STATE
HEALTH
INSURE.
#1

HOUSE RESEARCH AGENCY
Pouch Y - State Capitol
Juneau, Alaska 99811
465-3991

MEMORANDUM March 18, 1980

TO: Representative Bill Parker
Attn: Mr. Jim Erickson

FROM: Jack Kreinheder, Issues Analyst JK

RE: State Health Care Programs
Research Request No. 61

You have asked that we: (1) provide any available studies on Medicaid, state health insurance, and the State's health care program in general; and (2) determine whether the State could provide medical care for low-income groups in medically underserved areas of the state. The enclosed materials represent all the relevant materials we were able to locate, with the exception of past copies of the State Health Plan and the Medicaid Annual Status Report. These reports were not included because of their bulk and uncertain value to you; should you wish to review these documents, please let us know.

Our major findings with regard to direct State delivery of medical services are the following:

1. There appear to be no legal reasons why the State could not hire doctors to treat low-income groups or any other class of people; however, four major practical difficulties with such an approach were raised during the course of our research. The first problem is that everyone we contacted believed the medical community would oppose the competition which direct State participation in the delivery of medical services would represent. Second, the State would need to purchase malpractice insurance for doctors in its employment, thus incurring substantial costs. Third, if the legislature approved funding for such a program, and later discontinued it, or if State physicians' services were to be provided on a temporary basis, the problem of "medical abandonment" could result in lawsuits against the State unless adequate arrangements were made for the further treatment of patients handled under the program. Fourth, it appears that medical services provided by State physicians would not be eligible for federal Medicaid funds

except on a temporary or special situation basis; therefore, the State would have to bear the full cost of the program unless State-provided services were demonstrated to qualify for a waiver from the usual federal Medicaid requirements.

2. Withdrawal from the Medicaid program is not, however, a prerequisite to the establishment of a State physician program. My understanding of the alternative health care system you are considering is that the State would not necessarily provide all the medical services now administered by private physicians under the Medicaid program, but would instead make State doctors available in areas which are medically under-served either because of the lack of physicians, the lack of specific medical services, or because of the refusal of available physicians to accept Medicaid patients. It is clear that the State could continue to receive federal Medicaid funds for medical services provided by private physicians; and, in addition, it appears that funds could also be received for State-provided services if a federal waiver from certain regulations could be obtained. The State currently receives over $22 million per year in federal Medicaid funds.

3. It may be possible to improve medical care for low-income persons by means other than, or in addition to, direct State health care delivery, and without opting out of the Medicaid program. The principal problem with the Medicaid program, from the recipient's point of view, appears to be that many doctors in Alaska refuse to accept Medicaid patients. This reluctance to take Medicaid patients is, in turn, largely attributable to the extensive paper-work requirements and the extremely slow payment process of the current Medicaid system in Alaska. However, these problems are not inherent in the federal Medicaid system, and it appears that more rapid and efficient reimbursement of medical providers could substantially improve low-income access to medical care by encouraging more doctors to participate in the program. Of course, there may be other problems with the Medicaid program which might make withdrawal from the system desirable.

4. The expanded use of fiscal intermediaries may be one option for making more doctors available to low-income persons. Delta Dental Plan of Alaska is currently the only organization of this type in Alaska and handles only dental services, but all parties involved--the Department of Health and Social Services, the participating dentists, and the Medicaid recipients--seem to be very satisfied with the program. About 96 percent of the dentists in Alaska are members of Delta Dental and 95 percent of these participate in Medicaid. The fact that reimbursement to dentists by

Delta Dental for Medicaid cases usually occurs within two weeks, as compared to up to several months for other Medicaid claims handled by the State, is the main reason for the almost universal acceptance of Medicaid cases by Alaska dentists.

In an administrative review of the Alaska Medicaid program completed in 1979, HEW officials recommended that the Division of Public Assistance contract with a fiscal intermediary for Medicaid processing. The Division is planning to solicit within the next six months requests for proposals for the processing of all Medicaid claims by a fiscal intermediary, although H&SS may still elect to process claims in-house. Robert Ogden, Chief of Medical Assistance for the Division, stated that a fiscal intermediary handling all Medicaid claims could probably process claims as rapidly as Delta Dental currently does for dental claims, thus improving the prospects for physicians accepting Medicaid patients. However, the choice between the use of a fiscal intermediary and processing the Medicaid claims in-house will depend on administrative decisions made within the department.

Each of the four points summarized above will now be discussed in more detail.

State Medical Care

According to the sources we contacted, the basic answer to your second question is yes, the State could hire doctors to treat low-income groups. Eligibility could be determined in a number of ways and would not need to parallel the federal Medicaid system. Placement of the State-employed doctors throughout the state could be based on whatever criteria were deemed appropriate by the State.

The State already provides direct delivery of medical services to a limited degree. Nurses employed by the Division of Public Health administer the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) for children throughout the state. The program is small in comparison to other medical services, but it does provide a precedent on the State level for direct delivery of services.

Political resistance by the medical community was cited by several persons with whom we spoke as the greatest obstacle to the direct employment of doctors by the State. Our contacts believed that many doctors would view such an action as State competition with the private sector,

and as "socialization" of the medical profession. The apparent acceptance by the medical community of the EPSDT program suggests that opposition to the State physician approach would not be as strong if the approach were used only in a few selected areas or were clearly temporary in nature. For example, if the State adopted a procedure similar to that which was employed by the federal Department of Health, Education, and Welfare (HEW) to identify and designate the low-income population of Anchorage as a Critical Health Manpower Shortage Area (see Attachment A), doctors might be more willing to accept the State delivery approach than if it were part of a comprehensive, state-wide system.

Under the HEW system, which is authorized by section 332 of the Public Health Service Act, an area or population group of an area may be designated as a Health Manpower Shortage Area if the population-to-primary care physician ratio exceeds a certain level. An area is also given a degree-of-shortage classification based on this ratio. The population-to-physician ratio takes account of physician accessibility, rather than simply dividing the population by the number of physicians. For example, in Anchorage, the ratio of Medicaid eligible persons to all primary care practioners is estimated at 161:1, but when HEW adjusted for the fact that most of these physicians do not accept Medicaid patients, the final population-to-primary care physician ratio was determined to be 3,041:1.

This ratio qualified the low-income population of Anchorage as a degree-of-shortage group 4, which makes the area eligible to: (1) apply for placement of National Health Service Corps (NHSC) physicians; (2) be an eligible service area for purposes of repayment of health professions student loans and for the NHSC scholarship program; and (3) apply for grant funds under various sections of the Public Health Act.

A similar approach to improving medical care for medically underserved areas or population groups could be utilized by the State. Designation under the program might qualify an area for the placement of State-hired physicians, for grants to improve health care delivery, or perhaps for a special streamlined medicaid process which would encourage doctors to accept Medicaid patients. The latter option might be effective in a case like Anchorage's, in which the number of practicing physicians in an area is sufficient to meet the medical needs of the population, but the physicians will not accept Medicaid patients because of dissatisfaction with the reimbursement system.

Attachment B, which is a letter to Representative Martin from Commissioner Beirne, suggests other questions which should be considered if the State elects to provide medical care directly and/or withdraw from the Medicaid program. As Duncan Read indicated in his earlier memo, Dr. Frederick McGinnis, Deputy Commissioner of H&SS, has proposed a major study of health care financing options which would address questions relating to

State provision of health care, such as who would be eligible for the program, and what services should be provided. Dr. McGinnis has apparently expanded the scope of the proposed study and is attempting to obtain about $170,000 for the project. If the study is conducted, the results would be submitted to the 1981 legislature.

If the State physician health delivery system is to be pursued, the problems of malpractice insurance and medical abandonment must be considered. Neither of these problems would prevent the State from hiring doctors, but their cost and legal implications may have some bearing on the issue. The State currently carries a small amount of malpractice insurance for doctors employed in administrative capacities, apparently in the event that they are called upon in an emergency situation. To fully insure doctors employed by the State who regularly provided medical services would require a substantial expenditure. The magnitude of the insurance cost would depend on the number of doctors employed the service provided, and the scope of the program, but the cost could be significant.

Medical abandonment appears to be a relatively easy problem to avoid, but it could present legal problems if it is not considered in the design of any State-provided medical care program. Under state and federal law, physicians are responsible for arranging for continued medical care for their patients if, for any reason, they discontinue their treatment. A doctor not fulfilling this responsibility may be sued by a patient. The two ways in which the issue of medical abandonment could arise are: (1) if the legislature suddenly discontinued funding for the program, and (2) if the program were discontinued in an area because it was determined that the private physicians in the area could now adequately serve the population. In both instances, the problem of medical abandonment could be avoided by ensuring that adequate arrangements were made for the continuing treatment of patients after the State ceased providing service directly.

A final point to be considered regarding direct State delivery of medical care is the Medicaid funding question. I contacted officials with the Northwest regional office of the HEW Medicaid Bureau in Seattle to determine if federal Medicaid funding could be provided for medical services delivered by State-employed physicians. A firm answer could not be secured within the time frame of this project, but it appears that a waiver from certain federal regulations pertaining to reimbursement procedures and other matters would be required for federal funding to be given for State-provided services. The necessary conditions for such a waiver are also unclear at this time, but HEW officials indicated that the designation of an area or population group having a severe shortage of medical care might meet the waiver requirements.

You have indicated an interest in the possibility of the State withdrawing entirely from the Medicaid program, and the question of Medicaid support for State-provided services may therefore not be a major concern. However, the State currently receives over $22 million each year in federal Medicaid funds. It may, therefore, be desirable to retain these funds if a State medical care program could meet, or be exempted from, the necessary federal regulations without compromising the program. Please let us know if you would like a more concrete response to the Medicaid funding question. A written request to HEW would be required and their response could take two weeks or more, but we would be glad to pursue this issue if you would like.

Medicaid Issues

Although we were not asked to specifically address the Medicaid program in this memorandum, we obtained information on Medicaid during our research which may be of value to you in considering health care options. The greatest problem with the current Medicaid program in Alaska is that the claims processing system is inefficient, requires excessive paperwork, and results in long delays in provider reimbursement. It is the paperwork and the payment delays which have been the primary cause of Alaska physicians refusing to accept Medicaid patients. Attachments C and D provide a physician's perspective on the problems of the Medicaid system. In many cities, most notably Anchorage, the number of physicians seems to be adequate, but a Medicaid patient cannot see a doctor because the majority of physicians refuse to take Medicaid cases. It therefore appears that a more efficient and rapid claims processing system could do much to alleviate the difficulty of obtaining medical care for low-income Alaskans.

The current program of Medicaid dental services lends strong support to this premise. Medicaid claims for dental care do not go through the State system used for other medical services, but instead are handled by the Delta Dental Plan of Alaska, which acts as a fiscal intermediary between the providers and the State. The pertinent statistics regarding Medicaid participation by dentists were cited in the findings section, but the importance of Delta Dental in this discussion is that the vast majority of the state's dentists accept Medicaid patients. The two-week Medicaid reimbursement time which Delta Dental provides for dentists is the primary reason for the high degree of cooperation by Alaska dentists with the Medicaid program.

The obvious question, then, is if Delta Dental is so efficient, why doesn't the State use Delta or another fiscal intermediary to process all its Medicaid claims. There are a number of reasons why fiscal intermediaries do not represent an easy solution to the Medicaid and low-income health care problems.

The first is that Delta Dental does not appear eager, and may not have the capability to take on the processing of medical claims. Attachment D is a letter from the Pediatricians' Association to Representative Martin suggesting that the State contract with Delta Dental for payment of Medicaid claims for pediatric services. However, I spoke with Denise Knapp, Executive Director of Delta Dental, and she indicated that Delta has not agreed to process pediatric claims and is still only discussing the idea. Robert Ogden, Chief of Medical Assistance for H&SS, stated that while he has been very pleased with Delta's performance, he is not sure if Delta could handle the large volume of Medicaid claims for medical services, and knows of no other in-state firms who could.

A second possible problem with the expanded use of fiscal intermediaries is cost. Each claim processed by Delta Dental costs the State an average of more than $14, while the medical claims processed under the current system cost only about $1.45 each. However, Mr. Ogden was quick to point out that the current system does not meet federal requirements, and meeting these requirements is likely to increase the cost of processing claims whether a fiscal intermediary is used or not. In addition, Delta's cost is much higher than would be that of a fiscal intermediary handling all medical claims, because the fixed costs of the Delta claims processing system are spread over a relatively small number of claims (8,000 per year). A fiscal intermediary handling all Medicaid claims for medical services would process about 144,000 claims per year; cost per claim would therefore be much lower, perhaps in the $2.50 range, according to Mr. Ogden.

HEW has mandated that the Division of Public Assistance implement a new claims processing system by September, 1980. In an administrative review completed a year ago, HEW officials recommended that the Division contract with a fiscal intermediary for the processing of all Medicaid claims. (See Attachment E, Chapter 7, for more detail on this recommendation.) However, it is still uncertain whether this recommendation will be followed. The Division plans to solicit requests for proposals (RFP) for claims processing within the next six months. At least six to eight firms are expected to bid on the contract, but it appears that the decision to use a fiscal intermediary or to process Medicaid claims in-house will be more dependent on administrative decisions within H&SS than on the results of the RFP process.

We hope the information we have provided is useful to you. This memorandum is a brief treatment of a complex subject, so please let us know if you would like additional research, or if we may be of further assistance in any other way.

JK/dp

cc: Representative Terry Martin

Attachments:

A. HEW designation of Anchorage as a Health Manpower Shortage Area, from the Anchorage Neighborhood Health Center.

B. Letter from Commissioner Beirne to Representative Martin on Medicaid/State Health Care issues.

C. Letter from Dr. Lillibridge to HEW discussing Medicaid problems.

D. Letter from Dr. Lillibridge to Representative Martin on Medicaid problems and the Delta Dental program.

E. HEW administrative review of the Alaska Medicaid program.

F. H&SS task force recommendations on the Medicaid program.

G. Information supplied by Delta Dental on their program.

H. Alaska and National Health Insurance--report by Dr. McGinnis of H&SS.

I. Third Party Health Coverage in Alaska--1978 report by the former Legislative Affairs Research Division.

J. Opting-A Study of Medicaid Client Need--1977 report by the former Research Division.

K. H&SS 1977 Medicaid Annual Status Report.

L. January, 1980 State Health Plan.

Attachment A

ANCHORAGE NEIGHBORHOOD HEALTH CENTER
1217 EAST 10TH AVENUE · ANCHORAGE, ALASKA 99501 · 907-279-9586

February 18, 1980

Duncan Read, Director
House Research Agency
Pouch "Y"
State Capital Building
Juneau, Alaska 99811

Dear Mr. Reed:

As per request from your staff person, Carol Biggs, I am sending you a copy of the application which I submitted to the Bureau of Health Manpower, which resulted in a Critical Health Manpower Shortage Area designation for the low income population of Anchorage. Also enclosed, is a letter from the Bureau, in which they accepted the evidence we presented in the application, thus making the designation.

Sincerely,

Don Bantz
Executive Director

DB/jw
Enclosures

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION
HYATTSVILLE, MARYLAND 20782

BUREAU OF HEALTH MANPOWER

JAN 17 1980

Mr. Don Bantz
Executive Director
Anchorage Neighborhood Health Center
1217 East 10th Avenue
Anchorage, Alaska 99501

Dear Mr. Bantz:

We have reviewed your request as amended for designation of the low-income population of Anchorage as a population with a shortage of primary medical care manpower. In addition, we have contacted the Health Systems Agency for your area, the State Health Planning and Development Agency, and the Governor's office for their comments.

From this review, we have determined that the area appears to be rational for the delivery of primary medical care, and it has a population-to-primary care physician ratio of 3,034:1 and has unusually high needs for primary medical care services.

Therefore, we are designating the low-income population of the Municipality of Anchorage as a population group with a shortage of primary medical care manpower, under the authority of section 332 of the Public Health Service Act. The designated population is defined to include:

County	Parts
Anchorage Division	Municipality of Anchorage-low-income population

This area is assigned to degree-of-shortage group 4, as defined in the regulations for Designation of Health Manpower Shortage Areas.

As you probably know, designation under section 332 makes this area (1) eligible to apply for placement of National Health Service Corps personnel, (2) an eligible service area for purposes of repayment of health professions student loans, (3) an eligible obligated service area under the National Health Service Corps Scholarship Program, and (4) eligible to apply for (or to receive preference for) grant funds under various sections of the Public Health Service Act.

Applications for NHSC personnel are available from Dr. Art Lagace, NHSC Regional Program Consultant, in Seattle.

We appreciate your efforts to assist us in identifying health manpower shortage areas.

Sincerely yours,

Howard V. Stambler

Howard V. Stambler
Director
Division of Manpower Analysis

cc:
Office of the Governor
Health Systems Agency
State Health Planning and Development Agency

APPLICATION FOR THE MUNICIPALITY OF ANCHORAGE FOR DESIGNATION OF THE LOWER INCOME POPULATION AS A CRITICAL HEALTH MANPOWER SHORTAGE AREA GROUP

In April of 1977, the Municipality of Anchorage was designated as a Medically Underserved Area. This designation was based upon four indices:

1) percentage of population below the poverty level,
2) percentage of population over age 65,
3) infant mortality rate, and
4) primary care physicians per 1,000 population.

It is the contention now that the lack of access to primary care practitioners for the low income population group of Anchorage qualifies this group to be designated as a Critical Health Manpower Shortage group.

This application includes the following:

1) population methodology
2) primary care practitioners
   (a) background
   (b) primary care practitioner summary
   (c) Anchorage Human Resources Department survey
   (d) Anchorage Neighborhood Health Center survey
   (e) adjustments of the ratio: population group to primary care practitioners serving them
3) additional documentation
4) appendices

POPULATION METHODOLOGY

According to the Municipality of Anchorage Human Resource Planning Department, the population of Anchorage is 202,101 persons. Subtracting the Alaska native and military populations from this total leaves a non-federal population of 165,517 persons:

202,101	
- 28,500	military
- 8,084	Alaska native
165,517	

The 1978 Population Profile prepared by The Municipality of Anchorage lists the distribution of annual household incomes for Anchorage but the data is not broken down by number of persons in the household.

Table 1. DISTRIBUTION OF INCOME OF ENTIRE HOUSEHOLD BY SUBCOMMUNITY

Annual Household Income	Total Population
$ 0-$ 9,000	10.0%
$10,000-$14,999	9.2
$15,000-$19,999	9.5
$20,000-$24,999	10.9
$25,000-$29,999	10.1
$30,000-$34,999	12.2
$35,000-$39,999	7.7
$40,000-$49,999	12.8
$50,000-$59,999	9.0
$60,000 & Above	8.6
(n)	(1,177)
Mean	32,998
Median	30,155
Standard Deviation	20,555

The median household size in Anchorage is 3.0. (Population Profile - Municipality of Anchorage, Page 4 table I-1).

The Medicaid eligible population of Anchorage can be estimated by using the poverty guidelines for Alaska, issued by the Community Services Administration on May 7, 1979 in the Federal Register. (For a complete breakdown of these figures, see Appendix).

By these guidelines a family of 3 persons who makes $7,008 per year or less is Medicaid eligible. Using the

household incomes in Table 1, approximately 8% of the 165,517 non-federal population of Anchorage, 13, 241 persons, live below the poverty levels and are Medicaid eligible.

PRIMARY CARE PRACTITIONERS

There are, at present, 82 practicing primary care non-federal physicians in the Anchorage Municipality. The breakdown is as follows:

Family practice/general practice	42
Pediatrician	14
OB/GYN	17
Internists	9
Total	82

Source: Alaska State Medical Association. 1978-9 Medical Directory.

Background

The State of Alaska's Medicaid Program has experienced problems with its reimbursement system to the degree that a nine month lag in physician reimbursement is not uncommon. The Alaska Medical Society, at their annual meeting in 1979 went on record as rejecting any mandatory medical obligation to care for people who cannot pay. This resolution was written and sponsored by the Anchorage Medical Society (see attached newspaper article). It appears that this resolution was directed at efforts by the State to legally prohibit doctors from refusing to treat poor patients in retaliation to tardiness in paying Medicaid bills.

This has lead to the situation whereby Medicaid patients are being denied access to primary care practitioners in Anchorage. This has been documented by a number of independent surveys conducted by various health agencies in Anchorage during the past year. The situation is particularly acute with regards to prenatal care. The initial survey was done by the South Central Health Planning and Development Agency who concluded that a "shortage of OB services does exist, and that the economically disadvantaged patients are those who are most likely to directly experience that shortage" (December 12, 1978).

Anchorage Human Resources Department Survey

The Anchorage Human Resources Planning Department surveyed 38 of the 42 Family Practice physicians in March, 1979 and 33% responded that they do not accept Medicaid patients for any type of services. In a further study commissioned for the Human Resources Planning Department, the Anchorage Urban Observatory found that the primary care physicians have on an average 57 Medicaid patients per practice. This

would indicate that approximately 4731 Medicaid patients (57 x 83 physicians) are being seen on a regular basis by Anchorage primary care physicians. This represents about 36% of the Medicaid eligible population in Anchorage, and would seem to indicate that 64% of the Medicaid eligible population in Anchorage is not being seen regularly by primary care practitioners except for the two physicians at the Anchorage Neighborhood Health Center.

ANHC Survey

To further clarify the situation, the Anchorage Neighborhood Health Center conducted its own telephone survey in October, 1979. ANHC called 17 OB physicians, 36 family practice physicians, and 14 pediatricians in Anchorage.

Summary of results (see appendix for complete survey results).

1) Five OB practices are completely closed to new OB patients or Medicaid patients.

2) Six OB practices accept new OB patients but do not accept Medicaid patients.

3) The remaining four OB practices all require cash payments by the patients, up front, before they will be seen, thus limiting access to low income patients. Further, they will only accept a limited number of Medicaid patients.

4) None of the 36 family practice physicians accept new OB Medicaid patients.

5) Twelve of the fourteen pediatricians will not accept Medicaid patients. Two pediatricians who accept Medicaid patients do so on an extremely limited basis.

Adjustments To Primary Care Practitioners

1) Beginning Ratio $\frac{13,241}{82}$

2) Adjusting for physicians with closed practices to Medicaid patients. $\frac{13,241}{21}$

11 obstetricians (ANHC Survey - see appendix)
12 pediatricians (ANHC Survey - see appendix)
38 family practice (Anchorage Municipal Human Resource Planning Survey)

3) a) Adjusting for limited access to Medicaid patients - 36% of Medicaid eligible population, currently has access to primary care practitioners. This means that the 4,766 Medicaid eligible persons have access to the 21 remaining primary care physicians. $\frac{4,766}{21}$

b) The remaining 64% (8,475) of the Medicaid eligible population, in effect, has a total of 2 physicians (Anchorage Neighborhood Health Center) available to them on a full-time basis. $\frac{8,475}{2} = 1:4,236$

Thus, according to the data presented, a Critical Health Manpower Shortage area ratio exists in the Anchorage low income population. For the reasons outlined in this report, we are requesting that the Bureau of Health Manpower provide this designation immediately. A critical need in the area of prenatal care is particularly apparent, and the Anchorage Neighborhood Health Center intends to apply for a Family Practice National Health Service Corp Physician to help alleviate this problem.

ADDITIONAL DOCUMENTATION IN SUPPORT OF THIS APPLICATION

There is some evidence that the group above the Medicaid eligible population of Anchorage also lacks regular access to primary care practitioners. This "medically indigent" category is not well defined. However, using the HUD "Section 8" guidelines (the most generally accepted income guidelines for Anchorage), low and moderate income levels and target populations can be enumerated.

Table 2. HUD Section 8 Income Guidelines for Anchorage, July 31, 1979*

Number in Family	Low Income	Moderate Income	Median Income
1	8,960	11,200	14,000
2	10,240	12,800	16,000
3	11,520	14,400	18,000
4	12,800	16,000	20,000
5	13,600	17,000	21,250
6	14,400	17,800	22,500
7	15,200	19,000	23,750
8	16,000	20,000	25,000

* Source: Al Robinson, HUD Economist, Anchorage

According to HUD figures, an Anchorage family of 3 that makes $11,520 or less is considered to be low income. Referring again to Table 1, approximately 4% of the total Anchorage population falls above the poverty level, yet below the low income level (extrapolation of the 2 categories 0-9,000 and 10,000-14,999 per year). By this calculation, there are about 6,620 persons who fall within this medically

indigent category. end: 8876

Again, using the HUD figures, the moderate income level population can be estimated. This amounts to approximately 7%, or 11,586 persons in the low to moderate income range.

In summary, the income populations are shown below.

Anchorage Target populations

Poverty level (Medicaid eligible)	13,241
Low income	6,620
Moderate income	11,586
Total	31,447

Lack Of Access To Medical Care Services

Another indicator of the problem is the emergency room utilization. Providence Hospital had 27,000 emergency room visits during the past year. According to the administration office at Providence, 60% to 80% of these visits were non-emergency problems. This is one of the major indicators of the lack of access to a regular physician by a large segment of the Anchorage population.

Perceived Needs

The perceived needs of Anchorage health consumers seems to support the physician access problem. In a recent survey done for the Anchorage Municipality, the Anchorage Urban Observatory* found that 25.4% of the persons surveyed had difficulty paying for the uninsured cost of medical care.

*Ender, Richard. "Anchorage Health Needs Assessment Study: A Consumer's Health Survey", May, 1979.

Attachment B

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER / POUCH H 01 – JUNEAU 99811

February 6, 1980

The Honorable Terry Martin
Alaska State Representative
Pouch V
Juneau, Alaska 99811

Dear Mr. Martin:

Recently you requested information regarding key questions that might be addressed in a study analyzing the advantages and disadvantages of State of Alaska withdrawing from the federal Medicaid and Aid to Families with Dependent Children (AFDC). Our primary information sources for your request were Deputy Commissioner Frederick McGinnis, who has been designated to coordinate a special project on health care financing, and members of the Division of Public Assistance. They offered the following list of pertinent questions:

Medicaid Issues

1. What would be the impact of withdrawing from Medicaid without withdrawing from AFDC?

2. Which option services (such as eyeglasses) and mandatory services (such as doctor's visits) would be advantageous to the State to continue in a state designed and financed medical program?

3. Who would be eligible for the state replacement program? Would the State be interested in expanding its eligible group to cover certain needy or middle income persons now not routinely eligible for state assistance?

4. How would the issue of prior medical resources (Indian Health Service, Blue Cross coverage, etc.) be handled? Would the state only cover those persons with no other available resource to pay for or provide care? As is the case currently with General Relief Medicaid program.

5. Should the Medicaid requirement of "free choice of provider" be continued under any new state medical assistance program?

6. Would the services be offered in all areas of the state in the same manner? Or would regional planning and delivery of services be utilized?

7. How will National Comprehensive Health Insurance or National Catastrophic Medical Insurance programs now discussed on federal fronts impact the design of this program?

8. Other points to consider regarding loss of federal Medicaid funds if the State withdrew from Medicaid:

   a. 50% federal funds for medical services covered under Medicaid for persons eligible for a cash payment under AFDC, SSI and/or APA.

   b. 50% to 90% federal funds for medical services covered under Medicaid for persons not eligible for a cash assistance payment but who are in state institutions, in long-term care facilities and hospitals, and children in foster homes and private child-caring institutions.

   c. 100% federal funds which flow through the Medicaid program to the Alaska Area Native Health Services to provide funds to raise the quality of care of those facilities under the Indian Health Care Improvement Act.

   d. 75% to 90% federal funds for the development and operation of a computerized Medicaid claims payment and management information system to provide prompt payment of medical providers and detailed information necessary to do adequate budget projections.

   e. 75% to 100% federal funds for program management safeguards to assure that cost effective payment is being made to licensed providers for medically necessary services through a professional standards review organization for hospital care, medical utilization review for long term care and outpatient medical services and supplies, and medical provider fraud investigation.

   f. 75% to 100% federal funds for certification and licensing of health care facilities under Medicare and Medicaid to assure adequate care is being provided in safe and sound facilities.

   g. 50% to 75% federal funds to the Division of Public Health for nursing services provided to Medicaid eligible children for the detection, identification and treatment of diseases and deformities.

   h. 100% federal funds for federal program oversight, technical assistance, and program review to assist the Department in an effort to provide payment for cost-effective, high quality medical care.

   i. 50% to 90% federal funds for program administration costs claimable by the Department for the department-wide and

statewide cost allocation system designed to maximize federal receipts to offset state general fund expenditures.

AFDC Issues

An exhaustive study of this subject was completed by the former Research Division, Legislative Affairs Agency. The Department participated actively in this research project and has reviewed the draft. The Legislative Affairs Agency's Research Division was disbanded before the final report was approved for printing. We recommend you obtain a copy of this report to determine whether your current initiative may duplicate the massive effort required in that project.

Though the draft report discussed the features of the AFDC program that may make it desirable for Alaska to opt out and upon the costs of dropping the program, considerable attention was given to possible alternatives to replace AFDC. Among the topics covered in the study were:

(1) history of Alaska's assistance programs;

(2) problems in administering a federal program in Alaska;

(3) federal welfare reform proposals and their potential effects on Alaska;

(4) fiscal impact of withdrawal;

(5) alternatives to AFDC (including negative income tax and a universal child allowance);

(6) legislative and administrative alternatives and options within the current federal AFDC program; and

(7) work requirements for welfare recipients.

You may wish to contact Deputy Commissioner McGinnis directly at 278-4668 (Anchorage) and Rod Betit, Director of the Division of Public Assistance at 465-3355, for further clarification. For your information, Deputy Commissioner McGinnis has just begun the planning for a study with the Governor's approval to take a comprehensive look at the total health care financing picture in Alaska, of which Medicaid is a vital part. He plans to submit the results of his study to the 1981 Legislature.

We appreciate the opportunity to offer some input on your possible project.

Sincerely,

Helen D. Beirne

Helen D. Beirne
Commissioner

Attachment C

The Children's Clinic
3300 Providence Drive
Anchorage, Alaska 99504

907/279-8571

October 12, 1979

Mr. Leonard D. Schaeffer, Administrator, HCFA
Department of HEW
Mary E. Switzer Building, Room 5006
330 "C" Street, S.W.
Washington, D.C. 20201

Dear Mr. Schaeffer:

The purpose of this letter is to outline the difficulties The Children's Clinic has experienced in dealing with the Medicaid system in the State of Alaska. In addition, we are outlining some of the recommendations that would alleviate some of these problems.

(1.) Failure of Medicaid to pay anything in less than four months, with many accounts unpaid in 16 months. An example is given in Table 1.

(2.) The cost of processing Medicaid paperwork is excessive. For example, The Children's Clinic pays $1,700.00 in combined staff salaries to process Medicaid paperwork. The current disallowance rate pays us $ .62 for each $1.00 billed. In the month of September 1979 our doctors each made an average of 1,355 patient visits in the hospital and office. Thirty-eight percent of these visits or procedures are for Medicaid recipients. After correcting for the disallowed rate, the secretarial time to process paperwork, less office overhead of 55%, net receipts was $489.00. The average net is $3.62 to the doctors per patient procedure or visit. If this is converted into a net hourly rate, the amount is $4.31 per hour for Medicaid patients. Compare this with the net income per doctor per visit or procedure of $19.29 per visit or $28.30 per hour for patients having private insurance.

(3.) The fact that a doctor will be reimbursed $3.62 nine months after he provides the treatment is not conducive to his opening his practice to any new Medicaid patients. The fact that a Medicaid coupon is relatively worthless from the financial viewpoint means the Medicaid patient is, in effect, a second-class citizen in his attempts to obtain medical care.

(4.) The Medicaid office has repeatedly failed to advise the providers of changes in the system prior to the change taking place. This results in a great waste of time for the State employees, the providers, staff, and the Medicaid patient in generating and processing outdated forms.

(5.) The Medicaid office fails to keep Medicaid recipients notified of coverage to which they are entitled and the system by which they are to obtain these benefits.

(6.) The supervisory and clerical staff in Juneau change very often. A supervisor with whom we might have discussed various cases is no longer there when we telephone back a month later. The people who are now handling the account know nothing of what is going on and they request reapplication of the entire account. After a particular invoice is handed from one clerk to another, 6 months may have elapsed. If the paperwork must be resubmitted, coupons for the service provided 6 months ago cannot be provided by Medicaid. The patients themselves do not keep old coupons.

(7.) Although private insurance carriers will coordinate benefits between one another, when the patient has coverage by more than one company, Medicaid expects the doctor's office to do this. The physician's offices are skilled at providing Medicaid care, but not for employing insurance personnel for this type of activity.

(8.) The Medicaid office is not verifying whether or not the Medicaid recipients have insurance coverage. The social worker will determine that a divorced mother is working for a company that has insurance available. Many of these mothers choose not to have the insurance as it will reduce their take-home pay. This mother will be recorded by the Medicaid office as having private insurance when, in actual fact, no private insurance exists. It takes an average of 5 months of letter writing between the insurance company, employer, and the doctors to prove that no insurance coverage existed at the time. Again, when 5 months have elapsed, the patient does not have a coupon covering the appropriate time period. The Medicaid office refuses to provide the coupons or authorize payment for those services.

(9.) The Medicaid office in Juneau requires a separate coupon be obtained for each provider. When the patient comes to the hospital in the middle of the night for an emergency, often times the patient forgets to bring the coupon. The hospital will be reimbursed on a basis of a coupon number typed on the emergency room services sheet. The private physician who provides the service at the time of the visit is expected to obtain a coupon rather than use the same system as the hospital.

(10.) Payment vouchers are presently identified only by invoice numbers. They lack corresponding patient names. Transition errors are being made by Medicaid personnel in typing invoice numbers on the vouchers, consequently the doctors cannot find the invoice that should be credited with the payment. We need patient names included as well as the invoice numbers.

(11.) Lump sum payemnts are made, which do not give Explanation of Benefits that state what services are being paid and what date. For example, we will have provided 20 services for a family over a period of one year. Because of the reimbursement for Medicaid being delayed 6 to 12 months - some services are disallowed, others are questioned, and others are paid - we cannot properly credit the lump sum payment to the proper services. This particular procedure is necessary because invoices are constantly being lost in Juneau and we must reapply two or three times. We must have an itemization accompanying each payment voucher so that accounts can be properly credited and duplicate charges will not be submitted in error.

(12.) A mother who is pregnant is not permitted to get a coupon for the unborn child until after the birth of the child. In this office an average of 2 months elapses following the birth of a child before the mother can provide us with a coupon for that child. Medicaid mothers are a high risk for having premature infants and newborns with a high degree of sickness. The whole process of initiating paperwork to obtain reimbursement is delayed an additional two months, in addition to the five or six months already mentioned. If the social worker thinks that the mother has maternity benefits from her employer, the situation stretches out for a year.

(13.) Medicaid recipients only recieve 5 coupons per month which may be used in 2 visits to the doctor (one coupon for the doctor, one for the lab, one for the x-ray, and one for the pharmacy). Recipients tell us they go to the Medicaid office, but are unable to get any more coupons; as a result, patient care suffers.

The following recommendations are offered to IMPROVE MEDICAID.

(1.) It is time for the state and federal government to get out of the insurance business. The CHAMPUS program works very satisfactorily in Alaska. In Alaska, private insurance companies competitively bid to obtain one-year contracts for the CHAMPUS funds. The companies compete with one another to provide the government with more health care for less dollars. The insurance carriers are already very good at coordinating benefits for recipients having multiple coverage, and consistently accompany the voucher with the explanation of benefits for each individual patient. We would strongly urge that the federal government look at the actual cost in dollars per service to the patient, including the overhead for the cumbersome duplicating, inefficient system we have in Alaska. If the Medicaid in Juneau was to bid competitively with Blue Cross, Aetna, Metropolitan to obtain federal funds for the administration of reimbursement for medical care, the Medicaid would either shape up or lose the contract to a private carrier.

(2.) An alternative system to do away with reimbursing doctors altogether: Doctors would simply document the services provided and apply the patient fees for Medicaid patients as a tax credit to the Internal Revenue Service. The IRS already has an effective system of cross-checks and could audit office records simply and avoid suspicion of fraud on the part of the doctors. The amount of monies saved by doing away with salaries, equipment and rent for the Medicaid system could be reallocated into education, food, etc.

(3.) We understand from Mr. William Collings, of the D.H.E.W., that the Medicaid office in each state is to have a medical advisory committee in each state. The committee has not been functional in Alaska to our knowledge. The Alaska American Academy of Pediatrics and the Anchorage Medical Society have doctors who are knowledgeable and are willing to contribute their time and efforts to such a committee. These representatives could report back any changes in the system to the doctors in the communities.

(4.) To curbe the current widespread abuse of the Medicaid system by the patient, each patient should be required to make "token" payments in cash ($2.00) each visit. Children are being brought into the doctor's office for hang nails, etc., because they are on Medicaid and think they must be seen. If they paid $2.00 of their own slender dollars they would think carefully before going to the doctor or health clinic unnecessarily.

To prevent user abuse of the hospital emergency room, patients would be required to make a cash payment of $20.00 in advance if the emergency triage nurse determined that this visit is not an emergency. It is not unusual for a Medicaid mother to bring a 4-year-old to the emergency room at 3 a.m. because he has been crying for two weeks and cannot sleep. If his mother had to pay $20.00 in cash prior to the service she would make more efficient use of her Medicaid coupon and the medical services available to her. Thus, Medicaid would be charged only $28.00 for an office visit, instead of $100.00 for an emergency room visit.

(5.) As an interim measure, move the state Medicaid offices from Juneau to Anchorage or Fairbanks. These are the areas where the majority of the recipients live and the majority of the care is provided. This would facilitate communications between recipients, providers and administrators. Each area must have a strong manager who has the authority to authorize payment, issue coupons, etc.. locally.

The pediatricians of The Children's Clinic appreciate the opportunity to bring their ideas and concerns for caring of the Medicaid recipients to you at the Annual Meeting of the American Academy of Pediatrics. We hope that this type of dialogue will continue to benefit the Nation's Medicaid children.

Sincerely,

(Signed)

Clinton Lillibridge, M.D.—
The Children's Clinic
3300 Providence #112
Anchorage, Ak. 95504

cc: James Nesbitt, M.D.
Gerry Schriever, M.D.
Dion Roberts, M.D.
Elizabeth Hatton, M.D.

CL/pkd
(Retyped 10/22/79 -AAP-
AAP - TPR/ms)
(Attachments)

Attachment D

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

ALASKA CHAPTER
American Academy of Pediatrics

February 6, 1980

Representative Terry Martin
Pouch V
Juneau, Alaska 99811

Dear Sir:

By way of introduction, I am the alternate chairman of the Alaska Chapter of the American Academy of Pediatrics. The Academy represents 90 per cent of all of the pediatricians in Alaska. We have been struggling to develop new solutions to the Medicaid problems. It is our desire to provide excellent care for every child in Alaska, regardless of the ability to pay.

Many physicians (including some pediatricians) have refused to accept Medicaid patients simply because the entire fee for the office visit is expended in clerical time to process the paper work. To add insult to injury, after processing (and reprocessing) the paper work, payment is not forthcoming. From a financial standpoint, we would be better off to see Medicaid patients for free and not bother to process any paper work.

If we do this, however, an ethical problem arises with the patients who have jobs (and thus are not eligible for Medicaid) but do not earn enough to pay for medical care. If we give free care to one part of the population, we are ethically bound to do that for others. With no end in sight, this is not a viable solution.

We have been impressed with the capability of Delta Dental as an intermediary for handling Medicaid payments for dentists. We would strongly recommend that pediatric care, including handicapped children, and early screening for Medicaid recipient patients be contracted through Delta Dental.

Our experience with third party payers who are out of state has been dismal. Close and frequent communication is mandatory to facilitate understanding between the provider of care and the third party payer. This is simply impossible when the offices are out of state.

The carriers very effectively can set aside or delay payment, knowing there is no effective way we can communicate with them. As a result, our clerical costs are quite high and the costs to the system (because they do not understand what is going on in our offices, or any of Alaska for that matter) are quite high. It may seem on the surface that an outside carrier would be cheaper, but this is only in the short run. A close working relationship with open communications will greatly reduce costs, in the long run. Delta Dental has proven itself to be effective, and even if they have higher costs than an outside carrier, we firmly believe that the cost to the system will be much lower with Delta Dental carrying Medicaid for pediatrics.

Enclosed is a letter which gives you background information. It was originally presented for our discussions with Mr. Leonard Schaeffer of HEW.

Dr. James Nesbitt and I are willing and prepared to help you understand what is going on with the Mecicaid program as it presently exists and would like to work with you in developing new solutions so that needy children in our state can receive proper care and physicians can be reimbursed for the care they provide.

Sincerely yours,

C B Lillibridge MD

Clinton B. Lillibridge, M.D.
Alternate Chairman
Alaska Chapter
American Academy of Pediatrics

CL:sh

Enclosure

It's a shame that in a state as rich as ours, a lot of children receive poor medical care, simply because the State Does NOT PAY ITS Bills !

CL

REPORT ON

REGION X REVIEW OF MEDICAID OPERATIONS

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

STATE OF ALASKA

Prepared by

MEDICAID MANAGEMENT BUREAU

HEALTHCARE FINANCING ADMINISTRATION

REGION X - SEATTLE

MARCH 1979

Attachment E

CHAPTER I

EXECUTIVE SUMMARY

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

Introduction

This is a report of a review of Alaska's Medicaid program conducted during the week of January 15-20, 1979 by members of the Region X Medicaid Bureau staff. This review was conducted at the request of the Division of Public Assistance.

Chapters II through VII present the major findings, conclusions, and recommendations of the review. These are summarized in the next pages. Detailed reports from the members of the review team follow Chapter VII.

Summary of Findings, Conclusions, and Recommendations

Any review of this type tends to focus on weaknesses of present operations. At the same time, it must be recognized that, despite very considerable difficulties of staff turnover, budget limitations, and the problems of travel and communication within Alaska, the State's staff have made valiant efforts to keep the program functioning and to be responsive to recipients and providers.

There is no doubt, however, that Alaska'a Medicaid program has very serious problems. Staff turnover, staff shortages, and the need to deal with day-to-day crises have combined to place the program in a situation in which there are few controls over costs and the program is seriously vulnerable to fraud or human error.

The major changes recommended in the next six chapters cover:

- reorganization of the Division of Public Assistance to establish a clearly defined Medical Assistance Unit
- addition of staff in eligibility determination, medical policy, third-party liability areas, claims processing (unless fiscal agent employed), Medicaid quality control, and medical surveillance unit
- more emphasis on training efforts

- contracting for development of manuals and procedures
- improvements in accounting controls
- enhancement of the TPL collection function
- improvements in the maintenance of the claims history file
- improvements in control over provider enrollment
- establishment of a provider training program
- development of closer relationships with the provider community
- development of eligibility determination procedures and associated training
- improvements in gathering eligibility data, including a new Basic Eligibility Form
- implementation of a reasonable cost-related reimbursement system, incorporating a 90 percent minimum occupancy level
- re-establishment of admission review for API cases
- renegotiating the memorandum of understanding with APRO and developing an associated monitoring system
- increased emphasis on alternatives to institutional long-term care
- contracting for development of a new provider manual and claims processing procedures
- development of, or contracting for, a new claims processing system (preferably through use of a fiscal agent or facilities manager who would also operate the system)

Implementation Plan

Three of the recommendations potentially involve the use of contractors. Given the seriousness of the Alaska Medicaid program's problems, this is

an appropriate approach, since it provides some assurance that changes can be accomplished at a known cost, without dependence on the very limited -- and desperately busy -- existing staff of the Division of Public Assistance. The recommendations are for use of outside organizations to:

- develop manuals and procedures for providers, claim examiners, eligibility workers, etc.
- develop training materials
- develop a new claims processing system (preferably through use of a fiscal agent or facilities manager, who would also operate the system)

Contracting for the first should be done immediately. Contracting for the second should be done as soon as the manuals and procedures are developed. The feasibility of using a fiscal agent should be investigated immediately.

All the recommendations are urgent. Those involving adding staff should be examined immediately so that personnel can, if funds are available, be hired. Responsibilities for implementation of each recommendation should be assigned as rapidly as possible and detailed schedules and cost estimates developed.

II. ADMINISTRATION AND MANAGEMENT

Overview

This chapter discusses the administration and management of Alaska's Medicaid program in terms of organization, staffing, hiring, training, and operational procedures. The next five sections of this chapter present findings, conclusions, and recommendations for these five areas.

Organization

Alaska's Medicaid program is administered by the Department of Health and Social Services through the Public Assistance Division, which is designated as the State's Medical Assistance Unit. Other components of the Department with significant involvement in Medicaid administration are the Office of Information Systems, the Office of Internal Review, the Division of Public Health, the Division of Mental Health and Developmental Disabilities, and the Division of Administrative Services.

Major Findings and Conclusions

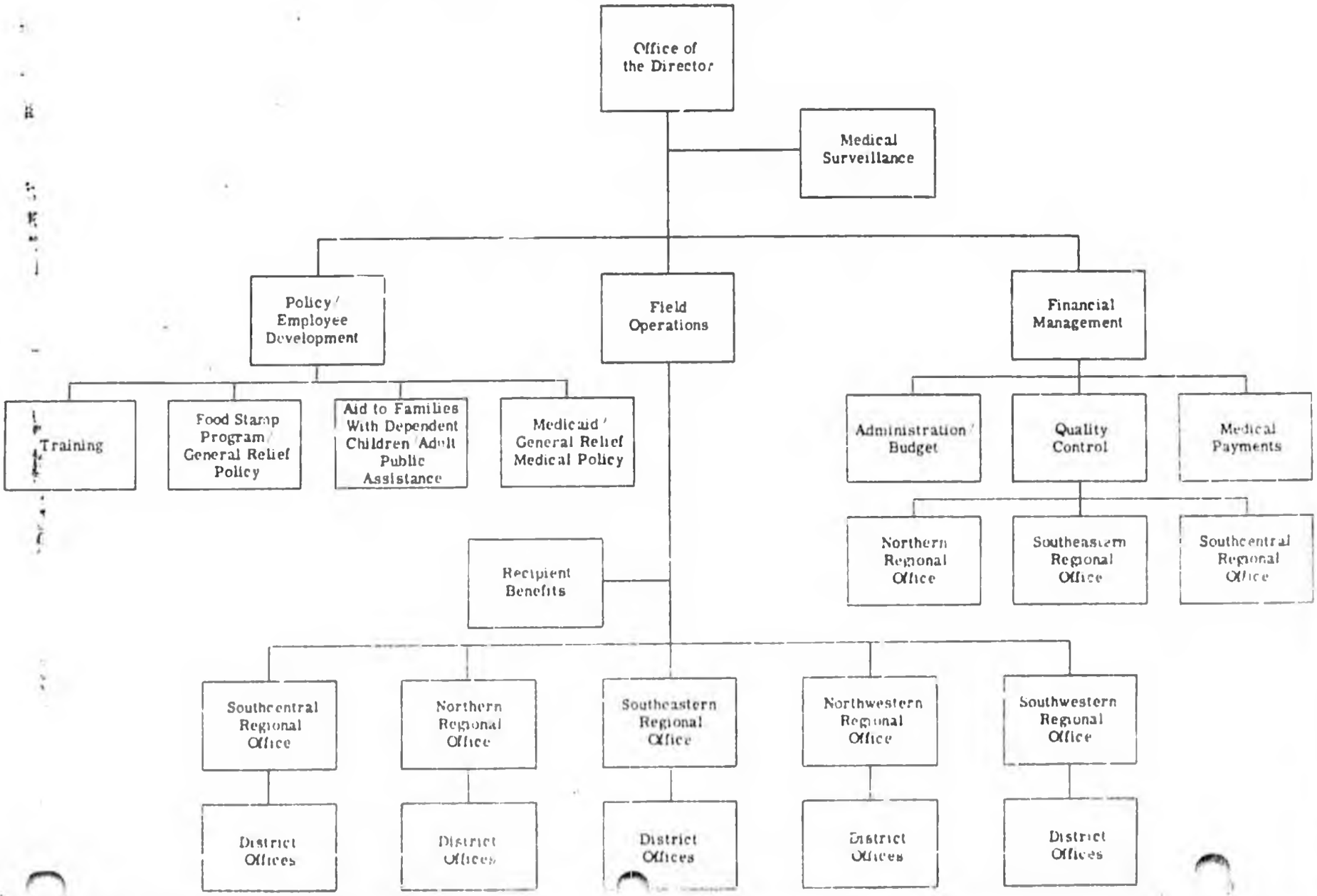
While the Department's organization structure is comparable to that of other states, the Division of Public Assistance's organization is significantly different and appears to result in a number of problems:

- The definition of the Public Assistance Division as the State's Medical Assistance Unit appears not to comply with the relevant Federal regulations (45 CFR 205.101 (b) and (c) and Part 2-40 of the Medical Assistance Manual), since the Division and its Director are responsible for a variety of other programs in addition to Medicaid. Thus it is doubtful that the Division meets the requirement that a State Medical Assistance Unit "provide a central point of responsibility for professional and technical aspects of medical services and medically related programs of the agency". The present organization is shown in Exhibit 1.

EXHIBIT 1

DHSS - DIVISION OF PUBLIC ASSISTANCE

UNIT ORGANIZATION CHART - JANUARY 1979



- From an organizational point of view, the dispersing of Medicaid functions, including policy-making, through a division which also administers other important programs, leads to a lack of direction of the Medicaid program. There is no part of the Division of Public Assistance whose sole responsibility is Medicaid policy. In practice, Medicaid policy decisions are made by the Medical Surveillance Section, the Medicaid/General Relief Medical Policy Section, and the Medical Payments Section. Each section performs a variety of other functions as well as Medicaid policy-making. Medicaid functions must compete with the AFDC, Adult Payment, Catastrophic Illness, and Food Stamp programs for the time and attention of the Division Director as well as for other Division resources. Directing and coordinating the varied elements of the Medicaid program is extremely difficult in this organizational arrangement.

- Responsibility for Medicaid claims processing is split between the Division of Public Assistance and the Division of Administrative Services. This leads to difficulties in controlling service utilization and in developing accurate financial and statistical data for the program. (This problem is discussed further in Chapter VII, Claims Processing.)

Recommendations

- Restructure the organization of the Division of Public Assistance to establish a clearly identifiable Medical Assistance Unit with responsibility only for Medicaid administration. The Medical Assistance Unit should be established either as a separate division or, preferably, as a major subdivision of Public Assistance co-equal with Field Operations and Financial Management. The Medical Assistance Unit should include the following present groups:

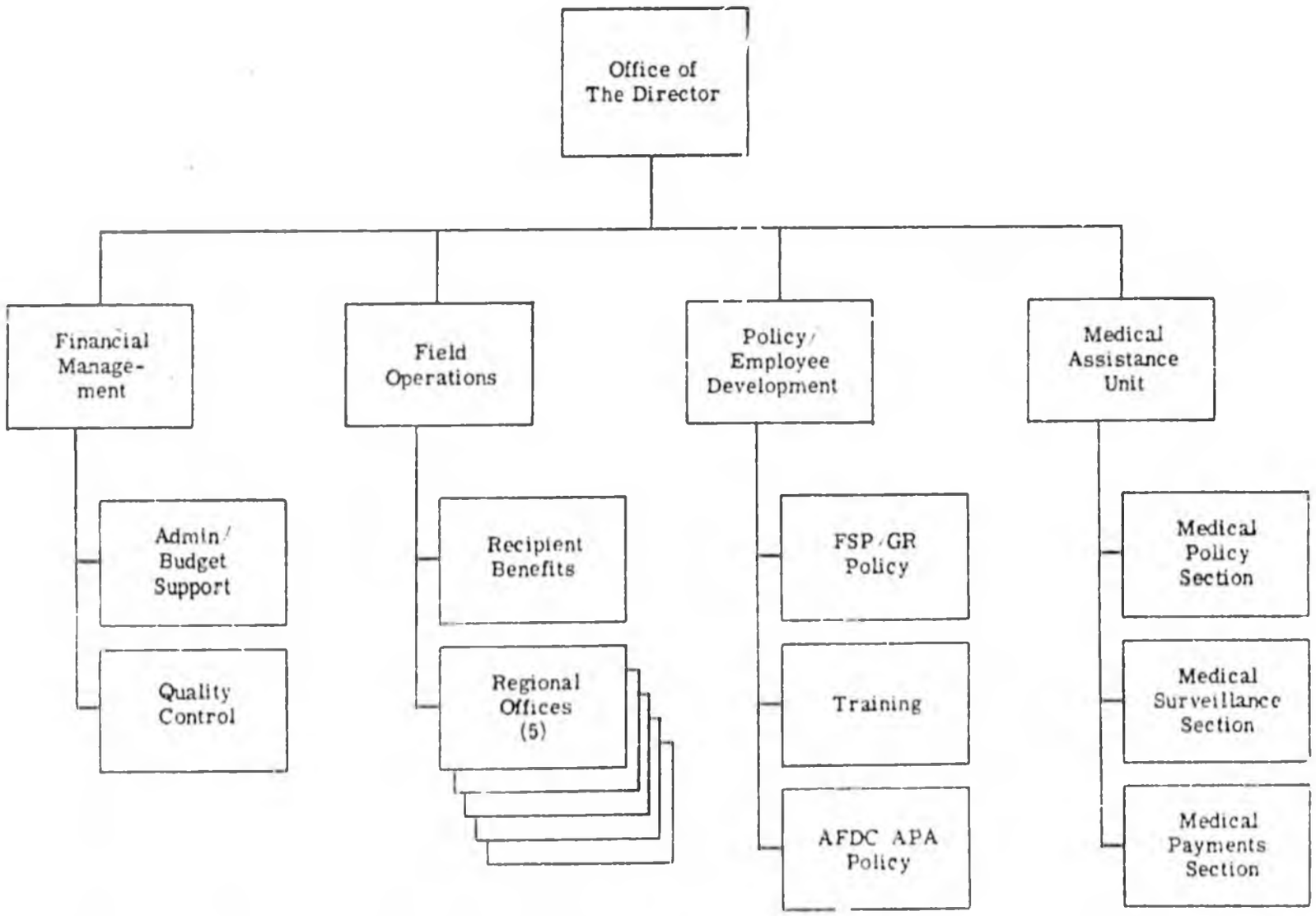
  Medicaid/General Relief Medical Policy Section
  Medical Surveillance Section
  Medical Payments Section
  Medical Assistance Administrator (Anchorage Regional Office)

The proposed organization structure is shown in Exhibit 2.

EXHIBIT 2

DIVISION OF PUBLIC ASSISTANCE

PROPOSED ORGANIZATION STRUCTURE FOR MEDICAL ASSISTANCE UNIT



- Provide clear definitions of policy-making and other responsibilities within the revised structure. Policy-making functions should be located in one section, not dispersed through the Medical Assistance Unit.

- Contain all Medicaid claims processing functions in one unit.

Staffing

Any examination of staffing in DHSS must take into consideration two factors: first, the State of Alaska is in a period of considerable budgetary constraint; second, most State agencies and many private sector businesses in Alaska experience problems of high staff turnover.

At the time of the review (January 6, 1979), the authorized versus actual staffing of the Division of Public Assistance was as follows:

Authorized	Actual
163 full-time	133 full-time
(plus 11 part-time)	(plus 8 part-time and 15 temporary)

It should be noted, however, that the 163 authorized positions are not fully funded; that is, some vacancies are assumed.

Major Findings and Conclusions

The effectiveness of Alaska's Medicaid program is currently hampered by insufficient staffing in some key areas and by high levels of staff turnover.

- DPA management anticipates a considerable staff shortage in the eligibility determination area in FY

1980, due to expected increases in numbers of eligibles without a corresponding staff increase. The staffing formula used by DPA indicates a need for an additional ten FTE personnel for eligibility determination.

- The Medicaid/GR Medical Policy Section is severely understaffed. At present, a program officer and an administrative assistant are responsible for developing Medicaid policy, GR Medical policy, and catastrophic illness program policy, provider enrollment, fair hearings, writing the Alaska Medicaid program regulations, drafting a Medicaid eligibility manual, consulting to field offices, and other ad hoc administrative activities.

- Only one person is currently assigned to third-party liability collection. Since Alaska's experience to date (borne out by that of other states) is that this is a highly cost-effective activity, there is a need for increased staffing to provide additional recoupment from third parties.

- High levels of staff turnover have undoubtedly contributed to problems in Medicaid administration. An analysis of two BRUs within DPA showed turnover rates of 44 percent within each during FY 1978. This is assumed to have resulted in too low experience levels in too many positions within the Division.

Recommendations

- Examine ways of increasing the eligibility determination staff for FY 1980. Possible approaches include:

  a supplemental request to the Governor's Office for ten eligibility positions

  use of CETA positions in District and Regional offices to carry out eligibility and/or clerical duties

  use of temporary hires in the District and Regional offices (the least desirable approach)

- Examine ways of increasing effectiveness of the eligibility determination staff. Possible approaches include:

  enhancement of automated systems for eligibility determination

  provision of additional training (discussed in a later section)

  provision of improved procedure manuals (discussed in a later section)

- Add one professional and one clerical position to the Medicaid/GR Medical Policy Section. It may be possible to add the professional position through reassignment of a vacant position elsewhere in the Division. One function of the new positions should be maintenance of manuals and procedures.

- Reassign the position of Medical Assistance Administrator from the Anchorage Regional Office to the Medicaid/GR Medical Policy Section in Juneau, since, although the Anchorage position is currently needed, implementation of other recommendations will allow its elimination.

- Add up to three additional positions to the third-party liability collection function in order to increase third-party reimbursement of Medicaid payments. Additional staff may be required to maximize these reimbursements.

- Examine ways of reducing staff turnover, including:

  acceleration of the Department of Administration's planned classification review of eligibility positions to the earliest possible date in 1979

  provision of improved training throughout DPA (discussed in a later section)

  provision of improved procedure manuals so that tasks are easier to perform and job pressures are somewhat eased (discussed in a later section)

Hiring

Hiring for new or vacant positions presents some unique problems in Alaska State government. The practical difficulties of attracting out-of-state personnel, combined with a policy of preference for State residents, and a limited State population, considerably constrains the available pool of persons qualified for open positions. It is important, then, that Division of Public Assistance hiring problems be examined in the light of these constraints.

Major Findings and Conclusions

At least in part for the reasons noted above, DPA has and is experiencing hiring problems.

- There have been some delays in filling positions, particularly in view of the high turnover rate. Currently the average time to fill an existing position is one month, and for new positions is up to six months.

- There has been a tendency to promote staff with minimal experience in their existing jobs, with new personnel hired only at low levels. While this has some positive aspects, it can lead both to "inbreeding" and to inadequately experienced supervisory staff.

Recommendations

There are obvious practical difficulties in solving DPA's hiring problems. The following recommendations, however, should alleviate the problems to some extent.

- Work with DHSS personnel staff and Department of Administration personnel staff to reduce the length of time to fill vacant positions.

- Aggressively utilize the "flexible" staffing authority for filling eligibility worker positions.

- For managerial positions, ensure the position requirements are sufficiently specific to allow recruiement of qualified employees.

Training

The preceding sections indicate weaknesses in staffing which might be, at least partly, alleviated by more extensive training. In fact, as discussed below, DPA's training efforts have been much reduced as a result of other pressures on the Division.

Major Findings and Conclusions

- The position of Training Specialist is currently filled only in name, since the incumbent is temporarily assigned to management of the Southeast Regional Office.
- Partly as a result of this temporary assignment, minimal training activities are currently being performed.
- As discussed earlier, the high level of staff turnover, combined with inadequate or nonexistent manuals and procedures, makes the need for training very urgent.

Recommendations

- Fill the Training Specialist position on a full-time basis.
- Contract for development of Medicaid training courses for Division staff.

Operational Procedures

The Medicaid Program is one of considerable complexity, and its proper administration depends on the availability of current, accurate, and understandable manuals and procedures for use by State and provider personnel. These manuals and procedures should meet the needs of providers, claims examiners, policy-makers, and management.

Major Findings and Conclusions

Development and maintenance of Medicaid manuals and procedures has suffered due to staff shortages and the need to deal with more immediate critical problems. Specifically:

- Medicaid regulations have been drafted but have not yet been adopted. Implementation is anticipated in May 1979.
- The Provider Manual is not current. The version available to providers was developed in 1974.
- There is no current eligibility worker manual for Medicaid.
- There are no procedures for use by claims examiners.
- There is no medical policy or staff operational manual for use by DPA management and staff.

Recommendations

- Complete the current review process and hearing on draft program regulations and implement by March 1979.
- Contract with a consulting firm to develop:

  provider manual(s)
  claims examiner desk procedures
  medical policy manual
  Medicaid eligibility manual

  At least the provider manual(s), claims examiner desk procedures, and medical policy manual should be completed by July 1, 1979.
- Establish a position in the Medicaid/GR Medical Policy Section to be responsible for maintenance of manuals and procedures (recommended also under Staffing).

Summary

The major changes recommended in the preceding sections cover:

- reorganization to establish a clearly defined Medical Assistance Unit
- addition of staff in eligibility determination, medical policy, and third-party liability areas
- more emphasis on training efforts
- contracting for development of manuals and procedures

In terms of costs, the reorganization should have minimal impact, the staff additions and training efforts (except for TPL) will increase costs in the short run but should contribute toward a more effective and better controlled program, and the development of manuals and procedures should pay for itself in reducing claims payment errors.

III. FINANCE AND ACCOUNTING

Overview

This chapter discusses the accounting systems and controls relevant to the Medicaid program, the third-party liability collection function, contracts management and financial reporting.

Accounting Systems and Controls

Accounting systems and controls for the Medicaid program are the responsibility of three groups within the Department of Health and Social Services: Financial Management Section (Division of Public Assistance), Finance Operations (Division of Administrative Services), and Office of Information Systems. Certain functions are also performed by the Department of Administration, which provides computer services and operates the Statewide accounting system (PBA).

Major Findings and Conclusions

Possibly in part because of the ongoing staffing problems, and more urgent situations such as claims backlogs, there are a number of weaknesses in accounting for the Medicaid program.

- There is a lack of control over Medicaid claims documents and over the entire claims payment process (discussed in more detail under Claims Processing).

- Specific weaknesses include: payment vouchers can be completed and certified by the same individual, provider enrollment can be completed without certification by an independent person, there is no system for verifying that recipients actually receive the services billed, remittance advices do not necessarily match warrants, batch integrity is not maintained over claims in data entry, and the PBA file does not match claims history file.

- While most Medicaid invoices are processed by the Division of Public Assistance, certain invoices (State institutions, other State agencies, certain non-medical claims) are processed by the Division of Administrative Services. The systems of controls, document storage, and invoice-to-warrant reconciliation processes used by the two divisions are all dissimilar. More important, the invoices paid by Administrative Services do not become part of the claims history file and are not checked for overlapping or duplicated services against the invoices processed by DPA. This fragmentation of processing makes projecting Medicaid costs extremely difficult.

Recommendations

- Provide organized secure storage for all accounting documents (medical coupons, invoices, vouchers, etc.).
- Eliminate the practice of persons certifying vouchers they have prepared.
- Implement a batch control system to provide complete batch integrity.
- Implement a system to provide reconciliation of warrants versus invoices.
- Contain payment of all Medicaid claims within one unit.
- Post all claims payments to the claims history file (discussed also under Claims Processing).
- Request a full-scope audit by the Office of Internal Review of the Title XIX program with specific emphasis on internal controls.

Third-Party Liability Collection

Third-party liability collection efforts provide an opportunity to achieve significant reductions in Medicaid program costs by collecting from (or

redirecting claims to) other medical insurers or a liable party in an accident case.

Major Findings and Conclusions

Alaska's TPL Collection function has only recently been established and is only beginning development. Limitations of the function include:

- Eligibility workers may not obtain details of other coverage from a newly eligible person.
- Only some claims are examined (manually) for possible third-party liability.
- Neither the eligibility nor claims processing computer systems are used in TPL detection.
- Insufficient staff are available to handle the potential volume of TPL collections.

Despite these limitations, over $30,000 has been recovered by the one person currently assigned in the short time this function has been in existence.

Recommendations

- Provide training to eligibility workers to enable them to obtain details of any other coverage.
- Add edits to claims processing computer system to identify potential TPL cases.
- Increase TPL collection staff to two professional and one clerical.

(The experience to date suggests that further cost-benefit analysis may justify a greater increase than this.)

Contracts Management

The contracts management function covers contracts with fiscal agents, consultants, and other contractors. The function is the responsibility of the Division of Public Assistance, although routine processing is performed by the Department of Administrative Services.

Major Findings and Conclusions

Comprehensive written policies regarding contracts management have recently been developed by the State. These policies are generally satisfactory. A few minor weaknesses are noted in the corresponding Detailed Review Report.

Financial and Statistical Reporting

Three groups of financial reports are prepared by the State which have relevance to the Medicaid program: monthly and annual reports of disbursements (generated by the Department of Administration's PBA System), internal State reports (prepared by DHSS), and Federal reports (prepared by DHSS). Only the Federal reports were reviewed in detail during the review, so the following findings and conclusions are limited to Federal reporting.

Major Findings and Conclusions

- Financial reports are out of phase with statistical reports.
- Expenditures by eligibility category are incorrectly reported.
- Expenditure projection reports are incomplete and inaccurate.

Recommendations

- Adopt written procedures covering preparation of Federal reports.

- Consolidate all claims processing in the Division of Public Assistance, to eliminate multiple sources of financial and statistical data (discussed elsewhere).

- Modify the claims processing system to provide a claims history file which reflects warrants issued, not merely claims adjudicated (recommended also under Claims Processing).

Summary

The major changes recommended cover:

- improvements in accounting controls

- enhancement of the TPL collection function

- improvements in the maintenance of the claims history file

Each of these changes involves increased expenditures. Each is important. The accounting control improvements are essential to avoid fraud and protect the integrity of the program. The additional staffing of the TPL collection function should more than pay for itself, based on other states' experience. The changes to claims history file maintenance are essential to provide proper controls and reporting.

IV. PROVIDER RELATIONS

Overview

This chapter discusses provider enrollment, provider education and training, and other provider relations activities.

Provider Enrollment

New providers are enrolled in the Medicaid program by the completion by provider, and the signing by the State, of a provider application and agreement, in accordance with 42 CFR 431.107.

Major Findings and Conclusions

The provider enrollment process is generally straightforward and effective except that:

- Under some conditions a fictitious provider could be enrolled.
- Out-of-State providers are not enrolled, nor is there any verification of the validity of their participation.
- Three different provider application/agreement forms are used: for mental health clinics, for audio/speech therapists, and for all other providers. These forms do not reflect all current Federal regulation citations.

Recommendations

- Direct the Department of Administration's Pre-Audit Unit to reject provider updates without an appropriate countersignature. (This is generally done now, but has not been formally or consistently applied.)
- Establish a verification process for out-of-State providers, including obtaining of state license number and social security or employer ID number.

- Consolidate the three provider application forms into a single common form, and update the references to Federal regulations.

Provider Education and Training

An ongoing program of provider education and training is important to the Medicaid program to ensure new (and existing) providers understand the requirements and constraints of the program and to help maintain good provider relations.

Major Findings and Conclusions

Alaska's Medicaid provider education and training is extremely limited:

- In the six months prior to the review only two training sessions, each for specific providers, were given.

- Responsibility for provider training is not clearly assigned to any one group.

Recommendations

- Establish an ongoing provider training program with more frequent provider workshops throughout the State.

- Assign responsibility for provider training to a specific unit in the Division of Public Assistance.

Other Provider Relations Activities

Other provider relations activities include attendance at professional society meetings, publication of newsletters, etc.

Major Findings and Conclusions

- Because of limited staff availability and the pressures of more immediate and urgent problems, few other provider relations activities have been performed.

Recommendation

- Develop closer relationships with the provider community, through participation in professional meetings, etc.

Summary

The major changes recommended cover:

- improvements in control over provider enrollment
- establishment of a provider training program
- development of closer relationships with the provider community

The cost increase associated with these changes is probably equivalent to the addition of one person. The result should be improved controls against fraud and a provider community with a better understanding of the program and its constraints.

V. ELIGIBILITY

Overview

This chapter discusses eligibility organization, eligibility policy, and eligibility procedures.

Eligibility Organization

The Medicaid eligibility organization consists of eligibility workers in district and regional offices, a central Recipient Benefits section, and a network of fee agents in the villages.

Major Findings and Conclusions

Alaska's eligibility program has some unique aspects. The fee agent network covers some 90 percent of the villages and provides an efficient mechanism for identifying potential eligibles and assisting in the application process.

In common with other parts of the Division, the eligibility organization suffers from the problems of high turnover and lack of training, identified in Chapter II. Since these problems are covered there, further details and recommendations are not presented here.

Eligibility Policy

Clear and correct understanding of Medicaid eligibility policy is essential to Medicaid cost control, to compliance with Federal regulations, and to ensure that potential Medicaid eligibles receive appropriate benefits.

Major Findings and Conclusions

For reasons similar to those for other problems -- lack of staff, high turnover, more urgent problems -- a number of weaknesses exist in the area of eligibility policy.

- Current Medicaid eligibility determination forms and manuals do not exist.

- Determination of eligibility appears to be based almost entirely on AFDC, SSI, and Adult Supplement eligibility, although Federal law and regulations provides many eligibility provisions peculiar to the Medicaid program. Thus, for persons not receiving cash grants, eligibility may be determined incorrectly.

- Particular misunderstandings of eligibility policy appear to exist for Alaska Psychiatric Institute cases, for which no Medicaid agency review of a need for admission (as required by 42 CFR 456.171) was occurring.

Recommendations

- Assign one person the responsibility of developing Medicaid eligibility policy. This is at least a half-time job on a continuing basis because of the frequent changes in Federal policy. This function could be combined with responsibility for training staff in Medicaid eligibility policy.

- Develop (or contract for) a Medicaid eligibility manual reflecting current State and Federal laws and regulations (also discussed in Chapter II).

- Develop a training plan for Medicaid eligibility training to be given to each eligibility worker within the first six months of employment, and for refresher courses.

Eligibility Procedures

Eligibility procedures must be adequate to ensure that eligibility is rapidly and accurately determined and the information correctly incorporated in appropriate files.

Major Findings and Conclusions

- The Basic Action Form used to convey information from the field to the State Office is in need of updating. Combined with the absence of up-to-date written procedures, the form is liable to be incorrectly completed.

- The Office of Information Systems, which has responsibility for the data processing system used for maintaining and reporting eligibility, has little documentation for the system and no one designated as responsible for its maintenance.

- For Alaska Psychiatric Institute cases, a form other than the Statement of Income and Resources normally used for AFDC eligibility was being used for gathering information. So little financial information is gathered via this other form that the eligibility of many children in API must be considered suspect.

Recommendations

- Update the Basic Eligibility Form and develop adequate instructions for using the new form.

- Designate an individual within the Office of Information Systems to be responsible for the eligibility system. Improve the quality of documentation of the system.

- Use the form used to gather eligibility data from AFDC recipients to gather data for children at API, or use some other form with adequate questions regarding financial status.

- Update the written instructions for determining the eligibility of children at API.

Summary

The major changes recommended cover:

- development of eligibility determination procedures and associated training
- improvements in gathering eligibility data, including a new Basic Action Form

The costs are a one-time cost for new procedures (already noted in Chapter II) and the addition of one staff person to have ongoing responsibility for maintenance of eligibility policy and related training. Savings should result from more accurate eligibility determination.

VI. UTILIZATION CONTROL AND RATE SETTING

Overview

This chapter discusses details of Alaska's rate-setting processes for long-term care, monitoring of appropriateness of care, utilization control, and the development of alternatives to long-term care.

Rate Setting for Long-Term Care

Long-term care costs represent the largest single component of Alaska's Medicaid costs. The generally high costs of labor, goods, and services in Alaska and the desirability of availability of long-term care in major communities present some constraints to cost reductions; nevertheless, any reductions which can be achieved will have a significant impact on overall program costs.

Major Findings and Conclusions

Long-term care costs in Alaska are very high, ranging from $40 to $170 per day with a weighted average daily rate of $75-80 per day. The following appear to be the major non-economic causes of the high rates.

- Responsibilities for interim rate setting are not clearly defined. This has led to at least one situation in which interim reimbursement rates were approved which included unallowable costs.
- There has been no systematic approach to rate setting, nor do any detailed procedures currently exist. Interim rates, in particular, have been approved as requested.
- Field audits have not always been performed. Settlement activity has been inadequate and has generally been a "rubber stamping" of reported costs.
- Current occupancy levels in SNF/ICF facilities average 70 percent. No occupancy minimums are included in the State reimbursement process.

Recommendations

- Define interim rate setting responsibilities clearly and provide adequate staffing.

- Implement a reasonable cost-related reimbursement system, incorporating a 90 percent minimum occupancy level. Because of the extent of the disparity currently existing, it may be necessary to phase in this occupancy level requirement.

- Expand the Medicaid Audit Section to ensure that, at least for the next three years, field audits of all facilities are performed annually.

Appropriateness of Care

From the viewpoints both of the Medicaid recipients and the State and Federal governments, it is important to ensure that recipients receive appropriate levels of care.

Major Findings and Conclusions

The State is currently in the process of developing Medicaid regulations which would include enforceable policies regarding levels of care determination and the placement of patients in long-term care. Accordingly, at least some of the following problems may be expected to be resolved with implementation of the new regulations.

- Generally, the approval process for admission to nursing homes works well and appears to be effective in ensuring appropriate care. However, there is currently no admission review for eligibles entering Alaska Psychiatric Institute. This is the responsibility of the Division of Mental Health and Developmental Disabilities but has not been done following the resignation of the psychiatrist assigned to the function.

- Monitoring of continued stays involves both periodic monitoring of patients' long-term stays and an annual review by the Medicaid Surveillance Unit of all patient

records in long-term care facilities. Both functions appear to be generally effective, except that patients have not been sent "adequate notice" of changes in their level of care as specified in 45 CFR 205. 10(a)(4)(14).

Recommendations

- Re-establish admission reviews for API, either by having the Medicaid Surveillance Unit reassume responsibility or by development of a clear memorandum of understanding with the Division of Mental Health and Developmental Disabilities. If the latter is chosen, some form of periodic monitoring by the Medicaid Surveillance Unit should occur.

- Ensure that adequate notice is sent to Medicaid recipients whenever a change is made in their level of care.

Utilization Control

Utilization control for Medicaid patients in acute care hospitals in Alaska is delegated to the Alaska Professional Review Organization (APRO). Utilization control for patients in long-term care facilities is the responsibility of the Medical Surveillance Unit and is covered in part in the preceding section.

Major Findings and Conclusions

Utilization control activities are performed for both hospital and nursing home patients. Weaknesses are listed in the following paragraphs:

- There is some indication that APRO's review procedures are inadequate and tend to "rubber stamp" hospital physicians' decisions. A current proposal by APRO to move to "sample review" could intensify the problem.

- The Division of Public Assistance has no mechanism for monitoring the APRO review process.

- The State is not performing the review of a sample of hospital claims agreed to in the memorandum of understanding with APRO.

- Long-term care utilization control is partly covered under the previous section on appropriateness of care. Utilization control efforts in nursing homes appear to be very much limited by staffing availiability and the absence of procedures.

Recommendations

- Renegotiate the current memorandum of understanding with APRO, to specify relative responsibilities, assurances that APRO will carry out a full review, and the monitoring system to be used by the State in reviewing APRO activities.

- Develop the monitoring system for reviewing APRO performance.

- Perform a review of a sample of hospital claims.

- Increase staffing in the Medical Surveillance Unit to enhance long-term care utilization control efforts.

Alternatives to Long-Term Care

The costs of long-term care in Alaska are such that, if alternatives can be developed, substantial savings could result.

Major Findings and Conclusions

The State has recognized the need to develop alternatives to long-term care and has recently established a committee to work on the issue. At present, however, the only possible alternative covered by the Medicaid program is home health agency services (available only in Anchorage). Use of these services appears to be discouraged by two factors:

- Many Medicaid recipients are Alaska natives, who have tended to use the Indian Health Services Hospital in Anchorage, which was until recently not subject to professional standards review and did not actively discourage long-term stays.

- There is an excess of ICF and SNF beds, which suggests there is a tendency to admit patients to long-term facilities although they could be served in their homes by an HHA.

Recommendations

- Continue to develop alternatives to long-term care, and critically examine any further plans to certify additional long-term care beds until plans are in place to offer a continuum of care which includes non-institutional placements.

Summary

The major changes recommended cover:

- implementation of a reasonable cost related reimbursement system, incorporating a 90 percent minimum occupancy level

- re-establishment of admission reviews for API cases

- renegotiating the memorandum of understanding with APRO, and developing an associated monitoring system

- increased staffing in the Medical Surveillance Unit

- increased emphasis on alternatives to institutional long-term care

Each change should have a significant impact on program costs. Only the fourth item involves an ongoing cost increase, of one staff member's salary. The other items will each take considerable short-term effort to achieve, however.

VII. CLAIMS PROCESSING

Overview

This chapter discusses the entire claims processing function, including plans for an improved data processing system and the use of AMOEBA.

Hospital, Physician, HHA, and Pharmacy Claims Processing Flow

Medicaid claims from hospitals and physicians (including crossover claims), home health agencies, and General Relief/Medical claims from pharmacies follow essentially the same overall claims flow:

- Claims are received in the DHSS mail room, normally with eligibility coupons attached, stamped with date of receipt, and passed to the claims receipt area in the Division of Public Assistance.

- Claims are checked for eligibility coupon. If coupon is attached, information will be transferred from coupon to claim. If there is no coupon, the on-line eligibility file is accessed to obtain eligibility data. If the recipient is not on file, the claim is returned to the provider.

- Claims are sorted by type of service and passed to a claims examiner for adjudication (they may be temporarily filed in the examiner's area).

- Adjudication is performed manually. Payment allowed is based on:

  lowest of actual charge, median charge, and Medicare reasonable charge (for physicians)

  percentage of charges (for hospitals)

  amount billed (for pharmacies)

- Claims are batched, "certified", and forwarded to data entry.

- Following data entry to diskette, the claims data is read into the Department of Administration computer system and processed through the Claims Processing System.

- The outputs from the Claims Processing System include remittance advices, an updated claims history file, punched cards for entry to the PBA accounting/warrant system, and various reports.

- Warrants are produced from the PBA system, matched with the remittance advices, and mailed to the providers.

Major Findings and Conclusions

There are significant problems with the present claims processing operations:

- No record is currently made of the number and type of claims received, making workload scheduling very difficult.

- The on-line eligibility file is for inquiry only and will not supply historical data on eligibility. If no coupon is attached, and the recipient is now eligible but was not at the time of service, the claim will be paid in error.

- Procedure coding is converted from 1969 RVS or 1974 RVS to 1964 RVS for comparison with Medicare profiles. The conversion and subsequent adjudication process is complex, time-consuming, and error-prone.

- There are no procedure manuals for claims processing.

- Where services are limited (e.g., x services per year), the manual system cannot determine when the limitation is met.

- Crossover claims are paid even when a Medicare EOB is not provided. This may result in overpayments.

- The experience level of the claims processing staff is low. The senior examiner has one year of experience, the other examiners only two to three months. (It is generally accepted that six months' experience is necessary for a claims examiner to become accurate and efficient).

- No validation of the reasonableness of pharmacy claims is made. (This finding applies to the GR/Medical program only.)

- Data entry is performed from the less legible carbon copies of the claims.

- Claims may be altered or removed from a batch during the data entry process.

- Data may be substituted in a field in data entry if the data is missing from the claim.

- The claims history file is updated before it is known that warrants can be or have been issued. Moreover, PBA cards created by the claims processing system may be altered prior to processing through PBA. Thus the claims history file does not reflect claims paid.

- The claims processing system does not provide an acceptable level of duplicate checking, does not verify coverage of procedures or services, and does not check for recipient eligibility.

Recommendations

Generally, the problems listed above have obvious solutions. Each problem must be eliminated if Alaska is to have a workable claims processing operation. The major changes which must be made are:

- Contract for development of adequate claims processing procedures (see also Chapter II).

- Contract for development of a new provider manual to reduce the errors created by providers.

- Develop, or contract for (preferably through use of a fiscal agent or facility manager), a new claims processing system incorporating automated claims pricing and adjudication.

- Update the claims history file with amount paid after the warrant is created by PBA.

- Examine the feasibility of turning over the entire claims processing function to a fiscal agent or facility manager. The feasibility would depend on:

  availability of interested qualified companies

  potential cost

  political acceptability

Claims Flow for Other Claims Types

Other types of Medicaid claims which do not follow the typical claims flow are nursing home claims, EPSDT screening claims, State institutional claims, transportation claims, other miscellaneous services claims, and out-of-State claims. The major exceptions to the claims flow described in the preceding section are noted in the following paragraphs:

- Nursing home claims are checked for prior authorization, a voucher prepared and forwarded via data entry to the PBA system, without editing, to create a warrant. Nursing home claims data is added to the claims history file at a later date, without processing through the full claims processing system.

- EPSDT screening claims are processed by the Nursing Section of the Division of Public Health. Except for screenings performed by a physician, no claim is submitted, only details of screening results. Screenings performed by Public Health nurses (95 percent of the total) are reimbursed on the basis of an annual time study. Nurse screenings are not added to the claims history file.

- Claims for miscellaneous services (e.g., wheelchairs, oxygen), some transportation claims (those not processed by the Division of Administrative Services), and out-of-State claims, generally follow the claims flow for hospital and physician claims.

Major Findings and Conclusions

The most important conclusion regarding processing of these other claims types is that the fragmentation of claims processing leads to inaccurate claims history and the possibility of incorrect payment.

Many of the problems identified for hospital and physician claims processing are valid for these other types also.

Recommendations

The same recommendations listed for hospital and physician claims flow apply to the other types of claims. In addition, the following recommendation made also in Chapter II is extremely relevant:

- Consolidate all claims processing in a single area.
- Ensure that all adjudicated claims update the claims history file.

Claims Data Processing System

The preceding sections have identified some problems with the present claims data processing system. The Office of Information Systems has developed plans for, and has programmed part of, a new claims processing system. The following findings and conclusions relate primarily to the possible new system, or to some alternative system.

Major Findings and Conclusions

- The new system which has been partially developed by OIS is based on the use of a schedule of maximum allowables which has been rejected by the provider community.
- The new system, as currently designed with a single fee schedule, is anticipated to be completed in December 1979, based on a development group of three analysts/programmers (two present staff plus one planned). However, the forthcoming conversion of the State's computers may delay this schedule.
- The present design for the new system, while offering substantially enhanced capabilities, does not provide for processing of all claims types.

- Whether or not the new system is implemented, there will be a substantial increase in computer processing costs for Medicaid as the Department of Administration installs a new larger computer and implements a charge-back system.

Recommendation

- The problems with the present claims processing system are so serious that development of a new system, whether that planned by OIS, or a system designed and developed by a contractor, must be a major priority.

Use of AMOEBA

The State has been considering for some time the use of AMOEBA, a set of computer programs designed to list questionable claims and identify symptoms of unusual utilization.

Major Findings and Conclusions

To date, one pilot run of AMOEBA has been made using the claims history file for a 30-month period. The experience leads to the following findings and conclusions:

- To use AMOEBA properly requires a significant amount of training and experience, particularly the latter. Without an understanding of the AMOEBA system, the output is likely to be so voluminous and misdirected as to be useless.

- Use of AMOEBA requires staff to be available to conduct detailed research of the claims listed by the system.

- AMOEBA should not be used by anyone not totally familiar with State Medicaid policy.

- If the preceding constraints can be overcome, AMOEBA can be extremely valuable.

Recommendation

- Use of AMOEBA should be delayed until plans for a new claims processing system are finalized. However, such plans should, at least tentatively, involve the use of AMOEBA once the new system is stabilized and provided adequate support staff can be provided.

Summary

The major changes recommended are:

- contracting for development of a new provider manual and claims processing procedures

- development of, or contracting for, a new claims processing system (preferably through use of a fiscal agent or facilities manager who would also operate the system)

Costs for new manuals and procedures are discussed in Chapter II.

Attachment F

DHSS MEDICAID TASK FORCE RECOMMENDATIONS

I. Authority: By memorandum dated May 4, 1979, Deputy Commissioner Catherine M. Lloyd appointed a task force specifically to develop recommendations to correct identified deficiencies in the Medicaid payments system. This task force was comprised of the following persons:

Rod Betit, Director, DPA
Tom Haas, Chief of Financial Management, DPA
Chris Dooley, Accountant IV, DPA
Lloyd Pukis, EDP Supervisor, Information Systems
Doug Goldbach, Finance Officer, Div. of Admin. Services
Ken Sather, Office of Interal Review.

II. Overview: The Medicaid payments system has been a constant source of problems for several years now. When originally installed the system was adequate to meet the billing demands of Medicaid/GR Med providers statewide. However, since 1972 billing demand has steadily grown to the point that the present manual system cannot keep current with billing activity. For purposes of the task force's review, "current" was defined as making payment in 30 days or less from the date of receipt of a billing. This 30 day timeframe is required by current federal regulations. At the time of review, processing timeframes were averaging 49 days and increasing.

Given this situation, the Division of Public Assistance requested and received a complete review of all Medicaid operations by representatives of the federal Medicaid agency in DHEW. This review generally disclosed no startling discoveries; but rather reinforced conclusions already reached by the Division with respect to what was wrong, and what was needed to correct the problem. The recommendations that follow come from careful consideration of the DHEW report, individual experiences from different agency representatives and consideration of the fact that additional manpower and funding were not made available by the Legislature to deal with the problem.

III. Task Force Recommendations

Recommendation #1

The Department should adopt regulations effecting a shift from the current profile pricing method to a schedule of maximum allowances. Adoption of a schedule is viewed the only viable means of reaching the target processing timeframe of 30 days. This recommendation is also most desirable for the following additional reasons; 1) timeliness of implementation will permit on-line operation by August 1 at the latest due to previous start-up work already completed, and 2) many of the deficiencies noted in the DHEW report would be corrected concurrent with installation of a schedule of maximum allowances. Other alternatives considered by the task force included:

- Contracting with a fiscal intermediary. This would provide no short-term relief to payment difficulties and could not be purchased without additional funds. With adequate funding committed, this would be a viable long term alternative.

- Contracting with Aetna Insurance, the current fiscal intermediary for Medicare claims processing. Discussions with Aetna data processing staff indicate that their system, although similar to what we desire for Medicaid claims processing, would not be readily convertable to the needs of a Medicaid processing system in terms of invoice handling, audits, and controls. Any potential for this alternative would require the expenditure of time and money for a long-range benefit. Again, no immediate benefits would be derived from this alternative.

- Automation of the current individual profile pricing system in-house. The work required of DHSS Information Systems to program such a system is estimated at approximately 12 man months. This would not bring immediate relief to the payment problem, nor would the final product be as maintenance free as a schedule of maximum allowances. Again, this could be a viable long term alternative.

- Adapting Aetna's claims processing system to Alaska's needs. The time involved in converting the programs and the expense of purchasing the software from Aetna would be prohibitive under our current budget constraints. Again, the needed expenditure of time and energy would prevent any short range benefits.

Recommendation #2

Although implementation of a schedule of maximum allowances would permit sending invoices directly to Data Processing's keypunch center, it is recommended that DPA maintain responsibility for batch control of all billing documents. This will leave the burden of batch accountability, provider relations and records retention with the Division of Public Assistance.

Recommendation #3

It is expected that the Department could potentially recover the time of two full time adjudicators with transition to a schedule of maximum allowances. It is recommended that one of these two positions be reclassified as a Third Party Liability Technician, and the other an Administrative Assistant II to provide support to the Medicaid Program Officer.

Recommendation #4

Until the current card-deck payment system can be replaced with a tape payment system, written procedures should be developed to place the card-deck system under tighter security controls. This may require a Memo of Agreement between DHSS and the Department of Administration.

Recommendation #5

That the Department renegotiate the Delta Dental contract for FY80 and not attempt to take this responsibility in-house until at least FY81, thereby permiting time to clean-up current operations once the schedule of maximum allowances is adopted.

Recommendation #6

That the Department locate funds to purchase development of new providers manuals and a staff manual for field workers on a contract basis. The present burden on DPA Medicaid staff is such that other critical projects will have to be deferred unless such a contract is arranged. Even then, a staff manual could not be produced prior to October 1, 1979.

Recommendation #7

That the Department should consolidate payment of all DHSS medical bills in the current DPA Medicaid Payments Section. Currently, medical payments are made throughout the Department with little or no system integration.

Recommendation #8

That the office of Information System should draw up an APD to request 90/10 match from DHEW to pay for completion of the new Medicaid DP system.

Recommendation #9

That installation of the new Medicaid system and any funds necessary to purchase hardware such as computer terminals receive top DHSS priority. This determination should be made immediately to permit purchase of needed equipment, and to isure DP staff concentration on installation of the new Medicaid system.

6/5/79
DATE

TASK FORCE MEMBERS

Rod Betit

Tom Haas

Christine Dooley

Lloyd Pukis

Doug Goldbach

Ken Sather

Attachment G

DELTA AND THE MEDICAID PROGRAM - Denise Knapp - director

I. History: Delta was organized in 1973, selected as fiscal intermediary for State Medicaid programs in 1973.

II. Participation: 96% of the dentists in the State are members of Delta, and 95% of these participating in the Medicaid program.

III. Significance to dentists for Delta in fiscal intermediary role.
- A. Prompt payment; bi-monthly.
- B. Payment on usual fee; not to exceed 75% percentile.
- C. Dental profession has a direct voice in program through Delta.
- D. Direct government intervention is avoided.

IV. Significance to State of Alaska for Delta in fiscal intermediary role.
- A. Professional dental services in providing review (pre- and post-operative) and quality assurance.
- B. Local processing, using Alaska employees who invest in Alaska to improve Alaska economy.
- C. Higher utilization by and satisfaction of patients through cooperation of the dental profession to allow free choice.
- D. Increased efficiency of processing and payment.
- E. Cost containment (verification made with dentists' fees on file) and utilization checks and balances.
- F. Provider agreements between Delta and the dentists.

V. Claims Cost Information:

	No. Claims	Total Amount	Av. Cost Per Claim	No. Eligibles
1975	1900	$250,600	$132	11,500
1978	7100	$887,000	$125	15,000

Attachment H

From: Report presented by Fredrick McKinnis at the Future Frontiers Conference.

ALASKA AND NATIONAL HEALTH INSURANCE

From time to time, as many as ten or twelve measures have been introduced simultaneously in the United States Congress proposing a variety of national health insurance programs. For a number of years, Alaska health leaders have been concerned with regard to the fragmentation of health delivery systems within Alaska as well as the escalating costs for all health services in the state. Delays have been encountered in active planning for an improved financing system for Alaska health programs because of the prospect of a national health insurance program being enacted by the federal Congress. Numerous discussions continue to go forward with regard to a national health insurance program for the entire United States. It now appears that the enactment of and implementation of such a plan are receding further and further into the future. Three of the more popular approaches to national health insurance have been those which have been introduced into the federal Congress by President Carter, Senator Edward Kennedy and Senator Russell Long. Appendix Number One at the end of this document outlines the "Three Approaches to National Health Insurance" as set forth by these national leaders. The topics covered in the table include coverage, benefits, administration, financing, cost, cost controls and timing for implementation of the respective plans.

There are several reasons why Alaska should consider developing, as rapidly as good planning will permit, a model health system for all the citizens of our state. With our extremely small population and with the numerous extensive health delivery plans in place already, it would seem that Alaska could adjust its present programs and add thereto in order to create a truly comprehensive and effective health system for Alaska. It will take bold, creative and extensive work to develop such a system.

Governor Jay S. Hammond, Lieutenant Governor Terry Miller, and the Commissioner of the Department of Health and Social Services, Helen D. Beirne, have expressed strong support for a revised and improved model health plan for Alaska. The Department of Health and Social Services leaders are taking certain initiatives at the present time in order to explore further the possibilities of changes within the present systems. In due course, numerous parties within the government and in the private sector will be invited to participate in the creation of a new health services financing system, as far as outlays of the state government are involved or will be involved in the future.

Recommendations:

1) It is recommended that the health planning organizations in the state, as well as the health agencies and providers in the state, embark on a joint program to make reasonable efforts at cost containment of health services. A detailed examination should be made for the reasons of the dramatic increases in hospital charges to patients and third-party payers, as well as the escalation in rates of physician fees, prescription drugs, and nursing home rates. Efforts at cost containment, while notable, have not been effective to any substantial degree. Ceilings proposed from time to time applied to specific parts of the health care system do not appear to be equitable, since all of the goods and services related to the delivery of health care have not been proposed for inclusion in the cost ceilings. One of the more urgent matters facing Alaskans, as well as the citizens of other states, is the rapid escalation of health service costs. Detailed attention should be given to any cost of a health service in the state of Alaska which begins to exceed approximately 60% over and above what the average for such cost would be elsewhere in the nation.

2) The Alaska Revenue Sharing Program provided by Alaska Statutes, as it relates to health services, hospitals, health facilities and construction aid, should be reviewed with the possibility of major revisions in order to create a more equitable revenue sharing basis as related to other municipal services. In some communities in Alaska where the local government is responsible for the operation of hospitals, the generous revenue sharing dollars flowing to those hospitals seem to be well justified. In some of the urban areas, in cases where hospital income dramatically is excessive over operational expenditures, an adjustment may be found to be in order. In those cases, the local government should have the freedom to utilize the revenue sharing dollars for those health services deemed to be the local government's priorities for expenditures.

3) A detailed study should be undertaken in Alaska of the 458,305 third-party coverages or non-fee for service coverages when projected on a population base of 411,211 in 1977. The cost benefit ratio of the double coverages should be examined in some length in some depth. At the same time, data seem to reveal that numerous Alaskans are not covered by any third-party coverage or non-fee for service program at all. Scientific research and detailed studies which may be undertaken with regard to the possibility of a model health system for the state could include the study recommended herein.

4) That a detailed review be made of the medicaid eligibles, medicaid coverages and medicaid expenditures in an effort to determine whether or not Alaska wishes to continue the escalation of covered groups, covered services and financial outlays experienced from 1973 to 1979. From a basic coverage of eight services in 1973, the coverage services have gone to 17 services. Minor changes in covered groups have been made by federal and state laws since 1973 and the initially covered groups have contributed substantially to the increase in financial outlays.

5) In the event studies are undertaken with regard to the covered services and the covered eligible groups under medicaid, consideration is recommended with regard to the cost effectiveness of implementing the "medically needy option" under the medicaid program. If Alaska is going to improve health financing assistance to the medically needy, if provided under the medicaid program, the federal government would match all expenditures on the basis of 50% federal and 50% state funds.

6) Regardless of what may develop in the near term with regard to other changes in medicaid, general relief medical coverage or under a model health system, immediate attention should be given to expanding coverage for catastrophic illnesses for Alaskans. This could be accomplished with an amendment to the present catastrophic statute, as well as additional appropriations for the catastrophic illness program.

The design of any amended catastrophic illness program should be undertaken in such a way as to fit in with the State's goal of a comprehensive revision of its health financing plans.

7) That immediate detail and urgent study be continued with regard to broadening the range of services to prevent premature institutionalization in long-term care facilities and more appropriate placements for some who may at present be institutionalized in nursing homes.

8) That the State of Alaska move ahead as rapidly as good planning will permit to develop a model health services financing program geared to the needs of Alaskans, whether or not such a revised program includes the federal medicaid program. In the event it is not possible for the State to carry out an extensive study and mature plans to revise its present financing programs for medical assistance, as a minimum it is recommended that the State consider dropping the medicaid program and rebuild a program with the State's current 50% of medicaid dollars furnished to the State, combined with the State's general relief medical funds, and thereby render services to the limit of funds available to a revised group of eligibles based on new priorities.

9) That the State consider a revised plan of reimbursement for physician services and hospitals in the early part of the 1980's, whether or not the medicaid program remains or is dropped. Strong emphasis should be placed then upon the free enterprise and competitive systems in order the market forces will be generally operable in the health care field as is demanded in all other fields of endeavor.

Attachment J

STATE OF ALASKA

Legislative Affairs Agency

OPTING

A Study of Medicaid Client Need

February 1977

O P T I N G

A Study of Medicaid Client Need

PREPARED BY

LEGISLATIVE AFFAIRS AGENCY
DIVISION OF RESEARCH

FEBRUARY, 1977

Foreword

In the fall of 1972, Alaska entered the national Medicaid program, providing certain of its citizens thereby a limited spectrum of medical care services.

Since this modest beginning, the legislature has increased Medicaid coverage by the addition of a few services above those which the state is required to cover in order to participate in the federal program. These optional services allowed the state to earn addition "matching" federal funds, some of which were a direct one-for-one offset to medical care expenditures that the state itself had been previously paying for in their entirety. Other program additions resulted in increased state expenditures, but provided a more complete medical coverage package.

In order to maximize the benefits from the additional expenditures, optional service additions must undergo careful scrutiny to insure that the options chosen return the greatest level of benefits in terms of meeting the health needs of the approximately seven percent of Alaska's population served by the Medicaid program. During 1976, a number of legislators indicated their desire to have better information upon which to base their decisions concerning the addition (or deletion) of various possible optional services. In order to meet this need, Miss Deborah Behr of the Research Division staff began, in June of 1976, an extensive effort directed at reviewing public assistance eligibility supervisors' perceptions of client requirements, analyzing written denials of additional client service requests, and obtaining information from various states regarding their experience with selected options. The present study is the result of this effort.

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Juneau, Alaska
February, 1977

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PART I. OVERVIEW OF THE MEDICAID PROGRAM

INTRODUCTION TO THE PROGRAM

Medicaid is a program funded jointly by the federal and state governments which aids certain needy Alaskans in providing payments for them to receive medical services. It helps assure that medical services are available to those needy eligible persons when they are ill or injured. It also assists in guaranteeing that the highest quality care of the kind required by the patient's condition is available, by mandating certain medical reviews of patient care and treatment. Medicaid also attempts to make services available by utilizing the present system of private practitioners, facilities, and institutions to provide the care required at the lowest possible cost to the taxpayer.

STATE PLAN FOR MEDICAID

The Medicaid program in Alaska is administered by a single state agency, the Department of Health and Social Services, which is required to submit a state plan to the Secretary of the federal Department of Health, Education, and Welfare for his review and approval.

The state plan is essentially a contract between the state department and the federal Department of Health, Education, and Welfare specifying conditions to be met in order to qualify for federal financial participation. Some topics included in it are:

1. eligibility determination
2. recipient eligibility
3. eligibility verification
4. medical services
5. health care
6. quality control
7. fair hearings
8. methods of administration
9. utilization review
10. fraud

Many of these items are required be included in the plan (mandatory), but others the state may decide whether or not to include (optional). The optional portions allow the state to shape a medical assistance program to the needs and financial resources of its citizens.

DIFFERENCES BETWEEN MEDICAID AND MEDICARE

Medicaid is often confused with the Medicare program in the state. Medicaid is a medical assistance program for certain needy low-income people. In Alaska, Medicaid is administered by the Division of Public Assistance, an agency of the Alaska Department of Health and Social Services. It is authorized under Title XIX of the federal Social Security Act and AS 47.07.010-.080 of the Alaska statutes. States can design their own programs within set federal guidelines to meet the needs and resources of its citizens. Medicaid programs can and do vary from state to state.

In comparison, Medicare is a medical insurance program for those people, rich or poor, covered by Social Security. It is administered by the Social Security Administration of the federal government. The program is the same in all fifty states. Almost everyone over 65 and some younger persons who have been receiving Social Security disability payments for at least two years qualify for the program.

BRIEF HISTORY OF MEDICAID PROGRAM IN ALASKA

On July 6, 1972, Alaska became the 49th state to provide the Medicaid program for its residents. The state had, since the mid-60's, provided for such services under the General Relief - Medical program. Costs had risen from $1.8 million to $8.7 million in FY 72. This dramatic increase was due to many factors, the major ones being:

1. The number of eligibles had increased, but the rate of expenditure was increasing at even a faster pace.

2. The scope of the program had been liberalized and expanded with a related increase in utilization of services.

3. Medical care costs were rising at a rate disproportionate to that of other costs of living.

In light of this situation, the administration and the legislature came to basic conclusions that the General Relief - Medical program, which was supported 100% with state monies, had need of administrative controls to review services and, hopefully, reduce health care expenditures. There was a general consensus that either the General Relief - Medical program had to be upgraded or research should be done to investigate the possibility of the implementation of the Medicaid program. In April, 1972, the Department of Health and Social Services contracted with Touche Ross and Company, a public accounting firm, to develop a cost benefit study of the Medicaid program. Budgets were developed and testimony was made to the legislature that session. On June 17, 1972, the enabling bill for the Medicaid program passed the legislature and was later signed into law with an effective date of July 6, 1972. (The history of the program can be traced on Table 1: Medicaid History Timeline.)

TABLE 1

State of Alaska
Medicaid History Timeline

Date	Occurrence
April 10, 1972	Touche Ross & Company begin Medicaid System Design
April 18-June 9, 1972	Departmental Presentation to Legislature
May 10, 1972	Department of Health and Social Services' Steering Committee Established
June 17, 1972	Enabling Bill Passes Legislature
July 6, 1972	Medicaid Becomes Law
September 1, 1972	Medicaid Implemented
September 28, 1972	State Plan Submitted to Federal Department of Health, Education and Welfare
April 4, 1973	Effective date of Intermediate Nursing Home Care Option
May 16, 1974	Effective date of Inpatient Psychiatric Hospital Option for Eligible Persons 65 or Over and Under 22
May 16, 1974	Effective Date of Miscellaneous Minor Eligibility Groups (Primarily needy children under 21 in foster care under supervision by Department of Health and Social Services)
July 13, 1974	Effective date of 60 day limit on filing Medicaid claims
April 15, 1975	New Division of Public Assistance Formed
September 2, 1975	Effective date of Intermediate Nursing Home Care for Mentally Retarded Under 21 who Meet AFDC Need Standards Option
March 12, 1976	Effective date of Eye Glasses and Optometrist Service Options
June 21, 1976	Effective Date of New Nursing Home Group of Eligibles
July 1, 1976	Effective Date of Limited Clinic Services Option (Primarily Community Mental Health Centers and State Operated Mental Centers)
July 1, 1976	Effective date of Treatment of Speech, Hearing, and Language Disorders Option

The Department of Health and Social Services worked during the interim period to provide the necessary procedures and organization to make Medicaid an administrative reality in Alaska. A new Division of Medical Assistance in the Department of Health and Social Services was formed to administer the new program, as well as the remnants of the General Relief - Medical program. On September 1, 1972, the Medicaid program was actually implemented. (The Division continued to administer the program until April, 1975, when the new Division of Public Assistance was formed. This new division combined the eligibility determination, income maintenance, and medical assistance functions into one organizational grouping in the state.) Later that month, the official state plan was submitted to the federal Department of Health, Education and Welfare for its approval.

With the approval of the state plan, Alaska realized the benefits due to implementation of the Medicaid program:

1. Federal matching funds for medical expenditures became 50%, thereby allowing the continuation of the level of medical services without further increase in state general fund expenditure.

2. Federal match for categorical assistance programs under the Social Security Act increased from 30% to 50%.

3. Administrative controls, seen as necessary, were implemented to fulfill Medicaid requirements in order to receive federal financial participation.

When the legislature approved the Medicaid program, it included a restriction in statute mandating that all new services or eligibility group additions must receive its approval. At time of passage, the enabling legislation included those services and eligibility groups mandated by the federal government in order to receive federal financial participation. Since that time, the legislature has added few additional services or eligible groups.

The legislature added the first additional service option in 1973. At that time, intermediate nursing home care was selected. This option permitted the coverage of a lower and less expensive level of nursing home care. This addition allowed many Medicaid recipients in skilled nursing, who did not require that level of treatment, to be properly placed in intermediate nursing care thus "saving" state general fund dollars.

In 1974, the inpatient psychiatric hospital services option was added for eligible persons 65 years of age or over and 21 or under. This allowed the state to claim federal reimbursement for some persons at Alaska Psychiatric Institute, who were eligible for Medicaid coverage and were at that time receiving their care 100% from state monies. Also, other small groups of new eligibles were added at that time. Primarily they consisted of certain needy foster care children under 21 supervised by the Department of Health and Social Services. Prior to

that time these children had, in most cases, received coverage for their health care through the General Relief-Medical program. Also, legislation was passed requiring that medical assistance claims be submitted promptly, no later than six months after date of service or third party payment was received. This permitted more administrative control of expenditures and allowed for greater accuracy in budget projections.

The option to include a new group of needy eligibles under 21 who were in intermediate nursing homes for the mentally retarded became effective in 1975. This permitted a group of children at Harborview Memorial Hospital, Alaska Psychiatric Institute, and Hope Park to receive Medicaid coverage and, hence, additional federal dollars could be earned for their care.

In 1976 the legislature chose to add four new items to the program. A new group of needy persons became eligible for Medicaid coverage for their nursing home care due to an addition of an option. Also, that session, prescription eyeglasses and optometrist's services were added to the program. The legislature also approved the addition of limited clinic services which allowed state operated mental health centers and state approved community outpatient mental health centers receiving grants under A.S. 47.30.520 - 47.30.620 to be covered. This permitted federal funds to be earned in these state general fund supported projects. Also, at that time, the coverage of treatment of speech, hearing, and language disorders was added to the Medicaid program.

The legislature has shown interest in examining and evaluating the available Medicaid options, as seen by the recent history of the program in the state. Many of these options, especially in the case of coverage of nursing home care for certain needy eligible persons, actually "saved" state money. By adding them to the Medicaid program, federal funds could be realized for some of those services, which were being paid at that time 100% from state general funds. Also, by increasing the scope of the service package, a more consistent medical treatment program could be offered to these needy persons. For example, prior to the 1976 addition, eyeglasses were not generally available to all Medicaid eligibles who needed them. Only Medicaid eligible children who had been seen in early screening programs and referred for eyeglasses could be reasonably assured of coverage under the program for their lenses. Needy adults, such as those in nursing homes, had no such guarantee.

Alaska was one of the last states to join the Medicaid program and has been cautious in increasing the scope of the program in the state. In comparison with many other states in the program, Alaska's program is limited, with few service and eligibility group options beyond those basic services and groups required to maintain compliance with the program. This paper will later examine the current scope of the program and the options available under it that the legislature may be called upon to evaluate in 1977 and thereafter.

PART II. CURRENT STATUS OF MEDICAID PROGRAM IN ALASKA

ELIGIBILITY OF CLIENTS

The Alaska Medicaid program provides coverage for certain needy persons receiving or eligible to receive public assistance under:

Federal Supplemental Security Income (SSI),

Alaska Old Age Assistance (OAA),

Alaska Aid to the Blind (AB),

Alaska Aid to the Disabled for Persons who Meet Federal Criteria for Disability (AD), or

Aid to Families with Dependent Children (AFDC),

and certain others (mostly children)

Alaska does not cover the medically needy under its Medicaid program.

In general to be eligible for Medicaid in Alaska, an individual must:

(1) Be physically present in Alaska at time of application and citizen of U.S. or lawfully admitted alien;

(2) Not be in a public institution such as a jail (a person may however be in chronic disease facility such as a nursing home);

(3) Not have more than $1,500 in non-exempt personal property; this excludes a home (there is no lien requirement), personal belongings, in certain cases, a necessary automobile and some types of income producing property;.

(4) Not have transferred property to qualify for assistance;

(5) Meet program requirements such as blind, disabled, aged over 65, or dependent child

The Division of Public Assistance examines the financial and living situation to determine if a person is eligible. As a basic rule, if a family of four meets general program requirements, has monthly net income of no more than $400 earned (excluding reasonable work related expenses) and unearned income, the family would qualify for assistance under Aid to Families With Dependent Children program. There is no geographical differential on the total amounts allowed. The amounts vary for the adult programs (OAA, AB, AD) but generally, if household expenses (excluding fuel) are over $35 a month and the net income is no more than $334 a month of earned (excluding reasonable work-related expenses) and unearned income, a single person family would qualify if other program requirements are met. The $334 figure can vary annually

in accordance with cost of living adjustments required in AS 47.25.640; 47.25.430; 47.25.810. Eligibility for categorical assistance programs automatically makes one eligible for Medicaid.

SERVICES COVERED UNDER MEDICAID

The State of Alaska covers basically two types of services: mandatory, which the states are required to provide, and optional, wh.ch the state may provide and receive federal reimbursement. Alaska provides all mandatory services, but optional services are limited.

Mandatory Services

Alaska must provide the following services: 1) inpatient hospital services; 2) outpatient hospital services; 3) physician's services; 4) x-ray and laboratory services; 5) skilled nursing home services; 6) nome health services; 7) early and periodic screening, diagnosis, and treatment of children under 21; and 8) family planning services. Alaska also is required to cover transportation necessary to receive medical service, if unavailable from any other source, but it is not listed as a federal requirement.

Optional Services

In addition to the mandatory services, Alaska provides and receives federal reimbursement for the following services:

(1) Inpatient psychiatric hospital services for individuals age 65 or older or under age 22
(2) Intermediate care facility services
(3) Skilled nursing for those persons under 21 years of age
(4) Emergency hospital services
(5) Eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist
(6) Services for individuals with speech, hearing, and language disorders
(7) Services through state approved out-patient community mental health clinics which receive grants under AS 47.30.520-47.30.620 and state-operated mental health clinics
(8) Optometrist's services and limited dental and prosthetic devices as required under EPSDT regulations

Other services that the state could choose to provide for certain of its needy individuals, but which has not yet opted for, include:

(1) Prescribed drugs
(2) Dental Serv.ces (for persons over 21 not covered under the early screening program)
(3) Dentures
(4) Prosthetic devices (for persons over 21 not covered under the early screening program)

(5) Private duty nursing
(6) Physical therapy and related services
(7) Chiropractor's services and other practitioners
(8) Podiatrist's services
(9) Care for patients aged 65 or older in Institutions for Tuberculosis
(10) Other diagnostic services, screening, preventive services, rehabilitative services

Parts III through V of this report deal later with these optional services in more depth, examining the need and aspects to consider in the evaluation of these alternatives to the program.

FINANCIAL PARTICIPATION BY FEDERAL GOVERNMENT

The federal government financially participates in the Medicaid program by means of matching state dollars for allowable administrative and medical expenditures. Services to eligible clients receive 50% reimbursement, except for family planning supplies and services which are matched at 90% level. Administrative costs are generally matched at 50%. Professional medical review staff are reimbursed at 75% level. (Certain other administrative services receive special match rates, such as 100% for certification and survey of nursing homes. These special rates are itemized in federal law and regulation.)

At the present time there is no "ceiling" or set limit for Alaska on the amount of federal funds available for reimbursement. There has, in recent years, been much discussion on the federal level to restrict such reimbursement, as was indicated in President Ford's budget address in January, 1976. At that time, he mentioned the possibility of placing the Medicaid program in a block grant package with other federally assisted health care programs. By this method, a dollar limit would have been set on the available federal funds for those purposes. Generally, though, the prospects for major funding modifications in the Medicaid program appear slim, although tighter management and administrative mechanisms to control fraud and quality of services seems to be a continued interest.

NEW DEVELOPMENTS IN MEDICAID

In the fall of 1976 the federal government placed additional responsibilities on the Medicaid program, through the passage of Public Law 94-437. That bill, known as the Indian Health Care Improvement Act, mandated closer coordination of Medicaid and Indian health services and required that all services for Medicaid eligible Alaska Natives in Indian health facilities be billed to Medicaid. The federal government would then reimburse the state's Medicaid program at 100% for such services. Additional administrative functions would receive normal federal reimbursement rates. The services eligible for reimbursement under Public Law 94-437 are only those included in the approved Medicaid state plan and provided to Medicaid eligible Alaskan Natives.

Total ramifications of the bill are yet unknown. Federal officials report though that Alaska is far ahead of other affected states in implementing the new law. For example, seven of Alaska's nine Indian Health Service hospitals currently meet statutory requirements for participation in Medicaid without further action. State officials note though that unless there is a major shift in procedures for handling people covered under Indian Health Improvement Act, field office work will increase greatly (e.g., issuing medical coupons, arranging necessary transportation, answering client and provider questions). These state officials voiced concern that estimates of the number of new Alaska Native clients attracted to apply for Medicaid coverage are unknown. The attachment of a dollar figure to the cost of medical services for these persons would be just a rough estimation.

PART III. GENERAL INFORMATION REGARDING OPTIONAL SERVICES

CONTROLS THAT STATES MAY IMPOSE ON MEDICAID OPTIONAL SERVICES

Since the addition of optional services is at the discretion of the state, the federal government allows great flexibility for states to determine the scope of the option that they wish to provide for their Medicaid clients. Generally, federal law and regulation define the basic objectives and requirements of the options, all of which must be met in order to obtain federal financial participation. Some of the requirements address equal offering of services to all eligibles, the qualifications of persons providing the services, and degree of supervision required for paraprofessionals. Within those broad parameters states can shape optional services to fit their unique needs and resources.

Alaska can limit optional services by (1) qualifying coverage, (2) requiring prior authorization, (3) limiting usage frequency, (4) requiring clients to share in cost of services, or (5) limiting the amount of provider reimbursement:

(1) *Qualifying Coverage*

Medicaid law and regulation permit the limiting of coverage of optional services. For example, dentures can be selected as a separate service without having to cover other prosthetic devices such as hearing aids, crutches, etc, or without having to cover other dental services. The Medicaid program does require that the option limitations be applied equally to all eligible clients. (There are certain exceptions to this policy. Some options are defined in federal law to include only specific age groups such as persons under 21 or over 65.) The state, for example, cannot as a general rule limit eligibility for optional service to only those persons receiving aid under a particular program such as Old Age Assistance. If a state chooses an optional service, it must be covered for all groups (except as noted in federal law or regulation) or federal reimbursement will be jeopardized.

(2) *Requiring Prior Authorization*

States can control inappropriate overutilization of optional services by requiring the client to receive approval from the Medicaid agency prior to obtaining certain medical care. Preauthorization is usually based on medical need for services and appropriateness of the care requested to the condition being treated. The Division of Public Assistance has, since the beginning of Medicaid, required preauthorization of all nursing home placements. This mechanism serves to reduce unnecessary placements, place clients at appropriate levels of care, and suggest alternative, and usually cheaper, methods of treatment.

(3) *Limiting Usage Frequency*

Optional services can also be limited by restricting client use. This is generally done by limiting the number of treatments or services paid by Medicaid in a specific time period. For example, Maryland limits adults to one eye examination and one pair of eyeglasses every two years. Arkansas limits Medicaid clients to three prescriptions per month. These restrictions must be applied though uniformly to all clients receiving assistance. Limitations of the amount of services should take into account unusual emergency situations. States cannot impose barriers to needed minimum levels of health care, or risk federal sanction.

(4) *Requiring Clients to Share in Cost of Services*

Some states require Medicaid clients to participate in sharing the costs of certain optional services. Federal regulation sets certain maximum allowable limits on the amount of payment that clients can be required to cover. Those regulations also specify the mechanisms that states can use to allow clients to share in the cost of certain services. Fees are generally limited to small amounts such as $.50 per prescription drug and $2.00 per pair of eyeglasses. Originally, this procedure was instituted to control overutilization of services and not to generate funds. California, along with some other states which elected this option, has found that the cost of administration of this mechanism generally did not offset the revenues gained. The charges did not significantly affect client use of services, and the states found that the collecting and controlling of such small fees were bothersome to both client and provider.

(5) *Limiting the Amount of Provider Reimbursement*

Costs of optional services can also be reduced by limiting the amount of provider reimbursement. Often this comes in the form of reducing reimbursement by a set percentage or by "freezing" payment levels at the current standards. (Medicaid pays "reasonable" rates to its providers. The costs allowable under its definitions often differ greatly from those accepted by Blue Cross and other insurance companies. Fees paid under Medicaid are often lower than fees paid by the general public for the same services.) The state of Michigan, for example, recently implemented an 11% reduction in normal fees paid to practitioners, dentists, laboratories, and other providers. Often such changes receive strong provider reaction and sometimes jeopardize the continued participation of those providers in the program. Federal officials also note the potential use of low bid health providers. For example, the state could solicit bids for a contract to supply Medicaid clients with specific services, such as eyeglasses. The state could select the most advantageous bid and award the contract without jeopardizing federal reimbursement.

OTHER ISSUES TO CONSIDER IN EVALUATING MEDICAID OPTIONAL SERVICES

Although this study focuses primarily on client need, there are other factors that must be considered in evaluating the merits of any given Medicaid option. Three of these major considerations are: availability of funds, costs versus benefits of options, and ease of administration.

The availability of funds plays a major role in the scope of services that a state believes it can provide for its citizens. The high cost of medical care demands an in-depth analysis of cost before any new service is added. Although this study does not discuss this financial issue, it is a major part of any decision to modify the program. Legislators who have a well defined proposal for additional option(s) may request the Research Division of the Legislative Affairs Agency to prepare an analysis of its costs, both direct and administrative.

The costs versus benefits of an option can be an important consideration in deciding whether or not the state should participate in it. For example, certain Medicaid options sometimes "save" state money, if that service is currently paid entirely from state funds or if it allows a client to receive less specialized and less expensive type of service that are more appropriate to this medical condition or problem. In 1976, the Alaska State Legislature added coverage of new limited group of needy eligibles who currently reside in nursing homes. The care for those persons at that time was paid for 100% from state general funds through the General Relief-Medical program. By adding that option, the state was able to claim 50% federal reimbursement for their care. Also, in 1973, the state added the intermediate nursing home care option. By covering this lower and less expensive level of nursing home care, many Medicaid recipients in skilled nursing, who did not require that level of treatment, could be placed in intermediate nursing care. The cost per day for each patient was reduced considerably.

The ease of administration is important also in evaluating the merits of certain options. The drug option, for example, requires that strict payment procedures regarding maximum allowable charges be in place. These are spelled out in some detail in the federal regulations, and the state must meet those requirements or risk loss of federal participation. Federal officials note that many of these cost containment mechanisms would normally be in place in any efficiently administered pharmaceuticals program, regardless of source of funding for it. The transfer of a program from state-only funding to federal assistance should cause minimal additional administrative expenses if adequate cost containment measures are in place in the existing program.

IV. MEDICAID CLIENT NEEDS

QUESTIONNAIRE OF PUBLIC ASSISTANCE SUPERVISORS

In Fall, 1976, a questionnaire was prepared to poll public assistance supervisors (eligibility work supervisors) on their estimation of client need for certain services based on their actual experience in the field. The questionnaire, prior to mailing, was reviewed by both the Division of Public Assistance and Department of Health and Social Services Commissioner's Office. The questionnaires were mailed to nineteen supervisors, many of whom had worked with public assistance clients for a significant period of time. (That sample of supervisors was chosen under the guidance of the Division of Public Assistance's Chief of Field Operations.) Approximately one month after mailing, a follow-up questionnaire was sent.

Fourteen, or 75%, of the supervisors polled responded to the questionnaire. All areas of the State were represented, including Anchorage, Fairbanks, Fort Yukon, Juneau, Kenai, Ketchikan, Nome, and Sitka. Each supervisor was asked specific questions concerning his or her evaluations of client need for Medicaid options not yet selected by the State.

QUESTION #1: In your experience, what optional services currently not covered under Medicaid do you feel your Medicaid eligible clients need most?

Table 2 shows the rank order obtained from the supervisor's responses to question #1. Interestingly, the top four items for each category (Adult Public Assistance and Aid to Families with Dependent Children program recipients) were the same. The ranking for dentures option differed slightly, being seen more necessary for older persons receiving Adult Public Assistance than the younger Aid to Families with Dependent Children recipients.

Since the Medicaid program requires that services included in the State Plan be offered equally to all eligible persons (except for certain specialized programs such as early childhood screening) the similar ranking of need options for both Adult Public Assistance and Aid to Families with Dependent Children Program is particularly meaningful. If it were called upon to evaluate new options, the legislature could be reasonably sure that any of the top four options (prescribed drugs, adult dental services, dentures, and physical therapy and related services) would be "needed" by both categories of clients.

QUESTION #2: On the average, how many Medicaid clients a month ask you if they can receive certain services?

Table 3 shows the responses by the supervisors concerning the requests of Medicaid eligibles for additional services. The responses to question #2 did not match the pattern formed from the supervisor's responses

TABLE 2

Average Ranking of Selected Medicaid Options by Type of Public Assistance Client

Rank	Recipients of Adult Public Assistance	Recipients of Aid to Families with Dependent Children
1st	Prescribed Drugs	Prescribed Drugs
2nd	Adult Dental Services	Adult Dental Services
3rd	Dentures	Physical Therapy and Related Services
4th	Physical Therapy and Related Services	Dentures
5th	Hearing Aids [1]	Chiropractor's Services
6th	Prosthetic Devices	Hearing Aids [1]
7th	Chiropractor's Services	Prosthetic Devices
8th	Private Duty Nursing	Private Duty Nursing
9th	Podiatrist's Services	Podiatrist's Services
10th	Care for Patients 65 or Over in Tuberculosis Institutions	Care for Patients 65 or Over in Tuberculosis Institutions

[1] *Hearing aids, at the time the survey was conducted, were not included in the coverage program offered to all Medicaid clients. An interpretation of Medicaid law and regulation by federal officials allowed hearing aids to be covered as part of the treatment of speech, hearing, and language disorders option. This policy change was implemented by the Division of Public Assistance in November.*

to question #1. For example, the Medicaid prescribed drug option which was ranked as needed first for both program categories, received less than 50% of the requests made for adult dental services, which was ranked as needed second by the supervisors. This could be anticipated for Medicaid clients who do not have prior health resources equal or better in coverage to General Relief-Medical automatically receive their drugs through GRM. One Juneau public assistance supervisor noted that for these persons, eligibility for prescription drugs under GRM is automatically determined at the time that Medicaid eligibility is confirmed. Therefore, few Medicaid clients would ask for prescription drugs, since coverage is established at the time they enter the Medicaid program.

Aid to Families with Dependent Children recipients requested fewer services than did the Adult Public Assistance recipients. This was expected, for the recipients of AFDC tend to be young and thus often have less need for diverse health services. Also, many AFDC recipients are eligible for a wider range of treatment service through the Early Periodic, Diagnosis and Treatment Program (EPSDT), a child check-up program. For example, dental care is available to public assistance recipients under 21 as a referral through EPSDT, but currently persons over 21 who are mostly on Adult Public Assistance programs cannot routinely receive preventative dental care under any of the state medical assistance programs.

Many of the Medicaid options available under the federal program do not match with Alaska's availability of services. In rural Alaska, it would be difficult to obtain chiropractor's or podiatrist's services close to home. Also, the option of care for patients 65 or over in tuberculosis institutions is not really relevant to Alaska, since there are no tuberculosis sanatoriums in the State. Care for such conditions would have to be provided in nursing homes, hospitals, and physicians' offices, all of which are currently covered under Medicaid.

The low number of requests in all categories may be due to lack of client awareness that these additional services sometimes can be covered under the state funded medical assistance program, General Relief-Medical. Because of limited funds under that program, the Division of Public Assistance has not actively conducted an outreach program to inform clients of eligibility requirements and services covered. Also, many clients may be reluctant to ask for services, which they feel they stand a likelihood of being rejected. Dentures are a good example of this. Because of funding limitations, dentures can only be covered in extreme hardship situations. Clients often are informed of this policy from their dentists, public health nurses, or social workers, before a formal request is made to the Division of Public Assistance.

SURVEY OF "DENIALS" OF SERVICE RECORDS

The needs of clients were also analyzed through a survey of all denials of requests for additional services for Medicaid clients. Medicaid clients sometimes require services that are not included in the Medicaid

TABLE 3

Total Average Number of Medicaid-Eligibles Requesting Optional Services Monthly by Program Category

Option	Recipients of Adult Public Assistance	Recipients of Aid to Families with Dependent Children	Total
Adult Dental Services	81.5	88.0	169.5
Dentures	60.5	21.0	81.5
Prescribed Drugs	38.0	39.0	77.0
Physical Therapy and Related Services	20.5	23.0	43.5
Hearing Aids [1]	27.0	16.0	43.0
Prosthetic Devices	25.5	12.0	37.5
Chiropractor's Services	15.5	15.0	30.5
Private Duty Nursing	13.5	5.5	19.0
Podiatrist's Services	4.0	1.5	5.5
Care for Patients 65 or Over in Tuberculosis Institutions	1.0	0.0	1.0
Total	287.0	221.0	508.0

[1] *Hearing aids, at the time of the survey, were not included in the coverage program offered to all Medicaid clients. An interpretation by federal officials of the treatment of speech, hearing, and language disorders options allowed hearing aids to be covered as part of a treament plan. This policy change was implemented in November.*

TABLE 4

Denials of Optional Services for Medicaid-Eligibles
(September 1, 1972 to July 31, 1976) [1]

1.	Dental Services	140 [2]
2.	Therapy	63
3.	Dentures	44 [2]
4.	Prosthetic Devices	37
5.	Prescription Drugs	28
6.	Hearing Aids	15 [3]
7.	Chiropractor's Services	3
8.	Podiatrist's Services	2
9.	Private Duty Nursing	1
10.	Tuberculosis Institution for 65 or Over	0

[1] *The figure includes only denials of requests submitted in writing to the Division of Public Assistance, Central Office. That Division also handles numbers of informal telephone requests, which are not included in these figures.*

[2] *The figure excludes Delta Dental Corporation denials. Delta Dental Corporation currently reviews and evaluates all public assistance clients requests for care. These records were not readily available in Juneau for the study period. In FY76, Delta Dental denied 454 Medicaid adults for dental services and 20 Medicaid adults for dentures.*

[3] *Hearing aids were added to the Medicaid program as of November, 1976. An interpretation by federal officials of the treatment of speech, hearing, and language disorders option added last session allowed hearing aids to be covered as part of the treatment plan.*

program. If the client has no other prior health care resource equal or better in coverage to that of General Relief-Medical (GRM) Program, that client may be able to receive those services through GRM. Since GRM is funded entirely by state general funds, monies are strictly controlled and extremely limited. In order to insure the equitable use of the funds, many services require pre-authorization by the Central Office of the Division of Public Assistance before they can be provided and paid for by the General Relief-Medical Program.

Requests for service can come in two forms: letters and phone calls. The Division of Public Assistance maintains files of only written requests for service. During the month of July, 1976, a tabulation of those records was performed. Table 4 shows the number of denials of optional services which were requested by Medicaid clients during the period September 1, 1972 to July 31, 1976.

Note that the top four options that eligibility work supervisors felt their clients needed appeared within the top five items requested for those clients. Thus, the public assistance supervisors confirm the client perceived need for dental services, therapy, dentures, and prescription drugs. The survey also revealed a client perceived need for prosthetic devices (such as artificial limbs, crutches, canes, etc.).

These tabulations of requests for service represent only written requests. Because of the "emergency" nature of some services and the ease of telephoning for approval, many denials of services are not represented in the written files. Also, many clients will not request a service which they know is unavailable or which they stand a likelihood of being denied. Clearly, then, these figures substantially under-represent client need.

RESULTS OF STUDY

1. Basically State of Alaska eligibility work supervisors feel that their Medicaid-eligible clients most need:

1. Prescription Drugs
2. Adult Dental Services
3. Dentures*
4. Physical Therapy and Related Services*

* *The rank order of these services varies by program which client is receiving aid. The adult public assistance clients are seen to need dentures much more frequently than do clients of Aid to Families with Dependent Children.*

2. The top four services that eligibility work supervisors feel that their Medicaid-eligible clients ask for most frequently are:

1. Adult Dental Services
2. Dentures
3. Prescription Drugs
4. Physical Therapy and Related Services

3. Records of "denials" of requests for services to be provided from the General Relief-Medical Program to Medicaid recipients indicate that the following services are requested and denied most frequently:

1. Dental Services
2. Therapy
3. Dentures
4. Prosthetic Devices

4. The records for the number of client requests generally underestimate client need because only written records are available and because many public assistance clients will not request a service which they know is unavailable or which they stand a likelihood of being denied.

PART V. ANALYSIS OF OTHER STATES' EXPERIENCE WITH SELECTED OPTIONS

OVERVIEW OF STATES PARTICIPATING IN SELECTED OPTIONS

The survey of denials of requests for services and tabulation of the responses to the questionnaire sent to the public assistance supervisors point to four service options which clients are perceived as needing most. These are: prescription drugs, adult dental services, dentures, and physical therapy and related services.

These optional services have been elected by many other states. For example--

- 96% of all states and United States protectorates have Prescription Drug Option *
- 64% of all states and United States protectorates have Dental Services Option *
- 60% of all states and United States protectorates have Physical Therapy and Related Services Option *

**Only states participating in Medicaid program are included in total figures. Data are as of June 1, 1976 and were obtained from United States Department of Health, Education and Welfare. (Data are unavailable on the number of states offering denture service to their eligibles.)*

Many states added these services in the mid-1960's when Medicaid first began. However, it was found that some states eliminated or restricted some of these options during the period January 1, 1975 to July 1, 1976. With the skyrocketing cost of medical care and the increasing demand upon state dollars, we decided to review the options that were selected as needed by public assistance supervisors and contact those states that had recently modified them.

QUESTIONNAIRE OF STATES MODIFYING SERVICES

In early December, the Research Division of the Legislative Affairs Agency prepared a questionnaire to ask the views of state Medicaid program administrators regarding the options they had recently restricted. Fourteen states that had recently modified optional services included in this survey were contacted. Eleven states (or 79%) responded to the questionnaire. Since existing federal reports do not pinpoint the number of states modifying their denture coverage, that option was not included in the discussion.

State Experience With Prescription Drug Option

Of the 51 states providing prescription drugs, 11 states (or 22%) reduced their coverage during the period of January 1, 1975 - July 1, 1976. Seven of those states responded to the questionnaire. The majority of those states reduced coverage of drugs in order to reduce expenditure of state dollars. They noted that it created a hardship, but most clients felt coverage of only certain drugs was better than no coverage at all of them. Basically, controls were maintained by limiting the number of monthly prescriptions any one client could obtain and by limiting the types of drugs covered.

It is interesting to note that one state, Oklahoma, added the drug option during this period. In responding to the questionnaire, the director of the Oklahoma program stated that the option was added at the direction of their legislature. Certain administrative restrictions were imposed when the option was added. Prescriptions were limited to three per client per month and the different categories of drugs were also restricted. The director noted that public reaction to the addition of services has been generally favorable.

State Experience With Dental Services Option

13% of the states which chose the dental services option eliminated it during the period January 1, 1975 to July 1, 1976. (Recently two states, Massachusetts and New Jersey, have reinstated coverage of this option). Five of the seven states eliminating this option responded to the survey.

Generally, these five states found that the adult dental services option was needed by clients and was easy to administer. Restrictions on the option were basically due to lack of state funds. In one instance, New Hampshire, the legislature set a priority list of services that were to be provided. Since adult dental services received a low priority and funds were limited, the option was dropped. The dropping of the option generated considerable negative client reaction, as evidenced primarily by an increased number of client administrative appeals on this issue.

State Experience With Physical Therapy and Related Services Option

Michigan was the only one of 32 states which included physical therapy and related services in their programs and chose to modify that option during the period January 1, 1975 to July 1, 1976. The Michigan Medicaid program responded to the questionnaire and noted its experience with the option. The respondent found that the option was needed by clients; however, the cut, an elimination of physical therapy in long term care institutions, was made in response to lack of sufficient funding. To date, this change in the program has not been rescinded.

RESULTS

1. At least 60% of all states participating in the Medicaid program also cover some form of prescription drugs, dental services, and physical therapy and related services options for their clients. These services were among the top four requested by Alaska public assistance clients and seen as needed most for them according to a survey of Alaska public assistance supervisors. (Nationwide data on the numbers of states covering dentures in their programs are not available.)

2. Two of the top four services seen as needed for public assistance clients, prescription drugs and dental services, were also the top two services restricted or eliminated by other states during the period January 1, 1975 - July 1, 1976. (See Part IV for survey results.)

3. Most states modified the options to reduce expenditure of state funds. They did not drop or restrict them because of lack of client need or complexities in administration.

4. Restrictions of service options were generally done in four ways: limiting coverage of service, limiting client access, reducing provider fee payments, and charging clients small fees.

5. Reduction of fees generally brought strong reaction by the provider sector.

6. The states believe that limiting coverage to certain number of services allowable per month and restricting coverage of type of service allowable under the option was generally more acceptable than totally eliminating it.

7. In most cases, states modifying these options chose to restrict prescription drug coverage but they chose to eliminate dental services (except as was required under the early screening program).

8. In some cases states reinstated changes in options a short time after they were made. This was generally due to the strong reaction received from the groups affected.

PART VI. CONCLUSIONS TO THE STUDY

From the responses to the questionnaire sent to public assistance supervisors concerning client need, the survey of denial records of requests for additional services, and the responses from other states regarding their experience with the program, the following conclusions can be drawn:

1. Of Medicaid optional services available that Alaska does not currently provide under its program, public assistance clients appear to need most(in descending order of need).

   (1) Prescription Drugs
   (2) Dental Services
   (3) Dentures*
   (4) Physical Therapy and Related Services*

   * *The rank order of these services varies by program under which client is receiving aid. The adult public assistance clients are seen to need dentures as a higher priority than do clients of Aid to Families with Dependent Children.*

2. hree of the optional services listed in Item #1 are included by over 60% of the states participating in Medicaid. Prescription drugs, for example, are included in 95% of all state programs. (Data on coverage of dentures are generally unavailable on nationwide basis.)

3. Two of the options that clients "need" most--prescription drugs and dental services--topped the list of options that states reduced or eliminated during the period January 1, 1975 - July 1, 1976. These modifications were done as cost containment measures and not as a response to lack of client need or to complexities of administering the options.

4. Alaska could be reasonably assured that services listed in Item #1 would be needed and used by clients. The choice to include them appears to be a decision based primarily on the state's availability of state funds. The state could choose to cover an option, but restrict that option in many ways to meet funding limitations.

GLOSSARY OF TERMS

AB - See Aid to the Blind.

AD - See Aid to Disabled.

ADC - See Aid to Families with Dependent Children.

AFDC - See Aid to Families with Dependent Children.

APA - See Adult Public Assistance.

APD - See Aid to Disabled. Stands for Aid to Permanently Disabled.

Adult Public Assistance - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education, and Welfare. Designed to provide a state-legislated level of cash assistance to aged, blind, and disabled persons who meet certain income and resource requirements, and who are predominately eligible for Supplemental Security Income (SSI) payments. State administrative costs as well as actual cost payments are 100% state only costs.

Aid to the Blind - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education, and Welfare. Designed to provide a state legislated level of cash assistance to those eligible blind persons who meet certain income and resource requirements, and who are predominately eligible for SSI payments. It is considered an "Adult Public Assistance" program.

Aid to Disabled - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education and Welfare. Designed to provide a state legislated level of cash assistance to those eligible disabled persons who meet certain income and resource requirements and who are predominately eligible for SSI payments. It is considered an "Adult Public Assistance" program.

Aid to Families with Dependent Children - A federal program administered by the state through an approved state plan filed with the U.S. Department of Health, Education, and Welfare. Designed to provide a state-legislated level of cash assistance to dependent children who have been deprived of one or both parents, and who meet certain income and resource requirements. Both administration costs and the actual cash payments provided to recipients are shared equally (50%) by the state and federal government.

Categorical Assistance - Aid, in form of income maintenance, to certain needy persons who receive assistance under Old Age Assistance, Aid to the Blind, Aid to the Disabled, Supplemental Security Income, and Aid to Families of Dependent Children programs.

Compliance - In a federal program, the act of performing certain set program functions in accordance with those requirements outlined in the state plan, federal law, and regulation. Generally, meeting all federal program requirements is necessary to receive federal financial participation in the program.

DHSS - See Department of Health and Social Services.

Department of Health and Social Services - A department of the executive branch designated to be single state agency to administer the Medicaid program for the state of Alaska.

EPSDT - See Early and Periodic Screening, Diagnosis and Treatment.

Early and Periodic Screening, Diagnosis and Treatment - A mandatory service under Medicaid which provides for special check-ups at set intervals for certain needy children, in order to find and treat health problems before they become serious. Coverage includes only those Medicaid eligibles under 21 years of age.

Eligible - A person qualified to receive assistance funded under particular program. Eligibility criteria can vary, so that eligibility must be established on program by program basis.

FFP - See Federal Financial Participation.

Federal Financial Participation - The means by which the federal government asssists in supporting certain specific program. The federal government generally provides aid by two methods: 1) matching dollars by set percentage or 2) formula money grants.

GRM - See General Relief-Medical.

General Relief-Medical - A state emergency medical program designed to respond to immediate medical needs of Alaskan families in time of extreme financial crisis. All assistance rendered under this program is in the form of vendor payments to medical providers. State administrative costs as well as actual cash payments to vendors are 100% state only costs.

Intermediate Nursing Care - An optional service available to be provided under Medicaid program. Denotes a less intensive and less expensive level of around-the-clock nursing care, in comparison to skilled nursing.

Mandatory Coverage - A portion of the Medicaid program that is required to be covered by each and every state in the program, in order for the state to be entitled to federal financial participation. Mandatory coverage items concern persons eligible to receive services and the services provided to those persons. States can still administratively "control" mandatory services and not jeopardize federal financial participation by controlling the amount of service available to client, amount of financial participation (deductible required to be paid by client) in order for the client to receive such services, and other mechanisms.

Medicaid - A federal assistance program established by Title XIX of the Social Security Act and administered by the state through an approved state plan filed with U.S. Department of Health, Education, and Welfare. Designed to provide medical coverage for recipients of Aid to Families With Dependent Children; Supplemental Security Income, elderly and blind recipients of Adult Public Assistance and those disabled persons who meet federal definitions of disability; and certain other groups. State administrative costs are shared equally (50%) by the state and federal governments, except for professional medical support personnel who are funded at 75% federal reimbursement. Actual medical vendor payments are shared equally (50%) by the state and federal government, except for family planning which is funded at 90% federal reimbursement.

Medically Needy - An optional group of eligibles for whom federal reimbursement for necessary medical care may be covered under the Medicaid program. Generally includes individuals who have insufficient income and resources to meet the costs of necessary medical or remedial care and services. Presently Alaska does not include the medically needy under its Medicaid program.

Medicare - An insurance program administered solely by the federal government to provide payments for necessary medical care for those people, rich or poor, who receive Social Security payments.

OAA - See Old Age Assistance.

Old Age Assistance - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education, and Welfare. Designed to provide a state legislated level of cash assistance to those eligible persons 65 and over who meet certain income and resource requirements and who are predominately eligible for Supplemental Security Income payments. It is considered an "Adult Public Assistance" program.

Option - A portion of the Medicaid program that is discretionary on the part of the state. Options generally deal with persons eligible for coverage or medical services available for those eligible persons. Options are set out in federal law and regulations and are generally eligible for federal financial participation. Since the choice of options is up to each state, options can generally be designed to fit the state's unique needs and available resources, but each option chosen must meet certain broad federal program requirements.

Public Assistance - A division of Department of Health and Social Services, responsible for administration of the Medicaid, General Relief-Medical, and Income Maintenance programs. This division determines the eligibility of state's residents for such services by carefully reviewing the person's income, resources, and other factors according to state and federal standards.

Quality Control - An office of the Department of Health and Social Services which is assigned the responsibility to verify that

randomly selected cases are eligible to receive services in month that service was rendered. The verification consists of check of files, client contact, and collateral sources.

Recipient - A person receiving income maintenance or assistance services funded under a particular program.

SSA - See Social Security Administration.

SSI - See Supplemental Security Income.

Skilled Nursing Care - A mandatory service required to be provided under the Medicaid program. Denotes highly professional round-the-clock nursing care and monitoring. Generally more expensive and more specialized care than intermediate care.

Social Security Administration - An agency of the federal Department of Health, Education and Welfare assigned the responsibility to administer Social Security, Medicare, and Supplemental Security Income programs.

State Plan - A contract between the single state agency to administer the Medicaid program and the federal Department of Health, Education and Welfare, specifying conditions to be met in order to be eligible for federal financial participation.

Supplemental Security Income - An assistance program funded and administered by federal government which provides payments to certain needy persons who are aged, blind, or disabled and meet program and financial requirements. Payments are uniform nationwide and are based on need.

Title XIX - A portion of the federal Social Security Act which outlines the Medicaid program.

Title XVIII - A portion of federal Social Security Act which outlines the Medicare program.

Utilization Review - Random records check of sample institutional Medicaid billing to insure that services rendered match with those billed to the program. Verifies that institutional records are complete, accurate, and up-to-date. Examines for overuse or misuse of treatment and professional resources and the patient's duration of stay relating to those resources.

Attachment K

Medicaid Annual Status Report

FISCAL YEAR 1977

Jay S. Hammond, Governor
State of Alaska

Helen D. Beirne, Commissioner
Department of Health and
Social Services

Richard R. Wilson, Director
Division of Public Assistance

MEDICAID ANNUAL STATUS REPORT

FISCAL YEAR 1977

JAY S. HAMMOND

GOVERNOR

STATE OF ALASKA

HELEN D. BEIRNE

COMMISSIONER

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

RICHARD R. WILSON

DIRECTOR

DIVISION OF PUBLIC ASSISTANCE

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Division of Public Assistance

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ABSTRACT OF MEDICAID FY 1977
STATUS REPORT

Medical Assistance Budget FY 1977 (not including supplemental appropriations):

Medicaid	$16,908,500
General Relief-Medical	2,542,100
Total	$19,450,600

Medical Assistance disbursements for FY 1977 (through February 28, 1978):

Medicaid	$18,608,568
General Relief-Medical	3,743,128
Total	$22,351,696 1/

Medicaid	50% federal funding for services and administration
	75% federal funding for professional staff (medical)
	90% federal funding for family planning services
GR Med	100% state funding
Catastrophic Illness	100% state funding

Savings to the State of Alaska through participation in Medicaid (vendor payments only):

Federal financial participation	$ 9,450,261
State financial participation	9,158,307
Total Medicaid payments	$18,608,568

Total number of persons receiving Medicaid services FY 1977: 11,815 2/
Total number of persons receiving GR Med services FY 1977: 2,631

Who is eligible for Medicaid? Persons eligible for cash assistance payments under any categorical assistance program: Old Age Assistance, Aid to the Blind, Aid to the Disabled meeting federal disability criteria, Aid to Families with Dependent Children. Additional eligibility criteria exist for persons in nursing facilities and children in foster care or juvenile care situations.

Who is eligible for GR Med? Persons having no prior Medical resources and who meet financial eligibility (need) requirements for the assistance programs listed above but do not meet other qualifications for Medicaid coverage (not blind or disabled under federal definition, under 65, both parents in the home are physically able to work).

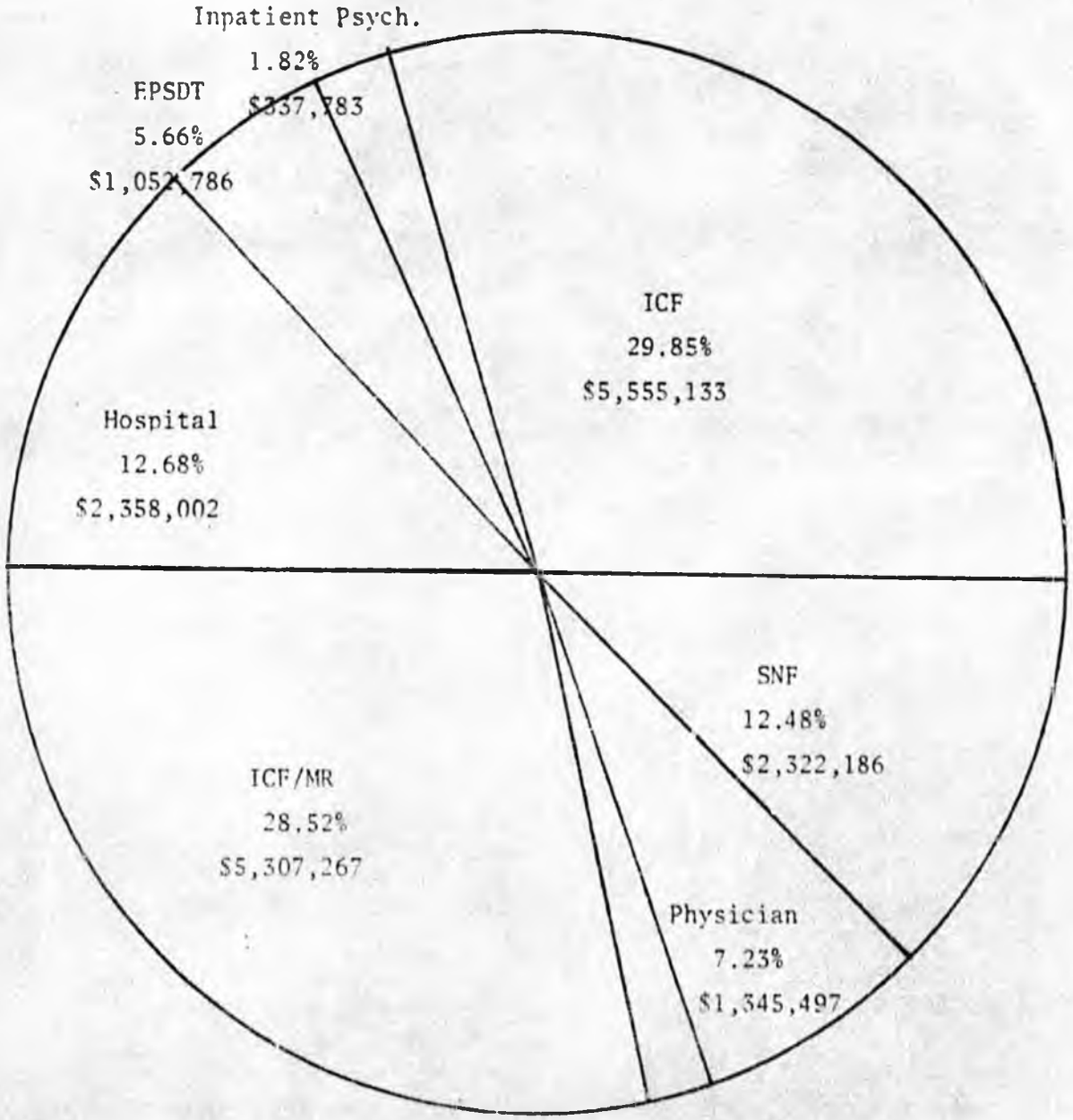
1/ - Not included in these statistics were approximately $500,000 worth of FY 1977 invoices which had not yet been paid as of 2/28/78, pending decision on the FY 1978 supplemental appropriation request.

2/ - Statistics based on federal report during the federal fiscal year October 1, 1976 to September 30, 1977.

DISTRIBUTION OF MEDICAID PAYMENTS BY TYPE OF SERVICE

BY DATE OF SERVICE

FISCAL YEAR 1977



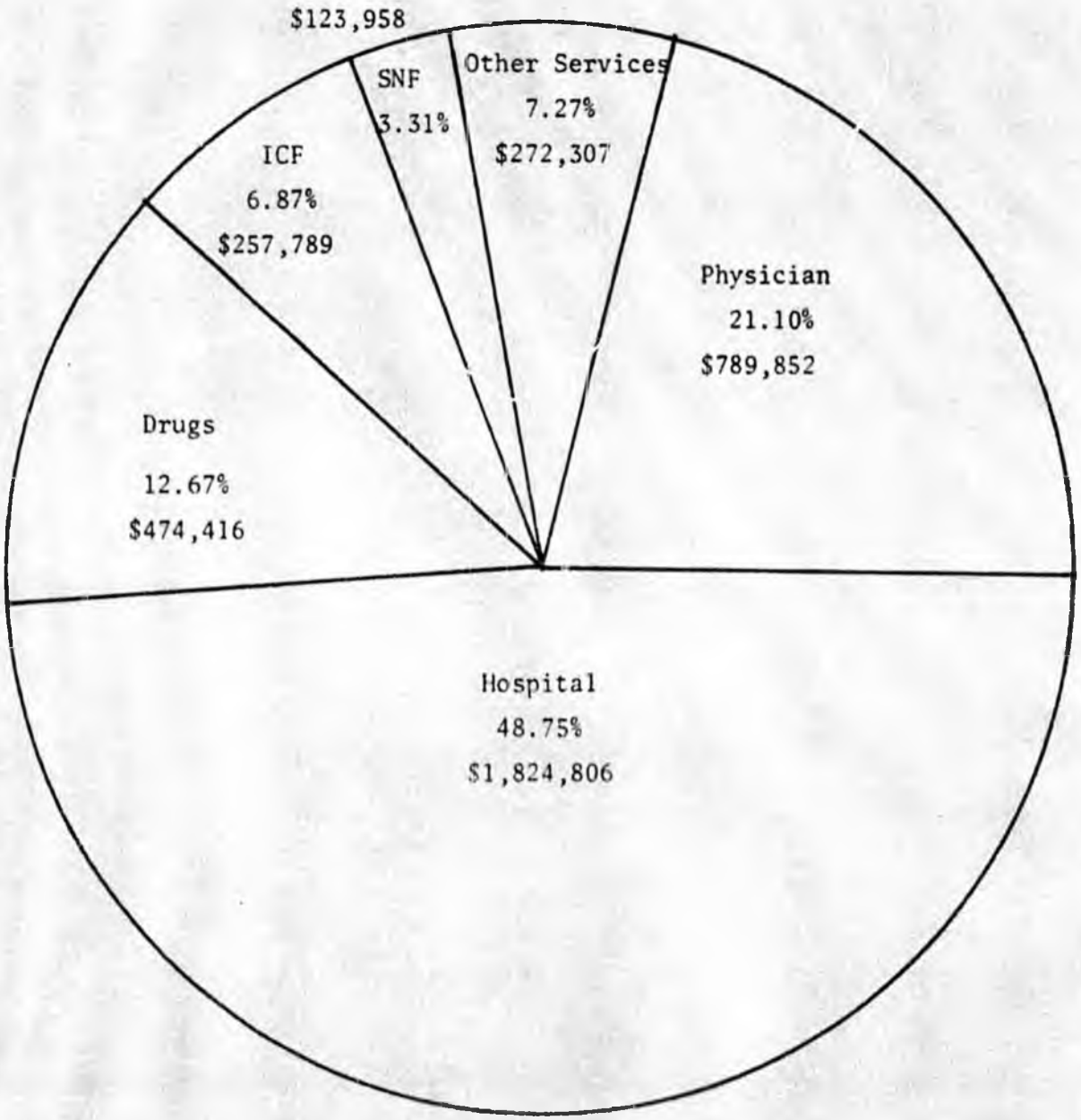
Total Medicaid Payments

$18,608,568

DISTRIBUTION OF GR MED PAYMENTS BY TYPE OF SERVICE

BY DATE OF SERVICE

FISCAL YEAR 1977



Total GR Med Payments

$3,743,128

MEDICAL ASSISTANCE EXPENDITURES - FY 1977 - BY PROVIDER BY DATE OF SERVICE

	MEDICAID	GENERAL RELIEF MED	TOTAL	STATE SHARE TOTAL	FEDERAL SHARE TOTAL
Hospital - Inpatient	$ 2,047,906	$ 1,718,698	$ 3,766,604	$ 2,742,651	$ 1,023,953
Outpatient	310,096	106,108	416,204	155,047	261,157
Laboratory & X-ray	13,247	4,279	17,526	10,903	6,623
Skilled Nursing (SNF)	2,322,186	123,958	2,446,144	1,285,051	1,161,093
Intermediate Care (ICF)	5,555,133	257,789	5,812,922	3,035,356	2,777,566
Intermediate Care for Mentally Retarded (ICF/MR)	5,307,267	-0-	5,307,267	2,653,633	2,653,634
Physician Services/Incl. EPSDT	1,353,097	789,852	2,142,949	1,466,400	676,549
Drugs	-0-	474,416	474,416	474,416	-0-
Home Health Services	11,798	-0-	11,798	5,899	5,899
Dental Care EPSDT Serv.	392,704	-0-	392,704	196,352	196,352
EPSDT Admin.	35,552	-0-	35,552	17,776	17,776
Other	-0-	81,828	81,828	81,828	-0-
Transportation/Inc. EPSDT	82,916	16,386	99,302	57,844	41,458
Family Planning	99,917	92,481	192,398	102,473	89,925
EPSDT Admin./RSA	503,913	-0-	503,913	251,956	251,957
Inpatient Psychiatric Hospital	337,783	-0-	337,783	168,891	168,892
Eyeglasses/Inc. EPSDT	160,576	15,725	176,301	96,013	80,288
Prosthetic Devices/Inc. EPSDT	12,244	21,014	33,258	27,136	6,122
Mental Health Clinics	40,151	-0-	40,151	20,075	20,076
Other/Inc. EPSDT	22,082	40,594	62,676	51,635	11,041
TOTAL	$18,608,568	$ 3,743,128	$22,351,696	$12,901,335	$ 9,450,261

ALASKA MEDICAID PROGRAM

Medicaid Objectives

Medicaid is based on three basic premises:

(1) That medical services are available to needy eligible persons when ill or injured;

(2) That the highest quality care is provided;

(3) That care is provided at the lowest possible cost to the taxpayers through existing health care providers.

Development of the Program

Medicaid is a state-administered medical assistance program funded by both federal and state sources. The program was implemented in Alaska on September 1, 1972. Since that time Medicaid expenditures have grown tremendously as a result of population growth, inflation, increased availability of services, rising cost of services, and increased utilization of federal revenues for programs that were previously (funded by state revenues alone).

FISCAL YEAR	MEDICAID EXPENDITURES	GR MED EXPENDITURES	ADMINISTRATION AND SUPPORT
1973	$ 4,447,219	$ 3,675,277	$ 481,890
1974	7,876,759	2,607,112	631,129
1975	9,309,702	2,358,080	722,778
1976	14,328,201	2,881,213	1,085,086
1977	18,608,568	3,743,128	1,253,002
1978 1/	25,915,719	6,213,100	1,346,800
1979 2/	38,811,695	6,769,100	1,423,950

1/ Projected expenditures

2/ Total of budget request including supplemental requests--includes $6,422,300 for Indian Health Care Improvement Act billings by ANHS; this is 100% federal funds.

Medical Care Advisory Committee

The Medical Care Advisory Committee is composed of health care providers, consumers (including Medicaid recipients), and government agency representatives. The committee is mandated by federal Medicaid regulations and deals with issues concerning Medicaid services, performs studies and makes recommendations for action by the Division of Public Assistance or legislature. The purpose of the committee is to provide oversight for implementation of the Medicaid program as well as provide an opportunity for input by both the provider and consumer communities.

Members of the Medical Care Advisory Committee are:

ALASKA'S MEDICAL CARE

ADVISORY COMITTEE

Charles Rush, Chairman	Anchorage	Pharmacist
Ann Maioriello Vice Chairman	Anchorage	Coordinator Home Health Care
Jimmy Anaver	Kipnuk	Consumer
Gloria Barclay	Juneau	Consumer
Sam Granato	Juneau	Director, Division of Social Services
Rose Davis	Fairbanks	Consumer
Robert Gregovich, MD	Juneau	Program Administrator Developmental Disabilities
J. Ray Langdon, MD	Anchorage	Physician
Sister Kathy McGinty, MD	Ketchikan	Catholic Community Services
Mildred Pelch, RN	Ketchikan	Nursing Home Administrator
Mary Wolcoff	Anchorage	Consumer

Health Care Providers

Health care providers in Alaska must be enrolled with the Division of Public Assistance to be eligible to bill the Division's Medical Assistance programs. Enrollment requires that the provider: (1) be licensed or eligible to provide a service covered under the Division's medical assistance programs; (2) have on file with the Division a signed and approved Division provider agreement form; (3) abide by the regulations and policies governing the Division's medical assistance programs; and (4) comply with TitIe VI of the Civil Rights Act of 1964.

Medical providers are required to keep records and furnish billing information when requested by state or federal officials for services provided to the Division's medical assistance recipients.

Provider Reimbursement

The Division sets maximum allowable fees for services provided outside of hospitals and nursing facilities. Maximum allowable fees must not exceed Medicare payment for the same service in Alaska. Providers are required to bill the Division for the lesser of: (1) their usual and customary charge to the public, or (2) the Division's maximum allowable fee (or Medicare upper limit, whichever is applicable).

For hospitals (both acute care and psychiatric), skilled nursing and intermediate care facilities and intermediate care for the mentally retarded, payment is based on reasonable cost reimbursement for services rendered. Interim payments are made and, after the close of a facility's fiscal year, settlement is made between the Division and a facility based on the cost report filed by a facility. In order for reasonable cost reimbursement to be effective the following aspects of the Division's Medicaid program must be functioning at maximum efficiency:

(1) Division policy must be organized and kept current to give adequate notice to providers;

(2) Utilization review of medical services--both by statistical survey and on-site review;

(3) Thorough audit of the financial reports and operations of each hospital and nursing facility.

Number of Medical Providers in Alaska

Hospitals	27
Nursing Facilities	14
Physicians	368
Dentists	135
Optometrists	24
Speech, hearing and language therapists	13
Home Health Agencies	1
Laboratories	5
Ambulance services	8
Opticians	12
Community Mental Health Clinics	10
Physical Therapists	16 1/
Pharmacies	68 1/
Others	35 1/

General Relief Medical Program

General Relief Medical (GRM) provides state-only coverage for two distinct classes of recipients: (1) those persons eligible for Medicaid who require services not included under the Alaska Medicaid program: and (2) those financially needy persons not eligible for Medicaid coverage who require medical care.

Under the first group, GRM only provides coverage for those medical services and supplies not covered under Medicaid (such as prescription drugs, prosthetic devices, and medical equipment). For the second group, GRM provides state-only funding for coverage under all Medicaid service categories as well as certain medical services and supplies not covered by Medicaid (drugs, prosthetic devices and medical equipment).

Catastrophic Illness

This program was created by the 1976 legislature to provide post-care financial assistance to Alaskans with large medical bills who did not meet the financial eligibility criteria for Medicaid or GRM at the time the person received the medical care. The Catastrophic Illness Committee is composed of a medical officer of the Department of Health and Social Services, a member of the insurance community appointed by the Governor and a lay member who has previously suffered a catastrophic illness.

SUMMARY OF SERVICES COVERED UNDER THE ALASKA MEDICAID PROGRAM

Medicaid is a federal-state program administered by the states. As a condition of participation states must provide coverage for a minimum number of services prescribed by federal law. Beyond this minimum, each state has the opportunity to add or delete other "optional services" described in federal regulations.

The advantages of Medicaid optional services are: (1) they allow compensation for services provided by tax-paying providers who may be suffering a loss on services currently provided to low-income customers, and (2) they allow states currently providing services using state-only funds to tap federal money as partial funding for programs funded soley by the state.

The following mandatory and optional services are covered under the Medicaid program in Alaska:

Mandatory Services

(1) Inpatient Hospital services. Public or private facilities, not including hospitals for mental diseases or tuberculosis; services must be physician-ordered; non-emergency out-of-state hospitalization must be prior authorized by the Division.

(2) Outpatient Hospital services. Emergency medical services; on-going ambulatory care; public or private facilities.

(3) Laboratory and X-ray services. Independent facility or one connected with a physician; services must be physician-ordered.

(4) Skilled nursing facility care (SNF). High level nursing and/or rehabilitative care; alternative to extended hospital care; must be prior authorized by the Division.

(5) Physician services. Inpatient and outpatient services performed by private physicians; cosmetic surgery must be prior authorized by the Division.

(6) Home Health Services. Provides an alternative to nursing home care by covering services to clients at home rather than in a nursing facility. Covered services under this category include nursing; medical supplies and equipment; physical, occupational and speech/hearing therapy when provided by a licensed home health agency.

(7) Family planning services and supplies. These services receive 90% federal financial participation; covers hospital and surgical procedures as well as contraceptive devices.

(8) Transportation. To or from a facility or provider of medical services; locally handled by Divisional offices except where cost is in excess of $250.00 or travel is out-of-state, in which case it must be prior authorized by the Division's Medical Practice Review Officer.

(9) Early Periodic Screening, Diagnosis and Treatment (EPSDT). Currently limited by the Department to federal minimum requirements for covered services; provides screening for all Medicaid-eligibles under 21 years of age; optional at client's choice; as a result of screening, referral is made to physician, audiologist, optometrist, dentist or therapist for further treatment; covered services include all mandatory services plus services for eyeglasses, hearing aids, treatment for visual and hearing defects, and dental services.

Optional Services

(1) Intermediate Care Facilities (ICF). Lower level nursing home care; alternative to skilled nursing and/or hospitalization; requires prior authorization by the Division.

(2) Intermediate Care for the mentally retarded or persons with related disabilities (ICF/MR). Lower level nursing home care for persons with mental retardation or developmental disabilities; requires prior authorization.

(3) Inpatient psychiatric hospital services. Acute care for persons suffering from psychological trauma or impairment; limited to persons under 21 years of age or over 65 years of age; prior authorization is required.

(4) Eyeglasses. Must be prescription glasses; new, repaired or replacement; no photogrey tints; cataract contact lenses must be prior authorized by the Division.

(5) Optometrists. Coverage is provided for both eye care and dispensing.

(6) Clinic services. Currently limited by state statute to state-operated and state-funded outpatient community mental health clinics enrolled for Medicaid; must be supervised by a physician.

(7) Services for speech, language and hearing disorders. Services rendered by speech pathologists or audiologists; requires prior authorization by the Division; must be ordered by a physician.

MEDICAID OPTIONAL SERVICES--INCLUDING THOSE NOT CURRENTLY COVERED BY THE ALASKA MEDICAID PROGRAM

The following is a list of all optional services under the Medicaid program. Optional services may be selected by the individual states for inclusion in their Medicaid program if a state decides to make those services available to all categories eligible for the basic Medicaid coverage. A brief description of each option is provided below followed by a comparison of optional services that are offered in Alaska, Idaho, Oregon and Washington, the four states comprising federal Region X. Those services covered in Alaska are indicated.

(1) Podiatrist services. Manipulation of the feet and treatment of corns, bunions, callouses, etc., by a licensed podiatrist.

(2) Optometric services. Covered under Alaska Medicaid.

(3) Chiropractic services. Treatment by a licensed chiropractor limited to manual manipulation of the spine.

(4) Other practitioner services. Naturopaths, homeopaths, herbalists, faith healers.

(5) Private duty nursing. Care by a registered nurse or licensed practical nurse under a physician's supervision in home, hospital or nursing facility when a person requires exceptional individual and continuous care.

(6) Clinic services. Under the Alaska Medicaid program this is currently limited to state-operated and state-funded community mental health clinics. This option could also include such other services as health care clinics, alcoholism treatment centers, ambulatory surgical centers, and rural health care clinics. Rural health clinics are now a mandatory service pursuant to Public Law 95-210.

(7) Physical therapy. Physician-prescribed services provided by a licensed or certified physical therapist (depending upon state licensing procedures).

(8) Occupational therapy. Physician-prescribed services provided by a licensed or certified occupational therapist (depending upon state licensing procedures).

(9) Services for speech, hearing, and language disorders. Included under the Alaska Medicaid program.

(10) Prescribed drugs. Covered by state-only General Relief Medical. Alaska is one of only two states without Medicaid coverage for this option.

(11) Dentures. Replacement of a full or partial set of teeth.

(12) Prosthetic devices. Physician-prescribed replacement, corrective or supportive devices that artificially replace a missing part of the body, to prevent deformity or malfunction, to support a weak or deformed portion of the body.

(13) Eyeglasses. Covered by Alaska Medicaid.

(14) Other diagnostic, screening, preventive and rehabilitative services. Identification of illness, injury or other health deviation; preventive and rehabilitative services to restore patient to functional level.

(15) Services to individuals over 65 years of age in institutions for tuberculosis. Facility providing services could be ICF, SNF or inpatient hospital.

(16) Services to individuals over 65 years of age in institutions for mental diseases. (a) Inpatient psychiatric care for persons over 65 is covered under the Alaska Medicaid program. (b) ICF and SNF care for persons over 65 with mental diseases is not covered in Alaska. Under this provision, it would be possible to provide nursing care for persons with mental disabilities who may not otherwise qualify for nursing care due to a lack of physical health problems requiring nursing home care.

(17) Intermediate care facilities (ICF). Covered under the Alaska Medicaid program.

(18) Inpatient psychiatric services for persons under 22 years of age. Covered by the Alaska Medicaid program.

(19) Transportation. Covered under the Alaska Medicaid program.

(20) Services by Christian Science nurses.

(21) Services by Christian Science Sanatoria.

(22) Skilled nursing facility care (SNF) for persons under 21 years of age. Covered by the Alaska Medicaid program.

(23) Emergency hospital services. Covered under the Alaska Medicaid program.

(24) Dental services. Adult dental services are not covered by Medicaid in Alaska.

(25) Personal care services. Physician-ordered services provided to a person in their home by a non-relative and supervised by a registered nurse.

(26) Intermediate care for the mentally retarded and persons with related conditions (ICF/MR). Covered under the Medicaid program in Alaska.

OPTIONAL SERVICES

OPTIONAL SERVICES	ALASKA	IDAHO	OREGON	WASHINGTON
Podiatrist Services	No	Yes	Yes	Yes
Optometric Services	Yes	Yes	Yes	Yes
Chiropractic Services	No	Yes	Yes	Yes
Other Practitioner Services	No	No	Yes	Yes
Private Duty Nursing	No	No	Yes	Yes
Clinic Services	Yes	Yes	Yes	Yes
Physical Therapy	No	Yes	Yes	Yes
Occupational Therapy	No	No	No	No
Services for Speech, Hearing & Language Disorders	Yes	No	No	Yes
Prescribed Drugs	No	Yes	Yes	Yes
Dentures	No	No	Yes	Yes
Prosthetic Devices	No	No	Yes	Yes
Eyeglasses	Yes	No	Yes	Yes
Other Services				
Diagnostic	No	No	Yes	Yes
Screening	No	No	No	Yes
Prevention	No	No	No	Yes
Rehabilitation	No	No	Yes	Yes
Services to Individuals Over 65 in Institutions for T.B.				
Inpatient	No	No	Yes	Yes
Skilled	No	No	Yes	Yes
ICF	No	No	Yes	Yes
Services to Individuals Over 65 in Institutions for Mental Diseases				
Inpatient	Yes	No	Yes	Yes
Skilled	No	No	Yes	Yes
ICF	No	Yes	Yes	Yes
Intermediate Care Facilities	Yes	Yes	Yes	Yes
Inpatient Psychiatric Services for Under 22	Yes	No	Yes	Yes
Transportation	Yes	Yes	Yes	Yes
Services for Christian Science Nurses	No	No	No	No
Services for Christian Science Sanitoria	No	No	Yes	No
SNF for Under 21	Yes	Yes	Yes	Yes
Emergency Hospital Services	Yes	Yes	Yes	Yes
Dental Services	No	No	Yes	Yes
Personal Care Services	No	No	No	No
ICF/MR	Yes	Yes	Yes	Yes

MEDICAID

A LOOK TO THE FUTURE

The federal government through the Department of Health, Education and Welfare (DHEW) continues to put greater emphasis on cost containment and accountability in the operation of the Medicaid program nationwide. This places added burdens on state-administered Medicaid programs to provide swift and accurate information to DHEW--while providing information about the program and prompt payment to medical providers.

In Alaska, the Division of Public Assistance is attempting to upgrade the overall operation of the Medicaid program in an effort to control costs as well as provide more adequate notice to providers about their rights and responsibilities under the program.

Several tools are necessary to accomplish that end--state administrative regulations, staff operational manual, provider manuals, schedules of maximum allowable fees, and a more efficient mechanized claims payment and data reporting system.

Program Tools

After five and one-half years of Medicaid participation, state administrative regulations are in the drafting stage with hearings tentatively scheduled for the summer of 1978. Federal statutes and federal regulations provide only a broad sketch of the Medicaid program. The Department of Health, Education, and Welfare assumes that states develop the details of the Medicaid program through state administrative regulations and agency policy. Without state regulations it is impossible to begin a program of effective cost containment to insure that improper and excessive utilization does not occur.

Federal law mandates that states have systems for investigation and prosecution of fraud and abuse by Medicaid providers. Without notice to providers through state administrative regulations and provider manuals, it is impossible for the state to control provider fraud and abuse. Broad state statutes and federal laws and regulations lack the detail necessary to insure that providers have specific notice of program requirements and limitations. Additionally, states must have a mechanism that allows providers to appeal decisions on invoices where payment is denied.

Provider manuals offer an organized structure within which notice is given to providers of recurrent changes in the program. Frequent updating of both regulations and manuals help assure that the state and provider are in compliance with federal requirements as well as guarantee that the state receives the maximum allowable federal matching funds afforded to Alaska.

Federal Accountability

Greater emphasis is being placed on state accountability to the federal government. States no longer have the luxury of running their Medicaid programs on an open account. Fraud and abuse control are being emphasized, and overall state management is being scrutinized. During the summer or fall of 1978, DHEW staff will be reviewing the entire Alaska Medicaid program as part of a nationwide management assessment program. Information from this review will be helpful in assessing the deficiencies and operational needs of the Division of Public Assistance, as well as providing DHEW information upon which it can base specific program improvement requests.

Federal budgeting is being revised to require more accurate quarterly expenditure and estimating reports. Revision is being made in part because DHEW is shifting its budgeting from one-year to three-year projection cycles, which places a greater burden on states to arrive at more accurate cost and utilization projections. The Division of Public Assistance must develop more accurate data to fulfill this budgeting requirement; with the present computer system, it will be extremely difficult to insure compliance in Alaska.

Increasing Efficiency in Claims Processing

A new federal statute that will have great impact on the Division's current operation requires that 90% of all "clean claims" (those invoices which require no correction or additional information from providers prior to payment) must be paid within 30 days of receipt. Given the present manual claims payment system, it will be virtually impossible to comply with this requirement.

In an attempt to speed up the claims processing system, the Division is seeking to shift to a schedule of maximum allowable fees for physician services rather than continuing with the present fee profile system. The basic difference between the two is that with maximum allowable fees, an upper limit is established for all providers for a particular medical or surgical procedure. The state pays the lesser of a provider's usual and customary billing or the maximum allowable fee.

With the current fee profile system, the amount paid varies from provider to provider--even within the same city or clinic! Also, with the fee profile system, providers submit invoices with the amount they normally charge for a service. This is then "adjudicated"--that is, reduced--if the charge exceeds the maximum fee for that procedure as established on the physician's fee profile.

A schedule of maximum allowable fees will guarantee: (1) that all physicians receive equal pay for equal work; (2) that they will receive a fair wage for their work; (3) that their invoices will be paid in a more timely manner; and, (4) that they will have notice at the time they perform the medical or surgical procedure of the amount they can expect to be paid.

Fraud and Abuse

More intensive fraud and abuse controls have been mandated by Public Law 95-142. Post-payment utilization review of medical services has been a requirement for several years. The Division is currently computerizing claims payment information and statistical analysis of that information. This computerized system is necessary in order to comply with the reporting and investigative requirements mandated by this new fraud and abuse legislation.

Medicaid Management Information System (MMIS)

Federal law provides for 90% federal funding for development and 75% funding for operation of MMIS. The funding level for a non-MMIS claims payment and information system is only 50%. Alaska has not yet taken advantage of this offer of funding by HEW. All new federal requirements for budgeting, reporting, claims payment, and fraud and abuse are geared to an MMIS operation. Without such a system, or at least the reporting and statistical analysis portion of that system (surveillance/utilization review), the State of Alaska faces several crises in the Medicaid system which could well result in withholding of federal matching money.

It may be possible for the Division to interface with an MMIS operation in another state, and the Division is currently preparing proposals to make this interface possible. This might be the least expensive means of securing an MMIS program. Another alternative would be the purchase of a surveillance/utilization review system to accompany the present claims payment system. If this latter alternative were used, it would allow the state to comply with reporting and budgeting requirements as well as providing statistical information needed for fraud and abuse control.

Indian Health Care Improvement

Public Law 94-437 (the Indian Health Care Improvement Act) provides for reimbursement of services rendered to Medicaid eligible persons by Indian Health Service (IHS) hospitals by allowing the facilities to bill Medicaid. There will be no impact on the State's portion of Medicaid program costs as all money paid to IHS providers will be 100% federal funds. However, there will be an impact on state administration costs as states must pay their percentage of the cost of processing these additional invoices (in Alaska, without MMIS, this is 50% of cost).

In Alaska, IHS has not yet begun to bill the Division for services provided to Medicaid eligible Natives. Start-up has been postponed as IHS is still in the process of establishing billing mechanisms for each of their facilities in Alaska. Several facilities are now ready to begin billing and full implementation of IHS participation may be achieved by July 1978.

Rural Health Clinics

Public Law 95-210 provides for Medicaid and Medicare reimbursement to rural health clinics.

Under P.L. 95-210, states will be required to provide Medicaid coverage for services provided to eligible recipients by a rural health clinic once a clinic has been certified for participation in the federally-administered Medicare program. In Alaska, this certification is performed by the Division of Public Health Office of Certification and Licensing.

Clinics are staffed by nurse practitioners and physicians assistants trained to provide services traditionally performed by physicians. Although there is need for physician supervision, it may be indirect supervision.

The earliest that Medicaid can cover rural health clinic services is July 1, 1978. In order for this required coverage to be implemented in Alaska it will be necessary for AS 47.07.030 to be amended to include rural health clinics. Also, implementing regulations will be needed to allow provision of medical services by physician assistants and nurse practitioners.

Child Health Assessment Program (CHAP)

A bill is presently in Congress (HR 6706 and SB 1392), which, if enacted, would expand eligibility under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program to include a larger number of children through modification of eligibility criteria. Medicaid coverage would be extended to children whose families meet some definition of low income but do not qualify for cash assistance payment as currently required for eligibility under the Medicaid program. Under the CHAP proposal, federal financial participation would be increased to 75% federal funding.

This amendment would greatly expand the EPSDT program beyond its current level of operation in Alaska, though the full impact of the proposal cannot be accurately projected until a decision is made on what age limit will be imposed on the low income children to be added to the program.

The amendment points out the necessity for the Division of Public Assistance to identify more accurately all services provided under the existing EPSDT program. The present billing system does not identify all services provided to children as a result of EPSDT screenings. With passage of the CHAP amendment, states will need to be able to identify all CHAP claims in order to receive the 75% federal matching funds. Changes must be made to allow a child to be "tracked" from the time of screening through completion of services performed by licensed providers for medical problems identified by the screening. This is not being done in Alaska currently.

Summary

The Carter administration's emphasis in medical care is gradually moving toward some form of national health insurance program. It appears that before Congress will take any step in that direction it must be proven that the existing Medicaid/Medicare system will operate efficiently. Rising cost of service, over-utilization, improper utilization and provider fraud and abuse must be controlled.

In order for the State of Alaska to fulfill its role within the nationwide framework of health care, and for the Medicaid program in particular, the following broad goals have been set out for our program.

(1) Assessment of services covered or potentially covered under Medicaid and General Relief Medical (including the Medicaid "medically needy" option and the state catastrophic illness program);

(2) Streamlining the claims payment system;

(3) Updating and expanding computer capability to provide for federal and state requirements in reporting and utilization review;

(4) Improvement of procedures to give more accurate notice of the existing program and changes as they occur (regulations, provider manuals, staff manual);

(5) Simplification of structure within the Department of Health and Social Services to allow for more independent operation of the Medicaid program by the Division of Public Assistance;

(6) Adequate staffing of the Division to allow for control of the medical programs within the framework of good management practice.