SB
698

COMMITTEE REPORT

SENATE

1/29/82

FURTHER: Finance

Date: 3-15-82

Mr. President:

The Committee on HEALTH, EDUCATION & SOCIAL SERVICES has had SB 698

state reimbursement of health facilities for medical assistance provided to needy persons

under consideration and (a majority of the committee) (the committee) reports it back with the following recommendations:

[✓] do pass   [ ] do not pass

[ ] do pass with attached amendments(s)

[✓] replace with CS for ______ [✓] same title [ ] new title

and recommends ______

[ ] AND attaches a "Letter of Intent"   [✓] New Fiscal Note

[ ] reports it back without recommendation

[ ] referred to the ______ Committee

MEMBERS SIGNING DO PASS

MEMBERS HAVING OTHER RECOMMENDATIONS:

CHAIRMAN

S 60 (Rev. 12/78)

POSITION PAPER
Senate Bill 698

An Act authorizing State reimbursement of health facilities for medical assistance on the basis of prospectively determined rates.

Senate Bill 698 would require that Medicaid and General Relief Medical (GRM) reimbursement for services provided by health facilities be based on a prospective determination of reimbursement.

Under present State and federal statutory language, prospective reimbursement is an optional method of payment.

Overview

The current system of reimbursing health facilities for services to provide Medicare, Medicaid, and GRM beneficiaries is retrospective in nature. That is, health facilities are paid for their services based on a cost report submitted after the services have been provided and after the end of each facility's fiscal year. The Medicare intermediary (Blue Cross) and the Department (as the agency administering the Medicaid and GRM programs) review the year-end cost reports and pay the facilities the lower of allowable costs or charges. During each year the intermediaries pay the health facilities an interim rate based on the prior year's cost report.

In response to this situation, approximately thirty-four states have instituted a prospective system of reimbursement for nursing home services under Medicaid, and sixteen states have instituted a prospective system of reimbursement for hospital services under Medicaid. These prospective systems have taken many forms, each state's structure a little different. However, they share the same philosophical purpose: "to encourage economy and efficiency, and to establish a uniform system of accounting, budgeting, and reporting in determining a health facility's future reimbursement."

SB 698 proposes a prospective reimbursement system for both hospitals and nursing homes under Medicaid and GRM. Less than ten states have both hospital and nursing homes under Medicaid and GRM. Less than ten states have both hospital and nursing homes covered under some type of prospective reimbursement system.

Department's Position

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

1) Standardization of health facility's accounting, reporting and budgeting.

2) Centralization of health facility operational data.

3) Reimbursement based on rates negotiated in advance of the fiscal year rather than after the fact.

4) Continual communication between the commission and health facility administrators on health care costs in Alaska.

5) Billing and payment simplification based on negotiated rates of reimbursement before services are provided, with no retroactive cost settlement.

I. Adequate Program Funding

While Senate Bill 698 would authorize, if passed, a prospective method of setting health facility rates it does not and cannot insure that there will be adequate Medicaid and GRM funds to meet the need based on rates approved by the commission. Therefore, the problem will always exist that the rates established prospectively by the commission may be greater than the rate that the Medicaid and GRM programs can afford to pay based on budget available. This situation will undoubtedly be brought back to the legislature when a disparity occurs.

Fortunately, however, when this does occur the data available to document the disparity will be prepared by an independent commission responsible to the public to document true and reasonable health facility costs. Also, the data will be organized in a standard and uniform manner and will appropriately compare facilities and their costs.

II. Voluntary or Mandatory System

The Department has changed its approach to the topics of a voluntary vs. a mandatory prospective rate system. We are now willing to support the concept that prospective rate setting be tried with only Medicaid and GRM at this time. If the prospective system established is successful, we feel public and possibly health facility pressure will cause it to be expanded to other financiers of health care.

III. Purpose

The Department would like to suggest that the purpose statement in SB 698 be amended by adding the following language at page 1, line 14 after "meet": "their fair share of".

IV. Uniform Accounting, Budgeting and Reporting

This is a critical part of any prospectively-negotiated reimbursement system. SB 698 does not clearly require the establishment of a uniform accounting, budgeting and reporting process.

We would suggest the following language be used to establish a uniform accounting, budgeting and reporting process:

"(a) The commission, after study and in consultation with advisory committees, if any, shall establish by regulation pursuant to the Alaska Administrative Procedures Act, AS 44.66, a uniform system of accounting, budgeting, and financial reporting, including methods by which facilities shall record their revenues, expenses, other income, other outlays, assets and liabilities, and units of service. All facilities shall adopt the system for their fiscal year period to be effective at the time and date as the commission shall direct. In determining the effective date for reporting requirements, the commission shall be mindful both of the immediate need for uniform reporting nformation to effectuate the purposes of this chapter and the administrative and economic difficulties which facilities may encounter in conversion, but in no event shall the effective date be later than one and one-half years from the date of enactment of this chapter.

"(b) In establishing uniform accounting, budgeting, and reporting procedures, the commission shall take in consideration:

"(1) existing systems of accounting, budgeting, and reporting presently used by health care facilities;

"(2) differences among facilities according to size; financial structure; methods of payment for services, scope, type, and method of providing services;

"(3) types of health care services provided; and

"(4) other pertinent distinguishing factors.

"(c) The commission shall, where appropriate, provide for modification consistent with the purposes of this chapter of reporting requirements to correctly reflect the differences among facilities and to avoid otherwise unduly burdensome costs in meeting the requirements of the uniform system of accounting, budgeting, and financial reporting.

V. Location of Commission

We would recommend the bill be revised to locate the commission within the Department of Commerce and Economic Development, and that it be clearly established as an independent commission much like the Alaska Public Utilities Commission.

VI. Certificate of Need and Revenue Sharing

The Department has also changed its position on this issue. We are willing to wait and give the prospective system as established in SB 698 time to organize and develop. At a later date we would discuss with the legislature the pros and cons of a interface between the rate commission, certificate of need and revenue sharing.

VII. Return on Equity Capital

The Department also has revised its positions on setting a specific amount in statute as the amount allowed for a return on equity. The amount established should set by the commission and will only be established after the issue of the method of determining equity is resolved.

Conclusion

As stated earlier, The Department of Health and Social Services supports Senate Bill 698 and feels its passage is an important link in the State of Alaska's efforts to document its "fair share" part of the costs of health facilities. As public funds for health services drop further and further away from the seemingly insatiable health service needs, public efforts to determine true costs will be very important.

A rate commission will establish an independent and therefore hopefully objective body to review the data presented by health facilities and the Department of Health and Social Services and report to the legislature the funding issues involved.

Recommended by Rod Betit 3/15/82
Rod Betit, Director
Division of Public Assistance

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

	Positions	Salary Range	Salary Cost	Monthly Salary TOTAL
100 Personal Service				
PA Program Officer	(1)	21	3475	3475
Auditors	(2)	18	2838	5676
CT III	(1)	8	1482	1482
MA Administrator	(1)	17	2640	2640
				13273

(12466 + .23 benefits) = 16325 x 12 mos = 195909.

200 Travel	
201 Commission	10.0
(5 person, 4 meetings/yr)	
202 Training & Audit	16.0
	26.0
300 Contractual	
310 Comm Telephone, postage	12.0
320 Printing	4.0
330 Rents/leases	15.0
340 Repair	1.0
360 Equip rental/copier	2.5
364 Typewriter	13.7
365 Telecommunications	5.0
(Commission public meetings)	
370 Data Processing	13.7
389 Contracts	
a) uniform budget	50.0
b) uniform acct	50.0
c) legal counsel	15.0
390 Misc	1.0
	182.9
400 Commodities	1.5
500 Equipment (office furniture)	6.0
FY83 TOTAL	375.5

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. SB 698
Title An Act creating the Health Care Facilities Commission
Requested by ______ Date ______

II. FISCAL DETAIL
Agency Affected Health and Social Services
Program Category Affected --
BRU, Program, or Subprogram(s) Affected GRM 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	0	196.0	220.0	247.0	276.0	309.0
200	TRAVEL	0	26.0	29.3	33.1	37.5	42.3
300	CONTRACTUAL	0	183.0	195.4	200.9	249.6	282.0
400	COMMODITIES	0	1.5	1.6	1.9	2.1	2.4
500	EQUIPMENT	0	6.0	1.0	0	0	0
600	LAND & STRUCTURES	0	--				
700	GRANTS, CLAIMS, ETC.			0	0	0	0
	GRM					0	0
	TOTAL	0	412.5	447.3	502.9	565.2	635.7

FUNDING (Thousands of Dollars)

GENERAL FUND		412.5	447.3	502.9	565.2	635.7
FEDERAL FUNDS		0	0	0	0	0
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME	0	5	5	5	5	5
PART TIME	0	-	-	-	-	-
TEMPORARY	0	-	-	-	-	-

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

A. Assumptions - Same as Detail Budget Instructions except a 13% yearly inflation figure is used.

B. Positions - See attached.
a. Uniform accounting system is necessary in order to compare costs of health facilities. Demonstration project in Washington state emphasized the need for uniform accounting.
b. Uniform budgeting system for reporting and projecting future expenditures which can then be compared with local, regional and national needs and trends. To establish a uniform accounting and budgeting system will take between 1 and 2 years for development and subsequent training of providers.
c. Lease data processing equipment and time from the Department of Administration for forecasting and analyzing health data.
d. Dollar figure in claims represents the cost to the Medicaid Program due to the switchover from retrospective "cost" system. See attached.

IV. DATE ______ PREPARED BY ______
AGENCY Health and Social Services/DPA
PHONE 465-3355

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

33-001 (Rev. 12/80)

	Positions	Salary Range	Salary Cost	Monthly Salary TOTAL
100 Personal Service				
PA Program Officer	(1)	21	3475	3475
Auditors	(2)	18	2838	5676
CT III	(1)	8	1482	1482
MA Administrator	(1)	17	2640	2640
				13273

(12466 + .23 benefits) = 16325 x 12 mos = 195909.

200 Travel

201 Commission (5 person, 4 meetings/yr)	10.0
202 Training & Audit	16.0
	26.0

300 Contractual

310 Comm Telephone, postage	12.0
320 Printing	4.0
330 Rents/leases	15.0
340 Repair	1.0
360 Equip rental/copier	2.5
364 Typewriter	13.7
365 Telecommunications (Commission public meetings)	[illegible].0
370 Data Processing	13.7
389 Contracts	
a) uniform budget	50.0
b) uniform acct	50.0
c) legal counsel	15.0
390 Misc	1.0
	182.9
400 Commodities	1.5
500 Equipment (office furniture)	6.0
FY83 TOTAL	375.5

The following tables show the increase or decrease in cost that can be expected if a propsective system similar to S.B. 698 is adopted. This bill allows costs which are currently not allowed under Medicare principles.

TABLE I*

Long T[illegible]m Care Cost Projections

Medicaid	Historical Cost	Prospective Rate System (-3%)	State Budget at 15% Annual Budget	Prospective vs. Historical	Prospective vs. State Budget
n = 15.2					
81 base	17073.0	17073.0			
82*	19668.0	19668.0			
83	22657.0	22067.0	20896.4	(590.0)	1170.6
84	26101.0	24759.0	24030.9	(1342.0)	728.1
85	30068.0	27780.0	27635.5	(2288.0)	144.5
86	34638.0	31169.0	31780.8	(3469.0)	(611.8)
87	39904.0	34971.0	36547.9	(4933.0)	(1576.9)
GRM					
n = 15.2					
81 base	449.4	449.1			0
82	568.1	568.1			0
83	654.5	637.4	501.1	(17.1)	136.3
84	753.9	715.2	576.3	(38.7)	138.9
85	868.5	802.4	662.7	(66.1)	139.7
86	1000.5	900.3	762.1	(100.2)	138.2
87	1152.6	1010.2	876.4	(142.4)	133.8

* n was derived from FY80 and FY81 PBA expenditures.

TABLE II

Hospital Cost Projections

Medicaid					
n = 20.4					
81 base	9010.0	9010.0			
82**	10848.0	10848.0			
83	13061.0	13061.0	11392.9		1668.1
84	15725.0	15253.3	13101.8	(471.7)	2151.5
85	18933.0	18365.0	15067.0	(568.0)	3298.0
86	22795.0	22111.2	17327.1	(683.8)	4784.1
87	27445.0	26621.7	19926.2	(823.3)	6695.5
GRM					
n = 20.4*					
81 base	3890.0	3890.0			
82	4683.0	4683.0			
83	5639.0	5639.0	4548.0		1091.0
84	6789.0	6585.3	5230.2	(203.7)	1355.1
85	8174.0	7928.8	6014.7	(245.2)	1914.1
86	9841.0	9545.8	6916.9	(295.2)	2628.9
87	11849.0	11493.5	7954.4	(355.5)	3539.1

* See Appendix 1 for derivation of n.

** During the first year of prospective budgeting, costs will increase 10%.

THE FY81 BASE FIGURE WAS DERIVED FROM THE PBA SYSTEM.

The n for LTC was computed from DPA expenditures for FY80 and FY81.

The n for Hospital was computed using AHA Hospital Statistic (See Appendix I) for expenses per adjusted admission from 1975 to 1980.

M E M O R A N D U M

TO: Medical Care Advisory Committee

FROM: Alaska State Hospital Association

DATE: December 3, 1981

RE: Prospective Rate Negotiation System

As you know, the Alaska State Hospital Association has decided to propose legislation for the implementation of a prospective rate negotiation system. A draft of the Association's proposed legislation will shortly be available. It will be based upon, and will reflect, the following principles:

1. Health care institutions must be financed at a level that supports the health objectives of the community.

2. The community must meet the financial requirements of its health care delivery system, and the providers must accept the responsibility for the system's proper planning and management.

3. The financial requirements that must be met are those that are not only necessary to meet current operating needs, but also sufficient to permit replacement of the physical plant and to allow for changing community health and patient needs and educational and research needs, as well as other needs necessary to the institutional provision of health care services.

4. Prudent management to insure institutional financial stability requires that there be a realistic appraisal of current operating requirements and operating margin.

5. Current operating requirements include the following:

5.1. Patient care.

5.2. Patients who do not pay.

5.3. Education.

5.4. Research.

6. The operating margin will provide necessary funds for the following:

6.1. Working capital requirements; financial stability is dependent upon having sufficient cash to meet current obligations as they come due.

6.2. Capital requirements necessary to finance necessary changes, such as renovations and repairs, replacement of plant and equipment, expansion and new technology.

6.3. For investor-owned institutions, a reasonable after-tax return on their owners' equity sufficient to attract and compensate shareholders.

7. In order for the community to provide proper financing for its health care delivery system, it is necessary that rates of reimbursement to health care facilities by the Medicaid and General Relief-Medical programs be prospectively negotiated so that the appropriate and equitable planning, utilization and management decisions can be made.

8. The prospective rate negotiation system should be implemented by statute. The system's elements should:

8.1. Be based principally upon the financial requirements outlined in this memorandum.

8.2. Include an independent medicaid budget review commission to implement the system, the decisions of which shall be subject to full judicial review.

8.3. Grant to the Department of Health and Human Services reasonable access to fiscal records of medicaid beneficiaries.

alaska state hospital association
319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

January 19, 1982

The Honorable Charles H. Parr
State Senator
State Capitol Building
Juneau, Alaska 99811

Dear Senator Parr:

Attached please find the definition of Equity Capital which I promised.

Sincerely,

Dennis L. DeWitt
President

DLD:bf
Attachment

alaska state hospital association
319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

January 19, 1982

The Honorable Charles H. Parr
State Senator
State Capitol Building
Juneau, AK 99811

Dear Senator Parr:

Attached is a refined draft of the State Medicaid Prospective Budget proposal. It was reviewed and adopted at our January 15, 1982 Executive Committee Meeting.

As you know, this Association is concerned that the out come of this legislation not differ in substance from the input document. As a result of that concern, the Executive Committee has reserved for itself the negotiation of any principle put forth in this January 18, 1982 draft.

The attached draft does not contain a definition of equity as it is in process. Additionally, the final legislation may need to repeal existing regulation providing for medicaid and general relief-medical reimbursement. We have not addressed the need to extend conflict of interest statutes to include the commission nor whether the commission's procedures should be governed by the Administrative Procedures Act. We will leave these to your judgement.

Thank you for your assistance in this matter.

Sincerely,

Dennis

Dennis L. DeWitt
President

DLD:jp

Proposed legislation relating to the Medicaid budget review process.

First Draft, December 11, 1981

Section ______. FINDINGS AND DECLARATION OF POLICY. The legislature finds and declares that health facilities are an integral part of the infrastucture of the State of Alaska. Accordingly, it acknowledges the need to reimburse health facilities for services provided beneficiaries of state programs at a level which will meet the true financial requirements of the institutions. In order to accomplish this end in a prudent fashion it is necessary that rates of reimbursement to be paid to health facilities by the Medicaid and General Relief/Medical program should be prospectively negotiated so that appropriate and equitable funding decisions can be made.

SECTION _____. REIMBURSEMENT FOR COST SETTLED PROVIDERS. The payment rate for health facilities shall be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. Reimbursement shall reflect a reasonable return on investment in addition to the other financial needs of the facility. Reimbursement shall be made for, by way of example and not by limitation, the following:

(a) Costs of current operating requirements, including but not limited to:

(1) Health facility operating expenses such as wages and salaries, purchased services,

supplies, insurance, leases, depreciation, taxes, interest expense, maintenance and minor remodeling;

(2) Bad debts;

(3) Education;

(4) Research; and

(5) All costs associated with preparing budgets and negotiating rates under this section.

(b) A reasonable operating margin, in order to provide for:

(1) Working capital necessary to meet current obligations as they come due; and

(2) Capital necessary for

(i) Major renovations and repairs;

(ii) Replacement of plant and equipment;

(iii) Expansion; and

(iv) New technology.

(c) A reasonable return on equity.

SECTION _______. BUDGET DETERMINATION. (a) No less ninety 90 before the start of the health facility's fiscal year, the Division of Public Assistance shall provide it with an estimate of its volume for that fiscal year.

(b) No less than 60 days before the start of the health facility's fiscal year, the health facility shall submit its proposed rates for Medicaid reimbursement and its budget projections on forms prescribed by the commission.

(c) Within 45 days after the proposed rates and budget projections are submitted, the commission shall review the proposed rates and the budget projections and shall, in accordance with section _____, issue a written decision. Reimbursement shall be made in accordance with the rates established in that written decision. The health facility shall be permitted to present oral testimony and a documentation in support of its proposed rates and budget projections. If the commission fails to issue a written decision within that period, the health facility's rates will be deemed approved.

(d) Within 30 days of issuance of the decision, the health facility may request the commission to reconsider the decision. Whether or not reconsideration is requested the health facility has the right to de novo judicial review of the decision by the superior court under the Rules of Appellate Procedure. During any reconsideration or appeal the health facility shall receive payment according to the rates approved by the commission.

(e) Any health facility may submit amended proposed rates and an amended budget during its fiscal year. Within 60 days of submission the commission shall review the amended proposed rates and amended budget and shall issue a written decision. If the commission fails to issue a written decision within that period, the health facility's amended rates and amended budget shall be deemed approved.

(f) Within 90 days after the close of the health facility's fiscal year, it shall submit to the commission, on forms prescribed by the commission, which forms shall be consistent with the budget projection forms, a report on its financial performance during that fiscal year.

SECTION _______. AUDIT AND INSTITUTIONAL REVIEW.

(a) As a condition of participation in the Medicaid program, health facilities must provide the division reasonable access to fiscal records of all Medicaid beneficiaries.

(b) Health facilities must allow inspection of fiscal records by the division and other state and federal agencies to the extent required by federal law and regulation.

SECTION ____. REIMBURSEMENT TO HEALTH FACILITIES UNDER GENERAL RELIEF/MEDICAL PROGRAM. (a) Reimbursement to health facilities under the General Relief/Medical program shall be made at the same rates as those established for Medicaid reimbursement.

(b) Health facilities shall submit all claims for reimbursement on invoices prescribed by the division and in accordance with its provider manuals.

(c) Claims for reimbursement must be filed promptly following the provision of care, and reimbursement shall be promptly made.

SECTION ____. MEDICAID BUDGET REVIEW COMMISSION. There is created in the Governor's Office the Medicaid Budget Review Commission.

SECTION ____. COMPOSITION OF COMMISSION. The Commission consists of the following persons:

(1) The chief executive officer of a health facility which is licensed by the state but not owned or operated by the state or federal government and which is subject to the budget review process as prescribed in section ______ through _______;

(2) A person with a professionally relevant background appointed to represent the insurance industry;

(3) A physician licensed by the state and actively engaged in the practice of medicine in the state who is not employed by the state or federal government;

(4) A person with a professionally relevant background appointed to represent the business community; and

(5) A person appointed to represent consumers of health services who does not have an interest, direct or indirect, in an entity engaged in health care delivery.

SECTION ____. APPOINTMENT OF MEMBERS. Members of the commission are appointed by the governor and shall serve at his pleasure.

SECTION ____. TERM OF MEMBERSHIP. Members shall be appointed for terms of three years, and they may not be appointed to successive terms. Terms shall be staggered. The initial terms shall be two members serving for three years, two serving for two years and one serving for one year. For purposes of initial appointments, appointing successors or filling vacancies, all terms shall be measured from January 1 of the year in which the term of the vacant position began, regardless of when the vacancy is filled. A member appointed to fill a vacancy serves for the unexpired term of the member he succeeds.

SECTION ____. COMPENSATION. The members of the commission serve without compensation but are entitled to per diem and travel expenses authorized by law for other boards and commissions.

SECTION ____. OFFICERS. At the first meeting of each year, the commission shall elect a chairman from among its members.

SECTION ____. MEETINGS AND QUORUM. The commission shall meet as frequently as necessary to conduct its business efficiently and expeditiously. Three members of the commission constitutes a quorum.

SECTION ____. DUTIES OF THE COMMISSION. The commission shall have sole responsibility to review proposed rates and budgets of health facilities and establish Medicaid and General Relief/Medical reimbursement rates for health facilities pursuant to Sections ____ through ______.

SECTION _____. EMPLOYMENT OF PERSONNEL. The commission may employ and determine the salary of an executive director. The executive director may, with the approval of the commission, select and employ additional staff as necessary. The executive director and all employees of the commission are in the exempt service under AS 39.25.

SECTION ____. AS 47.07.070 is repealed.

SECTION ____. AS 47.07.080(1) is repealed.

SECTION ____. DEFINITIONS. In this chapter,

(1) "health facility" shall include hospitals, skilled nursing facilities, intermediate care facilities, intermediate care facilities/mentally retarded, inpatient psychiatric facilities, home health agencies, rural health clinics, and out patient surgical clinics and any other entity which receives Medicaid or General Relief/Medical reimbursement for services traditionally provided in health facilities;

(2) "commission" shall mean the commission created pursuant to Section _____;

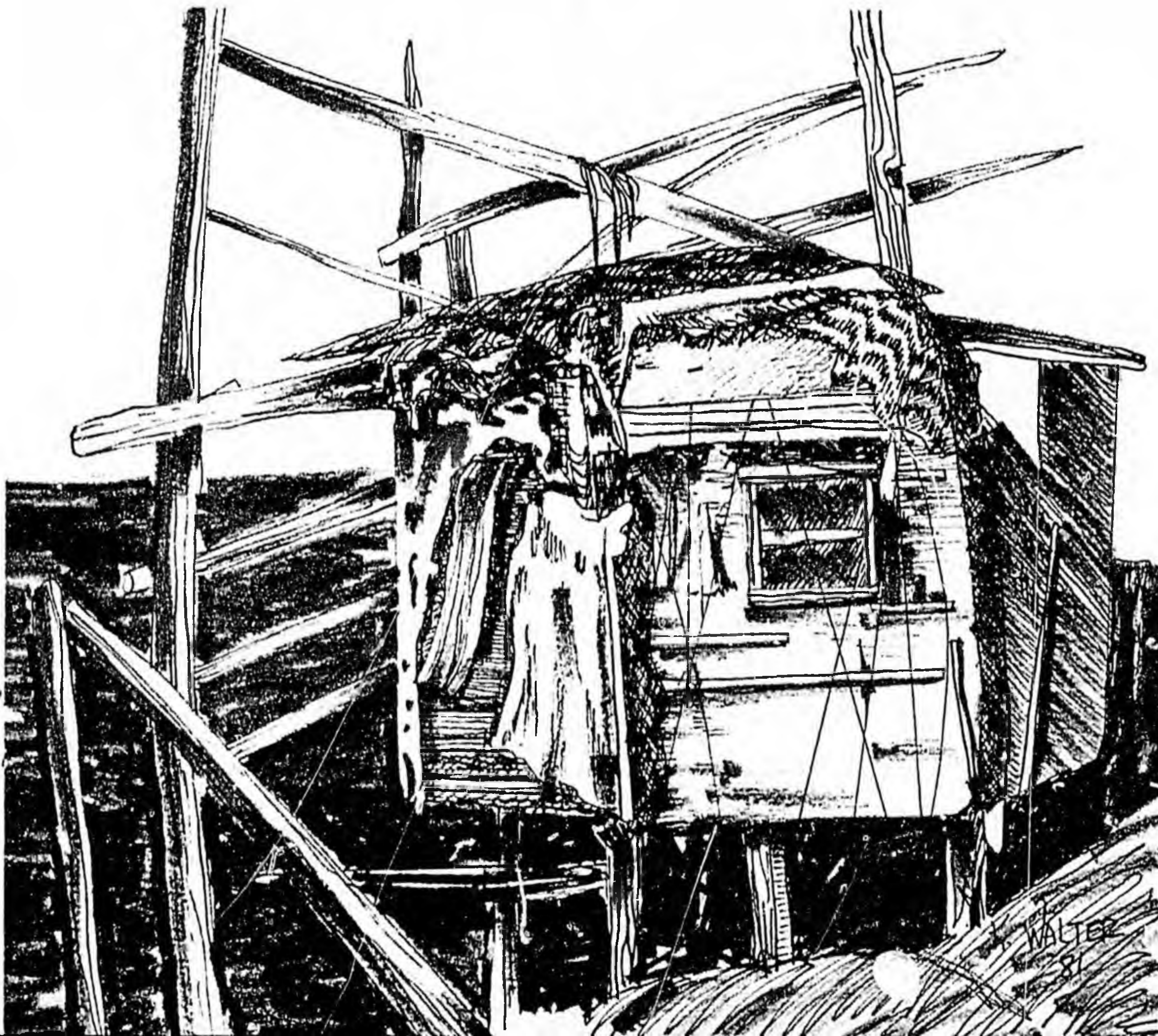
(3) "division" means the Division of Public Assistance of the Department of Health and Social Services; and

(4) "volume" means the total services provided to Medicaid and General Relief/Medical beneficiaries.

SECTION ____. This act takes effect January 1, 1983.

Medicaid

annual report FY 80-81



PUBLIC INFORMATION DOCUMENT

The following documents have been compiled to increase the reader's understanding of the Medicaid Program in Alaska. The documents contain information highlighting eligibility, services, and expenditures. It is hoped this information will aide the Legislature in formulating policy for the continued operation of the Medicaid Program.

Section A

The first set of policy questions deals with the Federal-State relationship in the administration of the Medicaid Program. The Omnibus Budget Reconciliation Act of 1981 changed some of the requirements of the program and established funding limitations and incentives to limit the amount of "federal" funds spent on Medicaid. A summary of these changes can be seen in Section C. The following are some of the more important changes and their potential impact on the Alaska Medicaid Program.

1. Foremost is the potential reduction in the FFP matching rate. The amount of FFP that a state claims will be reduced on a quarterly basis by the following percentages: FY 82, 3 percent; FY 83, 4 percent; and FY84, 4.5 percent. However, a state may recover all or part of that reduction. If a state's actual claim (before the percentage reduction) does not exceed the target amount for the fiscal year, the state will be entitled to a return of the total amount withheld. For FY 82, the target is 109 percent of a state's quarterly estimate made in February 1981 for FY 81. For FY 83 and FY 84, the target amount will increase or decrease by the percentage change in the index of the medical care expenditure component of the consumer price index (rather than the GNP deflator that was being pushed by the Senate). Just so nobody thinks that this is the end of the talk of placing a cap on Medicaid expenditures, the Act requires that the GAO study the medical assistance percentage with an eye toward revising it to assure equitable distribution of federal funds. For the present, states that exceed their projected target amounts will receive a lower matching rate with no limit placed on the amount of federal funds that can be claimed.

2. Medicaid payments of physician services and other medical supplies and laboratory services are not longer required to be limited to the Medicare payment for the same service. This will permit Alaska considerable latitude in determining how and how much we pay physicians and other providers.

3. States are permitted to seek waivers to establish pre-admission screening programs and make payment for community-based care as alternatives to long term care, so long as the alternative services do not exceed the cost that would have been incurred if the person had been institutionalized. Medicaid payment would be permitted for homemaker/home health aide services, adult day health, habilitation, case management, respite care, and other services approved by HCFA. In addition, the cost of a state assessment program would be eligible for FFP.

Also of considerable concern this year is the apparent decision of the Indian Health Service to discontinue paying the non-emergency medically related transportation costs of Alaska Natives travelling from their home to a Public Health Service facility for treatment. The Department has had a memorandum of agreement with the Indian Health Service (IHS) which held that the medically related transportation costs of Alaskan Natives eligible for Medicaid would be paid by IHS when the Native was travelling to or from his house to a IHS facility. The IHS decision to no longer fund transportation means that more state dollars may be required.

Section B

The above policy changes by the Federal Government and the IHS requires that the state reevaluate its program and develop regulations and policy and/or procedures to cope with these changes. Congress will control Medicaid over the long term either through a CAP or through incrementally larger penalties each year. In either case the net result will be a ceiling on Federal Medicaid expenditures for all practical purposes. This, coupled with state funds for Medicaid being held to a 15% increase each year, will force the department to make some difficult decisions by FY83..

On October 1, 1981, Medicaid could begin paying physicians, dentists, optometrists, and other individual practitioners based on their usual and customary billing. After approval by HCFA we could begin a long term care pre-admission screening program that would include coverage of services that are not presently covered under Medicaid but could be more cost-effective than institutionalization. We could begin developing a new method of establishing reasonable costs in hospitals and long term care facilities. All of these activities may or may not require Legislative activity; if they do, then we should begin immediately to attempt to incorporate them in our planning for FY 83.

The following is a list of policy options available to the State. The list is not an exhaustive list nor has the Department made any decision concerning the adoption of these options. This list is for discussion only.

1) Up front (negotiated) rates for hospitals and long term care facilities established via budget process rather than retrospective cost settlement.

2) Standardized Budgeting and Reporting that fit within the industries normal financial reporting system.

3) Computerization of data taken from Standard Budgeting and Reporting process would allow historical review and statistically accurate forecasting.

4) "Aggregation" of routine service costs in health care facilities to insure limits are not exceeded.

5) Establish r.gulations which limit program services such as:

a. Require prior authorization of all non emergency hospi admissions;

b. Limit the number of non emergency outpatient hospital and/or physician visits per month;

c. Require prior authorization of elective surgery;

d. Limit the number of days of long term care allowed;

e. Limit the number of eyeglasses purchased per year;

f. Limit number of physical therapy and occupational therapy visits per month.

6) Establish regulations which limit fees paid for services suc as:

a. Establish fee schedule for Laboratory and X-Ray service

b. Establish recipient co-payment requirements for option and mandatory services;

c. Establish fee schedules for ER and outpatient hospital visits and;

d. Tie reimbursement in hospitals and long term care facilities to occupancy rates.

7) Establish legislation which limits the number of individuals eligible for Medicaid:

a. Eliminate the following optional coverage groups presently covered by Medicaid;

1. Institutionalized recipient qualifying under the 300% Medicaid CAP.

2. Individuals in the 18 to 21 year old groups who would qualify under AFDC except for age.

3. Children who are in private child care facilities foster homes for whom the state is assuming full or partial responsibility.

b. Reduce the APA need standard and;

c. Reduce the AFDC need standard.

8) Develop strategies for staying within the Federal Medicaid Target such as:

a. Holding Harborview Medicaid Claims to their FY82 budget level.

b. Suspending Medicaid payments to the Alaska Psychiatric Hospital until late in FY82 when the overall Medicaid expenditures can be more accurately determined and then pay only the amount to API that is available without exceeding the Federal target.

9) Propose legislation to move services currently paid under the General Relief Medical program to services provided for and reimbursed for under Medicaid, i.e. pharmaceuticals, durable medical equipment, adult dental services, etc. This would save state dollars but would not assist in avoiding the penalty.

10) Establish regulations which eliminate certain optional services from the Medicaid Program such as:

Clinic Services
Services for Speech, Hearing & Language Disorders
Services to Individuals Over 65 in Institutions for Mental Diseases
Intermediate Care Facilities
Inpatient Psychiatric Services for Under 22
Transportation
SNF for Under 21
Emergency Hospital Services
ICF/MR

Section C

The following are some of the major changes made by the Omnibus Reconciliation Act of 1981:

1. Medicaid hospital reimbursement requirements have been changed to require that state payment for inpatient hospital services be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" in order to meet applicable laws and quality and safety standards. This is the same change as was made last year by Congress on payment for long term care services. The Act requires that by July 1, 1982, HCFA develop a model prospective payment methodology for inpatient hospital services that can be used by both Medicaid and Medicare.

2. States were authorized to purchase laboratory services and medical devices on a competitive bid basis. States were also authorized to

establish on a waiver basis a physician case management system and permit localities to assist Medicaid beneficiaries in selecting competing health plans. An important additional requirement is that HCFA must act on waivers within 90 days of submission or a state may proceed to implement the change.

3. The EPSDT penalty of a one percent reduction against the state AFDC federal claim has been eliminated, but the standards still exist. However, Congress intends that the present EPSDT reporting requirements should be significantly streamlined.

4. HMO and prepaid health plan requirements were loosened. Private, nonprofit, or governmental plans can include Medicaid beneficiaries so long as they do not exceed 75 percent of the total enrollees in a plan. States may enroll beneficiaries for up to a minimum enrollment period of 6 months even though they might lose their Medicaid eligibility during that period.

5. FFP is prohibited for payments made for inpatient hospital tests that are not specifically ordered by the attending physician, except in emergencies.

6. Physician assistants and nurse practitioners would be permitted to provide the 60-day recertification of continuing need for institutional care in a hospital or long term care facility instead of a physician.

7. States will be permitted to establish a reasonable floor for third party liability collections in cases where the cost of recovery is expected to exceed the amount recovered.

8. Changes were made which permit states to choose varying categories of services and groups of eligibles under a medically needy program without having to provide coverage to all possible groups and without having to cover all services covered for categorically eligible individuals. What this would permit a state to do is cover elderly and disabled individuals without covering families.

9. HCFA will be permitted to establish limits on Medicare costs or charges that will be considered reasonable for outpatient services provided by hospitals, community health centers, or clinics, and by physicians using these facilities. The limits will not apply to bona fide hospital emergency room services. Actual charges will be used in developing the limits, they will be reasonably related to the charges for similar services provided in physicians' offices, and exceptions may be provided in areas where physician services are not generally available..

10. Medicare reimbursement for inpatient alcohol detoxification services in freestanding facilities has been eliminated.

11. The Medicare reimbursement limit on hospital routine operating costs has been reduced from 112 percent to 108 percent of the mean costs; exemptions (such as for sole community providers) and exceptions granted by HCFA will still be permitted.

12. The Medicare Part B deductible was increased from $60 to $75 effective January 1, 1982.

Section D

The next several paragraphs will explain FY82 projected expenditures. Projections for FY82 were based on expenditures by date of service for hospitals, physicians, other, Nursing Homes and EPSDT. 18 months of data from January 1980 through June 1981 for expenditures, recipients and expenditures per recipient were used to compute trend lines. A percentage change over time was calculated using the slope of the trend line and the average expenditure. This percentage change was then multiplied by the FY81 actual to estimate FY82 expenditures.

The following table outlines the percentage increase used to project FY 1982 expenditures:

Table I

Service Category	XIX Percent Increase/Year (Major Factor)	GRM Percent Increase
Hospital	17.2 (cost/recipient)	9 (inflation)
Physicians	21.6 (recipient plus cost/recipient)	9 (inflation)
Other	14.3 (expenditures)	15.5 (expenditures)
EPSDT	15.2 (expenditures)	--
Nursing Homes	15 (expenditures)	15.0 (expenditures)
IHS	9 (expenditures)	--

Hospitals XIX Expenditure Projections showed a 10% increase in total expenditures with a decrease in total number of recipients served. Because we do not expect a continued decrease in recipients served, the trend line for cost per reicpient was used. This trend line showed a 17.2% increase per year.

Physicians expenditures showed an 18.2% increase in cost and recipients with a 3.4% increase in cost per recipient. The total of these figures was used to compute a 21.6% increase for FY82 and 83.

Nursing Homes showed a 15% increase in expenditures with no significant increase in recipients served.

Other and EPSDT showed a 14.3% and 15% increase in expenditures respectively.

<u>GRM expenditures</u>, except for Other Service, this program showed a decrease in recipients in FY81. For this reason we used a 9% increase in expenditures to cover increases in cost with no increase in recipients.

<u>GRM Other Services</u>, because of the high utilization of these services (pharmacy, PT/OT, dental, etc.) by Medicaid recipients, a percentage change similar to Title XIX was used.

Expenditures - Projection
Medicaid & General Relief Medical
FY 1982

	1	2	3	4	5	6	7	8	9	10	
BRU/Component	FY81 Authorized	2-8-82 FY81 CRT.BAL	FY81 Projected	FY82 Authorized	Revised Prog #1	FY82 Revised Authorized	(3X10) FY82 Projected	Less: MMR Saving	(7-8) Balance	FY82 Factor	(6-9) Over (Under) Budget
Medicaid											
Hospitals	$10,882.3	$ 8,918.4	$ 9,010.0	$10,354.5	-	$10,354.5	$10,559.7	229.4	$10,330.3	17.2	24.2
Physicians	5,419.9	4,958.4	4,970.0	5,052.3	-	5,052.3	6,043.5	95.6	5,947.9	21.6	(895.6)
Other Services	1,610.6	1,343.9	1,370.0	1,552.0	-	1,552.0	1,565.9	57.4	1,508.5	14.3	43.5
EPSDT	2,826.6	2,107.8	2,107.8	2,717.1	-	2,717.1	2.428.2	-	2,428.2	15.2	288.9
Nursing Homes	17,719.6	16,906.1	17,073.1	19,656.0	-	19,656.0	19,634.1	-	19,634.1	15.0	21.9
Sub-Total	$38,459.0	$34,234.6	$34,530.9	$39,331.9	-	$39,331.9	$40,231.4	382.4	$39,849.0		(517.1)
IHS	7,259.1	2,104.7	3,965.5	3,410.8	-	3,410.8	4,322.4	-	4,322.4	9.0	(911.6)
Total Medicaid	$45,718.1	$36,339.3	$38,496.4	$42,742.7	-	$42,742.7	$44,553.8	382.4	$44,171.4		(1,428.7)
General Relief Medical											
Hospitals	$ 6,005.8	$ 3,817.7	$ 3,890.0	$ 3,789.4	383.0	$ 4,172.4	$ 4,240.1	-	$ 4,240.1	9.0	(67.7)
Physicians	2,310.9	1,713.1	1,733.0	1,528.2	335.6	1,863.8	1,889.0	-	1,889.0	9.0	(25.2)
Other Services	2,330.3	2,077.5	2,085.0	2,399.5	2.9	2,402.4	2,408.2	-	2,408.2	15.5	(5.8)
Nursing Homes	449.9	449.4	253.2	568.1	(55.1)	513.0	250.7	-	250.7	(1.0)	262.3
Cat. Illness	905.5	885.7	885.7	1,980.2	(500.0)	1,480.2	1,480.2	-	1,480.2	-	-0-
Residential Care	166.4	-0-	-0-	166.4	(166.4)	-0-	-0-	-	-0-	-	-0-
Total General Relief Medical	$12,168.8	$ 8,943.4	$ 8,846.9	$10,431.8	-0-	$10,431.8	$10,268.2	-0-	$10,268.2		163.6

Medicaid & General Relief Medical
: 1982

AU/Component	1 FY81 Authorized	2 2-8-82 FY81 CPT.BAL	3 FY81 Projected	4 FY82 Authorized	5 Revised Prog #1	6 FY82 Revised Authorized	7 (3X10) FY82 Projected	8 Less: MMR Saving	9 (7-8) Balance	10 FY82 Factor	(6-9) Over (Under) Budget
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Residential Care	166.4	-0-	-0-	166.4	(166.4)	-0-	-0-	-	-0-	-	-0-
Total General Relief Medical	$12,168.8	$ 8,943.4	$ 8,846.9	$10,431.8	-0-	$10,431.8	$10,268.2	-0-	$10,268.2		163.6

Medicaid Annual Report

Outline

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Legend for Figures

AB Aid to the Blind

AD Aid to the Disabled

AFDC Aid to Families with Dependent Children

APA Adult Public Assistance

API Alaska Psychiatric Institute

Clinic Rural Health Clinics and Community Mental Health Centers

FY Fiscal Year (June to July)

HDC Harborview Developmental Center

HSP Hospital

ICF Intermediate Care Facility

ICF/MR Intermediate Care Facility for the Mentally Retarded

OAA Old Age Assistance

ALASKA'S MEDICAID PROGRAM

Introduction

MEDICAID'S OBJECTIVES

The Federal-State Medicaid assistance program has three basic objectives: (1) to assure that medical services are available to needy eligible persons when ill or injured, (2) to assure that the highest quality care of the kind required by the patient's condition is provided, and (3) to make the services available by utilizing the present system of private practitioners, facilities and institutions to provide the care required at the lowest possible cost to the taxpayer.

BACKGROUND

Alaska is the 49th state to participate in the Federal-State Medicaid program. The program was implemented September 1, 1972.

Alaska's Medicaid program covers those medical services necessary for the diagnosis and/or treatment of a specific problem. Preventive medicine as such is NOT a recognized service item under Alaska's Medicaid program except for a specialized health screening program for individuals 21 years of age and under. (Program known as Early, Periodic, Screening, Diagnosis and Treatment or E.P.S.D.T. for short.)

Medical need, therefore, is the fundamental concept underlying the program. Physicians, hospitals, dentists and other medical providers deliver needed medical services and receive reimbursement directly from the Medicaid program. Most medical procedures are routinely covered by Medicaid. Some are covered only if approved in advance by the Department; and a few are not covered at all (experimental type procedures).

The following general principles govern the administration of Medicaid, in Alaska and determine whether a particular medical service is reimbursable:

- That the individual originates all requests for medical services.

- That the individual receives those medical services necesary to correct the specific medical problem.

- That the individual makes no financial contribution (except for in a nursing home) for medical services received under Medicaid. This means that a provider accepts the Medicaid payment as payment in full and seeks no additional payment for any unpaid portion of the bill from the patient.

- That the individual receives medical services at the same cost or less as do non-Medicaid recipients. This means that Medicaid will not pay for services that are "free" to the general public, or in an amount greater than charged to the general public.

- That an individual be provided needed services without regard to his race, color, sex, age, national origin or economic status.

- That an individual has a right to appeal to the Department of Health and Human Services any decision or treatment that adversely affects him.

Medicare vs. Medicaid

The Social Security Act established two programs to help citizens pay for medical bills. Title 18 of the Act established Medicare and Title 19 established Medicaid.

Medicare is a Federal hospital and medical insurance program for almost everybody 65 or older, rich or poor. Medicare provides basic protection for part of the costs of inpatient hospital care, post hospital skilled nursing facility stays, post hospital home health care, physician services, medical services and supplies, and outpatient hospital services and therapy. The hospital insurance component of Medicare is financed through payroll deductions while the medical care component requires a monthly premium by the insured person. The insured person must pay deductibles and co-insurance expenses.

Medicaid on the other hand, is a State run medical assistance program financed through Federal, State and Local taxes to pay the medical bills of certain "needy" and low income people, chiefly the aged (65 and older), disabled, blind, members of families of dependent children and certain other needy children. The list of medical services covered by Medicaid is extensive and is stated in the services section of this report. The Medicaid recipient does not have any deductibles or co-insurance expenses.

SUMMARY OF SERVICES COVERED UNDER THE
ALASKA MEDICAID PROGRAM

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

Federal law requires that the following minimum services must be covered by all State Medicaid programs:

- inpatient hospital care
- outpatient hospital care
- laboratory and X-ray services
- skilled nursing facility care for individuals 21 and older
- home health care
- physician's services
- rural health clinic services
- early and periodic screening, diagnosis, and treatment services for individuals under 21 (EPSDT)
- transportation for medical reasons

In addition, a state may elect to provide coverage for a variety of optional services. Alaska has chosen to provide coverage for the following:

- community mental health clinic and State-operated mental health clinic services
- intermediate care facility services (including facilities for the mentally retarded or persons with related disabilities)
- skilled nursing facility services for persons under 21
- optometrist's services and eyeglasses
- mental institution services for persons over 65
- psychiatric hospital services for persons under 21
- treatment of speech, hearing and language disorders
- outpatient surgical care centers

Mandatory Services

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

(2) Outpatient Hospital Services Emergency medical services; ongoing ambulatory care; public or private facilities.

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

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

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

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

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

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

(9) Rural Health Clinics Includes primary health care services provided by a federally certified rural health clinic.

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

Optional Services

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

(2) Intermediate Care for the Mentally Retarded or Persons with Related Disabilities (ICF/MR) Nursing home care for persons with mental retardation or developmental disabilities; requires prior authorization.

(3) Inpatient Psychiatric Hospital Services Acute care for persons suffering from psychological trauma or impairment; limited to persons under 21 years of age or over 65 years of age.

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

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

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

(7) Services for Speech, Language and Hearing Disorders Covers services rendered by speech pathologists or audiologists; requires prior authorization by the Division; must be ordered by a physician.

(8) Outpatient Surgical Centers Providers payment for services in one day surgery centers as an alternative to costly hospitalization for minor surgery.

(9) Nurse Midwife Services Provides payment for pre and post-delivery services to registered nurses certified as Nurse Midwifes by the State.

Early Periodic Screening, Diagnosis and Treatment
(EPSDT)

The general program objective of the EPSDT program is to provide every eligible child under 21 years of age in the State of Alaska the opportunity for maximum health status through regular, periodic, preventive health services and the early detection and treatment of disease. The achievement of this objective requires successful implementation of the following program components:

1. An effective outreach program to ensure that all eligible and potentially eligible clients are made aware of the screening opportunity.

2. An adequate transportation system to ensure that means of transportation to the screening facility and to referral providers is available to all clients.

3. A screening program which evaluates each child with observations and tests which will effectively determine whether or not that child is "at risk" of having an unmet need for medical care.

4. A follow-up system for patient referrals to insure that problems uncovered during screening are diagnosed and treated.

5. A follow-up system to insure that children, once screened, will return for appropriate future periodic screening.

6. A formal system to encourage input from providers and from consumers.

7. A reporting system which will provide all necessary information on program evaluation.

The Division of Public Health has undertaken the major responsiblity for carrying out the screening in Alaska. Through a network of over 70 nurses stationed throughout the State, outreach, screening, referral and follow-up of Alaska's eligible children is being systematically performed.

REGION X
OPTIONAL SERVICES

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

MEDICAID ELIGIBILITY

To be eligible for Medicaid, an individual must meet certain income qualifications and categorical qualifications. These requirements are set forth in Aid to Families with Dependent Children Program, Adult Public Assistance Program and the Supplemental Security Income Program.

- Aid to Families with Dependent Children (AFDC) is a program which gives money for children of eligible low-income families who are deprived of one or both of their natural or adopted parents.

- Adult Public Assistance (APA) is a program that includes three categories of eligiblity (Old Age Assistance, Aid to the Blind, and Aid to the Disabled) and provides a supplemental payment to low-income adults whose income is not enough to provide for their own basic needs. All adults who qualify for APA must be either blind, OR 65 or older, OR physically or mentally disabled.

- Supplemental Security Income (SSI) is a federal program for low-income adults who are either blind, OR 65 or older, OR physically or mentally disabled. It also provides cash assistance for low-income children who are either blind or disabled.

The following is a summary statement of mandatory and optional Medicaid Coverage Groups in Alaska. Individuals who qualify in one of the Optional or Mandatory Coverage Groups are automatically eligible for Medicaid.

A. MANDATORY

1. All AFDC recipients.

2. AFDC individuals under 21 who would be eligible for AFDC except for age & school attendance requirements.

3. Families who become ineligible for AFDC due to increased income from employment (4 month post eligibility coverage for this group).

4. SSI Aged, Blind and Disabled recipients.

5. Individuals who received AB, OAA or AD payments prior to December 1973 and continued to receive those payments until the present time.

6. Inpatients or residnets in Title XIX facilities in December 1973 who remained inpatients and would have then and now qualified under the December 1973 requirements, of the OAA, AB, AD programs.

7. Old Age Survivors Disability Insurance (OASDI) recipients who would be eligible for:

    a. SSI or APA except for the cost of living increase started in OASDI during 1977 raised their income over the limit allowed under SSI or

    b. SSI, APA or AFDC except that the 1972 cost of living increases in OASDI raised their income over the limit allowed under Medicaid.

8. Individuals who are inelgible for SSI or optional state supplements because of requirements that do not apply under Title XIX such as the AFDC requirement for Social Security numbers.

9. Blind and disabled individuals who:

    a. Meet all current requirements for Medicaid except the criteria for blindness or disability.

    b. Were eligible for Medicaid in December of 1973 and

    c. Continue to satisfy the December 1973 criteria for blindness or disability.

B. OPTIONAL

1. Aged, Blind and Disabled individuals receiving optional State supplementary payments.

2. Individuals who are eligible for APA, AD, OAA, AB or AFDC programs but have not applied for cash assistance. These individuals are eligible for Medicaid even though they do not wish to receive a cash payment from APA, SSI or AFDC programs.

3. Inpatients in Title XIX facilities who would be eligible for cash assistance if they were not in the facility.

4. Inpatients in Title XIX facilities who would not be eligible for APA/Medicaid if they left the facility. Eligible under the 300% Medicaid Cap.

5. All children under age 21 for whom the Department is assuming full or partial financial responsibility and are in foster homes or private child caring institutions.

6. Reasonable classified individuals under 21 in ICF/MR or API who are financially eligible for one of the assistance programs (APA, SSI, or AFDC).

SINGLE STATE AGENCY

The Alaska Department of Health and Social Services (DHSS) is the single State agency within Alaska which is responsible for administering the Medicaid Programs. DHSS has delegated the authority for developing and maintaining the State plan under which the Medicaid Program is administered to the Division of Public Assistance (DPA). The Division is responsible for establishing and maintaining systems and methods to insure that the provisions of the Medicaid Program comply with all applicable State and federal statutes, regulations, guidelines, and objectives.

The Division is responsible for the initial determination and redetermination of eligibility and provision of benefits to recipients in the AFDC, Medicaid, General Relief-Medical, General Relief Cash Assistance, Old Age Assistance, Aid to the Blind, and Aid to Disabled, Food Stamp and Energy Assistance programs. It also provides funding and administrative support to the Catastrophic Illness Committee, which is appointed by the Governor to determine eligibility for the Catastrophic Illness program.

The Division maintains 19 District Offices throught the state. These offices are organized into 5 regions. Each region is supervised by a Regional Assistance Payments Manager who reports to the Chief of Field Operations. The application and eligibility determination processing and the provision of initial benefits for most programs are accomplished by the Division's District and Regional Offices.

Program policy and primary program administration, provision of on-going cash, and food benefits, and processing of medical provider payments are all accomplished in the Juneau Central Office of the Division.

The Division employs two fiscal agents, Computer Science Corporation (CSC) and Delta Dental Plan of Alaska to process medical claims for payment. CSC processes all medical invoices except dental, Long Term Care Facilities, transportation, Alaska Psychiatric Institute (API), Harborview (HDC), EPSDT screening, Indian Health Service, and outofstate medical claims. Dental claims are processed and paid by the Delta Dental Plan of Alaska. The remaining claims are processed by the Medical Claims Payment Section within DPA Central Office. In order to administer the Program the Division maintains memorandums of agreement with: (1) the Division of Public Health to perform parts of Family Planning Services, EPSDT Program and the Handicapped Children's Program; (2) the Division of Mental Health and Developmental Disability to aid in intake, application, and billings for API and HDC; (3) the Division of Administrative Services to perform audits and recommend daily rates for hospitals and long term care facilities; (4) the State Health Planning and Development Agency Certification and Licensing Section to certify and license skilled nursing facilities (SNF) and intermediate care facilities (ICF) for participation in the Medicaid and General Relief Medical Program; (5) the Social Security Administration for the exchange of information; (6) the Division of Vocational Rehabilitation, Department of Education to insure coordination of benefits and services to disabled individuals; (7) the United States Public Health Service Indian Health Service, Alaska Area Native Health Services to insure coordination of benefits to Alaskan natives and to automate the billings of PHS Medicaid claims; (8) and the Alaska Professional Review Organization to facilitate effective professional review in hospitals (This agreement ended August 1, 1981).

Medical Care Advisory Committee

Federal regulations require each state to establish a medical care advisory committee (MCAC). Alaska's Medical Care Advisory Committee originated in 1972. The present committee consists of 1 hospital administrator, 1 representative of dental community, 1 pharmacist, 1 physician, 1 representative from State Division of Public Health (also a physician), 2 consumers, 1 recipient, 1 Nursing Profession.

The Medical Care Advisory Committee produced a report on May of 1981 which identified the future role and responsibility of the MCAC. In general the MCAC goals and objectives are:

1. Advise Department Regarding Policy Issues

2. Act as Liaison Between Department of Health and Social Services and Community

3. Plan for Future Medical Assistance Programs

4. Evaluate the present Medical Assistance Programs

5. Work with the Legislature

6. Redefine regulations on skilled level of care in nursing homes

Present MCAC members are:

Member & Address

Chairman
Mr. David L. Swanson
P.O. Box 1
Fairbanks, Alaska 99701

Norma Lundy
6520 "H" Street
Elmendorf AFB, Alaska 99503

Denise Knapp
P.O. Box 3-726
Anchorage, Alaska 99501

Sister Barbara Haase
Administrator
Ketchikan General Hospital
3100 Tongass Avenue
Ketchikan, Alaska 99901

Dr. Edwin Rabeau,
Division of Public Health
Pouch H-06B
Juneau, Alaska 99811

Gail McGuill
SRA 529
Anchorage, Alaska 99507

William Doolittle, M.D.
1919 Lathrop Street
Fairbanks, Alaska 99701

Eileen Self
Coalition for Economic Justice
204 E. 5th, Suite 201
Anchorage, Alaska 99501

Gail McKenzie
1703 Stratford Court
Anchorage, Alaska 99504

Mike Huelsman
Municipality of Anchorage
Drug Abuse
825 "L" Street
Anchorage, Alaska 99507

James Jordan
4907 Wesleyan Dr.
Anchorage, Alaska 99504

THE PROVIDERS OF CARE

HEALTH CARE PROVIDER REQUIREMENTS

Every health care provider under the program has signed a participation agreement stipulating that he will keep necessary records, furnish information requested on claims, abide by applicable Alaska Statutes and Federal law and regulations, and practice medicine on a nondiscriminatory basis. Providers wishing to enroll should contact the Medical Claims Processing Section of the Central Office, DPA in Juneau.

Providers Enrolled in the Medicaid Program

Provider Type	Number
Hospital	24
Nursing Homes	12
Physicians	473
Home Health Agencies	1
Pharmacies	65
Laboratory	1
X-Ray	1
Rural Health Clinics	3
Community Mental Health Centers	16
Dentists	152
Psychiatric Facilities	1

Federally required utilization review, adjudication processes, and levels of reimbursement are used as required. Reimbursement levels for Medicaid are generally the same as for Medicare. These levels may not exceed the Medicare upper limits and may be lower.

Utilization review, physician profiles, and fee schedules assure that appropriate and necessary health care is rendered to needy persons at a reasonable cost to the State. It allows the State to eliminate waste by curbing over-utilization to insure that health care funds are used to the best advantage.

The only dental care provided under Medicaid is through the EPSDT program for children up to age 21. The Division of Public Assistance has contracted with Delta Dental Plan of Alaska to administer the EPSDT dental program. Emergency dental treatment for Medicaid eligible individuals over 21 and for individuals eligible for General Relief Medical is covered under the General Relief Medical (GRM) program.

CURRENT REIMBURSEMENT PRACTICES

Category of Service	Unit Purchased	Reimbursement Methodology
Hospital	Inpatient Service per diem rate	Payment is based on the lesser of (a) reasonable cost the same as for Medicare, (b) customary charges to the general public, or (c) fair compensation in accordance with Medicare regulations in the case of a public hospital rendering services free or at nominal charges
	Emergency/referred	Emergency hospital services. Provided when necessary to prevent death or serious impairment to health
Clinic Service		Usual, customary, and reasonable charges; clinics have no fee profile, each physician paid on his own profile - lower of actual, customary or prevailing rate
Outpatient Surgical Centers	Medical Procedure	Outpatient surgical care center services are reimbursed according to a pe diem fee per patient, pay in full as billed, based on reasonable charges not to exceed charges to the general public
Physician	Individual medical procedure	Lower of physician's actual, customary or prevailing charge
Drugs in Long Term Care Facilities	Prescribed drugs	Dispensed in medical facilities and ICF's - cost as determined during the annual cost settlement for each facility. Dispensed in other pharmacies - the lowest of (a) maximum allowable cost plus dispensing fee, (b) estimated acquisition cost plus dispensing fee, or (c) provider's usual and customary charge (these limitations do not apply when a physician certifi a specific brand as medically necessary)

CURRENT REIMBURSEMENT PRACTICES

Category of Service	Unit Purchased	Reimbursement Methodology
Medical Transportation	One way or round trip	Provided when determined by the agency to be necessary for securing medical examinations and/or treatment in the individual case and when volunteer resources are not available. Transportation expenses in excess of $50 require pre-authorization. Covered urban transportation includes public conveyances such as buses and taxi-cabs. In rural areas where these are not available, chartered aircraft and mileage payments to private individuals are utilized. In both urban and rural areas, ambulance services and commercial carriers provide transportation for Medicaid recipients. Ambulance services must be Alaska-licensed and enrolled in Medicaid. Commercial carriers (buses, airlines, taxi-cabs and marine carriers) must meet applicable laws and license requirements. Private carriers (airplanes, boats, or automobiles) must be properly registered and operated by appropriately licensed operators.
Home Health Agencies	Individual visit	Reasonable cost. Paid in full with cost settlement at the end of each year

CURRENT REIMBURSEMENT PRACTICES

Category of Service	Unit Purchased	Reimbursement Methodology
Nursing Homes	Day of care	Skilled nursing facility services: Payment is made for skilled nursing and intermediate care facility services on a reasonable cost-related basis. Each facility reports at prescribed intervals its state-designated allowable costs of state-designated uniform cost-reporting forms subject to state audit. Reasonable cost is determined according to Medicare methods. Rates - Reasonable cost-related payment rates are calculated by the state to enlist a sufficient number of providers and are high enough to cover the allowable costs of an efficiently and economically operated facility. The state establishes the rates retrospectively, subject to final adjustment, on a facility-by-facility basis. Final settlement includes consideration of economic trends. Upper limits on payment - Payment cannot exceed Medicare payment for the same type of care. No reserved beds - currently a new rate is being set by the Audit Unit; we are moving toward a composite rate for ICF and SNF.

CURRENT REIMBURSEMENT PRACTICES

Category of Service	Unit Purchased	Reimbursement Methodology
Optical Services and Goods	Examination and Optical Goods	Lower of optometrist charge or statewide maximum established by usual, customary, and reasonable charges up to maximum fees allowed by the Department's Fee Schedule.
Dentists	Individual dental	The actual charge; the median charge by the dentist for the particular services established by the dentist's charges for that service during the calendar year preceding the fiscal year covered by this contract the 75th percentile of the range of charges by all dentist in Alaska for a particular service during the calendar year preceding the fiscal year covered by this contract.
Laboratories	Individual laboratory procedure	Lower of actual, customary or prevailing
Family Planning	Initial visit Annual visit Routine visit Problem visit Supply visit Dispensed drugs	Reimbursed according to physician's profile or lower of actual, customary or prevailing charge. Paid in full as billed.

CURRENT REIMBURSEMENT PRACTICES

Category of Service	Unit Purchased	Reimbursement Methodology
Durable Medical Equipment and Prosthesis	Individual item (e.g. braces, hearing aides, orthopedic mattresses, batteries for electric wheelchairs, oxygen, custom-made shoes)	Most reasonable cost for item which will adequately meet the client's needs. Most reasonable cost is based on the lowest of two or three estimates given prior to purchase. Prior approval required.
All other non-classified	Services of registered nurses, LPNs, audiologists	Prevailing community rate. Audiologists are paid on a fee profile.
	Services of Psychologists in Community Mental Health Centers (CMHC)	According to test performed and time spent. CMHC are paid in full as billed according to a fee schedule established annually during the Grant process and reviewed by the Division of Mental Health and Developmental Disabilities.
	Services of speech, occupational and physical therapists	Usual, customary, and reasonable charge not exceeding the Department's fee schedule.
	Outpatient hospital services	Reasonable cost, the same as for Medicare.
	Other laboratory and X-ray services	Payment rate based on Medicare profiles.

Third Party Liability (TPL)

As detailed in the June 1979 report, "A Report on Third Party Liability, Identification and Recovery, State of Alaska", Alaska can reduce medical assistance expenditures significantly through a combination of two approaches, cost avoidance and TPL recovery.

The first approach requires that the Division of Public Assistance identify all TPL resources, such as private insurance, Medicare, V.A. insurance, etc. existing at the time of application. This TPL information is then conveyed by means of a medical assistance coupon to a provider, such as a hospital or doctor, so that the provider will not bill medical assistance until all third party resources are obtained. This "cost avoidance" approach provides the major share of medical assistance savings and is constantly being improved.

The second area for reducing medical assistance expenditures is recovery from insurors, who may be liable for the recipient's injuries such as workmen's compensation insurance when job related injuries occur. Although this area has been neglected in the past, the Division of Public Assistance is now effectively pursuing recovery through a system which concentrates on a review of medical assistance invoices in which the diagnosis code on the invoice indicates injury or trauma. The review process identifies any liable resource and the Division then pursues recovery of medical costs associated with the injury. Because these cases usually require complex legal action, they often are not concluded for two or more years. The Division has been able to recover $88,000.00 and identify more than $200,000.00 in future probable recovery.

Other important actions in the TPL area taken by the Division of Public Assistance were:

1. Established a communication channel between medical assistance and the Child Support Enforcement Agency to eventually enable pursuit of third party resources from absent parents when TPL exists.

2. Improved communications with the medical services and legal community relative to informing them that the State of Alaska is actively pursuing recovery of TPL resources when medical assistance has paid medical expenses.

Medicaid Expenditures

The Tables and Figures in Appendix I and II of this report outline the expenditures for medical services provided to eligible recipients. Because of the number of agencies processing medicaid claims it is not possible to determine an unduplicated recipient count.

Table I shows monthly unduplicated recipient count for all services except Long Term Care Facilities (ICF, SNF, ICF/MR) and API. The number of recipients in Long Term Care Facilities remains fairly constant from year to year with a combined census of approximately 700 recipients per month receiving services in ICF, SNF, ICF/MR, and Harborview.

Figure I shows that the Categorical Program which accounts for the largest number of Medicaid eligible individuals is the AFDC Program which makes up about 75% of the eligible population. AD, and OAA each represent about 12%. For purposes of this discussion an eligible individual who receives medical services will be called a beneficiary. The AFDC Program recipients comprise around 63% of the Medicaid Beneficiaries, Figure II. OAA and AD comprise about 17% and 20% respectively. However, when one looks at the expenditures by Categorical Programs, Figure III, one sees that AFDC expenditures add up to only 31% of the total expenditures. AD beneficiaries constitute 46% and OAA 23% of total Medicaid expenditures.

A logical question which needs to be asked here is "what causes the relationship between eligibles, beneficiaries and expenditures to appear the way it does?"

First it is necessary to point out that 75% of each Medicaid dollar goes to care rendered in an institution, Figure IV. Figure V shows that LTC facilities receive 66% of Medicaid institutional expenditures. API and acute-care hospital represent 7% and 28% respectively of expenditures for institutional care. Second, it is more likely that recipients of AD and OAA find themselves in need of institutionalized care.

Beneficiaries in Harborview and other ICF/MRs are considered disabled. Beneficiaries in ICF and SNF facilities are a mixture of AD and OAA recipients as shown in Figures VII, VIII, and XIX.

Table II and III represent Medicaid expenditure by month for FY 81 and FY 80. These tables are divided into 5 categories of service. Each category represents claims which are handled and/or processed differently than those of the other categories. Except for CSC Title XIX, the medical services provided within each category are self-explanatory. Since January 1, 1980 Computer Science Corporation has been responsible for processing the majority of all Medicaid Claims, some twelve thousand claims per month. (Table IX and Figure XI)

Total Medicaid Expenditures for FY 81 and FY 80 were $39,218,437 and 33,797,898 respectively. This represents a 16% increase from FY 80 to FY 81. Figure VI shows the percentage distribution of medicaid expenditures by category of care. As one can see ICF, Hospitals and Physicians, represent the three largest categories of care. The percentage of expenditures by category in decreasing order are: ICF, Hospitals, Physicians, Harborview Developmental Center, SNF, API, ICF/MR, Outpatient hospital, Dental, and Clinics. Table IV A and B and Table V A and B detail expenditures by service categories and categorical groups for claims processed by CSC. Note: CSC processed only claims received after December of 1979, thus the low volume during July to December 1979 reflects the lack of manually paid claims for that time frame.

Table VIII is a breakdown of the number of individuals eligible and individuals screened in the EPSDT Program. In FY 80 and FY 81, 50% and 52% respectively of the eligible children received screening. Dental problems were noted as the most significant single problem present.

Table XI and Figure X detail expenditures for dental claims for FY 80 and FY81. In FY80 and 81, the Medicaid Program paid over 750 thousand and 820 thousand dollars respectively for dental services for EPSDT children. The average cost per claim was around $160 and $152 respectively. The decrease in the average cost per claim is due mainly to the increase in the number of claims.

Major Developments during FY 80 and FY 81

The Medicaid Program has experienced several major developments within the past two fiscal years. Chief among these was the contracting with Computer Sciences Corporation as fiscal agent to process Physician, Hospital, and Pharmacy invoices. This represents about 13,000 invoices per month (See Table IX). CSC's efforts have significantly reduced the turnaround time for processing of clean claims from 100 days to 30 days. Add 7 to 14 days to this figure for issuing and mailing checks to providers and one has the turnaround time for medical claims (Figure XII).

Also in 1980, the Division conducted two reconciliation projects for services rendered prior to FY80 and the other for services rendered during FY80. The reconciliation projects were to:

- Pay providers for services that had gone un-paid due to claims processing failure.
- Determine whether the provider was enrolled as an eligible provider at the time services were rendered.
- Determine whether or not invoices submitted had been previously paid.
- Determine whether recipients identified on claims submitted were eligible for Medicaid or GRM at the time services were rendered.
- Determine whether services provided were covered under the Medicaid or GRM programs at the time the services were rendered.

For prior FY80 claims one hundred twenty-five providers submitted claims under the project. A total of 4,110 claims were submitted by participating providers. A total of 1,582 claims were recommended for payment. The amount of these claims was $285,135, of which $154,621 was identified as Medicaid program eligible claims and $130,514 as GRM program eligible claims. For the FY80 reconciliation project $282,131 and 1,124,619 was paid to physician and hospitals respectively.

1981 also saw the production and distribution of the Medicaid Eligibility Manual. This manual was designed to aid eligibility workers in making accurate and timely Medicaid eligibility determinations. Copies of the Manual are available from the Division of Public Assistance Central Office in Juneau.

With respect to medical services, during the final days of the 1981 legislative session, the Alaska Legislature passed into law a provision which adds Nurse Midwife Services to the list of Medicaid Services. A Nurse Midwife must be a registered professional nurse certified by the State and enrolled as a provider in the Division's Medical Assistance Programs.

Future Plans

Administration of the Medicaid Program will undergo significant change in the next year. With the addition of CSC in January of 1980 as fiscal agent, the time required to process and pay provider claims has decreased as can be seen in Table IX. However, CSC is responsible for processing claims for less than 50% of Medicaid expenditures. This fact means that a considerable amount of administrative effort is needed to identify, accumulate and verify total Medicaid expenditures. The result is unnecesary delays, duplication of effort and questionable statistics for management reports and utilization reviews. The Department has recently released two Request for Proposals (RFPs) which should significantly effect this Division's ability to produce timely and accurate decisions and statistics with respect to recipients, providers, utilization review, fiscal compliance, and management reports.

The first RFP is the Eligibility Information System (EIS) which calls for the development of a fully integrated, federally certified computer system for administration of Alaska's 10 Public Assistance Programs. The intent of EIS is to first implement a computer system for the AFDC and Food Stamp Programs that will automate a maximum number of functions now being performed manually, in such a way as to:

- reduce error rates in all programs;
- increase speed of service, from eligibility determination to receipt of benefits;
- provide consistent decisions on applications;
- enable management to test proposals, policy change recommendations and mass updates for cost, impact and feasibility;
- provide management information as necessary through an integrated data base structure;
- reduce future administrative cost increases for program operations through increased efficiencies in use of staff time.

The second RFP is for the development of an Alaska Medical Payment System (AMPS) which combines all the Medicaid claims processing components which are presently spread among four divisions and two contractors. The successful contractor will be responsible for all components within the Medicaid/GRM Programs dealing with:

Provider enrollment	Programming and systems support
Prior authorization	Computer operations
Claims screening	Provider payments
Exception claims processing/ inquiry	Surveillance and utilization
Professional claims review	Provider and recipient relations
Master file maintenance	Provider manuals and bulletins and claims form
Data entry/microfilm	Overpayment recovery
	Finance and accounting

The State would retain responsibility for:

- Eligibility determination
- Fiscal audit of providers
- Third-party liability collections
- Appeals
- Performance and fiscal audit of contractor
- General management and establishment of policies and procedures
- Rate setting
- Fiscal Agent relations
- Fraud and abuse investigation
- Provider compliance

Contracts for these RFPs should be awarded by late November of 1981 with operational systems in place by late 1982.

Also in late 1981, the Division plans to open a Medical Provider Relations Office in Anchorage to aid providers and recipients in solving medical claims problems. This office will include full-time support staff for the Medical Care Advisory Committee.

TABLE I *
MEDICAID BENEFICIARIES
FOR FY 78, FY 79, FY 80 & FY 81

Mth	7	8	9	10**	11	12	1	2	3	4	5	6
AGED												
FY 78	417	411	313	472	359	369	[illegible]	461	592	446	509	391
FY 79	419	344	258	376	361	544	400	765	458	556	405	544
FY 80	353	401	426	448	436	389	474	508	555	576	525	512
FY 81	548	575	449	555	673	588	692	483	683	680	452	700
BLIND												
FY 78	14	7	7	11	10	9	8	17	19	13	11	14
FY 79	15	11	8	10	14	11	11	20	13	11	11	20
FY 80	10	9	10	7	9	8	9	12	13	15	17	14
FY 81	11	11	19	20	15	19	18	15	20	13	5	23
DISABLED												
FY 78	531	489	481	567	506	479	394	621	861	697	583	556
FY 79	597	452	330	482	533	636	582	920	621	654	578	685
FY 80	474	556	582	617	622	549	701	676	722	743	725	656
FY 81	752	677	647	806	924	845	917	585	928	899	660	959
AFDC CHILDREN ***												
FY 78	1362	1044	929	1071	796	1163	948	1604	2238	1405	1366	1365
FY 79	1375	1257	1093	1226	1108	1944	1140	3084	1361	1178	1078	1039
FY 80	1260	1429	1418	1757	1554	1388	1686	1792	1845	1951	1856	1634
FY 81	1680	1719	1758	2054	2323	2222	2387	1363	2147	2646	1665	2655
AFDC ADULTS ***												
FY 78	665	450	519	589	422	356	315	761	1031	712	675	582
FY 79	496	512	654	692	651	952	728	1283	860	752	774	909
FY 80	665	753	742	926	820	732	889	944	973	1028	978	861
FY 81	904	925	947	1106	1250	1196	1285	734	1924	1424	897	1430
TOTAL												
FY 78	2989	2401	2249	2710	2093	2373	2025	3464	4741	3273	3144	2908
FY 79	2902	2576	2343	2789	2667	4087	2862	[illegible]	3126	3151	2950	3222
FY 80	2783	3196	3217	3788	3486	3091	3776	3949	4137	4332	4120	3694
FY 81	3905	3851	3826	4557	5193	4880	5310	3183	5331	5675	3595	5783

* This table represents an unduplicated recipient count within each month. It is likely that a recipient can be counted in several months . Does not include LTC,API,HDC or Dental.

** As of 10/80 computer program was changed to read processing date as apposed to service date . Computer run date 6/20/81

*** Children are defined as 65% of total AFDC population based on historical HCFA 120 DATA

TABLE II FY 81
MEDICAID EXPENDITURES

	FY	CSC TITLE XIX	LONG TERM CARE (LTC) ICF	SNF	ICF/MR	EPSDT DENTAL	HDC	API	FY 81 TOTAL
JULY	81	1,212,363	873,213	212,455	133,794	54,008	403,984	204,439	3,094,256
AUG.	81	1,014,451	889,795	153,326	137,957	47,315	419,446	196,842	2,859,132
SEPT.	81	970,889	877,785	177,200	135,060	53,860	415,471	161,350	2,791,615
OCT.	81	1,149,183	1,031,825	183,894	143,911	60,022	431,196	155,224	3,155,255
NOV.	81	1,471,661	980,030	174,439	134,602	70,176	420,988	174,974	3,426,870
DEC.	81	1,124,730	1,017,686	197,251	141,662	88,169	425,371	161,483	3,156,352
JAN.	81	1,735,809	1,022,379	190,956	136,000	52,556	431,127	146,475	3,715,302
FEB.	81	850,291	940,144	201,971	121,715	65,560	375,072	158,500	2,713,253
MARCH	81	1,589,737	1,064,663	326,640	135,976	94,351	409,892	169,825	3,791,084
APRIL	81	1,519,230	833,026	323,640	131,092	100,204	301,131	171,745	3,380,068
MAY	81	1,298,779	895,713	358,293	134,059	* 76,350	407,812	171,550	3,121,722
JUNE	81	1,750,178	824,516	359,980	122,888	67,163	403,771*	170,218*	3,681,449
		15,687,301	11,444,755	2,660,045	1,608,716	829,734	4,845,261	2,042,625	39,218,437

* estimated from first 11 months of FY 81
REPORT PREPARED 8/1/81

TABLE III FY 80
MEDICAID EXPENDITURES

		CSC	LONG TERM CARE						
	FY	TITLE.XIX	ICF	SNF	ICF/MR	EPSDT DENTAL	HDC	API	FY 80 TOTAL
JULY	80	448,081*	811,405	151,688	132,467	27,793	420,709	57,902	2,050,045
AUG.	80	533,059*	811,405	151,688	122,517	43,613	436,472	52,468	2,151,222
SEPT.	80	607,285*	811,405	151,688	132,615	39,414	431,603	65,708	2,239,718
OCT	80	871,360*	855,846	162,916	128,488	66,654	440,112	115,796	2,641,172
NOV.	80	792,537*	856,636	162,915	131,141	79,080	413,546	136,221	2,572,076
DEC	80	698,952*	955,275	164,961	141,602	73,588	399,435	158,589	2,592,402
JAN	80	961,854	840,605	222,781	120,125	39,364	407,913	171,820	2,764,462
FEB.	80	1,000,670	804,614	193,777	110,875	69,738	403,572	57,748	2,640,994
MARCH	80	1,014,817	827,681	210,032	119,375	99,740	428,926	74,184	2,774,755
APRIL	80	1,066,334	702,867	193,821	112,000	73,339	415,944	98,976	2,663,281
MAY	80	1,032,846	909,181	193,821	111,500	88,698	428,291	165,694	2,930,031
JUNE	80	1,081,830	1,016,129	193,821	107,500	65,131	388,017	176,962	3,029,390
		10,109,625	10,203,049	2,153,909	1,470,205	766,152	5,014,540	1,332,068	31,049,548
		2,207,072	**						33,256,620

* CSC WAS NOT RECORDING ALL CLAIMS FOR THESES MONTHS,MANUAL PAID CLAIMS ARE NOT INCLUDED .
** Manual payed claims estimate .
*** Estimate

TABLE IV PART A
SUMMARY OF CSC'S
FY 80 & FY 81 HCFA 120
MEDICAID PAYMENTS BY TYPE OF SERVICE *

	FY	JULY	AUG.	SEPT.	OCT.	NOV.	DEC	TOTAL
XIX TOTAL	80	448,081.	533,059.	60[illegible],285.	871,360.	792,537.	698,952.	2,900,188.0
	81	1,212,363	1,014,451	970,889	1,149,183	1,471,661	1,124,730.	6,943,277.0
INPT. HOSP	80	55,533.	88,930.	191,691.	333,961.	316,207.	283,120.	1,269,442.0
	81	574,725	468,042	465,369	413,019	725,073	462,350	1,989,957.0
PHYSICIAN	80	239,085.	242,716.	247,454.	296,221.	241,280.	220,000.	1,486,756.0
	81	354,089	286,855	267,210	429,731	398,001	429,169	2,165,055.0
OUTPT. HOSP.	80	4,831.	8,131.	20,160.	55,057.	72,787.	58,086.	219,052.0
	81	102,996	87,081	80,799	123,534	153,350	83,549	631,309.0
CLINIC SERVICE	*80	20,163.	18,634.	13,108.	23,073.	24,236.	19,263.	118,477.0
	81	20,182	23,964	16,767	34,719	69,970	28,949	194,551.0
HOME HEALTH	80	560.	380.	915.	1,105.	1,620.	1,213.	5,793.0
	81	270	120	2007	276	2,007	1,516	6,196.0
FAMILY PLANNING	80	3,474.	3,770.	4,614.	3,103.	2,448.	2,806.	20,215.0
	81	1,112	2,507	1,010	3,975	4,001	3,082	15,687.0
LAB & X-RAY	80	1,371.	4,184.	3,409.	6,979.	7,706.	5,384.	29,033.0
	81	6,117	4,721	4,804	6,496	7,582	7,553	37,273.0
EPSDT	80	12,178.	11,948.	13,192.	11,712.	18,070.	12,739.	79,839.0
	81	13,515	14,896	17,112	15,789	22,731	29,718	113,761.0
RURAL HEALTH	80	572.	411.	216.	416.	203.	245.	2,063.0
	81	35	54	0	118	0	305	512.0
OTHER SERVICES	80	110,314.	153,955.	112,526.00	139,733.	107,980.	90,096.	720,604.0
	81	138,322	126,211	115,811	121,526	88,937	77,455	668,262.0

* COMPUTER RUN 6/20/81 . CSC STARTED RECORDING DATA ON 1/80 t[illegible] a prior to 1/80 is incomplete. Also affective 10/80 data is recorded by processing date . DATA prior to then was recorded by service date . CSC data does not include ICF, SNF, ICF/MR , API , PHS , or DELTA DENTAL .

TABLE IV PART B
SUMMARY OF CSC'S
FY80 & FY81 HCFA 120
MEDICAL PAYMENTS BY TYPE OF SERVICE *

	FY	JAN.	FEB.	MR.	AP	MAY	JUN.	TOTAL
XIX TOTAL	80	961,854.	1,000,670.	1,014,817.	1,066,334.	1,032,846.	1,081,830	6,158,351
	81	1,735,809	850,291	1,589,737	1,519,230	1,298,779	1,750,178	8,744,024
INPT. HOSP.	80	447,828.	455,153.	373,099.	449,750.	441,812.	544,738.	2,712,380
	81	760,110	264,203	642,372	567,414	582,664	767,552	3,584,315
PHYSICIAN	80	276,906	290,920.	295,089.	336,271.	316,358.	340,356.	1,855,900
	81	486,440	240,204	529,375	534,667	336,274	546,694	2,673,654
OUTPT. HOSP.	80	73,420.	92,252.	101,070.	99,766.	99,444.	79,999.	545,951
	81	141,754	58,334	136,420	120,743	100,549	163,727	721,527
CLINIC SERVIC.	80	25,303.	24,478.	25,925.	30,530.	28,073.	31,752.	166,061
	81	32,539	8,994	48,919	22,216	25,335	22,807	160,810
HOME HEALTH	80	935.	595.	925.	330.	1,764.	720.	5,269
	81	1,731	625	818	1028	2,425	1,216	7,843
FAMILY PLANNING	80	1,497.	5,991.	4,721.	2,309.	3,584.	1,186.	19,288
	81	1,846	1,089	4,292	5,061	1,602	2,078	15,968
LAB & X-RAY	80	10,196.	9,722.	13,025.	10,689.	9,883.	8,759.	62,274
	81	11,529	11,864	24,129	23,457	14,143	16,681	101,803
EPSDT	80	19,009.	14,003.	19,561.	27,619.	16,340.	12,639.	109,171
	81	24,869	19,378	21,609	24,998	13,904	22,713	127,471
RURAL HEALTH	80	463.	499.	453.	388.	1,024.	466.	3,293
	81	0	0	69	36	10	0	115
OTHER SERVICE	80	106,297.	107,057.	180,949.	108,682.	114,564.	61,215.	678,764
	81	271,340	244,917	177,753	214,083	221,256	204,252	1,333,601

COMPUTER RUN | 6/20/81

TABLE V PART A * SUMMARY OF CSC'S HCFA 120
FY 80 &FY 81 MEDICAL PAYMENTS & BENEFICIARIES

CATEGORICAL PROGRAM	FY	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	TOTAL
XIX PAYMENTS	80	464,707.	554,033.	643,283.	907,111.	827,579.	728,083.	4,124,796.0
	81	1,212,363	1,014,451	970,889	1,149,183	1,471,661	1,124,730	6,943,277.0
AGED	80	70,859.	56,187.	67,912.	101,010.	84,094.	76,603.	456,665.0
	81	155,025	128,358	106,132	114,060	158,668	101,448	763,691.0
AB	80	634.	420.	5,413.	5,210.	7,958.	553.	20,238.0
	81	3,234	12,165	7,485	4,343	4,589	27,146	58,962.0
AD	80	96,083.	177,946.	190,566.	283,540.	250,693.	204,372.	1,203,200.0
	81	358,847	303,661	346,484	330,734	489,204	352,020	2,180,950.0
AFDC CHILDREN	80	107,317.	123,106.	141,817.	180,399.	191,156.	161,738.	905,533.0
	81	283,560	226,484	220,995	278,508	303,317	228,420	1,541,284.0
AFDC ADULTS	80	187,469.	191,585.	230,401.	333,924.	276,090.	262,184.	1,481,653.0
	81	409,006	343,150	288,511	420,005	510,920	413,900	2,385,492.0
OTHER	80	2,295.	4,789.	7,174.	3,028.	1,,588.	22,633.	57,507.0
	81	2,691	633	1,282	1,533	4,963	1,796	12,898.0
TOTAL XIX Beneficiaries		2,783.	3,196.	3,217.	3,788.	3,486.	3,091.	
	81	3,905	3,851	3,823	4,557	5,193	4,880	
AGED	80	353.	401.	426.	448.	436.	389.	
	81	548	514	449	555	673	588	
AB	80	10.	9.	10.	7.	9.	8.	
	81	11	11	19	20	15	19	
AD	80	474.	556.	582.	617.	622.	549.	
	81	752	677	647	806	924	845	
AFDC CHILDREN	**80	913.	1,113.	1,092.	1,422.	1,217.	1,080.	
	81	1,252	1,366	1,352	1,563	1,792	1,720	
AFDC ADULTS	80	1,012.	1,069.	1,073.	1,261.	1,157	1,040.	
	81	1,333	1,279	1,354	1,598	1,782	1,699	
OTHER	80	21.	48.	34.	33.	45.	25.	
	81	7	5	2	15	7	9	

* see comments for Table IV A
** CSC'S Program uses case number not age,AFDC Adults includes about 20% children .

TABLE V PART B FY 80 & FY 81 CSC'S HCFA 120
MEDICAL PAYMENTS & RECIPIENTS *

	FY	JAN.	FEB.	MR.	AP.	MAY	JUNE	TOTAL 80
TITLE XIX	80	995,580.	1,037,584.	1,057,983.	1,114,437.	1,065,361.	1,110,190.	6,381,135
	81	1,735,809	850,291	1,589,737	1,519,230	1,298,779	1,750,178	8,744,024
AGED	80	104,939.	123,886.	131,567.	126,523.	98,151.	91,356.	676,422
	81	196,131	112,841	140,849	134,264	160,850	202,130	947,065
BLIND	80	741.	15,632.	5,349.	6,517.	19,167.	3,457.	50,863
	81	13,006	5,591	9,014	3,895	2,403	5,792	39,701
DISABLED	80	345,224.	307,357.	300,203.	317,715.	329,181.	356,611.	1,956,291
	81	558,684	275,302	482,258	491,395	461,415	570,386	2,839,440
AFDC CHILDREN	80	203,217.	258,330.	272,190.	247,357.	224,779.	279,145.	1,485,018
	81	481,704	217,094	342,192	367,210	307,251	379,544	2,094,995
AFDC ADULTS	80	338,855.	326,848.	337,645.	405,587.	389,671.	374,256.	2,172,862
	81	485,557	239,406	610,280	420,481	364,266	590,375	2,710,365
OTHER	80	2,604.	5,531.	11,029.	10,738.	4,412.	5,365.	39,679
	81	727	57	144	1,985	2,594	1,951	7,458
TITLE XIX	80	3,776.	3,949.	4,1[illegible]7.	4,332.	4,120.	3,694.	24,008
	81	5,310	3,183	5,311	5,675	3,695	5,783	28,957
AGED	80	474.	508.	555.	576.	525.	512.	3,150
	81	692	483	683	680	452	700	3,690
BLIND	80	9.	12.	13.	15.	17.	14.	80
	81	18	15	20	13	5	23	94
AD	80	701.	676.	722.	743.	725.	656.	4,223
	81	917	585	928	899	660	959	4,948
AFDC CHILDREN	80	1,329.	1,447.	1,505.	1,600.	1,431.	1,179.	8,491
	81	1,842	1,059	1,819	2,147	1,312	2,142	10,321
AFDC ADULTS	80	1,246.	1,289.	1,313.	1,379.	1,403.	1,316.	7,946
	81	1,831	1,039	1,859	1,924	1,244	1,944	9,841
OTHER	80	17.	17.	31.	19.	19.	17.	120
	81	10	2	1	12	15	15	55

* see comments on Table V Part A

Table VI

Individuals Screened by the EPSDT Program

	FY 76	FY 77	FY 78	FY 79	FY 80	FY 81
Individuals	4527	5642	5454	5341	5773	6216

Table VII

Number of Individuals Receiving Early and Periodic Screening Services and Payments for such Services

	Age of Children Screened					
	Total		Under age 6 (2)		Age 6-20 (3)	
	FY 80 individuals	FY 81	FY 80	FY 81	FY 80	FY 81
Number of individuals screened	5773	6213	2904	3403	2869	2810
Average monthly eligible for screening..........	11512	11923	--	--	--	--
Number with referrable conditions uncovered or suspected during screening (sum of 3a & 3b)....	3362	5297	1267	2534	1995	2763
Number of individuals screened with:...........						
a. Visual problems......................	672	571	146	132	526	439
b. Hearing problems.....................	412	336	189	135	223	201
c. Dental problems......................	2297	3216	776	1181	1521	2035
d. Other problems.......................	4820	4364	2674	2517	2146	1847
Total payments for screening services..........						

TABLE VIII EPSDT
DENTAL EXPENDITURES

		MEDICAID FY 80				$ MEDICAID FY 81			
		Benifits	Admin.	Claims	$/Claims	Benifits	Admin.	Claims	$/Claims
JULY.	10	4709	565	34	135	20124	1965	130	154
	25	20107	2412	113	152	29219	2700	187	156
AUG.	10	15421	1850	118	131	25853	2488	174	148
	25	23520	2822	182	128	16684	2290	162	102
SEPT	10	17598	2111	130	135	22828	2587	180	126
	25	17594	2111	149	117	25376	3069	206	123
OCT.	10	21136	2536	188	112	23938	2622	176	136
	25	38377	4605	280	133	29734	3728	220	135
NOV.	10	36207	4344	218	166	28437	2980	200	142
	25	34401	4128	242	130	34692	4067	273	127
DEC.	10	20965	2515	135	123	30575	3218	216	141
	25	44740	5368	253	177	49564	4812	323	153
JAN.	10	13469	1616	169	117	19816	1877	126	157
	25	21142	3137	169	117	27511	3352	225	122
FEB.	10	30891	3706	202	133	25099	2786	187	134
	25	31376	3765	200	143	34234	3441	231	148
MAR.	10	44010	3393	214	182	47038	4484	301	156
	25	47388	4949	346	135	38568	4261	333	115
APRIL	10	32844	2771	196	167	46961	4961	333	141
	25	34429	3295	233	147	43589	4693	315	138
MAY	10	43158	4369	309	140	36208	3933	264	137
	25	37990	3181	173	183	32648	3561	239	136
JUNE	10	25175	2276	134	163	30350	3143	211	143
	25	34937	2743	191	185	30378	3292	221	137
		691,584	74,568	4,578		749424	80310	5,433	
	TOTAL = 766,154					TOTAL = 829,734			

$152 per claim for FY81

$167 per claim for FY80

8% increase in expenditures

TABLE IX FY 80 & FY 81

CSC ANALYSIS OF CLAIMS PROCESSING

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

AVERAGE	FY	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MR	AP	MAY	JUNE
# OF CLAIMS	80	5331	6570	7232	10974	10519	9291	11141	11768	12387	12698	12195	10894
	81	11818	10872	10540	13380	15511	13415	17198	7801	17457	18134	10008	18242
DATE OF SERVICE TO DATE OF RECEIPT	80	150	136	125	109	95	100	97	79	71	66	57	54
	81	53	52	51	67	78	80	62	74	62	61	74	66
DATE OF RECEIPT TO DATE OF ADJUDICATION		100	79	71	67	45	28	26	28	31	34	45	31
		30	27	20	30	47	61	21	15	48	20	26	20
DATE OF SERVICE TO DATE OF ADJUDICATION		205	194	173	141	123	124	113	107	101	99	102	85
		82	81	72	97	125	130	83	89	111	81	100	86

FIGURE I

RECIPIENTS BY CATEGORY OF ASSISTANCE

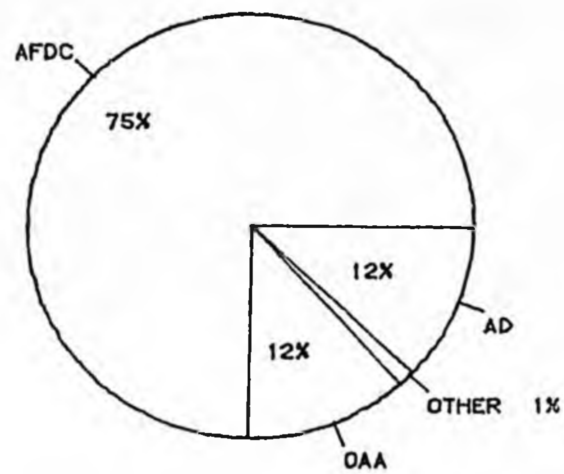


FIGURE II

MEDICAID BENEFICIARIES (AVERAGE MONTH)

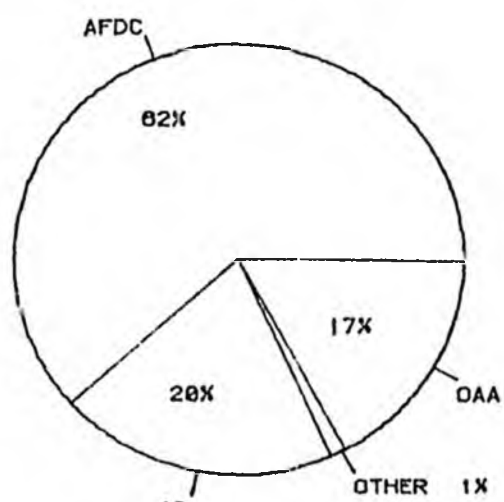


FIGURE III

MEDICAID EXPENDITURE BY CATEGORICAL GROUP

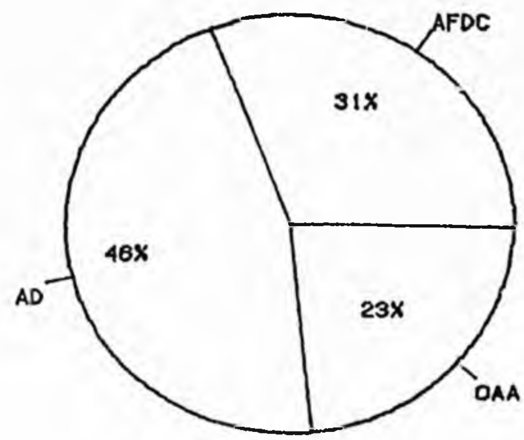
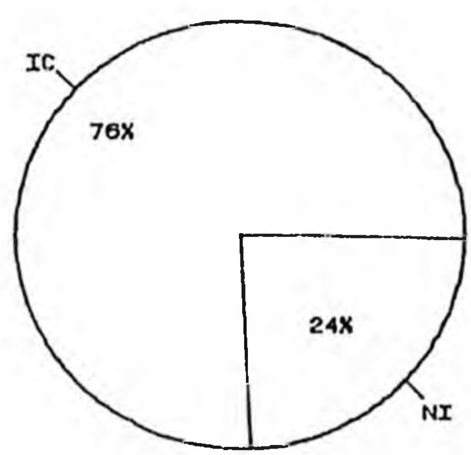


FIGURE IV

MEDICAID EXPENDITURES

INSTITUTIONAL VS NON INSTITUTIONAL CARE



NI-NON INSTITUTIONAL CARE

IC-INSTITUTIONAL CARE

FIGURE V
% MEDICAID EXPENDITURES
TO INSTITUTIONS

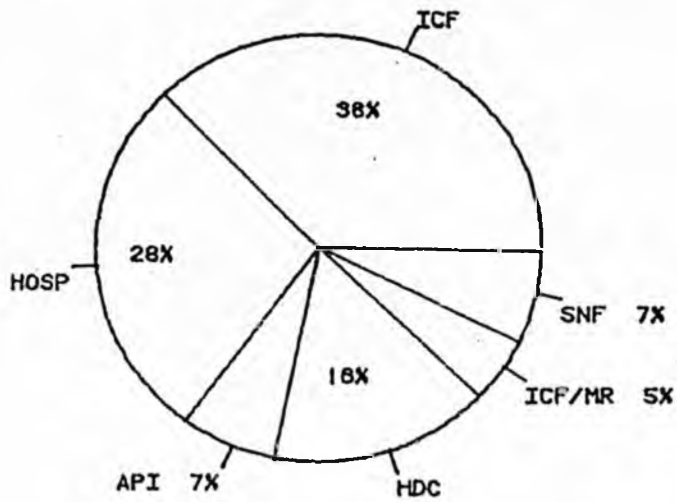
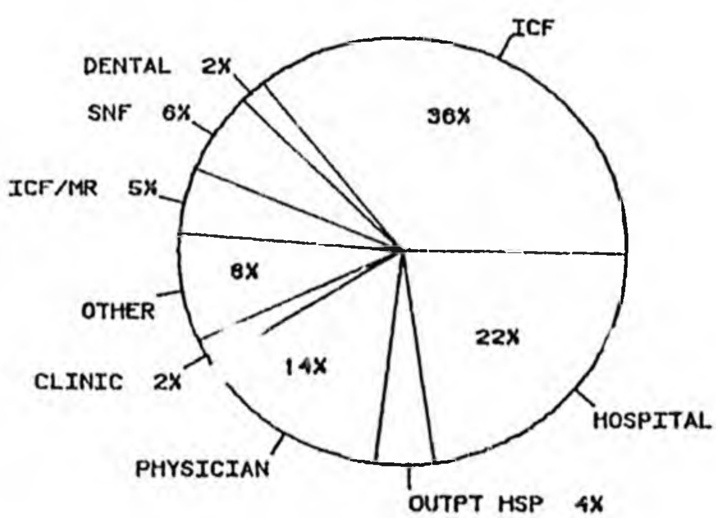


FIGURE VI
MEDICAID EXPENDITURE
BY SERVICE GROUP *



* DOES NOT INCLUDE API OR HDC

FIGURE VII

ICF * SNF PATIENT MIX

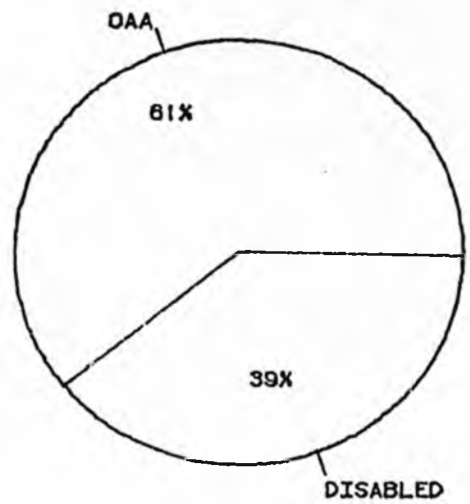


FIGURE VIII

SNF EXPENDITURE BY CATEGORY

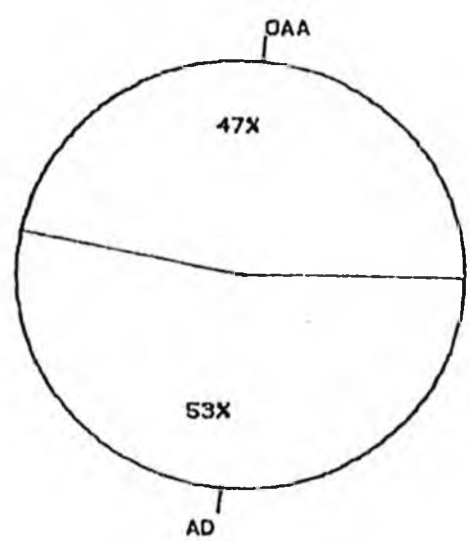


FIGURE IV

ICF EXPENDITURES BY CATEGORY

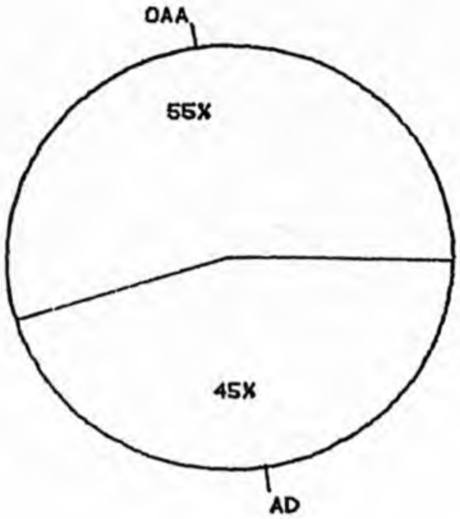


FIGURE X

CLAIMS PER MOMTH & AVERAGE COST PER CLAIM
MEDICAID PAYMENTS TO DELTA DENTAL FOR FY 80 & FY 81

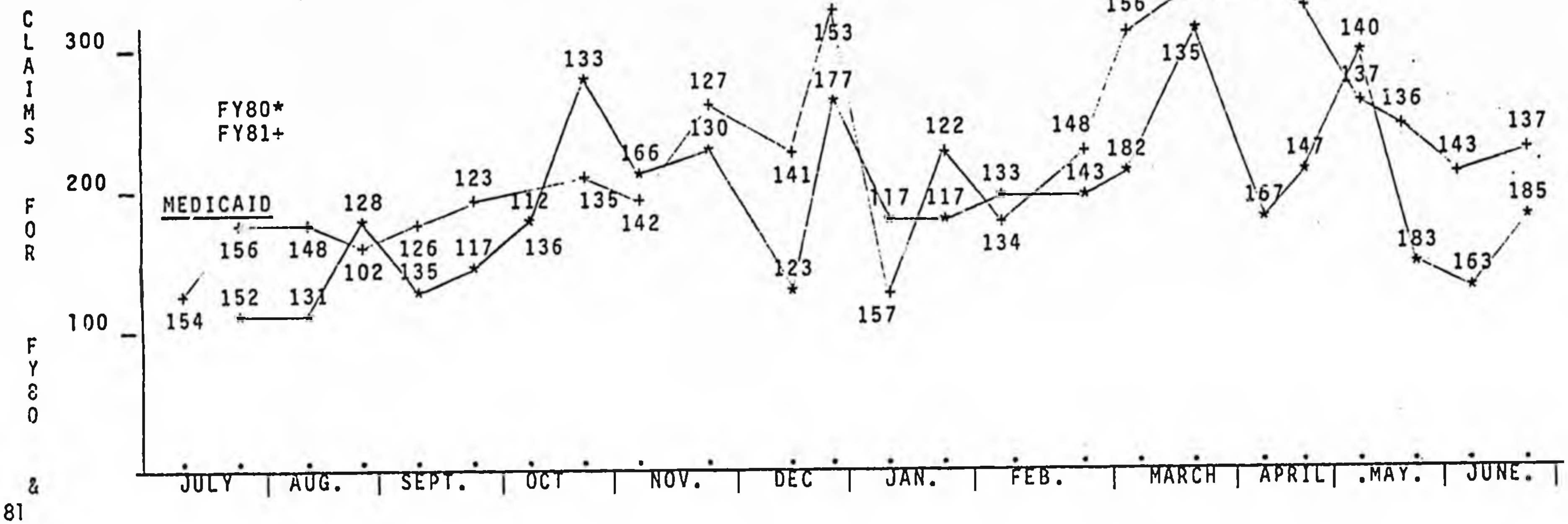
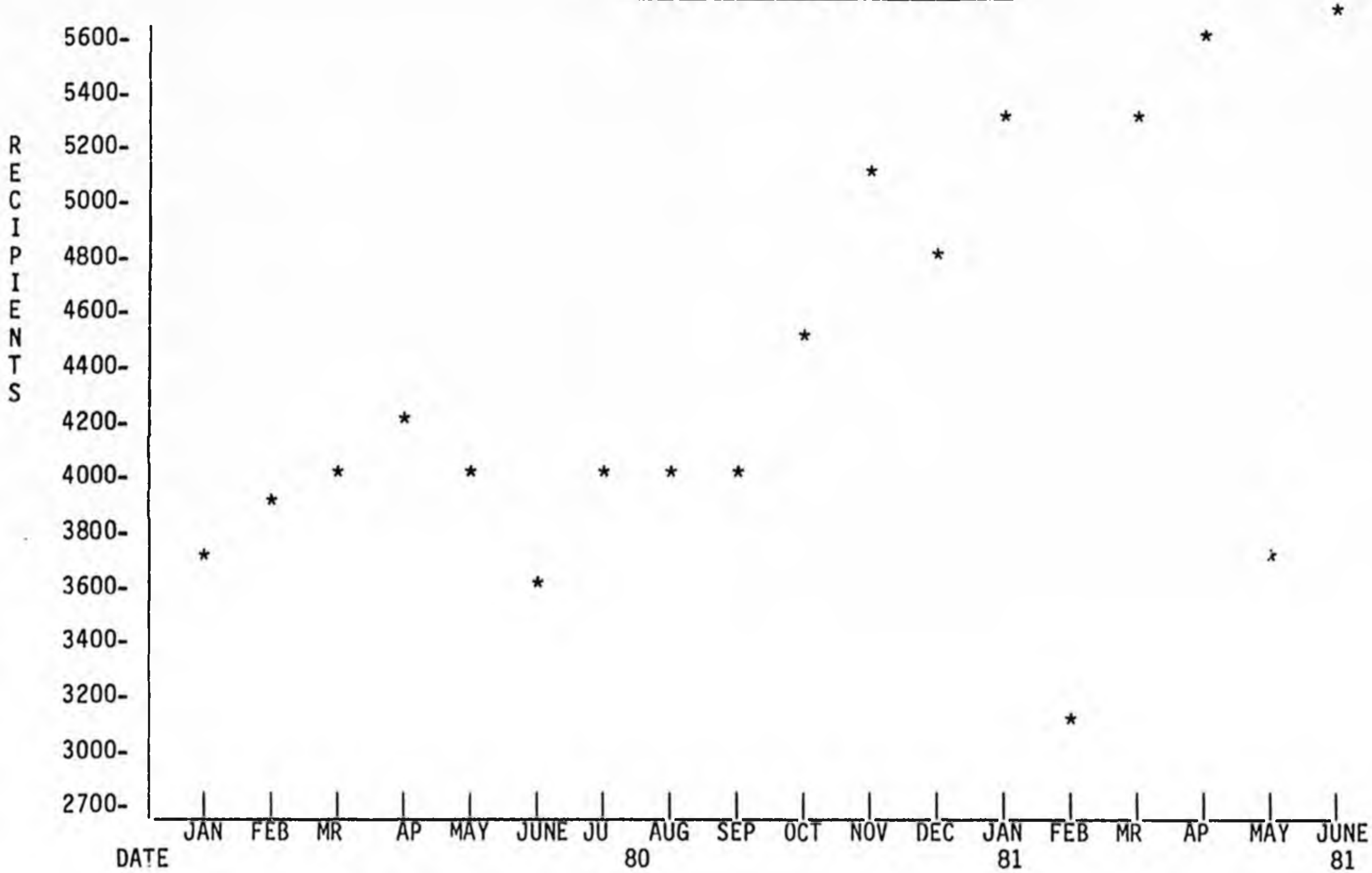


FIGURE XIII

MEDICAID BENEFICIARIES/MONTH



* See comments on FIGURE XI. Computer run 6/20/81