

SB

322

Introduced 1-15-80  
Logged 1-15-80  
Referrals Finance  
Comm. meeting 1-28-80 — held 3-17-80 — held 4-21-80 — held  
Comm. action

SB 322 3. HESS 79.80 Act authorizing prof. for  
By ~~the~~ <sup>services provided by</sup> ~~the~~ <sup>distance</sup>  
legislature ~~institutions and agencies to~~  
provide ~~the~~ <sup>medicine, dentistry, podiatry, optometry, and</sup>  
other ~~services~~ <sup>services</sup> ~~to~~ <sup>be determined</sup>

Notify (Bob Ogden) Ph: 3055  
(Melichie) Ph: 3355 ✓

Notify Rick Union ✓  
361-2315

Notify Jack Buck - St. Ann's ✓  
Nursing Home 586-3883  
Jim Burns 6-2611  
Bartlett Hospital  
New patient paper (additional)  
herein



# ALASKA STATE HOSPITAL ASSOCIATION INC.

5401 CORDOVA STREET  
PHONE: 277-1633

ANCHORAGE, ALASKA 99503

January 25, 1980

Senator Glenn Hackney  
Alaska State Legislature  
Pouch V  
Juneau, Alaska 99811

Dear Senator Hackney:

Careful consideration has been given to the following proposed legislative bills and we would appreciate at this time providing you and your committee with the following comments, which we hope will be of value in your considerations.

S.B. #308 - ASHA Endorses

S.B. #309 - ASHA Endorses

S.B. #320 - ASHA (Qualified) Endorsement

Presently lacks specific definition of eligibility defining "medically needy".

S.B. #321 - ASHA (Qualified) Endorsement

Increasing the number of eligible claims paid under the state medicaid program, which is unable to keep up with those presently eligible, may compound an already less than satisfactory system. This bill also does not speak to the eligibility of family members of those who would be eligible under this proposal.

S.B. #322 - ASHA (Unqualified) Opposition

The question that needs to be asked is, the basis on which this bill would be justified. A review of the data contained on pages (4&5) of the 1980 ASHA Cost Containment Report shows:

1. Alaska has the smallest number of licensed beds per 1000/population.
2. Alaska has the smallest number of admissions per 1000/population.
3. Alaska has the highest per capita income in the nation.
4. Alaska has the lowest hospital expense per capita as per cent of per capita income.
5. Alaska hospital expenses per admission is within \$6.00 of the national average, and is lower than all but one of the states which now have a "perspective hospital reimbursement rate control program".

WHY DOES ALASKA NEED A PERSPECTIVE REIMBURSEMENT PROGRAM SINCE WE LEAD THE NATION IN THE SHORTEST LENGTH OF STAY AND APPROXIMATE THE NATIONAL AVERAGE ON EXPENSE PER ADMISSION?

If such legislation is passed, particularly this bill, we would ask, "who would determine and how would the determination of a fair rate for the reasonable costs" be calculated. What type of interim adjustments would be allowed during the reimbursement period for our present inflation? Would the prospective rate be by type of service? cost per patient day? by occupied beds? regionally or state wide rate? etc. There appear to be a number of unanswered questions at this time.

Colorado had a rate control program and has just resinded that law. New York has just completed a study which indicates that 25% of hospital cost can be attributed to government regulations. We feel that voluntary cost containment is a better way to accomplish this control.

Due to the question of need for this type of legislation and the information obtained from other states concerning ineffectiveness and costs, we recommend that action on this bill be deferred until a greater analysis of the information supporting its need or justification is presented.

S.B. #323 - ASHA (Qualified) Endorsement

As written, this is a blank check authorization, we recommend that stated monetary guidelines be incorporated in the bill by program or category of service. How the program will administer these funds should also be spelled out.

Thank you for consideration of our comments, and if we can be of further service by presenting supporting data or testimony, please contact us at your convenience.

Sincerely,



Max Kersbergen  
Executive Director

MK/ic

# BARTLETT MEMORIAL HOSPITAL

P. O. BOX 3-3000 • JUNEAU, ALASKA  
MILE 3 — GLACIER HIGHWAY

• TELEPHONE (907) 586-2611

February 20, 1980

Senator Glenn Hackney, Chairman  
Senate HESS Committee  
Pouch V  
Juneau AK 99811

## SENATE BILL No. 322 - "PROSPECTIVE RE-IMBURSEMENT"

Bartlett Memorial Hospital supports the intent of the bill. Prospective reimbursement negotiations would give both the State and the health care facility some concrete figures for budgeting.

However, this is an extremely complex issue that requires an orderly well planned program. Since October 1977, hospitals have been working with HEW's Health Care Financing Administration on the System for hospital Uniform Reporting (SHUR). This has evolved into the Annual Hospital Report (AHR) and it is hoped that this proposal will be accepted. (see attached excerpt)

UNIFORM REPORTING: All health care facilities must be set-up on a uniform data base. The above mentioned AHR should be the keystone for this procedure. We recommend that the State of Alaska utilize one of the major national accounting firms for this step. This outside agent should be mutually agreed upon by the hospitals and the State.

This cost should not be passed on to the hospital's patients; it should be borne by the State of Alaska.

RATE NEGOTIATION: Concurrently, have a national accounting firm (the same or another) establish a procedure for prospective rate setting. Subject procedure to be arrived at mutually with the hospitals. Place this procedure into effect after the data base year has been completed.

RATE APPEALS: Utilize a national accounting firm as an arbitrator on all appeals. This will preclude the need for an expensive rate commission and eliminate more bureaucracy.

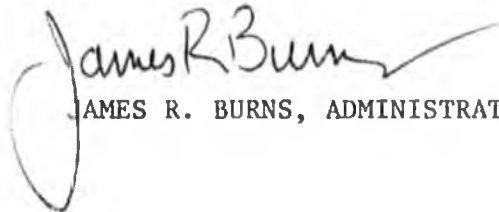
Senator Glenn Hackney, Chairman  
Senate HESS Committee  
Page 2

SENATE BILL No. 322 - PROSPECTIVE RE-IMBURSEMENT (con'd)

PROPOSED TIME SCHEDULE:

1st Year - set-up the reporting system  
2nd Year - establish one year data base  
3rd Year - negotiate rate

Every additional cost must be passed on to the patient or third party payor. Containment of cost is our goal - new legislation/rules must be cost effective for all concerned. I will assist in any way to provide information to your committee.

  
JAMES R. BURNS, ADMINISTRATOR

## Kaple: New report "dramatically" changed from SHUR

The Annual Hospital Report (AHR) is a "dramatically changed document" from the proposal it replaces — SHUR, the System for Hospital Uniform Reporting — and takes into account the hospital industry's concerns about cost and burden.

This is the opinion of James M. Kaple, Ph.D., acting director of the Office of Research, Demonstrations and Statistics of the Health Care Financing Administration (HCFA).

Kaple noted, however, that "the one issue the industry raised and we disagreed upon and therefore have not changed is the linkage of uniform reporting and reimbursement."



Kaple

"We clearly believe," he said, "that the data contained in the new Annual Hospital Report is that on which to base reimbursement decisions. It does not make sense, in my opinion, to put in place two reporting systems — one to gather uniform reporting data and another upon which to base reimbursement decisions.

### Data for reimbursement purposes

"Furthermore, Congress tended to believe that this data should be linked and used for reimbursement purposes. In

fact, the General Accounting Office (GAO) studied our implementation approach to Section 19 of P.L. 93-641. GAO's conclusion, presented in testimony, was that Congress did intend the use of this information for reimbursement purposes.

"Nevertheless, we have made a lot of changes, which are clearly responsive to the industry's request that the burden be reduced and the cost of collecting the data and maintaining it be reduced."

Kaple, noting the controversy that the SHUR proposal generated in 1979, said that "we have changed a great number of the reporting requirements that were contained in the original system — with an eye on reducing the burden on hospitals filing out the report and reducing the cost of maintaining and reporting the information."

"The resulting Annual Hospital Report," he explained, "takes into account virtually all of the specific comments on ways to reduce the reporting burden that were generated by the industry. There were one or two issues in which there were compromises. But, basically, we took the industry's recommendations on most of the burden and cost reduction issues."

Kaple commented:

"The Annual Hospital Report will become the cost information upon which reimbursement will be predicated for the federal programs. It will be an integral part of our operating

program. The purpose of the report is to collect uniform, operable cost and utilization information for our operating programs. It has been developed in such a way that it also should provide information for other parts of the department and other users at the state and local levels. This was done purposely in an effort to try to reduce the redundant reporting burden that hospitals now face from various segments of the third party payor industry and other regulators.

### HCFA to collect data

"We, for example, will be collecting the facility data through the Annual Hospital Report as opposed to having a separate system managed by the National Center for Health Statistics.

"We also will be supplying information to planners from this report on the range of services and the utilization of service by institutions in their areas. Again, this will preclude the necessity of developing new reporting systems specifically to support those activities.

"Internally, this report will, for the first time, provide us with a comparable uniform data base on which to analyze trends and costs in the hospital industry. We will be working directly with the fiscal intermediaries to bring the Annual Hospital Report data, possibly in summary form, into the central office for policy review and analysis and to support decisions on these programs within the Administration."

Kaple says there probably will be no increase in the size of his division's present staff to handle the report data.

"In the long run," he noted, "there may be some cost savings through the introduction of a uniform reporting system at the source of the data. We will use fiscal intermediaries to manage and reduce the data. Our early discussions with Blue Cross and certain other intermediaries suggest that receiving the data in the uniform form probably will permit management of the information with no net increase in personnel at the intermediary level. In the central office, we will be receiving the data in machinery that will actually expedite our collection and management of the information." □

Federation of American Hospitals

# REVIEW



December/January 1980

**Deregulation:  
A Report from Colorado Hospitals**



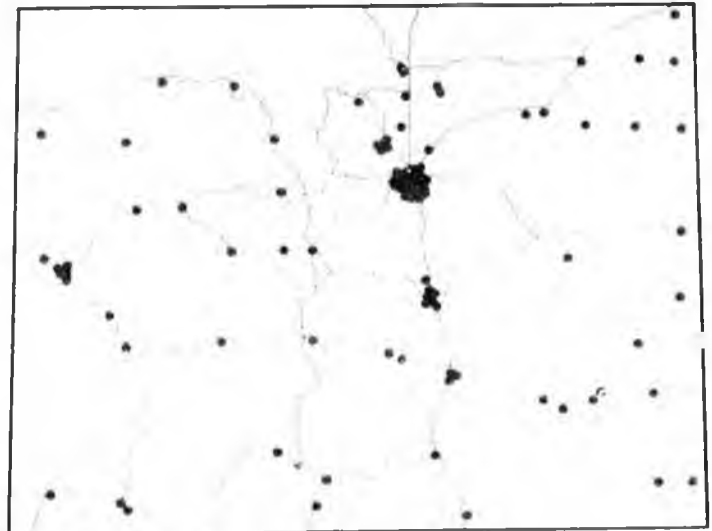
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**We are the 105 Colorado hospitals** employing 40,000 people and caring for more than 460,000 patients each year.

These facts distinguish us from a "national average," much as Colorado distinguishes itself from the rest of the

nation by its natural resources and quality of life.

Quality health care is available in Colorado, yet the cost of the average hospital stay in Colorado is still 6.3% below the rest of the nation, even as Denver's Consumer Price Index (CPI) climbed to 8% above the national CPI.



**Location:**

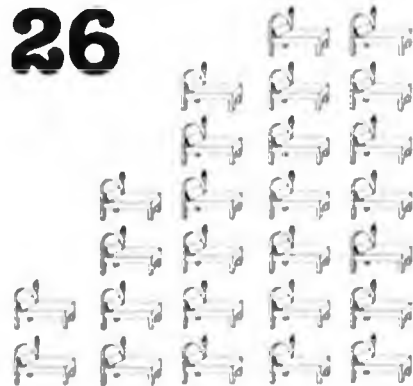
- 50 Rural
- 31 Denver
- 24 Other cities

**Type:**

- 53 Non-government, not-for-profit
- 40 State and local government
- 7 Investor-owned
- 5 Federal

**200 Beds & Over**

**26**



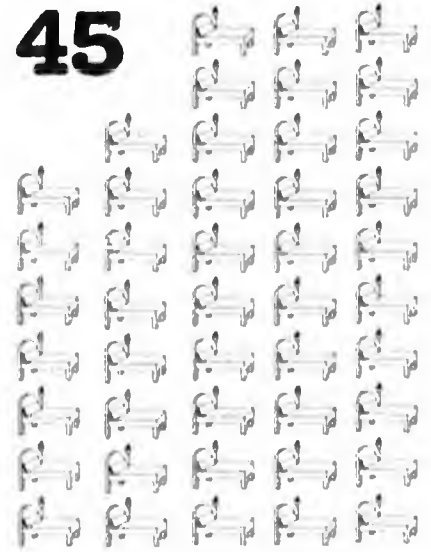
**50-199 Beds**

**34**

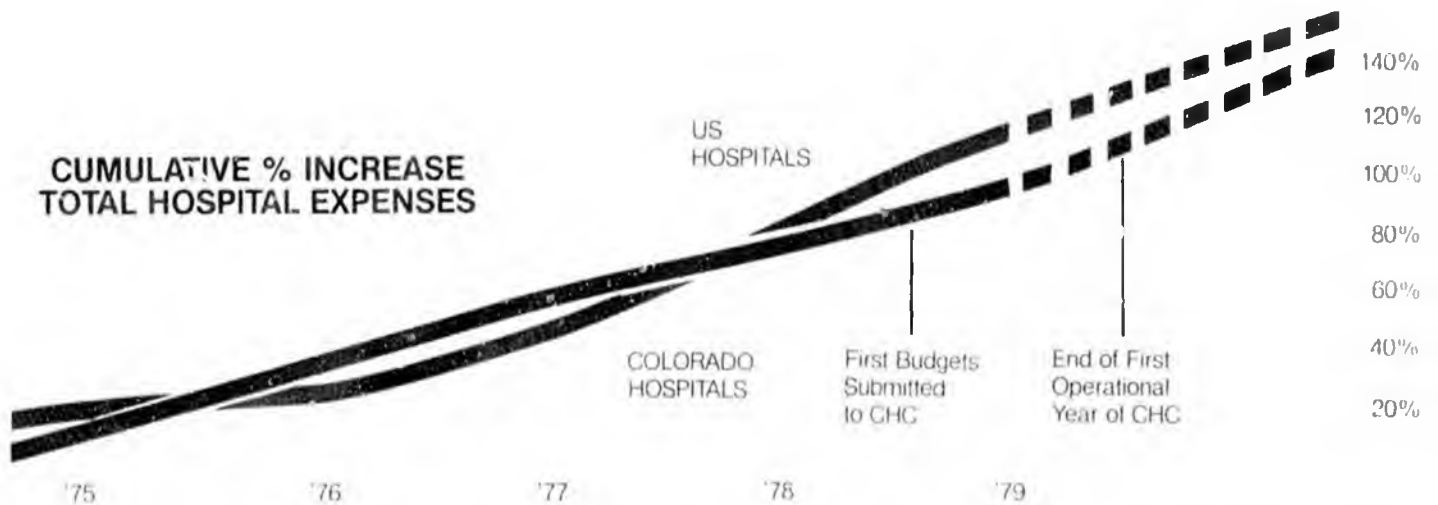
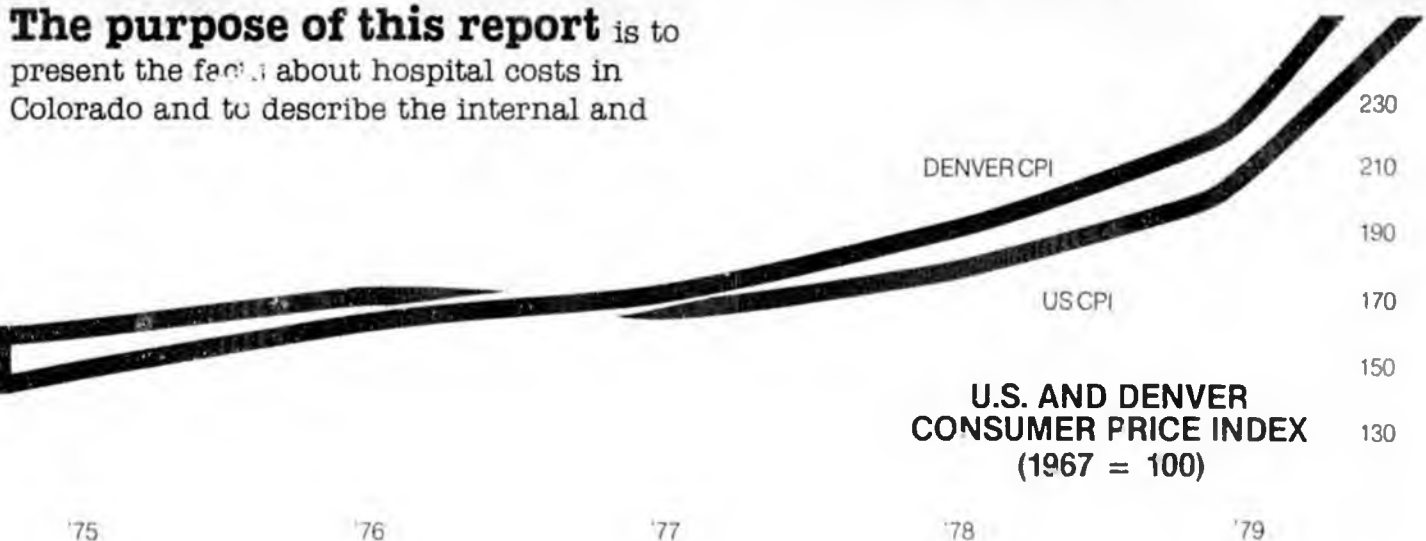


**6-49 Beds**

**45**



**The purpose of this report** is to present the facts about hospital costs in Colorado and to describe the internal and



Colorado hospitals are proud that our costs are 6.8% below the national average, even as Denver's CPI climbed to 8% above the national CPI. This leveling off trend in hospital expenses started a full two years before the Commission began reviewing budgets. During the period CHC has been in operation, costs in Colorado have closely paralleled the national average, indicating no measurable impact by the Commission.

external forces that have brought us to this point. We will trace the recent history of voluntary cost containment efforts and hospital cost regulation to provide the information needed to make decisions about the quality, cost and availability of health care in the 1980's. We will make the following points:

1. Other than general inflation, improved quality and availability of care is the main reason for the increase in hospital costs.
2. Colorado hospitals have led the effort to

contain health care costs long before the rush to regulation.

3. The responsibility and accountability of hospitals to their communities for the quality, cost and availability of health care must remain with the local representatives on Boards of Trustees.
4. The Colorado Hospital Commission failed, practically and philosophically.
5. Nationwide, the hospital industry's own "Voluntary Effort" to contain health care costs is working.

**Where it all started.** The first hospitals were charitable institutions where people went to die. Care was simple and mortality high. Health professionals, as we know them today, did not exist. The average "hospital" stay lasted several weeks and cost less than \$5 per day.

By the early 1900's scientifically-educated physicians and trained nurses were providing increasingly effective care, and some insurance companies were writing policies that covered hospital care. Most people, when they could afford to, were still paying their own hospital bills.

In the 1930's hospital reimbursement plans were introduced, providing hospitalization coverage for many patients who would have otherwise been unable to afford hospital care. After World War II, medical science gave us wonder drugs, new equipment and advanced surgical methods. Better quality medicine cost more, but insurance paid for more hospital care. With more people demanding hospital care, and with more effective treatments available, "reimbursement" from "third-party-payers" became more complex.

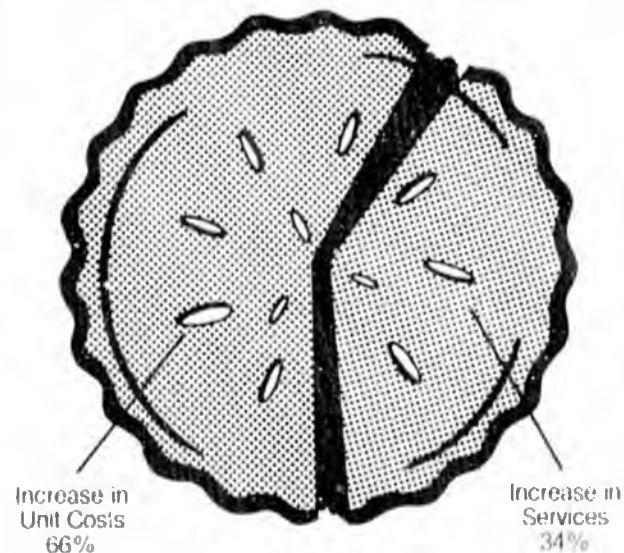
Under contracts with Blue Cross, hospitals were reimbursed based on **costs**, while other insurance carriers and private patients paid **charges**. Because insurers guaranteed prompt, full payment, hospitals allowed them discounts. Thus began a system of different levels of payment for the same service. Cost-based reimbursement system provided no incentive for holding down costs since hospitals and physicians were paid retrospectively for whatever they spent.

In fact, these cost-based payment mechanisms were used in Medicare and Medicaid programs to encourage growth and spending as a means of promoting wider availability and improved quality of health care.

In 50 years the effectiveness of medical treatment grew, the availability of services grew, the demand for health care grew and so did costs. Everything grew and everyone called it progress.

**Why costs went up.** With the advent of the government insurance programs, Medicare and Medicaid, in the mid-1960's, the rise in health care costs began to exceed general inflation. The causes can be grouped into four broad categories:

### The Causes of Hospital Expense Increases



$$\text{Total Hospital Expenses} = \text{Unit Costs} \times \text{Growth}$$

- |   |  |
|---|--|
| <input type="checkbox"/> Labor Costs                        | <input type="checkbox"/> Population Growth     |
| <input type="checkbox"/> Prices of Goods Hospitals Purchase | <input type="checkbox"/> Aging Population      |
| <input type="checkbox"/> Capital Expenditures               | <input type="checkbox"/> Technology            |
| <input type="checkbox"/> Expanded Regulations               | <input type="checkbox"/> Expansion of Coverage |
| <input type="checkbox"/> Quality Changes                    | <input type="checkbox"/> Government Programs   |
|   | <input type="checkbox"/> Private Insurance     |
|   | <input type="checkbox"/> Growth of Real Income |
|   | <input type="checkbox"/> Specialization        |

External factors, ranging from inflation to increased demand for services, have greatly contributed to the increase in hospital expenses.

- Increased demand for services
- General inflation
- Government regulation
- More effective care

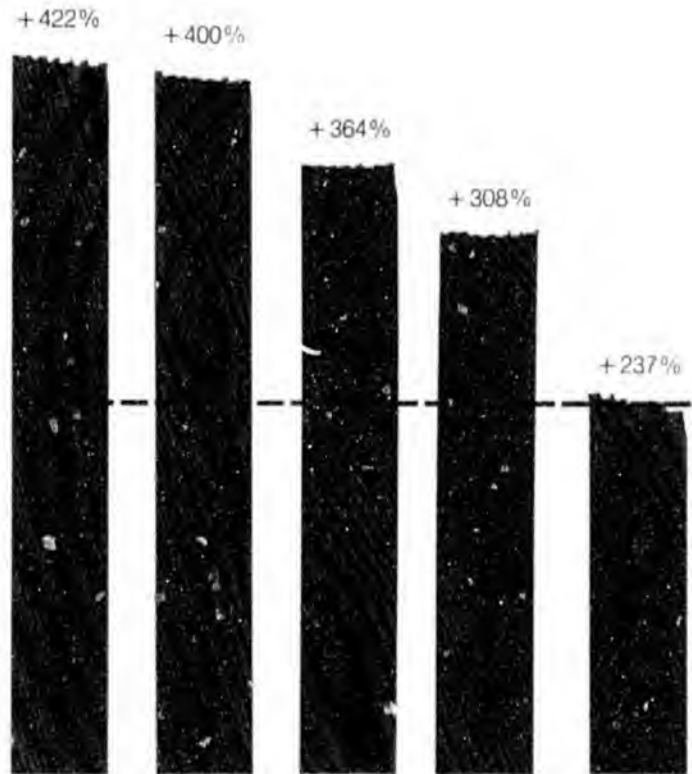
**Demand** created an intensive period of growth for the whole health industry. One third of the total increase in hospital costs is due to increased demand for services. In 1955, America's hospitals admitted 21 million patients — in 1975, 36 million. In the same period outpatient visits increased from 126 million to 255 million annually. Under Hill-Burton financing, the federal government encouraged communities to build or renovate 60 hospitals in Colorado. More people, with greater access to health care and more comprehensive insurance coverage, demanded more hospital services.

Simple **inflation** accounts for more than 50% of the increases in hospital costs. Supplies, services and staff cost more each year. Malpractice insurance rates have risen 450% over the last 5 years. Salaries and benefits (60% of total hospital expenditures) have increased rapidly to catch up with other industries.



**Regulation**, bureaucracy and "red tape" have added significantly to the cost of health care. In the last 15 years, Medicare, Medicaid, EEOC, NLRB, OSHA and Fair Labor Practices contributed to rising expenses. A New York study identified 164 agencies regulating hospitals. Compliance with these regulations costs \$40 per patient day. The list on page 10 shows the agencies and regulations that affect hospitals in Colorado. Last year HEW alone issued almost 600 new or proposed health-related

regulations. At the same time the Colorado Hospital Commission was requiring hospitals to submit up to 100 pages of budget information.



Hospital care is more effective, more available and of higher quality than ten years ago, yet the cost of the average hospital stay has not increased nearly as much as the cost of government

Rising hospital costs also reflect more **effective care** resulting from new treatments and technology. Because these improvements cure diseases, save lives and speed recovery, hospital care today cannot be realistically compared to 50, 25 or even 10 years ago. Intensive care units save 100,000 lives a year. The heart attack recovery rate has gone from under 50% in 1946 to over 85% today. Twenty-five years ago x-ray therapy, chemotherapy, hemodialysis and many orthopedic and

surgical procedures did not even exist. Health care costs more today than it did in 1940, but during that same period, life expectancy rose from age 63 to 72½ years.

In the 1960's the Great Society could afford guns, butter and men on the moon. Health care quality and availability increased substantially and no one counted costs. In the 1970's, the nation's outlook shifted to conservation, accountability and allocation of scarce resources. The last ten years have given us tremendous medical advances and the highest quality of health care in the world.

### **What happened in Colorado.**

Early in the 1970's, Colorado hospitals became increasingly involved in cost containment measures. Hospital management introduced more effective systems and developed a wide range of cooperative programs, such as group purchasing, combined data processing and other shared services. Colorado hospitals also became more involved in the legislative process, developing the 1973 prospective reimbursement legislation. This law created a pilot project which successfully demonstrated the cost savings incentives of a prospective payment system and provided a basis for developing a uniform accounting and reporting system. In 1975 and 1976 the Colorado legislature considered hospital rate review systems, but ultimately rejected them. Colorado hospitals actively opposed these early measures because they were poorly drafted and certain to undermine the quality and availability of health care.

By 1977, several hospital cost containment bills had been proposed nationally. However, Colorado hospitals were already working with former State Representative Frank Traylor (R-Jefferson Co.) to draft a bill for Colorado that would

address issues without sacrificing local control over the quality and availability of care. These efforts resulted in HB 1582, which a majority of Colorado hospitals supported. The act provided for three commissioners to prospectively review



hospital budgets, to approve the level of charges for each institution, and to provide for more equitable payment by all third-party-payors. HB 1582 was signed into law in July, 1977, and the Colorado Hospital Commission began its work in October.

The optimism of both hospitals and legislators was ultimately proved wrong. Within one year it became clear to many legislators that the Commission had become a perfect example of ill-advised, bureaucracy-ridden rules and regulations. Frustration with this system finally prompted legislators to seek repeal of the Commission. The legislation (SB-38) was introduced in January, 1979, by Colorado Senate President Fred Anderson (R-Loveland), one of the original sponsors of HB 1582.

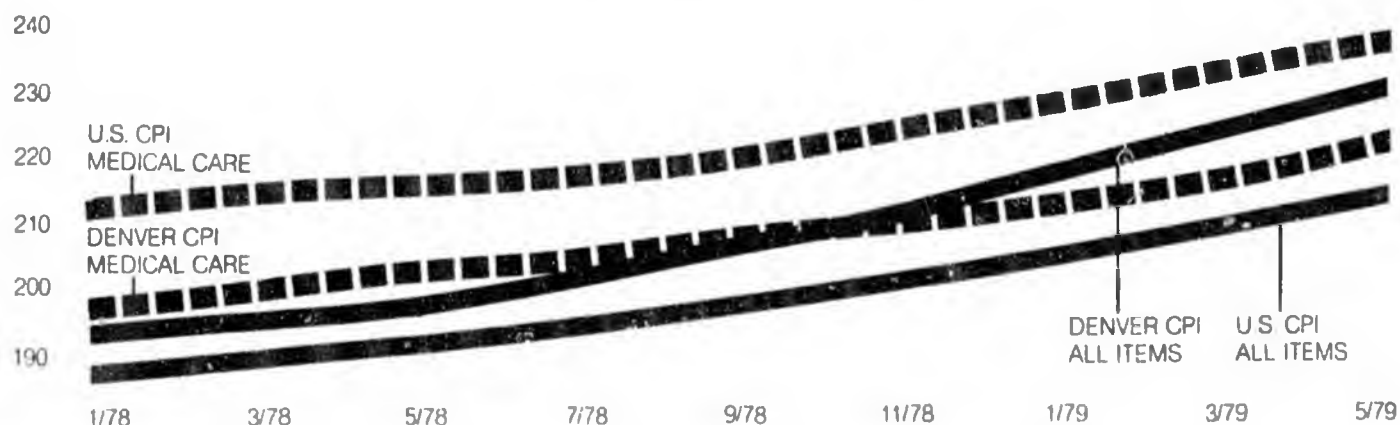
Hospitals did not initiate the effort to repeal the Commission. Over a full year they had met with the commissioners frequently to suggest constructive changes to make the system work. When these efforts finally proved fruitless, hospitals supported the effort to repeal. Third-party-payors, the Governor's office and several consumer groups opposed the repeal measure. The Senate passed SB-38 quickly by a 2/3 majority. At the request of the Governor, the House added amendments postponing the repeal date to March, 1980, and giving the Governor discretionary power to remove the commissioners. The amended version of SB-38 was passed and signed by the Governor on May 18, 1979, repealing the statute that had created the Colorado Hospital Commission, effective March 1, 1980.

**Why the hospital commission failed.** The primary problem with the Colorado Hospital Commission was bureaucracy. From the very beginning, the

Commission was counter-productive. It got off to a slow, disorganized start, fell behind and never caught up. It created frustrations by adopting an adversary stance and compounded it with legalistic procedures and arbitrary decisions.

- On the key issue of financial requirements for hospitals, the Commission seemed to act contrary to the intent of the legislation. The rules developed by the Commission allowed for no growth and development funds for hospitals to modernize and replace equipment in the future. Because of Commission actions, some hospitals had to use financial reserves for current operations.
- The Commission's budget review process concentrated on forms — over 40 pages of them. The forms, taken directly from the Maryland rate review system, were complicated, often not applicable, sometimes misleading and occasionally illegible. In some instances the Commission required accounting contrary to generally accepted practice in the hospital industry.
- Rule-making sessions often altered the intent of the law, especially on the issue of payment differentials for third-party-payors. The law decreed that they must be "quantified" to be allowed. No quantification took place.
- The Commission hearings were adversarial and this negative environment discouraged the resolution of substantive issues.
- The Commission created so much paperwork that both hospitals and the Commission staff staggered under the weight.
- After two years of operation, the Commission still had not defined what constituted compliance, nor had it put

## U.S./DENVER MEDICAL CARE COSTS



Since January, 1978, the medical care component of the CPI is up 11.9% nationally and 11.5% in Denver. The gap has remained roughly the same, indicating no measurable impact by the Colorado Hospital Commission. The overall Denver CPI increased substantially compared to the rest of the nation.

into place the uniform accounting system the law required.

- Overall, the Commission did little to reduce expenditures, especially when the direct and indirect costs of compliance are calculated.

In the Commission's Report to the Governor, three different methods are used for measuring effectiveness. The three justifications show savings of \$28 million, \$18 million or \$9 million, depending on the method of computation. Detailed examination of the \$28 million, the \$18 million and the \$9 million figures reveals basic fallacies in the arguments and supporting data.

The data available on actual hospital costs shows that Colorado continues to parallel the national trend. The graph on page 3 shows the comparison between Colorado and the rest of the nation for total hospital expenses. The graph above shows the comparison between medical care costs

in Denver and the rest of the nation, measured by the Consumer Price Index. Costs began leveling off before the Commission came into being and have shown no measurable deviation from the national (non-regulated) trend since the Commission completed its first cycle of budget reviews.

### **\$28 MILLION?**

The Commission uses CPI figures to claim that \$28 million was saved as the rate of increase of the Denver CPI medical care cost component dropped below the overall Denver CPI. The graph above shows that medical costs in Colorado have followed the national trend, while the overall Denver CPI has escalated considerably.

### **\$18 MILLION?**

The Commission uses rate of increase data from several sources to claim \$18 million in savings as the difference between

the level of approved budgets in Colorado and the target of the national Voluntary Effort. Aside from having the wrong data and attempting to compare apples and avocados, review of the actual expenses (shown in graph on page 3) shows no deviation from the national trend.

### **\$9.8 MILLION?**

The Commission cites \$9.8 million removed from budget submissions as savings, but over \$6.3 million of that was in requests for growth and development. The rules on these other financial requirements have since been changed to effectively eliminate the \$6.3 million "saved."

### **No substantial evidence exists to show that the Commission saved any money.**

Comparisons between Colorado and non-regulated states indicate conformance to the national trend.

The Colorado Hospital Commission failed. On the practical level, it was not worth the paperwork, the bureaucracy and the estimated \$1.8 million cost of compliance. Philosophically, it removed the responsibility and accountability from the locally appointed/elected Boards of Trustees, who should be making the community decisions on the quality, cost and availability of health care.

### **Where do we go from here: local board responsibility.**

Among the nine states that have regulated hospital costs, Colorado is the first to repeal a hospital rate review system. This happened two years after the Commission had been voted in with the support of Colorado hospitals. Other states, federal bureaucrats and congressional leaders are watching to see what happens next.

Now that the Legislature has passed SB-38 repealing the Colorado Hospital Commission, Colorado has an opportunity to show that local control, accountability and responsible management can work. Hospital Boards have the authority and the will to make a voluntary approach to cost containment work without undermining the quality and availability of health care in their communities. Certainly local Trustees, elected or appointed from the community, can better judge what the local hospital should provide than governmental bureaucrats in distant capitols.

To assist local hospital Boards, Colorado hospitals are now implementing **Initiative**, a program to monitor, analyze and report health care costs. This system will provide comprehensive management information to individual hospital Boards, and comparative data on similar-sized hospitals, regionally and nationally. Aggregate data on all participating hospitals in Colorado will be compiled quarterly through the Colorado Hospital Association. In coordination with the Colorado Voluntary Effort, this statewide data with national and regional comparisons will provide the public with the facts on health care costs in Colorado. A sample of this quarterly report is on page 10.

Regulatory and bureaucratic efforts to contain hospital costs have failed. The voluntary approach is working nationwide. A reporting system for hospitals that can assist local Boards of Trustees as a management tool and provide the public with aggregate data is the best way to contain costs while preserving local control over the quality and availability of health care in Colorado.

Colorado hospitals fully support the intent of SB-38 as passed by the legislature and signed by the Governor.

# Regulation in Colorado: A partial list

# SAMPLE: Initiative Report

Sample  
Quarter '79

## Federal Legislation

National Health Planning and Development Act  
Public Health Services Act  
Health Manpower Shortage Areas  
Health Manpower Training Act  
Nurse Training Act  
Hill-Burton Act  
Medicare  
Medicaid  
Social Security Amendments of 1972  
Equal Employment Opportunity Act  
Unemployment Compensation  
Workmen's Compensation  
Fair Labor Standards Act  
Occupational Safety and Health Act  
Equal Credit Opportunity Act  
Uniform Anatomical Gift Act  
Sherman Anti-Trust Act  
Federal Record Keeping Requirements

## Colorado Legislation

Colorado Certificate of Public Necessity  
Colorado Hospital Budgetary Review  
Health Facility Licensure Requirements  
Colorado Health Facility Standards  
Health Professional Licensure Requirements  
Colorado Occupational Safety and Health Act  
State Wage Orders  
Colorado Medical Records Access  
Colorado Patient Grievance Mechanism

## Federal Agencies

Department of Health, Education and Welfare  
Social Security Administration  
Health Care Financing Administration  
Public Health Service  
Emergency Medical Services  
Division of Alcohol, Drug Abuse and Mental Health  
Food and Drug Administration  
Division of Health Resources  
Civil Rights  
Equal Employment Opportunity Office  
Department of Labor  
Department of Justice  
Immigration and Naturalization Service  
Drug Enforcement Administration  
Atomic Energy Commission  
Environmental Protection Agency  
Department of Interior  
Bureau of Indian Affairs  
Consumer Product Safety Commission  
Department of Transportation  
Highway Safety Administration  
Internal Revenue Service  
Federal Communications Commission  
Federal Trade Commission  
Occupational Safety and Health Administration  
Veterans Administration  
Treasury Department  
Bureau of Alcohol, Tobacco and Firearms

## Colorado Agencies

Department of Social Services  
Department of Local Affairs  
Department of Labor and Employment  
Civil Rights Commission  
Colorado Health Care Financing Authority  
Department of Regulatory Agencies  
Colorado Hospital Commission  
Insurance Commission

|  |         |
|--|---------|
| Cost Per Stay (Adj.)                           | 1400.89 |
| Cost Per Patient Day (Adj.)                    | 232.66  |
| Gross Revenue Per Adj. Patient Day             | 246.80  |
| Medical & Surgical Nursing Units — % Occupancy | 63.2    |
| — Average Length of Stay                       | 6.4     |
| — Nursing Paid Hours Per Patient Day           | 7.27    |
| — % RN s in Nursing Service                    | 45.1    |
| Total Hospital Paid Hours Per Adj. Patient Day | 24.63   |
| — Salary Per Adj. Patient Day                  | 142.76  |
| — Non-Salary Expense Per Adj. Patient Day      | 88.55   |
| — Housekeeping Hours Per 1,000 Sq. Ft.         | 38.64   |
| Laundry Hours Per 100 Lbs                      | 3.75    |
| Days of Net Revenue in Accounts Receivable     | 66.61   |
| Total Number of Beds                           | 12,380  |
| Hospitals Reporting                            | 89      |

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Board of Medical Examiners  
Board of Pharmacy  
Practical Nurse Board  
Board of Nursing  
Board of Physical Therapy  
Department of Health  
Health Facilities Review Council  
Board of Health  
State Health Coordinating Council  
Emergency Medical Services  
Alcohol and Drug Abuse  
Medical Care Regulation and Development  
Licensing & Certification  
State Health Planning and Development Agency

## Local Government

Health Departments  
Zoning Commissions  
Land Use Commission  
Building Codes  
Fire and Safety Codes

| COLORADO<br>MEDIAN | MOUNTAIN STATES MEDIAN     |             |                       |                            | U.S. MEDIAN |                       |                            |
|--------------------|----------------------------|-------------|-----------------------|----------------------------|-------------|-----------------------|----------------------------|
|                    | Comparative<br>Quarter '78 | %<br>Change | Sample<br>Quarter '79 | Comparative<br>Quarter '78 | %<br>Change | Sample<br>Quarter '79 | Comparative<br>Quarter '78 |
| 1264.81            | 10.8                       | 1429.22     | 1274.19               | 12.2                       | 1465.95     | 1311.63               | 11.8                       |
| 197.63             | 17.7                       | 230.52      | 205.51                | 12.7                       | 195.46      | 172.58                | 13.3                       |
| 216.85             | 13.8                       | 244.54      | 216.99                | 12.7                       | 208.04      | 183.97                | 13.1                       |
| 63.4               | —                          | 59.7        | 60.8                  | -1.8                       | 71.3        | 70.4                  | 1.2                        |
| 6.4                | —                          | 6.2         | 6.2                   | —                          | 7.5         | 7.6                   | -1.3                       |
| 7.50               | -3.0                       | 8.05        | 8.00                  | .6                         | 7.25        | 7.24                  | —                          |
| 42.0               | 7.4                        | 39.7        | 37.3                  | 6.4                        | 35.1        | 34.1                  | 2.9                        |
| 24.75              | —                          | 24.87       | 24.44                 | —                          | 21.89       | 21.91                 | —                          |
| 121.28             | 17.1                       | 140.29      | 123.92                | 13.2                       | 113.49      | 101.18                | 12.2                       |
| 75.59              | 17.1                       | 88.43       | 80.16                 | 10.3                       | 80.90       | 70.33                 | 15.0                       |
| 35.03              | 10.3                       | 39.53       | 37.00                 | 6.8                        | 41.08       | 40.65                 | 1.1                        |
| 3.92               | -4.3                       | 3.80        | 3.91                  | -2.8                       | 3.25        | 3.35                  | -3.0                       |
| 68.15              | -2.2                       | 77.62       | 81.86                 | -5.2                       | 67.01       | 69.27                 | -3.3                       |
| 12,242             | 1.1                        | 51,520      | 50,739                | 1.5                        | 696,850     | 671,910               | 3.6                        |
| 88                 |                            | 397         | 391                   |                            | 3196        | 3196                  |                            |

### Quasi-Public/Voluntary Agencies

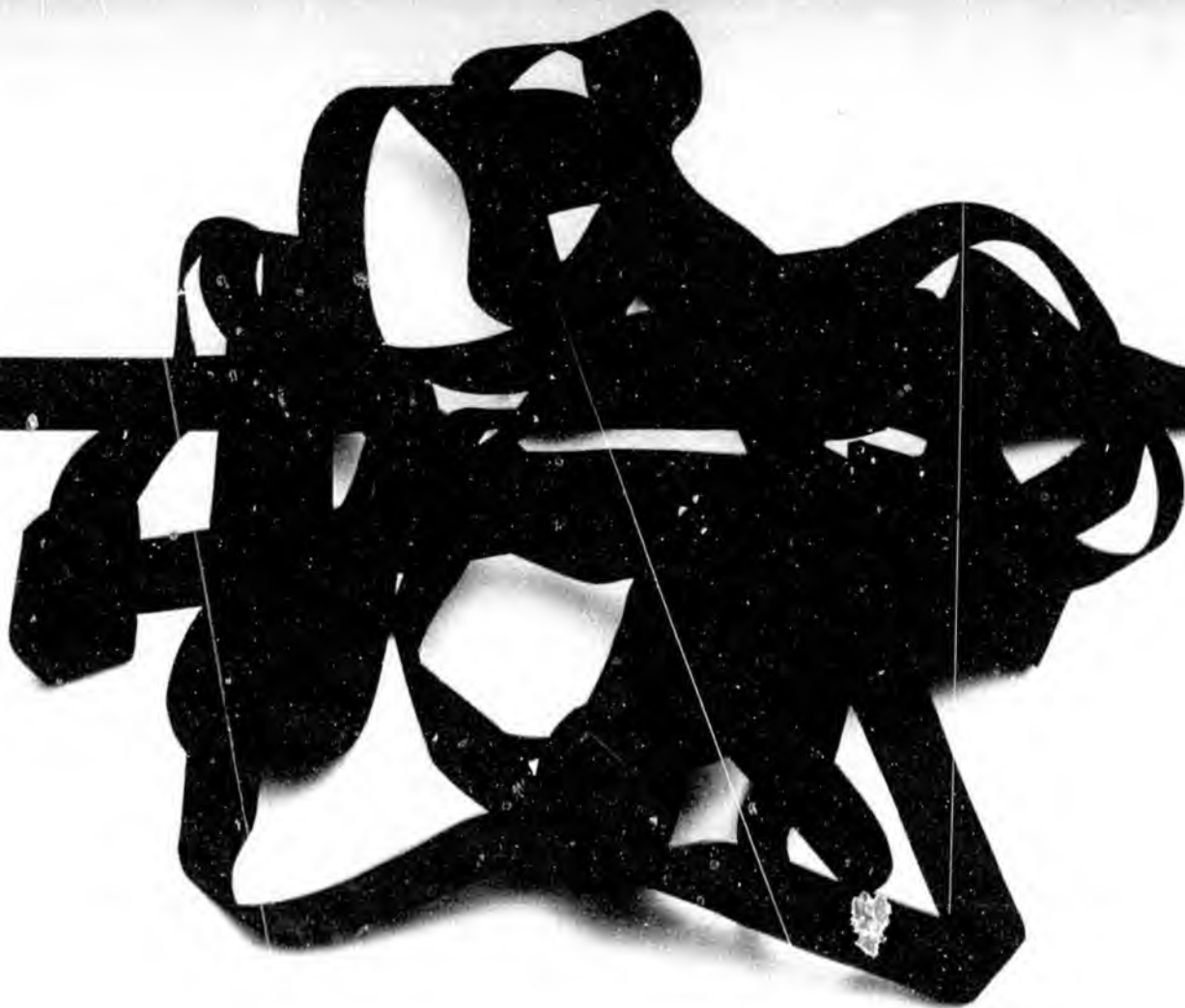
Joint Commission on Accreditation of Hospitals (JCAH)  
 American Osteopathic Association (accreditation)  
 Colorado Foundation for Medical Care  
 Professional Standards Review Organization  
 American Institute of Certified Public Accountants  
 Financial Accounting Standards Board  
 Cancer Registry of American College of Surgeons  
 Health Systems Agencies I, II, and III

### Sources for Statistical Data

Consumer Price Index (U.S. Dept. of Labor)  
 American Hospital Association National Panel Survey  
 Colorado Hospital Association  
 AHA/CHA Survey Sample  
 National Voluntary Effort to Contain Health Care Costs  
 Hospital Financial Management Association

### Background Reading on Hospital Rate Regulation

1. Maurice Moore, "Deregulation in Colorado: A Special Report," Review, (August 1979), 14-23.
2. Alain C. Enthoven, Ph.D., "Health Care Costs: Why Regulation Fails, Why Competition Works, How to Get There From Here," National Journal (May 26, 1979), 885-889.
3. Robert Austin Milch, M.D., "An Overview of the Economics of Health Care," World, (Autumn 1976), 30-35.
4. "Policy Brief Number 1, State Regulation of Hospital Expenses," American Hospital Association Office of Policy Studies (April 12, 1979), 1-9.
5. David Stockman, M.C., "The Administration's Case For 'Hospital Cost Containment': A Critical Analysis," Washington Memo, (May 16, 1979), 1-77.



**Member Hospitals in the Following Cities:**

|                |             |                  |            |             |                   |
|----------------|-------------|------------------|------------|-------------|-------------------|
| Akron          | Cortez      | Fort Collins     | Hugo       | Loveland    | Steamboat Springs |
| Alamosa        | Craig       | Fort Lyon        | Julesburg  | Meeker      | Sterling          |
| Aspen          | Del Norte   | Fort Morgan      | Kremmling  | Monte Vista | Trinidad          |
| Aurora         | Della       | Fruita           | La Jara    | Montrose    | USAF Academy      |
| Boulder        | Denver Area | Glenwood Springs | La Junta   | Pueblo      | Vail              |
| Brighton       | Durango     | Grand Junction   | Lakewood   | Rangley     | Waisenburg        |
| Brush          | Eads        | Greeley          | Lamar      | Rifle       | Walsh             |
| Burlington     | Englewood   | Gunnison         | Las Animas | Rocky Ford  | Wheat Ridge       |
| Canon City     | Estes Park  | Haxtun           | Leadville  | Salida      | Wray              |
| Cheyenne Wells | Fairplay    | Holyoke          | Longmont   | Springfield | Yuma              |
| Colo. Springs  | Florence    |                  |            |             |                   |



**COLORADO HOSPITAL ASSN.** 2140 South Holly, Denver, Colorado 80222 (303) 758-1630

# STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

POUCH H 01 - JUNEAU 99811

April 25, 1980

Document# 90-80

The Honorable Glenn Hackney  
Chairman, Senate HESS Committee  
Alaska State Legislature  
Pouch V  
Juneau, Alaska 99811

Dear Senator Hackney:

In the course of testimony on Senate Bill 312 - State Aid for Service Programs for the Benefit of Older Alaskans - the Committee requested that the Department provide a priority listing for additional state service dollars. The Committee asked that the list be based on broad categories of services in order to allow the proposed Older Alaskans Commission latitude in defining the specific services to be covered.

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Thank you for allowing us the opportunity to comment on the matter.

Sincerely,



Deborah E. Behr  
Special Assistant to  
the Commissioner

Enclosure

cc: Senator Frank Ferguson  
Senator Mike Colletta  
Senator Bettye Fahrenkamp  
Senator Arliss Sturgulewski  
Senator Pat Rodey  
Jim Kelly  
DHSS, Office on Aging

OFFICE ON AGING PRIORITIES FOR ADDITIONAL SERVICE DOLLARS

- April, 1980 -

| <u>Priority</u> | <u>Category of Service</u>   | <u>Examples</u>   |
|-----------------|--|---|
| 1               | Services to sustain more older persons in the least restrictive home environments                                      | Increased availability of homemaker and home health services; adult day care; home repair                         |
| 2               | Services to fill gaps in health care   | Purchase of hearing aids, eyeglasses, dentures; supplementary health screening and maintenance                    |
| 3               | Cost-effective alternatives to traditional nutrition service delivery methods  | Bush meal services; shopping services; native and ethnic foods services; special diet services                    |
| 4               | Services to provide economic stability   | Additional senior employment job slots; cottage industries  |
| 5               | Services to increase accessibility to other services   | More transportation; expanded and improved information and referral services; more out-reach; bush transportation |
| 6               | Services to upgrade the knowledge and skills of service deliverers to enable them to provide services more effectively | Service provider staff, board/council, volunteer training; circuit rider training                                 |
| 7               | Services to provide social stimulation and combat isolation  | More recreational and leisure-time services; visitor services; continuing education                               |
| 8               | Services to help older Alaskans receive public benefits to which they are entitled and resolve legal problems          | Legal assistance; public benefits counseling  |
| 9               | Services to extend lifetime productivity and promote feelings of usefulness  | Volunteer programs, such as foster grandparents; continuing education   |
| 10              | Counseling support   | Personal counseling; tax counseling; employment counseling  |

STATE OF ALASKA  
Interdepartmental Route Slip

|  |  |
|--|--|
| TO: Mail Station<br>3100               | Department<br>Legislature                                |
| Attention<br>Senator Ferguson          |  |
| <input type="checkbox"/> Approval      | <input type="checkbox"/> Note & Return                   |
| <input type="checkbox"/> Signature     | <input type="checkbox"/> Initial & Return                |
| <input type="checkbox"/> Comment       | <input type="checkbox"/> Return as Requested             |
| <input type="checkbox"/> Contact Me    | <input type="checkbox"/> Return for Approval             |
| <input type="checkbox"/> Prepare Reply | <input type="checkbox"/> Necessary Action                |
| <input type="checkbox"/> For Your File | <input checked="" type="checkbox"/> For Your Information |
| Remarks<br>Cap. Bldg. -<br>Rm 123      |  |
| FROM: Mail Station<br>01000            | Department<br>DNSS                                       |
| By<br>S. Rodriguez                     | Date<br>4/25/80  |

# STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

## DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

POUCH H 01 - JUNEAU 99811

April 25, 1980

Document# 90-80

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Special Assistant to  
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Enclosure

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Senator Mike Colletta  
Senator Bettye Fahrenkamp  
Senator Arliss Sturgulewski  
Senator Pat Rodey  
Jim Kelly  
DISS, Office on Aging

OFFICE ON AGING PRIORITIES FOR ADDITIONAL SERVICE DOLLARS

- April, 1980 -

| <u>Priority</u> | <u>Category of Service</u>   | <u>Examples</u>  |
|-----------------|--|--|
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| 2               | Services to fill gaps in health care   | Purchase of hearing aids, eyeglasses, dentures; supplementary health screening and maintenance                   |
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| 4               | Services to provide economic stability   | Additional senior employment job slots; cottage industries   |
| 5               | Services to increase accessibility to other services   | More transportation; expanded and improved information and referral services; more outreach; bush transportation |
| 6               | Services to upgrade the knowledge and skills of service deliverers to enable them to provide services more effectively | Service provider staff, board/council, volunteer training; circuit rider training                                |
| 7               | Services to provide social stimulation and combat isolation  | More recreational and leisure-time services; visitor services; continuing education                              |
| 8               | Services to help older Alaskans receive public benefits to which they are entitled and resolve legal problems          | Legal assistance; public benefits counseling   |
| 9               | Services to extend lifetime productivity and promote feelings of usefulness  | Volunteer programs, such as foster grandparents; continuing education  |
| 10              | Counseling support   | Personal counseling; tax counseling; employment counseling   |

STATE OF ALASKA  
Interdepartmental Route Slip

|  |                                  |
|--|----------------------------------|
| TO: Mail Station<br><i>3100</i>                          | Department<br><i>Legislature</i> |
| Attention<br><i>Senator Fabrikant</i>                    |                                  |
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| Remarks:<br><i>Assembly Bldg.<br/>Room 300</i>           |                                  |
| FROM: Mail Station<br><i>0600</i>                        | Department<br><i>DNSS</i>        |
| By<br><i>L Rodriguez</i>                                 | Date<br><i>4/25/80</i>           |

02-002 (Rev. 2/80)

# STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

## DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

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April 25, 1980

Document# 90-80

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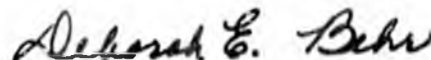
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DISS, Office on Aging

OFFICE ON AGING PRIORITIES FOR ADDITIONAL SERVICE DOLLARS

- April, 1980 -

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STATE OF ALASKA  
Interdepartmental Route Slip

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|--|--|
| TO: Mail Station<br><i>3100</i>          | Department<br><i>Legislature</i>                         |
| Attention<br><i>Senator Colletta</i>     |  |
| <input type="checkbox"/> Approval        | <input type="checkbox"/> Note & Return                   |
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| <input type="checkbox"/> For Your File   | <input checked="" type="checkbox"/> For Your Information |
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| FROM: Mail Station<br><i>0100</i>        | Department<br><i>DNSS</i>                                |
| By<br><i>L. Rodriguez</i>                | Date<br><i>4/25/81</i>                                   |

02-002 (rev. 2/80)

# STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

## DEPT. OF HEALTH AND SOCIAL SERVICES

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POUCH H 91 - JUNEAU 99811

April 25, 1980

Document# 90-80

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Alaska State Legislature  
Pouch V  
Juneau, Alaska 99811

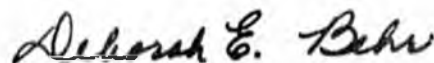
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| Attention<br><i>Senator Sturgulewski</i>                 |                                  |
| <input type="checkbox"/> Approval                        |                                  |
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| FROM: Mail Station<br><i>0600</i>                        | Department<br><i>DHSS</i>        |
| By<br><i>LA Rodriguez</i>                                | Date<br><i>4/25/80</i>           |

02-002 (Rev. 2/80)

# STATE OF ALASKA

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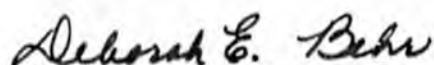
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DAW HUMPHREY - CPA - SEATTLE  
West Vir. / S. Carolina has set up program  
for those two states  
of reactions patents are as much care as  
more severely disabled co operative patients,  
Rate setting Commission or other entity.

Chris Beardsley  
oppose - at this time

Providence & Remorsement Co.

Chris Beussley left this  
memo for you. SB 322

3-19-80  
2:05 P.M.

Senator Hackney:

The Alaska State Hospital Assoc. met this morning AND passed a motion relating to suggested language you could use for a Committee substitute for SB 372 (no. to prospective rate setting for Medicaid/Medicare eligible patients). It was unanimously endorsed by all members including the long term care people.

A typed up version of this language will be submitted to you as soon as we can get it to you (probably within a couple of weeks).

A skeleton outline of the language includes:

- ① A 2 1/2 year study Commission

- ② Commission membership qualifications will be outlined.

- ③ although it may not be noted, the intent ~~is~~ <sup>probably</sup> would be to have the Commission be appointed by the Governor.

- ④ A suggested funding amount will be indicated (for per diem, transportation, making up of a report and hiring a consultant), however, we would appreciate your guidance and suggestions as to whether the amount is too little or too much.

Thank you for your help & guidance, and should you have any questions, please call me or Al Camosso. Chris Beardsley

DRAFT

IN THE LEGISLATURE OF THE STATE OF ALASKA ELEVENTH LEGISLATURE - SECOND SESSION.

For an Act entitled: "An Act relating to nursing home care for elderly persons."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

\* Section \_\_. AS 47.25.301

Sec. 47.25.301. PURPOSE. It is declared as a matter of public concern that elderly persons in this state receive necessary quality nursing home care that they need. Certain elderly persons on fixed or low-income have been denied access to care because of the inability to pay.

Sec. 47.25.302. ELIGIBLE PERSONS. All residents of the state who are 65 years or older and determined to be needy based on regulations adopted by the department are eligible to receive assistance under this chapter. Eligibility shall be reviewed by the department as frequently as considered necessary.

Sec. 47.25.303. <sup>NURSING HOME CARE</sup> MEDICAL ASSISTANCE PAYMENTS. The payment and the length of time for which a <sup>NURSING HOME CARE</sup> medical assistance payment is granted are left to the discretion of the commissioner and may vary from a small sum to an amount not exceeding the existing rate paid under 47.07.010-.080. The commissioner may require the patient and the family to contribute to the cost of care.

~~Sec. 47.25.304. MEDICAL SERVICES TO BE PROVIDED. Medical ser-~~  
Sec. 47.25.304. MEDICAL SERVICES TO BE PROVIDED. Medical ~~services to be offered to eligible persons include skilled and inte-~~ services to be offered to eligible persons include skilled and intermediate nursing home care. <sup>ONLY</sup>

Sec. 47.25.305. REIMBURSEMENT OF PROVIDERS. According to the provisions of this chapter, the department of health and social services shall reimburse providers of medical care for allowable unpaid costs of skilled or intermediate nursing home care.

Sec. 47.25.306. CALCULATION OF THE PATIENT'S SHARE. (a) The department shall <sup>adjust</sup> ~~adjust~~, by regulation, <sup>a</sup> formula to determine the

VENDOR PAYMENTS

<sup>nursing home</sup>  
patient's share of institutional care expenses, based on the applicant's annual gross income, number of dependents, amount of assets, and forthcoming third-party payments.

(b) In applying the formula to determine the applicant's share, the total gross income and the total assets of the family of the applicant may be taken into account with the following exceptions:

- (1) the applicant's permanent place of abode;
- (2) one noncommercial vehicle;
- (3) tools, equipment, vehicles and other assets required in a trade of business;
- (4) ordinary household and personal effects;
- (5) \$1,000 of liquid assets;
- (6) all nonliquid assets unless such an exclusion would bring about an inequitable result; however, all income derived from such property shall be taken into consideration in determining the recipient's gross income;
- (7) inalienable shares in a Native corporation created under the Alaska Native Claims Settlement Act, P.L. 92-203; 43 U.S.C. § 1601 et seq., for the period of their inalienability as specified in the Act;
- (8) Alaska longevity bonus payments;
- (9) any other assets specifically restricted for the use of the recipient by state or federal law;
- (10) assets received by the applicant as a custodian, guardian, conservator, or trustee for another are not considered assets of the custodian, guardian, conservator, or trustee himself.

Sec. 47.25.307. OBTAINING ASSISTANCE BY FRAUD. A person is guilty of a violation of AS 47.25.120 - 47.25.300 if he (1) by a statement, representation, or impersonation which he knows is false or by another fraudulent device, obtains or attempts to obtain or aids or abets another to obtain (A) assistance to which he is not entitled, (B) greater assistance than he is entitled to, or (C) payment of a forfeited ~~grant or~~ allowance; (2) aids and abets in buying or otherwise disposing of the property of the recipient of assistance for the

**DRAFT**

purpose of avoiding liability for the assistance granted; or (3) gives false or incorrect information, knowing it to be false or incorrect, as part of the procedure to obtain assistance, even if he does not actually obtain or use the assistance.

Sec. 47.25.308. PENALTY FOR VIOLATION. A person who violates a provision of AS 47.25.120 - 47.25.300 is guilty of a misdemeanor, and upon conviction is punishable by a fine of not more than \$1,000, or by imprisonment for not more than one year, or by both.

Sec. 47.25.309. DEFINITIONS. In this chapter (1) "applicant" means a person <sup>WHO IS IN NEED OF NURSING HOME CARE</sup> ~~to have suffered a catastrophic illness~~ and is applying for assistance in this chapter or is the subject of an application for assistance under this chapter;

(2) "commissioner" means the commissioner of the department of health and social services;

(3) "department" means the department of health and social services;

(4) "family" means two or more persons related by blood or marriage or adoption living as one economic unit;

(5) "liquid assets" means assets which can be readily converted to cash;

(6) "nonliquid assets" means all assets which are not liquid assets;

(7) "permanent place of abode" means a dwelling, or a dwelling unit in a multiple dwelling, including lots and out-buildings or an appropriate portion of these, which are necessary to convenient use of the dwelling unit;

(8) "provider" means a licensed hospital, <sup>licensed</sup> skilled nursing home, or <sup>licensed</sup> intermediate care facility, ~~providing skilled or intermediate care needs which has provided services not excluded by AS 47.08.050 to an applicant.~~ ✓

(9) "third-party payments" means payments of medical expenses related ~~to a catastrophic illness~~ by sources other than <sup>the nursing home care</sup>

**DRAFT**

*in chapter.*  
the applicant or the ~~committee~~, including but not limited to  
state and federal medical assistance programs, private health  
insurance, employment-related health insurance, military health  
insurance, workmen's compensation, violent crimes compensation,  
Indian Health Service of the United State Department of Health,  
Education, and Welfare, and awards in legal actions.

**DRAFT**

SB322 *Prospective Reimbursement*

The hospitals don't want this bill --- Nursing homes do.

*Good IDEA* Rod Betit explained line 13 mentioned in position paper. Hospitals & etc. use <sup>of</sup> the words intermediate and skilled- by adding "skilled we spell it out for them. He further mentioned that you had stated you might favor a CS and eliminate hospitals?????? Max Kersbergen, executive director of Alaska State Hospital Assn. along with members thereof will be in Juneau March 17th, 18th and 19th. They have left their afternoons open should you schedule this bill on any of days mention ed..

Let me know that I can advise them.

*M.*

Last meeting we had on this bill was Jan. 28th at which time we also had SB 320, SB321 and the minutes reveal that YOU said quote "We are treating these three bills more or less in the same package. Actually the first two are, I think it's safe to say, and either/or type of situation. Either we take one concept or the other. One being that the State of Alaska pays and the other being that the federal government pays half the money. I think that that's something we are going to have to work out philosophically as to whether we think it's worth the \$500,000 or whatever to get the federal government involved.."

Our agenda reveals SB 320 and SB321 scheduled for March 17th. Do you wan't to add SB322 inasmuch as Alaska State Hospital Association will be here. March 17th is a Monday, the 19th is a Wednesday and these members will still be here in Juneau sooooo you have your choice as to whether you desire to have 3 bills of this type on one day or hold SB322 until Wed. the 19th.

INTRODUCTION OF BILLS (Senate)(cont'd)

Medicaid Reimbursable Payments SENATE BILL NO. 322, by the Rules Committee by request of the Legislative Council (for the Interim Committee on Services for the Elderly. Repeals and re-enacts AS 47.07.070 regarding medicaid reimbursable payments to providers of health care. States payments to institutions for medicaid-eligible persons shall be made on the basis of a "prospective determination of fair rates for the reasonable costs of services rendered...." Provides Act effective July 1, 1980.

Introduced January 15 and referred to HE&SS and Finance.



# ALASKA STATE HOSPITAL ASSOCIATION INC.

5401 CORDOVA STREET  
PHONE: 277-1633

ANCHORAGE, ALASKA 99503

*Mary - file SB322  
note - file SB322* (4)

February 26, 1980

Senator Glenn Hackney  
Chairman - Health, Education, and  
Social Services Committee  
Alaska State Legislature  
Pouch V  
Juneau, Alaska 99811

Dear Senator Hackney:

I am writing to indicate an opportunity for the Alaska State Hospital Association members to provide direct testimony on S.B. 322, during the spring meeting scheduled in Juneau on March 17-19. We have left our afternoons open for legislative availability, therefore, if your committee has questions or wished to have direct provider input we would gladly make any necessary arrangements.

You already have our position paper, however, we would offer still further testimony if you feel it would be meaningful.

Sincerely,

Max Kersbergen  
Executive Director

# CARE

P.O. Box 3-488  
2200 E. 42ND AVE. • ANCHORAGE, ALASKA 99501

January 28, 1980

The Senator Glen Hackney  
Chairman- Health, Education, and  
Social Services Committee  
Alaska State Legislature  
Pouch U  
Juneau, Alaska 99811

Re: Testimony for Committee Hearings  
January 28, 1980  
Senate Bills 320, 321, & 322

Dear Senator Hackney:

SB 320 and SB 321

The "medically needy" of the State of Alaska are in great need of the relief that these two bills would provide by broadening income standards. We see, on a frequent basis, dignity being destroyed and families broken as individuals slightly over-income attempt to cope with the increasing costs of catastrophic illness. Legislation providing for the financial gaps in health care has long been needed. We commend the Interim Committee on Services on the Elderly for identifying this as a priority need.

SB 322

We wish to express our strong support for the concept of payment to certain institutions and agencies for Medicaid-eligible persons on the basis of prospectively determined rates. We believe that a "prospective rate" system in the State of Alaska would greatly enhance the quality of care available for a cost-effective dollar. The consequences of this bill are far reaching and of a major importance to the future of health care in this state. Detailed comments on this proposed legislation will be provided to you in the near future. I regret that this is not available to you at this time, but we do want to provide you with accurate and careful consideration on the details of this bill, while at this time expressing our firm conviction that "prospective rates" can be an appropriate solution to a crucial problem.

Respectfully yours,

HEALTH CARE SERVICES - ALASKA, INC.

*Donna M. Stephens*  
Donna M. Stephens, Administrator  
Careage House & Nakoyia Health Care Centers

*Dick Wilson*  
Dick Wilson, Administrator  
Careage North Health Care Center

DMS:DW:mlc

DRAFT  
POSITION PAPER  
ON  
SENATE BILL 322  
HOUSE BILL 612

"An Act authorizing payment for services provided by certain institutions and agencies to Medicaid-eligible persons on the basis of prospectively determined rates; and providing for an effective date."

Senate Bill 322 and House Bill 612 would require that Medicaid reimbursement for services provided by hospitals, long term care facilities, and home health agencies be based on a prospective determination of reimbursement.

Under the present State and Federal statutory language, such reimbursement is permissive.

The Department of Health and Social Services supports the concept of prospective determination of reimbursement. Major benefits of such a program are:

- Could be either prospective/retro*
- Also prospective*
- 1.) Standardization of Health facilities Reporting and Budgeting.
  - 2.) Centralization of hospital operational data.
  - 3.) Reimbursement based on budgeted costs instead of historical cost settlements.
  - 4.) Concurrent communication between the Department and health facilities manager.
  - 5.) Billing and Payment simplification based on pre-negotiated reimbursement.

While Senate Bill 322 or House Bill 612 would authorize, if passed, a prospective reimbursement system, however, it does not provide for the implementation of a Uniform Reporting Budgeting System which is paramount to the development of an efficient prospective reimbursement system.

After a historical review of prospective reimbursement programs, in other states, it was determined that prospective reimbursement requires basic provider education, technically qualified experienced staffing, and a systematic approach to operations.

Historical review also shows that it takes approximately two-three years to develop an effective uniform data base which provides for informed decisions in determining reimbursement.

In accordance with our agreement with the Senate Health Education Social Services committee hearing on January 28, 1980, the following alternative proposal to Senate Bill 322 has been developed.

The development of these alternatives have been in consultation with the Alaska State Hospital Association and Long Term Care Division, Health Service, Incorporated, a Proprietary Nursing Home Corporation in Alaska, and the Department of Health and Social Services.

Alternative #1: Tableing of both bills and the passage following resolution:

BE IT RESOLVED BY THE SENATE:

WHEREAS; The current systems for the payment of services provided by health facilities have become cumbersome, and unnecessarily complicated, and

WHEREAS; The cost of providing care has increased due to the administrative support involved in maintaining these systems, and

WHEREAS; The State costs for monitoring and administering these cumbersome and complicated systems has increased, and

WHEREAS; The Alaska Legislature, State of Alaska, and the Health Care Industry wishes to limit escalating costs for non-patient related services, and

WHEREAS; A State and Federally approved system for Health Facility Uniform Reporting and Budgeting (S.U.R ) would provide a solution, and

WHEREAS; a uniform system of prospective rate negotiation and reimbursement would assist in reducing non-patient service costs; therefore

BE IT RESOLVED that the Alaska Legislature provide funding for the establishment of an Alaska System for Health Facilities Uniform Reporting and Budgeting using the National Manual on Systems for Uniform Reporting as a guide, and

FURTHER RESOLVED that this system, once developed be accepted by the Federal government and State of Alaska as the system for all health facilities in the State of Alaska; and

FURTHER RESOLVED that the Alaska Legislature establish and fund a committee composed of representatives from the State Department of Health and Social Services, U.S. Department of Health and Welfare, and Alaska State Hospital Association, and Long Term Care Division to develop proposed legislation which would establish a uniform system for prospective rate negotiation and reimbursement in the State of Alaska, and

# Fairbanks Memorial Hospital

1650 Cowles St.

FAIRBANKS, ALASKA 99701

OPERATED BY  
LUTHERAN HOSPITALS AND HOMES SOCIETY  
FARGO, NORTH DAKOTA 58102

February 1, 1980

*Fill*



Senator Glen Hackney  
Alaska State Senate  
Pouch V  
Juneau, Alaska 99811

Dear Senator:

Recently I received a copy of Senate Bill 322 which is an act authorizing payment for services provided by certain institutions and agencies to Medicaid eligible persons on the basis of prospectively determined rates and providing for an effective date.

As I am sure you are aware, hospitals in the State of Alaska are currently being reimbursed on a cost basis as it relates to the Medicaid program. Some hospitals feel that the costs which Medicaid recognizes does not include the full cost of services. Since this mechanism is set up through the Federal Medicaid/Medicare regulations, the state has very little ability to change these.

As my understanding goes, the purpose of a prospective rate determination is for the distinct advantage of having hospitals lower their length of stay and/or occupancy rate. Fairbanks currently has a length of stay of less than four days while the national average is approximately 7.5. In addition, Fairbanks Memorial Hospital currently boasts a bed per thousand ratio of approximately 2.2, whereas the national average is 4.5. These are two main reasons why Senate Bill 322 should not be passed. In addition, the bill is very unclear as to who will determine a "fair rate or reasonable costs of services rendered". It is my impression that what Medicaid is attempting to do is to pay the hospitals less than their actual costs which they are receiving at the present time. In addition, it would be interesting to know the definition of reasonable costs of services which is located in paragraph 070 of the proposed legislation.

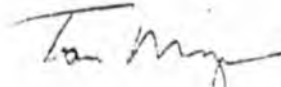
We at Fairbanks Memorial Hospital strongly oppose Senate Bill 322 for the reasons listed above and many reasons for which are not outlined here due to lengthy explanations which would be required to explain the prospective reimbursement system.

February 7, 1980

Page Two

On another matter we at Fairbanks Memorial Hospital are having severe nursing shortage problems, and since we are the only hospital in the area we have severe staffing problems especially when several of our nursing service personnel are picked for jury duty. We would be interested to see if you, as a legislator, could get the statute amended to exclude registered nurses in addition to teachers, etc. We feel that this is not unreasonable since these professionals play a very key part in the functioning of an acute care hospital.

Sincerely,



Tom Mingen  
Administrator

TM/mw

**ST. ANN'S NURSING HOME**  
415 Sixth Street, Juneau, Alaska 99801 (907) 586-3883

February 19, 1980

*File*  
↓

The Honorable Senator Hackney  
Senate Chambers  
State Capital Building  
Juneau, Alaska 99801

RE: Senate Bill No. 322  
Prospective Rate-Setting

Dear Senator Hackney:

Thank you for providing St. Ann's Nursing Home this opportunity to express its views on Senate Bill No. 322 relating to prospectively determined rates of reimbursement for care provided to Medicaid-eligible patients.

We readily understand the concern of the legislature concerning ever escalating costs to the taxpayer, and the very urgent need to put a lid on purchases of whatever kind. However, we are also concerned that prospectively determined rate-setting will, of itself, add to the cost push of this inflationary cycle. The Department of Health and Social Services has, in their position paper, given testimony to the need for development of an effective data base to provide information for informed decisions in determining reimbursement, and they show that it takes two to three years to achieve this readiness to start!

In our view, the Senate Bill No. 322 has significant short-comings. It says payment shall be made on the basis of a prospectively determined fair rate for reasonable costs, but fails to say who will determine what the fair rate is. It includes payment for patient care, without defining which of our patients' every-day needs are included in this designation of patient care. It leaves the whole field of determining the details of legislation open, presumably for some regulatory body to determine either with or without consultation of the providers that will be regulated. With such open-ended legislation, I would hope to see appeal processes spelled out in great detail.

As we at St. Ann's understand the proposal for Prospective Rate-Setting, all costs of patient-care, including the ancillary charges for Physiotherapy and Occupational Therapy, as well as drugs and supplies would be included in the rate

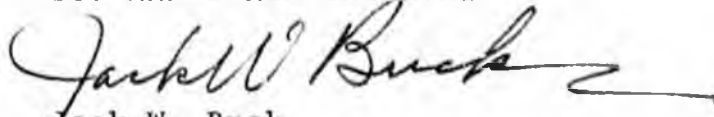
assigned as fair reimbursement. Since the above services are totally unpredictable, there is a clear danger that we would be forced to budget our costs aggressively in order to be sure that we could break even. This would clearly cause a precipitous jump in the cost to the state of doing Medicaid business. The alternative would be to specifically exempt such unpredictable costs and retrospectively reimburse at year-end, a situation that would completely negate the purpose of this bill.

Another possibility does exist, one that any concerned citizen would have to reject out-of-hand, and that is the possibility of reducing the level of care given to the patients by such a margin as to maintain the current cost level. Clearly, no provider is willing to take such measures, and we are convinced the legislature would condemn this method of cost containment.

It is our understanding that an alternative has been proposed that would involve only the free-standing nursing homes. This nursing home does not support that stand. St. Ann's Nursing Home has been in business just two and a quarter years, is still growing, and hopes to attain eighty percent census late this year. It can be seen that prospective costing would be a serious impediment to our doing business, in that we have not yet acquired sufficient data base to forecast with any great deal of accuracy.

We do understand that such a method of budgeting would have immediate advantages to the proprietary sector of the nursing home business. In the proprietary sector, it would be a distinct advantage to be able to show a predictable profit in case of negotiations to borrow funds, or to sell, or even to market stock or securities. Therefore, we offer as yet another alternative, the possibility that the proprietary sector of the Skilled and Intermediate Care Nursing Home industry be subject to prospective rate-setting for a developmental period.

Sincerely,  
ST. ANN'S NURSING HOME

  
Jack W. Buck  
Administrator

JWB:ar

Options for State Only Medical Assistance Program  
for Medically Needy

**DRAFT**

- I. Who should be eligible for the program?
- a. All medically needy (including intact families, single adults, etc.)
  - b. Select groups:
    1. Elderly (need to define cut-off age - 55, 60, 65).
    2. Blind.
    3. Disabled (need to define degree of disability).
    4. Families with children.
      - A. AFDC-related (at least one parent away from home).
      - B. All families.
    5. Single adults
      - A. Employable (work requirements?).
      - B. Unemployable.

**DRAFT**

II. To what income level should people spend down to?

- a. Same as General Relief-Medical.
  1. \$ \_\_\_\_\_ - single.  
\$ \_\_\_\_\_ - couple.
  2. Higher level.

III. What kinds and amounts of resources allowed?

- a. General Relief-Medical level.
- b. Higher or lower level.
- c. Special consideration.
  1. Home.

IV. What services to cover?

- a. Same as General Relief-Medical.
- b. Same as General Relief-Medical plus residential care or other home care (adult - foster care; adult - day care) ✓
- c. Select services:

1. Hospital.
2. Physician services.
3. Nursing home.
4. Drugs.
5. In-patient psychiatric services.
6. Mental health clinic.
7. Eyeglasses and optometric exams.
8. Hearing <sup>aids</sup> ~~aids~~ and evaluation.
9. Residential care.
10. In-home services (home health; adult-foster care; adult-day care).
11. Out-patient surgical center.
12. Medically necessary transportation.

V. Legal Mechanism:

- ~~a. Modify Catastrophic Illness statute (payment after the services).~~
- a. Modify Catastrophic Illness statute (payment after the services).
- b. Modify General Relief-Medical statutes.
- c. Separate <sup>new</sup> programs administered by Public Assistance.

VI. Funding.

- a. Open-ended appropriation (supplementals will be honored).
- b. Fixed sum "full need" appropriation (supplemental will not be honored).
- c. Pilot project or limited funded statewide project.



# ALASKA STATE HOSPITAL ASSOCIATION INC.

5401 CORDOVA STREET  
PHONE: 277-1633

ANCHORAGE, ALASKA 99503

February 19, 1980

Senator Glenn Hackney  
Chairman - Health, Education, and  
Social Services Committee  
Alaska State Legislature  
Pouch U  
Juneau, Alaska 99811

Re: Testimony for Committee Hearings  
February 1980  
Senate Bill 322

Dear Senator Hackney:

Speaking for our association, I wish to elaborate on our position related to S.B. 322/H.B. 612 concerning "prospective reimbursement for hospitals, nursing facilities, intermediate care facilities, etc." Due to the briefness of the bill as it now stands, we cannot effectively comment other than to state that an effective date of July 1, 1980, we feel, is overly optimistic. Other states who presently have prospective reimbursement have implemented their system after several months of preparation, and we recognize the need for similar time in Alaska.

Identification should be clearly made that the primary interest in a prospective reimbursement program in Alaska at this time is most closely aligned with some free-standing nursing facilities rather than hospitals. Health Care Services of Alaska Inc., a proprietary nursing home corporation, has spearheaded the movement because it would address a number of problems they are now faced with under the retrospective system. Due to the nature of long-term care reimbursement (a per diem rate) it more readily identifies with a prospective settlement. It is our recommendation that if a prospective reimbursement program is necessary at this time in Alaska, consideration be given to limiting the program to free-standing nursing homes who wish to participate as a pilot for other health care providers.

The purpose for which such legislation was initiated should be clearly spelled out and a follow-up program to evaluate its effectiveness should be developed at its inception. I have enclosed a report from the State of Colorado showing where a similar program has just been deregulated due to a lack of effectiveness.

Association endorsement for an inclusive prospective reimbursement system for both hospitals and long-term care institutions requires some assurances to the following:

1. That a reporting and budgeting system be established which would provide for uniformity in establishing the reimbursement for Medicare/Medicaid patients throughout the state, taking into consideration geographic and other unique variables.
2. That adequate time prior to implementation be allowed to develop the software, education and appeal processes for an effective program.
3. That the costs associated with the change-over in programs not be assessed the institutions participating or their private patients.


4. That allowable reimbursement include all of the necessary costs of operation including: bad debts; charity (mandated by federal law for Hill-Burton hospitals); debt service costs; adequate depreciation and an equity factor allowing for new technology and expansion.
5. That the present Medicare/Medicaid reimbursement program be replaced by the prospective system so as not to add an additional billing requirement.
6. That the determination of rates, i.e. the "rate authority", would be truly a representative body, including providers.
7. That the initial and ongoing cost of the regulatory body not be borne by the providers.
8. That an appeal process be established at the very outset of the program to deal with inequities which may surface and could be substantiated.
9. That the program be monitored by the legislature to determine if the regulatory body is carrying out the intent of the legislation.
10. That the regulations for this program be developed through cooperative efforts between representatives who are providers, working in conjunction with the regulatory agencies.
11. That special consideration be given to institutions providing both acute and long-term care in determining their budgeting and reporting requirements.
12. That reporting requirements be based on a recognized standard in the industry and be as simplified as possible.

Major concerns rest with the fact that many of our hospitals are operating with a limited census, with approximately 85% of their budget accounted for in wages and fixed overhead. Smaller facilities may not have the manpower or financial resources to comply with an immediate prospective program.

A final concern relates to the lack of success in other states in making significant improvement in containing costs through this mechanism. We have been more successful than many who already have a rate commission and prospective budget approval.

If we can be of further service to your committee, please contact our office at your convenience.

Sincerely,



Max Kersbergen  
Executive Director

MK/ic

Enclosure

ADDENDUM TO  
POSITION PAPER  
ON  
SENATE BILL 322  
(Identical to House Bill 612)

"An act authorizing payment for services provided by certain institutions and agencies to Medicaid-eligible persons on the basis of prospectively determined rates; and providing for an effective date."

Senate Bill 322 would require that Medicaid reimbursement for services provided by hospitals, long term care facilities, and home health agencies be based on a prospective method of reimbursement by July 1, 1980.

Under the present State and Federal statutory language, such reimbursement is allowed.

Overview

The current systems and methods of reimbursing health facilities for services to Medicare and Medicaid beneficiaries is retrospective in nature. That is, health facilities are paid for their services based on a cost report submitted after the fact at the end of each facilities fiscal year. The Medicare intermediary (Blue Cross) and The Medicaid intermediary (State Department of Health and Social Services) review these year end cost reports and pay the facilities the lessor of allowable costs or charges. During each year the intermediaries pay the health facilities an interim rate based on the prior year's cost report.

This system of reimbursement was established with the advent of Medicare in the 1960's. It has been revised and added to, over the years so that today it has become very cumbersome, complicated and duplicative. Nationally, the "retrospective" system is considered one of the major causes of the escalation in health care costs as the system lacks incentives to control expenditures. The current system is static and inflexible. Decisions are often made by accountants, based on "generally acceptable accounting principles", rather than on the merits of each individual situation.

In response to this situation, twenty-seven to thirty-four States have instituted a "prospective" system of reimbursement. These prospective systems have taken many forms, each state's structure a little different. However, the philosophic purposes seem to be common "To encourage economy and efficiency to establish a uniform system of reporting and determination of a health facilities future reimbursement."

Department's Position

The Department of Health and Social Services supports the concept of prospective reimbursement. Major benefits of such a program would be:

- 1.) Standardization of Health Facilities Reporting and Budgeting.
- 2.) Uniform Collection of hospital operating data for the purpose of determining reasonable rates.
- 3.) Reimbursement based on current budgeted costs instead of historical cost settlements.
- 4.) Routine communication between the Department and health facilities managers.

While Senate Bill 322 would authorize, if passed, a prospective reimbursement system, it does not require the implementation of a Uniform Reporting and Budgeting System which is critical to the development of an efficient prospective reimbursement model.

After a historical review of prospective reimbursement programs in other states, it was determined that installation of a prospective system requires basic provider education, technically qualified and experienced cost accounting staff, and a phased approach to implementation.

Based on our analysis of other state's experience with prospective reimbursement, the department recommends a phased approach to the development of a prospective reimbursement system be considered as follows:

- 1.) The Legislature authorize and fund the development of a State and Federal approved system of health facilities uniform reporting and budgeting. In meetings with the Alaska State Hospital Association, it has been clear that the hospitals and long term care facilities in the State agree that this is a necessary pre-requisite prior to implementing a prospective reimbursement system.

A Uniform Reporting and Budgeting system should be implemented as a first priority. This system should be patterned after the nationally recognized System for Hospital Reporting (SHR) and the American Health Care Associations, Chart of Accounts. It is

envisioned that this system would be developed with the intention of consolidating in the State of Alaska, all State and Federal Budget and Reporting requirements, ie: Medicare, Medicaid, Alaska Native Health, General Relief Medical, etc.

- 2.) That a task force be formed composed of representatives of the United States Department of Health, Education and Welfare, Alaska Department of Health and Social Services, and two representatives of the Alaska State Hospital Association. That this task force be charged with publishing a report recommending legislative actions; proposed regulations to support the recommended legislative action and that these recommendations be published prior to the January 1981 legislative session.

A fiscal note and estimated time line for this approach is attached. If this suggested phased approach were used a prospective reimbursement system could be operational by July 1, 1981.

If the legislature simply passes legislation beginning a prospective system effective July 1980, the Department would be in a position of "pushing" a system that has not received adequate health facility education, would impose yet another budgeting and reporting system on health facilities without their support, and would require holding public hearings over a very compressed period of time. This method of implementing a prospective system could result in as much or more time being required to implement a working system as will be required through the Department's suggested method.

The Department supports Senate Bill 322 in concept but would prefer a more phased method of implementing a prospective rate setting system.

Recommended by: Rod Betit March 12, 1980  
 Rod Betit, Director  
 Division of Public Assistance

Approved by: Helen D. Beirne 3/12/80  
 Helen D. Beirne, Commissioner  
 Department of Health & Social Services

POSITION PAPER  
ON  
SENATE BILL 322

"An Act authorizing payment for services provided by certain institutions and agencies to Medicaid-eligible persons on the basis of prospectively determined rates; and providing for an effective date."

Senate Bill 322 would require that Medicaid reimbursement for services provided by hospitals, long term care facilities, and home health agencies be based on a prospective determination of rates based on reasonable cost. Under present statutory language, such reimbursement is permissive.

Line 13 of the bill should be amended to add "skilled" between "hospital," and "nursing."

The Department of Health and Social Services supports the concept of a prospective method of determining reasonable rates of reimbursement. A prospective system would provide for an up-front negotiation between the State and the provider before services are provided rather than an after-the-fact review as exists under the present retroactive reimbursement system. Providers, the Department, and the Legislature would know in advance what budgetary limitations exist, how much would be spent, and for what services. Barring major emergency or extreme economic change, cost-settling practices should be eliminated for these categories of service.

While this bill would begin to address cost containment in the area of hospitalization and long term care, additional administrative costs would be incurred due to the requirement for contract development and negotiations. Various approaches may be used to implement a prospective reimbursement system. The Department is drafting a detailed explanation of those options and will have additional information on cost, program, and administrative impact.

The Department supports S.B. 322 in concept but must oppose its passage as the Governor's Budget Review Committee has not had an opportunity to approve the additional funding in administrative costs which would be required.

Recommended by:

*Rod Betit*

Rod Betit, Director  
Division of Public Assistance

*1/25/80*  
(DATE)

Approved by:

*Helen D. Beirne*

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

*1/25/80*  
(DATE)

THE LEGISLATURE OF THE STATE OF ALASKA  
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. SENATE BILL 322

Title "Prospective Reimbursement for Health Facilities"

Requested by Senate HEWW Committee

Date 1/25/80

II. FISCAL DETAIL

Department of Health and Social Services

Agency Affected

Program Category Affected Medical Assistance

BRU, Program, or Subprogram(s) Affected Public Assistance Administration

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

|                          | FY 80        | FY 81          | FY 82         | FY 83 | FY 84 | FY 85 |
|--------------------------|--------------|----------------|---------------|-------|-------|-------|
| 100 PERSONAL SERVICES    | 9,485        | 56,910         | 28,455        |       |       |       |
| 200 TRAVEL               |              | 20,064         |               |       |       |       |
| 300 CONTRACTUAL          |              | 70,500         |               |       |       |       |
| 400 COMMODITIES          |              | 3,000          | 1,000         |       |       |       |
| 500 EQUIPMENT            |              |                |               |       |       |       |
| 600 LAND & STRUCTURES    |              |                |               |       |       |       |
| 700 GRANTS, CLAIMS, ETC. |              |                |               |       |       |       |
| <b>TOTAL</b>             | <b>9,485</b> | <b>149,974</b> | <b>29,455</b> |       |       |       |

FUNDING (Thousands of Dollars)

|                             | FY 80 | FY 81  | FY 82  | FY 83 | FY 84 | FY 85 |
|-----------------------------|-------|--------|--------|-------|-------|-------|
| GENERAL FUND                | 4,743 | 74,987 | 14,728 |       |       |       |
| FEDERAL FUNDS               | 4,742 | 74,987 | 14,728 |       |       |       |
| OTHER (Specify Fund Source) |       |        |        |       |       |       |

POSITIONS

|           | FY 80 | FY 81 | FY 82 | FY 83 | FY 84 | FY 85 |
|-----------|-------|-------|-------|-------|-------|-------|
| FULL TIME |       |       |       |       |       |       |
| PART TIME |       |       |       |       |       |       |
| TEMPORARY | 2     | 2     | 2     |       |       |       |

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

This fiscal note assumes legislation authorization for this program by April, 1980.

The fiscal note provides for beginning activity in late FY 80, a full year operation in FY 81 and a 1/2 year transition to existing audit staff in FY 82.

Original: Legislative Finance  
cc: Budget and Management  
Prime Sponsor (First Legislator Named)

Prepared by: *R. Betit* Rod Betit Date: 3/12/80  
Division/Office: Public Assistance PH: 465-3355  
Department of Health & Social Services

33-001 (Rev. 12/79)  
Modify by DHSS (71-28-79)

Approval DHSS Mgt. & Bdgt: *Paul Oulore* Date: 3/12/80

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1.) One auditor to assist current state audit staff in development of State's portion of Uniform Budgeting & Reporting, as well as to staff task force in the development of the task force report.

SR 18= 2517x 2 months x .25% = 6,292  
2517x 12 months x .25% 37,755  
2517x 6 months x .25% 18,897  
\$ 62,924

2.) One clerk typist to support the auditor and assist in task force minutes, document distribution etc.

SR 8= 1,277 x 2 months x .25%= 1,193  
1,277 x 12 months x .25%= 19,155  
1,277 x 6 months x .25%= 9,578  
\$31,926

Travel and Perdiem

1.) Task Force Operations  
Eight Meetings of Task Force  
in Anchorage (Six persons)

a.) Travel  
8 x 6 x \$300= 14,400

b.) Perdiem  
6 x \$59 x 3 days x 8 meetings= 5,664

TOTAL \$ 20,064

Contractual

1.) Contract with firm specialized in prospective rate setting system, contract to include two regional meetings with health facilities to review proposed budget-reporting forms and system  
\$70,000

Commodities

1.) Postage and Printing costs  
for correspondence and reports  
4,000

*See copy*

BY THE RULES COMMITTEE BY  
REQUEST OF THE LEGISLATIVE  
COUNCIL (for the Interim  
Committee on Services for  
the Elderly)

1 IN THE SENATE

2 SENATE BILL NO. 322

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 ELEVENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act authorizing payment for services provided by  
7 certain institutions and agencies to Medicaid-eligible  
8 persons on the basis of prospectively determined rates;  
9 and providing for an effective date."

10 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

11 \* Section 1. AS 47.07.070 is repealed and re-enacted to read:

12 Sec. 47.07.070. PAYMENT TO INSTITUTIONAL PROVIDERS. Payment for  
13 services provided by hospitals, nursing facilities, intermediate care  
14 facilities, inpatient psychiatric facilities, and home health agencies  
15 shall be made to the providers of services for Medicaid-eligible persons  
16 on the basis of a prospective determination of fair rates for the  
17 reasonable costs of services rendered, including

18 (1) patient care;

19 (2) charity and credit losses in accordance with regulations  
20 of the United States Department of Health and Human Services;

21 (3) maintenance, improvement and expansion of buildings and  
22 equipment;

23 (4) debt service for amortization of principal and interest  
24 payments.

25 \* Sec. 2. AS 47.07.080(1) is repealed.

26 \* Sec. 3. This Act takes effect July 1, 1980.

27  
28  
29