that direction because they were unable to afford OB services (Question #5). One thing is clear, however, the current disdain expressed by physicians for home birth, and the lack of alternative "legitimizing controls" upon the practice, creates a potentially dangerous situation. The home birth people are a fact, albeit an unpleasant one in the eyes of the allopathic practitioners; the question is whether they (home birthers) will be allowed to continue activities as "outlaws", outside the pale of public and professional evaluation and control.

As for the efforts of the established medical system (Question #6) there are signs of change. More and more OB specialists are bringing OB nurse practitioners into their office practices, and the hospitals are beginning to discuss alternative modes of birthing. Recently, one OB specialist suggested that if each physician currently working in OB would take one Medicaid OB patient and one medically indigent OB patient per month, on a voluntary basis, the problem would probably clear up.

It has been reported that the OB section at Providence Hospital has appointed an informal committee to work with the Anchorage Neighborhood Health Center on some of these problems.

The interviews below were subjectively gathered, and are most certainly subjectively expressed. If as those of you who participated as interviewees read what we thought you said, you feel we have done violence to your intended meaning, please call, and we will circulate an errata among the participants. Copies of this report are being circulated to those people whose names appear on the list, which appears at the end of the interview section, in order that a sharing process among the principal actors may be started.

Copies are also being sent to all OB-Gyn practitioners and family practice physicians performing OB services, to Dr. Fred McGinnis, Deputy Commissioner of Alaska Department of Health and Social Services, and the administrators of all local hospitals, to the Alaska Professional Review Organization, and to all SCHPD, Inc. Board members.

At the end of the report is a survey of Anchorage OB-Gyns and family practitioners that was carried out by Jan Gehler, Human Resources Planner for the Municipal Planning Department. The survey has been invaluable to the conduct of this effort, and especially to various referral agencies in the community to whom such information is vital.

THE INTERVIEWS

Jerry Ekvall, Family Planning, Municipality

Jerry was quite aware of the difficulty in obtaining specialist services (OB-Gyn) for expectant mothers. She knows of very few who will take Medicaid patients, so she has been referring most Medicaid eligible and the medically indigent to the Anchorage Neighborhood Health Center. Jerry knew of one woman who could not afford physician or hospital costs who received no prenatal care prior to showing up at the hospital emergency room. Even though the ANHC is not able to provide the full range of OB services, referral is made because of concern that there would be more similar cases.

Cathy Bickerstaff, Planned Parenthood

Cathy has heard from many of the women who touch base with her that the OBs in town are not accepting new patients. She is quite certain that many OBs have said they won't accept Medicaid, and none will accept Medicaid for tubal ligations. She knows of a GP who will remove a uterus under Medicaid. She indicated it is becoming very difficult to obtain a legal abortion under Medicaid, but that legal abortions are difficult under normal economic circumstances, due to the limited access to services. She thinks a crucial issue is that it appears new patients are not being taken. Cathy is aware of the Medicaid snafu and is concerned that access to quality medical care for women will be seriously limited as a direct result.

Pam Albrecht and Evon Williams, Birthright

The belief of volunteers at Birthright is that a real crisis exists in obtaining adequate prenatal services for their clients--particularly among Medicaid qualified and the medically indigent. In an effort to determine which Obstetricians and Family Practice physicians would provide services for their clients, Birthright conducted a survey of all OB-Gyns and Family Practice physicians in August of 1978. With few exceptions, the results of that survey were similar to those of the enclosed survey, completed in mid-November by Jan Gehler, of the Municipal Planning Department. The Gehler survey was used to update the Birthright list (see attached).

Patty Boylan, Booth Memorial Home

It is Patty's impression that there is general difficulty in obtaining OB-Gyn services in Anchorage. She concedes that the extreme youth of the Booth Memorial Home client population may contribute to the reluctance by specialists to take them on as patients. Patty indicated that the Municipal Health Department had been very helpful in the past, in obtaining services. Patty was not particularly aware of a special problem with Medicaid.

Mrs. Wyrick, CHAMPUS Advisor, Elmendorf Hospital

Mrs. Wyrick definitely believes there is a shortage of OB services in Anchorage. She explained that only 60 deliveries per month can be performed at Elmendorf; any more than that must go into the civilian market under the CHAMPUS program. The patient is given a list of Obstetricians. Many OB specialists won't take OB patients, Mrs. Wyrick stated, and many who do seem to specialize in performing "C" Sections. Many OB specialists severely limit the number of patients they take, and very few will take CHAMPUS patients.

Jean Wolf, Community Health Nursing, Municipality

Community Health Nursing is usually not aware of a problem until they are put in the position of having to find OB services for one of their patients. Most of these referral problems involve Medicaid eligible, or medically indigent patients. The traffic has varied from one or two per day, to two to three per week. Referrals have been made to Anchorage Neighborhood Health Center for prenatal care, but most often, personnel from Community Health Nursing will stay on the telephone until a physician has been found who will take the patient.

Jean is aware that many home deliveries are being done in Anchorage, and while she is somewhat unsure as to the competence of current home delivery services, she indicated that there is a fairly large demand. Some women, either Medicaid eligible, or medically indigent, often experiencing the frustration of not obtaining physician services, simply say they will present themselves to an emergency room when it is time to deliver.

Jean acknowledged that, although the hospitals are probably "carrying" patients who are unable to pay, it is not common knowledge among the public that free services are available in a "crunch". Also, in the case of physicians who assert their willingness to accept charity cases—that fact may not be completely understood by the physician's reception personnel, who are motivated to keep the physician solvent, and who may thus discourage the charity patient.

Jean concurs with the majority medical opinion, which perceives home deliveries as basically dangerous; but on the other hand, she is sorry people who have no other alternative are forced to "sneak around" in order to deliver at home--the medical community is turning its back on this rather sizeable activity.

Jean believes a meeting of principle participants is needed in order to solve this community problem.

Gayle Stevens, Nurse, Open Door Clinic

Gayle said it has been very difficult to obtain obstetric services for their patients from time to time. It was particularly bad during the past summer—so bad that Open Door conducted a telephone survey of OB-Gyns, and Family Practice physicians, in order to determine who was taking new patients, who would provide prenatal care for home births (for those women who stated a determination to do that), who would accept Medicaid, and how much each charged for services. The results of the Open Door clinic survey were very similar to

those of the Gehler survey (see attached).

Open Door Clinic was doing some prenatal awhile back, but as the Anchorage Neighborhood Health Center began to take more prenatal visits, the number of such visits to the Open Door Clinic abated somewhat.

A considerable number of women are delivering their babies at home, but that activity is not seen as legitimate by, and is not under the control of, the established medical community. Home birth is a sizeable "in the closet" activity in Alaska.

A possible reason that physicians are reluctant to take Medicaid or CHAMPUS patients, is that the maximum allowable charges under those programs are considerably lower than their "usual and customary" charges.

William Compton, M.D., Providence Professional Bldg.

Dr. Compton agrees that there is a great demand for obstetrical services, but is unclear as to the extent of shortages. Obstetricians do have more than enough work. Many obstetricians are sliding toward elective gynecological work because it is less demanding than OB work.

Dr. Compton's own process is to see to the patient's care first, then deal with the money questions later. He thinks most patients fall into some form of financial capability, Medicaid, CHAMPUS, insurance, etc. On the other hand, he acknowledged that he has a tremendous accounts receivable situation, which he felt sure is the case with his colleagues.

See 1/19/79 Anch Daily News article

That physicians are somewhat reluctant to work with Medicaid and CHAMPUS is understandable, in light of the discrepancy which exists between the "maximum allowable" costs provided by those programs, and the real costs of services reflected in physician's "usual and customary" charges.

Dr. Compton indicated that the problem of obtaining OB services for Medicaid patients was not a new one, and that he favored an effort by obstetricians to voluntarily deal with the problem. He does not view current efforts by the Anchorage Neighborhood Health Center to provide additional prenatal services as ideal, since that agency has no OB-Gyn on staff, utilizes an OB consultant to the Nurse practitioners from several miles away, and will then expect emergency room, on-duty and on-call physicians to deal with crisis situations as women present themselves for delivery—all this without prior contact between patient and medical personnel.

Dr. Compton is of the opinion that home deliveries are extremely dangerous and does not support movement in that direction. He sees Providence Hospital's development of "birthing" rooms as a "maybe" compromise for families who want a more comfortable and relaxed birth experience.

Pat Vezina, Nurse, Labor and Delivery, Providence Hospital

Pat discussed the addition of the new "birthing" rooms at Providence Hospital. Except that a woman will not be moved from one room to another during

labor and delivery, she perceives that the new set up will offer minimal advantage over the existing system. The new rooms will require the same amount of staffing over time, so that, except that staff will have one less room to clean up, actual costs will not be much less than before. Of course, the rooms will be comfortably decorated in a much more homey atmosphere than previously. Naturally, if length of stay is reduced, that will substantially affect the cost for the patient, but it is not clear that length of stay will actually be reduced.

Pat suspects that the medically indigent have a good deal of trouble obtaining OB services. She estimated that several women per month show up at the emergency room for delivery without having had adequate prenatal care.

How much of the current "crisis" is related to the events surrounding Alaska Clinic is uncertain—Providence Hospital, in two months, delivered 169 babies each month, a record number.

The shortage of prenatal care is perhaps not acute, but is rather a distribution problem. Many physicians who are qualified to perform those services have moved over into elective gynecology, she stated.

Pat had a concern about the Anchorage Neighborhood Health Center's recent movement in the direction of providing additional prenatal care <u>without</u> delivery services. Agreements with emergency rooms notwithstanding, ERs are not in the delivery business—they don't always have the expertise. Physicians, on call or in house, will know very little about case histories of individual patients as they show up at the ER for delivery.

Pat believes some of the financial pressure, as well as reported shortages might be solved by the OB-Gyns employing more OB nurse practitioners/midwives in their practices. She was not sure this would solve the more severe financial difficulties experienced by some patients.

On the issue of home birth, Pat pointed out that she was a midwife in England, where she performed home deliveries, but where there was a mobile emergency capability especially set up for home birth. She has since discovered that in the time she has been away from England, that situation has changed--most deliveries now occur in the hospital there.

Most deliveries are normal, she said, and will present no special difficulty. She thought about 4 or 5% of deliveries will require technological intervention. A portion of that 4 to 5% can be successfully screened, so that the early detected problem could have been referred for a hospital delivery in the first place. Other serious problems (the remainder of this percentage) would not become obvious until labor and delivery had begun.

An impediment to the utilization of midwives in Providence Hospital, is that presently, only physicians and dentists are allowed to admit patients. There would need to be a change in hospital bylaws covering admitting practices, before nurse midwives could be utilized with any force.

William Ivey, M.D., Gynecologist, Alaska Hospital

Dr. Ivey did not address the question of whether or not there is a shortage of obstetrical services directly. He did say that obstetricians tend to get

bored with routine deliveries--because they are trained to deal with problems. He added that physicians in family practice could probably not allow themselves to become too heavily burdened by deliveries.

He believes there needs to be a less expensive service for routine OB, and that that may very well be in an increased utilization by the medical system, of nurse/midwives, but only in a hospital setting.

Jerry Travis, Director, Municipal Emergency Service

Jerry stated that his paramedics, up through Nov. 27, had responded to 91 calls that they classified as "OB-Gyn". He estimated that from 40% to 45% of those were births, some of which occurred in-transit in the vehicle. He did say there were no "code red" calls, which indicates that emergency personnel were primarily involved with completing the delivery.

Jerry stated that many of these responses involve economically indigent and minority (but non-Natives--he said they had had very few transports to ANS for Natives).

Judy Anderson, New Mother, Anchorage

Judy is very disappointed in the limited options available to the expectant mother in Anchorage. She is particularly critical of the hospital setting as a place to have babies, stating that hospital staff and physicians tend to be very authoritarian, which does not offer the woman any control in birthing.

Judy's notion of an ideal birthing center is a place where prenatal care, birth, and postnatal care occur. It has a "home-like" atmosphere, where the family (if desired), even children, may participate in the birthing. It is medically staffed to handle the unscreened emergencies, or has close access to that capability. Even "C" Sections might be performed there. The Birthing Center would not be available for the "pre-screened" serious compl[illegible]tion.

Judy is of the opinion that what Providence Hospital is planning could in no way be called a Birthing Center. Doing everything in one room (birthing and after birthing) is only what every hospital should be doing anyway and should not be perceived as a great stride forward. Pictures on the wall do not make a birthing center, in her estimation, trained staff, and a major change in institutional attitude are required for that.

Judy is for home delivery as long as there is careful screening and competent personnel involved.

Peggy and Clay Newman, Homebirth Classes, Anchorage

Prenatal care is scarce for persons planning home birth, according to Peggy and Clay Newman. Currently, they utilize two or three physicians to provide prenatal services. However, since physicians tend to put patients

Freda Refuge, Information and Referral, Women's Resource Center

Freda says they have a logbook full of women calling in for help in getting OB care. A lot of it is abortions but much is also prenatal care. She says there are also many complaints about not being able to get general medical care if you're Medicaid other than at ANHC. Referrals from there get "tough" as providers "won't accept medicaid patients".

Rona Meyers, Home Birth Person, Anchorage

Rona, who is present at about five home deliveries each month, states that pregnant women are having extreme trouble in finding prenatal care in Anchorage. The Open Door Clinic has provided some, and most recently, Anchorage Neighborhood Health Center. She says she has far more demand for participation with couples wanting home delivery than she could ever handle. She screens couples intensively, therefore, and actually participates with only a small portion of those who approach her. She believes only about 40% of home deliveries are for financial reasons--the rest want to deliver in the home for other reasons.

Doris Williams, Ph.D., Naturopath, Anchorage

Dr. Williams is certin many expectant couples have been refused service, simply because the schedules of OB specialists are filled up and they aren't taking any more patients. However, she believes there is not so much a shortage of OB services in the community, as there is a limited choice.

Dr. Williams estimates that home birth may account for up to 5% of all deliveries in Anchorage. She said many who start out with the intention of delivering in the home, change their minds later--they may develop some fear about what they are doing, or they may develop complications which can only be dealt with in a hospital. In her estimation, roughly ½ of home deliveries are for reasons of finance--the remainder simply do not want to deliver in a hospital.

Judy Sharp, Social Services, Providence Hospital

Chris Beardsley, Public Relations, Providence Hospital

Mr. Beardsly believes there is a shortage of OB services if one is speaking exclusively about the number of OB-Gyns in the community, but thinks that by adding in family practitioners who are involved in delivering babies, that situation changes dramatically for the better. He thinks many people could get high quality care from family paractice physicians, but prefer a specialist, which adds to the problem, since, even among the OB-Gyn, a small number are in <u>very</u> high demand as opposed to others. He also stated that we might get a different picture of "shortage", if we knew whether a lot of "physician shopping" may be conducted by couples in their <u>third trimester</u>. The third trimester pregnancy would discourage some physicians from accepting a patient.

Judy was of the opinion that there definitely <u>is</u> a shortage of OB services in the community, and thought there might be a way information could be obtained from patient records, which would give the community a better understanding of how many women come into the emergency room or L and D, having had inadequate prenatal care through their gestation period. She personally could recall three

deliver at home, will refuse to continue as physician in the case. Many couples who are aware of the physician displeasure with home birthing will not inform their physician of their intention to deliver at home, thus risking the possibiljty that during prenatal some aspect of the developing pregnancy which would ordinarily rule against a safe home birth, might not be articulated.

The immediate future of the recently "stepped up" prenatal work being performed by Paula at the Anchorage Neighborhood Health Center is in doubt. From January through April, she will be attending Midwifery school in the Lower 48, during which time, prenatal care at the Center will have to be curtailed. What this will mean to the community is unknown.

Contributor/Participants of the Childbirth Survey
(In order of interview)

Jerry Ekvall - Family Planning, Municipality
Cathy Bickerstaff - Planned Parenthood
Evon Williams & Pam Albrecht, Birthright
Patty Boylan, Booth Memorial Home
Mrs. Wyrick, Champus Advisor, Elmendorf Hospital
Jean Wolf, Community Health Nursing, Municipality
Gayle Stevens, Nurse, Open Door Clinic
William Compton, M.D., Providence Professional Building
Pat Vezina, Nurse, Labor and Delivery, Providence Hospital
William Ivey, M.D., Alaska Hospital
Jerry Travis, Director, Anchorage Municipal Emergency Service
Judy Anderson, new mother, Anchorage
Peggy Newman, Teacher, Homebirth Classes, Anchorage
Clay Newman, Teacher, Homebirth Classes, Anchorage
Cheryl Westley, Chairman, Education Committee of Childbirth Educ. Assn.
Trudy Keller, Childbirth Ecucation Assn., Anchorage
Betsy Baker, Director, Women's Resource Center, Anchorage
Freda Refuge, Information and Referral, Woman's Resource Center, Anchorage
Rona Meyers, Homebirth person, Ancho_age
Doris Williams, Ph.D., Naturopath, Anchorage
Judy Sharp, Social Services, Providence Hospital
Chris Beardsly, Public Relations, Providence Hospital
William Larson, M.D., Anchorage Neighborhood Health Center
Kaaren Riehle, Planner, Providence Hospital
Pat Sandberg, Social Services, Alaska Hospital
Obed Nelson, Chaplain, Alaska Hospital
Jan Gehler, Human Resource Planner, Municipality of Anchorage
Paula Korn, Anchorage Neighborhood Health Center

Survey Date: November 9, 1978

SUMMARY OF SURVEY FINDINGS

N = 55 physicians (38 family practice; 16 OB-GYN)

	Family Practice	OB-GYN
Do you take OB patients?	13 Yes*	13 Yes 3 GYN only
(* one FP sees OB's for first visit only; then refers to OB-GYN)		
Are you currently accepting new OB's?	12 yes	9 yes most on limited basis; not before 3rd month.
Average waiting time first appointment?	2-4 weeks	4-6 weeks
Will you admit to either hospital?	5 both 7 only Providence 0 only Alaska	4 both 7 only Providen[ce] 2 only Alaska
Will you accept Medicaid patients?	2 limited (2-4/months) 0 unlimited	4 limited 1 unlimited
What is your deposit and/or fee for normal delivery?	Range for 1st visit deposit Range for full fee	\$0 to \$350 \$550 to \$750

2 out of 38?

5 out of 13 –

However look at up-front fee demands which, if followed, would Eliminate in practice all Medicaid

Survey conducted b[y]

Jan Gehler
Human Resources Pl[anner]

Anchorage Municipal
Planning Department

NAME:	Specialty Type	Do you take OB patients?	Are you currently accepting new OB patients?	What is the average waiting time for first visit?	Will/Do admit to either hospital? Which if only one?	Will/Do you accept Medicaid patients?	What is your "deposit" fee for OB patient
Agnew	FP	No (Provides list of OBs)	Taking no new pts. now		Both	Some	
Arbow	FP	Yes	Yes	< 1 week	Only Prov.	No, CHAMPUS	$600 total due within 3 months
Billings	FP	No					
Bing	FP	Yes, only 1st visit; refer to Dr. Eastburn	Yes			Yes	N.A.
Bosveld	FP	Yes	1st appt. in 3rd mo., sooner if problem	1-2 weeks	Yes, mostly Providence	No. CHAMPUS, Yes.	$560, $2 [illegible]
Bryan	FP	No, refer all to Dr. Eastburn.					
Burgess	FP	No, provide list of all OBs.					
Cates	FP	No.					
Colyar	FP	No, refer all to Nist.					
Compton	OB	Yes.	No, Booked annual exam thru Jan.		Yes, Prefer Providence	Yes, some. No CHAMPUS.	$600 tot
Cormack	FP	No, refer all to Eastburn.					
Crawford	FP	No.					
Eastburn	OB	Yes, current no GYN	Yes, if [illegible], or more	6 weeks to see Nurse Pr.	Only Prov.	Yes, no CHAMPUS	$50 down $707.50 b 9th mon.
Erkman	OB	Yes.	Yes	2-3 weeks	Only Prov.	Yes, 3-4 mos No CHAMPUS	$700 by 9 mon., No
Ekvall	OB	Yes.	NO, refers to Erkman & Hanson		Only Prov.	No	$700
Feirtag	FB	No					
Ferucci	OB	Yes	Yes	1-2 N.P. --small group 3-4 wks. DR.	Only Prov.	No. No CHAM.	$600
Foland	FP	Yes, limited to 6 mos.	No	4-6 wks.	Yes, Mostly AHMC	No	$560 total due by P.I. $250 at 1st appt.
Gibson	OB	Yes, only continuing	No	Will not see 'til 3rd mo. 2-3 weeks	Only Prov.	Yes, a few per month	$700 by 9 month

Name	Specialty Type	Do you take OB patients?	Are you currently accepting new OB patients?	What is the average waiting time for first visit?	Will/Do admit to either hospital? Which if only one?	Will/Do you accept Medicaid patients?	What is your "deposit" fee for OB patient
Gills	OB	Yes, only if due before June, Dr. will be gone summer.	Yes, Ltd.	At 3 months 1-2 wks.	Only Prov.	No, No CHAM.	$750 $175/mon.
Guenther	OB	Yes	Yes	At 3 months 2-3 weeks	Only AHMC	No. Yes, CHAM.	$600 plus Post-pa
Benson	OB	Yes	Yes, if 8wks or more		Only	Yes, No, CHAM.	$700 to
Ivy	OB	No, only GYN	Refers to Phone book		Only AHMC		
Jackson	FP	Yes	Yes	1-2 weeks	Only Prov	Yes, 3/mo. CHAMPUS	$600 tota $64/first
Jones, L.	FP	Yes	Yes	<1 weeks	Only Prov	No. CHAMPUS	$600 w/in months
Jones, W.	FP	Yes	Yes	2-4 wks.	Only Prov	None	$550; $50/ visi
Kiessling	FP	N.A.					
Laufer	FP	Yes	Yes	< 1 week	Only Prov	No. CHAMPUS	$600/w/in
Little	FP	Yes	Yes, 1st appt. at 3 mo., earlier if problem	1-2 weeks	Yes, most Pr	No. CHAMPUS	($560 due) $250, 1st
Manwiller	FP	Yes	Yes	2-4 weeks	Only Prov.	None	$550; $50 vi
Martin	FP	No					
Mayer	FP	No					
McCumber	FP	No					
Monlux	FP	No					
Morgan	FP	No					
Moseley	FP	No					
Newton	OB	Yes, mostly GYN, repeat C-sections	No		Both	No	
Nist	OB	Yes	Yes, 10 del. per month	1-2 weeks	Yes, Prefers AHMC	None	$350/1st
Nolan	FP	No, refers to Eastburn					
Olsen	FP	No					
Orren	OB	Yes	Yes	4-6 weeks	Only Prov.	None	$100/1st v
Persons	FP	No					

NAME:	Specialty Type	Do you take OB patients?	Are you currently accepting new OB patients?	What is the average waiting time for first visit?	Will/Do admit to either hospital? Which if only one?	Will/Do you accept Medicaid patients?	What is your "deposit" fee for OB patient
Renn	OB	Yes	Yes	4 weeks	AHMC	No. CHAMPUS	20-50% of total pri to delive
Romig	FP	No					
Smith	FP	No, refers to Eastburn.					
St. John	FP	No					
Straasky	OB	No					
Sutherland	FP	No					
Sydnam	FP	Yes	Yes	4 weeks	AHMC only	No. CHAMPUS	20-50% pr to delive
Wagnon	FP	No					
Wallner	OB	Yes, only C-sections	No		Both	None	
White	FP	No					
Wieland	FP	Yes	Yes, 1st ap @ 3 mos., sooner if problems	1-2 weeks	Yes, mostly Providence	No. CHAMPUS	$560 tot $250 dow
Taylor	FP	Yes	Yes	<1 week	Only Prov.	None	$600 with 3 months
Addenda:							
Sangster	FP	Only Prenatal			No	Some	Blood wk. Papsmear Visit

ALASKA PUBLIC INTEREST RESEARCH GROUP

Post Office Box 1093/Anchorage, Alaska 99510/(907) 278-3661

Board of Directors: Hugh Fleischer, Chairperson; Julie Wroe, Vice-Chairperson; Molly Crenshaw, Secretary; Don Clocksin, Treasurer; Eleanor Andrews; David Case; Judy Whitney Eckholm; Bob Goldberg, ~~Terry Stimson~~ Phil Voland

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INTRODUCTION

The Alaska Public Interest Research Group newsletter is available to any AkPIRG member. The subscription price is the same as membership dues: $10 to individuals, $25 for institutions or businesses, and $5 for persons on limited incomes. The Alaska Public Interest Research Group is a non-profit citizens group, tax exempt under 501 (c) (3) of the Internal Revenue Code.

AkPIRG offices are located at 513 West Seventh Avenue, Anchorage, Alaska. The mailing address is P.O. Box 1093, Anchorage, Alaska 99510. The phone number is 278-3661.

Comments on the newsletter, or any other aspect of AkPIRG activities are appreciated.

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NEW DATE FOR ANNUAL MEETING

The annual meeting of all AkPIRG members has been rescheduled. Originally planned for the 17th of January, the meeting will now be held January 25, 1979 at the Pioneer School house at 3rd and Eagle. The time of the meeting is set for 7:00 P.M..

(Continued on Page 3)

DOCTORS TO CANCER PATIENT - DROP DEAD -

Early in May, right before break up, Kristi Carnes, her husband Doug and their two year old daughter Annathea, borrowed a friends dog team and traveled 200 miles from their home, near Ambler, to Kotzebue. There Kristi and her family camped out while Doug found a construction job to earn some summer money to last the rest of the year.

In early June she visited the Kotzebue health clinic for a routine medical check-up. But the check-up was anything but routine. Kristi's Pap test indicated the presence of early stages of cancer.

Kristi then contacted Dr. Ed Vandenberg, who worked at the local Public Health Service hospital. He performed two separate biopsies. The diognosis was moderate to severe dysplasia - a cancerous growth on her cervix. The doctor recommended the surgical removal of part of her cervix, a procedure known as cone biopsy. The goal of the operation was to remove the cancerous growth before it spread to the uterus and other parts of her body. No doctors at the Kotzebue hospital had ever done it before, so a visit was planned to seek medical care elsewhere. Later in the year she visited her family in Chicago, and saw another doctor who performed four new biopsies which confirmed the earlier diagnosis. He as well recommended the cone biopsy at the earliest possible date.

(Continued on next page)

After Kristi and Doug paid their doctor bills, had some dental work done, paid off old debts, and bought provisions for the winter, they were nearly broke. Kristi then turned to medicaid, the state program which provides medical care to indigent people. Doug traveled to Anchorage, where he began contacting doctors. He explained Kristi's situation. She needed the cone biopsy operation, and she needed it soon, if she was to avoid a hysterectomy. Kristi was only 23 years old, and she and Doug planned on having another child. They didn't have any money for the operation, but they were approved for medicaid.

Doug talked with Dr. Orren. His office said they were sorry, but Dr. Orren did not take any medicaid patients. Doug was given the names of other doctors to call. When none of them panned out, Doug called Dr. Orren's office back and asked once more if he would treat his wife. The receptionist said that they were sorry, but they were not taking ANY medicaid patients.

Doug talked with eight other Anchorage doctors. None of them would treat his wife. Some said that they just were not taking any new patients, while others, like Drs. Renn, Stransky, and Guenther, said they would not see her because she was a medicaid patient.

But Doug and Kristi were lucky. Through a friend they found Carolyn Brown, a Palmer doctor who had no qualms about treating medicaid patients. But the implications of her experience are shocking. There are a large number of doctors in the Anchorage area who refuse to treat poor people on medicaid.

To find out why local doctors would refuse medical treatment to poor people, AkPIRG contacted Martha MacDearmaid, the Executive Director of the Alaska State Medical Association. She was very open in explaining the situation. Lots of doctors do not treat medicaid patients, and the reason is economic. The state is chronically late on its payments, and the doctors claim that the state only pays two-thirds their normal bill.

Kristi's situation was explained, and Ms. MacDearmaid said that there was probably some doctor who would treat her on medicaid, although some patients would undoubtably go without proper medical care due to the widespread doctors boycott of the medicaid program. She indicated that there had been some meetings with state officials regarding the problem, and expressed hope that the state would improve its record and the doctors would begin treating medicaid patients once again.

After all, she said, you have to remember that those doctors have to borrow money from banks at high interest rates to pay their bills, while waiting for the medicaid checks. Lately, Ms. MacDearment said, they have been paying 13 to 14 percent interest on those loans. And, business is business.

PRUDHOE BAY PRODUCIBILITY AND THE ALCAN GASLINE

(Ed. NOTE: The following article was written by Anchorage resident Jerry McCutcheon. Jerry has taken a keen interest in the issue of managing oil producing fields, so that proper conservation methods are employed to insure the full recovery of the oil. He has embarked on a one man crusade to convince state legislators and other public offices to consider these important issues.)

Of the 22 billion barrels of oil in Prudhoe Bay, 14 to 15 billion barrels are producible with current technology similar to that being used in the Swanson River Field on the Kenai Peninsula.

This fact can be established in the technical literature and is admitted by the oil companies. It requires the injection of gas from other sources and in an amount equal to that necessary to maintain the original pressure and that gas would have to be cycled through the reservoir 3 or 4 times.

If only the existing gas is reinjected but not cycled through the reservoir and the reservoir is water flooded to help maintain pressure in the 6th year, oil recovery falls to 9 billion barrels. Had the reservoir (Prudhoe Bay) been water flooded from the start of production the oil recovery would have been 9.6 billion barrels. For every 100 pounds of pressure that Prudhoe

POSITION PAPER
ON
HOUSE BILL NO. 226

"An Act amending the definition of unprofessional conduct in the practice of medicine."

This bill would redefine the definition of unprofessional or dishonorable conduct in the practice of medicine by the addition two paragraphs.

(I) requires physician to disclose to the patient the nature of the patient's illness, injury and disease; and

(J) to prevent the wilful misrepresentation by a physician to a patient of the nature of the patient's illness, injury, or disease.

(I) attempts to substitute a simplistic legal mandate to a judgmental physician/ patient relationship and ignores the sensitive paitent/physician relationship involving interface of scientific knowledge and the art of practicing medicine and in the interpretation of the patient's overall well being. An example, a potentially suicidal patient does not immediately need to know his diagnosis and imparting the knowledge is a decision of the physician and patient's family.

Paragraph (J) would already seem to be adequately covered in the principles of medical ethics of the American Medical Association and the Alaska State Medical Association.

Recommended by: Robert I. Fraser, M.D., Director
Division of Public Health

Approved by: Helen D. Beirne, Commissioner
Dept. of Health & Social Services

POSITION PAPER
ON
HOUSE BILL NO. 228

This bill is directed at resolving current difficulties in receiving medical care from Alaska physicians through the state/federal Medicaid program. The bill would expand the present definition of "non-professional or dishonorable conduct" under the state licensing provisions found at AS 08.64.380(3).

Essentially, the bill is designed to force physicians who receive public funds from any governmental source to see and treat Medicaid patients upon demand. House Bill 228 is designed to avert a crisis, such as the one that lead to the difficulties in receiving medical care under Medicaid and GR Medical in late 1978 and continuing to date.

These difficulties are the result of three factors:

(1) The Department's shortfall of funds for physicians services during FY 78. This shortfall occurred because the FY 78 Medicaid appropriation prevented transfer of available funds from one line item to another without specific legislative authorization. This system of legislative appropriation was changed in FY 79 and physicians are not experiencing any difficulty in receiving payments on current year bills.

(2) Slow turnaround of provider billings caused by an inefficient payment process. Currently, bills are paid within five weeks of receipt as compared to an average of three months in late 1978. This improvement resulted from additional temporary staff, not from a permanent improvement to the processing system. The Department is in the process of evaluating alternatives to the existing payment system.

(3) Costing-down of physician's bills paid by Medicaid and GR Medical.

House Bill 228 appears predicated on the following assumptions:

(1) Physicians should have continued to see and treat Medicaid/GR Medical clients in spite of the financial severity of the Department's shortfall of funds in FY 78 and its effect on their personal practice. (Note: Between Medicaid and GR Med, the Department fell 35% short in funds available for physicians services in FY 78.)

(2) That there are not other factors present in Alaska which may have contributed to this problem such as a shortage of doctors in certain areas of specialization.

(3) That this crisis cannot be adequately addressed by the Department through the administrative process, or by narrowing the scope of

House Bill 228 specifically to the Medicaid statute. House Bill 228 makes refusal to see Medicaid patients a violation of licensure rather than a violation of the contractual agreement between the physician and the Department. It therefore has the potential of adversely affecting physicians not currently enrolled as medical providers under Medicaid who may yet provide some public services such as those delivered in the correctional institutions.

The Department is presently involved in an independent study to determine whether this medical crisis will be largely resolved once the FY 78 supplemental is passed (House Bill 143) and pending bills are paid. Our study will attempt to ferret out those doctors who are in fact interested in seeing Medicaid patients without restriction, and determining if the resultant number of available doctors is adequate to cover all specialties. Until this effort is completed, the Department believes it premature to take a position on House Bill 228.

Recommended by: Rod Betit — Feb 20, 1979
Rod Betit, Director (DATE)
Division of Public Assistance

Approved by: Helen D. Beirne — 2/30/79
Helen D. Beirne, Commissioner (DATE)
Department of Health and Social Services

AkPIRG takes doctors to task

By SUZAN NIGHTINGALE
Daily News Staff Writer

The Alaska Public Interest Research Group says it will ask the Alaska State Medical Association to adopt a standard making it unethical to discriminate against Medicaid clients.

Many physicians around the state won't accept Medicaid patients because they don't like the state's management of the Medicaid system, which owes doctors between $500,000 and $1 million due to a 1978 budget shortage. Others say they don't want to deal with the paperwork required to treat Medicaid patients and complain that they are paid only a fraction of their total bill under the program.

BUT AkPIRG director James Love says the doctors are making poor people pay for state mistakes. "Sure the bureaucracy is screwed up," Love said, "but it's not the bureaucracy that's standing out in the halls unable to get medical care, it's people.

"We'd like the medical community to take responsibility for indigent people and health care. Their attitude is, 'It's not our fault,' but they enjoy special privilege and special status in this society and they have some responsibility for that."

Referring to the current refusal of some doctors to treat Medicaid patients, Love said if those doctors refused to treat people with insurance policies and concentrated only on cash patients, "there would be a hue and cry like you would not believe. The only reason that doesn't happen with Medicaid in this community is because they're poor people."

IN A LETTER sent to the medical association by AkPIRG board chairman Hugh Fleischer, the consumer group requested a meeting with the doctors to discuss the problem.

"The present situation with the Medicaid program can only be described as a crisis for poor people," that letter said.

In his letter Fleischer maintained that the medical profession itself has benefited from public programs in the form of grants, research, tax breaks and state-financed hospital construction, and so cannot turn its back on its public responsibility. "Our organization is upset with the behavior of the medical community. It seems incredible that poor people who need medical treatment would be refused for any reason, let alone the stated grievances of the medical community. Physicians, as a class, are doing very well in Alaska.

"ALASKA doctors deal with no more red tape regarding the Medicaid program than doctors elsewhere."

But at least one health care representative questioned that claim. Dan VanEaton, business administrator for the Alaska Clinic, said Monday that the state's Medicaid system was "a key reason" in the clinic's closure last year. VanEaton said the state owes the clinic, which treated an estimated 80 percent of the Medicaid patients in Alaska, $200,000.

"They've owed us $200,000 for seven months," VanEaton claimed. "And I'm certain, I'm certain, if and when the legislature ever appropriates a supplemental budget, they'll tell us they haven't processed the paperwork yet."

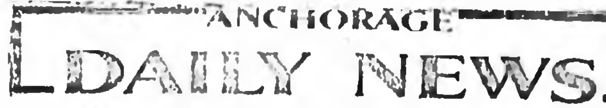
CAUSE OF the immediate health care crisis was a budget shortfall during fiscal year 1978 when the section of the Medicaid budget earmarked for doctors ran short. A new state law prevented public assistance officials from transferring funds from another section of the Medicaid budget without legislative approval.

With the legislature now in session, public assistance officials say they hope that transfer can be made soon, clearing up the backlog in 1978 Medicaid payments.

Fiscal year 1979 payments are being made.

Poor people are having trouble getting health care in Alaska, partially, doctors say, because the state's Medicaid system has burdened physicians with paperwork, expense and hassle. But what about the people who are turned away from office after office? What are the reasons? Where is the responsibility?

4—Anchorage Daily News, Saturday, February 3, 1979


ANCHORAGE DAILY NEWS

Lawrence Fanning
Editor and Publisher, 1967 to 1971

Katherine Fanning
Editor and Publisher

Stan Abbott
Executive Editor

Alaska's Only Morning Newspaper
Founded in 1946 by Norman C. Brown

2/3/79 ADN

Saturday Forum: Medicaid

Do poor have a 'right' to care?

By JAMIE LOVE

To say that people should have proper health care is like saying they should have food to eat and a roof over their heads. Few will readily disagree, and there will be much nodding of heads.

That poor people should have the same rights to health care as others seems to most a reasonable goal, and one that many assume is already achieved. But the stark reality of today's world is much different. Yes we have a government program to provide health care to the poor: Medicaid. But no, poor people can't get health care through the Medicaid program. Doctors, or at least growing numbers of doctors, won't accept Medicaid patients.

This is of no small concern. Real people with serious medical problems can't get treatment;

— A woman comes from Kotzebue to Anchorage for an operation. She is told she has an early stage of cancer. No doctor in Anchorage will treat her.

— A woman sits in a hospital waiting room. She has an open wound and needs attention. She waits five hours but still no doctor will see her since she is on Medicaid. She leaves and goes home.

— Another who is pregnant has placenta prevea. She may bleed to death. No doctor will see her.

— Several women are told by public health nurses they have toxemea, and are poisoning their unborn children. Doctors will not treat them because they are Medicaid patients.

Since the Alaska Clinic shut down last summer it has gotten tough. At one time many doctors treated Medicaid patients. Now it is few. In Anchorage, only two pediatricians. It is next to impossible to find an OB/GYN doctor who sees Medicaid patients. Other specialties are not yet as grim, but things are getting worse.

What is the problem?

— **Doctors complain that medicaid vouchers are not paid timely.** In fact, this is only a problem for those Medicaid billings from the last quarter of fiscal year 1978, which ended on June 30, last year. Doctor billings were higher than expected, and the money ran out. This will soon be solved by a special appropriation. When doctors bill for Medicaid services being performed today, however, payment is made within five to six weeks.

— **Doctors complain about the paperwork.** But, Alaskan doctors only fill out the same forms every other doctor in the country uses. They are not particularly long, and one clerk can prepare the monthly billings for six doctors in a single day.

— **Doctors complain because Medicaid only pays 70 percent of their billings.** Indeed, this is true for some doctors. But it is only the result of a formula that is required by federal law. That formula limits the fees doctors charge to average billings from the previous year. Doctors who charge high prices for care get their bills reduced, others don't.

Why don't doctors treat Medicaid patients? Some just don't like people on welfare. For the rest, it's a combination of the reduced fees and the chance to avoid the extra hassle. Plenty of patients to choose from, so why take Medicaid patients? Blue Cross offers a better deal.

And this is it. Adam Smith's invisible hand on the market. Doctors are looking after their own economic self interest. Medicaid patients just don't pay as well as others.

This is unacceptable. Health care is not just another snowmobile or Maytag washing machine. The doctor's boycott of the Medicaid program is the worst type of blackmail. The pitch is blunt. Your money or your life. And while doctors have been quick to say they don't like the system, they offer no alternatives. They say they treat charity cases, but check with the patients — they don't.

The doctors' solution for poor people is simple: Ignore them.

The community must deal with this crisis. If doctors in private practice refuse to see Medicaid patients, and if they can't be forced to treat them, the society has a responsibility to take over where the physician's professional ethics end. And speaking of ethics, I'd like to quote from an ethical standard the American Medical Association actually adopted in 1934:

"One of the strongest holds of the profession on public approbation and support has been the age-old professional ideal of medical service to all, whether able to pay or not. That ideal is basic in our ethics. The abandonment of that ideal and the adoption of a principal of service only when paid for would be the greatest step toward socialized medicine which the medical profession could take. . . .

Too often this ethic is honored in the breach, but the message remains the same.

James Love is director of the Alaska Public Interest Research Group.

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Fable of a 'sick system'

By WINTHROP FISH, M.D.

When I was in medical school, a lovely lady obstetrician at the university gave free care to all the nurses, doctors' wives and such. She was very, very nice, very, very popular, and very, very free. In short order, she was exhausted, going broke, and had to leave. She was prologue.

The media of late has raised a modest hue and cry over the plight of the Medicaid recipients in Alaska, suggesting that perhaps medical care was not readily available to some. The ruckus seemed to stem from two sources: a self - appointed group protecting the public interest that appeared to suggest doctors were discriminating against Medicaid recipients; and some physicians who felt economic discrimination by the state Medicaid

"Suppose for the moment that once upon a time most grocers felt a centuries-old, charitable obligation to contribute to the community soup-kitchens . . ."

program.

Both are right to a point although, in Alaska at least, the doctors' complaints are probably more valid. But, if either group were transported to the barrios of East Los Angeles, to the socio - economic scene there, and confronted Medi - Cal, their troubles here would seem trivial indeed. For both complaints are simply symptoms of a sick, sick system; both are indicators, early in Alaska, of at least two evolutionary outgrowths of this sick system: 1) inflation of medical costs; and 2) what the politicians never mention in public — rationing of medical care! To understand better, a little parable is in order.

Suppose for the moment that once upon a time most grocers felt a centuries - old, charitable obligation to contribute to the community soup - kitchens. Then, suppose that a couple of decades ago the government declared nutrition a basic human right and promised equal access and quality of food for all Americans, started a program supported by Social Security tax dollars, called Nutricare and Nutricaid for the old and poor respectively; formed a huge sprawling Nutricare Administration; and offered the states matching funds for the State Nutricaid programs. The states, as usual, naturally snatched at the "free" federal dollars.

The state Nutricaid recipients received food stamps, redeemable by the state government at 50 cents on the dollar. The Nutricare Administration made it an offense, punishable by fine or imprisonment, for grocers to charge Nutricaid recipients the difference. The stamps could purchase anything in the store — lobster, steak, caviar — as much as wanted. And since it was free, naturally they tended to want quite a lot. Then the Administration passed regulations forcing grocers accepting Nutricaid Stamps to undergo regular inspections; use a special billing system; employ personnel to audit food quality; put the burden of proof on the grocers that mark - ups were reasonable and food quality for Nutricaid recipients equal to the general public. Then, when the stamps were submitted by the grocers for redemption, payment was delayed for months or simply not paid because the state Nutricaid fund was depleted. Now, what do you suppose happened to the price of food? And who do you suppose paid?

Right! The grocers, naturally, were forced to cover Nutricaid losses and extra expenses by raising the price for everyone else. Thus, the general public paid twice: in skyrocketing Social Security taxes; and a second hidden tax of inflated food prices. And who was forced to curtail buying and economize? The Nutricaid recipient or the working public? And whom do you suppose the government blamed?

Right again! The administration not only blamed the grocers for the Nutrition cost crisis, it accused them of ripping off the Nutricaid system and sent out squads of undercover agents to ferret out fraud and abuse amongest the grocers.

The state, meanwhile, noting that it was expending far more to get the matching federal bucks than it had helping subsidize soup kitchens before Nutricaid, took the logical steps to control the state's spiraling Nutricaid costs. First, it cut its food stamp redemption to 25 cents on the dollar. But more important, it put price ceilings on all food sold to Nutricaid recipients. For instance, grocers could charge Nutricaid only $1 per pound for lobster which cost the general public $10 per pound. And to prevent abuse, inspections were set up to assure that Nutricaid lobster was not inferior and that two sets of scales were not used. The inspections usually closed the store for one working day per month.

And the grocers? Well, some of them didn't like it. Those in poor neighborhoods with mostly Nutricaid customers were even in financial difficulties with rent, supply and labor costs, and refused to participate in the Nutricaid Program. That provoked an immediate response from the Public Interest Groups who shrilled that the grocers were letting people starve.

To give an appearance of doing something, the Congress passed a nationwide ceiling on food costs, leaving labor and other commodity inflation running wild. The grocers, to stay alive, had to cut costs. But they had to retain all the employees needed to comply with the federal regulations. There was only one way to go. Most of the checkers, shelf - stockers, box boys and butchers went, as well as any plans for expansion,

". . . soon there was little on the shelves for those who could afford it; the lines outside the store stretched for miles so that the elderly or weak sometimes froze or starved to death . . ."

improvements, replacement or modernization.

Soon there was little on the shelves for those who could afford it; the lines outside the store stretched for miles so that the elderly or weak sometimes froze or starved to death, thus reducing the demand on Nutricare and Nutricaid funds. And the steak, caviar and lobster? What little was left was in the Federal Commissaries.

Dr. Fish is an Anchorage physician who treats Medicaid patients.

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State ponders the problems—and solutions

BY THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Commissioner Helen D. Beirne and the staff of the Department of Health and Social Services are very concerned about the problems being experienced by Medicaid clients and providers in Alaska. Dr. Beirne and employees of several department divisions and offices are continuing to devote a great deal of time and energy to resolving issues related to the Medicaid system and improving communications between providers, consumers, and the State.

There are approximately 19,000 persons in the state who could participate in the Medicaid program by virtue of their eligibility for financial assistance under Aid to Families with Dependent Children (AFDC), Old Age Assistance (OAA), Aid to the Blind (AB), or Aid to the Disabled (AD) programs. Eligibility is determined by federal and state law on the basis of income.

The majority of Medicaid - eligible persons are AFDC clients. For nearly 80 percent of the cases on AFDC in March 1977, public assistance was the only source of income. Currently, the average monthly AFDC payment is $350, so it's evident that persons who are eligible for Medicaid are probably unable to obtain medical services without the assistance provided by the program.

The total Medicaid budget for current FY 79 is $38.5 million, of which $2.1 million is for physicians' services. Other line items or categories of the Medicaid budget include hospitals ($4.7 million), early screening programs ($1.5 million), nursing homes ($16.9 million), state institutions ($6.4 million), Indian Health Service ($6.4 million), and other services ($.5 million). At the end of FY 78, $2.7 million remained unspent in the Medicaid budget, principally in the nursing home line item. The amount owed to physicians for Medicaid and General Relief Medical services, however, was in excess of the amount budgeted by $1.1 million.

The Department of Health and Social Services has been unable to pay the physicians' invoices because the funds had been appropriated by specific, limited line item and were not transferable from the nursing home line item to the physicians' line item without Legislative authorization. The Department has submitted a request for a supplemental appropriation and expects the legislature to take action to solve this problem in the near future, at which time Alaska's Medicaid providers will be paid for FY 78 bills. The unusable funds lapsed on June 30, 1978 will more than offset the supplemental request.

Although the current year $2 million Medicaid budget for physicians' services is a small portion of the total Medicaid budget, the processing of bills from physicians requires the greatest expenditure of man - hours. The reason for this is that there are approximately 400 physicians enrolled in the Medicaid program, and individual bills are submitted for each patient. Also, the volume of claims has been increasing rapidly. In the AFDC Medicaid - eligible caseload alone, there was a 24 percent increase from 1976 to 1978.

As a result of this continually increasing volume of Medicaid claims and the fact that bills were being processed through a manual, non-computerized system, the Division of Public Assistance fell three to four months behind in the payment of bills from physicians who had treated Medicaid patients during FY '78. Only four bill processors handled invoices from all 400 physicians in the program.

However, this problem has been solved for the moment by employing additional temporary staff to pay physicians' bills. Now, bills are being paid within five to six weeks after receipt.

ALASKA PUBLIC INTEREST RESEARCH GROUP
Post Office Box 1093/Anchorage, Alaska 99510/(907) 278-3661
Board of Directors: Hugh Fleischer, Chairperson; Julie Wroe, Vice Chairperson; Molly Crenshaw, Secretary; Don Clocksin, Treasurer; Eleanor Andrews; David Case; Judy Whitney Eckholm, Bob Goldberg, Terry Stimson; Phil Voland

1934:
1965:

January 30, 1979

Bruce Norton, AMA Legal, Chicago

Rep. Bill Parker
Pouch V
Juneau, Alaska 99811

Dear Rep. Parker:

We are writing to inform you of a very serious matter which has recently come to our attention--the fact that many doctors in Anchorage will not treat patients who are on Medicaid. Consequently, we are asking the Alaska State Medical Association to adopt an ethical code which would require doctors to treat patients without regard to their ability to pay. This ethical standard was once endorsed by the American Medical Association but it was discarded in the late sixties. Enclosed is a copy of the letter which has been sent to the Medical Association explaining our position in greater detail.

We need your support. This is an important issue affecting the lives of many thousands of Alaskans. There are approximately 16,500 persons on the Medicaid rolls in the state of Alaska. It is becoming increasingly difficult for these people to find doctors who will care for them, even when an emergency exists.

In checking with doctors in the Anchorage area, we have found that the problem exists mainly in the areas of gynecology, obstetrics, pediatrics and family medicine. Since this is also where most of the demand exists, this problem probably affects the majority of those eligible for Medicaid. According to officials in the Municipal Health Department of Anchorage, many expectant mothers are not able to obtain critical prenatal care even when there is a history of problems. We have also heard of women who were dropped by their gynecologists and pediatricians because they are on Medicaid. Only two pediatricians in Anchorage treat Medicaid patients and one of those is at the Anchorage Neighborhood Health Center, a facility specifically set up to handle the health needs of low-income people. They cannot possibly handle the demands of all the children from low-income families in the Anchorage area.

We would like your support. Draft a letter to the Alaska State Medical Association explaining why you think this issue is an important one. It would be helpful, also, if you could send a copy of your letter to the Alaska Public Interest Research Group.

The problem of poor people going without proper medical care is too serious to be ignored or swept under the rug. We hope you will join us in our attempt to alter an inexcusable situation.

Thank you for your time.

Sincerely,

Rebecca E. Graham

Rebecca E. Graham
AkPIRG Staff

Enclosure

The Anchorage Times, Sunday, February 4, 1979

Health Care: A Quiet Subject No Longer

By HELEN GILLETTE
Times Staff Writer

Health care — more specifically its availability to the poor — has become a matter of debate.

One activist group — Alaska Public Interest Research Group — insists that doctors are simply ignoring welfare patients.

Medical spokesmen deny the charge, but agree that Medicaid accounts are less attractive because the government foots only 70 to 75 percent of the bill, always pays late and requires excessive paperwork.

Theoretically, everybody in Alaska gets health care. People eligible for welfare — and there are 19,000 of them — are covered by Medicaid, with bills paid by government money, half federal and half state.

(This is separate from Medicare, an insurance program for the elderly administered, but not funded, by the government.)

A survey of doctors gives conclusive proof of general dissatisfaction with the Medicaid program. The surveyor comes away with the feeling that most of them would prefer not to see any Medicaid patients. For one thing, they have to settle for the 70 to 75 percent of the fee that government pays, since they are forbidden by law from collecting the rest from the patient.

The Alaska research group has claimed that a high percentage of Anchorage doctors simply do not treat Medicaid patients. "Doctors are looking after their own economic interests," director Jamie Love said. "Medicaid patients just don't pay as well."

Dr. C.J. Little, president of the Anchorage Medical Society, says it's not only Medicaid people who have trouble getting established with a physician. Anybody who's new to the community has this problem, he said, because there aren't enough doctors for the growing population.

This is particularily true for young pregnant women, "because we're very short of obstetricians, pediatricians and general practicioners in Anchorage."

One problem, he said, is that many of the 14 or so specialists in the field here are getting older and "have been delivering babies day and night for years. They're getting burned out and turning to the field of specialized gynecology."

A spot check of 10 Anchorage medical clinics by the Anchorage Times revealed that five said they will accept new Medicaid patients. Two said they will see only their ex-

(See Page A-2, Col. 1)

SULA
RION
KENAI, ALASKA 25¢ THURSDAY, JANUARY 25, 1979

First in state

Soldotna doctors opt out of Medicaid

By RONNIE CHAPPELL
Clarion Editor

On January 15 more than half of the doctors now serving the Central Peninsula area quit accepting Medicaid and General Relief Medical coupons as payment for medical treatment.

Other doctors around the state have limited the number of Medicaid patients they will treat, while others have quietly dropped out of the program.

The local physicians, however, are the first in Alaska to officially notify the State Department of Health and Social Services that they no longer plan to participate in the welfare program.

The doctors, all members of the Peninsula Medical Center, Inc. in Soldotna, are Paul G. Isaak, M.D.; Roy E. Benward, M.D.; Lavern R. Davidhizar, D.O.; Joseph A. Sangster, M.D. and Alexander B. Russell, M.D..

Approximately 10 - 15 percent of the center's total patient load will be affected by the policy change. Obstetric patients who have yet to deliver their babies and patients with chronic conditions who are already receiving treatment under the Medicaid program will not be.

In a letter sent to the center's Medicaid patients earlier this year, the doctors said, "We are reluctant to take this step, however, we have not been paid by the Department of Welfare for many services we provided in the past. Our clinic cannot continue to operate by extending credit to the State of Alaska."

The letter also informed patients "We will be glad to continue service to all patients who are willing to adhere to our credit policy. If you cannot pay for your visit at the time of service, financial arrangements must be made in advance. As far as we know, the other physicians in the area are still accepting coupons for medical services."

Two other local doctors, Elmer E. Gaede and Peter O. Hansen plan to continue participation in the welfare program, although both claim that it costs them money to do so.

"We plan to treat patients on an individual basis," said Sangster of the Peninsula Medical Center's policy change. "If a patient wants to receive treatment he will have to come talk to us and see what type of (financial) arrangements can be worked out."

"We have not and will not refuse to give emergency care," Sangster emphasized.

"What we want to do is let the individual asume responsibility for the service we provide," said Isaak. We don't intend to deny service, but we're not playing second fiddle to the state any more."

"A patient's obligation should be to us. When we provide a service and the state doesn't pay us, we're left holding the bag," he continued.

Medicaid patients who cannot pay for treatment at the time it is delivered will be treated like the center's other patients and asked to fill in a credit application - financial statement.

The doctors do not anticipate having to deny service to many patients seeking treatment, even if the patient can only make small weekly payments towards the cost of a relatively expensive proceedure.

According to Benward, "a good faith effort to pay," is what the clinic is seeking, even if the patient can only afford $10 a week.

Patients who receive service and then fail to make an effort to pay their bills will be denied treatment of "non-emergency" problems by the clinic.

Sangster predicts this will open up the center and its medical staff to charges of "denial of medical care" to which everyone believes they have a right.

Sangster pointed out that food, clothing and shelter are just as important to a person's well being as good medical care, and noted that no one expects a grocer or clothing retailer to give away food or clothing without receiving payment.

The decision to opt out of participation in the state

(Continued on page 12)

...Doctors opt out of state

(Continued from page 1)

Medicaid program came after 2 and a half years of haggling with the State Department of Health and Social Services for the payment of bills submitted by the Peninsula Medical Center.

According to a Debbie Kimple, who heads the center's accounting department, some of the upaid bills date to May of 1976.

The doctors at the center refused to put a dollar figure on the unpaid balance owed them by the state, but called it "considerable."

Records in Juneau, however, show that the center is currently requesting payment of approximately $20,000 in Medicaid claims, a figure that is down substantially from December of 1978 when the total debt exceeded $40,000.

The state has acknowledged the fact that it owes the Peninsula Medical Center and other health care providers for Medicaid proceedures performed prior to July of 1978. In an undated memorandum sent to doctors this fall the Department of Health and Social Services advised physicians that letters of "Prior Year Debt Acknowledgement" were available if doctors found it necessary to "borrow against the amounts owed your" for the purposes of meeting operating expenses.

"Although we cannot at this time make payment to you we will make available for you a letter of debt acknowledgement to provide you support in borrowing from a lending institution," the memorandum said.

But more than just the state's inability to pay Medicaid

Medicaid program

claims within a reasonable time frame is bothering the five Soldotna doctors. Their complaints about the Medicaid system go right to the heart of the state program.

"It is an extremely cumbersome, inefficient bureacracy," charged Benward. The doctors claim that the paperwork required by the state requires the attention of a full time clerk, and that the amount of money paid by the state, when claims are paid, is insufficient to cover the cost of providing the service billed for.

"We havn't been able to meet expenses treating Medicaid patients," said Isaak.

"We're doing this (refusing to accept Medicaid coupons) because it is an economic necessity," added Benward.

Two other doctors in the area, Elmer Gaede and Peter Hansen bear out the claims of the Soldotna physicians.

"There's no question we're losing money doing it (treating Medicaid patients)" said Hansen. "It's a matter of to what degree you can take a loss."

Hansen, who has already had to go to the bank to borrow against his Medicaid debt to stay in operation notes that he "couldn't begin to accepet all of the Medicaid patients who come in" to his office. He plans to continue treating them on a limited basis.

Gaedes, of the Soldotna Medical Clinic, said he couldn't blame the five other Soldotna doctors "one bit" for pulling out of the program and added that "we discussed it ourselves."

Sangster said that the state routinely disallows proceedures performed for Medicaid patients while discounting the value of the proceedures they do pay for.

"If a service is disallowed we have no recourse," said Sangster, "and then we are only paid a certain percentage (70 to 75 percent) of what they do allow.

"The medical profession is the only profession that accepts payment at less than face value," Sangster said, pointing out that the price of potatoes is not dropped for citizens participating in the foodstamp program.

Sangster went on to charge that the claims submitted by the 300 doctors now practicing in the state were reviewed by "personnel who know nothing about medicine. Who don't even know the words on the claims or the code numbers."

Sangster points out that these people, who have no formal medical training, decide which proceedures are paid for and which are not.

The center's physicians also have an extreme lack of faith in the state's ability to process the Medicaid claims efficiently. They point to a November meeting with George Haas of the Department of Health and Social Services at which the problem of unpaid Medicaid balances was addressed.

Haas advised the health care providers assembled for the meeting that if they had not received acknowledgement of Medicaid claims submitted prior to October of 78 that "they would be wise to resubmit them because they had probably been lost."

Haas told the Clarion earlier this week he had made such a statement, and admitted that at one time the Department did have "quite a paper handling problem.

"A lot of invoices were disappearing between the time they were sent by the provider and by the time we got around to cutting the check," Haas said.

"We were aware of the fact that some of them could have been lost," Haas said, noting that since discovery of the problem the Department has "established more paper control."

Haas said that a number of accounts had been readjusted on the basis of resubmitted claims, but did not know exactly how many.

Even if the state promptly settles the $20,000 unpaid Medicaid balance due the Peninsula Medical Center, the center's member physicians doubt they will again participate in the program.

"I'm not in favor of continuing," said Sangster. "I'm tired of third party encroachment on the practice of medicine."

"We probably will not unless they change the system," added Isaak.

"We would eventually end up in the same situation," predicted Benward.

Editor's note: Tomorrow the Peninsula Clarion will publish a related story on the Medicaid program and it problems statewide. Included will be comments from Rod Betit, Acting Director of the Division of Public Assistance, Department of Health and Social Services and the results of a survey, conducted by the Alaska Public Interest Research Group, of doctors in the Anchorage area who were asked the question "Do you treat Medicaid patients?

Poll reveals many doctors won't take Medicaid patients

By RONNIE CHAPPELL
Clarion Editor

While the five member physicians of the Peninsula Medical Center in Soldotna are the first doctors in Alaska to officially notify the State Department of Health and Social Services that they no longer plan to accept Medicaid and General Relief Medical coupons as payment for medical treatment, they are by no means the first to get out of the state welfare program.

No one knows exactly how many of the state's 300 doctors have quietly limited or completely dropped their treatment of Medicaid patients, but a survey conducted by the Alaska Public Interest Research Group (APIRG) of doctors practicing in and around the Anchorage area reveals that the number could be extremely high.

"Essentially, we conducted a spot survey," said Hugh Fleischer, "asking doctors the basic question....do you take Medicaid patients?"

All told, of the 45 physicians polled, 33 or 73 percent replied "no."

Fleischer said that the doctors polled in the survey practiced medicine in the fields of Obstetrics-Gynecology, Pediatrics, Family Practice and General Practice.

Physicians practicing these specialties were picked, Fleischer said, because many of the patients using Medicaid are young women with "female problems related to child birth."

Fleischer said that APIRG's pollsters contacted 13 of the 14 Ob-Gyn specialists listed in the Anchorage phone book. Of those, only one accepted Medicaid patients....12 did not.

Fourteen of the 15 Pediatricians listed in the directory were polled....eight did not take Medicaid patients, six did. Of the 18 Family and General Practicioners contacted, only five accepted Medicaid patients.

"An inordinate number of physicians contacted said they would not take Medicaid patients," Fleischer said.

While Fleischer could not say how many doctors around the state had quietly

(Continued on page 3)

Poll indicates doctors not

(Continued from page 1)

stopped participating in the program, he noted that in light of the findings of APIRG's survey, it was "a reasonable question to ask."

If the motives of the Anchorage doctors who quietly stopped accepting Medicaid patients mirror those of the five Soldotna physicians who officially notifed the State that they were pulling out of the welfare program, their dissatisfaction with Medicaid revolves around one crucial element.....money.

The local doctors claim:

(1) That the rate of reimbursement, which is usually only 70-75 percent of their normal charge, is insufficient to cover the cost of rendering treatment to Medicaid patients. According to the physicians at Peninsula Medical Center, they lose money on Medicaid patients, even when the state pays the claim.

(2) That claims for payment are arbitrarily disallowed by clerks at the state level who have no medical training and therefore, no basis for judgement when deciding which proceedures are appropriate and which are not. The doctors charge that the clerks disallow claims in a "haphazard" fashion so that they, as practicioners never know what they are going to be paid for and what they are not.

(3) That payment by the state is generally slow in coming, and that often they are forced to carry large Medicaid debts on their books.

(4) That the Department of Health and Social Services lacks the ability to efficiently and fairly handle the claims submitted by doctors treating any of the 16,000 patients around the state certified to receive Medicaid benefits.

And adding to all of this dissatisfaction with the program is the fact that the state did not have the money to pay all of the Medicaid claims submitted prior to July 1978.

According to Rod Betit, Acting Director of the Division of Public Assistance, of the State Department of Health and Social Services, there was money in the division's total budget to cover the claims, but a rigid budget structure prevented state officials from moving funds from categories with surplus monies, to those running deficits.

The Department acknowledged it's fiscal difficulty in an undated memorandum sent to physicians around the state earlier this year, advising them that when the "legislature convenes in January, the first order of business of this administration will be to request an appropriation to pay the amount owed you."

According to Betit, the estimated total owed the doctors of the state for services provided under both the Medicaid and General Relief Medical programs is approximately $1.5 million.....an average of $5,000 for each of the 300 doctors now working in Alaska.

Attached to that same memorandum was a notice from the Department to the effect that "although we cannot pay you, we will make available for you a letter of debt acknowledgement to provide you support in borrowing from a lending institution."

"The state owes us a lot of money and expects us to provide service when the funds for the service have not been authorized," said Dr. Peter Hansen of Kenai who still sees Medicaid patients on a limited basis.

According to Betit, the state is powerless, under the Medicaid program to up the rate of reimbursement allowed doctors for providing treatment to Medicaid patients.

accepting Medicaid

"The rate of reimbursement is determ...ed by the Federal government," Betit said, noting that rates were the same for Medicaid as they are for Medicare. The two programs do differ, however, in that Medicare claims are paid to the patient who then uses the funds to help reimburse the physician for the total amount charged for treatment. Under Medicaid, the burden for filing the claim is placed on the physician who must accept only a percentage of the amount due for the treatment rendered.

Betit does believe that the claims submitted by physicians are "ajudicated" fairly by the three clerk-technicians who go over each invoice to determine which charges are to be allowed and which are not.

According to Betit, these technicians spend about 20 minutes on each of the invoices submitted checking claims to make sure that (1) no duplicate proceedures were performed and charged for, that (2) authorized services were performed only by physicians in whose area of specialization the service lies, and (3) that pre-authorization was obtained for those services requiring it.

Betit said that whenever there is a question about a proceedure listed on a claim submitted by a physician, the proceedure is reviewed by the state's Medical Review Officer. Betit added that "no medical judgement" is required of the technicians.

When asked if, in his opinion, the system was fair and consistant with regard to the charges disallowed, Betit responded affirmatively.

Betit also said that the Department was working to streamline it's operations so that participating physicians could (1) expect payment of claims within 30 days of their submission, and (2) not find themselves waiting on payment from the state because funding for the program ran out before the end of the fiscal year.

According to Betit, representatives from the Federal Department of Health, Education and Welfare had been to visit the state office to offer suggestions on increased computerization of the adjudication and payment process.

"The current system is cumbersome and time consuming," Betit admitted. He added that under present circumstances 3 technicians were not enough to adjudicate the claims submitted.

It is doubtful, however, that any of the solutions now being considered by the Department of Health and Social Services will be satisfactory to the state's medical community.

As long as the practice of retro-active denial of claims continues, and as long as doctors only receive a percentage of the charges submitted to the state for the treatment of Medicaid patients, those qualifying for treatment under the welfare program are going to have trouble "getting in to see a doctor."

The issue is sure to come to a head later this year when APIRG goes before the Alaska State Medical Association to request that it urge it's membership to end the practice of denying treatment to Medicaid patients. Specifically, APIRG plans to ask the association to adopt language which used to be contained in the American Medical Association's code of conduct which deals with rendering of medical care to all persons "irrespective of their ability to pay."

"We're talking about medical care for 16,000 non-native, poor Alaskans," said Fleischer. "The only reason we have heard for not treating them is a financial one. We think that adoption of the measure would be consistant with the past history of the medical profession."

Fleischer also said APIRG was considering an appearance before the state legislature and was considering the introduction of bills designed to deal with the problem of physicians refusing to treat Medicaid patients.

When asked if APIRG was planning to propose a bill which would require physicians in the state to participate in the Medicaid program he replied by saying, "It's conceivable."

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Local pharmacies too

Hospital accepting Medicaid

By RONNIE CHAPPELL
Clarion Editor

While doctors around the state are refusing to accept Medicaid coupons as payment for medical treatment other health care providers involved with the program appear to be sticking with it.

To date, local pharmacies and the Central Peninsula General Hospital have yet to follow the lead of the five member physicians at the Peninsula Medical Center who are the first doctors in Alaska to officially notify the State Department of Health and Social Services they no longer plan to participate in the welfare program.

"We will continue to see them (Medicaid patients)," said Simon Hancock, administrator at Central Peninsula General.

According to Hancock, the Medicaid program for hospitals is similar to the one for doctors in that bills submitted are "adjudicated" or "costed down" before being paid by the state.

It is also similar, in that the state did not have ample funds to pay all of the claims submitted by Alaska hospitals prior to June 30, 1978.

According to Rod Betit, the acting Director of the Division of Public Assistance, a total of $160,000 is still owed state hospitals for claims submitted in the last fiscal year.

The Division is paying current charges submitted by Alaska hospitals, and hopes to get a supplemental appropriation from the state legislature to cover lasy year's outstanding debt.

According to Hancock, the state owes Central Peninsula General a total of $24,686 in outstanding Medicaid bills. Of that, $10,000 represents unpaid claims submitted prior to June 30, 1978.

The oldest charge dates back to April of last year.

While the debt is a large one, it has yet to work a financial hardship on the local hospital.

"We're fortunate in that we're not seeing a great percentage of Medicaid patients," said Hancock.

"Otherwise," he added, referring to Peninsula Medical Center, "we'd be hurting too."

Hancock went on to say that it was the hospital's policy to treat everyone, regardless of ability to pay.

This is especially true in the case of emergency medical treatment. Hancock emphasized that no patients are turned away. But the situation differs when it comes to "non-emergency" services and "elective surgery" such as having a hernia repaired.

In those cases, the key to hospital admission is held by local physicians.

This means, for example, that a woman in labor can report to the hospital emergency room and have her child delivered by the physician on call. She cannot, however, check into the hospital during the early months of pregnancy for tests or other types of pre-natal care unless she is admitted by one of the physicians on the hospital staff.

In terms of reimbursement, local pharmacies have fared much better than the other health care providers in the Central Peninsula area.

"From our standpoint, the reimbursement is fine," said Earl Mundell the owner of both Kenai and Soldotna Drug stores.

Unlike the claims submitted by doctors and hospitals, the bills turned in by Alaskan pharmacies are not "costed down" by the state before payment.

Doctors and hospitals in the state receive 70 to 75 percent of what they charge back from the state.

"Our system is set up so we bill the customary amount and receive that," said Judy Waring the pharmacist at Kenai Drug.

"Reimbursement on our prescriptions is pretty good," Waring added. "We submit our claims the first of the month and generally receive what we submitted."

But sometimes, the state witholds payment of some claims, making it necessary to resubmit the charges of some Medicaid patients.

"It makes for a lot of extra book work," said Mundell who noted last year he had to work through the Governor's office to obtain payment of some Medicaid claims dating back to 1972.

Mundell added that his drug stores would continue par-

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....hospital taking Medicaid

(Continued from page 1)

ticipating in the Medicaid program as long as the state continued paying its bills.

The story is much the same at Carr's in Kenai where head pharmacist Gloria McConnell reports "no problems" with reimbursement under the program.

Carr's will continue to fill Medicaid prescriptions, McConnell said.