SB
817

COMMITTEE REPORT

SENATE

2/23/32

FURTHER: Finance

Date: 3-29-82

Mr. President:

The Committee on HEALTH, EDUCATION & SOCIAL SERVICES has had SB 817

medical assistance for needy persons

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

[X] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[X] replace with CS for [illegible] [X] 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

[signature]

[signature]

[signature]

MEMBERS HAVING OTHER RECOMMENDATIONS:

[signature]

CHAIRMAN

S 60 (Rev. 12/78)

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 Term 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.

BATTELLE STUDY

Options suggested:

1. Add "medically needy" with patient cost sharing.
2. Add "unemployed parent" families to Medicaid coverage only.
3. Add ineligible children to Medicaid.
4. Change GRM standards to match Medicaid.
5. Add "spend down" provision to GRM
6. Adopt services now covered by GRM in Medicaid:

   Prescription drugs

   Physical therapy

   Occupational therapy

   Prosthetic devices

   Adult dental

7. Patient cost sharing:

   For optional services for the categorically needy

   For GRM program

   Seek waiver for mandated services for categorically needy program

8. Develop prospective reimbursement methodology for hospitals and nursing homes.

(These options would provide coverage for approximately 4,000 of the uncovered population, costs are shown on the charts supplied from the Battelle study, though these are estimates based on figures they agree are sketchy)

STATE SUBSIDIZED EMPLOYMENT-BASED PROGRAM

1. A plan of subsidies for small employers who offer health insurance to their workers. Eligibility will be determined once a year based on a payroll criterion and a subsidy criterion designed to exclude large employers and small firms of high income workers.

Battelle estimates that 3,275 employers will qualify for the subsidy. The two subsidy schedules considered would reach 6,500 and 15,000 at a cost of $2.5 million and $9 million respectively.

A PLAN TO MANDATE RETENTION OF COVERAGE UPON TERMINATION OF EMPLOYMENT

Nearly 50% of the unemployed remain so for only 5 weeks, so mandating an exit lag would provide interim insurance for these people. These contributions would be relatively minor to employers except for small businesses with high turnover and seasonal businesses.

The authority of the Director of Insurance is subject to legal interpretation but is judged by Battelle to be greatest in the case of a medical services corp. (such as Blue Cross) and weakest in self insured trusts(such as Teamsters). The Director has no authority in the cases of medical insurance corp. or policies written out of state.

These options will have no effect on persons employed in temporary or part-time capacities in large firms.

A STATE SPONSORED HEALTH INSURANCE PLAN

This option recommends a system similar to that proposed in HB 41, but with higher subsidy rates, deductibles and copayments. Battelle points out the incentive to switchover from other plans to the state plan, but admits that any effort to avoid this would be an administrative burden.

Battelle recommends a differential in premium rates, though also administratively cumbersome, to discourage switchover. The plan would serve three groups: low-income people who qualify for a subsidy; those who do not qualify for a subsidy, and the high risk group. (the high risk group would not be combined with the others in risk sharing, and the state would subsidize totally the higher cost.)

Battelle recommends annual or semi-annual enrollment and a waiting period on pre-existing conditions

IMPROVING RURAL HEALTH CARE

The Battelle group chose nine communities capable of supporting a regional health center manned with a para-professional(Mountain Village, Hooper Bay, Toksook Bay, Quinhagak,Aniak, Sand Point, Alakanuk, Akolmute and Kake)

#2. A statewide entity for joint planning and resource allocation between Alaska and the IHS.

#3. Maximize Medicaid services to eligible Natives in IHS facilities.

- -encourage IHS ownership of rural facilities so that they are eligible to collect Medicaid dollars, even if the state must support operating costs.
- -expand the definition of Medicaid eligible providers to include IHS facilities.
- -assist rural clinics with the necessary administrative expertise to become eligible providers under the rural health clinic component of Medicaid.

#4. Maximize private reimbursement:

- -assist regional corporations seeking to take over IHS care.
- -promote and expand contracts with regional corporations for direct service delivery.

#5. Encourage regional corporations to expand their prospective to include all people living in their region.

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Senate Bill 817
Title An Act relating to medical assistance for needy persons
Requested by Senate HESS Committee Date 3/19/82

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health
BRU, Program, Or Subprogram(s) Affected General Relief Medical
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		(11603.0)	(13330.9)	(15321.9)	(17610.9)	(20241.9)
TOTAL		(11603.0)	(13330.9)	(15321.9)	(17610.9)	(20241.9)

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		(11603.0)	(13330.9)	(15321.9)	(17610.9)	(20241.9)
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME						
PART TIME						
TEMPORARY						

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

Entire General Relief Medical budget transferred to new budget request unit titled "Medical Assistance" and to the Eligibility Determination budget request unit to provide funding for administrative costs associated with the addition of new eligibles to the Medicaid program.

IV. DATE 3/22/82 PREPARED BY David M. Davidson
AGENCY Division of Public Assistance
PHONE 465-3347

Original· Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

Introduced: 2/23/82
Referred: Health, Education & Social Services and Finance

IN THE SENATE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

SENATE BILL NO. 817

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWELFTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to medical assistance for needy persons; and providing for an effective date."

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

* Section 1. AS 47.07.020(b) is amended by adding new paragraphs to read:

(8) persons under 21 years of age who would be eligible for benefits under the federal aid to families with dependent children program, but who do not qualify because they are not dependent children;

(9) persons who would be eligible for benefits under the federal aid to families with dependent children program if coverage under the program were as broad as coverage allowed under Part A of Title IV of the Social Security Act.

* Sec. 2. AS 47.07.020 is amended by adding new subsections to read:

(e) In addition to the persons specified in (a) of this section, the following classes of medically needy persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) pregnant persons;

(2) persons included in (b)(3), (5), (7), and (8) of this section;

(3) caretaker relatives;

(4) persons 65 years of age or older;

(5) blind persons; and

(6) permanently and totally disabled persons.

(f) In (e) of this section

(1) "blind person" means a person who has no vision or whose vision is so defective as to prevent the performance of ordinary activities for which eyesight is essential;

(2) "caretaker relative" means a person who meets the definition of caretaker relative under 45 C.F.R. 233.90(c)(1)(v)(A);

(3) "medically needy persons" means persons who meet the definition of "medically needy" under 42 C.F.R. 435.4;

(4) "permanently and totally disabled persons" means persons defined in AS 47.25.960(3).

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

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

* Sec. 4. AS 47.07.030 is amended by adding a new subsection to read:

(b) "Clinic services" means services provided by state-approved outpatient community mental health clinics that receive grants under AS 47.30.520 - 47.30.620, state-operated community mental health clinics,

and physician clinics.

* Sec. 5. AS 47.07.080(4) is repealed.

* Sec. 6. This Act takes effect immediately in accordance with AS 01.10.-070(c).

alaska state hospital association

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

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Fairbanks Memorial Hospital
Fairbanks

Chairman-Elect
Ronald A. Pavolles
Alaska Hospital and Medical Center
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Secretary/Treasurer
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Sitka Community Hospital
Sitka

Immediate Past Chairman
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Ketchikan General Hospital
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Providence Hospital
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Alternate Delegate to the American Hospital Assoc.
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Alternate Trustee Delegate to American Hospital Association
Robert Jensen
Central Peninsula Hospital
Soldotna

President
Dennis L. DeWitt
Juneau

March 29, 1982

The Honorable Charles H. Parr
Alaska State Senate
Pouch V, State Capitol Building
Juneau, Alaska 99811

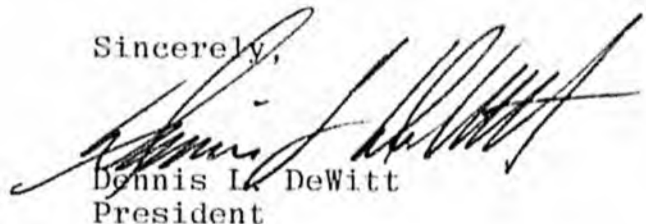
Dear Senator Parr:

The Alaska State Hospital Association wishes to encourage your consideration of the amendments that the Department of Health and Social Services has proposed to Senate Bill 817.

This Association has long advocated an overhaul of the relationship of Medicaid and General/Relief Medical to maximize federal financial participation and increase Alaska's ability to offer health care to its needy residents. The proposal by the Department of Health and Social Services is a bold and forthright step in recognizing the importance of prudent fiscal approach to providing health care. We believe that it is imperative that the legislature make those changes needed to maximize federal financial participation in indigent health care in Alaska before it adjourns the Second Session of the Twelfth Legislature.

We stand ready to lend our assistance to this activity.

Sincerely,



Dennis L. DeWitt
President

DLD:bf
cc: Friday Mailing
Governor Hammond
Lt. Governor Miller
Commissioner Beirne
Members Senate HESS

TO: Charlie

FROM: Nancy

RE: Medicaid changes

The following page lists changes to the present statute for Medicaid eligibles, services and the clinic definition change that has been requested by everyone to include the three IHS clinics who cannot now claim reimbursement because of the limitations in the definition.

Explaination:

(8) adds children who would be eligible for AFDC except for the family make-up (two parent families) This would effect a primarily native group which is 100% federally subsidized. The children who are the healthiest are in this group since those in facilities are already covered by medicaid. It is estimated that this would save the state $385,000 in reduction in GRM.

(9) This adds the unemployed parent category to Medicaid coverage without adding them to categorical assistance. These people are believed to be covered by GRM, so there would not be any further expense to the state. A significant population of natives would be covered, and 100% subsidized by the Federal government, as above. Adding these two groups of natives to medicaid should save some of the other funding to maintain services through IHS.

(10) The medically needy group (extending coverage to ALL optionals) is judged to increse costs, at most, by 10%. Estimates in the Battelle study were based on the experience of other states without taking into consideration the liberal programs for the elderly in this state under Medicaid. We are already covering 98% of those in nursing homes, so there are few more to add in that category.

The state has the option to set the limit up to 133% of the income eligibility so that the person would have to spend down to that amount. People in nursing homes have to spend down to the $70 allowable as is. You may remember the Bill we had last year relating to pregnant women which estimated only $90,000 for medical coverage of that group.

Added services: these are currently covered by GRM and there is anticipated very little addition to cost, if any. Long term care non-institutional services is new and requires a waiver from the Feds. It includes: Case managemnet services (nursing home pre-admission screening), Homemaker/Home Health, personal care services, Adult day services, habilitation services and respite care. This is specifically designed to help keep people out of institutions through providing funding for community based services that are much less expensive.

MEDICAL ASSISTANCE FOR NEEDY PERSONS

Sec. 47.07.020 ELIGIBLE PERSONS.

(8) Individuals under age 21 who would be eligible for AFDC but do not qualify as dependent children;

(9) Individuals who would be eligible for AFDC if coverage under the state's AFDC plan were as broad as allowed under title IV-A;

(10) The medically needy who meet applicable income and resource standards, including:

a) All pregnant women during the course of their pregnancy who, but for income and resources, would be eligible for categorically needy;

b) All individuals under age 21 as specified in this chapter;

c) Caretaker relatives:

d) Aged;

e) Blind;

f) Disabled.

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED.

Physical therapy, occupational therapy, prescribed drugs, prosthetic devices and medical supplies and long term care non-institutional services.

Sec. 47.07.080. DEFINITIONS

(4) "clinic services"means services provided by state approved outpatient community mental health services which receive grants under AS 47.30.520-47.30.620, state-operated community mental health clinics, and physician clinics.

MEDICAID/GENERAL RELIEF MEDICAL
FISCAL AND PROGRAM ADJUSTMENTS--FY 83

TOTAL MEDICAID	STATE FUNDS	FEDERAL FUNDS	DESCRIPTION OF PROGRAM CHANGE	GEN RELIEF MEDICAL	NEW PERSONS COVERED
$50559.4	$23154.0	$27405.4	FY 83 Budget Request after reductions	$11603.0	
			Deduction for Catastrophic Illness	(2158.4)	
50559.4	23154.0	27405.4		9444.6	
3102.6	1613.4	1489.2	Transfer of services from GRM to Medicaid (increase GRM amount by 50% for potential crossover)	(1613.4)	
53662.0	24767.4	28894.6		7831.2	
467.6	243.2	224.4	Addition of coverage for pregnant women	(243.2)	191
54129.6	25010.6	29119.0		7588.0	
1500.0		1500.0	Addition of IHS clinic services		
55629.6	25010.6	30619.0		7588.0	
6520.5	3390.7	3129.8	Addition of matchable children	(3390.7)	700
62150.1	28401.3	33748.8		4197.3	
3346.6		3346.6	Addition of 100% federal match children		3300
65496.7	28401.3	37095.4		4197.3	
220.2	111.5	108.7	GRM savings from Alaska participation in Medicare Part B buy-in	(111.5)	
65716.9	28512.8	37204.1		4085.8	
1355.2	1007.7	347.5	Elimination of Medicaid penalty caused by change in rate of federal funding	(1007.7)	
67072.1	29520.5	37551.6		3078.1	
1000.0	520.0	480.0	Medicaid trans due to IHS funding cuts	(520.0)	
68072.1	30040.5	38031.6		2558.1	
309.2	160.7	148.5	Admin costs of adding children	(160.7)	
68381.3	30201.2	38180.1	Balance after adjustments	2397.4	

ATTACHMENT B

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

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

19 March 1982

DOCUMENT NO. 104-82

Honorable Charles H. Parr
Alaska State Senate
Pouch V
Juneau, Alaska 99811

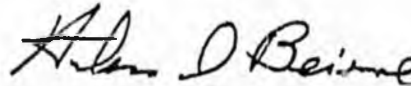
Dear Senator Parr:

Since our recent meeting and after discussion within the Department, I believe SB 817 is the mechanism to make basic changes in the way the Department administers the Medicaid and General Relief Medical (GRM) programs. With the budget limitations that have been placed on all agencies of state government it is increasingly more important to be able to respond to spending limits by making reasoned changes in programs to remain within those limits. With the Medicaid and GRM programs, projected shortfalls in funding during FY 83 have caused the Department to plan for reductions in each program. In Medicaid, that effort has focused on limiting access to services and reducing payments to hospitals and long term care facilities; in GRM, planning has focused on reducing eligibility and availability of coverage.

As described more thoroughly in the attached position paper, an amended SB 817 and changes in budgeting for Medicaid and GRM would increase flexibility in the two programs and would allow the Department to continue providing a full range of health care services to needy children, the aged, and the disabled. By transferring funds from GRM to Medicaid, the Department could gain increased purchasing power for services by earning more federal Medicaid receipts. The remaining GRM program would be limited to emergency medical coverage for single employable individuals and employable couples meeting the income and resource requirements of the program. All children presently eligible only for GRM would be transferred to Medicaid, and 3000 to 4000 new children would become eligible for Medicaid coverage.

I know you will agree with me that state funds should first be used to provide financial assistance to those persons least able to provide for their own needs. The changes made by SB 817 would assure that the limited funds available for Medicaid and GRM would be used to pay for health care services for needy children, the elderly, and the disabled.

Sincerely,



Helen D. Beirne
Commissioner

06-F38LH

POSITION PAPER

SENATE BILL NO. 817

"An Act relating to medical assistance for needy persons; and providing for an effective date."

I. BACKGROUND

The Alaska Medicaid program was created by the Legislature in 1972 and sections in the statutes were created to list all categories of service and groups of eligibles. The original legislation created a program providing basic medical coverage for individuals eligible for cash payments under the Aid to Families with Dependent Children (AFDC) and the Adult Public Assistance (APA) programs, individuals in long term care facilities, and children under supervision of the Department in foster homes and private child-caring facilities. Since 1972, the Legislature has amend the statutes several times to add new groups of eligibles or categories of service.

The new groups of eligibles added to AS 47.07.020 since 1972 have been institutionalized individuals for whom the state had previously paid all of their cost of care. By adding them to the Medicaid program, the state was able to receive federal funds to partially offset state funds.

The new categories of service added to AS 47.07.030 since 1972 have been fairly low cost services when compared to the total Medicaid program. Several of the new categories of service had the effect of permitting the state to receive federal funds to partially offset state funds being used to provide services.

II. NEED FOR CHANGES IN MEDICAID AND GRM

At this time the Department is anticipating having to make reductions in the Medicaid and General Relief Medical (GRM) programs during FY 83 as the funds requested will not cover expenditures based on historical usage. Since the Medicaid categories of service and groups of eligible are set out in statute, the only flexibility available to the Department is to limit access to services or reduce payment to providers. Since GRM categories of service and eligibility requirements are not in statute, the Department has more flexibility to make program changes. Attachment C breaks down the Medicaid and GRM programs to allow identification of the areas in each program where the Department can make changes to remain within expected FY 83 program budgets without passage of SB 817.

For Medicaid, the Department has proposed: (1) limiting access to providers in an attempt to reduce the amount of services individuals receive; and (2) reducing the rates of payment to hospitals and long term care facilities so that in many cases, payment will be below the amount that would be paid if the Department was paying for the full cost of providing care to Medicaid eligibles.

For GRM, the Department has proposed: (1) limiting GRM eligibility to one two-month period of coverage during any 12 months except for

emergency medical needs; and (2) reducing the rates of payment to hospitals and long term care facilities as proposed under Medicaid. It should also be added that the income and resource limits under the GRM program have not been increased since 1977 and are far below the limits for Medicaid.

SB 817 could be used to permit the Department to make adjustments in the Medicaid and GRM programs if the changes discussed below are made in the bill and in the FY 83 appropriation for the Medicaid and GRM programs. These proposed changes are based on the assumption that one primary goal of the Medicaid and GRM programs should be to provide financial assistance to those persons least able to provide for their own needs.

The present Medicaid program provides coverage for financially needy aged, blind, and disabled individuals through their eligibility for APA. Coverage is also available for financially needy children in AFDC households where there is only one parent. However, because the Alaska AFDC program does not provide financial assistance to families with two employable adults regardless of their financial need, many needy children are not receiving the full range of health care services available under Medicaid. While a limited range of health care services are available under GRM to children in families without other medical resources, few truly needy children are covered by GRM because income and resource standards under GRM are considerably lower than they are for Medicaid.

By passage of SB 817, Medicaid coverage for needy children not in AFDC households would be established. This new Medicaid coverage could be provided <u>without</u> new funds if changes are made in the FY 83 appropriation. The GRM budget request unit should be incorporated in the Medicaid budget request unit and specific intent included giving the Department authority to move funds between components in order to comply with the changes made in the Medicaid program as a result of changes made by SB 817. This change in budgeting would permit the Department to use GRM as the state matching funds needed to earn federal Medicaid funds. Attachment A contains a draft summary sheet for a Medical Assistance BRU to replace the Medicaid and GRM BRUs, with proposed intent language to accomplish this change.

The remaining GRM funds would be used for three things: (1) to eliminate the Medicaid penalty in the FY 83 budget and continue providing Medicaid services at present levels without limiting access to health care services and without reducing the rates of payment to hospitals and long term care facilities; and (2) to absorb Medicaid transportation costs associated with reduction in IHS funding; and (3) to continue the GRM program as an emergency medical assistance program for single employable individuals and employable couples with or without children, to the extent permitted by available funding.

The theory behind the second proposal is based on the Department's experience administering the Catastrophic Illness program. Except in cases of extremely costly medical care, individuals usually have the ability to work out some type of payment agreement with health care providers, often over an extended period of time if there is some reasonable expectation of payment. While it may be desirable for the state to provide that payment on behalf of needy employable individuals, funding limitations often force priorities to be assigned. In the case of state funding for health care services, individuals least able to

provide for themselves should receive a higher priority rating that employable individuals.

III. PROPOSED AMENDMENTS TO SB 817

Section 1 should be amended to eliminate proposed subsection (9). Subsection (9) would add employable adults and, given the present state funding limitations, it would be a better use of scarce resources to provider a full range of health care services, including preventive screening services and dental care, to a maximum number of needy children.

Section 2 would create a Medicaid medically needy program. While this would provide some financial assistance for individuals with income above the level presently covered by Medicaid, it should not be included in SB 817 because it represents new costs. Instead, Section 2 should be limited to adding pregnant women under Medicaid, coverage which is presently provided under GRM for a limited number of individuals could be expanded with funds from the GRM program.

Sections 4 and 5 contain a drafting error which causes the definition of clinic services to be moved from AS 47.07.080, the definitions section, to AS 47.07.030, the section listing services covered under Medicaid. The amended definition of clinic services should remain in the definitions section.

IV. EFFECT OF SENATE BILL NO. 817

Section 1 of the bill amends AS 47.07.020 by adding all children with income below the need standards for payment under the AFDC program, but who are not eligible because they do not meet the definition of dependent children under the AFDC program as discussed above

Section 3 would transfer from GRM to Medicaid the cost of providing the following categories of service to Medicaid eligible individuals: physical and occupational therapy, prescribed drugs, and prosthetic devices and medical supplies. In addition, SB 817 would give the Department increased flexibility in the area of long term care services.

The Department has projected some cost savings resulting from this amendment. Since the Medicaid program permits eligible individuals free choice of medical providers, individuals eligible for Medicaid and the Indian Health Service can choose between private providers and IHS facilities when they seek medical treatment. While experience has shown that the "crossover" to private health care providers under Medicaid is a small percentage of total Medicaid-IHS dual eligibles, changes in IHS funding or policies could result in increased crossover.

With the passage of the Omnibus Reconciliation Act of 1981, Congress provided increased flexibility to states in the management of the Medicaid program. States may now receive federal funds for certain noninstitutional services when these services are provided to keep an individual out of a long term care facility. The following home and community-based services (other than room and board) may be covered

under the long-term care noninstitutional category of service: case management, homemaker and home health aide, personal care, adult day health, habilitation, respite care, and minor physical adaptation to an individual's home.

While there will probably be no cost savings initially by the addition of this new category of services, over the next several years the rate of growth of long term care institutional services should decrease as individuals receive services at home, in residential care facilities, and other less costly living situations rather than in institutions. While the fiscal note does not reflect any increase in cost to implement this provision, it should be clearly stated that the Department be permitted the flexibility to transfer funds between BRUs and to use Medicaid program funds to provide the case management services necessary to make the program work. The Medicaid nursing home budget request for FY 83 is $21,831,300 so even the deferral of as little as 5 percent of that total could provide over $1 million for noninstitutional services.

Sections 4 would revise the definition of clinic services to add physician clinics. While this will not add any new private providers to the Medicaid program, it will permit clinics owned by the Indian Health Service to receive 100 percent federally-funded reimbursement under Medicaid. Without a change in statute, these clinic will continue to be barred from collecting approximately $1,500,000 in federal Medicaid funds. Since IHS in Alaska is experiencing funding problems, these new federal Medicaid funds should permit clinics to continue operating at their historical service levels and help avoid increasing demand for services from private providers which would be covered under Medicaid using state and federal funds rather than federal funds only.

V. DEPARTMENTAL POSITION

The Department supports SB 817 with the amendments to the bill and the Medicaid and GRM FY 83 appropriations proposed by this position paper.

Recommended by: Rod Betit by RBO

Rod Betit, Director
Division of Public
Assistance

Date: 3/19/82

Approved by: Helen D. Beirne

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

Date: 3-22-82

DG-58 3/22/82

ATTACHMENT A

PROPOSED FY 83 MEDICAL ASSISTANCE
BUDGET REQUEST UNIT IMPLEMENTING SB 817

BUDGET COMPONENT	FY 83 GOVERNOR'S REQUEST			SB 817 ADDITIONS			REVISED FY 83 BUDGET			RECALCULATION FOR 52/48%		
	GF	FED	TOTAL	SFG	FF	TOTAL	SFG	FF	TOTAL	SFT	FF	TOTAL
MEDICAID												
Hosp.	6163.9	6163.9	12327.8							8022.2	7405.2	15427.4
Phy. Svcs	3929.1	3929.0	7858.1							5098.2	4706.1	9804.3
Other Svcs	816.7	878.8	1695.5							3762.0	3477.8	7239.8
EPSDT	1376.0	1375.9	2751.9							1805.8	1666.9	3472.7
SUBTOTAL	12285.7	12347.6	24633.3	5878.8	5432.1	11310.9	18164.5	17779.7	35944.2	18688.2	17256.0	35944.2
Nursing Homes	10915.7	10915.6	21831.3	0.0	0.0	0.0	10915.7	10915.6	21831.3	11352.3	10479.0	21831.3
SUBTOTAL	35487.1	35610.8	71097.9	5878.8	5432.1	11310.9	29080.2	28695.3	57775.5	30040.5	27735.0	57775.5
IHS	0.0	5450.0	5450.0	0.0	4846.6	4846.6	0.0	10296.6	10296.6	0.0	10296.6	10296.6
SUBTOTAL	70974.20	76671.60	147645.80	5878.8	10278.7	16157.5	29080.2	38991.9	68072.1	30040.5	38031.6	68072.1
Med. Penalty	<47.4>	<1307.8>	<1355.2>	1007.7	347.7	1355.2	960.3	<960.3>	0.0	0.0	0.0	0.0
MEDICAID TOTAL	23154.0	27405.4	50559.4	6886.5	10626.2	17512.7	30040.5	38031.6	68072.1	30040.5	38031.6	68072.1
GEN. REL. MED												
CIP	2158.4	0.0	2158.4	0.0	0.0	0.0	2158.4	0.0	2158.4	2158.4	0.0	2158.4
GRM	10019.9	0.0	10019.9	<6886.5>	0.0	<6886.5>	3133.4	0.0	3133.4	3133.4	0.0	3133.4
SUBTOTAL	12178.3	0.0	12178.2	<6886.5>	0.0	<6886.5>	5291.8	0.0	5291.8	5291.8	0.0	5291.8
GRM Reduction	<575.3>	0.0	<575.3>	0.0	0.0	0.0	<575.3>	0.0	<575.3>	<575.3>	0.0	<575.3>
ALL GRM TOTAL	11603.0	0.0	11603.0	<6886.5>	0.0	<6886.5>	4716.5	0.0	4716.5	4716.5	0.0	4716.5
TOTAL SERVICES	34757.0	27405.4	62162.4	0.0	10626.2	10626.2	34757.0	38031.6	72788.6	34757.0	38031.6	72788.6
ELEG. DETER.												
GRM Total				2558.1	0.0	2558.1	2558.1	0.0	2558.1			
Less Admin. Costs				<150.7>	0.0	<160.7>	<160.7>	0.0	<160.7>	2397.4	0.0	2397.4
GRM Rinal Total				2397.4	0.0	2397.4	2397.4	0.0	2397.4	160.7	148.5	309.2
Elig. Deter. Total												

LEGISLATIVE INTENT:

To implement changes in coverage caused by passage of SB 817, the Department has the authority to transfer funds between components as needed to cover new categories of service and groups of eligibles under the Medicaid program, to reduce the scope of the General Relief Medical program, and to make up the Medicaid penalty.

LEGISLATIVE INTENT:

The Department has the authority to transfer funds from the Medical Assistance BRU to the Eligibility Determination BRU to provide funding for up to 7 new field positions when they are needed to determine eligibility for new Medicaid eligibles under SB 817.

MEDICAID/GENERAL RELIEF MEDICAL
FISCAL AND PROGRAM ADJUSTMENTS--FY 83

TOTAL MEDICAID	STATE FUNDS	FEDERAL FUNDS	DESCRIPTION OF PROGRAM CHANGE	GEN RELIEF MEDICAL	NEW PERSONS COVERED
$50559.4	$23154.0	$27405.4	FY 83 Budget Request after reductions	$11603.0	
			Deduction for Catastrophic Illness	(2158.4)	
50559.4	23154.0	27405.4		9444.6	
3102.6	1613.4	1489.2	Transfer of services from GRM to Medicaid (increase GRM amount by 50% for potential crossover)	(1613.4)	
53662.0	24767.4	28894.6		7831.2	
467.6	243.2	224.4	Addition of coverage for pregnant women	(243.2)	191
54129.6	25010.6	29119.0		7588.0	
1500.0		1500.0	Addition of IHS clinic services		
55629.6	25010.6	30619.0		7588.0	
6520.5	3390.7	3129.8	Addition of matchable children	(3390.7)	700
62150.1	28401.3	33748.8		4197.3	
3346.6		3346.6	Addition of 100% federal match children		3300
65496.7	28401.3	37095.4		4197.3	
220.2	111.5	108.7	GRM savings from Alaska participation in Medicare Part B buy-in	(111.5)	
65716.9	28512.8	37204.1		4085.8	
1355.2	1007.7	347.5	Elimination of Medicaid penalty caused by change in rate of federal funding	(1007.7)	
67072.1	29520.5	37551.6		3078.1	
1000.0	520.0	480.0	Medicaid trans due to IHS funding cuts	(520.0)	
68072.1	30040.5	38031.6		2558.1	
309.2	160.7	148.5	Admin costs of adding children	(160.7)	
68381.3	30201.2	38180.1	Balance after adjustments	2397.4	

ATTACHMENT B

MEDICAID/GRM EVALUATION WORKSHEET

MEDICAID

Eligibility Groups	Service Categories	Rate Schemes
CATEGORICALLY NEEDY	FED MANDATORY	¢ Raise/lower APA
# AFDC cash household	$ Hospital	¢ Raise/lower AFDC
# SSI cash household	$ Physician	Hospital rates
1 APA cash household	$ Skilled nursing	LTC rates
2 300% institutional	$ Lab and X-ray	Raise/lower phys pymt
3 DHSS foster children	$ Medical trans	Raise/lower others
4 API under 21 class	$ Home health care	Limit access to svcs
5 ICF/MR under 21 class	$ EPSDT/incl dental	Prior auth of IP svcs
* Pregnant women	$ Family planning	Prior auth of OP svcs
* Non-AFDC children	$ Rural hlth clinic	Limit IP svcs to emgcy
* Noninstitutional 300%		Limit OP svcs to emgcy
* AFDC-UP household	FED OPTIONAL	Copymt on opt svcs
* Caretaker relatives	1 Intermed nursing	Copymt on mand svcs
	2 Prescribed drugs	
MEDICALLY NEEDY	3 Eye care/glasses	
* Non-AFDC children	4 Speech, hearing	
* Pregnant women	5 PT/OT	
* DHSS foster children	6 ICF/MR	
* APA-type adults	7 Psych facility	
* AFDC-type household	Clinic services:	
* AFDC-UP-type household	8 Mental health	
* Caretaker relatives	* Birthing ctrs	
	* Physician (IHS)	
	9 Surgical care ctrs	
	10 Nurse midwife	
	11 Med supplies & eqpt	
	* Noninstl LTC	
	* Personal care	
	* Podiatrist	
	* Dentures	
	* Dental	
	* Chiropractic	
	* Diag, rehab, etc	
	* Pvt duty nursing	
	* Physician assts	
	* Pvt psychologists	
	* Nurse practitioners	

GENERAL RELIEF MEDICAL

Eligibility Groups	Service Categories	Rate Schemes
1 AFDC-UP children	1 Hospital	Raise/lower standards
2 Single employables	2 Physician	Raise/lower resources
3 Employable couples	3 Prescribed drugs	Hospital rates
	4 Lab and X-ray	LTC rates
	5 PT/OT	Raise/lower phys pymt
	6 Medical trans	Raise/lower pymt--other
	7 Emergency dental	Limit access to svcs
	8 Med supplies & eqpt	Prior auth of IP svcs
	9 Eye care/glasses	Prior auth of OP svcs
	10 Family planning	Limit IP svcs to emgcy
	11 Abortions	Limit OP svcs to emgcy
	12 Surgical care ctrs	
	13 Speech, hearing	
	14 Skilled nursing	
	15 Intermed nursing	

ATTACHMENT C

*--Not covered under Alaska Medicaid program
#--Federally-mandated groups of eligibles--not ranked
$--Federally-mandated categories of service--not ranked
¢--Payment rates established by Alaska Legislature
Columns with numbers are ranked from most important to least important--no rankings are indicated for changes in rate schemes

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Senate Bill 817
Title An Act relating to medical assistance for needy persons
Requested by Senate HESS Committee Date 3/19/82

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health
BRU, Program, Or Subprogram(s) Affected Medicaid*
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS,CLAIMS,ETC.		22068.5	25378.7	29185.5	33563.4	38597.9
TOTAL		22068.5	25378.7	29185.5	33563.4	38597.9

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		11442.3	13158.6	15132.4	17402.3	20012.6
FEDERAL FUNDS		10626.2	12220.1	14053.1	16161.1	18585.3
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME						
PART TIME						
TEMPORARY						

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

Transfer of State General Funds from General Relief Medical budget request unit and claiming of federal matching funds.

*The Medicaid budget request unit will be changed to the "Medical Assistance" budget request unit to reflect inclusion of Medicaid and General Relief Medical in one budget request unit.

IV. DATE 3/22/82 PREPARED BY David M. Davidson
AGENCY Division of Public Assistance
PHONE 465-3347

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. Senate Bill 817
Title An Act relating to medical assistance for needy persons
Requested by Senate HESS Committee Date 3/19/82

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services
Program Category Affected Social and Economic Assistance
BRU, Program, Or Subprogram(s) Affected Eligibility Determination
(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 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES		210.2	231.2	254.3	279.8	307.7
200 TRAVEL		7.7	8.5	9.3	10.3	11.3
300 CONTRACTUAL		79.5	87.4	96.1	105.8	116.3
400 COMMODITIES		3.9	4.3	4.7	5.2	5.7
500 EQUIPMENT		7.9				
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		309.2	331.4	364.4	401.1	441.0

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		160.7	172.3	189.5	208.6	229.3
FEDERAL FUNDS		148.5	159.1	174.9	192.5	211.7
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME		6	6	6	6	6
PART TIME						
TEMPORARY						

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

State General Funds transferred from General Relief Medical budget request unit to Eligibility Determination to provide funding for administrative costs associated with the addition of new eligibles to the Medicaid program.

IV. DATE 3/19/82 PREPARED BY David M. Davidson
AGENCY Division of Public Assistance
PHONE 465-3347

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Senate Bill 817
Title An Act relating to medical assistance for needy persons
Requested by Senate HESS Committee Date 3/19/82

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health
BRU, Program, Or Subprogram(s) Affected General Relief Medical
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS,CLAIMS,ETC.		(11603.0)	(13330.9)	(15321.9)	(17610.9)	(20241.9)
TOTAL		(11603.0)	(13330.9)	(15321.9)	(17610.9)	(20241.9)

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		(11603.0)	(13330.9)	(15321.9)	(17610.9)	(20241.9)
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME						
PART TIME						
TEMPORARY						

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

Entire General Relief Medical budget transferred to new budget request unit titled "Medical Assistance" and to the Eligibility Determination budget request unit to provide funding for administrative costs associated with the addition of new eligibles to the Medicaid program.

IV. DATE 3/22/82 PREPARED BY David M. Davidson
AGENCY Division of Public Assistance
PHONE 465-3347

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

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

April 23, 1982 DOCUMENT NO. 150-82

The Honorable Don Bennett
Senator
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Re: Senate Bill 817

Dear Senator Bennett:

I would like to provide additional clarification of the pharmaceutical issue involved in CSSB 817 and the Department's position on its deletion from the bill. From the outset I would like to make it clear that the Department strongly supports CSSB 817 even if the pharmaceutical change is deleted. Although for reasons elaborated below the pharmaceutical transfer would increase our FY83 purchasing power by nearly $1 million, the remaining provisions of CSSB 817 are even more critical and require legislative passage this session.

As you know, pharmacies currently provide drugs to Medicaid and General Relief Medical recipients through the General Relief Program paid solely from state funds. Pharmacy costs are expected to be $1.7 million in FY83.

Senate Bill 817 would, among other things, move pharmaceuticals for Medicaid recipients under Medicaid where the State would receive 48% cost sharing by the federal government for pharmaceutical costs. The sole federal condition for accepting a 48% cost sharing for pharmaceuticals is that Alaska begin paying pharmacists on a formulary basis rather than actual charges. As the Department intended to establish a formulary anyway in FY83, this federal requirement did not present a major problem. On the average this could represent a 15% reduction below actual charges for pharmacists.

It is our understanding that pharmacists oppose this change primarily because of the greater reimbursement flexibility they perceive under GR Medical than Medicaid. Although we appreciate this view, the Department will be reimbursing all medical providers, to include pharmacists, at a reduced rate in FY83 if CSSB 817 fails to pass this session.

The purpose of CSSB 817 is to stretch the purchasing power of limited state funds by maximizing federal earnings in order to ensure that all of Alaska's needy children continue to receive a full range of medical services in FY83, and that provider rate reductions are minimized.

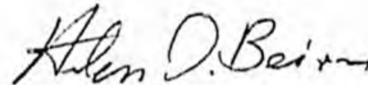
06-F38LH

Removing the pharmaceutical transfer from CSSB 817 does not make the bill any less critical, but will reduce our purchasing power by nearly $1 million as we will not be earning federal funds for this item so long as it remains under GR Medical. This $1 million would, by our estimate, have purchased medical services for approximately an additional 1000 persons in FY83.

Again, the Department very strongly supports passage of CSSB 817 even without the pharmaceutical transfer included, as without the remaining provisions of CSSB 817, a great many children from low-income families may be limited to receiving only emergency medical services in FY83. The remaining provisions of CSSB 817 would prevent this from happening.

I sincerely hope this letter has served to clarify the Department's views on the pharmaceutical issue, and the criticality of CSSB 817 to our FY83 medical program even if the pharmaceutical transfer is removed from the bill.

Sincerely,



Helen D. Beirne
Commissioner

cc: Allen Korhonen
Rod Betit

AMENDED NOTICE OF ADOPTION OF EMERGENCY REGULATIONS

As required by AS 44.62.250, notice is given that, under the authority of AS 47.05.010, the Department of Health and Social Services adopted on this date 7 AAC 46.100, 46.110, 46.120, 46.130 and 46.140, and amended 7 AAC 46.040 and 46.090 as emergency regulations relating to the food stamp program, including changes in the methods by which eligibility and allotment amounts are determined and changes in the requirements which recipients must fulfill in order to remain eligible as well as responsibilities of the agency to notify clients and methods to recoup overpayment.

This action will require increased administrative effort which is expected to be off-set by reduced error correction, a decrease in caseload through timely elimination of ineligible cases and increased processing times. This action is not expected to require an increased appropriation.

Copies of these regulations may be obtained by writing to Division of Public Assistance, Pouch H-07, Juneau, Alaska 99811.

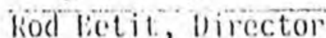
Notice is also given that the Department of Health and Social Services intends to make this change in regulations permanent under AS 62.260, and any person interested may present oral or written comment at public hearings to be held in: Room 426 of the MacKay Building
338 Denali Street
Anchorage, Alaska
on March 15, 1982 at 9 AM, or

Room 19 of the Alaska Office Building
350 Main Street
Juneau, Alaska
on March 19, 1982 at 10 AM;

or mail or present written statements or arguments relevant to the action proposed to: Department of Health and Social Services
Division of Public Assistance
Alaska Office Building, Room 310
Pouch H-07
Juneau, Alaska 99811

before 4:30 p.m., March 30, 1982.

DATE: 2/25/82
Juneau, Alaska



Rod Betit, Director

FINDING OF EMERGENCY

The Department of Health and Social Services finds that an emergency exists and that the attached regulations and amendments are necessary for the immediate preservation of the public peace, health, safety, or general welfare. A statement of facts constituting the emergency is:

> The State has received notice from the United States Department of Agriculture (USDA) that its Food Stamp error rate is unacceptable, and corrective actions must be implemented by April 1, 1982 or the State may experience a fiscal sanction. These regulations are essential for the implementation and execution of the corrective actions agreed to between the State of Alaska and USDA.

ADOPTION ORDER

Under authority of AS 47.05.010, the regulations and amendments are adopted as emergency regulations and amendments to take effect immediately upon filing by the Lieutenant Governor as provided in AS 44.62.180(3).

DATE: 2-25-82
Juneau, Alaska

Helen D. Beirne, Commissioner

FILING CERTIFICATION

I, Terry Miller, Lieutenant Governor for the State of Alaska, certify that on February 25, 1982 at 1:30 p.m., I filed the attached regulations according to the provisions of AS 44.62.

Lieutenant Governor

Effective: February 25, 1982
Register 81, April 1982
Expires: June 24, 1982

7 AAC 46.040 is amended as follows:

(b) The department will conduct administrative fraud hearings. The hearing officer will be appointed by the commissioner or his designee. The hearing will be conducted under the Administrative Procedure Act, AS 44.62.330 - 44.62.640.

(Eff. 9/10/81, Register 79; am 2/25/82, Register 81)

Authority: AS 47.25.975
AS 47.25.980

7 AAC 46.090 is amended by adding the following paragraphs:

(8) "adequate notice" means a notice which complies with 7 CFR 273.13(a)(1). This notice must be on a form designated by the division for this purpose and explain the reason for the action, the right to a fair hearing, and instructions about how to contact the agency for additional information;

(9) "initial" means the beginning period, month, application, benefit or allotment for an applicant who did not participate in the program during the month immediately preceding the month of application;

(10) "retrospectively" means referring back to a previous month; for example, when computing benefits for the month of March, they may be determined based on the income received in January.

(Eff. 9/10/81, Register 79; am 2/25/82, Register81)

Authority: AS 47.25.975
AS 47.25.980

7 AAC 46.100. REPORTING REQUIREMENTS. (a) The division will advise an applicant in writing within ten days of a determination of eligibility of how he is to report a change in circumstance. The division will periodically advise recipients of the same reporting requirements.

(b) A recipient must report any change which may affect his eligibility or monthly assistance amount. The report must be made to the office of the division nearest the recipient's residence and must be made within 10 days after the change becomes known to the household. The report may be made in writing on a form provided by the division or another form or orally in person or by telephone.

(c) In addition to the reporting requirement of (b) of this section, a recipient must report monthly all changes which occurred in the past month and all changes expected to occur in the coming month or the absence of any change upon a form specified by the division. Failure to submit this report, signed and with every question answered, on or before the 10th of the month will result in termination of the next month's food stamps. Households without earned income and composed entirely of recipients of Adult Public Assistance or Supplemental Security Income benefits under Title XVI of the Social Security Act or disability and blindness payments under Title I, II, X, XIV and XVI of the Social Security Act are exempt from the monthly reporting requirement but must report changes within 10 days after the date the change becomes known to the household.
(Eff. 2/25/82, Register 81) Authority: AS 47.25.975
AS 47.25.980

7 AAC 46.110. INITIAL MONTH OF ASSISTANCE. The division will determine an applicant's initial eligibility and first month's benefits prospectively. The division will base its initial determination under this section on its estimate of the applicant's circumstances which are likely to exist in each of the two months in the initial determination period.
(Eff. 2/25/82, Register 81) Authority: AS 47.25.975
AS 47.25.980

7 AAC 46.120. SUBSEQUENT MONTHS OF ASSISTANCE. The division will determine a recipient's eligibility prospectively. However, the recipient's monthly allotment amount after the initial two-month period will be computed retrospectively.
(Eff. 2/25/82, Register 81) Authority: AS 47.25.975
AS 47.25.980

7 AAC 46.130. NOTICE OF ADVERSE ACTION. The division will send an adequate notice of termination of benefits to all recipients failing to submit completed monthly reports as required by 7 AAC 46.100. The notice must be sent the end of the month in which the form was due in the division office.

(Eff. 2/25/82, Register 81) Authority: AS 47.25.975
AS 47.25.980

7 AAC 46.140. RECOUPMENT: CLAIMS AGAINST HOUSEHOLDS. (a) When the division determines that a household has received more food stamps than it is entitled to, the division shall determine the amount and the cause of the loss.

(b) If the loss appears to be due to fraud, the division will refer the case to the department's fraud investigations unit.

(c) Non-fraud client-caused losses will be collected from any members of the household that may have benefitted from the client-caused error. Collection may be through full payment, regular payments over a period of less than three years or through reduction in monthly food stamp benefits. Minimum payments shall be $10 per month except for a final payment which may be less. Recoupment through involuntary reduction of food stamp benefits will be $10 or 10 per cent of each month's allotment, whichever is greater. Households may voluntarily authorize a higher rate in writing.

(d) The department must notify households in writing of the amount of loss, methods of repayment and the right to a fair hearing, at least thirty days before manditory recoupment can be implemented.

(e) The division may initiate civil court action to obtain payment of the claim.

(Eff. 2/25/82, Register 81) Authority: AS 47.25.975
AS 47.25.980

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

NOTICE OF ADOPTION OF EMERGENCY REGULATIONS

As required by AS 44.62.250, notice is given that, under authority of AS 47 05.010, the Department of Health and Social Services amended or rep[illegible]d on this date substantial portions of 7 AAC 47 relating to the General Relief Medical (GRM) program and portions of 7 AAC 43.005 relating to the Medicaid program, which emergency regulations will take effect May 17, 1982. These emergency regulations place additional limitations upon benefits available under the GRM program, terminate certain benefits, and change the manner of application. They are based on a finding made on this date that appropriated funds are not sufficient to maintain benefits at current levels throughout the remainder of fiscal year 1982. These emergency regulations, which are to remain in effect for an indefinite period, are not expected to require increased appropriations.

Copies of these emergency regulations may be obtained by contacting David M. Davidson, Medical Assistance Program Officer, Division of Public Assistance, Pouch H-07, Juneau, Alaska 99811, (907) 586-1503.

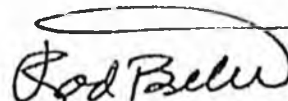
Notice is also given that the Department of Health and Social Services intends to make this regulation permanent substantially as described above under AS 44.62.260, and any person interested may present oral or written statements or arguments relevant to the action proposed at a teleconference hearing to be held on Wednesday May 12, 1982, at 2:30 PDT, 12:30 ADT, 11:30 BDT, at Legislative teleconference sites in the following locations (check with the Legislative Information office in the community for the exact address and room number):

Anchorage, Barrow, Bethel, Delta Junction, Dillingham, Fairbanks, Haines, Homer, Juneau, Ketchikan, Kodiak, Kotzebue, Matanuska-Susitna, Nome, Petersburg, Sand Point, Seward, Sitka, Soldatna, and Valdez.

Any person interested may also present written statements or arguments relevant to the action proposed by delivering them to Rod Betit, Director, D[illegible]ision of Public Assistance, Department of Health and Social Services, Pouch H-07, Juneau, Alaska 99811, no later than May 10, 1982.

DATE: April 15, 1982

Juneau, Alaska



Rod Betit, Director
Division of Public Assistance
Department of Health and Social Services

DESCRIPTION OF RESIDUAL GRM PROGRAM UNDER SB 817

Based on the position paper and fiscal information submitted by the Department, General Relief Medical (GRM) program funds would be reduced to approximately $2.4 million for FY 83 by the passage of SB 817. The GRM program has provided payment for a broad range of medical services for very low income individuals and families not eligible for Medicaid and without other available medical resources. Under SB 817, all children receiving coverage under GRM would be moved to Medicaid leaving single employable individuals and employable couples as the only persons eligible for GRM. However, it is anticipated that $2.4 million will not provide adequate funds to continue operating GRM at its present level.

Regardless of the action taken on SB 817, the Department has considered making GRM an emergency medical program because of funding limitations. The Department would like to propose that the new GRM program become a subsidiary coverage for the Catastrophic Illness program (CIP), with CIP paying eligible costs above $1000 per illness or injury.

The Department would use GRM funds to establish a health loan program that would loan up to $1000 to meet uncompensated, covered medical expenses. Individuals would still be required to meet narrow income and resource guidelines, but they would be given the opportunity to receive medical care with the agreement that they repay the Department within a set time period after conclusion of treatment.

The philosophy behind this GRM program concept is quite simple: health care assistance, unlike cash or food stamps, by its very nature is subject to much less abuse. Healthy adults have nothing to gain by being eligible for medical assistance because they do not receive a valuable commodity (money or food stamps). By establishing a health care loan fund, applicants would not receive something for nothing, and thus the issue of need would be largely self-policing. Individuals with medical need would access the loan fund and agree to repay the fund within a set period of time. Provisions would be established to permit postponement or cancellation of repayment under limited circumstances. Individuals receiving health care loans who do not repay them would be subject to legal process through attachment or garnishment in the same way that they are liable for payment on a consumer loan or child support payment.

The cost of implementing this health loan fund would be two Administrative Assistant positions added to the Division of Public Assistance collections section.

(1) He was receiving OAA, AB, APTD, or AABD; or

(2) He would have been eligible for one of those programs except that he had not applied, and the Medicaid plan covered this optional group; or

(3) He would have been eligible for one of those programs if he were not in a medical institution or intermediate care facility, and the Medicaid plan covered this optional group.

(b) The individual would currently be eligible for SSI or a State supplement except that the increase in OASDI under Pub. L. 92-336 raised his income over the limit allowed under SSI. This includes an individual who—

(1) Meets all current SSI requirements except for the requirement to file an application; or

(2) Would meet all current SSI requirements if he were not in a medical institution or intermediate care facility, and the State's Medicaid plan covers this optional group.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24883, Apr. 11, 1980]

§ 435.135 Individuals who become ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977.

(a) If an agency provides Medicaid to aged, blind, or disabled individuals receiving SSI or optional State supplements, it must provide Medicaid to individuals who—

(1) Are receiving OASDI;

(2) Were receiving SSI or optional State supplements but become ineligible for those payments because of OASDI cost-of-living increases paid under section 215(i) of the Act after April 1977; and

(3) Would still be eligible for SSI or optional State supplements if the amount of OASDI cost-of-living increases paid after April 1977 were deducted from income.

(b) Cost-of-living increases include the increases received by the individual or his financially responsible spouse.

(c) If the agency adopts more restrictive eligibility requirements than those under SSI, it must provide Medicaid to individuals specified in paragraph (a) of this section on the same basis as Medicaid is provided to individuals continuing to receive SSI or optional State supplements. If the individual incurs enough medical expenses to reduce his income to the financial eligibility standard for the categorically needy, the agency must cover him as categorically needy. In determining the amount of his income, the agency may deduct the cost-of-living increase paid under section 215(i), up to the amount of the increase that made him ineligible for SSI, and subsequent increases.

Subpart C—Options for Coverage as Categorically Needy

§ 435.200 Scope.

This subpart specifies options for coverage of individuals as categorically needy.

§ 435.201 Individuals included in optional groups.

Except where otherwise specified, a Medicaid agency that chooses to cover an optional group must provide Medicaid to all eligible individuals in that group. For example, in the options applicable to families and children and the aged, blind, or disabled, the agency may not provide Medicaid only to families and children; similarly, in the options applicable to the aged, blind, or disabled, it may not cover only the blind.

Options for Coverage of Families and Children and the Aged, Blind, and Disabled

§ 435.210 Individuals who would be eligible for but are not receiving cash assistance.

The agency may provide Medicaid to individuals who would be eligible for AFDC, SSI, or an optional State supplement as specified in § 435.230 but who are not receiving these benefits.

§ 435.211 Individuals who would be eligible for cash assistance except for their institutional status.

The agency may provide Medicaid to individuals in title XIX reimbursable medical institutions and intermediate care facilities who are ineligible for AFDC, SSI, or an optional State sup-

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plement because of lower income standards used under these programs to determine eligibility for institutionalized individuals, but who would be eligible for AFDC, SSI, or an optional State supplement as specified in § 435.230 if they were not institutionalized.

[45 FR 24884, Apr. 11, 1980]

Options for Coverage of Families and Children

§ 435.220 Individuals who would be eligible for AFDC if child care costs were paid from earnings.

(a) The agency may provide Medicaid to individuals who would be eligible for AFDC if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure.

(b) The agency may use this option only if the State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.

Removed 9/30/81 46 FR 47985

§ 435.221 Caretaker relatives of children who would be eligible for AFDC if they met age or school attendance requirements.

The agency may provide Medicaid to individuals who meet the definition of a caretaker relative under 45 CFR 233.90(c)(1)(v)(A), if they have in their care a child under age 21 who would be eligible for AFDC if he met the AFDC age or school attendance requirements.

§ 435.222 Individuals under age 21 who would be eligible for AFDC but do not qualify as dependent children.

Revised 9/30/81 46 FR 47985

(a) The agency may provide Medicaid to individuals under age 21 who would be eligible for AFDC if they met the definition of dependent child. (See 45 CFR 233.90(c)(1).)

(b) The agency may cover all individuals described in paragraph (a) of this section or individuals in reasonable classifications including the following:

(1) Individuals under age 21 in foster homes or private institutions for whom a public agency is assuming a full or partial financial responsibility. If the agency covers these individuals, it may also provide Medicaid to individuals under age 21 placed in foster homes or private institutions by private nonprofit agencies.

(2) Individuals under age 21 in adoptions subsidized in full or in part by a public agency.

(3) Individuals under age 21 in intermediate care facilites, if intermediate care facility services are provided under the plan. If the agency covers these individuals, it may also provide Medicaid to individuals in intermediate care facilities for the mentally retarded.

(4) Individuals under age 21 receiving active treatment as inpatients in psychiatric facilities or programs, if inpatient psychiatric services for individuals under 21 are provided under the plan.

Revised 9/30/81 46 FR 47985

§ 435.223 Individuals who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A.

(a) The agency may provide Medicaid to individuals who—

(1) Would be eligible for AFDC if the State's AFDC plan included individuals whose coverage under title IV-A is optional (for example, Medicaid may be provided to unborn children or members of families with an unemployed parent even though AFDC is not available to them under the State's AFDC plan); or

(2) Would be eligible for AFDC if the State's AFDC plan did not contain eligibility requirements more restrictive than, or in addition to, those required under title IV-A.

(b) The agency may cover any AFDC optional group without covering all such groups.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24884, Apr. 11, 1980]

Options for Coverage of the Aged, Blind, and Disabled

§ 435.230 Individuals receiving only optional State supplements.

(a) The agency may provide Medicaid, in one or more of the following classifications, to individuals who receive only an optional State supplement that meets the conditions specified in paragraph (b) of this section

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(3) All disabled
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(b) Payments u
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(1) Based on nee
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mine eligibility for
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State option, more
are made (see § 43
tions on FFP in Med
for individuals recei
supplements); and
(3) Available to all
State; however, the
for variations in the
by political subdivi
cost-of-living differen

§ 435.231 Individuals
are eligible under
level.

(a) If the agency
under § 435.211 to in
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not be eligible for SS
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and who would be eligible for SSI except for the level of their income:

(1) All aged individuals.

(2) All blind individuals.

(3) All disabled individuals.

(4) Only aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(5) Only blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(6) Only disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(7) Individuals receiving a federally administered optional State supplement that meets the conditions specified in this section.

(8) Individuals in additional classifications specified by the Secretary for federally administered supplementary payments under 20 CFR 416.2020(d).

(b) Payments under the optional supplement program must be—

(1) Based on need and paid in cash on a regular basis;

(2) Equal to the difference between the individual's countable income and the income standard used to determine eligibility for supplement. Countable income is income remaining after deductions required under SSI or, at State option, more liberal deductions are made (see § 435.1006 for limitations on FFP in Medicaid expenditures for individuals receiving optional State supplements); and

(3) Available to all individuals in the State; however, the plan may provide for variations in the income standard by political subdivision according to cost-of-living differences.

§ 435.231 Individuals in institutions who are eligible under a special income level.

(a) If the agency provides Medicaid under § 435.211 to individuals in institutions who would be eligible for AFDC, SSI, or State supplements except for their institutional status, it may also cover aged, blind, and disabled individuals in institutions who—

(1) Because of their income, would not be eligible for SSI or State supplements if they were not institutionalized; but

(2) Have income below a level specified in the plan under § 435.722. (See § 435.1005 for limitations on FFP in Medicaid expenditures for individuals specified in this section.)

(b) The agency may cover individuals under this section whether or not the State pays optional supplements.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24884, Apr. 11, 1980]

Subpart D—Optional Coverage of the Medically Needy

§ 435.300 Scope.

This subpart specifies the option for coverage of medically needy individuals.

§ 435.301 General rule.

(a) A Medicaid agency may provide Medicaid to individuals specified in this subpart who—

(1) Either—

(i) Have income that meets the standards in §§ 435.812 through 435.816; or

(ii) If their income is more than allowed under those standards, have incurred medical expenses at least equal to the difference between their income and the applicable income standard; and

(2) Have resources that meet the standards in § 435.840 or § 435.841.

(b) If the agency chooses this option, the agency must provide Medicaid to all the individuals specified in this subpart.

§ 435.310 Medically needy coverage of families and children.

If the agency provides Medicaid to the medically needy, it must provide Medicaid to the following individuals who meet the income and resource standards in Subpart I of this part;

(a) Members of families with dependent children (§ 435.110);

(b) Individuals under age 21 who are ineligible for AFDC because of age or school attendance requirements (§ 435.111);

(c) Individuals who are ineligible for AFDC because of an eligibility requirement under that program that is specifically prohibited under title XIX (§ 435.113);

7. A new § 435.115 is added to read as follows:

§ 435.115 Individuals deemed to be receiving AFDC.

(a) The Medicaid agency must provide Medicaid to individuals deemed to be receiving AFDC, as specified in this section.

(b) The State must deem individuals to be receiving AFDC who are denied a cash payment from the title IV-A State agency solely because the amount of the AFDC payment would be less than $10.

(c) The State may deem pregnant women to be receiving AFDC under section 406(g)(2) of the Act. This section permits States, for purposes of title XIX, to deem a pregnant woman to be receiving AFDC if—

(1) She would be eligible for AFDC cash payments if the child had been born and was living with her in the month of payment; and

(2) The pregnancy has been medically verified.

(d) The State may deem participants in a work supplementation program to be receiving AFDC under section 414(g) of the Act. This section permits States, for purposes of title XIX, to deem an individual and any child or relative of the individual (or other individual living in the same household) to be receiving AFDC, if the individual—

(1) Participates in a State-operated work supplementation program under section 414 of the Act; and

(2) Would be eligible for an AFDC cash payment if the individual were not participating in the work supplementation program.

8. Section 435.120 is revised to read as follows:

§ 435.120 Individuals receiving SSI.

(a) *General provisions.* Except as allowed under § 435.121, the agency must provide Medicaid to aged, blind, and disabled individuals or couples who receive SSI, including—

(1) Individuals receiving SSI pending a final determination of blindness or disability;

(2) Individuals receiving SSI under an agreement with the Social Security Administration to dispose of resources that exceed the SSI dollar limits on resources; and

(3) From January 1, 1981 until December 31, 1983, individuals considered to be receiving SSI under 1619(b) of the Act (blind individuals or those with disabling impairments whose income equals or exceeds a specific SSI limit). (See 20 CFR 416.263–416.269 for determinations of eligibility under this provision.)

(b) *Exclusion.* Individuals entitled to benefits under section 1622 of the Act are not to be considered individuals receiving SSI. Section 1622 of the Act provides for certain individuals whose minimum benefits under title II of the Act were reduced by section 2201 of Pub. L. 97–35.

9. Section 435.121 is amended by revising paragraph (c) to read as follows:

§ 435.121 Individuals in States using more restrictive requirements for Medicaid than the SSI requirements.

* * * * *

(c) The following sections of this part apply to the agency's use of more restrictive eligibility requirements:

(1) Section 435.135, treatment of individuals who receive OASDI cost-of-living increases.

(2) Section 435.330, medically needy coverage.

(3) Section 435.530, more restrictive definitions of blindness.

(4) Section 435.540, more restrictive definitions of disability.

(5) Sections 435.731 through 435.733, more restrictive income and resource requirements.

(6) Sections 435.812, 435.823, 435.831, and 435.841, medically needy financial eligibility requirements.

10. The table of contents is amended by removing § 435.221.

§ 435.221 [Removed]

11. Section 435.221 is removed.

12. Section 435.222 is revised to read as follows:

§ 435.222 Individuals under age 21 who would be eligible for AFDC but do not qualify as dependent children.

(a) The agency may provide Medicaid to individuals under age 21 (or, at State option, under age 20, 19 or 18) who would be eligible for AFDC if they met the definition of dependent child. (See 45 CFR 233.90(c)(1).)

(b) The agency may cover all individuals described in paragraph (a) of this section or in reasonable classifications of those individuals. Examples of reasonable classifications are as follows:

(1) Individuals in foster homes or private institutions for whom a public agency is assuming a full or partial financial responsibility. If the agency covers these individuals, it may also provide Medicaid to individuals of the same age placed in foster homes or private institutions by private nonprofit agencies.

(2) Individuals in adoptions subsidized in full or part by a public agency.

(3) Individuals in intermediate care facilities, if intermediate care facility services are provided under the plan. If the agency covers these individuals, it may also provide Medicaid to individuals in intermediate care facilities for the mentally retarded.

(4) Individuals under age 21 receiving active treatment as inpatients in psychiatric facilities or programs, if inpatient psychiatric services for individuals under 21 are provided under the plan.

13. Section 435.223 is revised to read as follows:

§ 435.223 Individuals who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A.

(a) The agency may provide Medicaid to individuals who—

(1) Would be eligible for AFDC if the State's AFDC plan included individuals whose coverage under title IV-A is optional (for example, Medicaid may be provided to members of families with an unemployed parent even though AFDC is not available to them under the State's AFDC plan); or

(2) Would be eligible for AFDC if the State's AFDC plan did not contain eligibility requirements more restrictive than, or in addition to, those required under title IV-A.

(b) The agency may cover any AFDC optional group without covering all such groups.

14. The table of contents is amended by adding §§ 435.308, 435.322, 435.324, 435.330, and 435.340, revising §§ 435.310 and 435.320, and removing §§ 435.321 and 435.325 as follows:

Subpart D—Optional Coverage of the Medically Needy

435.300 Scope.
435.301 General rule.

* * * * *

435.308 Medically needy coverage of individuals under age 21.
435.310 Medically needy coverage of caretaker relatives.
435.320 Medically needy coverage of aged in States that cover individuals receiving SSI.
435.322 Medically needy coverage of the blind in States that cover individuals receiving SSI.
435.324 Medically needy coverage of the disabled in States that cover individuals receiving SSI.
435.330 Medically needy coverage of aged, blind, and disabled individuals in States that impose more restrictive eligibility requirements.
435.340 Protected medically needy coverage for blind and disabled individuals eligible in December 1973.

* * * * *

15. Sections 435.301 is revised to read as follows:

§ 435.301 General rules.

(a) A medicaid agency may provide Medicaid to individuals specified in this subpart who—

(1) Either—

(i) Have income that meets the applicable standards in §§ 435.812 through 435.814; or

(ii) If their income is more than allowed under those standards, have incurred medical expenses at least equal to the difference between their income and the applicable income standard; and

(2) Have resources that meet the applicable standards in §§ 435.840 through 435.843.

(b) If the agency chooses this option, the following provisions apply:

(1) The agency must provide Medicaid to—

(i) All pregnant women during the course of their pregnancy who, but for income and resources, would be eligible for Medicaid as categorically needy; and

(ii) All individuals under age 21 (or, at State option, under age 20, 19, or 18), as specified in § 435.308. For purposes of this requirement, the agency may provide for individuals under age 21 as—

(A) Categorically needy, as specified in § 435.222; or

(B) Medically needy, as specified in § 435.308.

(2) The agency may provide Medicaid to any of the following groups of individuals:

(i) Individuals under age 21 (§ 435.308).

(ii) Caretaker relatives (§ 435.310).

(iii) Aged (§§ 435.320 and 435.330).

(iv) Blind (§§ 435.322, 435.330 and 435.340).

(v) Disabled (§§ 435.324, 435.330 and 435.340).

(3) If the agency provides Medicaid to any individual in a group specified in paragraph (b)(2) of this section, the agency must provide Medicaid to all individuals eligible to be members of that group.

16. A new § 435.308 is added to read as follows:

§ 435.308 Medically needy coverage of individuals under age 21.

(a) If the agency provides Medicaid to the medically needy, it must provide Medicaid to individuals under age 21 (or, at State option, under age 20, 19, or 18), as specified in paragraph (b) of this section, who meet the income and resource standards in Subpart I of this part. (See § 435.301 for required coverage as either categorically or medically needy.)

(b) The agency may cover all individuals described in paragraph (a) of this section or reasonable classifications of those individuals. Examples of reasonable classifications are as follows:

(1) Individuals in foster homes or private institutions for whom a public agency is assuming full or partial financial responsibility. If the agency covers these individuals, it may also provide Medicaid to individuals placed in foster homes or private institutions by private nonprofit agencies.

(2) Individuals in adoptions subsidized in full or in part by a public agency.

(3) Individuals in intermediate care facilities, if intermediate care facility services are provided under the plan. If the agency covers these individuals, it may also provide Medicaid to individuals in intermediate care facilities for the mentally retarded.

(4) Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if inpatient psychiatric services for individuals under 21 are provided under the plan.

17. Section 435.310 is revised to read as follows:

§ 435.310 Medically needy coverage of caretaker relatives.

(a) If the agency provides for the medically needy, it may provide Medicaid to caretaker relatives, as specified in paragraph (b) of this section, who meet the income and resource standards of Subpart I of this part.

(b) "Caretaker relatives" mean individuals who—

(1) Meet the definition of a caretaker relative under 45 CFR 233.90(c)(1)(v)(A); and

(2) Have in their care an individual who is determined to be dependent, as specified in § 435.510.

18. Section 435.320 is revised to read as follows:

§ 435.320 Medically needy coverage of the aged in States that cover individuals receiving SSI.

If the agency provides Medicaid to individuals receiving SSI and elects to cover the medically needy, it may provide Medicaid to individuals who—

(a) Are 65 years of age and older, as specified in § 435.520; and

(b) Meet the income and resource requirements of Subpart I of this part.

19. A new § 435.322 is added to read as follows:

§ 435.322 Medically needy coverage of the blind in States that cover individuals receiving SSI.

If the agency provides Medicaid to individuals receiving SSI and elects to cover the medically needy, it may provide Medicaid to blind individuals who meet—

(a) The requirements for blindness, as specified in §§ 435.530 and 435.531; and

(b) The income and resource requirements of Subpart I of this part.

20. A new § 435.324 is added to read as follows:

§ 435.324 Medically needy coverage of the disabled in States that cover individuals receiving SSI.

If the agency provides Medicaid to individuals receiving SSI and elects to cover the medically needy, it may provide Medicaid to disabled individual who meet—

(a) The requirements for disability, as specified in §§ 535.540 and 435.541; and

(b) The income and resource requirements of Subpart I of this part.

21. Section 435.321 is redesignated as § 435.330 and revised to read as follows:

§ 435.330 Medically needy coverage of the aged, blind, and disabled in States that impose eligibility requirements more restrictive than used under SSI.

(a) If an agency provides Medicaid as categorically needy only to those aged, blind, or disabled individuals who meet more restrictive requirements than used under SSI and elects to cover the medically needy, it may provide Medicaid as medically needy to those aged, blind, or disabled individuals who—

(1) Are not categorically needy, as specified in paragraph (b) of this section;

(2) Have income and resources within the standards established under Subpart I of this part; and

(3) If applying as blind or disabled, meet the blindness or disability requirements established under § 435.121.

(b) To determine whether an individual is covered as categorically needy or medically needy, the agency must—

(1) Consider as categorically needy those individuals who meet the State's categorically needy financial standard and—

(i) Who, before their incurred medical expenses are deducted from income, meet the financial eligibility requirements for SSI or a State supplement; or

(ii) Whose OASDI increases are not counted under §§ 435.134 and 435.135.

OPTION 1

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(2) Consider as medically needy all other individuals.

22. Section 435.325 is redesignated as § 435.340 and revised to read as follows:

§ 435.340 Protected medically needy coverage for blind and disabled individuals eligible in December 1973.

If an agency provides Medicaid to the medically needy, it must cover individuals who—

(a) Where eligible as medically needy under the Medicaid plan in December 1973 on the basis of the blindness or disability criteria of the AB, APTD, or AABD plan;

(b) For each consecutive month after December 1973, continue to meet—

(1) Those blindness or disability criteria; and

(2) The eligibility requirements for the medically needy under the December 1973 Medicaid plan; and

(c) Meet the current requirements for eligibility as medically needy under the Medicaid plan except for blindness or disability criteria.

23. Section 435.520 is amended by revising paragraph (a) to read as follows:

§ 435.520 Age requirements for the aged and children.

(a) The agency must not impose—

(1) An age requirement of more than 65 years;

(2) An age requirement that excludes an individual under age 19 who meets the definition of dependent child under the State title IV-A plan; or

(3) A lower age requirement than that under the State's AFDC plan.

* * * * *

24. The table of contents for Subpart I is revised as follows:

Subpart I—Financial requirements for the medically needy

435.800 Scope.

Medically Needy Income Standards

435.811 Medically needy income standards: General requirements.
435.812 Medically needy income standards: Reasonableness.
435.813 [Reserved]
435.814 Medically needy income standards: State plan requirements.
435.815 [Reserved]

Financial Responsibility of Relatives

435.821 Financial responsibility of relatives: Individuals under the age 21 and caretaker relatives.
435.822 Financial responsibility of relatives of aged, blind, or disabled individuals in States using SSI eligibility requirements.
435.823 Financial responsibility of relatives of aged, blind, or disabled individuals in States using more restrictive requirements than SSI.

Medically Needy Income Eligibility

435.831 Income eligibility.
435.832 Post-eligibility treatment of income and resources of institutionalized individuals: Application of patient income to the cost of care.

Medically Needed Resource Standards

435.840 Medically needy resource standards: General requirements.
435.841 Medically needy resource standards: Reasonableness.
435.843 Medically needy resource standards: State plan requirements.

Determining Eligibility on the Basis of Resources

435.845 Medically needy resource eligibility.

Treatment of Income and Resources

435.850 Treatment of income and resources: General requirements.
435.851 Treatment of income and resources: Reasonableness.
435.852 Treatment of income and resources: State plan requirements.

25. Section 435.811 is revised to read as follows:

Medically Needy Income Standards

§ 435.811 Medically needy income standards: General requirements.

To determine eligibility of medically needy individuals, a Medicaid agency must use an income standard under this subpart that is—

(a) Based on family size;

(b) Uniform for all individuals in a covered group;

(c) For FFP purposes, not in excess of 133⅓ percent of the highest money payment that ordinarily would be made in the State AFDC program to an individual or a family of comparable size (see § 435.1007); and

(d) Reasonable (see § 435.812).

26. Section 435.812 is revised to read as follows:

§ 435.812 Medically needy income standards: Reasonableness.

(a) The agency must use a medically needy income standard that is reasonable.

(b) The following medically needy income standards are presumed to be reasonable:

(1) The agency provides one medically needy income standard for all covered medically needy groups. Except as provided in paragraphs (c) and (d) of this section, the standard must at least equal the highest income or payment standard used to determine eligibility in the cash assistance programs (or an optional State supplement, if the agency provides Medicaid under § 435.230) related to the covered medically needy groups.

(2) The agency provides a different medically needy income standard for each covered medically needy group. Except as provided in paragraphs (c) and (d) of this section, the standard for each covered group must at least equal the income or payment standard used to determine eligibility in the cash assistance program (or an optional State supplement, if the agency provides Medicaid under § 435.230) related to that covered medically needy group.

(c) The agency may use a lower medically needy income standard than the standards specified in paragraph (b) of this section if—

(1) The income standard used under paragraph (b) of this section exceeds the maximum dollar amount on income allowed for purposes of FFP under § 435.1007; and

(2) The lower income standard at least equals the maximum amount allowed for purposes of FFP.

(d) In the case of an agency that provides Medicaid for the aged, blind, or disabled individuals only if they meet more restrictive requirements than used under SSI, the following provisions apply:

(1) The agency may use an income standard for those individuals that is lower than the standard specified in paragraph (b) of this section.

(2) The lower standard must at least equal the medically needy income standard for those aged, blind, or disabled individuals under the State's plan on January 1, 1972.

(e) If the agency uses a medically needy income standard not specified in paragraphs (b) through (d) of this section—

(1) That standard is not presumed to be reasonable; and

(2) HCFA must approve the standard.

27. Section 435.814 is revised to read as follows:

§ 435.814 Medically needy income standards: State plan requirements.

(a) The State plan must specify the income standard for each covered medically needy group.

(b) If the agency uses an income standard that is not presumed to be reasonable under § 435.812, the State plan must describe that standard.

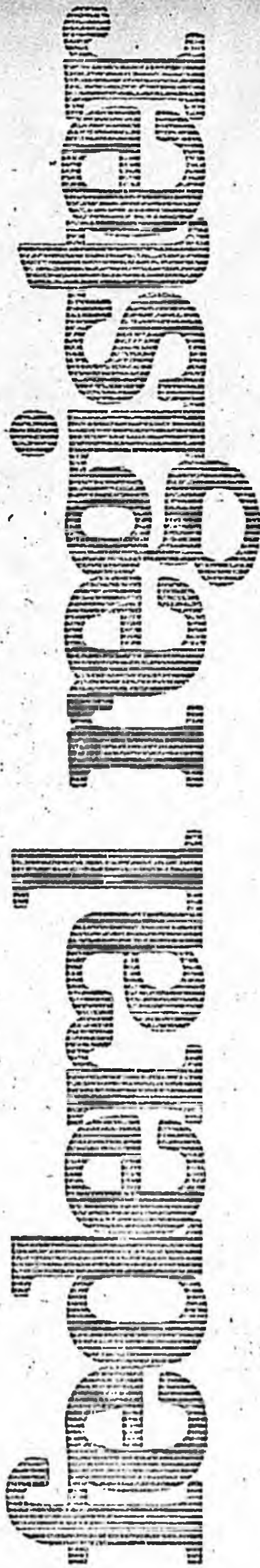
§ 435.816 [Removed]

28. Section 435.816 is removed.

29. Section 435.821 is revised to read as follows:

NOTE REGARDING THE FOLLOWING FRAME ON MICROFILM:

COMPLETE DOCUMENT IS AVAILABLE IN ORIGINAL FILES IN ALASKA STATE ARCHIVES. TITLE PAGE ONLY HAS BEEN FILMED.



Thursday
October 1, 1981

Part V

Department of Health and Human Services

Health Care Financing Administration

Medicaid Program; Home and Community-Based Services

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

M E M O R A N D U M

February 18, 1982

SUBJECT: Medical assistance for needy persons (Work Order No. 12-2419)

TO: Senator Charles H. Parr
Attn: Nancy Deitrick

FROM: Edward H. Hein
Legislative Counsel

Enclosed is the draft you requested for an act relating to medical assistance for needy persons. I drafted this bill after consulting with Dave Davidson of the Department of Health and Social Services. He assures me that this approach will achieve your intent, namely, expanding the number of persons for whom the federal government will pay some portion of additional medical assistance. Mr. Davidson, who will be out of town until approximately February 23rd, has not had the opportunity to review this draft. Thus, it should not be assumed that all the details of this draft would meet Mr. Davidson's approval. I have, however, tried to draft the bill in accordance with my understanding of his explanation of the law to me.

As a caveat, I should tell you that I am not well versed on the intricacies of federal benefit programs, such as medicaid, AFDC, and social security. I cannot personally explain with any degree of precision the legal implications of this draft. I have had to defer to Mr. Davidson's judgment.

A couple of points are worth mentioning. At Mr. Davidson's suggestion I have made the provisions dealing with medically needy persons a separate subsection of the bill. In an attempt to define the persons covered under (e) I have revised the labels for categories (e)(1) through (6) and have included a separate subsection (f) to define those terms where necessary. Note that subsection (f) relates only to subsection (e). You will need to determine, perhaps

through the department, whether the persons included in (e)(4), (5), and (6) are intended to be the same aged, blind, or disabled persons included in AS 47.07.020(b)(4).

EHH:ljb

Enclosure

By: Rod Betit 3/15/82
Rod Betit
Director, DPA
DHSS

SB 817 Reference	Medicaid/GRM Modifications	GRM Costs (State Funds Only)	Medicaid Costs (State Funds Only)	New Cases Covered
(Section 1)	* Move AFDC U.P. (Including Ribicoff Kids) to Medicaid BRU	(5076.6)	6377.6	3561
(Section 1)	* Add Pregnant Women to Medicaid	(155.3)	252.6	191
(Section 2)	* Cover APA & Certain Other Medically Needy Kids	---	1736.1	400
(Section 3)	* Move Certain Services from GRM to Medicaid	(1200.0)	900.0	-0-
	Net Savings and New Persons Added	(6431.9)	9266.3	4152

Other Medical Needs Not Addressed By SB 817

		GRM Costs	Medicaid Costs	New Cases Covered
a)	Cover travel costs dropped by AANHS	250.0	500.0	-0-
b)	Cover penalty assessment in Medicaid	---	1260.0	-0-
c)	Cover FY83 GR Medical shortfall	500.0	---	-0-
d)	Cover Medicare Part B for certain elderly	306.7	---	2130
e)	Raise GRM limits to Medicaid standard	---------- Not Known	----------	----------
f)	Cover AFDC medically needy adults except U.P.	---	3300.0	534
g)	Cover AFDC-U.P. medically needy adults	---------- Not Known	----------	----------

FISCAL NOTE SUMMARY

SENATE BILL NO. 817

	TOTAL NEW MEDICAID	NEW STATE	NEW FEDERAL	NEW POSITIONS
1.a. Addition of New Medicaid Eligibles: Transfer of Services	$17860.5	$ 6377.6	$11482.9	11
1.b. Addition of Pregnant Women as Medicaid Eligibles	467.6	252.6	215.0	0
2. Decrease in GRM Due to Transfer of Services and Eligibles		(5531.9)	0	0
3. Addition of Clinic Services under Medicaid	1500.0	0	1500.0	0
SUBTOTAL	$19828.1	$ 1098.3	$13197.9	11
4. Addition of New Medicaid Medically Needy Eligibles	3338.6	1736.1	1602.5	1
TOTAL	$23166.7	$ 2834.4	$14800.4	12

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Senate Bill 817
Title An Act relating to medical assistance for needy persons
Requested by Senate HESS Committee Date 3/15/82

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health/Social and Economic Assistance
BRU, Program, Or Subprogram(s) Affected Medicaid/Elig. Deter./PA Admin.
(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 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES		350.4	385.4	423.9	466.3	512.9
200 TRAVEL		12.8	14.1	15.5	17.0	18.7
300 CONTRACTUAL		132.5	145.7	160.3	176.3	193.9
400 COMMODITIES		6.5	7.1	7.8	8.6	9.5
500 EQUIPMENT		13.1	0	0	0	0
600 LAND & STRUCTURES		0	0	0	0	0
700 GRANTS, CLAIMS, ETC.		17812.8	20484.8	23557.6	27091.2	31154.9
TOTAL		18328.1	21037.1	24165.1	27759.4	31889.9

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		6630.2	7603.8	8730.0	10023.7	11509.8
FEDERAL FUNDS		11697.9	13433.3	15435.1	17735.7	20380.1
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME		11	11	11	11	11
PART TIME						
TEMPORARY						

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

IV. DATE ________ PREPARED BY ________
AGENCY ________
Ori nal: Legislative Finance PHONE ________
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33 01 (Rev. 12/81)

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

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Bill/Resolution No. Senate Bill 817
Title An Act relating to medical assistance for needy persons
Requested by Senate HESS Committee Date 3/15/82

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Agency Affected Department of Health and Social Services
Program Category Affected Health
BRU, Program, Or Subprogram(s) Affected Medicaid
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS,CLAIMS,ETC.		1500.0	1725.0	1983.7	2281.3	2623.5
TOTAL		1500.0	1725.0	1983.7	2281.3	2623.5

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		0	0	0	0	0
FEDERAL FUNDS		1500.0	1725.0	1983.7	2281.3	2623.5
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME						
PART TIME						
TEMPORARY						

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

IV. DATE ______ PREPARED BY ______
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Original: Legislative Finance PHONE ______
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

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Title An Act relating to medical assistance for needy persons
Requested by Senate HESS Committee Date 3/15/82

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health
BRU, Program, Or Subprogram(s) Affected General Relief Medical
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		(5531.9)	(6361.7)	(7316.0)	(8413.4)	(9150.7)
TOTAL		(5531.9)	(6361.7)	(7316.0)	(8413.4)	(9150.7)

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		(5531.9)	(6361.7)	(7316.0)	(8413.4)	(9150.7)
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME						
PART TIME						
TEMPORARY						

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

IV. DATE ______ PREPARED BY ______
AGENCY ______
Original: Legislative Finance PHONE ______
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
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II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health/Social and Economic Assistance
BRU, Program, Or Subprogram(s) Affected Medicaid/PA Admin/Elig. Deter.
(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 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES		35.0	38.5	42.3	46.5	51.1
200 TRAVEL		2.0	2.2	2.4	2.6	2.9
300 CONTRACTUAL		13.3	14.6	16.1	17.7	19.5
400 COMMODITIES		.6	.7	.8	.9	1.0
500 EQUIPMENT		1.3	0	0	0	0
600 LAND & STRUCTURES		0	0	0	0	0
700 GRANTS,CLAIMS,ETC.		3286.4	3779.4	4346.3	4998.2	5747.9
TOTAL		3338.6	3835.4	4407.9	5065.9	5822.4

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		1736.1	1994.4	2292.1	2634.3	3027.6
FEDERAL FUNDS		1602.5	1841.0	2115.8	2431.6	2794.8
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME		1	1	1	1	1
PART TIME						
TEMPORARY						

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

IV. DATE PREPARED BY
AGENCY
Original: Legislative Finance PHONE
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

Proposed Amendments to SB 698
BY THE ALASKA STATE HOSPITAL ASSOCIATION

March 15, 1982

1. Page 1, line 14 after "meet" insert "their fair share of".

This clarifies the fact that the Medicaid program will pay the full cost of care for its patients only.

2. Page 2, after line 12 insert "(E) Retirement of debt".

This is necessary to permit funding such items as balloon payments within a debt structure.

3. On page 2, line 20 strike "medical services".

This makes the sentence read properly.

4. On page 2, line 24 strike "approve or deny the proposed rates" and insert "shall establish the rates to be paid pursuant to Section 47.07.070".

This clarifies the purpose of the Commission and specifies that the rates established are the rates paid by the Medicaid and General Relief/Medical programs.

5. On page 6 strike line 21 and insert:

> "Section 9. The Medical Assistance Budget Review Commission shall begin its review of health facility budgets after it has adopted uniform accounting, budgeting, and reporting forms but it shall not review budgets sooner than is necessary to perform the function prescribed in Section 47.07.072 for budgets of facilities whose fiscal year begins on July 1, 1983."

This change in the effective date makes certain that the uniform systems are available so that review is consistent and specifies that the system should be in place beginning with the 1983 fiscal year.

6. On page 3 after line 16, add "Section 47.07.073 Uniform Budgeting, Accounting, and Reporting.

"(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 information 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 into consideration:

"(1) existing systems of accounting, budgeting, and reporting procedures 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 to the uniform system of accounting, budgeting, and financial reporting."

This clarifies the references to uniform budgeting and reporting referenced in Section .072 and clearly establishes a uniform process for prospective budgeting.

alaska state hospital association

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

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Tom Mingen
Fairbanks Memorial Hospital
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Trustee, Providence Hospital
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Alternate Trustee Delegate to American Hospital Association
Robert Jansen
Central Peninsula Hospital
Soldotna

President
Dennis L. DeWitt
Juneau

Position Paper

Senate Bill 698

The Alaska State Hospital Association requested the introduction of SB 698 and is pleased that the Senate Health, Education and Social Services Committee has chosen to make it a committee bill.

The Medicaid program in Alaska has suffered from its inception from a poor data base and an inability to accurately forecast its own financial needs. There have been many notions as to the cause of this problem. We believe that two major factors can be addressed this year. The first is the implementation of the Alaska Medicaid Payment System (AMPS) which will give the program better forecasting tools. We wish to discuss the latter issue more fully.

As a result of poor data, the legislature has severely underfunded the Medicaid and General Relief/Medical programs in this budget year and appears headed toward even more serious underfunding in the coming budget year. We, as an Association, reviewed these problems and decided that we must involve ourselves in the solution of this critical problem.

As the program now exists the legislature controls access and benefits and funding. In the current budget year, the legislature appropriated less funds than is necessary to fund the level of benefits and access which it has mandated in law. The Department of Health and Social Services was then told to continue to provide the same level of services with not enough money to do so. This of course causes a great deal of consternation within the Department and the provider community.

For hospitals and nursing homes, the prospect of the Medicaid program running out of funds is horrifying. Since we are reimbursed after the service is rendered, the costs incurred, there is no way that such a provider can protect himself from economic disaster. For most hospitals, it means going to the local property tax to bail out a failing state program. Like the Department, we are victims of the legislature's decisions on access and benefits.

We believe that the prospective system which we have proposed will help address this problem. We will negotiate our budgets prospectively and know our Medicaid rates before our fiscal year begins. You as a legislature will be privy to our <u>approved</u> budgets upon which the Department will base its budget requests. We believe that this major reorganization of the Medicaid payment system will enable more rational funding of the Medicaid program.

While many may suggest that this process will save the state many dollars, this Association is not prepared to jump on that bandwagon.

We believe the advantages of this system are in its organizational structure and prospective nature. That is, it will permit better decisions on a superior data base.

As we constructed this proposal, we established the following principles which permitted us to support such a major change in the reimbursement system.

1. It be limited in scope to the Medicaid and General Relief/Medical programs. These same programs which are of greatest interest to the legislature and while they are a major reimburser to many facilities, a failure of this experiment would not collapse the entire industry.

2. It must be statutory in nature with the principles of reimbursement in statute. This will protect the industry from regulators who may not understand nor much care about the financial viability of health facilities. Further, major changes in the reimbursement system would require legislative debate and could not be changed merely to force health facilities to fund the Department's deficits.

3. Small facilities should be reasonably expected to comply with the requirements of the program.

4. The Commission must be of high quality and independant of the payor agency.

5. There must be an appeals mechanism.

We believe that SB 698 accomplishes these objectives as well as offers the state a much needed management tool,

that of prospective data.

The Alaska State Hospital Association has labored over the interim to develop a reasonable prospective system for Medicaid. We believe that SB 698 is worthy of your favorable consideration.

We have, attached, several technical amendments which should be considered and are prepared to respond to any questions you may have.

Proposed Amendments to SB 698

1. Page 1, line 14 after "meet" insert "their fair share of". This clarifies the fact that the Medicaid program will pay the full cost of care for its patients only.

2. Page 2, after line 12 insert "(E) Retirement of debt". This is necessary to permit funding such items as balloon payments within a debt structure.

3. On page 2, line 20 strike "medical services". This makes the sentence read properly.

4. On page 2, line 24 strike "approve or deny the proposed rates" and insert "shall establish the rates to be paid persuant to Section 47.07.070". This clarifies the purpose of the Commission and specifies that the rates established are the rates paid by the Medicaid and General Relief/Medical programs.

BACKGROUND INFORMATION FOR FISCAL NOTES
ON SPONSOR SUBSTITUTE FOR HOUSE BILL 41

MEDICAID

Component/New Service Groups	FY 82 Request	New Categorically Needy Groups	New Medically Groups	Total with Categorically Needy	Total with all New Groups
Hospital	11,826.7	2,614.9	1,287.9	14,441.6	15,729.5
Physician	6,415.2	1,418.4	698.6	7,833.6	8,532.2
Other Services	1,759.6	389.1	191.6	2,148.7	2,340.3
EPSDT	3,455.5	2,315.2	1,140.3	5,770.7	6,911.0
Nursing Homes	21,521.0			21,521.0	21,521.0
Subtotal	44,978.0	6,737.6	3,318.4	51,715.6	55,034.0
Indian Health	7,239.1	4,850.2	2,388.9	12,089.3	14,479.2
Subtotal	52,217.1	11,587.8	5,707.3	63,804.9	69,513.2
New Other Serv.		2,323.0	1,144.1	2,323.0	3,467.1
New Dental Serv.		1,843.6	908.1	1,843.6	2,751.7
New Drug Serv.		2,138.6	1,053.4	2,138.6	3,192.0
Total	52,217.1	17,893.0	8,812.9	70,110.1	78,924.0

BACKGROUND INFORMATION FOR FISCAL NOTES
ON SPONSOR SUBSTITUTE FOR HOUSE BILL 41
(CONTINUED)

GENERAL RELIEF MEDICAL

Component	FY 82 Request	Fiscal Note	Total Remaining
Hospital	7,102.7	(2,343.9)	4,758.8
Physician	2,954.6	(975.0)	1,979.6
Other Services	2,600.4	(1,300.2)	1,300.2
Nursing Homes	305.9		305.9
Catastrophic	980.2		980.2
Residential	189.7		189.7
Total	14,133.5	(4,619.1)	9,514.4

CASELOAD ESTIMATES FOR FISCAL NOTES
ON SPONSOR SUBSTITUTE FOR HOUSE BILL 41

Program Category	Current Caseload	GRM Reduction	Categorically Needy	Medically Needy	Total with Categorically Needy	Total with all New Groups
AFDC	6665		3752	534	10,417	10,951
OAA	2421			193	2421	2614
AB/AD	2398			193	2398	2591
GRM	4464	(1607)			2857	2857
Total	15,948	(1607)	3752	920	18,093	19,013

4- Sec 3 SB 817
5- Sec 1 (9)
6- services
7- GRM limits raised.

— services to Medicaid
— add preg. women
— Sec 1 modified to same income level as GRM

By: Rod Betit 3/15/82

Rod Betit
Director, DPA
DHSS

SB 817 Reference	Medicaid/GRM Modifications	GRM Costs (State Funds Only)	Medicaid Costs (State Funds Only)	New Cases Covered
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	Net Savings and New Persons Added	(6431.9)	9266.3	4152

3/4 of cost for kids

Other Medical Needs Not Addressed By SB 817

medically necessary

		GRM Costs	Medicaid Costs	New Cases Covered
a) 1	Cover travel costs dropped by AANHS	250.0	500.0	-0-
b) 2	Cover penalty assessment in Medicaid	---	1260.0	-0-
c) 3	Cover FY83 GR Medical shortfall	500.0	---	-0-
d)	Cover Medicare Part B for certain elderly	306.7	---	2130
e)	Raise GRM limits to Medicaid standard	Not Known		
f)	Cover AFDC medically needy adults except U.P.	---	3300.0	534
g)	Cover AFDC-U.P. medically needy adults	Not Known		

gov's budget short for medicaid (b, c)

*12/per person/per month (d)

FISCAL NOTE SUMMARY

SENATE BILL NO. 817

	TOTAL NEW MEDICAID	NEW STATE	NEW FEDERAL	NEW POSITIONS
1.a. Addition of New Medicaid Eligibles; Transfer of Services	$17860.5	$ 6377.6	$11482.9	11
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3. Addition of Clinic Services under Medicaid	1500.0	0	1500.0	0
SUBTOTAL	$19828.1	$ 1098.3	$13197.9	11
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TWELFTH LEGISLATURE

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Bill/Resolution No. Senate Bill 817
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Requested by Senate HESS Committee Date 3/15/82

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Agency Affected Department of Health and Social Services
Program Category Affected Health/Social and Economic Assistance
BRU, Program, Or Subprogram(s) Affected Medicaid/Elig. Deter./PA Admin.
(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 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES		350.4	385.4	423.9	466.3	512.9
200 TRAVEL		12.8	14.1	15.5	17.0	18.7
300 CONTRACTUAL		132.5	145.7	160.3	176.3	193.9
400 COMMODITIES		6.5	7.1	7.8	8.6	9.5
500 EQUIPMENT		13.1	0	0	0	0
600 LAND & STRUCTURES		0	0	0	0	0
700 GRANTS, CLAIMS, ETC.		17812.8	20484.8	23557.6	27091.2	31154.9
TOTAL		18328.1	21037.1	24165.1	27759.4	31889.9

FUNDING (Thousands of Dollars) Kids & AFDC UP.

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		6630.2	7603.8	8730.0	10023.7	11509.8
FEDERAL FUNDS		11697.9	13433.3	15435.1	17735.7	20380.1
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME		11	11	11	11	11
PART TIME						
TEMPORARY						

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

IV. DATE ______ PREPARED BY ______
AGENCY ______
Original: Legislative Finance PHONE ______
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Senate Bill 817
Title An Act relating to medical assistance for needy persons
Requested by Senate HESS Committee Date 3/15/82

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health
BRU, Program, Or Subprogram(s) Affected Medicaid
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS,CLAIMS,ETC.		1500.0	1725.0	1983.7	2281.3	2623.5
TOTAL		1500.0	1725.0	1983.7	2281.3	2623.5

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		0	0	0	0	0
FEDERAL FUNDS		1500.0	1725.0	1983.7	2281.3	2623.5
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME						
PART TIME						
TEMPORARY						

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

IV. DATE PREPARED BY
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THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

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II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health
BRU, Program, Or Subprogram(s) Affected General Relief Medical
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars) GRM

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		(5531.9)	(6361.7)	(7316.0)	(8413.4)	(9150.7)
TOTAL		(5531.9)	(6361.7)	(7316.0)	(8413.4)	(9150.7)

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		(5531.9)	(6361.7)	(7316.0)	(8413.4)	(9150.7)
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME						
PART TIME						
TEMPORARY						

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

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TWELFTH LEGISLATURE

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Program Category Affected Health/Social and Economic Assistance
BRU, Program, Or Subprogram(s) Affected Medicaid/PA Admin/Elig. Deter.
(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 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES		35.0	38.5	42.3	46.5	51.1
200 TRAVEL		2.0	2.2	2.4	2.6	2.9
300 CONTRACTUAL		13.3	14.6	16.1	17.7	19.5
400 COMMODITIES		.6	.7	.8	.9	1.0
500 EQUIPMENT		1.3	0	0	0	0
600 LAND & STRUCTURES		0	0	0	0	0
700 GRANTS, CLAIMS, ETC.		3286.4	3779.4	4346.3	4998.2	5747.9
TOTAL		3338.6	3835.4	4407.9	5065.9	5822.4

FUNDING (Thousands of Dollars)

medically needy

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		1736.1	1994.4	2292.1	2634.3	3027.6
FEDERAL FUNDS		1602.5	1841.0	2115.8	2431.6	2794.8
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME		1	1	1	1	1
PART TIME						
TEMPORARY						

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

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LEGISLATIVE INTENT:

To implement changes in coverage caused by passage of SB 817, the Department has the authority to transfer funds between components as needed to cover new categories of service and groups of eligibles under the Medicaid program, to reduce the scope of the General Relief Medical program, and to make up the Medicaid penalty.

LEGISLATIVE INTENT:

The Department has the authority to transfer funds from the Medical Assistance BRU to the Eligibility Determination BRU to provide funding for up to 7 new field positions when they are needed to determine eligibility for new Medicaid eligibles under SB 817.

DG-58 3/22/82

ATTACHMENT A

PROPOSED FY 83 MEDICAL ASSISTANCE
BUDGET REQUEST UNIT IMPLEMENTING SB 817

BUDGET COMPONENT	FY 83 GOVERNOR'S REQUEST			SB 817 ADDITIONS			REVISED FY 83 BUDGET			RECALCULATION FOR 52/48%		
	GF	FED	TOTAL	SFG	FF	TOTAL	SFG	FF	TOTAL	SFT	FF	TOTAL
MEDICAID												
Hosp.	6163.9	6163.9	12327.8							8022.2	7405.2	15427.4
Phy. Svcs	3929.1	3929.0	7858.1							5098.2	4706.1	9804.3
Other Svcs	816.7	878.8	1695.5							3762.0	3477.8	7239.8
EPSDT	1376.0	1375.9	2751.9							1805.8	1666.9	3472.7
SUBTOTAL	12285.7	12347.6	24633.3	5878.8	5432.1	11310.9	18164.5	17779.7	35944.2	18688.2	17256.0	35944.2
Nursing Homes	10915.7	10915.6	21831.3	0.0	0.0	0.0	10915.7	10915.6	21831.3	11352.3	10479.0	21831.3
SUBTOTAL	35487.1	35610.8	71097.9	5878.8	5432.1	11310.9	29080.2	28695.3	57775.5	30040.5	27735.0	57775.5
IHS	0.0	5450.0	5450.0	0.0	4846.6	4846.6	0.0	10296.6	10296.6	0.0	10296.6	10296.6
SUBTOTAL	70974.20	76671.60	147645.80	5878.8	10278.7	16157.5	29080.2	38991.9	68072.1	30040.5	38031.6	68072.1
Med. Penalty	<47.4>	<1307.8>	<1355.2>	1007.7	347.7	1355.2	960.3	<960.3>	0.0	0.0	0.0	0.0
MEDICAID TOTAL	23154.0	27405.4	50559.4	6886.5	10626.2	17512.7	30040.5	38031.6	68072.1	30040.5	38031.6	68072.1
GEN. REL. MED												
CIP	2158.4	0.0	2158.4	0.0	0.0	0.0	2158.4	0.0	2158.4	2158.4	0.0	2158.4
GRM	10019.9	0.0	10019.9	<6886.5>	0.0	<6886.5>	3133.4	0.0	3133.4	3133.4	0.0	3133.4
SUBTOTAL	12178.3	0.0	12178.2	<6886.5>	0.0	<6886.5>	5291.8	0.0	5291.8	5291.8	0.0	5291.8
GRM Reduction	<575.3>	0.0	<575.3>	0.0	0.0	0.0	<575.3>	0.0	<575.3>	<575.3>	0.0	<575.3>
ALL GRM TOTAL	11603.0	0.0	11603.0	<6886.5>	0.0	<6886.5>	4716.5	0.0	4716.5	4716.5	0.0	4716.5
TOTAL SERVICES	34757.0	27405.4	62162.4	0.0	10626.2	10626.2	34757.0	38031.6	72788.6	34757.0	38031.6	72788.6
ELEG. DETER.												
GRM Total				2558.1	0.0	2558.1	2558.1	0.0	2558.1			
Less Admin. Costs				<150.7>	0.0	<160.7>	<160.7>	0.0	<160.7>	2397.4	0.0	2397.4
GRM Rinal Total				2397.4	0.0	2397.4	2397.4	0.0	2397.4	160.7	148.5	309.2
Elig. Deter. Total												

ATTACHMENT C

MEDICAID/GRM EVALUATION WORKSHEET

MEDICAID

Eligibility Groups

CATEGORICALLY NEEDY

- # AFDC cash household
- # SSI cash household
- 1 APA cash household
- 2 300% institutional
- 3 DHSS foster children
- 4 API under 21 class
- 5 ICF/MR under 21 class
- * Pregnant women
- * Non-AFDC children
- * Noninstitutional 300%
- * AFDC-UP household
- * Caretaker relatives

MEDICALLY NEEDY

- * Non-AFDC children
- * Pregnant women
- * DHSS foster children
- * APA-type adults
- * AFDC-type household
- * AFDC-UP-type household
- * Caretaker relatives

Service Categories

FED MANDATORY

- $ Hospital
- $ Physician
- $ Skilled nursing
- $ Lab and X-ray
- $ Medical trans
- $ Home health care
- $ EPSDT/incl dental
- $ Family planning
- $ Rural hlth clinic

FED OPTIONAL

- 1 Intermed nursing
- 2 Prescribed drugs
- 3 Eye care/glasses
- 4 Speech, hearing
- 5 PT/OT
- 6 ICF/MR
- 7 Psych facility
- Clinic services:
  - 8 Mental health
  - * Birthing ctrs
  - * Physician (IHS)
- 9 Surgical care ctrs
- 10 Nurse midwife
- 11 Med supplies & eqpt
- * Noninstl LTC
- * Personal care
- * Podiatrist
- * Dentures
- * Dental
- * Chiropractic
- * Diag, rehab, etc
- * Pvt duty nursing
- * Physician assts
- * Pvt psychologists
- * Nurse practitioners

Rate Schemes

- ¢ Raise/lower APA
- ¢ Raise/lower AFDC
- Hospital rates
- LTC rates
- Raise/lower phys pymt
- Raise/lower others
- Limit access to svcs
- Prior auth of IP svcs
- Prior auth of OP svcs
- Limit IP svcs to emgcy
- Limit OP svcs to emgcy
- Copymt on opt svcs
- Copymt on mand svcs

GENERAL RELIEF MEDICAL

Eligibility Groups

1. AFDC-UP children
2. Single employables
3. Employable couples

Service Categories

1. Hospital
2. Physician
3. Prescribed drugs
4. Lab and X-ray
5. PT/OT
6. Medical trans
7. Emergency dental
8. Med supplies & eqpt
9. Eye care/glasses
10. Family planning
11. Abortions
12. Surgical care ctrs
13. Speech, hearing
14. Skilled nursing
15. Intermed nursing

Rate Schemes

- Raise/lower standards
- Raise/lower resources
- Hospital rates
- LTC rates
- Raise/lower phys pymt
- Raise/lower pymt--other
- Limit access to svcs
- Prior auth of IP svcs
- Prior auth of OP svcs
- Limit IP svcs to emgcy
- Limit OP svcs to emgcy

*--Not covered under Alaska Medicaid program
#--Federally-mandated groups of eligibles--not ranked
$--Federally-mandated categories of service--not ranked
¢--Payment rates established by Alaska Legislature
Columns with numbers are ranked from most important to least important--no rankings are indicated for changes in rate schemes

alaska
state
hospital
association

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

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Anchorage

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American Hospital Assoc.
Moe Kadish
Trustee, Providence
Hospital
Anchorage

Alternate Trustee Delegate
to American Hospital
Association
Robert Jensen
Central Peninsula Hospital
Soldotna

President
Dennis L. DeWitt
Juneau

March 29, 1982

The Honorable Charles H. Parr
Alaska State Senate
Pouch V, State Capitol Building
Juneau, Alaska 99811

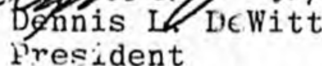
Dear Senator Parr:

The Alaska State Hospital Association wishes to encourage your consideration of the amendments that the Department of Health and Social Services has proposed to Senate Bill 817.

This Association has long advocated an overhaul of the relationship of Medicaid and General/Relief Medical to maximize federal financial participation and increase Alaska's ability to offer health care to its needy residents. The proposal by the Department of Health and Social Services is a bold and forthright step in recognizing the importance of prudent fiscal approach to providing health care. We believe that it is imperative that the legislature make those changes needed to maximize federal financial participation in indigent health care in Alaska before it adjourns the Second Session of the Twelfth Legislature.

We stand ready to lend our assistance to this activity.

Sincerely,



Dennis L. DeWitt
President

DLD:bf
cc: Friday Mailing
Governor Hammond
Lt. Governor Miller
Commissioner Beirne
Members Senate HESS

By: Rod Betit 3/15/82
Rod Betit
Director, DPA
DHSS

SB 817 Reference	Medicaid/GRM Modifications	State Funds Only: GRM Costs	State Funds Only: Medicaid Costs	New Cases Covered
(Section 1)	* Move AFDC U.P. (Including Ribicoff Kids) to Medicaid BRU	(5076.6)	6377.6	3561
(Section 1)	* Add Pregnant Women to Medicaid	(155.3)	252.6	191
(Section 2)	* Cover APA & Certain Other Medically Needy Kids	---	1736.1	400
(Section 3)	* Move Certain Services from GRM to Medicaid	(1200.0)	900.0	-0-
	Net Savings and New Persons Added	(6431.9)	9266.3	4152
	Other Medical Needs Not Addressed By SB 817			
	a) Cover travel costs dropped by AANHS	250.0	500.0	-0-
	b) Cover penalty assessment in Medicaid	---	1260.0	-0-
	c) Cover FY83 GR Medical shortfall	500.0	---	-0-
	d) Cover Medicare Part B for certain elderly	306.7	---	2130
	e) Raise GRM limits to Medicaid standard	----------	Not Known	--------------
	f) Cover AFDC medically needy adults except U.P.	---	3300.0	534
	g) Cover AFDC-U.P. medically needy adults	----------	Not Known	--------------

FISCAL NOTE SUMMARY

SENATE BILL NO. 817

	TOTAL NEW MEDICAID	NEW STATE	NEW FEDERAL	NEW POSITIONS
1.a. Addition of New Medicaid Eligibles; Transfer of Services	$17860.5	$ 6377.6	$11482.9	11
1.b. Addition of Pregnant Women as Medicaid Eligibles	467.6	252.6	215.0	0
2. Decrease in GRM Due to Transfer of Services and Eligibles		(5531.9)	0	0
3. Addition of Clinic Services under Medicaid	1500.0	0	1500.0	0
SUBTOTAL	$19828.1	$ 1098.3	$13197.9	11
4. Addition of New Medicaid Medically Needy Eligibles	3338.[illegible]	1736.1	1602.5	1
TOTAL	$23166.7	$ 2834.4	$14800.4	12

THE LEGISLATURE OF THE STATE OF ALASKA
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OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME		11	11	11	11	11
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Agency Affected Department of Health and Social Services

Program Category Affected Health

BRU, Program, Or Subprogram(s) Affected Medicaid

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

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
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POSITIONS

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EXPENDITURES (Thousands of Dollars)

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FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

FULL TIME						
PART TIME						
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400 COMMODITIES		.6	.7	.8	.9	1.0
500 EQUIPMENT		1.3	0	0	0	0
600 LAND & STRUCTURES		0	0	0	0	0
700 GRANTS,CLAIMS,ETC.		3286.4	3779.4	4346.3	4998.2	5747.9
TOTAL		3338.6	3835.4	4407.9	5065.9	5822.4

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	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		1736.1	1994.4	2292.1	2634.3	3027.6
FEDERAL FUNDS		1602.5	1841.0	2115.8	2431.6	2794.8
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME		1	1	1	1	1
PART TIME						
TEMPORARY						

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

IV. DATE _____ PREPARED BY _____
AGENCY _____
Original: Legislative Finance PHONE _____
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Senate Bill 817
Title An Act relating to medical assistance for needy persons
Requested by Senate HESS Committee Date 3/19/82

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health
BRU, Program, Or Subprogram(s) Affected General Relief Medical
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		(11603.0)	(13330.9)	(15321.9)	(17610.9)	(20241.9)
TOTAL		(11603.0)	(13330.9)	(15321.9)	(17610.9)	(20241.9)

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		(11603.0)	(13330.9)	(15321.9)	(17610.9)	(20241.9)
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME						
PART TIME						
TEMPORARY						

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

Entire General Relief Medical budget transferred to new budget request unit titled "Medical Assistance" and to the Eligibility Determination budget request unit to provide funding for administrative costs associated with the addition of new eligibles to the Medicaid program.

IV. DATE 3/22/82 PREPARED BY David M. Davidson
AGENCY Division of Public Assistance
PHONE 465-3347

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Senate Bill 817
Title An Act relating to medical assistance for needy persons
Requested by Senate HESS Committee Date 3/19/82

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health
BRU, Program, Or Subprogram(s) Affected Medicaid*
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS,CLAIMS,ETC.		22068.5	25378.7	29185.5	33563.4	38597.9
TOTAL		22068.5	25378.7	29185.5	33563.4	38597.9

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		11442.3	13158.6	15132.4	17402.3	20012.6
FEDERAL FUNDS		10626.2	12220.1	14053.1	16161.1	18585.3
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME						
PART TIME						
TEMPORARY						

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

Transfer of State General Funds from General Relief Medical budget request unit and claiming of federal matching funds.

*The Medicaid budget request unit will be changed to the "Medical Assistance" budget request unit to reflect inclusion of Medicaid and General Relief Medical in one budget request unit.

IV. DATE 3/22/82 PREPARED BY David M. Davidson
AGENCY Division of Public Assistance
PHONE 465-3347

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. Senate Bill 817
Title An Act relating to medical assistance for needy persons
Requested by Senate HESS Committee Date 3/19/82

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Social and Economic Assistance
BRU, Program, Or Subprogram(s) Affected Eligibility Determination
(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 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES		210.2	231.2	254.3	279.8	307.7
200 TRAVEL		7.7	8.5	9.3	10.3	11.3
300 CONTRACTUAL		79.5	87.4	96.1	105.8	116.3
400 COMMODITIES		3.9	4.3	4.7	5.2	5.7
500 EQUIPMENT		7.9				
600 LAND & STRUCTURES						
700 GRANTS,CLAIMS,ETC.						
TOTAL		309.2	331.4	364.4	401.1	441.0

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		160.7	172.3	189.5	208.6	229.3
FEDERAL FUNDS		148.5	159.1	174.9	192.5	211.7
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME		6	6	6	6	6
PART TIME						
TEMPORARY						

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

State General Funds transferred from General Relief Medical budget request unit to Eligibility Determination to provide funding for administrative costs associated with the addition of new eligibles to the Medicaid program.

IV. DATE 3/19/82 PREPARED BY David M. Davidson
AGENCY Division of Public Assistance
PHONE 465-3347

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

MEDICAID/GRM EVALUATION WORKSHEET

MEDICAID

Eligibility Groups

	CATEGORICALLY NEEDY
#	AFDC cash household
#	SSI cash household
1	APA cash household
2	300% institutional
3	DHSS foster children
4	API under 21 class
5	ICF/MR under 21 class
*	Pregnant women
*	Non-AFDC children
*	Noninstitutional 300%
*	AFDC-UP household
*	Caretaker relatives

	MEDICALLY NEEDY
*	Non-AFDC children
*	Pregnant women
*	DHSS foster children
*	APA-type adults
*	AFDC-type household
*	AFDC-UP-type household
*	Caretaker relatives

Service Categories

	FED MANDATORY
$	Hospital
$	Physician
$	Skilled nursing
$	Lab and X-ray
$	Medical trans
$	Home health care
$	EPSDT/incl dental
$	Family planning
$	Rural hlth clinic

	FED OPTIONAL
1	Intermed nursing
2	Prescribed drugs
3	Eye care/glasses
4	Speech, hearing
5	PT/OT
6	ICF/MR
7	Psych facility
	Clinic services:
8	Mental health
*	Birthing ctrs
*	Physician (IHS)
9	Surgical care ctrs
10	Nurse midwife
11	Med supplies & eqpt
*	Noninstl LTC
*	Personal care
*	Podiatrist
*	Dentures
*	Dental
*	Chiropractic
*	Diag, rehab, etc
*	Pvt duty nursing
*	Physician assts
*	Pvt psychologists
*	Nurse practitioners

Rate Schemes

¢	Raise/lower APA
¢	Raise/lower AFDC
	Hospital rates
	LTC rates
	Raise/lower phys pymt
	Raise/lower others
	Limit access to svcs
	Prior auth of IP svcs
	Prior auth of OP svcs
	Limit IP svcs to emgcy
	Limit OP svcs to emgcy
	Copymt on opt svcs
	Copymt on mand svcs

GENERAL RELIEF MEDICAL

Eligibility Groups

1	AFDC-UP children
2	Single employables
3	Employable couples

Service Categories

1	Hospital
2	Physician
3	Prescribed drugs
4	Lab and X-ray
5	PT/OT
6	Medical trans
7	Emergency dental
8	Med supplies & eqpt
9	Eye care/glasses
10	Family planning
11	Abortions
12	Surgical care ctrs
13	Speech, hearing
14	Skilled nursing
15	Intermed nursing

Rate Schemes

Raise/lower standards
Raise/lower resources
Hospital rates
LTC rates
Raise/lower phys pymt
Raise/lower pymt--other
Limit access to svcs
Prior auth of IP svcs
Prior auth of OP svcs
Limit IP svcs to emgcy
Limit OP svcs to emgcy

*--Not covered under Alaska Medicaid program
#--Federally-mandated groups of eligibles--not ranked
$--Federally-mandated categories of service--not ranked
¢--Payment rates established by Alaska Legislature
Columns with numbers are ranked from most important to least important--no rankings are indicated for changes in rate schemes

ATTACHMENT C

MEDICAID/GENERAL RELIEF MEDICAL
FISCAL AND PROGRAM ADJUSTMENTS--FY 83

TOTAL MEDICAID	STATE FUNDS	FEDERAL FUNDS	DESCRIPTION OF PROGRAM CHANGE	GEN RELIEF MEDICAL	NEW PERSONS COVERED
$50559.4	$23154.0	$27405.4	FY 83 Budget Request after reductions	$11603.0	
			Deduction for Catastrophic Illness	(2158.4)	
50559.4	23154.0	27405.4		9444.6	
3102.6	1613.4	1489.2	Transfer of services from GRM to Medicaid (increase GRM amount by 50% for potential crossover)	(1613.4)	
53662.0	24767.4	28894.6		7831.2	
467.6	243.2	224.4	Addition of coverage for pregnant women	(243.2)	191
54129.6	25010.6	29119.0		7588.0	
1500.0		1500.0	Addition of IHS clinic services		
55629.6	25010.6	30619.0		7588.0	
6520.5	3390.7	3129.8	Addition of matchable children	(3390.7)	700
62150.1	28401.3	33748.8		4197.3	
3346.6		3346.6	Addition of 100% federal match children		3300
65496.7	28401.3	37095.4		4197.3	
220.2	111.5	108.7	GRM savings from Alaska participation in Medicare Part B buy-in	(111.5)	
65716.9	28512.8	37204.1		4085.8	
1355.2	1007.7	347.5	Elimination of Medicaid penalty caused by change in rate of federal funding	(1007.7)	
67072.1	29520.5	37551.6		3078.1	
1000.0	520.0	480.0	Medicaid trans due to IHS funding cuts	(520.0)	
68072.1	30040.5	38031.6		2558.1	
309.2	160.7	148.5	Admin costs of adding children	(160.7)	
68381.3	30201.2	38180.1	Balance after adjustments	2397.4	

ATTACHMENT B

7 AAC 43.005(c) is amended to read:

(c) Payment will be available through the General Relief Medical program, 7 AAC 47, for medicaid beneficiaries for the medical services and supplies listed below when those services are not otherwise available under the medicaid program

(1) repealed 5/17/82;

(2) family planning services;

(3) prescribed pharmaceuticals;

(4) repealed 5/17/82;

(5) repealed 5/17/82;

(6) emergency medical services as defined in 7 AAC 47.900(18). Eff. 8/18/79, Reg. 71; am 5/17/82, Reg. 82)

Authority: AS 47.05.010
AS 47.07.030
AS 47.07.050

7 AAC 47.030. APPLICATION EXCEPTION. Repealed 5/17/82.

7 AAC 47.050 is amended to read:

7 AAC 47.050. ELIGIBILITY DECISION. The division will render an eligibility decision upon each identifiable application for assistance and will forward to the applicant a written notice-of-eligibility decision no later than 60 days from the receipt of the application by a district office. In this section, "identifiable" application means one which contains at least the applicant's name, mailing address, and signature or witness mark. In order for assistance to be granted, the applicant must complete all portions of the application. (Eff. 3/23/78, Reg. 65; am 5/17/82, Reg. 82)

Authority: AS 47.05.010
AS 47.25.170

7 AAC 47.060. PERIOD OF ELIGIBILITY. Repealed 5/17/82.

7 AAC 47.070 is amended to read:

7 AAC 47.070. AVAILABILITY OF HEARING. Any applicant or recipient whose application is not acted upon within 60 days after receipt, whose application is modified or denied, or whose assistance is reduced or discontinued, shall, upon presentation of an oral or written request to any employee of the division, be granted an opportunity for a prompt hearing before a representative of the division. This hearing must be conducted under the procedures established by 7 AAC 49. (Eff. 3/23/78, Reg. 65; am 5/17/82, Reg. 82)

Authority: AS 47.05.010
AS 47.25.180

deleted: GRM may pay for services in month before application.

7 AAC 47.110 is amended to read:

7 AAC 47.110. VENDOR PAYMENTS. With the exception of the payments authorized under 7 AAC 47.120 of this chapter, General Relief payments for rent, food, fuel, clothing, utilities, house repair, transportation, or funeral and burial expenses, as well as all General Relief Medical assistance payments, may be made only to the vendor or provider and not to the recipient of assistance. No General Relief vendor payments may be made for services or goods provided before the month of application. (Eff. 3/23/78, Reg. 65; am 5/17/82, Reg. 82)

Authority: AS 47.05.010
AS 47.25.170

written cert. to recipient of GRM Eligib.

7 AAC 47.180. PROVISION OF MEDICAL BENEFITS. Repealed 5/17/82.

7 AAC 47.200 is amended to read:

deleted list of 14 services emerg. only

7 AAC 47.200. GENERAL RELIEF MEDICAL COVERAGE. (a) The General Relief Medical program provides payment on behalf of persons eligible under this chapter for emergency medical services.

(b) The General Relief Medical program provides payment on behalf of persons eligible under 7 AAC 43 for the services set out in 7 AAC 43.005(c). (Eff. 3/23/78, Reg. 65; am 5/2/79, Reg. 70; am 5/17/82, Reg. 82)

Authority: AS 47.05.010
AS 47.25.120

7 AAC 47.210 is amended to read:

7 AAC 47.210. EXCLUSIONS FROM GENERAL RELIEF MEDICAL PROGRAM. Payment will not be made for more than 30 days of hospitalization, skilled nursing care, or both, during any single illness or injury regardless of the need for continued care.(Eff. 3/23/78, Reg. 65; am 5/2/79, Reg. 70; am 5/17/82, Reg. 82)

Authority: AS 47.05.010
AS 47.25.120

7 AAC 47.220. RESPONSIBILITY OF RECIPIENT. Repealed 5/17/82.

7 AAC 47.900 is amended to read:

7 AAC 47.900. DEFINITIONS. In this chapter

(1) "central office" means the Juneau office of the division of public assistance;

(2) "district office" means one of the local offices of the division of public assistance which is staffed to accept applications for cash, food, medical and adult residential care assistance;

(3) "division" means the division of public assistance of the Department of Health and Social Services;

(4) repealed 5/17/82;

(5) repealed 5/17/82;

(6) "provider" means a person, business, or private or public agency or institution which offers goods or services of a medical, dental or pharmaceutical nature to the public;

(7) "regional manager" means an employee of the division of public assistance who has direct administrative responsibility for the operation of district offices within his geographic region of the state;

(8) "APA" means the Adult Public Assistance program administered by the division of public assistance under 42 USC 601 - 611 and AS 47.25.310 - 47.25.420;

(9) "Alaska longevity bonus" means the cash benefit program administered by the Department of Administration under AS 47.45.010 - 47.45.170;

(10) "department" means the Department of Health and Social Services;

(11) "division of mental health and developmental disabilities" means the division of mental health and developmental disabilities of the Department of Health and Social Services;

(12) "division of public assistance" means the division of public assistance in the Department of Health and Social Services.

(13) "division of social services" means the division of social services of the Department of Health and Social Services;

(14) "division of vocational rehabilitation" means the division of vocational rehabilitation of the department of education;

(15) "general relief medical" means the medical assistance program administered by the division of public assistance under AS 47.25.120 - 47.25.300;

(16) "medicaid" means the medical assistance program administered by the division of public assistance under 42 USC 1396 - 1396k and AS 47.07.010 - 47.07.080;

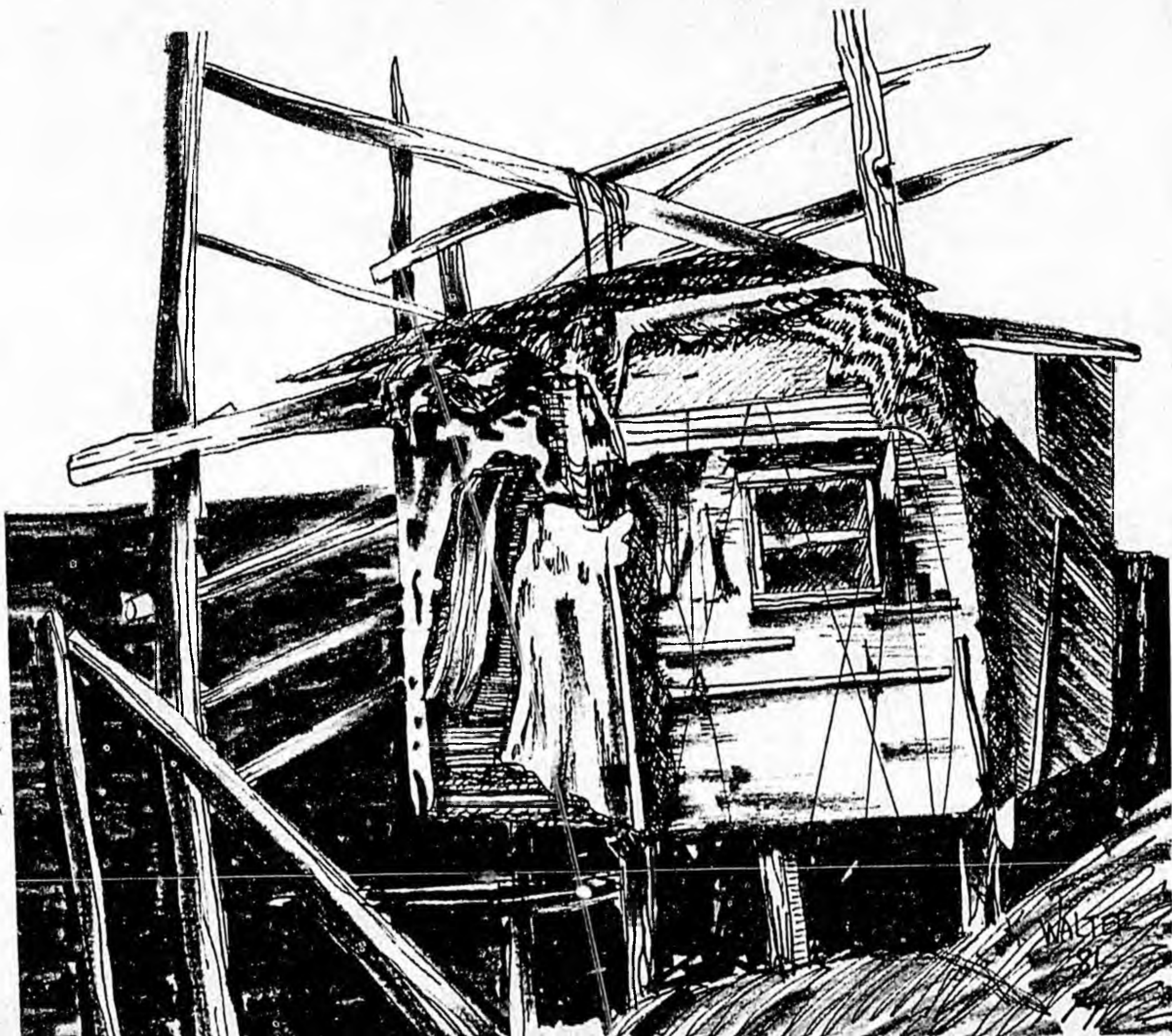
(17) "SSI" means the Supplemental Security Income program administered by the federal government under 42 USC 1381 - 1383c;

(18)"emergency medical services" means medical and dental services and supplies which are necessary to prevent death or serious health impairment and which, because of the threat to life or health, necessitate immediate action. (Eff. 3/23/78, Reg. 65; am 11/23/80, Reg. 76; am 5/17/82, Reg. 82)

Authority: AS 47.05.010
AS 47.25.120

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 regulations which limit program services such as:

a. Require prior authorization of all non emergency hospital 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 such as:

a. Establish fee schedule for Laboratory and X-Ray services;

b. Establish recipient co-payment requirements for optional 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 or 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.

GRM expenditures, 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.

GRM Other Services, 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

BRU/Component	1 FY81 Authorized	2 2-8-82 FY81 CRT.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
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

...penditures - Projection
...icaid & General Relief Medical
...Y 1982

...U/Component	1 FY81 Authorized	2 2-8-82 FY81 CRT.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

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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,
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Gail McGuill
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William Doolittle, M.D.
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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
Prior authorization
Claims screening
Exception claims processing/inquiry
Professional claims review
Master file maintenance
Data entry/microfilm
Programming and systems support
Computer operations
Provider payments
Surveillance and utilization
Provider and recipient relations
Provider manuals and bulletins and claims form
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	360	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	6072	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	3695	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

	FY	CSC TITLE.XIX	LONG TERM CARE 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.	607,285.	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.	96,096.	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 thus data 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

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	684.	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.	17,588.	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.	4,137.	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

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	80	100	79	71	67	45	28	26	28	31	34	45	31
	81	30	27	20	30	47	61	21	15	48	20	26	20
DATE OF SERVICE TO DATE OF ADJUDICATION	80	205	194	173	141	123	124	113	107	101	99	102	85
	81	82	81	72	97	125	130	83	89	111	81	100	86

FIGURE I

RECIPIENTS BY CATEGORY OF ASSISTANCE

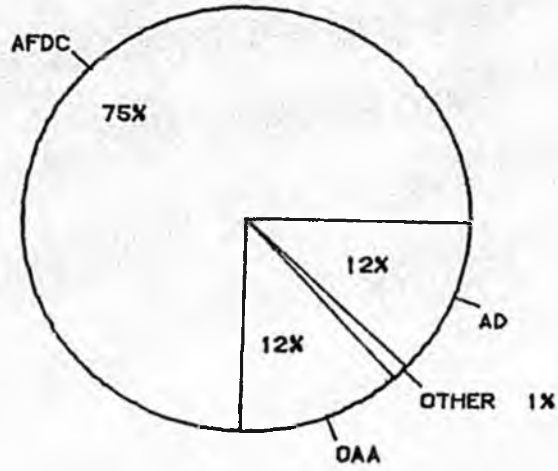


FIGURE II

MEDICAID BENEFICIARIES (AVERAGE MONTH)

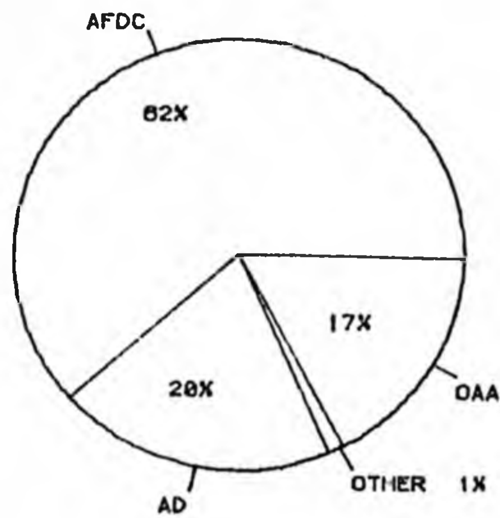


FIGURE III

MEDICAID EXPENDITURE BY CATEGORICAL GROUP

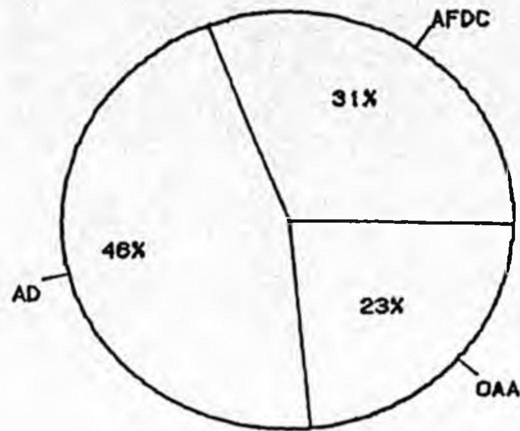
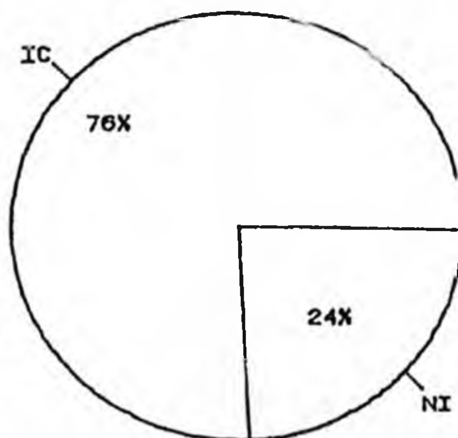


FIGURE IV

MEDICAID EXPENDITURES

INSTITUTIONAL VS NON INSTITUTIONAL CARE



NI=NON INSTITUTIONAL CARE
IC=INSTITUTIONAL CARE

FIGURE V

% MEDICAID EXPENDITURES

TO INSTITUTIONS

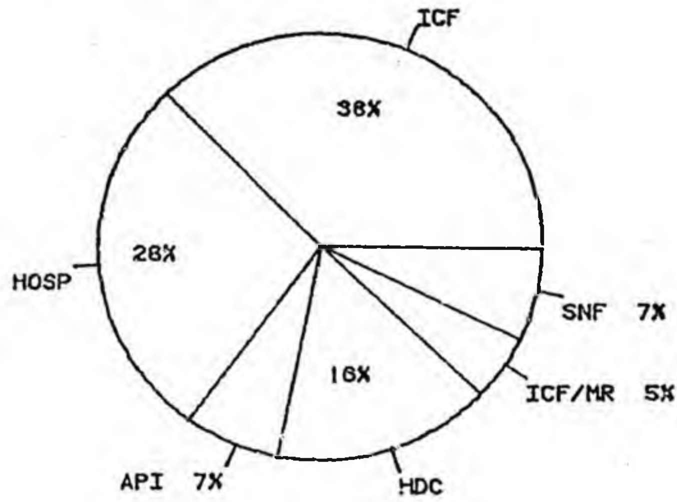
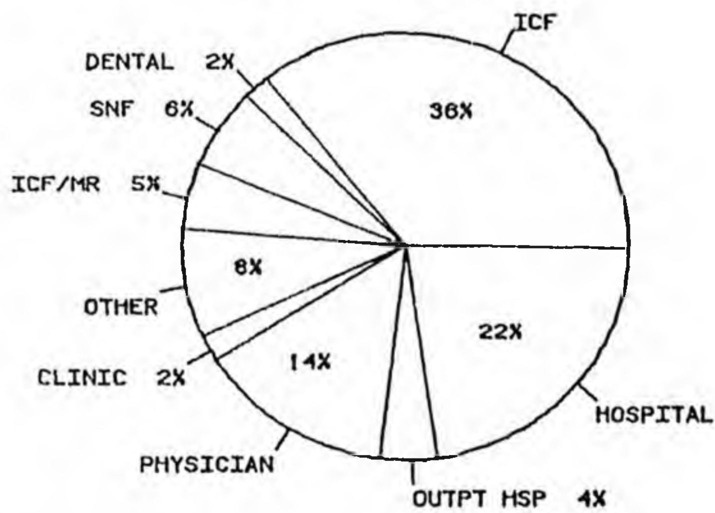


FIGURE VI

MEDICAID EXPENDITURE

BY SERVICE GROUP *



* DOES NOT INCLUDE API OR HDC

FIGURE VII

ICF * SNF PATIENT MIX

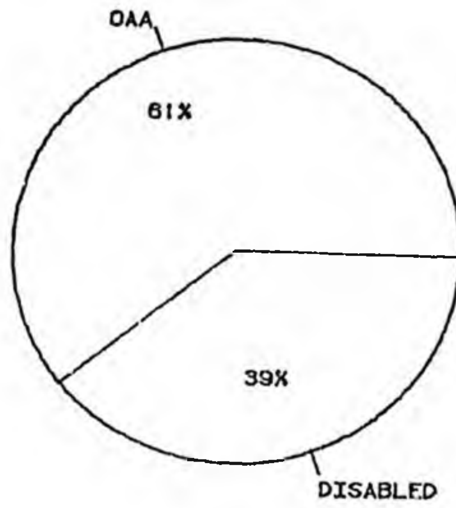


FIGURE VIII

SNF EXPENDITURE BY CATEGORY

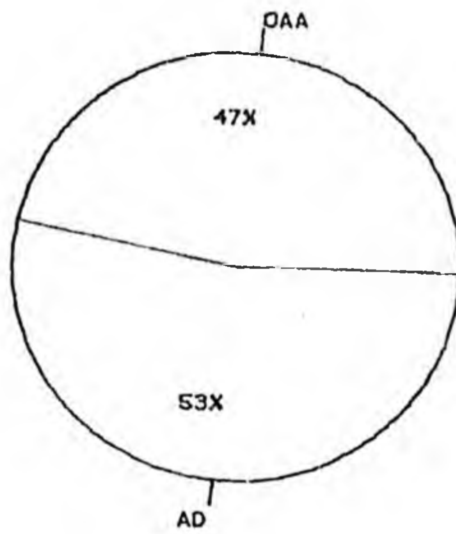
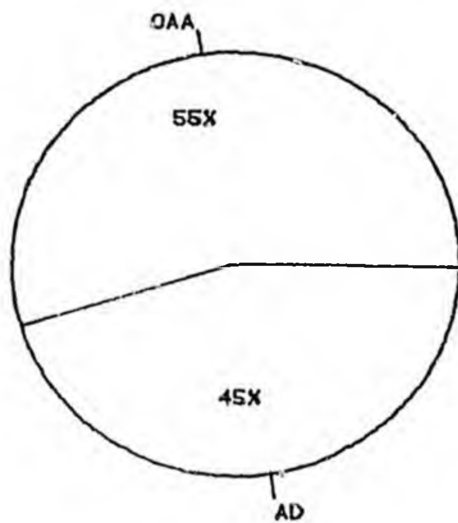


FIGURE IX

ICF EXPENDITURES BY CATEGORY



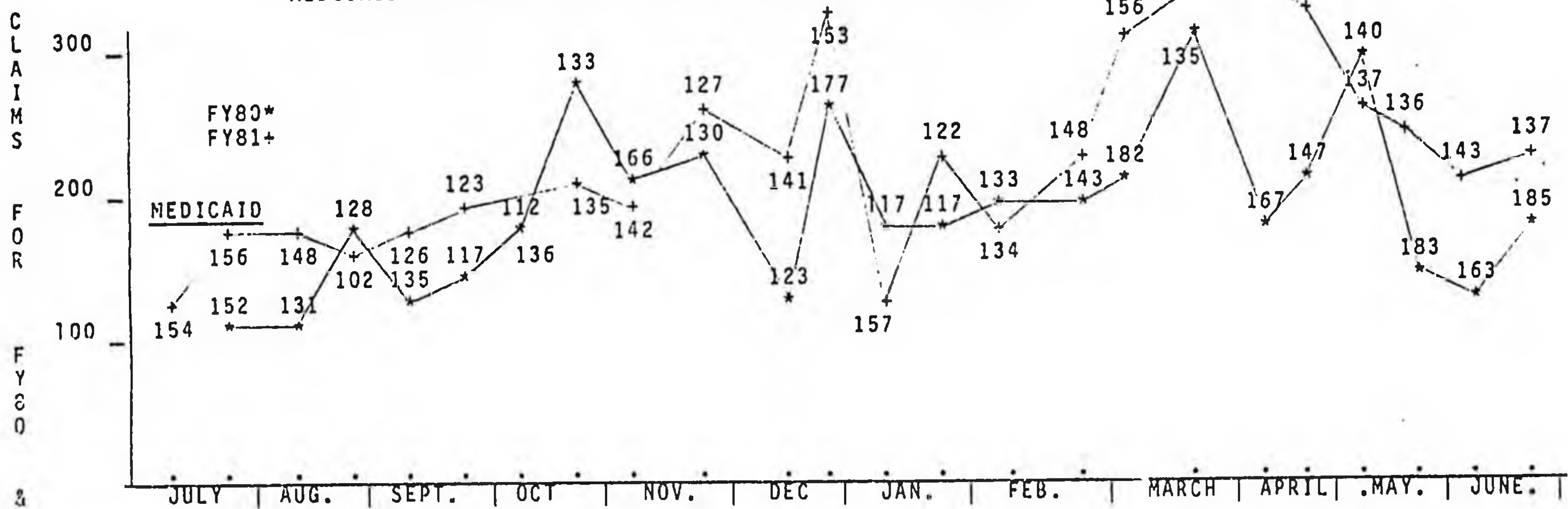
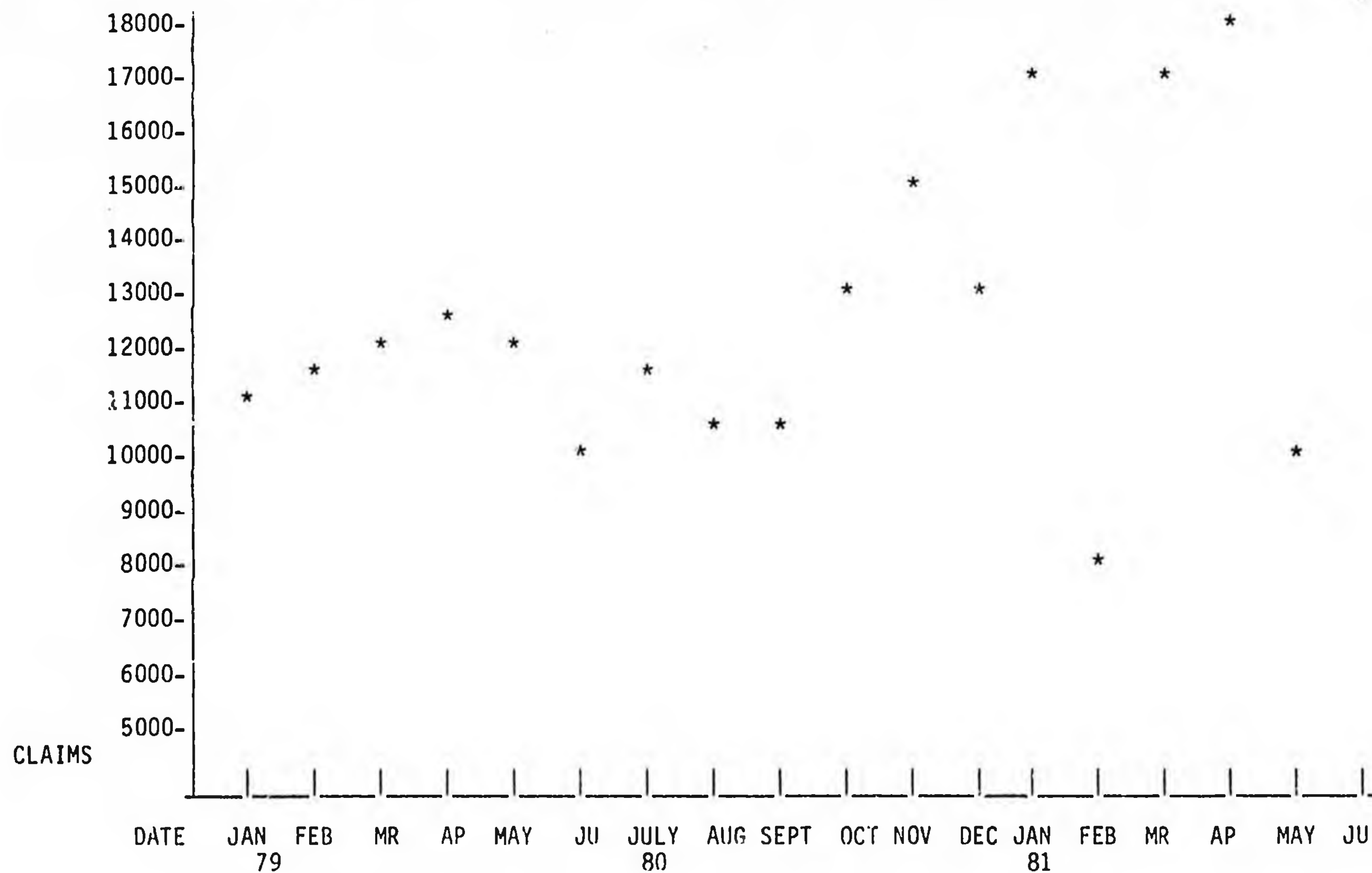


FIGURE Y
CLAIMS PER MOMTH & AVERAGE COST PER CLAIM
MEDICAID PAYMENTS TO DELTA DENTAL FOR FY 80 & FY 81
CLAIMS FOR FY80 & 81
300
200
100
FY80*
FY81+
MEDICAID
JULY
AUG.
SEPT.
OCT
NOV.
DEC
JAN.
FEB.
MARCH
APRIL
MAY.
JUNE.

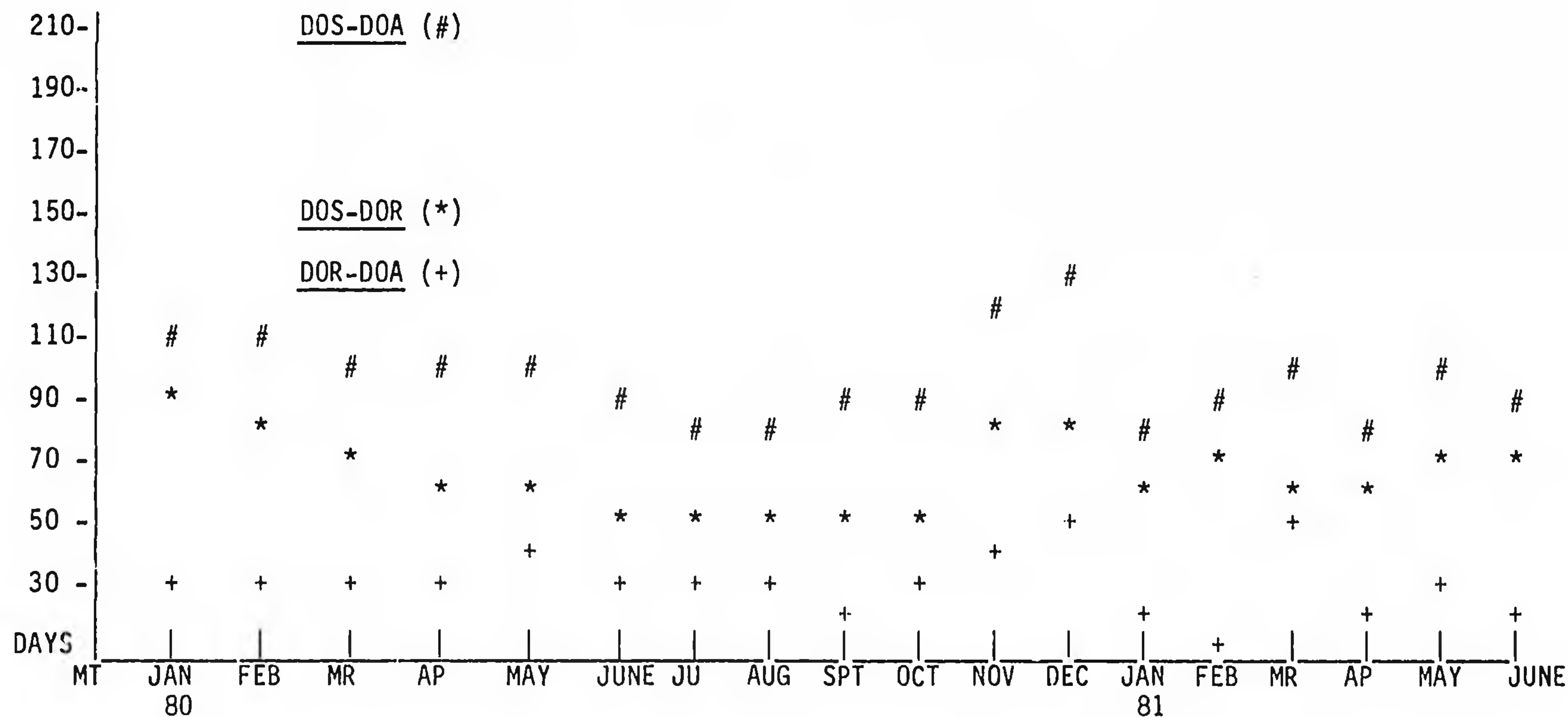
FIGURE XI

CLAIMS PROCESSED BY CSC STARTING FOR FY 80 & FY 81 +



+ See comments on Table IV. Computer run 6/20/81

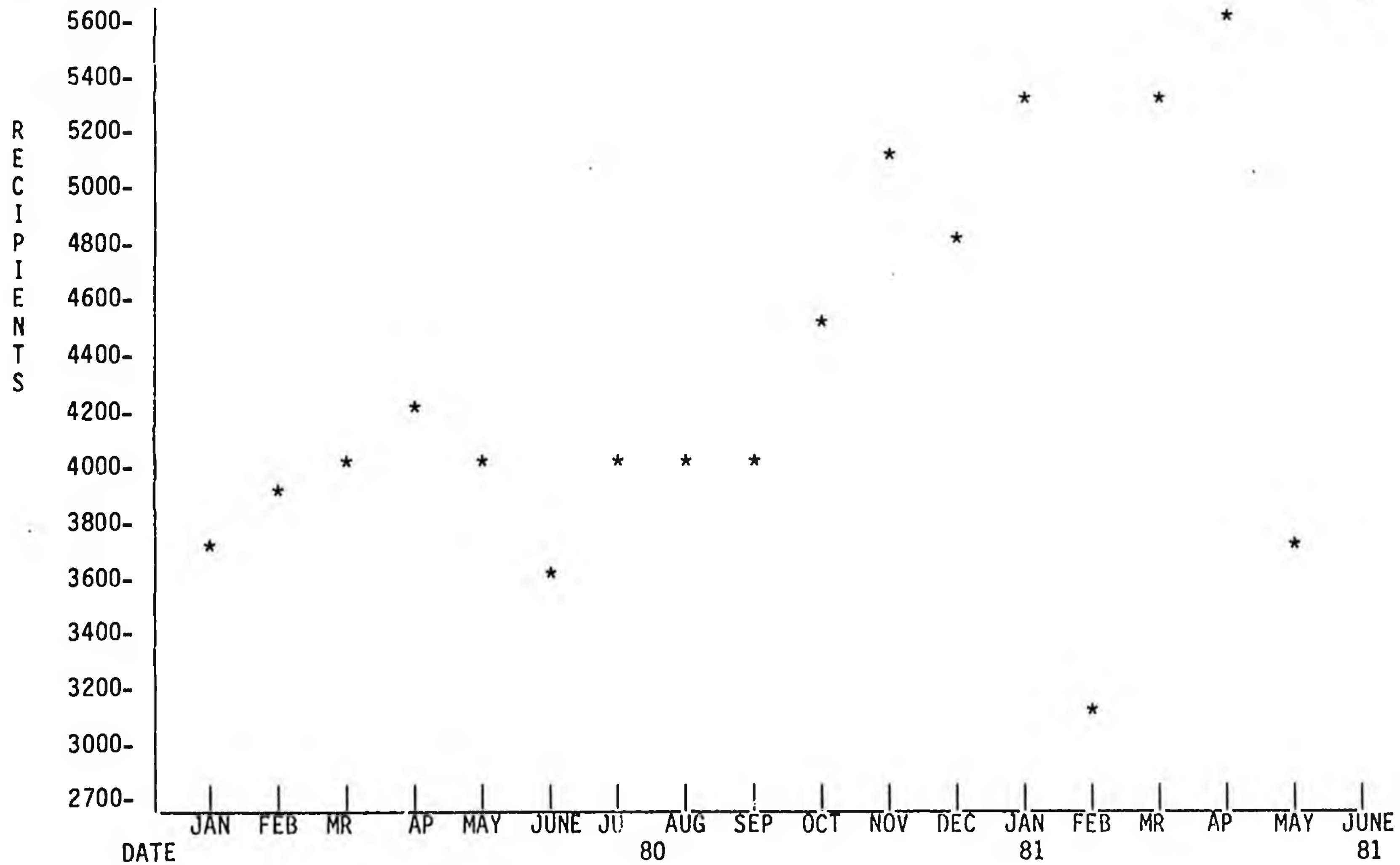
FIGURE XII
CSC CLAIMS PROCESSING ANALYSIS
FOR FY 80 & FY 81 *



* See comments on Figure XI - DOR-DOA+ 1.5 weeks = turnaround time
DOS- date of service
DOR- date of receipt
DOA- date of adjudication

FIGURE XIII

MEDICAID BENEFICIARIES/MONTH



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

1 (8) Battelle estimates 700 net new eligibles out of 2300 estimated.

New Medicaid expend. of $2.3 million
2/3 of this a reduction in GRM = State savings of $385,000

estimated 3300 eligible native children. Feds pay 100% of their services in IHS facilities where they would, presumably, still get care.

medically needy – 10% increase in Medicaid

4 (9) AFDC - unemployed parent
- mitigate tendency of AFDC to break up families
- weighted increase in other states of 9.4%
- add 215 non-natives - many may be covered by GRM = savings of $100,000

NATIVE

Eligibility requires work in 6 of last 13 quarters but not more than 100 hours per month for the last 2 mos.

Native AFDC cost $600,000 to $3.1 million assuming all have IHS facility care.

2. no medically needy served now