

MEDICAID

3331

Bob Pettit Div. of Pub. Assst.
Bob Ogden

Statute Title 47. 07. 3355

Jeff Hubbard 3347 (Pub. Assst)

HAAC - 43 725 Ch. 43

Medicaid Medicaid

Regio. passed Clinic

Services - defined as Comm.

Mental Health Services.

Clinic must bill under

Payor (where check issued)

and Provider no. (Physician)

if Regio. passed bill

as clinic services - the

clinic could be Payor &

Provider.

Clinic - physician services

are covered - but any

services w/ Clinic other than
Physician not covered.

80% budget to institutional
care for period of illness

no medical prevention

no yearly exam / dental

Reason

5% Cap on services

50% funds from Feds - want
to change reimbursement to
relate to per/capita income.

CESA

cut reimbursement for
Medicare and supporting services.

More people are eligible for
services. More people
eligible in long term care

operated
by state
at
Div of
Ment. Health
in Div.
Distribution

They can take back money
more quickly if they decide
not to increase expenditures.

Bill Fed. each quarter
for \$100,000/services. Can
appeal - takes 1 1/2 years
Can take deferral out of
budget of questioned area
only.

STATE OF ALASKA

THE LEGISLATURE

BUDGET AND AUDIT COMMITTEE

AUDIT DIVISION
POUCH W—ALASKA OFFICE BUILDING

FINANCE DIVISION
POUCH WF—STATE CAPITOL

JUNEAU, ALASKA 99811

February 26, 1981

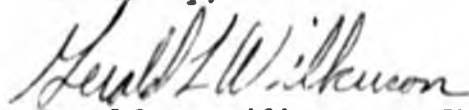
Senator Charles H. Parr
Chairman
Senate Health, Education
and Social Services Committee
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

At the February 24, 1981 meeting, the Legislative Budget and Audit Committee approved for release to the public the attached audit report which may be of interest to your Committee.

If you have any questions on this report, please contact our office.

Sincerely,



Gerald L. Wilkerson, CPA
Legislative Auditor
Division of Legislative Audit

Enclosure

A REVIEW OF
THE DEPARTMENT OF
HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE
MEDICAID BUDGET REQUEST UNIT

For the Fiscal Year Ended June 30, 1980

Commissioner, Department of
Health and Social Services

Dr. Helen D. Beirne

Deputy Commissioners, Department
of Health and Social Services:

Management Services

Allen K. Korhonen

Field Operations and Local,
State, Federal Liaison

Frederick McGinnis

Program Management

Dean F. Tirador, M.D.

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PURPOSE OF THE REVIEW

In accordance with the provisions of Title 24 of the Alaska Statutes, we conducted a review of the Department of Health and Social Services, Division of Public Assistance, Medicaid Budget Request Unit. This component does not include costs for Medicaid administration, or payments made to Harborview or Alaska Psychiatric Institute.

The purpose of our review was to determine:

1. If the financial statements appearing in the State Annual Financial Report for the fiscal year ended June 30, 1980 are fairly presented.
2. The compliance by the Department of Health and Social Services with applicable State statutes and regulations governing fiscal activities.

ORGANIZATION AND FUNCTION

The Medicaid program is organized under the Department of Health and Social Services, Division of Public Assistance. The purpose of the program is to provide health care financial assistance under Title XIX of the Federal Social Security Act. This Title allows medical expenses of eligible Alaskans to be paid with federal and State funds.

All Medicaid expenditures, except those for administration, Harborview, or Alaska Psychiatric Institute, are charged to the Medicaid Budget Request Unit. Medicaid services include the following:

1. Physicians' services.
2. Hospital care.
3. Laboratory and X-ray services.
4. Nursing home care.
5. Early and periodic screening, diagnosis, and treatment for persons under 21.
6. In-patient and psychiatric-home care for the mentally retarded.
7. Transportation if such services are otherwise unavailable.

Medicaid recipients submit coupons as payment to doctors, hospitals, and other health care organizations. The organizations are reimbursed when they submit these coupons to the Division of Public Assistance.

FINDINGS AND RECOMMENDATIONS

Recommendation No. 1

The Department of Health and Social Services (DHSS) should strengthen its internal accounting controls over Medicaid payments.

Internal controls in effect during FY'80 were not sufficient to provide reasonable assurance that accounting records for the Medicaid Budget Request Unit (BRU) are reliable and accurate, and therefore we have disclaimed an opinion on the financial statements. The major findings that led us to this decision are discussed below, along with recommendations where applicable:

- A. Over ^{75-80%} 50% of the FY'80 Medicaid BRU expenditures were charged to the Nursing Home component. DHSS did not perform or contract audits adequate to ensure that billed costs were accurate and/or allowable.

DHSS should continue its efforts to increase audit staff and should provide the training needed to properly audit long-term care facilities once staff is on board. Further, it should make every effort to audit FY'80 and future cost reports, or contract with a reliable firm to provide this service.

- B. DHSS implemented a new claims processing system in January 1980. Approximately the first 35,000 claims are being reprocessed because they include items that were incorrectly paid or recorded. Reprocessing was not completed prior to preparation of the FY'80 financial statements or at the time of our audit.
- C. Controls during FY'80 were not sufficient to ensure that claims processed through Computer Sciences Corporation (CSC) were in fact paid. In particular, DHSS did not reconcile the expenditures charged to and the warrants written by the State accounting system (PBA) against the payment tape supplied by CSC. This is an ongoing reconciliation that must be performed each time a payment tape is processed through PBA.

- D. Claims received without Medicaid coupons attached were not adequately controlled and accounted for. Even when these claims had been checked for eligibility, they were sometimes processed for payment without adequate proof that this determination had been made.

DHSS now requires that claims checked for eligibility be stamped and initialed by the person making the determination. In addition, systems changes have been planned that would provide greater control over invoices from the time of receipt. We recommend that DHSS implement these changes as soon as possible.

- E. Controls during FY'80 were not adequate to prevent duplicate payments. Controls were significantly enhanced with the introduction in late FY'80 of a duplicate edit report for claims processed through CSC. This edit is limited, however, because CSC's history file is incomplete (see Recommendation No. 3).

In addition, DHSS has agreed to make advance payments to certain providers for unresolved FY'80 claims. This was a policy decision and is intended to ease cash flow problems that may be caused by the State's untimely payment of medical bills. It should be noted, however, that duplicate payments will inevitably result, and DHSS will yet again be faced with a major adjustment and reconciliation process.

Recommendation No. 2

DHSS should place greater emphasis on third party liability identification and recovery efforts.

Federal regulations 42 CFR 43.135 specify that federal Medicaid financial participation is not available if a state does not have an adequate third party liability (TPL) identification and recovery program. In response to these regulations, DHSS requested that we review the Department's current TPL program and make recommendations for improvement. Our major findings and recommendations follow:

- A. The best source of TPL information is the applicant. We found, however, that application forms for some of the public assistance programs do not ask the right kind of question and, further, that eligibility workers are not trained to recognize potential TPL resources.

Accordingly, we recommend: (1) DHSS should review the information needs of the various programs affected - Collections, Aid to Families with Dependent Children (AFDC) and Child Support Enforcement Agency (CSEA), Adult Public Assistance, Food Stamps, etc.; (2) forms should be revised to accumulate all necessary information without undue duplication of paperwork; (3) eligibility workers should be made aware of the importance of TPL resources and trained to recognize them; (4) Medicaid manuals, which include information and regulations applicable to TPL, should be distributed to eligibility workers and other appropriate personnel.

- B. DHSS employs a one letter "resource code" to record TPL information. For example, "A" designates Blue Cross, "D" designates Commercial Insurance/Hospital, and "P" designates U.S. Public Health (Alaska Native Health). The resource code is very important because it tells the provider whether a third party must be billed prior to Medicaid and is the basis for certain TPL and control edits.

The codes are too limited, however. Assume, for example, that an applicant is qualified for and is coded as U.S. Public Health (P), but that he or she also has commercial insurance. Unless the provider learns of the insurance and then volunteers that information to the State, DHSS will process the applicant's claims as though no other third party resource exists. If either the provider or the applicant also bills and recovers from the insurance company, DHSS probably will not detect it.

DHSS should correct this systems problem by expanding or modifying its codes to allow the recognition of more than one TPL resource.

- C. Trauma or accident claims have a high potential for TPL recovery because they often involve another party who might be legally liable for medical bills. During 1979, DHSS manually screened for trauma claims and forwarded copies to the Collections office in Anchorage for further research. When this practice was discontinued in early 1980, TPL collections dropped and Collections lost one of its major tools for identifying potential TPL recovery.

It would not be practical to re-implement the manual screen for trauma claims. However, we recommend that CSC generate monthly or quarterly listings of these claims. This will at least provide a basis for determining that potential recoveries exist.

- D. Most of Alaska's AFDC cases are coded as having no third party resources. However, experience from other states has shown that the AFDC recipient may not know or want to tell about resources available through the absent parent,

To determine whether these resources exist, however, it is necessary to start with the agency working with the absent parent - in this case, CSEA - and work backwards. This is because CSEA is more likely to have the kind of information necessary to cost-effectively identify TPL resources. For example: Parents currently making support payments are more apt to be employed, and parents who are employed are more apt to have insurance that covers the spouse's or children's medical bills. CSEA can identify persons making support payments; DHSS cannot.

We recommend that CSEA and DHSS work together on TPL identification and recovery for AFDC cases. An agreement should be developed that outlines each agency's responsibilities with regard to administration, investigation, and enforcement. Thereafter, cases with high TPL potential should be investigated, resource codes updated, and payment recovery procedures begun.

- E. Alaska's medical assistance statutes do not include a subrogation provision empowering the State to recover directly from third parties, nor does DHSS request or require that all medical assistance applicants sign an "assignment of benefits" form. This complicates the process and sometimes negates the cost benefit of seeking reimbursement for medical assistance payments.

* We recommend that DHSS work with the Attorney General's office to draft and then submit a subrogation statute for all medical assistance payments. We also suggest that the Department work closely with its Collections manager in this regard, as he has done considerable work in this area over the last two years.

In summary, we found that the Department's support of its TPL program has been minimal. For example, the above recommendations are not new - they have been proposed both by federal Medicaid reviewers and even in a formal report prepared by the DHSS employee responsible for TPL collections. In addition, there is a wealth of TPL literature available. It is time that DHSS gave serious thought as to whether it wants a TPL program that is an integral part of sound fiscal control, or whether it should continue to expend the minimal resources necessary to comply with federal regulations.

Recommendation No. 3

DHSS should data capture all payments onto its medical history file. Medical history file reports should be sorted and formatted to better meet users' needs.

Claims processed through CSC are data captured onto a medical history file. This data is potentially useful to many DHSS offices such as Quality Control, Audit, Collections, Fraud Investigations, Medical Claims, and Public Assistance Administration. We have noted two major problems with the medical history file, however. (First) it is incomplete. Second, reports generated from the file are not adequate to meet the various users' needs.

A. The medical history file is incomplete because:

- 1) The medical data on hand-vouchered payments is not captured. This includes payments to out-of-state providers, nursing homes, dental claims, and many claims that were hand processed prior to implementation of the CSC system in January 1980.
- 2) When the CSC system was introduced, systems and control problems were extensive. For example, the history file shows payments that were never actually processed; conversely, payments that were processed were erroneously deleted. The extent of these problems is unknown.
- 3) Previous to July 27, 1979, DHSS had an in-house medical claims system. The history file produced under that system was also inaccurate. In fact, the system is referred to by many DHSS staff as the "black hole" because invoices would enter and then disappear.

DHSS is making efforts to clean up old claims processed through CSC and to improve controls over data currently captured in the medical history file. To fully utilize

the file, however, it must be complete. Therefore, we recommend that hand-vouchered payments also be data captured.

- B. However, a complete and accurate medical history file is of little value if data is not sorted and formatted to meet users' needs. The most frequent complaint we heard in this respect is that there is no patient profile report - ie., a listing of medical history data by patient name or case number. This not only inconveniences many offices, it prevents several from doing their jobs effectively. For example:

- 1) Quality Control (QC) is required to sample eligibility rolls and review payments made on recipients' behalf. QC was unable to do this during FY'80 because it could not get patient payment histories. A run was finally received in the Fall of FY'81 to cover the testing period October 1, 1979 - March 31, 1980, but it had insufficient detail for QC to efficiently conduct its review.
- 2) Collections is responsible for recovering moneys paid by the State for medical claims that were also paid by or chargeable to some other resource. Because Collections has been unable to access the medical history file for patient payment data, it has had to derive this vital information from other sources (lawyers, providers, etc.). It is inefficient, error prone, and embarrassing to have to ask how much money the State has paid so that the State can then demand it back.
- 3) The Fraud Investigations unit is similarly handicapped when it comes to assessing the dollar impact of a crime, or whether fraud has indeed occurred. Also, the lack of a complete medical history file is one of the roadblocks to the establishment of a "certified" Medicaid fraud control unit that would be eligible for 90% federal funding.

There are many other ways in which available information can be accessed to create usable information. We stress the need for DHSS to work more closely with all users about the format and content of reports they need, and we make the following recommendations:

- 1) Patient profiles should be produced at least quarterly. Quarterly provider profiles should continue to be produced.
- 2) Other listings of data sorted or selected on the basis of specified fields (invoice date, diagnosis code, etc.) should be produced on an as need basis.
- 3) Reports requiring more sophisticated data manipulation should be evaluated to determine whether they are integral to an office's operations and are cost effective. Management's decision whether to devote programming, computer, and financial resources should be based accordingly.

Recommendation No. 4

Alaska should reconsider the "buy-in" option for Medicare.

Alaska is one of the few states that does not purchase Medicare coverage (ie., "buy-in") for eligible public assistance recipients. This is the result of a decision made many years ago. The State subsequently reconsidered its decision but was told that the option is no longer available. The matter was actively pursued until 1976 but was then more or less dropped.

We believe that the issue of whether the State could and should purchase Medicare coverage deserves reconsideration. The legal issues involved have always been subject to debate and are still so. Moreover, the organizational and personnel makeup of the U.S. Department of Health and Human Services (formerly Health, Education and Welfare) has changed considerably since 1976, and that agency may be more receptive to the State's case. Finally, we have no precise figures, but all indications are that the benefits of a buy-in option would outweigh the costs, and that the benefits would increase over time.

Recommendation No. 5

DISS should encourage providers to become Medicare eligible.

Medicare, in addition to requiring that individuals be eligible for the program and pay the applicable premiums, also requires that the medical services be performed by Medicare certified providers. Many nursing homes in the

State do not meet this criteria. As a result, the State Medicaid and General Relief Medicine programs pay for care that Medicare would cover.

We believe that the State should make a substantial effort to have providers become Medicare certified and thereby shift the cost of some nursing home care to Medicare. This would be additionally beneficial in that Medicare certified nursing homes have greater review procedures which would benefit recipients and the State.

STATE OF ALASKA

AUDIT DIVISION
POUCH W—ALASKA OFFICE BUILDING

THE LEGISLATURE

FINANCE DIVISION
POUCH WF—STATE CAPITOL

BUDGET AND AUDIT COMMITTEE

JUNEAU, ALASKA 99811

November 3, 1980

Members of the
Legislative Budget and Audit Committee:

We have examined the Statement of Revenues - Budgeted and Actual and the Statement of Expenditures and Encumbrances Compared with Appropriations for the Department of Health and Social Services, Medicaid Budget Request Unit, for the Fiscal Year ended June 30, 1980. As part of our examination, we made a study and evaluation of the agency's system of internal accounting control to the extent we considered necessary to evaluate the system as required by generally accepted auditing standards. The purpose of our review was to determine the nature, timing, and extent of auditing procedures necessary for expressing an opinion on the financial statements and would not necessarily disclose all weaknesses in the agency's internal accounting controls.

However, our study and evaluations disclosed the following conditions:

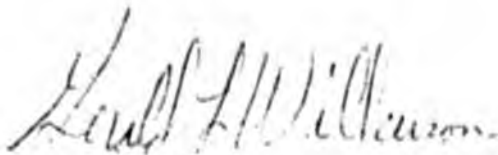
1. Over 50% of the FY'80 Medicaid Budget Request Unit expenditures were charged to the Nursing Home component. The Department did not perform or contract audits adequate to ensure that billed costs were accurate and/or allowable.
2. The agency implemented a new claims processing system in January 1980. Approximately the first 35,000 claims are being reprocessed because they include items that were incorrectly paid or recorded. Reprocessing was not completed prior to preparation of the FY'80 financial statements.
3. Reviews done by the agency's Quality Control section did not adequately test FY'80 Medicaid payments.
4. Approximately 7,000-10,000 invoices were paid at a flat percentage and then later adjudicated and adjusted. Many of these invoices were charged to the wrong fiscal year.

5. Claims received without Medicaid coupons attached were not adequately controlled and accounted for. Even when these claims had been checked for eligibility, they were sometimes processed for payment without adequate proof that this determination had been made.
6. Controls during FY'80 were not adequate to prevent duplicate payments or to ensure that processed claims were in fact paid.
7. There is no complete medical history file. Furthermore, information that is available is not sorted and formatted in a way that facilitates quality control, fraud investigation, or audit efforts.

In addition, we requested that management furnish us a letter acknowledging responsibility for the financial records and making certain representations regarding the accuracy and completeness of those records. The Department concluded that such a letter would be inappropriate.

As described above, the internal control procedures followed by the Department were not adequate to assure the accuracy of the financial statements, and it was not practicable to attempt to satisfy ourselves by use of extended auditing procedures.

Accordingly, we cannot and do not express an opinion on the financial statements referred to in the first paragraph.



Gerald L. Wilkerson, CPA
Legislative Auditor
Division of Legislative Audit

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE
MEDICAID BUDGET REQUEST UNIT (Note 2)
STATEMENT OF REVENUES - BUDGETED AND ACTUAL
For the Fiscal Year Ended June 30, 1980

<u>Classification</u>	<u>Final Revised Budget</u>	<u>Actual</u>	<u>Over or (Under) Budget</u>
<u>Restricted Revenue</u>			
<u>Federal Grants-in-Aid</u>			
<u>Social Services</u>			
Title XIX	\$21,234,500	\$16,054,431	\$(5,180,069)
Title V	-0-	314	314
<u>Total Social Services</u>	<u>21,234,500</u>	<u>16,054,745</u>	<u>(5,179,755)</u>
<u>Health</u>			
Federal Projects	-0-	60,259	60,259
<u>Total Federal Grants-in-Aid</u>	<u>21,234,500</u>	<u>16,115,004</u>	<u>(5,119,496)</u>
<u>Interagency Receipts</u>			
Health and Social Services	3,347	-0-	(3,347)
<u>Other Restricted Receipts</u>			
Reimbursement and Recovery - Prior Year	-0-	32,321	32,321
<u>Total Restricted Revenue</u>	<u>21,237,847</u>	<u>16,147,325</u>	<u>(5,090,522)</u>
<u>Total Medicaid BRU Unrestricted and Restricted Revenue (Note 3)</u>	<u>\$21,237,847</u>	<u>\$16,147,325</u>	<u>\$(5,090,522)</u>

See Auditor's Disclaimer of Opinion and Accompanying
Notes to the Financial Statement.

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE
MEDICAID BUDGET REQUEST UNIT (Note 2)
STATEMENT OF EXPENDITURES AND ENCUMBRANCES
COMPARED WITH APPROPRIATIONS
For the Fiscal Year Ended June 30, 1980

Budget Category	1979 - 1980 Budget Act	Continuations Supplements and Revisions	Total Authorizations	Expenditures	Encumbrances at Close of Year	Unencumbered Balances	
Health Category						Continuing Programs (Note 4)	Lapsed
Medicaid	\$33,266,700	\$ 2,464,695	\$35,731,395	\$23,887,210	\$7,210,540	\$196,085	\$4,437,560
<u>Total Medicaid Budget Request Unit</u>	<u>\$33,266,700</u>	<u>\$ 2,464,695</u>	<u>\$35,731,395</u>	<u>\$23,887,210</u>	<u>\$7,210,540</u>	<u>\$196,085</u>	<u>\$4,437,560</u>
<u>By Object</u>							
Personal Services	\$ -0-	\$ 6,695	\$ 6,695	\$ -0-	\$ -0-	\$ 6,695	\$ -0-
Travel and Moving	-0-	-0-	-0-	4,578	458	(5,036)	-0-
Contractual Services	-0-	-0-	-0-	47,669	48,097	(95,766)	-0-
Assistance Grants and Benefits	33,266,700	2,458,000	35,724,700	23,834,963	7,161,985	290,192	4,437,560
<u>Total By Object</u>	<u>\$33,266,700</u>	<u>\$ 2,464,695</u>	<u>\$35,731,395</u>	<u>\$23,887,210</u>	<u>\$7,210,540</u>	<u>\$196,085</u>	<u>\$4,437,560</u>
<u>Source of Funds</u>							
Appropriation Act, Ch. 80, SLA 1979	\$ 3,882,300	\$20,005,600	\$ -0-	\$ 9,378,800	\$33,266,700		
Supplemental Appropriation (Ch. 50, SLA 1980, Sec. 70)	1,229,100	1,228,900	-0-	-0-	2,458,000		
Salary Increases	3,348	-0-	3,347	-0-	6,695		
<u>Total Source of Funds</u>	<u>\$ 5,114,748</u>	<u>\$21,234,500</u>	<u>\$ 3,347</u>	<u>\$ 9,378,800</u>	<u>\$35,731,395</u>		

See Auditor's Disclaimer of Opinion and Accompanying
Notes to the Financial Statement.

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE
MEDICAID BUDGET REQUEST UNIT
NOTES TO THE FINANCIAL STATEMENTS

Note 1 - Summary of Significant Accounting Policies

Alaska Statute 37.05.150 requires the State of Alaska to conform to generally accepted accounting principles. The following is a summary of the significant policies applicable to the Department of Health and Social Services.

Bases of Accounting. The accrual basis of accounting is followed, with minor exceptions. The General Fund utilizes the modified accrual basis of accounting. Modifications in such method from the accrual basis and modifications used by the Department are as follows:

1. Revenues are recorded as received in cash except for:
 - (a) Revenues susceptible to accrual.
 - (b) Material revenues that are not received at the normal time of receipt.
2. Expenditures are recorded on accrual basis except for:
 - (a) Certain types of expenses which are considered expenditures at time of purchase:
 - (1) Inventory type items.
 - (2) Prepaid expenses, such as insurance.
 - (3) Interest on long-term debts.
 - (b) Encumbrances which represent:
 - (1) Valid obligations accrued at June 30, 1980 and paid during the July-August reappropriation period.
 - (2) Purchase orders and contract commitments at June 30, 1980 which were recorded by August 31, 1980.

Note 2

The Medicaid Budget Request Unit (BRU) does not include all the costs of the Medicaid program. In general, the Medicaid BRU only includes payments to providers for medical services. It does not include payments to Harborview or Alaska Psychiatric Institute, which are State institutions, nor does it include the administrative costs of the Medicaid program. These costs are also funded in part by the federal Medicaid program and are accounted for in other BRU's within the Department.

Note 3

\$9,375,800 of the expenditures reported in the financial statements are offset by Federal Revenue Sharing receipts budgeted to the Medicaid BRU but not reflected in that program's accounts. Instead, these receipts were credited to the Federal Revenue Sharing Fund (#128), and general ledger transfers were periodically made to "replenish" the General Fund for Medicaid expenditures.

Note 4

These funds were appropriated in Ch. 50, SLA 1980, Sect. 70, for the fiscal year ending June 30, 1980, while another section of that act authorizes their use until June 30, 1981. No conflict arose, however, because the agency allowed the funds to lapse on June 30, 1980.

Note 5

At the completion of our audit, there were eight unresolved federal compliance issues that had been identified by federal Medicaid Bureau reviewers. Most issues were procedural in nature and were not associated with specific dollar amounts. If not resolved satisfactorily, however, they could affect the funding or operation of Alaska's Medicaid program.

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

February 24, 1981

Gerald L. Wilkerson, C.P.A.
Legislative Audit Division
Pouch W
Juneau, Alaska 99811

RECEIVED

FEB 24 1981

**LEGISLATIVE
AUDIT**

Re: Review of Medicaid, Division of Public Assistance

Dear Mr. Wilkerson:

Although a few areas of disagreement exist, the findings cited in your report are generally accurate and reflect a fair assessment of the problems incurred by the new Medicaid system during its early months of operation. Initial start-up problems were expected as the Department had to design and install a new system within this same time frame. The implementation effort for a new system of this scope and complexity would normally evolve over a period of 12 to 24 months. Unfortunately, the Department's old Medicaid system had already collapsed and the Department simply did not enjoy the normal lead time for system replacement.

The current claims processing system is working with regularity and vendors are being paid within liveable time frames. We are still fine-tuning the system however, and new problems do arise from time to time. To graphically indicate the improvement in the claims processing system, we have attached a graph that shows how the claims payment time has diminished.

The Department's specific remarks to each of the specific audit findings and recommendations are as follows:

RECOMMENDATION NO. 1

✓A. Audits of Long-Term Care Facilities Inadequate:

We concur with this finding... Contact with Region X federal officials indicates that a number of states have experienced difficulty with Blue Cross contract audits. The Department of Health and Social Services is currently recruiting nationwide to obtain needed audit staff. Every effort will be made to provide comprehensive professional audits of long-term care facilities.

B. Errors in First 35,000 Invoices Processed Through New System:

As mentioned above, problems were experienced with the first 35,000 invoices processed by the system. Foreseeing the possibility of

such problems, the Department maintained a second complete set of these invoices for reconciliation purposes. This reconciliation is complete as of this writing. All claims have been accounted for and have been paid.

C. Lack of Controls in Claims Processing System:

We disagree some with this finding in that DHSS did identify claims rejected by the PBA system. However, C.S.C. failed to take prescribed actions to delete these claims from the history file then reprocess them for payment. DHSS did fail to monitor this process adequately, a control is now in place.

D. Lack of control over claims received without Medicaid coupons:

The auditors are correct that 25% of all claims are received by the Department without supporting Medicaid coupons. This requires these claims to be separated from all other claims, at the time of receipt, for purposes of eligibility research. The Department has not maintained manual logs for claims in this status simply because it was not possible to do so with the staff resources available to the Department. In fact, it is still out of the question. However, the Department did take measures to bring these claims into a more controlled environment. On October 1, 1980 CSC implemented reporting of all claims (paid, denied, and suspended) on a regular basis to each provider. This marks a significant milestone in Medicaid processing in Alaska as such reporting never occurred before. This system change permits CSC systems to notify medical providers of all claims pending an eligibility check so that they know the claims were received and are in process. This improvement will alert the Department to any claims which might be misplaced during the manual eligibility verification process.

E. Controls to prevent duplicate payments were not in effect during much of FY 80:

Given the compressed time frame within which the Department was forced to implement this system and restore Medicaid claims processing, the Department's primary concern was to make payment on a five month backlog of bills. It became apparent early in the CSC system that the duplicate check subsystem was not functioning properly. Rather than discontinue claims processing entirely, the Department chose to discontinue the duplicate check activity for a temporary period. Duplicate checking was reinitiated several months later and has continued uninterrupted since that time.

February 24, 1981

RECOMMENDATION NO. 2

Third party liability program improvements:

✓ A. Approximately one year ago DPA introduced a combined application for food stamps and AFDC which collects information on third party medical resources for all AFDC applicants. However, the APA and medical assistance applications have not been revised in the same manner and therefore does not provide the same quality or amount of information. This is particularly a problem in the case of non-institutionalized APA cases. The new Medicaid staff manual with provider directions on identification of third party resources in a manner not previously available to field staff. The APA and noncash assistance applications will be revised to conform to the Food Stamp-AFDC application at a future date.

B. The BAF manual provides instructions to field staff on the proper coding to create a record of eligibility for cash and medical assistance programs. Section 7002.2, items 24a and 24b were revised in November, 1979 to clarify what the medical eligibility and resource code means and how they are to be used. Because of the limitations of the present eligibility system used by DPA, the Office of Information Systems has informed us that they are unable to make any changes to the system. The revised BAF manual was an attempt to curtail the problem until a new eligibility system is installed. A new eligibility system is currently being developed via a consultant.

C. CSC is at this time sending monthly listings of all claims paid on which a trauma code was indicated. They have sent a similar report covering the period from July 1979 to the present.

✓ D. We are aware of the potential that CSEA offers as a source of information on medical resources, and plan to pursue it at a later date. However the lack of staff to perform existing program functions makes it impossible for DPA to undertake the negotiations and planning necessary to develop an agreement between the two agencies in the near future.

✓ E. Proposed statutory language on subrogation was considered for submittal to the Legislature during the 1981 session, but the proposal was not accepted. We agree that a subrogation law is a vital part of a third party recovery program and plans call for reconsideration of this proposal during the next legislative cycle.

RECOMMENDATION NO. 3

A. There is no complete medical history file:

Letter
Gerald Wilkerson

- 4 -

February 24, 1981

Because the State did not contract with CSC for payment of all medical claims, some claims paid by the State are not included in the CSC data history file. As the CSC payment systems is scheduled for replacement in early, 1982, the Department has to live with this situation until then. A major change to the CSC system at this stage of its life expectancy would not be cost-effective.

2. B. Reports from history files do not meet user needs:

We disagree with this finding at this time. The user reports have been implemented for Quality Control, Collections,, Fraud Investigation as well as various management reports that provide minimal but at least some assistance.

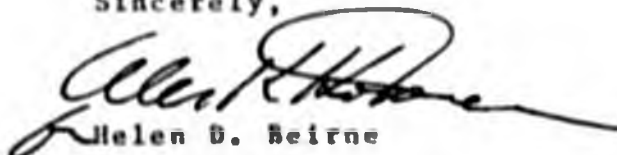
RECOMMENDATION NO. 4

A. The "buy-in" period has just been reopened with the passages of P.L. 96-599. The Department intends to make a decision on this issue during 1981.

RECOMMENDATION NO. 5

A. We strongly agree with your recommendation. In fact, the Department has introduced State Medicaid regulations in August, 1979 which required all skilled Nursing Facilities participating in Medicaid to also participate in Medicare. (See TAAC43.170(1)(A)). This was done to increase third party receipts from Medicare and thereby reduce costs assessed to Medicaid for nursing home care. It was also done to try to assure that SNF beds are available in Alaska to non-Medicaid individuals with Medicare coverage, rather than being forced to remain in hospitals at a considerably additional expense or having to leave the state for the services. It should be noted that only six of the state's twelve nursing homes may receive Medicare reimbursement, since Medicare coverage is restricted to facilities offering skilled nursing care (SNFO). Additionally, Medicare reimbursement has proven extremely difficult for the nursing homes to recover for seemingly eligible SNF patients. Nakoyia has put considerable effort into its Medicare collections effort and has earned less than 5% of their overall revenue from this source. Alaska is not alone in this regard. In P.L. 97-499, Congress required the Secretary of Health and Human Services to look into the question of requiring dual participation and report back within one year.

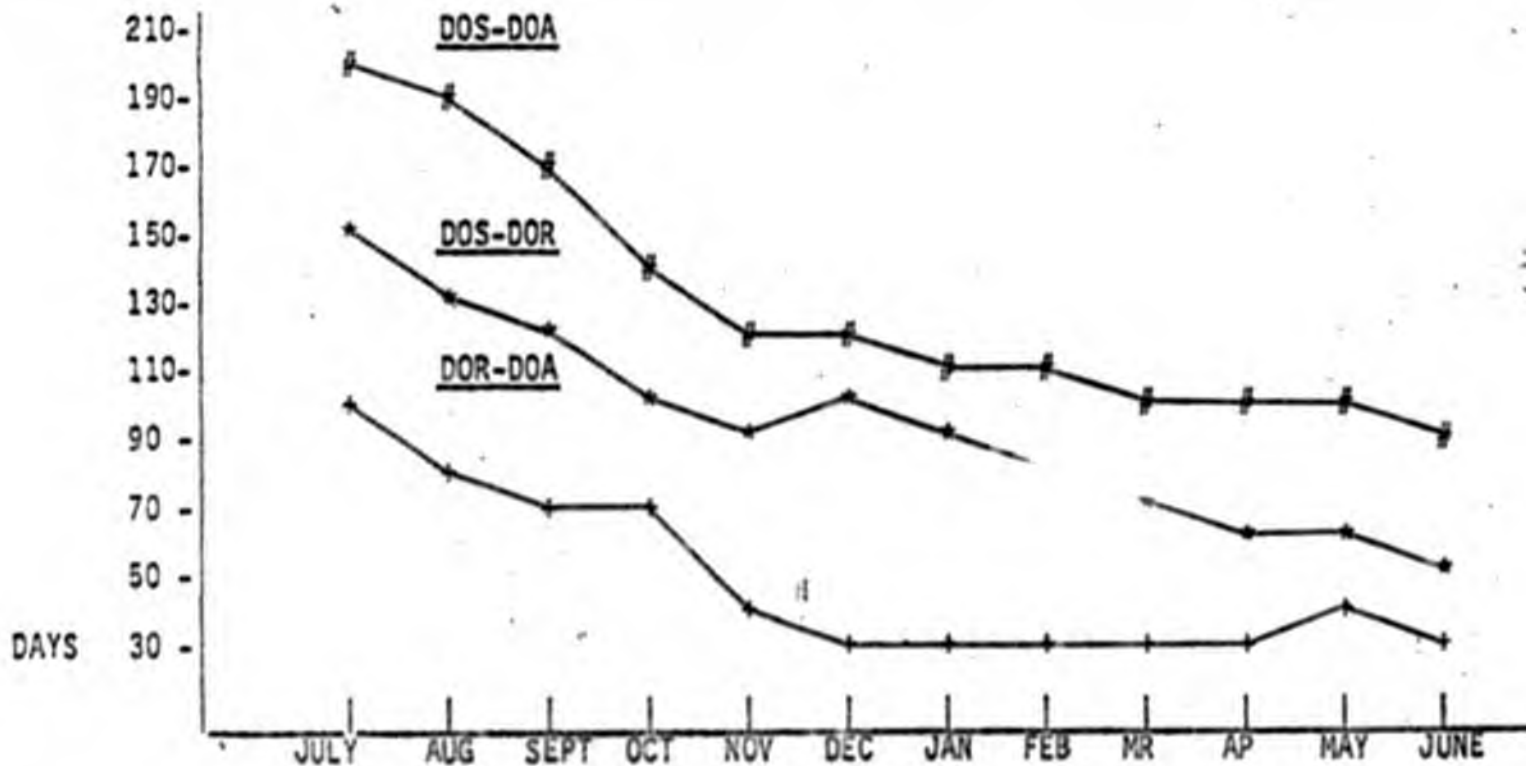
Sincerely,


Helen D. Beirne
Commissioner

Y 80
CSC ANALYSIS OF CLAIMS PROCESSING

DATE OF SERVICE-TO-DATE OF RECEIPT-TO-DATE OF ADJUDICATION

AVERAGE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MR	AP	MAY	JUNE
# OF CLAIMS	5331	6570	7232	10974	10519	9291	11141	11768	12387	12698	12195	10894
DATE OF SERVICE TO DATE OF RECEIPT	150	136	125	109	95	100	97	79	71	66	57	54
DATE OF RECEIPT TO DATE OF ADJUDICATION	100	79	71	67	45	28	26	28	31	34	45	31
DATE OF SERVICE TO DATE OF ADJUDICATION	205	194	173	141	123	124	113	107	101	99	102	85



HEALTH CARE FINANCING AMENDMENTS OF 1981 - MEDICAID

1. Limit Federal contributions to Medicaid to \$16.4 billion (\$100 million less than 1981) allowed to rise with the rate of inflation as measured by the GNP inflator.
2. All Federal requirements for eligibility and benefits for the Medically Needy are eliminated.
3. End AFDC coverage for the 18-20 year olds. Also eliminate the requirements for medicaid coverage to continue four months after AFDC termination.
4. Repeal "freedom of choice" requirements that beneficiaries can choose their own providers.
5. Eliminate Federal requirements for the amount and methods of reimbursement of providers.
6. Eliminate specific methods of utilization and control, effective PSRO's will be funded until 1983. States will establish their own requirements and contract for review.
7. Permit coverage of approved non-medical coverage to prevent institutionalization.
8. The Secretary will provide waivers to states for other provisions:
 - a. That all provisions be in effect state-wide.
 - b. Cooperative agreements with state health and Vocational Rehabilitation.
 - c. Requirements for review of nursing home patients.
 - d. Licensing of nursing home administrators.
 - e. Prohibitions of co-payments by the categorically needy for outpatient hospital and emergency room services.
 - f. Requirements which prevent states from sharing savings with recipients of cost effective care.
9. Repeal Early Periodic Screening notification of AFDC children.

10. Eligibility of non-U.S. citizens take in the income of their sponsors
11. Civil penalties to punish fraud, providers will be fined up to \$2,000 and twice the amount of the fraudulent claim.
12. Higher Federal matching for automated eligibility systems. Match state expenditures 90% for system development and 75% for operation.
13. Immediate return of Federal "disallow" funds pending appeal of state claim.

AFDC ADMINISTRATION PROPOSALS FOR 1982

1. Income ceiling at 150% of state standard of need.
2. Dependent children defined to the age of 18.
3. No AFDC to workers on strike.
4. AFDC to pregnant women only in the third trimester.
5. Standardize allowable resources.
6. Count lump-sum income only in the month received.
7. Count income of step-parents and other unrelated adults living in the home.
8. Count sponsor's income for aliens.
9. Consider food stamps and housing subsidies as income.
10. Standardize work related income (\$75/mo.) and child care (\$50/mo.) 'Income Disregard' of \$30 + one third discontinues after 4 months of employment.
11. States required to establish community work experience programs:
 - a. Age 16-65 unless in high school, disabled or caring for small children.
 - b. divide family AFDC + Food Stamps by minimum wage to determine the number of hours required to work.
 - c. Those attending college required to meet work requirements.
12. Improve Administration:
 - a. Prompt correction of over/under payments.
 - b. eliminate payments under \$10.
 - c. Liens on AFDC homes.
 - d. AFDC payments based on previous month.
 - e. More vendor payments for AFDC.
 - f. Information access to government agencies on AFDC cases.
 - g. Establish Government recipient information system
 - h. State training match 50%

ADMINISTRATIVE PROPOSALS FOR LEGISLATIVE CHANGES TO TITLE II (CSEA)

1. CSEA collects alimony and child support payments.
2. The IRS will collect alimony and child support payments from administrative orders.
3. Repeal bankruptcy declaration to avoid the payment of child support.
4. Charge 10% of support collected for administrative costs.
5. Federal payments to states for AFDC reduced from 15% to 7½%.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

JAY S. HAMMOND, GOVERNOR

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

May 6, 1981

Document# 125-81

The Honorable Charles Parr
Alaska State Senate
Pouch V, State Capitol
Juneau, AK 99811

Dear Senator Parr:

Recently you requested information regarding the status of Delta Dental's Medicaid contract with this Department. Our Director of the Division of Public Assistance has prepared a short briefing paper on this issue which we thought would be of interest to you.

If you have further questions, please do not hesitate to contact me at 465-3030 or Rod Betit, the Director of Division of Public Assistance at 465-3347.

Sincerely,



Helen D. Beirne
Commissioner

Enclosure

DELTA DENTAL CONTRACT

The Department of Health and Social Services currently has a Medicaid/GR Medical Claims processing system wherein responsibility is shared between three parties:

- * Computer Science Corporation of Sacramento, California
- * Delta Dental Plan of Anchorage, Alaska
- * Alaska Division of Public Assistance

Currently, Delta Dental processes all dental billings submitted to the Department's Medicaid and General Relief Medical programs while all other types of claims are processed by Computer Science Corporation (CSC) and the Division of Public Assistance. This current system was designed as an interim solution to claims processing until such time that the Department could develop and install a more efficient claims system for the long term. The Department is presently nearing completion of the general design for this permanent claims system, scheduled for actual implementation in October 1982.

One of the issues facing the Department relative to design of this permanent system was whether to consolidate all claims processing under one contractor, or to continue processing dental claims under separate contract beginning in October 1982. Under either approach the contracts will be awarded on a competitive basis and will require state as well as federal approval of the procurement procedures used.

The Department has decided to release two Request for Proposals (RFP), one for design of a permanent claims processing system for all claims except dental, and one solely for processing of dental claims as is currently the arrangement with Delta Dental of Alaska.

Although this approach will permit Delta Dental to compete effectively for continued processing of dental claims for Medicaid and General Relief Medical beneficiaries after October 1982, it by no means guarantees that Delta Dental will ultimately be selected as the dental claim vendor. This decision will be made based on which vendor submits the lowest price for an acceptable system. It is fully expected that Delta Dental of Alaska will be competing for this contract against some of the largest private firms in the business including Computer Science Corporation, Blue Cross, Electronic Data Federal System, The Computer Company and Bradford National. Delta Dental will receive a 5% edge over some of these firms since it is an Alaska based business.

It should be noted that the Department has been satisfied with Delta Dental's contract performance to date, and that we intend to continue our current arrangement through September 1982. After that date, however, the Department must operate through the vendor submitting the best technical and cost proposals for the development, installation and operation of the dental claims system over a five year period.

Prepared by:
Division of Public Assistance
Department of Health & Social
Services
May 4, 1981

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC ASSISTANCE

POUCH H-07
JUNEAU, ALASKA 99811

November 28, 1980

Senator Charles Parr
S.R. Box 50599
Fairbanks, Alaska 99701

Dear Senator Parr:

On December 12 and 13, 1980, in Anchorage, at the Sheraton Hotel, the Medical Care Advisory Committee will be meeting to review the current operation of the Medicaid program and its future development.

As you may or may not know, this committee is an advisory group to the Commissioner of the Department of Health and Social Services on topics relating to the Medicaid program. I have attached a copy of our agenda in hopes that you will consider attending. I have also enclosed a list of the committee members in case you wish to contact any of them directly.

We would of course be happy to have you attend and participate in the discussions the committee has regarding the over-all operation of Medicaid.

Sincerely,


J. Ray Langdon, M.D.
Chairman

Enclosure

cc: Helen Bierne
Allen Korhonen
Rod Betit
Bob Ogden

Medical Care Advisory Committee

AGENDA

12/1213/80
Sheraton Hotel

December 12th

- 9:00 a.m. Approval of minutes - meeting August 11 & 12, 1980
- 9:15 a.m. Review of M.C.A.C. budget as developed by Division of Public Assistance
- 9:45 a.m. Development of Alaska Statutory authority for existence of Medical Care Advisory Committee
- 10:30 a.m. Break
- 10:45 a.m. Development of an E.P.S.D.T. sub-committee
- 12:00 Lunch
- 1:00 p.m. Report on the status of the Medical Health Care Project
- 2:00 p.m. Report of the Long Term Care sub-committee
- 3:00 p.m. Persons to be heard.

December 13th

- 9:00 a.m. Medicaid Operational Review
- (1) Current claims payment status
 - (2) FY 1979 Reconciliation Project
 - (3) FY 1980 Reconciliation Project
 - (4) Development of permanent claims payment and management reporting system.
- 10:30 a.m. Break
- 10:45 a.m. Report by David Johnson, M.D. regarding physician pricing issues surfaced during recent visit to Washington D.C.
- 12:00 Lunch
- 1:00 p.m. Usual and customary rates for physicians services under General Relief Medical
- 2:00 p.m. Review of Medical Review Section and it's location
- 3:00 p.m. Development of Provider Relations Seminars

MEDICAL CARE ADVISORY COMMITTEE

<u>Member & Address</u>	<u>Period of Term</u>
Chairman Dr. J. Ray Langdon 3401 East 42nd Ave. Anchorage, Alaska 99504	June 30, 1980 - 1981
Mr. David L. Swanson P.O. Box 1 Fairbanks, Alaska 99701	June 30, 1980 - 1982
Dr. David E. Johnson 3612 Tongass Ave. Ketchikan, Alaska 99901	June 30, 1980 - 1983
Denise Knapp Delta Dental P.O. Box 3-726 Anchorage, Alaska 99501	June 30, 1980 - 1983
Sister Barbara Haase Administrator Ketchikan General Hospital 3100 Tongass Ave. Ketchikan, Alaska 99901	June 30, 1980 - 1982
Dr. Dave Spence Chief Section of Family Health Division of Public Health Pouch H-06B Juneau, Alaska 99811	June 30, 1980 - 1981
Mrs. Norma Lundy 6 - 520 "H" Street Elmendorf AFB, Alaska 99503	June 30, 1980 - 1982
Principle Division Representative Rod Betit Division of Public Assistance Pouch H-07 Juneau, Alaska 99811	

POSITION PAPER

COMMITTEE SUBSTITUTE FOR HOUSE BILL NO. 330 (Finance) am

For an Act entitled: "An Act relating to payment of the cost of care of pregnant women; and providing an effective date".

CSHB No. 330 provides for the expansion of pregnancy-related health and social services.

a) Section 2 expands the Medicaid Program coverage of medical care services to certain women, who have countable incomes of less than \$457 a month; are single, or separated from their spouses; and have no other dependent children living in the home. The provision of the medical services will be financed on a 50/50 matching basis with state and federal revenues.

b) Section 3 of this Act authorizes state funding of the cost of non-medical services for pregnant women experiencing social and economic difficulties during the prenatal and postpartum periods. These services are to include the cost of birthing centers and midwife services, adoption assistance, counseling, transportation, care received in maternity and foster homes, and training in parenting skills.

DISCUSSION

Current Services

The Department of Health and Social Services is one of multiple private and public resources providing pregnancy-related services to Alaskan women. The Department takes an active role in assuring that public health nursing and social services are available throughout the State.

1) The Division of Family and Youth Services provides adoption placement and family counseling for Alaskans.

2) The Division of Public Assistance provides financial, food and medical assistance for low income women through the Aid to Families with Dependent Children, Food Stamp, Medicaid, General Relief Medical and Adult Public Assistance programs.

3) The Division of Public Health provides health care screening, including pregnancy testing and prenatal counseling, education, referral and follow-up through the activities of Public Health Nurses. Nutrition supplement and education is offered to low income pregnant women and their children in 26 communities by the Women, Infant and Children Program. In addition, the Division also sponsors medical care financing for low income and medically high risk women through demonstration projects in Juneau and Fairbanks.

Gaps in Services

Although the Department offers a wide range of public services, many women experience difficulties and hardships in obtaining timely and adequate pregnancy care. These difficulties are associated with economic barriers to private care and the unavailability of many services in rural communities. These gaps in pregnancy related services may be summarized as:

(1) Financial inability of many low income and adolescent women to purchase medical care from private providers, and to pay for travel outside of their communities for medically necessary care.

(2) Fragmentation of the pregnancy care delivery system, that inhibits provision of education, counseling, referral, medical and follow-up services required by many women.

(3) Unavailability of many pregnancy-related services in rural communities.

(4) Lack of appropriate housing near major medical centers, where women from rural communities may stay while obtaining outpatient maternal care services.

(5) Insufficient adoption counseling and placement services.

CSHB No. 330 addresses some of the gaps that occur in the delivery of prenatal care. Section 2 offers medical care coverage to single or separated, low income women who have no dependents living in the home. This Act will effectively provide medical care to certain women (approximately 286), who have not been Medicaid eligible. The state previously had this unborn child coverage in the Medicaid Program, but the legislature eliminated it in 1976 for budgetary reasons.

Section 3 of this Act will expand the types of social and other non-medical services available to maternal clients beyond the present scope of State sponsored activities. The services offered will include birthing center and midwife services, counseling, round trip transportation between a client's residence and maternity or foster home, adoption assistance and training parenting skills to potentially all women experiencing social and economic difficulties associated with childbearing. It is anticipated that provision of maternity and foster home care will be administered through contract arrangements with community based services by the Division of Family and Youth Services.

While Section 3 offers fairly comprehensive social and other non-medical support services, there will continue to be gaps in the medical care services. Many women with countable annual incomes exceeding approximately \$5,500 do not qualify for medical assistance. These women often experience more difficulties in purchasing medical care than those who are eligible for public assistance.

In some cases women who are receiving the social and other non-medical services provided by this Act, will continue to be ineligible for medical care assistance that is necessary for a successful pregnancy outcome.

RECOMMENDATIONS

Recommendation A:

This Act offers transportation, counseling, adoption assistance and maternity or foster home care to women experiencing economic and social difficulties associated with childbearing. The Bill at the present time does not include specific definitions of "economic and social difficulties associated with childbearing", but allows the department to adopt regulations to define those terms. As part of the adoption of regulations process, we intend to conduct public hearings to assist us in formulating appropriate standards on which to determine eligibility for such aid. At this point, it is perceived that we would draft proposed regulations which would define (1) economic need to be up to 200% of the Federal Community Services Administration's Alaska Non-Farm Poverty Guideline (attached), and (2) social need to include pregnant women who are at risk of being unemployed or under employed, dependent upon welfare, inadequately educated, unable to function socially or having psychiatric problems.

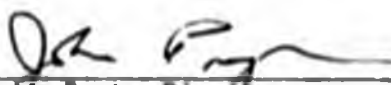
Recommendation B:

Section 3 provides for social and other non-medical services associated with the prenatal and postpartum periods of pregnancy. The House in passing CSHB 330 added a floor amendment to this Section which would cover the cost of midwife and birthing center care. Since these services are primarily associated with medical care, we recommend that CSHB 330 be amended to reflect the medical care status of these services. These amendments would add medicaid coverage for certain needy women for care received from a birthing center or a nurse midwife. By adding these services to medicaid, the state would realize additional federal funds for covering medical care services. To incorporate nurse midwife and birthing center services into the medicaid, the Department recommends the attached amendments.

POSITION

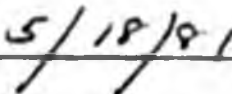
The Department recognizes the value of the needed services that will become available to certain women. We endorse the health promotion concepts of this Bill and feel that it will contribute to the comprehensiveness of pregnancy related services throughout Alaska.

Recommended by:



John Pugh, Director
Division of Family and Youth
Services

Date:



5/18/81

POSITION PAPER/Department of Health & Social Services

Rod Betit

Rod Betit, Director
Division of Public Assistance

Date:

May 18, 1981

David Bruce

David Bruce, Deputy Director
Division of Public Health

Date:

May 15, 1981

Approved by:

H. D. Beirne

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

Date:

5/18/81

Community Services Administration
Non-Farm Poverty Income Levels for Alaska

March 5, 1981

<u>Size of Family</u>	<u>Poverty Income</u>	<u>200% Poverty Income</u>
1	\$5,410	\$10,810
2	7,130	14,260
3	8,850	17,700
4	10,570	21,140
5	12,290	24,580
6	14,010	28,020

Original sponsors: Miller, Martin,
Carney, et al

Offered: 4/30/81
Referred: Rules

IN THE HOUSE

BY THE FINANCE COMMITTEE

CS FOR HOUSE BILL NO. 330 (Finance) am
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE - FIRST SESSION
A BILL

For an Act entitled: "An Act relating to payment of the costs of services for pregnant women; and providing for an effective date."

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

*Section 1. LEGISLATIVE FINDINGS AND PURPOSE. The legislature finds that there are insufficient maternal and infant care services available to women experiencing social and economic difficulties associated with child-bearing. As a result of these inadequate services, some children may develop health conditions that require state-supported services throughout their lives. In order to promote healthier generations of Alaskan, the legislature wishes to invest in the state's future by providing prenatal care and social services to pregnant women.

*Sec. 2. AS 47.07.020(b) is amended by adding a new paragraph to read:
(8) women who are medically confirmed to be pregnant.

*Sec. 3. AS 47.07.030 is amended to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, home health care services early periodic screening and diagnosis and treatment of persons under 21 years of age, clinic services, nurse midwife, treatment of speech, hearing and language disorders, and reasonable transportation to and from the point of medical care. No additional services may be provided unless approved by the legislature.

*Sec. 4. AS 47.07.080(4) is amended to read:

(4) "Clinic services" means services which are restricted state-approved outpatient community mental health services which receive grants under AS 47.30.520 - 47.30.620 and state-operated mental health clinics and birth centers licensed by the state under AS 18.20.010 - 18.20.130

*Sec. 5. AS 47.07.080 is amended by adding a new subsection to read:

(5) "Nurse midwife" means a registered professional nurse who is certified as an advanced nurse practitioner under AS 08.68.410 (a) and authorized to practice as a nurse midwife under regulations adopted in accordance with AS 06.68.410(5).

*Sec. 6. AS 47 is amended by adding a new chapter to read:

CHAPTER 42. PURCHASE OF SERVICES FOR PREGNANT WOMEN.

Sec. 47.42.010. PURCHASE OF SERVICES FOR PREGNANT WOMEN. The Department of Health and Social Services shall pay the cost of prenatal services other than medical services for a pregnant woman experiencing social and economic difficulties, [INCLUDING THE COSTS OF BIRTHING CENTERS, MIDWIFE SERVICES] and transportation to and from a maternity home or a foster home, counseling, adoption assistance, maternity home and foster home care, postnatal care, and parenting skills.

Sec. 47.42.020. LICENSING AND SUPERVISION. (a) A person providing services purchased by the Department of Health and Social Services under this chapter shall be licensed and supervised in the same manner as foster homes, boarding homes, maternity homes, and other agencies and institutions under AS 47.35.010 - 47.35.100.

(b) Nothing in this section requires the licensing of [MIDWIFE AND] transportation services provided to a pregnant woman under this chapter.

*Sec. 7. This Act takes effect immediately in accordance with AS 01.10.070(c).

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CS FOR HOUSE BILL NO. 330 (Finance) am
 Title "An Act relating to payment of the cost of care for pregnant women"
 Requested by House HESS Committee Date May/8, 1981

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services
 Program Category Affected Health & Social Services
 RRU, Program, or Subprogram(s) Affected Various - See separate fiscal notes attached.
 (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 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES		40.7	44.4	48.4	52.7	57.4
200 TRAVEL		1.7	1.9	2.0	2.2	2.4
300 CONTRACTUAL		4.8	5.2	5.7	6.2	6.8
400 COMMODITIES		.4	.4	.5	.5	.6
500 EQUIPMENT		1.2				
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		2,584.1	2,816.6	3,070.2	3,345.5	3,647.7
TOTAL		2,632.9	2,868.5	3,126.8	3,408.1	3,714.9

FUNDING (Thousands of Dollars)

GENERAL FUND		2,418.4	3,634.7	2,872.0	3,130.3	3,412.1
FEDERAL FUNDS		214.5	233.8	254.8	277.8	302.8
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		1	1	1	1	1
PART TIME						
TEMPORARY						

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

Attached Social and Health Service Analysis.

IV. DATE May 7, 1981

PREPARED BY Dwayne Peoples
 AGENCY Department of Health and Social Services
 PHONE 465-3100

Original: Legislative Finance
 cc: Budget and Management
 Prime Sponsor (First Legislator Named) M. H. ... M&B Approval M. H. ... Date 5/7/81

I. REQUEST
 Bill/Resolution No. CS FOR HOUSE BILL NO. 330 (Finance) am
 Title "An Act relating to payment of the costs of care for pregnant women...."
 Requested by House HESS Committee Date May 18, 1981

II. FISCAL DETAIL
 Agency Affected Department of Health and Social Services
 Program Category Affected Social Services
 IRU, Program, or Subprogram(s) Affected _____
 (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 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES		47.7	44.4	48.4	52.7	57.4
200 TRAVEL		1.7	1.9	2.0	2.2	2.4
300 CONTRACTUAL		4.8	5.2	5.7	6.2	6.8
400 COMMODITIES		.4	.4	.5	.5	.6
500 EQUIPMENT		1.2				
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		2,155.1	2,349.0	2,560.5	2,790.9	3,042.1
TOTAL		2,203.9	2,400.9	2,617.1	2,852.5	3,109.3

FUNDING (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
GENERAL FUND		2,203.9	2,400.9	2,617.1	2,852.5	3,109.3
FEDERAL FUNDS		0	0	0	0	0
OTHER (Specify Fund Source)						

POSITIONS

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
FULL TIME		1	1	1	1	1
PART TIME						
TEMPORARY						

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

In 1979 there were 9,129 births to Alaskan residents. 1,273 or 14% were births to unmarried women.

1979 Births to Unmarried Women

<u>Age of Mother</u>	<u>Number of Births</u>
Under 15	9
15-19	440
20-24	504
25-29	224
30-34	76
35-39	16
40-44	4
	1,273

IV. DATE 5/18/81 PREPARED BY John R. Pugh John R. Pugh, Director
 AGENCY Division of Family and Youth Services

Original: Legislative Finance
 CC: Budget and Management
 Prime Sponsor (If Not Legislative Counsel) M&B Approval [Signature] Date 6/1/81

The Department assumes that the services delineated in this Bill would be utilized mostly by unmarried women. Using this pool as the target group the Department would further assume that the more youthful unmarried women (under 15-24) would be more likely to utilize maternity and foster home care; whereas the older group (25-44) would utilize the community services, such as counseling and adoption assistance.

The younger age group consists of 953 women. The Department estimates that approximately 200 of this group would avail themselves of the services of a maternity home or foster home (75 maternity and 125 foster), another 250 would utilize available counseling and adoption assistance, and 30 would use birthing centers and midwife services.

The older age group consists of 320 women. The Department estimates that approximately 50 women would utilize maternity homes or foster home care (15 maternity and 35 foster homes). An additional 100 would utilize counseling and adoption assistance. The Department estimates 20 would use birthing centers and midwife services.

The Department recommends that the entire range of services be contracted out to local community providers. This would reduce the amount of administrative costs. However, it is recommended that an Associate Coordinator (Range 18) be established to coordinate the program on a statewide basis. This individual would be responsible for planning, program development, preparation of requests for proposals and contracts, and contract monitoring and program evaluation.

Estimated costs are as follows:

Foster Home Care

160 persons x \$422/mo. x 6 mos. = \$ 405,120

Maternity Home Care

90 persons x \$2,250 (\$75.00 per day) x 6 mos. = \$1,215,000

Counseling/Adoption Assistance

350 persons x \$1,000 = \$ 350,000

Transportation To and From Placement

250 persons x \$500 average/trip = \$ 125,000

Birthing Centers and Midwife Services

50 persons x \$1,200 = \$ 60,000

Subtotal \$2,155,120

Associate Coordinator, Range 18

Personal Services	\$40,665	
Travel	1,728	
Contractual	4,798	
Commodities	400	
Equipment	<u>1,230</u>	\$ 48,821

TOTAL \$2,203,941

The costs for Associate Coordinator position includes: Travel - two trips of three day each to perform program reviews; Contractual - telephone rental and long distance of \$678, postage of \$300, copier usage of \$120, printing and advertising of \$1,000, and office space rent of \$2,700; Commodities - \$400 for general office supplies; and Equipment - \$1,230.

A 9% inflation rate has been added to future years' estimated costs.

Medical costs will be borne by the Division of Public Assistance.

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CS FOR HOUSE BILL NO. 330 (Finance)am
 Title "An Act relating to payment of the costs of care of pregnant women..."
 Requested by House HESS Committee Date 5/7/81

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services
 Program Category Affected Health
 BRU, Program, or Subprogram(s) Affected Medicaid
 (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 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
70 GRANTS, CLAIMS, ETC.		429.0	467.6	509.7	555.6	605.6
TOTAL		429.0	467.6	509.7	555.6	605.6

FUNDING (Thousands of Dollars)

GENERAL FUND		214.5	233.8	254.9	277.8	302.8
FEDERAL FUNDS		214.5	233.8	254.8	277.8	302.8
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

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

Approximately 286 pregnant women would be added to the Medicaid program. The addition of this coverage under Medicaid would reduce participation under the General Relief Medical program by approximately 95 women, who would become eligible for Medicaid. The remaining 191 women would be new eligibles who do not receive coverage under the General Relief Medical program because of the method used in counting available income.

The average cost per case is approximately \$1500 for FY 82. Because of the reduction in General Relief Medical participation, the cost of the program will also be reduced, making funds available to become the state General Fund matching portion of the Medicaid program coverage. Therefore, new state General Fund matching is 72.0 (214.5 - 142.5 = 72.0).

IV. DATE 5/7/81 PREPARED BY David M. Davidson
 AGENCY Division of Public Assistance
 Original: Legislative Finance PHONE 465-3347
 cc: Budget and Management
 Prime Sponsor (First Legislator Named) MSB Approval David Hubbard Date 5/7/81

FISCAL NOTE

I. REQUEST

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Agency Affected Department of Health and Social Services
 Program Category Affected Health
 BRU, Program, or Subprogram(s) Affected General Relief Medical
 (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 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		(142.5)	(155.3)	(169.3)	(184.5)	(201.1)
TOTAL		(142.5)	(155.3)	(169.3)	(184.5)	(201.1)

FUNDING (Thousands of Dollars)

GENERAL FUND	(142.5)	(155.3)	(169.3)	(184.5)	(201.1)
FEDERAL FUNDS					
OTHER (Specify Fund Source)					

POSITIONS

FULL TIME					
PART TIME					
TEMPORARY					

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

IV. DATE 5/7/81 PREPARED BY David M. Davidson
 AGENCY Division of Public Assistance
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Pregnancy Related Health and Social Services

Service Agencies	Eligibility Requirments	Services	Population Served	Service Gaps
Maternal & Infant Care Project - Juneau	<p>pregnant women who resides in the Juneau City and Borough</p> <p>high risk conditions of pregnancy and low income (up to \$12,500 for a family of 2) in the city care</p>	<p>a. education, and counseling available to all</p> <p>b. medical care assistance provided according to a family's ability to pay based on a sliding fee scale</p>	<p>approx. 125 per year</p> <p>approx. 70 per year</p>	<p>Limitation of financial assistance to only those women in target area. All other low income women experience difficulties in obtaining care.</p>
Improved Pregnancy Outcome Project - Fairbanks	<p>pregnant women who reside in the Fairbanks Borough</p> <p>pregnant and low income women (up to \$12,500 for a family of 2)</p> <p>high risk medical conditions of pregnancy and low income (up to \$12,500 for a family of 2)</p>	<p>a. education counseling, and patient follow-up to all</p> <p>b. Medical care assistance for initial prenatal physician visit. The amount of assistance is provided according to a family's ability to pay based on a sliding fee scale.</p> <p>c. Medical care assistance for all outpatient prenatal medical care. The amount of assistance provided according to a family's ability to pay based on a sliding fee scale.</p>	<p>approx. 250 per year</p> <p>projected 70 per year</p>	<p>Prenatal medical care assistance not available to low income women who are not medically high risk. No inpatient medical care assistance is provided.</p>

Pregnancy Related Health and Social Services

Service Agencies	Eligibility Requirements	Services	Population Served	Service Gaps
General Relief Medical	low income (Adult 1 child \$4,000 per year) who are not eligible for Medicaid coverage	medical care assistance	approx. 7,000 per month	Those who fall marginally above the income guidelines are not eligible for assistance.
Catastrophic Illness	those who have suffered a catastrophic illness/injury and who do not have the resources to meet the expenses	medical assistance as determined by a three member committee	approx. 300 per year	Doesn't cover normal pregnancies and limited to "catastrophic illness"
Medicaid	must be covered by State and categorical programs such as AFDC or Adult Public Assistance	medical care assistance to those individuals eligible for categorical programs	approx. 18000 per month	Low income people not eligible for categorical programs experience difficulties in obtaining medical care.
<u>of Public Health</u>				
Public Health Nursing	None	health screening, including pregnancy testing, prenatal education and counseling, post-partum follow-up home visiting and well child clinics	approx. 4,000 visits per month	Lack of unified counseling education and referral services. The unavailability of some services on full-time basis in rural communities.
Women Infant Children (WIC)	low income (family of 2, up to \$12,500) pregnant women and children up to age 5	nutrition supplement coupons and nutrition education and counseling	approx. 1600 per month in 26 communities	Estimated 36000 potentially eligible statewide not being served
Early, Periodic, Screening, Diagnosis and Treatment (EPSDT)	under 21 years of age, Medicaid eligible	preventive health screening services for children and adolescents, referral to treatment and medical care assistance through Medicaid	approx. 7,000 per year	Low income families who are not qualified for Medicaid do not receive medical treatment services.
Handicapped Childrens Program	children with physical and handicapping conditions	Medical diagnostic assistance provided to all - medical treatment based upon a sliding fee scale - of a family's ability to pay. Transportation and per diem are also included.	approx. 1800 per year	Premature newborns are not covered by this program.

Pregnancy Related Health and Social Services

Service Agencies	Eligibility Requirements	Services	Population Served	Service Gaps
<u>v. of Family & Youth Svs.</u>				
1. Family Counseling	None	marriage, parenting, family adolescent, and crisis intervention counseling	approx. 1000 per year	Staff time available is limited.
2. Foster Home Care	State must have legal custody of client.	counseling, foster care placement, financial assistance, medical care through Medicaid	approx. 1040 per year	Insufficient foster homes.
3. Adoption Counseling & Placement	State must have legal custody of client to provide adoption placement services. Adoption counseling is available to anyone on request.	counseling, screening and placement	approx. 40 adoption placements per year	Additional counseling services needed.
<u>v. of Public Assistance</u>				
1. Food Stamps	low income (\$6,300 for a family of 2)	Food supplement coupons	approx. 38000 per month	There are no regional adjustments cost of living. One income and benefits standard is used state-wide which results in inequities of purchasing power.
2. Aid to Families with Dependent Children (AFDC)	low income women(\$5,500 per year for a family of 2) who are single or separated with dependent children living in the home	income maintenance and medical care assistance through Medicaid	approx. 13000 per month	Women who meet the income and single/separated status but are pregnant with no dependents living in the home are ineligible. Low income women who are married with the spouse living at home are ineligible.
3. Adult Public Assistance	blind, disabled and aged, with income of \$5,700 per year for single adults	income maintenance, and medical assistance through Medicaid	approx. 5000 per month	Those blind, disabled and aged that are above the income guidelines

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

JAY S. HAMMOND, GOVERNOR

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

June 2, 1981

Document# 153-81

The Honorable Vic Fischer
Alaska State Senate
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Fischer:

Recently you requested information regarding the coverage of three major Alaska Area Native Health Service satellite clinics in Ketchikan, Juneau, and Fairbanks to bill for Medicaid-eligible services and the state to receive 100% federal reimbursement. Representative Clocksin's staff made a similar request, but indicated that they wished to have available to him more limited language to make that necessary statute adjustment. We have prepared a response to that request. We thought it might be of interest to you to see another more limited way to amend the statutes to accomplish the same goal. We have attached it for your reference.

You will note that our estimate of federal fiscal impact due to the passage of such a change to Medicaid has been revised downward from our previous figure. We currently estimate the costs to be about \$750,000 to \$1,000,000 in the first fiscal year of operation. This is due to the receipt of more current information from AANHS based on its actual billing history.

We appreciate the opportunity to comment on this matter.

Sincerely,



Helen D. Beirne
Commissioner

MEDICAID UTILIZATION MANAGEMENT PROGRAM

QUARTERLY REPORTS

SECTION II

June 1981, No. 17

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A. ACTIVITIES OF THE OFFICE OF QUALITY CONTROL PROGRAMS

MEDICAID QUALITY CONTROL

Administrators of state Medicaid programs are challenged with developing and maintaining adequate management control to assure the accurate and appropriate expenditure of Medicaid funds. The Medicaid Quality Control (MQC) program is a tool with which the states can monitor the strengths and weaknesses of their MMIS system, and more specifically, the accuracy of eligibility determinations/terminations and state payments/denials. The MQC program also assists in identifying areas requiring corrective action, as well as targeting liable third parties to recover incorrectly expended state funds.

Title XIX of the Social Security Act requires that the Department of Health and Human Services (DHHS) assure proper and efficient administration of the Medicaid program by the states. The MQC program under the direction of the Office of Quality Control Programs, Bureau of Quality Control (BQC) in HCFA, represents this joint state-federal effort to improve program administration, reduce errors and prevent monetary forfeiture. All states participating in the Medicaid program are required to have MQC systems in operation.

The MQC program was designed to identify case and payment errors so that corrective action can be undertaken to prevent repetition. Data collected through the system must be fully analyzed so that strengths and weaknesses can be recognized. Analysis is performed

at three levels: state, regional and federal. States are required to investigate a statistically valid sample of eligible Medicaid beneficiaries' cases based on total monthly Medicaid caseload. Both the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) programs established their own individual quality control checks prior to the development of the MQC system. A determination is made as to whether the eligibility and payment status on these claims is accurate. Subsequently, HCFA staff review a representative sampling of these cases to evaluate state determinations. The MQC examiners utilize findings from the quality control systems of the other two programs to obtain information about those beneficiaries who are also covered by Medicaid. Through this integrated system, duplicative reviews are avoided and sample accuracy is increased.

The following fundamental elements are inspected by the MQC program:

- verification of the accuracy of eligibility determinations;
- examination to determine whether the state has taken action to recover monies for which other third parties are liable;
- examination of the accuracy of state payment of Medicaid claims for active cases;
- review of the accuracy of denials and terminations of eligibility; and
- examination of the types of services that may be covered and reimbursement levels.

These reviews are meant to assure that public funds are directed only to beneficiaries who are eligible under state and federal law, that claims are paid only for covered services to eligible providers in the correct amount, and that third party liability (TPL) is fully recognized, thereby assuring Medicaid as the payor of last resort (after other liable parties, such as Medicare, insurance companies, Workers' Compensation plans, absent fathers and estates of deceased persons, have paid their proper share of a beneficiary's medical expenses).

All quality control periods are conducted on six-month cycles from October to March and from April to September. States individually sample approximately 78,000 cases during each semi-annual period out of an estimated monthly list of 9.3 million cases in the Medicaid program. The HCFA staff re-examines approximately 16,000 of these cases to assure the accuracy of the states' findings. The results are then utilized in computing eligibility, claims processing (CP) and TPL error rates for every state for each six-month review period.

Under current regulations, states with error rates above the national average are required to reduce eligibility error rates by approximately 15.7 percent annually. The results of the base review period are compared with results of present periods to determine if states have met the required error rate reduction targets. Federal matching payments are disallowed if performance targets are not met. If this is the case, corrective actions are recommended.

By regulation, all states are required to submit a formal plan each July that specifies what actions are planned to correct problems uncovered through the MQC process. Most states initiate corrective action throughout the year, based on individual case findings or on a pattern of findings that are attributed to system defects. Both state and federal MQC staff participate in planning corrective action and some states and regional offices have established corrective action committees. Federal staff also provide on-site technical assistance to states requesting aid in reducing high error rates.

Medicaid Action Transmittal No. 80-67 (September 1980) clarified the following calendar dates for review completion and reporting deadlines:

1. States are required to report progress in completing their reviews via telephone on a bi-weekly basis.
2. On a monthly basis, states must identify the reviews they have completed and their findings for those cases in a written report.
3. Within eight months of the close of the sample period, states must submit eligibility, TPL and CP data. Therefore, the deadlines are May 31st for the April to September review period and November 30th for the October to March review period.
4. Within ten months of the completion of the April to

September sample period, (or by a deadline of July 31st) states must submit an annual corrective action plan for reducing their error rates. Similarly, January 31st is the deadline for the October to March sample period.

MQC began these reviews with the 1978 base-line period. The first three months of 1979 were set aside as a "grace period" in anticipation of the states' tightening up their programs. Therefore, the first actual review period began in April of 1979. Most states have made considerable improvements in determining Medicaid payments as shown with the following findings for the July to December 1978 and the April to September 1979 review periods:

- . The national weighted average eligibility payment error rate (excluding SSI cases) decreased from 6.2 percent in the July to December 1978 base period to 4.9 percent in the April to September 1979 review period.
- . The national weighted average eligibility payment error rate for all Medicaid cases decreased from 5.1 percent in the July to December 1978 base period to 4.33 percent in the April to September 1979 review period.
- . The national weighted average eligibility payment error rate for Medical Assistance Only (MAO) cases decreased from 6.5 percent to 5.2 percent; for AFDC, decreased from 2.7 percent to 2.3 percent; and for SSI cases,

increased from 1.7 percent to 2.1 percent.

- . The national weighted average gross TPL payment error rates decreased from 0.5 percent to 0.3 percent and the case error rate decreased from 0.8 percent to 0.7 percent.
- . The national weighted average CP gross and unduplicated payment error rates for the April to September 1979 review period was 0.5 percent.
- . The deflated national CP payment error rate for the July to December 1978 review period was 1.6 percent (prior to revision of the CP review methodology), and the gross national payment error rate for the April to September 1979 review period was 0.5 percent.
- . The total national weighted average gross payment error rate for the April to September 1979 review period was 5.1 percent and the unduplicated rate was 5.0 percent.

Many states are assessing this data in preparation for corrective action planning.

Approximately 1,000 state man-year equivalents consisting of supervisors, reviewers, statisticians, clericals and others comprise the MQC state work force. Over 600 of these state employees are reviewers. Staff turnover is high due to extensive travel requirements. At the federal regional level, there are 147 staff members working on the MQC program. In the central

office there are 29 MQC staff members. The cost of such staffing can be viewed as nominal in contrast with the benefits accrued by the review system in identifying problem areas and system defects, and ultimately recouping monies for which other third parties are liable. (For further cost-benefit information, see the Research Study on third party recovery beginning on page 13 of this issue.)

Numerous clarifications and revisions of instructions and policies have been disseminated as a result of these findings to further assist state Medicaid administrators in utilizing the MQC system to their benefit, i.e., calendar dates, to emphasize that reviews must be completed by the required dates, as previously cited.

- Certain specific data entries for complete conveyance of case information have been made optional for the states.
- Corresponding edits for MQC Review Schedule coding have been appended to the regulations.
- More efficient instructions for capturing TPL data have been established.
- A number of proposed editorial changes would facilitate reading of the regulations and are not intended to have any substantive effect on requirements.

These technical changes help to clarify the requirements of the MQC program, provide a better flow of information and promote more efficient management of the Medicaid

program. The MQC system represents a systematic approach to monitoring the effectiveness and validity of the Medicaid program.

INTERVIEW WITH JOHN BERRY, DIRECTOR, OFFICE OF QUALITY CONTROL PROGRAMS

To further enhance the understanding of MQC program objectives and the implications of future MQC programs, an interview was recently conducted with Mr. John Berry, Director of the Office of Quality Control Programs. Mr. Berry has been with MQC for two years. Prior to that, he was employed in a variety of management assistance positions in a regional office and earlier with the Department of Defense.

The Office of Quality Control Programs performs the following functions:

- Designs and implements statistically-based reviews to determine the effectiveness of Quality Control Programs operated by carriers, intermediaries, state agencies, the Office of Direct Reimbursement and other related organizations.
- Develops and promulgates policies, standards and guidelines for state MQC programs, state utilization control programs, EPSDT penalty surveys, the Part A Quality Assurance Program, the Part B end-of-line review and other similar formal QC efforts.
- Designs and implements new QC programs (i.e., EPSDT QC) to

assure proper expenditures of federal funds by carriers, intermediaries, state agencies and other HCFA-related organizations.

- Initiates recommendations for financial penalties and disallowances on the basis of formal review results.
- Evaluates regional performance in monitoring QC programs and conducting sample reviews.
- Participates with other HCFA components in developing regulations, policies and procedures for program administration.
- Provides consultation and technical guidance to carriers, fiscal intermediaries, state agencies and regional offices.

QC programs presently in place consist of state MQC programs, the Part A Quality Assurance Program and the Part B end-of-line review. Two programs are presently under review, according to Mr. Berry. These are: the Negative Case Action QC program, which examines Medicaid beneficiaries incorrectly terminated or denied access to program benefits, and the Utilization Review QC program, which examines the decision to place and retain individuals in long-term care facilities. The former may be reduced due to staffing constraints and lack of management involvement; the latter is being reviewed for cost effectiveness.

The EPSDT QC program has been shifted to the Bureau of Program

Operations (BPO). BQC ran the first quarter review and then transferred the responsibility to BPO to enhance efficiency. For provider information, Mr. Berry suggested contacting Mr. John Jansak, Director, Office of Standards and Performance Evaluations at (301) 594-8432.

The Cost Report Evaluation Program (CREP) is currently responsible for Medicare hospital cost reporting. This quality control program entails the evaluation of the correct allocation of hospital costs to the Medicare program. The rigorous review program is on its third year run, and HCFA is examining the feasibility of expanding the program to cover Medicaid. This information helps substantiate the costs associated with rendering quality care and can be used to more efficiently examine hospital reimbursement levels. HCFA is "not interested in a sanction right now, but dollars saved," according to Mr. Berry. A pilot program has been initiated this year involving 35 states with Medicaid programs. "Preliminary results will not be available until late this summer and final results early next year," claims Mr. Berry.

QC is one of HCFA's approaches to controlling Medicaid expenditures. According to Mr. Berry, the purpose of the MQC program is "to conserve program dollars for eligible beneficiaries. The QC program's success must be measured by improvements in the overall program." Mr. Berry feels the program is an "attention getter." The states have responsibility for the MQC program and "cooperate to upgrade ideas on how to solve problems." MQC performs top-down reviews,

beginning at the state level, in contrast with MAR and SURS (Validation Office), under which reviews are conducted upwardly, beginning with individual providers. MQC has provided additional input to the MARS reports, whereas MARS data is not a source of feedback for MQC evaluations.

According to Mr. Berry, MQC is attempting to reduce the burden on states while continuing to promote accurate and timely data. The findings for the October 1979 to March 1980 review period have recently been released. This latest published report calls for disallowance of federal funds incorrectly/inappropriately expended in 10 states, but this was suspended in favor of taking corrective action.

State error rates have been found to be inconsistent between review periods. HCFA is looking to reduce samplings where error rates are low and increase samplings where state error rates are high due to a shortage of program funds.

MQC review has been used to encourage the development of the Medicaid Management Information System (MMIS). MQC will become an important tool in examining MMIS contract performance and in expediting evaluation, according to Mr. Berry. As an example, the federal MQC CP review uncovered substantial Medicaid funds that are not being reviewed by a particular state, as well as a major flaw in the contractual relationship between that state and its fiscal agent. The state is renegotiating the terms of the contract to correct these problems.

Federal and state budgets for medical services to the indigent face many constraints. Some states are electing to decrease their benefit packages. "Every state has a different view of the Medicaid program," claims Mr. Berry. MQC efforts can assure that available services are rendered to appropriate beneficiaries. MQC, in its conservation of funds for eligible beneficiaries, has become a vital part of Medicaid management. The most significant contribution to the quality control effort during the 1980's will be the capacity to provide analysis of error-causing factors for managers, as well as to facilitate corrective action, according to Mr. Berry. Through quality control, the Medicaid program will reveal flaws in policy and procedures at the federal and state levels.

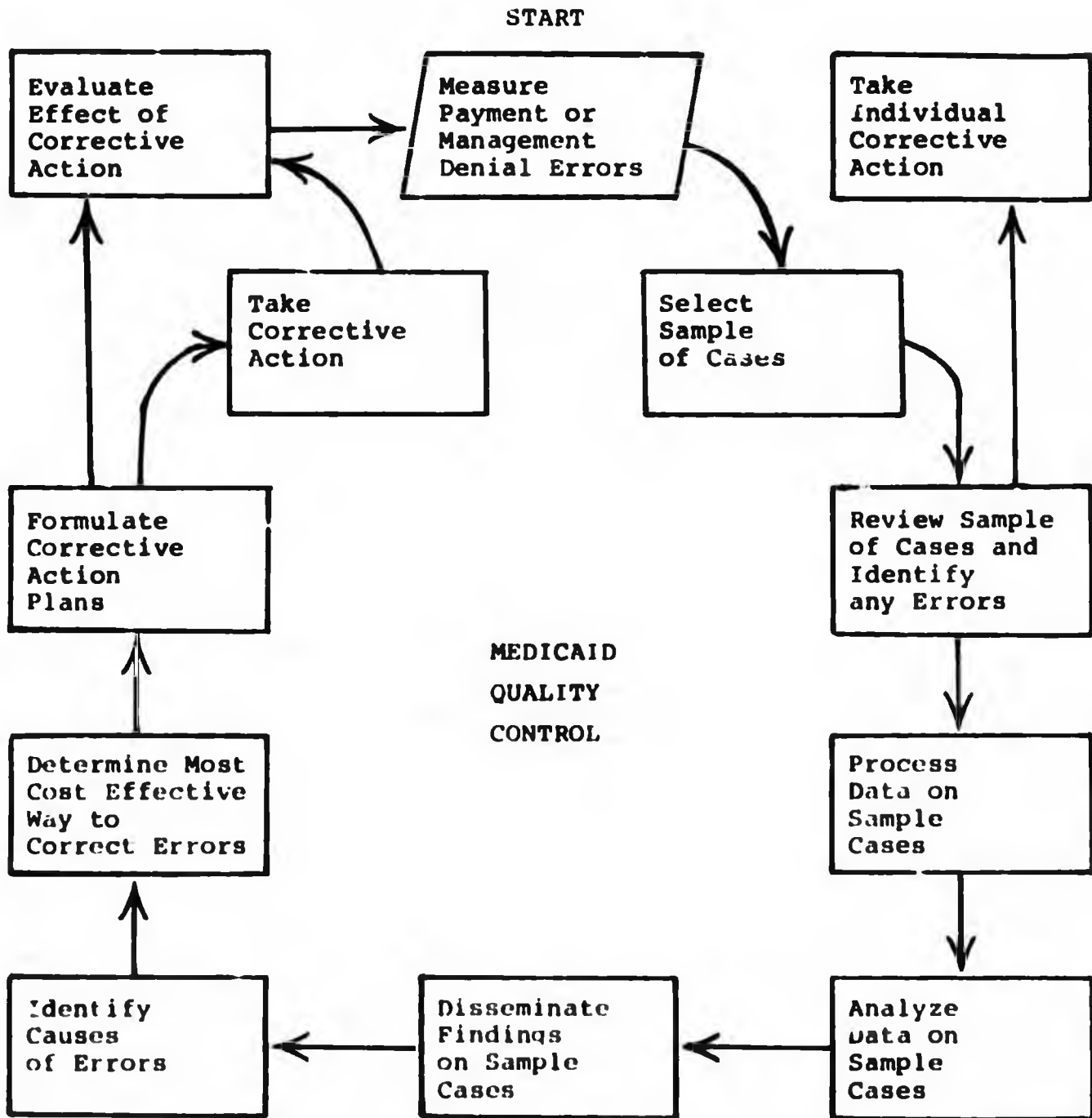
The chart on the following page illustrates the MQC process.

B. LEGISLATIVE AND REGULATORY UPDATE

MEDICAID CAP

In recommendations to the House Budget Committee, the House Committee on Energy and Commerce strongly opposed the administration's attempt to use the budget process in effecting major Medicaid program changes. Now that the Administration's budget has been approved, both the House and Senate must determine how and where specific program cuts will be made in order to meet overall budget objectives. For further information, contact Jack McDonald, House Budget Committee, (202) 225-7290.

Exhibit 1
The MQC Process



MEDICAID ELIGIBILITY

A bill has been introduced (S.667) by Senator Alan Cranston (D-Ca.) to amend the Social Security Act, extending Medicaid eligibility to low-income pregnant women and newborn children under specific circumstances. Considering proposed federal expenditures, this places a further burden on tight state finances, particularly because no incentives have been developed to encourage the expectant mother to apply to the local welfare office for medical assistance for her unborn child. For further information, contact Senator Cranston's office, (202) 224-3553.

TERMINATION OF ELIGIBILITY

Representative Richard Shelby (D-Ala.) has introduced H.R.2423 that would amend Title XIX of the Social Security Act to permit states to terminate Medicaid eligibility for up to one year for program abusers. For further information, contact Rep. Shelby's office, (202) 225-2665.

ASSETS UTILIZED IN DETERMINING SSI

P.L. 96-611 requires that any possessions transferred within a prior twenty-four month period by parties being considered for SSI eligibility be computed as assets. The proposed rule for Medicaid eligibility, which appeared in the Federal Register in April 1981 is currently going through the requisite comment period. States have the option of establishing their own regulations concerning these assets when determining Medicaid eligibility, providing

they are not more restrictive than those governing SSI eligibility. For further information, contact Richard Cody, Acting Director, Division of Medicaid Eligibility Policy, Bureau of Program Policy, HCFA, (301) 594-9050.

BLIND OR DISABLED INDIVIDUALS RECEIVING SSI

Effective January 1, 1981, Section 201 of P.L.96-265 provides that under certain conditions severely impaired blind or disabled individuals be eligible for SSI benefits even if their income exceeds the income limits. States have the option of augmenting these benefits. States are expected to obtain updated TPL information from these individuals or their employers. HCFA will be responsible for making available to SSA information concerning the initial and updated threshold amount figures for Medicaid. Eligibility for this special SSI status will be re-evaluated at least annually. For further information, contact Richard Cody, HCFA, (301) 594-9050.

NURSING HOME RESIDENTS

A bill has been introduced (H.R. 2421) by Rep. Richard Shelby (D-Ala.) to permit relatives of Medicaid eligible nursing home residents to make payments to a state fund for services rendered. For further information, contact Rep. Shelby's office, (202) 225-2665.

REIMBURSEMENT FOR NURSING HOMES

Section 962 of P.L.96-491 has deleted Medicaid reimbursement for nursing homes on a reasonable cost-related basis. The substituted

requirement specifies that nursing home rates meet the costs of "efficiently and economically operated homes" according to applicable federal and state standards.

HOME HEALTH CARE SERVICES

A bill has been introduced (H.R.2414) by Rep. Guy Molinari (R-N.Y.) to encourage the establishment of home health care programs and to amend the Social Security Act to provide expanded coverage of home health care services under Medicaid and Medicare. The Senate Committee on Labor and Human Resources has held hearings on the legislation. The Committee plans to hold further hearings in June and to begin mark-up in the fall. For further information, contact Rep. Molinari, (202) 225-3371.

CERTIFICATE OF NEED

P.L.96-538 provides for a one year extension for states to bring their certificate of need laws into compliance with federal requirements established by the Health Planning Amendments of 1979. The effective compliance date is one year from the start date of each state's 1981 legislative session.

MEDICARE DEDUCTIBLE

A bill has been introduced (H.R.2223) by Rep. C.W. Bill Young (R-Fla.) which would amend the Social Security Act to reduce the Medicare inpatient hospital deductible to its 1978 level. The bill was referred to the Ways and Means Committee. If this bill passes, state Medicaid agencies would be responsible for a larger portion of hospital bills for

Medicaid recipients who are also Medicare beneficiaries. For further information, contact Rep. Young, (202) 225-5961.

CERTIFICATION FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

42 CFR 442.115 has been amended to authorize a state survey agency, in specified circumstances, to certify intermediate care facilities for the mentally retarded in those cases where the facility has not met the July 18, 1980 compliance deadline. Plans to correct deficiencies must be completed by July 18, 1982. Extensions will be granted beyond the deadline where, under limited circumstances, litigation has caused delay. For further information, contact Dr. Wayne Smith, Health Standards and Quality Bureau, HCFA, (301) 594-7651.

PREPARATION OF THE QUARTERLY REPORT OF ABORTIONS

Reporting requirements have been established for the preparation of the quarterly report of abortions for the Medicaid program (Sections 1903a5 and 1905a4c of the Social Security Act). For the quarter ending December 31, 1980, and all subsequent quarters until superseded, the revised form HCFA 74.9b is the abortion reporting document to be completed by the states. The submission of these forms will be thirty days after the conclusion of each quarter (i.e., April 30, July 30, October 30 and January 30).

All abortions performed between September 20, 1980 and December 31, 1980, meeting Hyde Amendment criteria should appear in section A of the report with an appropriate

explanation. Those abortions not meeting Hyde Amendment criteria are not allowable for federal funding and should not be included in the report. Appropriate revisions should be reported on current submissions if any incorrect expenditures or number of abortions were included on reports already submitted.

C. NEWS

INFLATION AND HEALTH CARE COSTS

Controlling Medicaid costs will be the predominant health care issue facing most of the states in 1981. Many states are reporting significant budget problems with their Medicaid programs, finding it necessary to consider Medicaid eligibility and services limitations.

Additionally, President Reagan has proposed to cap federal funding of the Medicaid program and to decentralize welfare responsibility, thereby forcing states to reassess health care benefits for their indigent population. The nation's governors are strenuously opposed to Reagan's proposal, believing that Medicaid should remain largely a federal responsibility.

State budget forecasts reflect the seriousness of the current fiscal situation. Massachusetts wants to cut more than \$200 million from its program. New Jersey, Maryland, and Tennessee would like to cut \$50 million from each of their programs. Virginia is facing a \$27 million deficit, California's shortage could reach \$800 million, Wisconsin will need \$174 million over the next two years and the District of Columbia will have a deficit of up to \$20 million.

Medicaid programs have become the single most expensive item in many state budgets. The program consumes approximately 10 to 15 percent of state general funds. The mounting fiscal pressures are generating numerous inquiries regarding the goals and accomplishments of Title XIX programs. An efficient MQC program (see lead article) can pinpoint unwarranted program costs and lay the groundwork for corrective action.

PREPAID MEDICAID SERVICES IN FLORIDA

Florida has become the first southern state to contract for Medicaid services on a prepaid basis. Medicaid recipients are enrolling for a prepaid health plan on January 1, 1981, under an agreement between the state Medicaid program and the Palm Beach County Health Department. The plan offers comprehensive health services, including inpatient care. The state will pay a flat fee for each Medicaid enrollee, with the County Health Department assuming financial responsibility for all designated health services used by plan members. The fees have been set for six eligibility categories based on the historical cost of each, and will be updated at contract renewal on July 1, 1981.

MARYLAND LIMITS HOSPITAL SERVICES

In Maryland, the number of Medicaid inpatient hospital days in 1980 was 15 percent higher than in 1979. Several measures have been instituted to reduce Medicaid expenditures for hospital services, including a coverage limit of 20 days per spell of illness per year.

After the 20th day, the hospital cannot receive Medicaid reimbursement for further services. In addition, there must be a discharge period of 15 consecutive days for a second stay to be covered. By imposing these limitations, it is anticipated that physicians will be encouraged to hospitalize their patients only for the period that is medically necessary. Data on the cost impact are not available yet since the program only became effective January 1, 1981.

NEW JERSEY PLANS TO COVER MEDICAID DEFICIT

The New Jersey State Legislature will transfer surplus dollars to offset the projected \$57 million deficit in the state's Medicaid program. Had this not been approved, the state's Commissioner of Human Services had planned to terminate funding for pharmaceutical, dental, vision, chiropractic, orthopedic, hearing aid and convalescent care services. New Jersey and the federal government will expend approximately \$1 billion during the 1981-1982 fiscal year on Medicaid services to state beneficiaries.

CHANGES IN MEDICAID TAKEOVER FORMULA

New York Governor Hugh Carey has revised his proposed program, whereby the state would take over the counties' responsibility for Medicaid funding. The original proposal called for counties to transfer into property tax reduction 90 percent of the savings gained through the proposed state takeover of local Medicaid expenditures. As revised, the legislation would allow counties to keep 25

percent of the Medicaid savings until 1985. The final proposal would also permit counties to recoup, in property taxes, any savings transferred to city, town and village governments within their boundaries. The legislation is still pending until the disposition of the President's proposed Medicaid cap on federal funds to states has been determined.

PHYSICIANS ASK FOR MEDICAID PAY RAISE

The New Hampshire Department of Welfare has been asked by physicians to either increase reimbursement for services rendered to Medicaid recipients or to set up a system of tax credits whereby their contributions to the state government would be recognized. The New Hampshire Medical Society claims that physicians are being reimbursed at rates established ten years ago (approximately 50 cents for every dollar of care rendered). The medical society is seeking just compensation for physicians' services to Medicaid recipients, preferably through a formula utilizing inflation and the demand for services as a basis, i.e., the Medicare formula. The state Health and Welfare Department's budget request for the next two years entails reimbursement for physicians at approximately 32 percent of their bill to Medicaid recipients. Another proposal entails increasing the figure to 38 cents on the dollar.

HMOs PROMOTING MEDICARE AND MEDICAID

HCPA's Office of Demonstrations and Evaluations is sponsoring five projects designed to increase Medicare and Medicaid enrollment in

HMOs and promote cost effectiveness and competition in the health care field. HHS will evaluate the effect of alternative HMO risk reimbursement methods, rather than the current cost-based approaches. Any savings achieved through these programs are to be applied toward increased benefits and reduced cost sharing. Enrollment is in various stages in these HMOs.

NEW HHS UNDERSECRETARY

David Swoap was sworn in March 23 as HHS Undersecretary. His nomination by President Reagan in early February to the second ranking HHS post was confirmed by the Senate on March 17.

HCFA APPOINTMENTS

Dr.Carolyn K. Davis was sworn in as Administrator of HCFA by HHS Secretary Richard Schweiker on March 2. Prior to her appointment, Dr. Davis was Associate Vice President for Academic Affairs at the University of Michigan and a professor in the Schools of Nursing and Education since 1975. She received her Ph.D. in higher education from Syracuse University, as well as a B.S. in nursing from Johns Hopkins University.

Paul R. Willging, Ph.D., formerly acting as Deputy Administrator, has been officially appointed to that position. Previously, he was Deputy Director of the HCFA Bureau of Program Operations and, before the reorganization, was Deputy Director of the Medicaid Bureau.

James Scott has been appointed Director of the HHS Office of Intergovernmental Affairs, HCFA, effective May 1, 1981. Mr. Scott

was vice-president of the Kansas Hospital Association.

Patrice Hirsch Feinstein has been appointed as Director, Office of Legislation and Policy, HCFA. Ms. Feinstein has co-authored several publications including National Health Insurance Issues: The Adequacy of Coverage and Project Hope Report on the Consequences of Hospital Cost Containment Regulation. Other experience includes serving as the former editor of the Roche Medicaid Utilization Management Program.

D. MMIS STATUS IN THE STATES

Currently, 34 states (one partially) have received approval for 75 percent federal financial participation for operation of a mechanized claims processing and information retrieval system. Four states and several regions in New York State are anticipating approval during federal fiscal year 1981. The chart on the following page shows the current status of MMIS development in the states and territories.

E. RESEARCH STUDIES

AN EFFECTIVE APPROACH TO THIRD PARTY RECOVERY OF TITLE XIX FUNDS

A demonstration project was undertaken in Region X due to that region's concerns in identifying third party liability resources. While it dealt specifically with a proposed approach to Medicaid Quality Control review and development, it was designed to include procedures that could be used routinely in front-end eligibility review.

STATUS OF MMIS IMPLEMENTATION BY STATE

	Inactive	Development Stage	Requesting Certification	Certified
Alabama.....				X
Alaska.....		X		
Arkansas.....				X
California.....				X
Colorado.....				X
Connecticut.....		X		
Delaware.....	X			
District of Columbia.....		X		
Florida.....				X
Georgia.....				X
Hawaii.....				X
Idaho.....				X
Illinois.....		X		
Indiana.....				X
Iowa.....				X
Kansas.....				X
Kentucky.....		X		
Louisiana.....				X
Maine.....				X
Maryland.....		X		
Massachusetts.....		X		
Michigan.....				X
Minnesota.....				X
Mississippi.....				X
Missouri.....				X
Montana.....				X
Nebraska.....				X
Nevada.....		X		
New Hampshire.....				X
New Jersey.....				X
New Mexico.....				X
New York.....			partially	X
North Carolina.....				X
North Dakota.....				X
Ohio.....				X
Oklahoma.....				X
Oregon.....		X		
Pennsylvania.....			X	
Rhode Island.....	X			
South Carolina.....			X	
South Dakota.....			X	
Tennessee.....				X
Texas.....				X
Utah.....				X
Vermont.....				X
Virginia.....				X
Washington.....				X
West Virginia.....			X	
Wisconsin.....				X
Wyoming.....	X			
<u>Territories:</u>				
Guam.....	X			
N. Mariana Islands.....	X			
Puerto Rico.....	X			
Virgin Islands.....	X			

The report identified the major reason for shortcomings in the third party recovery process to be failure to obtain correct and sufficient information at the time of eligibility determination. Current procedures depend on the recipients to supply information on TPL, but the recipient is not always fully aware of the health insurance benefits for which he or she is qualified. Another problem is that the information may not enter into the processing system due to errors and oversights in transmitting data among the various agencies. Therefore, in this study, case reviewers received specific instructions for review procedures to include thorough investigations and intensive interviews.

PROJECT APPROACH

The project plan was to re-examine sample cases in two states, Idaho and Oregon. After a review of all MQC sample cases for the review period October to December 1978, selection of project cases was accomplished in a series of steps. First, the basis chosen for projections consisted of those cases for which there were claims paid for services rendered during the first review month. These cases were then screened for the following:

1. easily accessible locations; and
2. likelihood of producing a good lead.

This latter screen involved prioritizing cases according to a tentative TPL profile developed by the project team and used in the Idaho project; the profile was

refined and finalized for use in Oregon. The factors used included:

- . AFDC eligibility with deprivation based on continued absence of either parent;
- . Evidence of established paternity in AFDC cases;
- . Established whereabouts of an absent parent;
- . Established legal responsibility for health care or coverage on the part of an absent parent or other relative;
- . Employment of an absent parent or other relative;
- . Known health coverage held by an absent parent or other relative;
- . Evidence of accident/trauma related medical services (e.g., no-fault);
- . Employment of recipient(s);
- . Indications of military service in disability or blindness cases;
- . A disabled or blind minor who is a member of a mainstream family with gainfully employed parents; and
- . Indications of military retirement benefits in any type of case (e.g., CHAMPUS, CHAMPVA).

During the final screen, if it was not possible to locate recipients with a reasonable amount

of effort or if recipients refused to cooperate, the cases were omitted from the survey. All cases not completely reviewed would be assumed to contain no new TPL information. However, states should realize that these omitted cases would be just as likely to yield positive results if these new procedures had been applied at recipient application.

The reviews consisted of two approaches. The first was done by the project staff in researching cases, developing leads, and following them up to establish positive verification of available TPL. This included extracting useful information from the MQC case record, visiting the local welfare office responsible for the case (including SSI eligibles, examined by the District office and AFDC cases, examined by the state's child support enforcement agency), personal interviews with recipients or any other sources of information discovered during the review, and finally verification of potential coverage with insurance companies or liable persons.

The second approach in the review involved asking five major health insurance carriers to match the names of the recipients in the project sample against their own files. This served to validate the effectiveness of review procedures used by the staff. In some instances, this type of approach provides additional leads to TPL at relatively low cost.

ANALYSIS AND FINDINGS

The project base included 148 cases from the Region X states of Idaho and Oregon. After dropping

25 cases, 123 total reviews were completed with 68 new TPL sources identified. Of these identified cases, 37 (54 percent) were from AFDC absent parent leads which were obtained from information routinely collected by child support enforcement agencies, and 15 cases (22 percent) were related to employment of AFDC mothers.

Table 1 on page 20 presents a breakdown of all cases selected in each state's sub-base of MQC sample cases with paid claims in the original MQC review month. The totals for each state are less meaningful than the stratum figures because the numbers of AFDC and MAO cases are not in proportion to their relative sizes in the states' total Medicaid populations. Additionally, the AFDC and MAO strata have different Medicaid utilization rates and claim dollar distributions.

Calculations were made for recoverable dollar amounts from the "hit" cases or those with positive results. Before inclusion of a case, verification of TPL was obtained from liable persons and the five major health insurance carriers who cooperated with the study. Then all claims for the recipient(s) were collected. Deductible computations were performed using two different assumptions. First, to compute an extremely conservative estimate of the amount recoverable, it was assumed that all individual deductible amounts had to be net before any claims could be paid (this was referred to as "Comp 1"). Since the coverage groups encountered tended to involve several people from one family unit, a more realistic estimate would assume that where family

maximum deductible amounts applied, each recipient would probably not have had to meet his full individual deductible. "Comp 2" assumes that each recipient would have had to satisfy 50 percent of the individual deductible in those situations. Deductible computations in the review month were based on the average utilization rate seen over the full year's utilization of coverable Medicaid services. Based on that utilization rate, it was estimated whether the entire deductible would have been satisfied by the review month.

Recoverable dollar amounts based on a full year's utilization treat the period July 1978 through June 1979 as though it were a calendar year for purposes of computing deductibles. Within that period, only those months during which coverage was actually in effect (and the case remained in the states' Medicaid active files) were included in the computations. Therefore, the full year's utilization yielded savings that were less than the review month savings multiplied by twelve. For Oregon, the recoverable dollar amount was about \$10,800 using Comp 1 (with \$635.30 average dollars per hit case) and \$12,500 using Comp 2 (\$521.57 average). For Idaho, the Comp 1 recoverable dollar amount was about \$2,300 (an average of \$386.53 per case) and Comp 2 revealed a recoverable dollar amount of \$3,000 (an average of \$376.51 average).

In presenting projections, the study cautioned that although assumptions were made to assure that any projections would be underestimated, there is still uncertainty in projecting such a small study, particularly against

national expenditures. Many states have realized great savings from expanding their TPL recovery systems with similar efforts in front-end eligibility review and supplementing MQC data with information and verification from liable persons and health insurance carrier files, as well as unemployment insurance files, inquiries from attorneys, and various codes indicating trauma or accident.

Savings were projected to the states' Medicaid populations using both Comp 1 and Comp 2 and also using two different sample universes. Universe 1 is defined as the number of AFDC claims in the MQC sample period with paid claims in the review month. Universe 2 is less conservative, because it compensates for those cases which were omitted due to geographical location (beyond the limited resources of the study). In Idaho, out of 77 AFDC cases in the complete three month sample, 58 had claims in the review month, and 57 fell within the geographical region selected for review. In Oregon, out of 407 total AFDC cases, 268 had claims in the review month and 193 satisfied the geographical requirement.

Statewide projected figures for the two states combined are as follows:

	<u>Comp 1</u>	
Universe 1	\$1,903,631	or 3.1%
Universe 2	\$2,541,543	or 4.2%
	<u>Comp 2</u>	
Universe 1	\$2,244,751	or 3.7%
Universe 2	\$2,984,777	or 4.9%

The above percentages are of Medicaid program expenditures for

APDC families for the period July 1978 through June 1979 (\$10,881,862 for Idaho and \$49,817,337 for Oregon).

During the period July 1978 through June 1979, total Medicaid expenditures nationwide were \$18.5 billion of which \$6.66 billion were attributed to APDC families. Thus, for that time period, nationwide projected savings range from \$206.5 million to \$326.3 million. Projections for the following fiscal year, based on projected Medicaid program expenditures of \$26 billion, yield estimates for savings in the APDC category from \$190.2 million to \$458.6 million. Finally, the MAO savings in the demonstration amounted to 9.4 percent of the APDC savings. Including this amount, total savings were projected between \$317.5 million and \$501.8 million for the entire Medicaid program nationwide.

CONCLUSIONS

The study revealed that a significant amount of TPL goes undetected under the current system employed by Region X and that it is relatively easy to identify good leads as other states have proven (e.g., Michigan - see May 1980 Special Report issue). There is enough financial incentive to justify a major effort along the lines of this project for those states that have not increased efforts in TPL recovery.

This project prompted the following recommendations:

- to replicate this demonstration in states radically different from Idaho and Oregon. In addition to being

useful to the individual states, it will help yield better estimates of national TPL recovery potential.

- to undertake an intensive effort to train eligibility workers and QC reviewers about the importance of TPL and the subtleties of its identification.
- to develop closer ties between child support enforcement agencies, medical assistance units and local offices, and an effective flow of information to state Medicaid claims processing systems.
- to develop a set of instructions aimed at developing TPL information during eligibility reviews; and to change TPL review procedures to capture more useful information.

This demonstration project prompted a number of activities in Region X with the potential of producing substantial savings:

1. Insurance carriers are working with the state of Oregon to identify alternative coverage for Medicaid recipients prior to the payment of claims submitted to the state. Wherever possible, printouts of child support records and current employment data are accessed. Thus, all current information from the sources shown to be productive in this study are utilized prior to state payment of claims.

2. A team of Region X staff was organized to establish a series of TPL training sessions in the states for attendance by those responsible for training eligibility and medical assistance workers.
3. Alphabetised master lists of all Region X employee groups by state, identifying the health insurance carrier in each case, were produced and distributed to the local offices and claims processing units in the states. All health insurance carriers have been requested to provide the Region with regularly updated lists of the employers whose policies they currently hold.
4. A TPL task force was formed in the regional office to handle all recovery issues which arise in the region. The task force is comprised

of financial management specialists, program specialists, QC staff, and the regional corrective action specialist to assure maximum coordination and communication.

A choice is presented then for states to make a concerted effort to identify and collect TPL resources through expansion of the front-end eligibility review and supplementing MQC data with information from insurance carriers and other resources, or to continue as they do at present. Many states have undertaken such efforts, but the availability of data quantity and quality reveals significant diversity in data collection practices within each state. Comparison can be made to identify problem areas and methodologies. As this study indicates, TPL recovery warrants more substantive efforts to fully realise all TPL resources and ultimately to reallocate these otherwise misspent Title XIX funds.

Table 1

Summary of Project Findings

	AFDC	Idaho MAO	TOTAL	AFDC	Oregon MAO	TOTAL
No. of MQC cases with paid claims in the MQC review month	58	71	129	268	89	357
No. of cases selected for review	32	17	49	84	15	99
No. of cases dropped during review	7	4	11	13	1	14
No. of recipient interviews conducted	24	11	35	55	14	69
No. of reviews completed	25	13	38	71	14	85
Total No. of hits found (possibly more than one hit per case)	17	7	24	41	3	44



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

MEMORANDUM

February 15, 1980

TO: Representative Terry Martin

FROM: Duncan L. Read, Director *DLR*

RE: Proposed Study on Medicaid and Alternative Health Care
Financing Programs (Research Request No. 72)

Attached are a draft resolution and a draft appropriations measure pertaining to a study on medicaid and health care financing alternatives. Billy Barrier suggested that a resolution and an appropriations measure in combination would be more appropriate as legislative vehicles than a bill. We have transmitted them to the Division of Legal Services for formal drafting and introduction by the personal bill deadline, February 18. In the process of gathering information necessary for the drafting of the resolution and the appropriation, we did compile some materials and data that you may find of interest. After we have reviewed them, we shall forward any of significance to you.

DLR/dp

cc: Representative Hayes

IN THE HOUSE

BY REPRESENTATIVE MARTIN,
HAYES

HOUSE CONCURRENT RESOLUTION NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

Directing the Legislative Council
to conduct an evaluation of the
State of Alaska's medicaid and
general medical relief programs
and alternative means of meeting
the health care needs of the
state's citizens.

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

WHEREAS an estimated \$400,000,000 is spent annually on health care
in Alaska; and

WHEREAS a projected amount in excess of \$50,000,000 will be expended
for the State's medicaid and general relief medical programs this fiscal
year; and

WHEREAS costs of these programs by Fiscal Year 1981 will have
increased over 300 percent in the past five years; and

WHEREAS there are continuing operational problems in expeditiously
reimbursing health care providers for treatment provided medicaid clients
and associated difficulties of Medicaid clients in securing services;
and

WHEREAS existing State medical services record systems do not
provide adequate information on the extent and nature of medical care
provided; and

WHEREAS many Alaskans are medically underserved, while others may have dual coverage of their health care needs; and

WHEREAS other states are exploring options to participation in the federal medicaid program and some have recently taken innovative steps to assure that their citizens' health care needs are better served and that health care financing is more cost efficient;

BE IT RESOLVED by the Alaska State Legislature that under provisions of AS 24.20.090 and Uniform Rule 48(c) the Legislative Council is directed to conduct a study that would evaluate:

- (1) the health care needs of Alaskans, the services currently available to meet them, and the present means of financing those services;
- (2) the cost implications of the State of Alaska withdrawing, in part or in whole, from the federal medicaid program;
- (3) the feasibility of other means of health care financing in Alaska, including, but not limited to, expanded private insurance coverage and State delivery of services to medically underserved citizens, either directly or indirectly through private, non-profit corporations; and be it

FURTHER RESOLVED that major parties of interest, including private health care providers and insurance carriers and the federal government as well as the State Department of Health and Social Services, be involved in the study; and be it

FURTHER RESOLVED that a report containing the study's findings and options for legislative action be transmitted to members of the Alaska State Legislature no later than February 1, 1981.

IN THE HOUSE .

BY REPRESENTATIVE MARTIN,
HAYES .

HOUSE BILL

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the Legislative Affairs Agency for an evaluation of the State's medicaid and general medical relief programs and an assessment of alternative means of health care financing."

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

* Section 1. The sum of \$200,000 is appropriated from the General Fund to the Legislative Affairs Agency with which to perform a study on the State of Alaska's medicaid and general medical relief programs and an evaluation of alternative means of health care financing.

* Sec. 2. This Act takes effect immediately in accordance with AS

* Sec. 3. A report of this study's findings shall be transmitted to members of the Twelfth Alaska State Legislature no later than February 1, 1981.

May 15, 1981

The Honorable George Bush
President of the Senate
United States Senate
Washington, D.C. 20510

Dear Mr. President:

Enclosed for consideration by the Congress is a draft bill "To provide a ceiling on Federal expenditures for Medicaid, to increase States' flexibility to determine the scope of their Medicaid programs, to make other amendments to the Medicare and Medicaid programs, and for other purposes." When enacted, the bill would be cited as the "Health Care Financing Amendments of 1981".

The draft bill would set a ceiling on Federal expenditures for Medicaid for fiscal year 1981 and succeeding fiscal years. Federal financial assistance for Medicaid would be limited to \$16,399,914,000 for fiscal year 1981, and \$16,995,308,000 for fiscal year 1982. For succeeding fiscal years, Federal funding for Medicaid would change by a factor equal to the Gross National Product Deflator. Federal funding for automated eligibility determination and Medicaid management information systems would be subject to a separate ceiling. Funds for State fraud control units, and funds to reimburse States' claims for program costs incurred before fiscal year 1981, would be outside the ceiling.

In order to enable States to control costs to the fullest extent consistent with maintenance of program quality, and to assure that States would not be forced because of the ceiling on Federal payments to absorb a greater share of Medicaid costs than under present law, the draft bill would repeal or modify many State plan and other statutory requirements. In addition, the Secretary would be authorized to waive other State plan requirements where he found that the waivers sought would be consistent with program goals.

The amendments proposed by this draft bill would greatly increase States' flexibility to determine the scope of their Medicaid programs and to assure that services are provided in an efficient and cost-effective manner, while continuing to safeguard the access of beneficiaries to an adequate supply of quality health services. States would be able to tailor their eligibility criteria, benefit packages, reimbursement methods, and plan administration to make the best use of the resources available to meet the needs of their population. To cite only a few examples, these amendments would permit

States to reimburse hospitals, physicians, and other providers of services in a more prudent manner, to use competitive bidding to obtain the most economical services, and to limit coverage of optional benefits to certain groups most in need of them (for example by providing influenza immunizations only to those groups most at risk).

In addition, the draft bill would enact reimbursement and systems reforms to allow more efficient and economical administration of the Medicare and Medicaid programs, and would enact amendments designed to reduce fraud and abuse in these programs.

The draft bill's provisions are described in detail in the enclosed sectional summary. We estimate that a net cost of \$201,000,000 for fiscal year 1981 and a net savings of \$2,131,000,000 for fiscal year 1982 would result from enactment of the draft bill. A net cost, rather than net savings, for fiscal year 1981 results solely from repeal of the postponement (enacted by the last Congress) from fiscal year 1981 to fiscal year 1982 of certain periodic Medicare payments to hospitals. An estimate of savings and costs (by section) for fiscal years 1981 through 1986 is enclosed.

We urge that the Congress give the draft bill its prompt and favorable consideration.

We are advised by the Office of Management and Budget that enactment of this draft bill would be in accord with the program of the President.

Sincerely,

/s/ Richard S. Schweiker

Secretary

Enclosures

**SUMMARY OF ESTIMATED COST IMPACT OF THE HEALTH FINANCING AMENDMENTS
OF 1981**

(to nearest million dollars)

Section	FY 1981	FY 1982	FY 1983	FY 1984	FY 1985	FY 1986
101	-100	-1,039	-2,012	-2,963	-3,950	-5,055
102	<u>1/</u>	<u>1/</u>	<u>1/</u>	<u>1/</u>	<u>1/</u>	<u>1/</u>
103	0	4	<u>1/</u>	<u>1/</u>	<u>1/</u>	<u>1/</u>
104	-122	0	0	0	0	0
105	<u>1/</u>	<u>1/</u>	<u>1/</u>	<u>1/</u>	<u>1/</u>	<u>1/</u>
201	0	-23	-47	-78	-119	-127
202	0	-2	-2	-2	-2	-2
203	0	-4	-4	-4	-4	-4
204	-35	-250	-285	-350	-435	-530
205	0	<u>1/</u>	<u>1/</u>	<u>1/</u>	<u>1/</u>	<u>1/</u>
206	-1	-6	-6	-7	-8	-9
207	-4	-35	-41	-46	-52	-58
208	-20	-70	-90	-110	-120	-130
209	-5	-13	-15	-17	-20	-23
210	0	-2	-4	-4	-5	-5
211	-2	-17	-19	-22	-25	-28

212	-1	-9	-10	-11	-13	-15
213	-1	-7	-8	-9	-10	-11
214	0	-6	-6	-6	-6	-6
215	515	-522	0	0	0	0
216	-8	-66	-70	-103	-106	-108
217	-15	-55	-45	-45	-50	-55
301	0	-7	-7	-7	-7	-7
302	<u>2/</u>	<u>2/</u>	<u>2/</u>	<u>2/</u>	<u>2/</u>	<u>2/</u>
303	0	0	0	0	0	0
304	0	0	0	0	0	0
305	0	0	0	-67	-67	-67
306	0	0	0	0	0	0
307	0	0	0	0	0	0
308	0	0	0	0	0	0
TOTAL	201	-2,133	-2,671	-3,851	-4,999	-6,240

1/ Savings would not reduce Federal outlays below level set by section 101, but would provide some additional savings to States.

2/ No cost is anticipated since to date the Department has not assessed any penalties.

PROPOSED HEALTH CARE FINANCING AMENDMENTS OF 1981
SECTION-BY-SECTION SUMMARY

Short Title

Section 1 gives the short title of the draft bill. When enacted, it would be cited as the "Health Care Financing Amendments of 1981".

TITLE I - MEDICAID

Limitation on Authorization of Appropriations; Allotments to States

Section 101 would provide for a ceiling on appropriations for Medicaid for fiscal year 1981 and succeeding fiscal years. The bill would authorize appropriations of \$16,399,914,000 for fiscal year 1981 and \$16,995,308,000 for fiscal year 1982. For fiscal year 1983 and succeeding fiscal years, authorized appropriations would change by a factor equal to the Gross National Product Deflator published by the Department of Commerce. For fiscal years 1981 and 1982, the territories would receive an allotment from the total appropriation equal to their ceilings under present law; each of the fifty States and the District of Columbia would receive an allotment bearing the same ratio to the remainder as the State's estimate of Medicaid expenditures for fiscal year 1981 bears to the sum of all States' estimated expenditures for fiscal year 1981. For fiscal year 1983 and succeeding fiscal years, each State and territory would be allotted a share of the appropriation equal to its share of the appropriation for fiscal year 1982.

Federal funding for Medicaid fraud control units would be outside the ceiling. Federal funding for automated eligibility determination and Medicaid management information systems would be provided by a separate appropriation of \$210,000,000 for fiscal year 1982 and such sums as the Congress found necessary and appropriate for each succeeding fiscal year. Funds appropriated for automated information systems would be allocated to the States on a formula that took into consideration States' shares of the basic appropriation for Medicaid and their need for funds to develop or operate information systems. Federal funds to pay claims for expenditures prior to fiscal year 1981 would also be outside the ceiling. States would be required to file claims for program expenditures during fiscal year 1980 by October 1, 1981, or (where the requirement was waived in exceptional circumstances) by January 1, 1982.

Waivers and Modifications of Federal Requirements

Section 102 would modify and repeal certain statutory requirements and authorize the Secretary to waive others, in order to give States greater flexibility to control costs of their Medicaid programs.

The bill would modify some requirements with respect to eligibility and benefits and would repeal others, in order to permit States to focus delivery of medical care and services under the program on those most in need of them.

The bill would eliminate all requirements with respect to eligibility and benefits of the medically needy, and all requirements (other than requirements with respect to mandatory services for the categorically needy) to provide benefits of equal amount, duration, and scope to all medically needy and to all categorically needy. States would still be required to provide all mandatory services to the categorically needy (primarily individuals receiving cash assistance under Federal or Federal-State programs under the Social Security Act ("the Act")), but could use any reasonable criteria to determine eligibility and benefits for other needy individuals or groups, and to determine optional benefits available to categorically needy individuals or groups.

The bill would eliminate the requirement to provide coverage for 18-to 20-year-olds who would be eligible for AFDC if under 18; it would eliminate the requirement to extend for four months Medicaid eligibility of families losing AFDC eligibility because of increased income from employment; and it would leave to State discretion whether to continue Medicaid coverage of certain individuals who have become ineligible for SSI because of cost-of-living increases in Social Security benefits.

The requirement of present law to afford Medicaid beneficiaries "freedom of choice" of providers of medical care would be replaced by a requirement to provide such standards as could reasonably be expected to afford recipients covered medical care of adequate quality. Amendment of this requirement would enable States to effect significant cost savings while maintaining quality care, for example by soliciting competitive bids for provision of covered services.

Except for the general requirement described above, all requirements with respect to the amount and method of reimbursement of providers would be eliminated, including requirements for reimbursement of inpatient hospital services and nursing home services, barriers to reimbursement based on fee schedules, and requirements that have restricted reimbursement on a prepaid capitation basis to health maintenance organizations (HMOs).

The bill would repeal most requirements with respect to utilization review and utilization control, including review by Professional Standards Review Organizations (PSROs). Choice of methods to prevent unnecessary or inappropriate utilization of medical care and services would be left to the States' discretion. The bill would also revise the requirements for Medicaid management information systems (MMIS) and other automated information systems to preserve incentives to States to develop and operate these systems when Federal Medicaid funds are capped.

The bill would also permit States to cover non-medical support services to individuals who without them would require institutionalization; it would repeal the requirement that a State which has ever funded optometrists' services continue to do so; and it would make other amendments.

The Secretary could waive certain State plan requirements where the State demonstrated to his satisfaction that its alternative plan would be consistent with the goals of the Medicaid program. Requirements which could be waived would include requirements that all provisions of the State plan be in effect statewide; requirements to provide for cooperative arrangements with the State health and vocational rehabilitation agencies; procedural requirements with respect to reviews of care of nursing home patients; and requirements for licensing of nursing home administrators; prohibitions on copayment requirements for the categorically needy for certain hospital services; and provisions which would bar direct payments to Medicaid recipients to share savings realized from use of more economical types of medical care.

The bill would also require the Secretary to approve or disapprove proposed State plans or waiver requests within 90 days after receiving the State request (or, if later, 90 days after receiving information needed to make a final determination).

Increased Federal Matching for Automated Eligibility Assessment Systems

Section 103 would provide the same Federal matching rate for automated eligibility determination systems that is presently available for Medicaid Management Information Systems (90 percent for development and 75 percent for operation).

Recovery of Disputed Claims

Section 104 would provide that overpayments to States which were disallowed by the Secretary would be recovered by the Secretary pending the final determination with respect to the correct payment amount (rather than retained by the State, at State option, as provided by present law).

Attribution of Sponsor's Income and Resources to Aliens

Section 105 would permit States, if an alien seeks Medicaid coverage within the first three years after entering the United States, to attribute to the alien the income and resources of the alien's sponsor for purposes of determining his eligibility for medical assistance.

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TITLE II - MEDICARE

Contracts for the Administration of Benefits

Section 201 would make changes in the provisions of law under which Medicare contracts with outside organizations to determine and pay claims under Medicare. Providers of services would no longer have the right to nominate specific organizations to process Medicare claims, reimbursement on the basis of costs would no longer be required, contracts could be entered into with any public or private entity, and, after an initial five year phase-in period, all contracts would be subject to the same competition requirements as are other Federal contracts. Section 201 would also consolidate the contracting requirements into one section, and move to a more appropriate section of the Medicare title provisions concerned with defining "reasonable charge".

Elimination of Requirement for a Railroad Retirement Board Carrier Contract

Section 202 would eliminate the requirement for a separate Railroad Retirement Board carrier contract.

Repeal of Statutory Time Limitation on Agreements with Skilled Nursing Facilities

Section 203 would repeal the 12 month statutory limitation on agreements with skilled nursing facilities.

Limitation on Cost Differentials

Section 204 would bar payment for routine inpatient care, including nursing care, in hospitals and skilled nursing facilities, greater than the percentage of total allowable costs equal to the percentage of total patient days attributable to Medicare patients, unless it were demonstrated to the satisfaction of the Secretary that care of Medicare patients was more costly than care of other patients. This amendment would be effective July 1, 1981.

Withholding of Payments for Certain Medicaid Providers

Section 205 would provide a mechanism for withholding payments to institutional and individual providers of services under Medicare to offset overpayments to them under Medicaid, where they had terminated or substantially reduced their participation in Medicaid, leaving the State Medicaid agency and the Secretary unable to recover the amounts due.

Annual Limit of 200 Visits for Home Health Services

Section 206 would establish a 100 visit annual limit under the Hospital Insurance (HI) program and a 100 visit annual limit

under the Supplementary Medical Insurance (SMI) program for home health services.

Elimination of Need for Occupational Therapy as a Basis for Entitlement to Home Health Services

Section 207 would eliminate the need for occupational therapy as a basis for entitlement to home health services.

Elimination of Part A Coverage of Alcohol Detoxification Facility Services

Section 208 would eliminate coverage under the HI program of alcohol detoxification facility services.

Elimination of Part B Coverage of Outpatient Rehabilitation Facility Services

Section 209 would eliminate coverage under the SMI program of outpatient rehabilitation facility services.

Reduction in Limit for Outpatient Physical Therapy Services

Section 210 would reduce from \$500 to \$100 the annual limit for outpatient physical therapy services furnished by an individual physical therapist.

Elimination of Additional Dental Coverage

Section 211 would eliminate coverage under the HI program of hospitalization required solely because of the severity of a dental problem and would allow payments to dentists only for certain specified procedures.

Elimination of Unlimited Open Enrollment

Section 212 would restrict open enrollment for the SMI program to the first quarter of each year.

Restrictions on New Buy-in Agreements

Section 213 would eliminate any additional "buy-in" coverage under the SMI program requested during 1981 by State Medicaid programs.

Repeal of Requirement for End-Stage Renal Disease Networks

Section 214 would repeal the requirement for end-stage renal disease networks.

Elimination of Temporary Delay in Periodic Interim Payments

Section 215 would eliminate the temporary delay for the last 21 days of fiscal year 1981 in periodic interim payments to hospitals.

Repeal of Utilization Review Requirements

Section 216 would repeal utilization review requirements.

Elimination of Coverage for Pneumococcal Vaccine

Section 217 would eliminate Medicare coverage for pneumococcal vaccine.

TITLE III - OTHER PROVISIONS

Civil Monetary Penalties for Medicare and Medicaid Fraud

Section 301 would authorize the Secretary to impose a civil money penalty of up to \$2,000 for a fraudulent claim for reimbursement under the Medicare or Medicaid program, plus a fine of twice the amount of the fraudulent portion of a claim. The Secretary could also bar from participation in Medicare and Medicaid any person determined pursuant to this section to have filed a fraudulent claim. Before a penalty could be imposed, the Secretary would be required to give written notice and an opportunity for a hearing on the record with the right to be represented by counsel, to present witnesses, and to cross-examine. Use of this administrative procedure in any case would be subject to the agreement of the Department of Justice.

Repeal of Requirement to Notify Families With Dependent Children of Availability of Early and Periodic Screening, Diagnosis, and Treatment

Section 302 would repeal the requirement under part A of title IV of the Act that States notify families with dependent children of the availability under the Medicaid program of early and periodic screening, diagnosis, and treatment of children.

Notice, Hearing, and Judicial Review Requirements for Termination of a Professional Standards Review Organization Agreement; Agreements of Less Than a Year

Section 303 would eliminate the requirement that the Secretary provide a formal hearing to terminate an agreement with a professional standards review organization (PSRO), would require the Secretary to give 90 days notice of a termination, would preclude judicial review of a termination, and would permit the Secretary to enter into agreements of shorter duration than a year.

Abolition of Statewide Professional Standards Review Councils

Section 304 would abolish the statewide professional standards review councils.

Discretion of Secretary in Funding Professional Standards Review Organizations

Section 305 would give the Secretary the discretion to determine how much (if any) funding to provide to PSROs.

Voluntary Participation by State Medicaid Programs in Professional Standards Review

Section 306 would permit any State to withdraw its Medicaid program from the purview of professional standards review.

Repeal of Certain Requirements for Studies and Demonstrations

Section 307 would repeal requirements that the Secretary support --

- demonstration projects concerning a single coordinated appeal hearing to adjudicate cost items determined under a coordinated audit,
- a study of the need for skilled nursing facilities to participate in both Medicare and Medicaid,
- evaluations of the cost-effectiveness of review of particular health care services by PSROs,
- a nationwide study of regional differences in medical criteria and length-of-stay norms utilized by PSROs,
- a study concerning possible Medicare coverage of drug detoxification services,
- a demonstration project concerning nutritional therapy in early renal failure,
- a study concerning possible Medicare coverage as a home health benefit of services furnished by registered dietitians,
- demonstration projects as to making the services of clinical social workers more generally available as Medicare benefits,
- a study concerning possible Medicare coverage of orthopedic shoes,
- a study concerning possible Medicare coverage as a home health benefit of respiratory therapy services, and
- a study of the costs of various approaches to improving Medicare coverage for the treatment of foot conditions.

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Section 307 would also postpone for one year, to December 1954, the date by which a report must be submitted on the provision of long-term care services by hospitals.

Repeal of Obsolete Authority for Medical Assistance

Section 308 would repeal obsolete authority to provide medical assistance together with cash assistance in State programs under titles I, IV-A, X, XIV, and XVI of the Act. This authority has been replaced by the Medicaid program under title XIX of the Act.



STATE OF ALASKA
LEGISLATIVE AFFAIRS AGENCY

GENE KENNEDY
DIRECTOR

ALASKA LEGISLATIVE
INFORMATION OFFICE
400 NORTH CAPITOL N.W., SUITE 181
WASHINGTON D.C. 20001
(202) 624-5673



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

January 29, 1981

MEMORANDUM

TO: Representative Ken Fanning

FROM: Christine Johnson
Research Staff

SUBJECT: Medicaid Expenditures and Claimants
Research Request 81-7

Attached please find several tables showing the Medicaid statistics you requested for FY78, FY79, and FY80.

Medicaid Data

Much of the information in the tables had to be compiled by the House Research Agency from records kept by the Department of Health and Social Services, as the Department does not regularly aggregate the state's Medicaid expenditures or the total number of Medicaid claimants.¹ Consequently, although the statistics presented in the tables have been verified with the Department of Health and Social Services, they should be viewed as approximations.

In particular, the claimant averages for each year and the average expenditure per service should be used with care; although again, these have been reviewed by the Department. The statistics we show for FY80 are estimates for the year based on the totals reported for the last six months. The number of claimants and the cost per service were only systematically compiled during the last half of FY80, after the Department contracted with a data processing firm to process Medicaid claims. The numbers for FY78 and FY79 were compiled by this Agency from "HCFA 120" forms which the Department prepared on a monthly basis during those years. According to the Department, these forms may not be entirely accurate, although they did not express major reservations about us using the data.

¹As you can see from attachment A to this memorandum, the Executive Budget for FY82 includes a separate Budget Request Unit for Medicaid; however, the totals which are reported in this BRU do not include Medicaid expenditures for patients in API and Harborview, and do not represent any of the administrative costs associated with the program.

Medicaid Funding

The State and the federal government equally share the costs of most of the medical services provided under Medicaid, and the cost of administering the program. The federal government assumes 100% of the cost of the Indian Health Care component of the program.

The annual Medicaid expenditures for FY78, FY79, and FY80 are shown on Table 1. The State's cumulative expenditure for these years was \$46.6 million. The federal government's share of program costs over this period equaled \$49.2 million, resulting in a total program expenditure of almost \$95.8 million for the three years. The FY80 expenditure represented almost a 50% increase over FY78 costs, or an increase of approximately \$12.6 million. According to Table 1, the largest growth during this period was in the category of payments to health care providers. The increase in this category is attributable to a number of factors, including rising cost of services, growth in the population eligible for Medicaid, increase in the number of health care services covered under Medicaid, and inflation.

Medicaid Claimants

As Table 2 indicates, the number of Medicaid claimants increased by 48% or 1600 people between FY78 and FY80. However, the average monthly expenditure per claimant remained approximately the same, fluctuating between \$620 and \$670.

It may be somewhat misleading to calculate an overall average monthly expenditure per claimant, as the average monthly expenditure differs significantly according to the medical service provided. For example, according to Table 2, in FY80 the average monthly expenditure per claimant was \$625. However, as Table 3 shows, 86% of the monthly claimants received care costing less than \$275. Clearly, the overall average is distorted by the small number of claimants receiving expensive institutional care. As Table 2 indicates, institutional care is extremely costly. Although there are only an average of 25 patients in the Alaska Psychiatric Institute who are eligible for Medicaid coverage, the monthly expenditure for those patients totals \$157,000 or \$6,200 per person. Harborview Developmental Center is slightly less expensive per patient; however, the total Medicaid expenditure for the 92 patients in that institution is over \$400,000 a month, or \$4,400 per person.

Medicaid Program Administration

As Table 1 indicates, it cost approximately \$1.1 million to administer Alaska's Medicaid program during FY80. Administration of the Medicaid

Representative Ken Fanning
January 29, 1981
Page 3

program currently requires the equivalent of 11.9 full-time employees, according to estimates computed by the Department of Health and Social Services and this Agency.

We did not anticipate that it would take nearly so long to collect his data, and apologize for the delay in delivering it to you. Should you require any further information, please do not hesitate to contact us.

CJ/dp

Attachments

TABLE 1
Medicaid Expenditures
FY78 - FY80

	<u>FY78 Actual</u>	<u>FY79 Actual</u>	<u>FY80 Actual</u>
<u>Medicaid Budget Request Unit</u>	\$18,789.5	\$25,235.4	\$30,036.2
<u>State Institutions</u>	\$ 5,751.4		
API		\$ 1,260.9	\$ 1,888.5
Harborview		\$ 4,995.1	\$ 4,841.8
<u>Administration and Support</u>	<u>\$ 722.2</u>	<u>\$ 1,108.8</u>	<u>\$ 1,113.7</u>
Total Expenditure	\$25,263.1	\$32,600.2	\$37,880.2
State Share of Program Cost ¹	\$12,631.6	\$15,577.2	\$18,358.1
Federal Share of Program Cost ¹	\$12,631.6	\$17,023.1	\$19,522.2

¹The State and the federal government equally split the cost of most of the services offered under the Medicaid program. However, the federal government pays 100% of the costs incurred under the Indian Health Care component of the program. This component was added to the State's Medicaid program in FY79.

Source: Alaska Department of Health and Social Services

TABLE 2
Average Monthly Medicaid Expenditure Per Claimant
FY78 through FY80

	<u>FY78</u>	<u>FY79</u>	<u>FY80</u>
Average Monthly Health Care Expenditure¹	\$ 2,045,075	\$ 2,624,283	\$ 3,063,875
Average Monthly Claimants	3314	3918	4902
Average Monthly Expenditure Per Claimant	\$ 617	\$ 670	\$ 625

¹Average monthly health care expenditures were computed by dividing the annual expenditure for health care (see Table 1) by twelve.

Source: House Research Agency, 1/27/81, from data reported on HCFA 120 forms July 1977 - June 1980.

TABLE 3
Medicaid Expenditures Per Claimant¹
FY80

	<u>Average Monthly Expenditure</u>	<u>Average Monthly Claimants</u>	<u>Average Monthly Expenditure Per Claimant</u>
Physician Services	\$ 321,417	2401	\$ 134
Clinic Services	\$ 29,057	158	\$ 184
Home Health Services	\$ 904	4	\$ 226
Family Planning	\$ 3,236	41	\$ 79
Lab/X-ray	\$ 11,102	158	\$ 70
Dental	\$ 51,632	362	\$ 143
Early Periodic Screening & Diagnosis	\$ 18,261 ²	176	\$ 104 ²
Other Services	\$ 114,105	420	\$ 272
<u>Hospitals</u>			
Inpatient Care	\$ 469,722	133	\$ 3,532
Outpatient Care	\$ 99,021	513	193
<u>Nursing Homes</u>	\$1,194,308	419	\$ 2,850
<u>State Institutions</u>			
API	\$ 157,375	25	\$ 6,295
Harborview	\$ 403,483	92	\$ 4,386

¹Amounts shown on this chart for FY80 are estimates based on data for six months of the year (January 1980 through June 1980.)

²Includes some costs of administering the EPSDT program.

Source: House Research Agency, 1/27/81, from data provided by the Department of Health and Social Services and HCFA 120 forms.

MEDICAID - HOSPITALS

1) States can design alternative reimbursement method

a) incentives for efficiency & economy

b) payments not to exceed Medicare "reasonable cost"

c) secure participation / quality of care

d) appeals mechanism

e) no payments in excess of those charged to the general public

Administrators

2) Common audit for Medicare and Medicaid.

3) improve bill processing techniques

4) occupancy rate - imputed as actual

5) major operating cost associated with capital improvements are at present "burdened" with cost

6) states primarily allocate resources which pay for

a) laboratory reports

b) hospital contributions

c) health care costs (often during winter)

d) accreditation fees

7) facilities all have pay withheld Administrators

- 8) not know percentage contracts of physicians employed by hospital as they often receive % of payments from their department in addition to salary
- 9) deduct surpluses for grants, gifts and endowment incomes
- 10) Lab & x-ray reimbursed at rate no higher than large, automated units.
- 11) Federal Grants to outpatient care - screening mechanism for emergency rooms. Patients could be designed to utilize the appropriate setting for which the service should be rendered

* Comparison of
 1. Medical
 2. Management
 3. Financial

1) Medical Management

2) Financial Management

- 3) DSRD - Management of Resources
 - a) Criteria for need for admission
 - b) Risk for early death, disability
 - c) Availability of services
 - d) Admission criteria
 - e) Initial and interim care review
 - f) Review care utilization
- 4) Review of necessity and availability of health care
 - a) Understanding differences between levels of care
 - b) Role of the patient in care
 - c) Role of the provider - criteria, review of interest
 - d) Review - criteria - with provider in care

Utilization Control

1. Medical Management Dept. System (MMS)
2. Review Utilization Review Plan (URP) for approval

SNF 1/0F

HEALTH CARE FINANCING AMENDMENTS OF 1981

1. Limit Fed. contribution to Medicaid to \$6.4 billion (200 million less than 1981)
allowed to rise w/ rate of inflation as measured by GNP deflator
2. Medically needy - all Fed. requirements for eligibility and benefits eliminated
3. End FIDE coverage for 65 yr old
Also eliminate requirements for Medicaid to continue 6 months after age termination.
4. Reduce "random access" requirements
No longer can state opt out
5. Eliminate Federal matching requirement
No amount of federal matching required if provider
6. Eliminate specific medical & utilization rules
All states. Allowing states to be decided state by state (not subject to federal review or enforcement)
7. Reduce coverage of long-term care services
Coverage of private long-term care
8. Secretary can opt to not participate in Medicaid
1. Health care to be provided
2. Coverage of long-term care to be provided
3. State can opt out of Medicaid
4. Federal matching requirement
5. Federal review of state Medicaid plans
6. Federal review of state Medicaid plans

F. Requirements which prevent states from sharing with recipients savings of cost-efficient care.

9. Repeal ETO notification of AFDC children.
10. Eligibility of non-US citizens take in the income of the individual sponsor.
11. Civil penalties to prevent fraud. Providers fined up to \$500 plus three times fraudulent claim.
12. Create Federal monitoring for automated eligibility systems. Make state expenditures of the system development and maintenance explicit.
13. Amend state welfare and federal benefits and financing approach. A state claim.