

HB

98

Senate Health, Education and Social Services Committee

Legislation Checklist

Bill number: HB 98  
Sponsor: GOVERNOR  
Date referred to committee: 5/10  
Synopsis completed:  
Fiscal note:  
Further referrals: JUDICIARY

CONTACTS:

Rod Betit, DHSS 3355

testify  
2-27  
Bob Franken, Gov's Council  
694-8986

Dennis DeWitt, Hospitals 6-1790

Ed Hein, Legal 2450

STATE OF ALASKA  
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY  
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POUCHY - STATE CAPITOL  
JUNEAU, ALASKA 99811  
907-465-3800

May, 1986

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS date base CM 14. In order to save space copies of minutes have not been left in the files.

Jeanie Henry

Senate Health Education and Social Services Committee 2/4/86, 1:44 pm  
" " " " " " 2/27/86, 1:36 pm

# STATE OF ALASKA

## DEPARTMENT OF HEALTH AND SOCIAL SERVICES

### STATEWIDE HEALTH COORDINATING COUNCIL

APR 18 1986

NRN - file  
HB 98  
BILL SHEFFIELD, GOVERNOR

POUCH H-01A  
JUNEAU, ALASKA 99811  
PHONE:

April 17, 1986

The Honorable Bill Sheffield  
Governor  
State of Alaska and  
Members of the Alaska State Legislature

RE: HOUSE BILL 98

The Statewide Health Coordinating Council endorses passage of Senate CS for CS for House Bill 98 (Finance) with the improvements recommended in the Department of Health and Social Services position paper dated March 12, 1986. House Bill 98 provides several technical amendments to existing law, however, the issues with which the SHCC is most concerned are:

#### CLARIFICATION OF THE RELATIONSHIP OF THE MEDICAID RATE COMMISSION'S RATE SETTING RESPONSIBILITIES TO THE MEDICAID BUDGETING PROCESS.

The SHCC believes a means of assuring containment of medical costs to reasonable levels while preserving a prospective rate setting structure is an essential part of HB 98. This Bill will create an equitable consideration by the Medicaid Rate Commission between the financial needs of Alaska's health facilities, and the financial constraints of the Department of Health and Social Services budget.

#### INCLUSION OF PERSONAL CARE SERVICES PROVIDED IN A RECIPIENT'S HOME AS A SERVICE PAYABLE UNDER MEDICAID.

Personal care services are those services necessary to "accommodate long-term maintenance or supportive care, at a skill level less than most duties included under home health care as performed by Home Health Aides." The SHCC believes these services should be made available under the Medicaid program to persons in need.

#### INCLUSION OF DENTAL CARE UNDER THE MEDICAID PROGRAM.

Adult emergency dental care has been offered to Medicaid recipients under the General Relief Medical program since 1972. Although it has been necessary for such services to be deleted under the General Relief Medical program, HB 98 provides a means of restoring these services under the Medicaid program using 50% federal funding.

RE: House Bill 98

PRIORITIZING OF MEDICAL SERVICES PAYABLE UNDER THE MEDICAID PROGRAM.

It has been several years since the existing priority of payment for services under the Medicaid program was adopted. HB 98 provides a more equitable prioritization of services given the changing needs of Alaskans and financial considerations affecting the Medicaid program.

To demonstrate our firm support for passage of House Bill 98 the members of the SHCC have signed this endorsement.

STATEWIDE HEALTH COORDINATING COUNCIL

MEMBER

Paul Murray

Paul Young

Arthur E. Willman

James Munn

Charlotte Barnes

Alma P. Cook

Maria Osterlund

Jim Ankut

James A. Keene

Hertie Esmailka

Sharon L. King

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COMMUNITY

OF RESIDENCE

Fairbanks, AK

PO BOX 176740600

SITKA, ALASKA

Anchorage

T-HONKO BAY

Healy, AK 99922

Seward Point, AK. 99661

Anchorage

KOTZEBUE

Huslia, AK.

Sturtevant, AK. 99833

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# Alaska State Legislature

BETTYE FAHRENKAMP, Chairman  
ARLISS STURGULEWSKI, Vice Chairman  
JOE JOSEPHSON  
PAUL FISCHER  
EDNA ARMSTRONG-DE VRIES



*Sandra*

P O BOX V  
STATE CAPITOL  
JUNEAU, ALASKA 99811  
(907) 465-3834  
(907) 465-3762

## Senate Committee on Health, Education and Social Services

### MEMORANDUM

TO: Members, Senate Committee on Health, Education and Social Services

FROM: Committee Staff

RE: Committee Meeting, February 4, 1986

DATE: January 31, 1986

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On Tuesday, February 4, from 1:30-3:30 pm in the Beltz Room the Senate Committee on Health, Education and Social Services will hear two bills relating to Medicaid.

Draft SCS CSHB 98 (HESS) proposes to:

1. Amend the filing deadlines on claims for Medicaid and general relief assistance. Under current statute the Department may only pay a claim filed within six months of the date of service, an impractical period of time if a third party payor or a court hearing is involved. Section 1 would extend the payment period in these specified circumstances, and give the Department authority to approve partial payment of a claim filed at any time if the provider demonstrates good cause for failure to meet the statutory deadline.
2. Give the Department statutory basis for "first right" to recovery of medical assistance expenses from any insurance or court settlement awarded to a Medicaid recipient. Federal law requires all Medicaid applicants to assign their rights to third party payments as a condition of receiving Medicaid assistance. State statute is silent on the issue and as a result the Department must go to court to obtain recovery. Expenses recovered would be shared with the federal government.
3. Amend Alaska's Medicaid statutes to bring them into conformance with federal law. This is necessary due to changes enacted by Congress in the Deficit Reduction Act of 1984. Specifically, when a state accepts the Medicaid program it must

agree to offer certain mandatory services and may elect to offer a variety of additional services. Section 1 places in the mandatory category coverage of children under age 5 and pregnant women who meet eligibility criteria. These services are currently covered by the state as one of our options.

4. Add to the state's optional programs personal care services in a recipients' home. In past years funding for personal care attendants has been 100% state funded through the General Relief Medical program. Adding the service under Medicaid would allow costs to be shared with the federal government.

5. Clarify the order in which optional services are to be deleted if the Medicaid program runs into funding difficulties. To date, the Department has not needed to use this deletion provision.

6. Requires that in determining payment rates to health facilities the Medicaid Rate Commission consider the amount of state and federal funds that are available. Established under AS 47.07.110 in 1983, the Commission is charged with setting rates based on costs of current operations and appropriate capital development. The rate of increase approved by the Commission has been averaging over 15% a year. The Department will be proposing an additional change to the Medicaid Rate Commission statute (see document marked "For Discussion") which would mandate that rates set by the Commission not exceed the amount budgeted by the Department for the fiscal year.

CSHJR 58 urges the United States Department of Health and Human Services to ease the restrictions against granting Medicaid waivers for Home and Community Based Services. The waiver provision was intended to contain rapidly rising medical costs by offering payment for services within the community rather than in high cost institutions. Since 1982 the Department has been in the process of applying for a waiver. The latest application was returned to be rewritten according to new federal regulations which have construed the waiver so strictly as to effectively preclude eligibility. Specifically, the regulations require that the cost of care in the community, including all associated medical costs, be 25% less than the cost of institutional care.

*adopted  
Conf Comm*

*file*

# STATE OF ALASKA 1986 LEGISLATIVE SESSION FISCAL NOTE

Revision Date: \_\_\_\_\_

## REQUEST

Bill/Resolution No. : SCS/CSHB98 (HSS)  
Title : An act relating to Medical Assistance  
Sponsor : Rules/Governor  
Requestor : \_\_\_\_\_  
Date of Request : 5/7/86

## FISCAL DETAIL

Agency Affected : Health and Social Services  
BRU : Medical Assistance Non-Facility  
Components : Medicaid Non-Facility

## EXPENDITURES/REVENUES : (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES		45.2	47.0	48.8	50.8	52.8
TRAVEL		8.6	8.9	9.3	9.7	10.1
CONTRACTUAL		.8	.8	.9	.9	.9
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS		1,959.1	3,459.5	3,597.9	3,741.8	3,891.5
MISCELLANEOUS						
TOTAL OPERATING		2,013.7	3,516.2	3,656.9	3,803.2	3,955.3

CAPITAL						
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REVENUE		250.0	270.0	292.0	315.0	340.0
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## FUNDING : (Thousands of Dollars)

GENERAL FUND		881.9	1,623.1	1,682.4	1,744.1	1,807.7
FEDERAL FUNDS		881.8	1,623.1	1,682.5	1,744.1	1,807.6
OTHER		250.0	270.0	292.0	315.0	340.0
TOTAL		2,013.7	3,516.2	3,656.9	3,803.2	3,955.3

## POSITIONS :

FULL-TIME		1.0	1.0	1.0	1.0	1.0
PART-TIME						
TEMPORARY						

ANALYSIS : Attach a separate page if necessary

Prepared by : Rod Betit, Director *RB* Phone : 465-3355  
Division : Medical Assistance Date : 5/7/86

Approved by Commissioner : John St. Onge Date : 5/7/86  
Agency : Department of Health and Social Services

Distribution (by Agency preparing fiscal note) :

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget

*ace*

Fiscal Note

Summary SCS CSHB98 (HESS)

FY87

5/7/87

<u>Section</u>	<u>Subject</u>	<u>FY87 Total</u>	<u>FY87 State</u>
I	Six Month Law	29.2	14.6
II	Subrogation	(250.0)	(125.0)
III	Optional Needy Groups	-0-	-0-
IV	Optional Medical Services	2,157.5	1,078.7
A.	<u>Personal Care</u>		
	(a) 190 recipients X 600 hours X \$9.00/hour =	1,029.2	Total
	(b) New position and associated costs =	54.6	Total
B.	<u>Adult Dental</u>		
	(a) 2716 recipients X \$331.63 =	900.7	Total
V	Priority Medical Services	-0-	-0-
VI	Medicaid Rate Commission	<u>-0-</u>	<u>-0-</u>
	Total \$ Impact	1,763.7	881.9

file HB 98

SCS CSHB 98 (FIN)

- 7. Physical Therapy ] combined in .035
- 7. Occupational Therapy ]
- 8. Speech, Hearing and Language Disorder Treatment
- 9. Optometrist Services
- 10. Intermediate Care Facility for Services
- 11. Eyeglasses ] combined in .035
- \* Prosthetic Devices ]
- \* Skilled Nursing Facility for Under Age 21
- \* Emergency Hospital Services

C. Optional Services Not Offered in Alaska

- \* Chiropractors Services
- . Other Practitioners Services
- . Private Duty Nursing
- \* Dental Services
- . Prescribed Drugs
- . Dentures Services
- . Diagnostic Services
- . Screening Services
- . Preventive Services
- . Rehabilitative Services
- . Services for Age 65 or Older in TB Institutions
- \* Personal Care Services
- . Christian Science Nurses
- . Christian Science Sanitoria

\* These optional services and eligible groups are not currently listed in AS 47.07.035 but have been included in the revision proposed in HB98.

SCS CSHB 98 (FIN)

REQUEST FISCAL DETAIL  
 Bill/Resolution No.: SCS CSHB98(F Agency Affected: Health and Social  
 Title: As Act Relating to Program Category Affected:  
Medical Assistance  
 Sponsor: Rules/Governor BRU, Program or Subprogram(s) Affected:  
 Requestor: Medical Assistance Non-Facility/  
 Date of Request: 5/2/86 Medicaid-None-Facility

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
OPERATING						
100 PERSONAL SERVICES			45.2			
200 TRAVEL			8.6			
300 CONTRACTUAL			20.8			
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS			2000.0			
800 MISCELLANEOUS						
TOTAL OPERATING			2074.6			

CAPITAL	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
REVENUE			250.0			

FUNDING: (Thousands of Dollars)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
GENERAL FUND			912.3			
FEDERAL FUNDS			912.3			
OTHER						
TOTAL			1824.6			

POSITIONS:

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
FULL-TIME			1.0			
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

- (1) Funding is net after revenue to program.
- (2) See attached detail financial summary.

Prepared By: Senator Frank R. Ferguson Phone: 465-4923  
 Division: Legislature Date: 5/2/86

Approved by Commissioner: \_\_\_\_\_ Date: \_\_\_\_\_  
 Agency: \_\_\_\_\_

SCS CSHB 98 (FIN)

SCS CSHB 98 (FIN)

Section	Subject	FY87 Total	FY87 State
I	Six Month Law	29.2	14.6
II	Subrogation	(250.0)	(125.0)
III	Optional Needy Groups	-0-	-0-
IV	Optional Medical Services	2157.5	1078.7
<b>A. Personal Care</b>			
	(a) 190 recipients X 600 hours X \$9.00/hour =	1,029.2	Total
	(b) New position and associated costs =	54.6	Total
<b>B. Chiropractor</b>			
	(a) 600 recipients X \$255 average =	153.0	Total
	(b) One time computer costs =	20.0	Total
<b>C. Adult Dental</b>			
	(a) 2716 recipients X \$331.63 =	900.7	Total
V	Priority Medical Services	-0-	-0-
VI	Medicaid Rate Commission	-0-	-0-
	<b>Total \$ Impact</b>	<b>1936.7</b>	<b>968.3</b>

MEDICAID  
ELIGIBLE GROUPS

A. Mandatory Eligible Groups:

- .AFDC Recipients
- .Deemed Recipients of AFDC
- .Families that lost AFDC because of employment
- .Individuals ineligible for AFDC because of requirements inapplicable under Medicaid ] Win MMR
- .Individuals eligible for AFDC except for the SSA increase in 1972
- .Qualified pregnant women and children under 5 born after 9/30/83
- .Newborn children of Medicaid - eligible women
- .Children for whom adoption assistance or foster care maintenance payments are made under Title IV-E
- .The Aged, Blind, or Disabled under SSI
- .Individuals ineligible for SSI or State supplements because of requirements inapplicable under Medicaid
- ."Grandfathered" individuals

B. Optional Eligible Groups Covered in Alaska

11. Individuals under 21 who cannot qualify for AFDC because they are not dependent children
12. Institutionalized individuals under a special income eligibility level
13. Individuals who do not receive SSI but qualify for Adult Public Assistance
14. Pregnant women
  - \* Individuals eligible for financial assistance but not receiving it
  - \* Individuals eligible for financial assistance except for institutional status (not listed in draft bill under .035)

C. Optional Eligible Groups Not Covered

- .Noninstitutionalized disabled children
- .Noninstitutionalized individuals receiving home and community based service under a special income eligibility level
- .The medically needy
- .Individuals who could qualify for AFDC if AFDC were as broad as federally allowed
- .Individuals eligible for assistance under AFDC if child care costs were paid from earnings

\* These optional services and eligible groups are not currently listed in AS 47.07.035 but have been included in the revision proposed in HB98.

MEDICAID  
SERVICES

A. Mandatory Services:

- .Inpatient Hospital Services
- .Outpatient Hospital Services
- .Rural Health Clinics Services
- .Other Laboratory and X-Ray Services
- .Skilled Nursing Facilities Services
- .Home Health Services
- .Nurse Midwife Services
- .Early and Periodic Screening Diagnosis and Treatment for Individuals under 21
- .Physician Services
- .Medical Transportation

A. Optional Services Offered in Alaska

1. Long-Term Care Noninstitutional Services
2. Medical Supplies and Equipment
3. Surgical Care Center Services ] under clinic services in .035
4. Clinic Services
5. Inpatient Psychiatric Service for Under Age 22 ] combined in .035
5. Inpatient Psychiatric Service for over Age 65 ]
6. Intermediate Care Facility for Mentally Retarded

Distributed by Sen. Fahrenkamp

HB 98 MEDICAL ASSISTANCE

ADOPT FINANCE COMMITTEE SUBSTITUTE.

- SEC. 1      ALLOWS DEPT. TO PAY "PAST DUE" (MORE THAN 6 MONTHS OLD) MEDICAID CLAIMS UNDER CERTAIN CONDITIONS
- SEC. 2      PROHIBITS DEPT. FROM PAYING CLAIMS THAT ARE PAYABLE BY A 3rd PARTY (I.E. INSURANCE)
- SEC. 3      MAKES CHANGES IN MANDATORY SERVICES AS REQUIRED BY FEDERAL LAW.
- SEC. 4      ADDS PERSONAL CARE ATTENDANTS, ADULT DENTAL, AND CHIROPRACTIC AS MEDICAID SERVICES COVERED IN ALASKA.
- SEC. 5      RE-PRIORITIZES MEDICAID OPTIONS ON A LIFE-SAVING TO LIFE-ENHANCING SCALE. PRIORITY WOULD BE USED IF FUNDING WERE INSUFFICIENT TO PAY FOR ALL SERVICES AUTHORIZED.
- SEC. 6-8     ALLOWS MEDICAID RATE COMMISSION TO REDETERMINE RATES FOR FACILITIES, AND TO CONSIDER STATE BUDGET WHEN DOING SO.
- SEC. 9-10   DEFINITIONS OF SERVICES BEING ADDED
- SEC. 11     ALLOWS DEPT. TO CONTRACT FOR MEDICAL SERVICES OF THE NEEDY.
- SEC. 12     ALLOWS DEPT. TO PRORATE PAYMENTS UNDER GENERAL RELIEF MEDICAL.
- SEC. 13     PRIORITIZES GENERAL RELIEF MEDICAL SERVICES. HIGHEST PRIORITY IS INPATIENT HOSPITAL SERVICES; THIS MAY BE ALL FUNDING IS AVAILABLE FOR.
- SEC. 14     REPEALS OLD LANGUAGE ON PAYMENT OF CLAIMS (SEE SEC. 1).
- SEC. 15     IMMEDIATE EFFECTIVE DATE.

(added in Finance)

added in Finance

(NOTE: BILL DOES NOT ADD PRESCRIPTION DRUGS TO MEDICAID.)

SUPPORTED BY: HEALTH ASSOCIATION OF ALASKA (DENNIS DEWITT)  
 DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
 GOVERNOR'S COUNCIL ON HANDICAPPED AND GIFTED  
 ACCESS ALASKA  
 AND OTHERS...

HB 98, relating to medical assistance, was heard by the Senate Committee on Health, Education and Social Services on February 4, 1986. The bill proposes some revisions to the administration of the Medicaid program, and adds personal care services under Medicaid.

Also discussed at the hearing was expansion of the Medicaid program to maximize the use of federal dollars in light of 1) a potential federal "cap" on the Medicaid program, and 2) the Governor's proposed reductions to the state's General Relief Medical (GRM) program.

The following programs currently offered under GRM are available under Medicaid:

	FY 87 GRM COST	# SERVED ANNUALLY	FY 87 ESTIMATED MEDICAID COST (STATE SHARE)	# SERVED ANNUALLY
PERSONAL CARE SERVICES	\$200,000	8	\$527,000	455
Services under GRM are provided under a waiver granted by the Commissioner. Medicaid services would include those necessary to accommodate long-term maintenance or supportive care.				
ADULT DENTAL	\$725,546	2,216	\$450,352	2716
Services under GRM are limited to emergency care. Medicaid services could be expanded to include diagnostic, preventive, and corrective procedures.				
PHARMACEUTICALS	\$2.53 M	14,767	\$1.25 M	15,000

Eligibility criteria for Medicaid and GRM differ. Adding services to Medicaid will expand coverage for Medicaid-eligibles, but a certain population will continue to need coverage under GRM. The Department estimates that approximately 3,990 of the 16,690 persons who used GRM in FY 85 were not Medicaid eligible. (The use of the GRM program by Medicaid eligibles was mainly for dental and pharmaceutical coverage).

With no change to services offered or program eligibility, the funding need of GRM for FY 87 is \$12 million; the Governor's budget contains \$5 million. He has introduced HB 678, which is intended to effect some cost savings to the program through establishing a co-payment provision, limiting the amount of assistance to any one individual, requiring repayment of medical assistance under certain conditions, and allowing the Department to prioritize services and pro-rate payments in the event of a funding shortfall.

Other programs available under Medicaid not currently offered by the state include:

	STATE COST	# SERVED
CHIROPRACTIC	\$80,000	600

SB 109, which adds chiropractic services under Medicaid, has passed the Senate and is awaiting scheduling on the House floor.

MEDICALLY NEEDY	\$709,938	1525
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Services would be limited to children and pregnant women whose income before deducting medical expenses is above the Medicaid qualifying level, but whose income once medical bills have been paid is reduced to 133% or less of the income eligibility level.

#### ADULT PREVENTIVE SERVICES

Services include physicals, TB tests, flu shots and other immunizations such as hepatitis and tetanus. Currently provided to children under Medicaid.

#### REHABILITATIVE SERVICES

Services include psychiatric or other day treatment services, child development centers for children who are developmentally disabled or mentally retarded, adult day health centers, rehabilitation centers providing physical therapy, occupational therapy and speech, language and hearing services.

The costs of the Medicaid program are shared 50-50 by the state and federal governments. The Governor's budget contains \$36.5 million as the state's share for FY 87 (up from \$33.2 million in FY 86).

A new draft committee substitute, making the following changes, is attached:

1. Establishes a new prioritization of optional services, ranging from life sustaining to life enhancing. Developed with advice from the Department.

2. Adds language developed by the Department intended to more closely tie hospital and nursing home rates to legislative appropriations for Medicaid. Since the February 4 HESS meeting, the Medicaid Rate Commission has adopted emergency regulations to prohibit the accounting of bad debt and charity in figuring rates. (This should result in a \$2 million cost savings to the state annually). No decision has been made on freezing rates for FY 87.

- 1- payment of claims
- 2- 3rd party paymerits
- 3- conform to federal law
- 4- personal care services
- Original sponsor: Rules/governor
- 5- prioritization of options
- 6-8 - Medicaid Rate Commission
- 9-10 - definitions
- 11 - old language on payment
- 12- effective date

Hein  
2/24/86.

**DRAFT**

BY THE HEALTH, EDUCATION AND  
SOCIAL SERVICES COMMITTEE

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SENATE CS FOR CS FOR HOUSE BILL NO. 98 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - S<sup>COND</sup> SESSION

A BILL

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

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

\* Section 1. AS 44.77 is amended by adding a new section to read:

Sec. 44.77.015. CLAIMS FOR MEDICAL SERVICES. (a) For the purposes of filing claims for medical services provided under AS 47.07 or 47.25.120 - 47.25.300, "promptly," in AS 44.77.010(a), means (1) within six months after the date of service, or as provided in (b) of this section, if there is no third-party claim, or (2) within 12 months after the date of service if there is a third-party claim. Except as provided in (c) of this section, a claim may not be paid if it is not filed promptly; an inference to the contrary may not be drawn from AS 09.10.050, AS 09.50.250 - 09.50,300, or AS 37.25.010.

(b) In accordance with (a) of this section, a claim may be considered to be filed promptly if (1) the claim was filed more than six months after the date of service because the medical provider had reason to believe that the beneficiary was ineligible for service under AS 47.07 or AS 47.25.120 - 47.25.300; (2) a court of competent jurisdiction or an administrative hearing officer finds that the beneficiary was eligible for service under AS 47.07 or AS 47.25.120 - 47.25.300 on the date of service; and (3) the claim is filed within six months after the date that the court or administrative finding is rendered. The beneficiary is responsible for notifying the medical provider of the judicial or administrative finding.

1 (c) The commissioner of health and social services may authorize  
2 payment to a medical provider of a claim not promptly filed, upon good  
3 cause shown. Payments under this subsection may not exceed 50 percent  
4 of the allowable charges presented in the claim. In this subsection,  
5 "good cause" does not include a beneficiary's failure to notify a  
6 provider of a judicial or administrative finding of eligibility.

7 (d) In this section,

8 (1) "beneficiary" means a person who is found to be eligi-  
9 ble to receive medical services under AS 47.07 or AS 47.25.120 -  
10 47.25.300;

11 (2) "medical provider" means a person, firm, corporation,  
12 association, or institution that, on the date of service, was approved  
13 to provide medical assistance, in accordance with regulations adopted  
14 by the Department of Health and Social Services.

15 \* Sec. 2. AS 47.05 is amended by adding a new section to read:

16 Sec. 47.05.070. SUBROGATION. (a) If the department provides or  
17 pays for medical assistance for injury or illness under this title,  
18 the department is subrogated to the rights of the recipient of that  
19 medical assistance for any claim arising from the injury or illness  
20 and to the proceeds of an insurance policy covering the injury or  
21 illness to the extent of the value of the medical assistance provided.

22 (b) If a recipient of medical assistance under this title set-  
23 tles a claim or obtains an award or judgment arising from the injury  
24 or illness for which the medical assistance was received, the depart-  
25 ment shall reimburse the recipient for attorney fees and costs commensurate  
26 with the amount of the settlement, award, or judgment to which  
27 the department is entitled under (a) of this section. Regardless of  
28 the manner in which the amount of the attorney fees is derived, reim-  
29 bursement of attorney fees shall be in accordance with the applicable

1 rules of court governing the award of attorney fees in civil matters.

2 \* Sec. 3. AS 47.07.020(b) is amended to read:

3 (b) In addition to the persons specified in (a) of this section,  
4 the following optional groups of persons for whom the state may claim  
5 federal financial participation are eligible for medical assistance:

6 (1) persons eligible for but not receiving assistance under  
7 any plan of the state approved under 42 U.S.C. 601 - 615 (Title IV-A,  
8 Social Security Act, Aid to Families with Dependent Children) or 42  
9 U.S.C. 1381 - 1383c (Title XVI, Social Security Act, Supplemental  
10 Security Income);

11 (2) persons in a general hospital, skilled nursing facility  
12 or intermediate care facility, who, if they left the facility, would  
13 be eligible for assistance under one of the federal programs specified  
14 in (1) of this subsection;

15 (3) persons under age 21 who are [YEARS OF AGE] under  
16 supervision of the department, for whom maintenance is being paid in  
17 whole or in part from public funds, and who are in foster homes or  
18 private child-care institutions;

19 (4) aged, blind, or disabled persons, who, because they do  
20 not meet income requirements, do not receive supplemental security  
21 income under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act),  
22 and who do not receive a mandatory state supplement, but who are  
23 eligible, or would be eligible if they were not in a [GENERAL HOSPITAL  
24 OR] skilled nursing facility or intermediate care facility to receive  
25 an optional state supplementary payment;

26 (5) persons under age 21 who are [YEARS OF AGE] in an  
27 institution designated as an intermediate care facility for the men-  
28 tally retarded and who are financially eligible as determined by the  
29 standards of the federal aid to families with dependent children

1 program;

2 (6) persons in a medical or intermediate care facility  
3 whose income while in the facility does not exceed 300 percent of the  
4 supplemental security income benefit rate under 42 U.S.C. 1381 - 1383c  
5 (Title XVI, Social Security Act) but who would not be eligible for an  
6 optional state supplementary payment if they left the hospital or  
7 other facility;

8 (7) persons under age 21 who are [YEARS OF AGE] receiving  
9 active treatment in a psychiatric hospital and who are financially  
10 eligible as determined by the standards of 42 U.S.C. 601 - 615 (Title  
11 IV-A, Social Security Act, Aid to Families with Dependent Children);

12 (8) persons under age 21 and not covered under (a) of this  
13 section, [YEARS OF AGE] who would be eligible for benefits under the  
14 federal aid to families with dependent children program, except that  
15 they have the care and support of both their natural and adoptive  
16 parents [BUT WHO DO NOT QUALIFY BECAUSE THEY ARE NOT DEPENDENT CHILD-  
17 REN];

18 (9) [WOMEN WHO ARE] pregnant women not covered under (a) of  
19 this section and who meet the income and resource requirements of the  
20 federal aid to families with dependent children program.

21 \* Sec. 4. AS 47.07.030 is repealed and reenacted to read:

22 Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. (a) The de-  
23 partment shall offer all mandatory services required under 42 U.S.C.  
24 1396 - 1396p (Title XIX of the Social Security Act).

25 (b) In addition to the mandatory services specified in (a) of  
26 this section, the department may offer only the following optional  
27 services: personal care services in a recipient's home; emergency  
28 hospital services; long-term care noninstitutional services; medical  
29 supplies and equipment; clinic services; inpatient psychiatric

1 facility services for individuals age 65 or older and individuals  
2 under age 21; physical therapy; occupational therapy; treatment of  
3 speech, hearing, and language disorders; prosthetic devices and eye-  
4 glasses; optometrists' services; intermediate care facility services,  
5 including intermediate care facility services for the mentally re-  
6 tardated; skilled nursing facility services for individuals under age  
7 21; and reasonable transportation to and from the point of medical  
8 care.

9 \* Sec. 5. AS 47.07.035 is repealed and reenacted to read

10 Sec. 47.07.035. PRIORITY OF MEDICAL ASSISTANCE. If the depart-  
11 ment finds that the cost of medical assistance for all persons eligi-  
12 ble under this chapter will exceed the amount allocated in the state  
13 budget for that assistance for the fiscal year, the department shall  
14 eliminate coverage for optional medical services and optionally eligi-  
15 ble groups of individuals in the following order:

- 16 (1) emergency hospital services;
- 17 (2) treatment of speech, hearing, and language disorders;
- 18 (3) optometrists' services and eyeglasses;
- 19 (4) occupational therapy;
- 20 (5) prosthetic devices;
- 21 (6) medical supplies and equipment;
- 22 (7) clinic services;
- 23 (8) physical therapy;
- 24 (9) personal care services in a recipient's home;
- 25 (10) long-term care noninstitutional services;
- 26 (11) inpatient psychiatric facility services;
- 27 (12) intermediate care facility services for the mentally  
28 retarded;
- 29 (13) intermediate care facility services;

1 (14) individuals under age 21 who are not eligible for  
2 benefits under the federal aid to families with dependent childrer  
3 program because they are not deprived of one or more of their natural  
4 or adoptive parents;

5 (15) skilled nursing facility services for persons under age  
6 21;

7 (16) aged, blind, and disabled individuals who, because they  
8 do not meet the income requirements, do not receive supplemental  
9 security income under Title XVI of the Social Security Act, but who  
10 are eligible, or would be eligible if they were not in a skilled  
11 nursing facility or intermediate care facility, to receive an optional  
12 state supplementary payment;

13 (17) individuals in a hospital, skilled nursing facility, or  
14 intermediate care facility whose income while in the facility does not  
15 exceed 300 percent of the supplemental security income benefit rate  
16 under Title XVI of the Social Security Act, but who, because of in-  
17 come, are not eligible for the optional state supplementary payment;

18 (18) individuals under age 21 under supervision of the  
19 department, for whom maintenance is being paid in whole or in part  
20 from public money and who are in foster homes or private child-care  
21 institutions.

22 \* Sec. 6. AS 47.07.040 is amended to read:

23 Sec. 47.07.040. STATE PLAN FOR PROVISION OF MEDICAL ASSISTANCE.  
24 The department shall prepare a state plan in accordance with the  
25 provisions of 42 U.S.C. 1396 1396p (Title XIX, Social Security Act,  
26 Medical Assistance) and submit it for approval to the United States  
27 Department of Health and Human Services. The plan shall designate  
28 that the Department of Health and Social Services is the single state  
29 agency to administer this plan. The department shall act for the

1 state in any negotiations relative to the submission and approval of  
2 the plan. The department, including the Medicaid Rate Commission,  
3 [AND] may make those arrangements or regulatory changes, not inconsis-  
4 tent with law, as may be required under federal law to obtain and  
5 retain approval of the United States Department of Health and Human  
6 Services to secure for the state the optimum federal payment under the  
7 provisions of 42 U.S.C. 1396 - 1396p (Title XIX, Social Security Act,  
8 Medical Assistance). In addition, the department shall provide a  
9 report to the legislature no later than March 15 of each year concern-  
10 ing the status of this program and recommendations, with supporting  
11 fiscal data, as to any changes in the coverage of eligible persons or  
12 services to be provided.

13 \* Sec. 7. AS 47.07.070 is amended by adding a new subsection to read:

14 (d) In determining a rate of payment to a health facility under  
15 this section, the commission shall consider the appropriation limit  
16 set by the legislature for the department's programs under this chap-  
17 ter and under AS 47.25.120 - 47.25.300, and available federal revenue.  
18 The commission shall set rates for health facilities in the state so  
19 that, taking into account projected rates of utilization, the aggre-  
20 gate state payments to health facilities should not exceed the budget-  
21 ed amounts for the state fiscal year.

22 \* Sec. 8. AS 47.07.180 is repealed and reenacted to read:

23 Sec. 47.07.180. DUTIES. (a) The commission shall review  
24 proposed payment rates for health facilities under this chapter and  
25 AS 47.25.120 - 47.25.300.

26 (b) The commission may review budgets of, and ~~shall~~ <sup>shall</sup> establish  
27 payment rates for, health facilities under this chapter and AS 47.-  
28 25.120 - 47.25. 300.

29 (c) The commission shall consult with the department on the

1 state plan as it relates to health facilities. The commission may not  
2 change the unit of payment without the written consent of the depart-  
3 ment.

4 (d) By March 1 of each year, the commission shall develop for  
5 the [REDACTED] fiscal year <sup>starting the next July 1</sup> an annual estimate of medical assistance program  
6 expenditures in health facilities under the jurisdiction of the com-  
7 mission. The estimate shall consider anticipated utilization and  
8 payment rates for each facility. The methodology used by the  
9 commission to develop the estimate shall be consistent with the  
10 regulations governing the commission's rate-setting process.

11 \* Sec. 9. AS 47.07.900(1) is amended to read:

12 (1) "clinic services" means services provided by state-  
13 approved outpatient community mental health clinics that receive  
14 grants under AS 47.30.520 - 47.30.620, state-operated community mental  
15 health clinics, outpatient surgical care centers, and physician clin-  
16 ics;

17 \* Sec. 10. AS 47.07.900 is amended by adding new paragraphs to read:

18 (7) "emergency hospital services" means services that

19 (A) are necessary to prevent the death or serious  
20 impairment of the health of the individual; and

21 (B) because of the threat to the life or health of the  
22 individual, necessitate the use of the most accessible hospital  
23 available that is equipped to furnish the services, even if the  
24 hospital does not currently meet

25 (i) the conditions for participation under Medi-  
26 care; or

27 (ii) the definitions of inpatient or outpatient  
28 hospital services under 42 C.F.R. secs. 440.10 and 440.20.

29 (8) "personal care services in a recipient's home" means

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services prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is

- (A) qualified to provide the services;
- (B) supervised by a registered nurse; and
- (C) not a member of the recipient's family.

\* Sec. 11. AS 44.77.010(b) is repealed.

\* Sec. 12. This Act takes effect immediately in accordance with AS 01.-10.070(c).

# STATE OF ALASKA 1986 LEGISLATIVE SESSION FISCAL NOTE

Revision Date : \_\_\_\_\_

**REQUEST**

Bill/Resolution No. : SCS CSHB98 (HESS)  
 Title : An act relating to medical assistance and providing for an effective date.  
 Sponsor : HEIN  
 Requestor : \_\_\_\_\_  
 Date of Request : 2/1/86

**FISCAL DETAIL**

Agency Affected : Health & Social Services  
 BRU : Medical Assistance Non-Facility  
 \_\_\_\_\_  
 Components : Medicaid Non-Facility  
 \_\_\_\_\_

**EXPENDITURES/REVENUES : (Thousands of Dollars)**

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES		45.2	47.0	48.8	50.8	52.8
TRAVEL		8.6	8.9	9.3	9.7	10.1
CONTRACTUAL		.8	.8	.9	.9	.9
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS		1,029.2	2,446.6	2,544.5	2,646.3	2,752.2
MISCELLANEOUS						
<b>TOTAL OPERATING</b>		<b>1,083.8</b>	<b>2,503.3</b>	<b>2,603.5</b>	<b>2,707.7</b>	<b>2,816.0</b>

<b>CAPITAL</b>						
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<b>REVENUE</b>		250.0	270.0	292.0	315.0	340.0
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**FUNDING : (Thousands of Dollars)**

GENERAL FUND		416.9	1,116.6	1,155.7	1,196.3	1,238.0
FEDERAL FUNDS		416.9	1,116.7	1,155.8	1,196.4	1,238.0
OTHER						
<b>TOTAL</b>		<b>833.8</b>	<b>2,233.3</b>	<b>2,311.5</b>	<b>2,392.7</b>	<b>2,476.0</b>

**POSITIONS :**

FULL-TIME		1.0	1.0	1.0	1.0	1.0
PART-TIME						
TEMPORARY						

**ANALYSIS :** Attach a separate page if necessary

\* Note: Funding is net after revenue to program.

Summary of sections to bill.

Prepared by : *Rod Ballew*  
 Division : MA Medical Assistance

Phone : 465-3355  
 Date : 2/4/86

Approved by Commissioner : *John A. Dwyer*  
 Agency : Department of Health & Social Services

Date : 2/4/86

**Distribution (by Agency preparing fiscal note):**

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

Fiscal Note  
 Summary SCS CSHB98 (HESS)  
 FY87

<u>Section</u>	<u>Subject</u>	<u>SGFM</u>	<u>Federal</u>
I	Six Month Law	14.6	14.6
II	Subrogation	(125.0)	(125.0) <i>(1st right)</i>
III	Optional Needy Groups	-0-	-0-
IV	Optional Medical Services	527.3	527.3 P.C.A.
V	Priority Medical Services	-0-	-0-
VI	Medicaid Rate Commission	-0-	-0-

*gen funded*

Committee Substitute House Bill 98  
Assumptions

This projection for personal care services is based on the following:

- (a) personal care services can be divided into two categories of allowed Title XIX services (personal care and medically related home care).
- (b) Oregon showed an average of 21.2 hours personal care and 38.12 hours of home care per case per month.
- (c) unit cost is based on 1 hour of work.
- (d) recipient utilization figures for the Oregon personal care services program showed total utilization equal to 8.6% of the Aged, Disabled, and Blind eligibles. Alaska has approximately 5,200 APA recipients of which 455 is the estimated number of recipients of this program.
  - 1. 30% Personal Care (PC) reimbursed at \$11.90 per hour. (Oregon's hourly rate multiplied by 1.25).
  - 2. 70% Home Care (HC) at \$8.13. (Oregon's hourly rate multiplied by 1.25)

Projected Cost Personal Care Services

	<u>Hours</u>	<u>Rate</u>	<u>Cost</u>
Single recipient PC/mo.	11.2 x	11.90 =	\$133.28
Single recipient HC/mo.	<u>38.1</u> x	8.13 =	<u>309.92</u>
Single recipient PC&HC/mo.	49.3		\$443.20
Single recipient yearly	591.6		5,318.40
Total 455 recipients	<u>269,178</u>		<u>\$2,419,872.00</u>

While the analysis projects a total annual cost of \$2,419,872, the Division estimates the first year cost at \$1,000,000. The Division anticipates that both a 10/1/86 program start date, as well as client unfamiliarity with the program will reduce the programs first year cost.

Committee Substitute House Bill 98

Division of Medical Assistance

Personal Services:

1 - New Medical Assistance Administrator position  
at range 17A \$2,895 x 12 months x 30% benefits = \$45,162

Travel:

Semi-annual travel to personal care sites by Medical  
Assistance Administrator to monitor the personal care  
services each client is receiving.  
Estimate transportation 7,000  
Estimate per diem, 20 days at \$80 per day 1,600

Contractual:

Printing and advertising for personal care services 800

Increases from fiscal year to fiscal year are budgeted at 4% for all lines.

Attachment A

MEDICAID  
SERVICES

A. Mandatory Services:

- .Inpatient Hospital Services
- .Outpatient Hospital Services
- .Rural Health Clinics Services
- .Other Laboratory and X-Ray Services
- .Skilled Nursing Facilities Services
- .Home Health Services
- .Nurse Midwife Services
- .Early and Periodic Screening Diagnosis and Treatment for Individuals under 21
- .Physician Services
- .Medical Transportation

A. Optional Services Offered in Alaska

1. Long-Term Care Noninstitutional Services
2. Medical Supplies and Equipment
3. Surgical Care Center Services ] under clinic services in .035
4. Clinic Services
5. Inpatient Psychiatric Service for Under Age 22 ] combined in .035
5. Inpatient Psychiatric Service for over Age 65 ]
6. Intermediate Care Facility for Mentally Retarded
7. Physical Therapy ] combined in .035
7. Occupational Therapy ]
8. Speech, Hearing and Language Disorder Treatment
9. Optometrist Services
10. Intermediate Care Facility for Services
11. Eyeglasses ] combined in .035
- \* Prosthetic Devices ]
- \* Skilled Nursing Facility for Under Age 21
- \* Emergency Hospital Services

C. Optional Services Not Offered in Alaska

- .Chiropractors Services
- .Other Practitioners Services
- .Private Duty Nursing
- .Dental Services
- .Prescribed Drugs
- .Dentures Services
- .Diagnostic Services
- .Screening Services
- .Preventive Services
- .Rehabilitative Services
- .Services for Age 65 or Older in TB Institutions
- .Personal Care Services
- .Christian Science Nurses
- .Christian Science Sanitoria

\* These optional services and eligible groups are not currently listed in AS 47.07.035 but have been included in the revision proposed in HB98.

**DEPT. OF HEALTH AND SOCIAL SERVICES**

*DIVISION OF MEDICAL ASSISTANCE*

POUCH H-07  
JUNEAU, ALASKA 99811  
PHONE:

February 12, 1986

BRIEFING PAPER  
GENERAL RELIEF MEDICAL

I. HISTORY OF GENERAL RELIEF MEDICAL PROGRAM

The GR Medical Program has been in existence since 1953. The number of persons covered and medical services offered varied depending on the funding available each year. During that early period, the GR Medical Program primarily offered major medical care to low income persons not otherwise covered by private health insurance, or covered under other federal programs such as the Indian Health Service. The largest group in the GR Medical population consisted of public assistance recipients (Aid to Families with Dependent Children, Old Age Assistance, Aid to the Blind and Aid to the Disabled).

In 1972, Alaska became the 49th State to enter the federal Medicaid Program. All public assistance recipients were at that time moved from GR Medical to Medicaid and became eligible for a broad range of preventative as well as major medical services. The GR Medical was concurrently redefined to cover only those low income adults and children who did not qualify for Medicaid, and who had no other medical coverage. After 1972, the single biggest group of GR Medical eligibles were low income families with young children who did not qualify for AFDC because both parents lived with the children. After 1972, GR Medical recipients were provided virtually the same range of medical services as were available to Medicaid recipients. These services included:

- . Inpatient hospital
- . Outpatient hospital
- . Skilled nursing facility
- . Intermediate care facility
- . Intermediate care facility for mentally retarded persons
- . Laboratory and X-ray services
- . Visual care services, dispensing and ophthalmic materials
- . Medical transportation
- . Speech, hearing and language services
- . Nurse midwife services
- . Home health care services
- . Physician services
- . Physical and occupational therapy
- . Prosthetic devices and medical supplies
- . Family planning services (including elective abortions)
- . Outpatient surgical care centers
- . Rural health clinic services
- . Emergency dental services for adults
- . Hearing aids

Three medical services were not picked up by the Legislature under Medicaid in 1972. These were prescription drugs, elective abortions, and emergency dental services for adults. These services were left under GR Medical but Medicaid recipients were allowed access to them if they had no other coverage. This remains the case through FY86.

*not available under Medicaid*

The last major change to GR Medical was made in 1982. The Alaska Legislature moved two more eligible groups from GR Medical into Medicaid. The first group consisted of pregnant women who did not qualify for Aid to Families with Dependent Children (AFDC) because this was their first child, or they were living with the father of the child. The second group consisted of all low income children who did not qualify for AFDC because they were living with both parents. These 1982 changes further reduced the population covered under GR Medical to only those adults between the ages of 21 and 64, who were either unemployed or under employed, and who met the income requirement.

The evolution of Alaska's GR Medical program is not unlike that found in many other states. In fact, most states have a residual statewide program like GR Medical to meet the needs of medically indigent individuals who are not covered under Medicaid, or other state and federal programs. As of July 1985, 34 states offered statewide programs designed to assist the medically indigent using state funds, and in some instances, local fund match. In the remaining 16 states, counties and municipalities carry some legal obligation to provide medical care to those without any other coverage.

*however AK pays rates at 75th percentile; many states pay 50th percentile.*

## II. CURRENT ELIGIBILITY REQUIREMENTS

In order to qualify for Alaska GR Medical at the present time, an adult must:

- have income under \$300 a month,
- have liquid assets under \$500 (excluding their home and vehicle),
- have no other medical coverage to meet the need

In certain circumstances, the Commissioner of Health and Social Services has "waived" the income and asset eligibility requirements under the authority of AS 47.25.252, and extended medical benefits to persons who would otherwise not be eligible. Less than 30 such waivers have been approved to date with an approximate annual cost of \$700,000.

## III. DEMOGRAPHICS OF GR MEDICAL POPULATION

Because Medicaid recipients access certain medical services under GR Medical the demographics of GR Medical users is heavily skewed by the Medicaid population. TABLES I, II and III demonstrate this clearly. In analyzing the data in Tables I, II, and III we note that of the 16,696 persons who used GR Medical in FY85 (See TABLE I) 14,767 or 88% used prescription drugs. Most of these individuals were Medicaid recipients crossing over to use GR Medical services. The same close interrelationship to Medicaid is evidenced with respect to dental services. Here again, most would be Medicaid recipients. Adjusting for the Medicaid recipient cross-over factor, we estimate that approximately 3990 Alaskans used only GR Medical in FY85, and had no connection to Medicaid.

TABLE I

GR MEDICAL UTILIZATION BY AGE - FY85

TYPE OF MEDICAL CARE OR SERVICE	AGE IN YEARS				
	-----				
	UNDUPLICATED TOTAL (1)	UNDER 6 (2)	6 - 20 (3)	21 - 64 (4)	65 AND OVER (5)
1. TOTAL	16,696	3,705	3,576	8,210	1,205
2. INPATIENT HOSPITAL SERVICES	657	6	15	629	7
3. SNF/ICF SERVICES - ALL OTHER	45	0	0	25	20
4. PHYSICIANS' SERVICES	2,205	42	144	1,997	22
5. DENTAL SERVICES	2,216	8	32	2,076	100
6. OTHER PRACTITIONERS' SERVICES	702	8	18	673	3
7. OUTPATIENT HOSPITAL SERVICES	994	14	33	937	10
8. FAMILY PLANNING SERVICES	55	0	3	52	0
9. LAB AND X-RAY SERVICES	135	3	2	128	2
10. PRESCRIBED DRUGS	<u>14,767</u>	<u>3,663</u>	3,477	6,475	1,152
11. EARLY AND PERIODIC SCREENING	45	12	6	16	11
12. RURAL HEALTH CLINIC SERVICES	4	1	2	1	0
13. OTHER CARE	642	12	86	533	11

TABLE II

GR MEDICAL UTILIZATION BY SEX - FY85

TYPE OF MEDICAL CARE OR SERVICE	SEX		
	MALE	FEMALE	UNKNOWN
1. TOTAL	5,696	10,866	134
2. INPATIENT HOSPITAL SERVICES	309	348	0
3. ICF SERVICES - ALL OTHER	20	25	0
4. PHYSICIANS' SERVICES	936	1,269	0
5. DENTAL SERVICES	573	1,643	0
6. OTHER PRACTITIONERS' SERVICES	422	280	0
7. OUTPATIENT HOSPITAL SERVICES	477	517	0
8. FAMILY PLANNING SERVICES	0	55	0
9. LAB AND X-RAY SERVICES	48	87	0
10. PRESCRIBED DRUGS	4,809	9,819	139
11. EARLY AND PERIODIC SCREENING	10	35	0
12. RURAL HEALTH CLINIC SERVICES	0	4	0
13. OTHER CARE	207	435	0

TABLE III

GR MEDICAL UTILIZATION BY RACE - FY85

TYPE OF MEDICAL CARE OR SERVICE	-----RACE/ETHNICITY-----					
	WHITE NOT OF HISPANIC ORIGIN	BLACK NOT OF HISPANIC ORIGIN	AMERICAN INDIAN OR ALASKAN NATIVE	ASIAN AMERICAN	HISPANIC	UNKNOWN
1. TOTAL	11,801	1,332	2,261	286	406	610 = 16,696
2. INPATIENT HOSPITAL SERVICES	545	28	20	12	12	40
3. ICF SERVICES - ALL OTHER	31	1	7	2	0	4
4. PHYSICIANS' SERVICES	1,766	126	132	52	42	87
5. DENTAL SERVICES	1,667	20	162	53	62	72
6. OTHER PRACTITIONERS' SERVICES	430	39	199	7	13	14
7. OUTPATIENT HOSPITAL SERVICES	839	57	32	22	17	27
8. FAMILY PLANNING SERVICES	47	2	2	2	1	1
9. LAB AND X-RAY SERVICES	107	7	5	7	3	6
10. PRESCRIBED DRUGS	10,613	1,259	1,741	253	369	532
11. EARLY AND PERIODIC SCREENING	29	6	5	1	2	2
12. RURAL HEALTH CLINIC SERVICES	0	0	4	0	0	0
13. OTHER CARE	350	50	207	9	7	19

Table IV demonstrates another interesting fact<sup>?</sup> about the GR Medical program. Approximately 32% of the persons open for GR Medical coverage in January 1986 were individuals awaiting a disability determination from Social Security, which if favorable would entitle the individual to state and federal cash assistance payments as well as Medicaid. Typically, a pending disability client must wait an average of 2 to 3 months to learn whether their eligibility for cash assistance and Medicaid will be approved. GR Medical meets many of these individuals medical needs in the interim.

TABLE IV

GRM CASES OPEN IN JANUARY 1986

DISTRICT	# GRM	PENDING DISABILITY	TOTAL
21 Juneau	13	3	16
22 Sitka	2	1	3
23 Ketchikan	20	7	27
24 Petersburg	2		2
41 Fairbanks	76	24	100
44 Fairbanks Field Unit	1		1
45 Barrow	1		1
49 Minto	5		5
78 Tok	3	1	4
46 Nome	3		3
47 Kotzebue		1	1
51 Bethel	18	14	32
55 Aniak	6	2	8
71 Anchorage Intake	17	83	100
83 Anchorage Maintenance	102		102
72 Valdez	3		3
75 Kodiak	14		14
76 Kenai	31	12	43
77 Palmer	<u>31</u>	<u>12</u>	<u>43</u>
Total	348	160	508

In summary, the average GR Medical recipient has these characteristics:

- . white adult - fairly equal number of men and women
- . between the age of 21 and 64
- . medically in need - many having filed for disability
- . predominantly live in Anchorage, Fairbanks, Juneau or Ketchikan
- . predominantly unemployed or unable to work because of disability

#### IV. MEDICAL SERVICES BEING USED

Tables V, VI and VII give total expenditures for GR Medical in FY85 by type of medical service by age, race and sex of those using the services. Again, these numbers must be adjusted for the Medicaid cross-over to isolate the services used by the GR Medical only population. The principal service categories used solely by the GR Medical population are hospital services (both inpatient and outpatient) and physician services.

TABLE V

#### AMOUNTS OF MEDICAL PAYMENTS BY AGE - FY85

TYPE OF MEDICAL CARE OR SERVICE	TOTAL (1)	AGE IN YEARS			
		UNDER 6 (2)	6 - 20 (3)	21 - 64 (4)	65 OR OVER (5)
1. TOTAL	10,861,550.42	241,987.74	390,445.50	9,368,367.12	860,750.06
2. <del>INPATIENT HOSPITAL SERVICES</del> <i>maintained from budget</i>	4,533,962.29	8,774.62	45,137.92	4,428,529.30	51,520.45
3. SNF/ICF SERVICES - ALL OTHER	308,239.75	0	0	81,675.64	226,564.11
4. PHYSICIANS' SERVICES	2,001,164.57	11,547.89	55,011.90	1,917,309.17	17,295.61
5. <del>DENTAL SERVICES</del>	<del>677,806.50</del>	1,216.00	7,519.50	640,233.50	22,837.50
6. OTHER PRACTITIONERS' SERVICES	127,461.66	1,052.54	2,141.39	123,907.82	359.91
7. OUTPATIENT HOSPITAL SERVICES	400,234.09	2,893.46	9,001.61	386,415.16	1,923.86
8. CLINIC SERVICES	0	0	0	0	0
9. HOME HEALTH SERVICES	0	0	0	0	0
10. FAMILY PLANNING SERVICES	61,663.28	0	224.00	61,439.28	0
11. LAB AND X-RAY SERVICES	8,732.31	94.32	61.88	8,498.11	78.00
12. PRESCRIBED DRUGS	2,528,103.87	212,093.68	246,425.67	1,537,660.24	531,924.28
13. EARLY AND PERIODIC SCREENING	3,499.43	435.51	273.25	1,121.53	1,669.14
14. RURAL HEALTH CLINIC SERVICES	1,281.70	58.93	626.01	596.76	0
15. OTHER CARE	215,400.97	3,820.79	24,022.37	180,980.61	6,577.20

TABLE VI

#### AMOUNTS OF MEDICAL PAYMENTS BY SEX - FY85

TYPE OF MEDICAL CARE OR SERVICE	MALE	FEMALE	UNKNOWN
1. TOTAL	4,892,562.42	5,961,246.53	7,711.47
2. INPATIENT HOSPITAL SERVICES	2,438,429.56	2,095,532.73	0
3. SNF/ICF SERVICES - ALL OTHER	167,812.70	140,427.05	0
4. PHYSICIANS' SERVICES	972,219.78	1,028,944.79	0
5. DENTAL SERVICES	166,066.60	505,739.90	0
6. OTHER PRACTITIONERS' SERVICES	85,992.52	41,469.14	0
7. OUTPATIENT HOSPITAL SERVICES	194,001.33	206,232.76	0
8. FAMILY PLANNING SERVICES	0	61,633.28	0
9. LAB AND X-RAY SERVICES	3,054.71	5,677.60	0
10. PRESCRIBED DRUGS	778,715.13	1,741,677.27	7,711.47
11. EARLY AND PERIODIC SCREENING	689.91	2,809.52	0
12. RURAL HEALTH CLINIC SERVICES	0	1,281.70	0
13. OTHER CARE	85,580.18	129,820.79	0

TABLE VII  
 AMOUNTS OF MEDICAL PAYMENTS BY RACE - FY85

TYPE OF MEDICAL CARE OR SERVICE	RACE/ETHNICITY					
	WHITE NOT OF HISPANIC ORIGIN	BLACK NOT OF HISPANIC ORIGIN	AMERICAN INDIAN OR ALASKAN NATIVE	ASIAN AMERICAN	HISPANIC	UNKNOWN
1. TOTAL	8,560,794.22	801,469.40	636,265.91	224,703.14	171,331.28	474,305.
2. INPATIENT HOSPITAL SERVICES	3,521,843.74	365,201.56	114,942.31	113,865.92	53,691.42	264,412.
3. SNF/ICF SERVICES - ALL OTHER	283,201.55	601.90	25,841.38	0	0	5,918.
4. PHYSICIANS' SERVICES	1,610,992.33	141,944.01	67,692.98	36,445.34	40,907.25	103,183.
5. DENTAL SERVICES	534,915.35	49,984.35	33,271.80	12,055.00	25,248.00	16,332.
6. OTHER PRACTITIONERS' SERVICES	78,204.54	20,927.64	23,813.19	1,020.97	1,770.21	1,725.
7. OUTPATIENT HOSPITAL SERVICES	342,399.25	23,746.31	10,715.69	7,811.90	7,857.75	7,703.
8. FAMILY PLANNING SERVICES	51,022.78	3,645.00	1,042.00	3,253.50	2,312.00	300.
9. LAB AND X-RAY SERVICES	6,769.71	686.52	271.08	485.60	118.12	401.
10. PRESCRIBED DRUGS	1,886,524.54	180,433.89	307,946.51	46,186.86	37,772.69	69,239.
11. EARLY AND PERIODIC SCREENING	2,227.76	602.41	216.02	102.79	77.54	272.
12. RURAL HEALTH CLINIC SERVICES	0	0	1,281.70	0	0	
13. OTHER CARE	142,692.67	13,695.81	49,231.25	3,475.26	1,576.30	4,729.

V. CHANGES PROPOSED FOR FY87

Insufficient funds were available to the Department in FY87 to continue funding both Medicaid and GR Medical at maintenance levels. Departmental priority was placed on programs targeted at children, pregnant women, the elderly and the disabled. Within this priority, Medicaid was funded at a level adequate to continue all existing medical services, and to cover new eligibles expected in FY87. As a result of this prioritization, major reductions were required in GR Medical.

The ~~estimated need~~ for GR Medical in FY87 is \$12 million. Approximately \$2.5 ~~million~~ of this was for continuation of prescription drugs, primarily benefiting Medicaid eligible children and adults. Since HB209 is being considered restore this \$2.5 million to GR Medical, the GR Medical program need in FY87 excluding drugs is \$9.5 million. Only \$5 million is requested in the Governor's FY87 budget which represents a reduction of 45% below FY86 (FY86 authorized was \$9.4 million excluding prescription drugs).

A number of FY87 program reductions were considered. Some were not viewed reasonable, such as attempting to continue offering all medical services but ~~reducing payments for those services to nearly 50¢ on the dollar.~~ Since acceptance of GR Medical patients by hospitals and physicians is voluntary, individuals could experience serious ~~difficulty in accessing health care if this option were selected.~~

under  
FY 87  
budget

On the other hand, the Department deemed it essential to cover medically necessary **hospital based procedures**, and their associated expenses (physician, transportation etc.). Under this model, all hospital admissions, except those of an emergency nature, would require prior approval from the Division to be eligible for payment. While this "major medical" program was estimated to cost nearly \$5 million in FY87, financing essential hospital care was considered extremely important because:

- (1) Unlike other states, Alaska has not required local governments to meet the acute care needs of medically indigent Alaskans. The only place where this responsibility exists is at the state level.
- (2) Hospital care triggers the largest financial liability a person will experience. The financial impact on a family could be disastrous, particularly for persons who could not meet the \$10,000 minimum applicant share under Catastrophic Illness.
- (3) A predictable number of adults need medically necessary hospital care each year and there must be an on-going state commitment to meet this need.

Another area considered essential was continued financing of pregnancy related services, specifically elective abortions. Financing for these services would not be otherwise available for either Medicaid or GR Medical recipients. A decision to discontinue this medical service would likely face serious legal challenge under Alaska Statutes in view of Alaska's abortion statute and previous Attorney General's advice.

General outpatient care, not directly related to either a medically necessary hospital admission or a pregnancy related service was deemed important but only if funds were available after covering necessary hospital care and pregnancy related services. Ideas for reducing state expenditures to achieve savings to cover some outpatient care were examined. These ideas, which have been included in a ~~BPP~~ **to be introduced by the Governor**, include:

- (1) ~~Looking at~~ an individual's annual income rather than monthly income. Some individuals qualify for GR Medical under current rules because they do not maximize their annual, mostly seasonal, earnings.
- (2) Clarifying in statute that related household members must contribute to the medical care of another household member.
- (3) Limiting the per individual amount of assistance available under GR Medical to **\$25,000 maximum annually.**
- (4) Requiring a **\$50 per day deductible**, not to exceed \$200 per hospital admission.
- (5) Requiring an individual to ~~repay~~ **repay** the full amount of assistance received under GR Medical ~~if~~ **if** the individual receives income and resources sufficient to do so **within two years.**

It was hoped that these measures and others (such as paying only a percent of hospital charges) might permit enough savings to offer a limited set of outpatient medical services. Additionally, special contracts might be possible to maximize the services purchased for the dollars available in the larger urban settings such as Anchorage. Delivery of these services could likely not be limited to certain communities as previous court decisions have ruled that statewide programs must be available to all qualified persons in need of the services.

Because of their cost or lack of essential nature, certain services might not be available at all for GR Medical recipients such as GR Medical waivers, adult dental care, visual care and glasses, hearing aids, and nursing home care.

Within the limitations of a \$5 million program, the Department is committed to offering the maximum amount of medical assistance possible. While the very limited funding available will result in some medical services no longer being offered, the Department would be in a position to seek out competitive arrangements with medical providers to reduce the unit service cost for the most essential medical services below that possible under the present financing arrangements. Unfortunately, ~~until some experience is gained~~ relative to the competitiveness of the Alaska medical market, it is difficult to forecast what can be purchased for \$5 million beyond major medical care and pregnancy related services. It is anticipated that some basic outpatient program could be defined and afforded within the \$5 million, particularly if a percentage reduction is applied to hospital bills.

Specific questions or concerns not addressed by this GR Medical summary may be directed to Mr. Rod Betit, Director Medical Assistance, at 465-3355.



# DRAFT

Original sponsor: Rules/Governor:

IN THE HOUSE

BY THE HEALTH, EDUCATION AND  
SOCIAL SERVICES COMMITTEE

SENATE CS FOR CS FOR HOUSE BILL NO. 98 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

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

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

\* Section 1. AS 44.77 is amended by adding a new section to read:

Sec. 44.77.015. CLAIMS FOR MEDICAL SERVICES. (a) For the purposes of filing claims for medical services provided under AS 47.07 or 47.25.120 -- 47.25.300, "promptly", in AS 44.77.010(a), means (1) within six months after the date of service, or as provided in (b) of this section, if there is no third-party claim, or (2) within 12 months after the date of service if there is a third-party claim. Except as provided in (c) of this section, a claim may not be paid if it is not filed promptly; an inference to the contrary may not be drawn from AS 09.10.050, AS 09.50.250 -- 09.50.300, or AS 37.25.010.

(b) In accordance with (a) of this section, a claim may be considered to be filed promptly if (1) the claim was filed more than six months after the date of service because the medical provider had no reason to believe that the beneficiary was ineligible for service under AS 47.07 or AS 47.25.120 -- 47.25.300; (2) a court of competent jurisdiction or an administrative hearing officer finds that the beneficiary was eligible for service under AS 47.07 or AS 47.25.120 -- 47.25.300 on the date of service; and (3) the claim is filed within six months after the date that the court or administrative finding is rendered. The beneficiary is responsible for notifying the medical provider of the judicial or administrative finding.

1 (c) The commissioner of health and social services may authorize  
2 payment to a medical provider of a claim not promptly filed, upon good  
3 cause shown. Payments under this subsection may not exceed 50 percent  
4 of the allowable charges presented in the claim. "Good cause" does  
5 not include a beneficiary's failure to notify a provider of a judicial  
6 or administrative finding of eligibility.

7 (d) For the purposes of this section,

8 (1) "beneficiary" means a person who is found to be eligi-  
9 ble to receive medical services under AS 47.07 or AS 47.25.120 --  
10 47.25.300;

11 (2) "medical provider" means a person, firm, corporation,  
12 association, or institution that, on the date of service, was approved  
13 to provide medical assistance, in accordance with regulations adopted  
14 by the Department of Health and Social Services.

15 \* Section 2. AS 47.05 is amended by adding a new section to read:

16 Sec. 47.05.070. SUBROGATION. (a) If the department provides or  
17 pays for medical assistance for injury or illness under this title,  
18 the department is subrogated to the rights of the recipient of that  
19 medical assistance for any claim arising from the injury or illness  
20 and to the proceeds of an insurance policy covering the injury or  
21 illness to the extent of the value of the medical assistance provided.

22 (b) If a recipient of medical assistance under this title set-  
23 tles a claim or obtains an award or judgment arising from the injury  
24 or illness for which the medical assistance was received, the depart-  
25 ment shall reimburse the recipient for attorney fees and costs commen-  
26 surate with the amount of the settlement, award, or judgment to which  
27 the department is entitled under (a) of this section. Regardless of  
28 the manner in which the amount of the attorney fees is derived, reim-  
29 bursement of attorney fees must be in accordance with the applicable  
rules of court governing the award of attorney fees in civil matters.

(old SB 91)

9 \* Section 3 AS 47.07.020(b) is amended to read:

10 (b) In addition to the persons specified in (a) of this section  
11 the following optional groups of persons for whom the state may claim  
12 federal financial participation are eligible for medical assistance:

13 (1) persons eligible for but not receiving assistance under  
14 any plan of the state approved under 42 U.S.C. 601 -- 615 (Title IV--  
15 Social Security Act, Aid to Families with Dependent Children),  
16 42 U.S.C. 1381 -- 1383c (Title XVI, Social Security Act, Supplemental  
17 Security Income);

18 (2) persons in a general hospital, skilled nursing facility  
19 or intermediate care facility, who, if they left the facility, would  
20 be eligible for assistance under one of the federal programs specified  
21 in (1) of this subsection;

22 (3) persons under age 21 who are [YEARS OF AGE] under  
23 supervision of the department, for whom maintenance is being paid in  
24 whole or in part from public funds, and who are in foster homes or  
25 private child-care institutions;

26 (4) aged, blind, or disabled persons, who, because they do  
27 not meet income [REDACTED] requirements, do not receive supple-  
28 mental security income under 42 U.S.C. 1381 -- 1383c (Title XVI  
29 Social Security Act), and who do not receive a mandatory state

1 supplement, but who are eligible, or would be eligible if they were  
2 not in a ~~skilled nursing facility or intermediate~~ skilled nursing facility or intermediate  
3 care facility to receive an optional state supplementary payment;

4 (5) persons under age 21 who are [YEARS OF AGE] in  
5 institution designated as an intermediate care facility for  
6 mentally retarded and who are financially eligible as determined  
7 the standards of the federal aid to families with dependent children  
8 program;

9 (6) persons in a medical or intermediate care facility  
10 whose income while in the facility does not exceed 300 percent of the  
11 supplemental security income benefit rate under 42 U.S.C. 1381  
12 1383c (Title XVI, Social Security Act) but who would not be eligible  
13 for an optional state supplementary payment if they left the hospital  
14 or other facility;

15 (7) persons under age 21 who are [YEARS OF AGE] receiving  
16 active treatment in a psychiatric hospital and who are financially  
17 eligible as determined by the standards of 42 U.S.C. 601 -- 613 (Title  
18 IV-A, Social Security Act, Aid to Families with Dependent Children);

19 (8) individuals under age 21 not covered under (a) of  
20 this section who would be eligible for the federal Aid to  
21 Families with Dependent Children program except that they  
22 have the care and support of both their natural or adoptive  
23 parents;

24 (9) pregnant women not covered under (1) of this  
25 section who meet the income and resource requirements of the  
26 federal Aid to Families with Dependent Children program.

27 \* Sec. 4 AS 47.07.030 is repealed and reenacted to read:

28 Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. (a) The  
29 department shall offer all mandatory services required under 42 U.S.C.  
30 1396 -- 1396p (Title XIX of the Social Security Act).

31 (b) In addition to the mandatory services specified in (a)  
32 this section, the department may offer only the following optional  
33

services: personal care services in a recipient's home; emergency  
hospital services; long-term care noninstitutional services; medical  
supplies and equipment; clinic services; inpatient psychiatric facility  
services for individuals age 65 or older and individuals under age  
21; physical therapy; occupational therapy; treatment of speech  
hearing, and language disorders; prosthetic devices and eyeglasses;  
optometrists' services; <sup>including intermediate care facility services for the mentally retarded</sup> intermediate care facility services; skilled  
nursing facility services for individuals under age 21; and reasonable  
transportation to and from the point of medical care.

\* Sec. 6 AS 47.07.035 is repealed and reenacted to read:

Sec. 47.07.035. PRIORITY OF MEDICAL ASSISTANCE. If the department finds that the cost of medical assistance for all persons eligible under this chapter will exceed the amount allocated in the state budget for that assistance for the fiscal year, the department shall eliminate coverage for optional medical services and optionally eligible groups of individuals in the following order:

- (1) personal care services in a recipient's home;
- (2) emergency hospital services;
- (3) long-term care noninstitutional services;
- (4) medical supplies and equipment;
- (5) clinic services;
- (6) inpatient psychiatric facility services;
- (7)

intermediate care facility services for the mentally retarded;

- (8) physical therapy and occupational therapy;
- (9) treatment of speech, hearing, and language disorders;
- (10) prosthetic devices and eyeglasses;
- (11) optometrists' services;

(12) intermediate care facility services;

(13) individuals age five and over, but under age 11, who are not eligible for benefits under the federal aid to families with dependent children program because they do not meet the definition of dependent children;

(14) individuals under age 21 under supervision of the department, for whom maintenance is being paid in whole or in part from public money and who are in foster homes or private child-care institutions;

(15) individuals in a health facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under Title XVI of the Social Security Act and who would not be eligible for the optional state supplementary payment if they left the facility;

(16) aged, blind, and disabled individuals who, because they do not meet the income and resource requirements, do not receive supplemental security income under Title XVI of the Social Security Act, and who are not eligible to receive a mandatory state supplement but who are eligible, or would be eligible if they were not in a general hospital or skilled nursing facility or intermediate care facility, to receive an optional state supplementary payment;

(17) skilled nursing facility services for persons under age 21.

\* Sec. 6 AS 47.07.070 is amended by adding a new subsection to read:

(d) Notwithstanding (a) -- (c) of this section, the commission shall also consider available state and federal revenue when making rate decisions.

\* Sec. 7 AS 47.07.900(1) is amended to read:

(1) "clinic services" means services provided by state-

1 approved outpatient community mental health clinics that receive  
2 grants under AS 47.30.520 -- 47.30.620, state-operated community  
3 mental health clinics, outpatient surgical care centers ~~and~~ and  
4 physician clinics;

5 \* Sec. 4 AS 47.07.900 is amended by adding new paragraphs to read:

6 (7) "emergency hospital services" means services that

7 (A) are necessary to prevent the death or serious  
8 impairment of the health of the individual; and

9 (B) because of the threat to the life or health of the  
10 individual, necessitate the use of the most accessible hospital  
11 available that is equipped to furnish the services, even if the  
12 hospital does not currently meet

13 (i) the conditions for participation under  
14 Medicare; or

15 (ii) the definitions of inpatient or outpatient  
16 hospital services under 42 C.F.R. secs. 440.10 and 440.20;

17 (8) "personal care services in a recipient's home" means  
18 services prescribed by a physician in accordance with the recipient's  
19 plan of treatment and provided by an individual who is

20 (A) qualified to provide the services;

21 (B) supervised by a registered nurse; and

22 (C) not a member of the recipient's family.

23 \* Sec. 9. AS 44.77.010(b) is repealed.

24 \* Sec. 10. This Act takes effect immediately in accordance with AS 01-  
25 10.070(c).

BILL SHEFFIELD  
GOVERNOR



*Personal care  
services*

STATE OF ALASKA  
OFFICE OF THE GOVERNOR  
JUNEAU

January 29, 1986

Honorable Bettye Fahrenkamp  
Chairman, Health, Education and  
Social Services Committee  
Alaska State Senate  
P.O. Box V  
Juneau, AK 99811

Dear Senator Fahrenkamp:

During the last legislative session, I sponsored HB 98, a bill relating to the provision of mandatory and optional medical services under the state Medicaid program. Seeking to amend portions of AS 47, the bill addressed which medical services must be provided and which are optional under the Medicaid program, and in what order individuals and optional services will be eliminated in the event costs exceed state budget allocations for medical assistance.

These amendments became necessary due to recent changes in the federal Medicaid laws, with which the state must conform as a prerequisite to the state's eligibility for federal financial participation in the state Medicaid program. Conformance with federal law will not only ensure Alaska's receipt of the full amount of federal financial participation, but will aid us in avoiding federal fiscal sanctions for program noncompliance.

A House Finance Committee substitute made minor choice-of-language changes in sec. 3 of the bill; that amendment was supported by this office. The House passed CSHB 98(Fin); that bill currently resides in your committee.

In recent months, the executive branch has received public support for the inclusion in our Medicaid program of another optional service, personal care services in a recipient's home. Provision of personal care services in a recipient's home is expected to ease the current waiting lists that

exist for nursing home admission. In addition, this measure may reduce the number of hospital and nursing home admissions, and the high cost of those admissions, where a recipient may as easily be cared for at home by a qualified attendant. In the event of a budget shortfall, this optional service would be the first to be eliminated.

The inclusion in our Medicaid program of personal care services in a recipient's home offers a desirable alternative to institutional care for our disabled and senior citizens, and I urge your committee to consider sponsoring a substitute for CSHB 98(Fin) to include this optional service. A proposed committee substitute, accomplishing that, accompanies this letter.

The proposed committee substitute differs from CSHB 98(Fin) only in that it adds provisions relating to personal care services in a recipient's home in the following places: page 3, line 1; page 3, line 17; and page 5, lines 17 -- 22.

Passage of such a bill will not only assure needy persons in the state of uninterrupted, necessary medical care, but will also offer this desirable alternative to institutional care within the budgetary limits set by the legislature.

Sincerely,

  
Bill Sheffield  
Governor

now Sec. 2 of 303HB98 (HESS)  
BILL SHEFFIELD  
GOVERNOR



STATE OF ALASKA  
OFFICE OF THE GOVERNOR  
JUNEAU

dk.  
91

January 23, 1985

The Honorable Don Bennett  
President of the Senate  
Alaska State Legislature  
Pouch V  
Juneau, AK 99811

Dear Senator Bennett:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill relating to subrogation. The bill establishes, for the Department of Health and Social Services, a statutory right to subrogation in cases in which the department provides medical assistance for which a third party is liable.

Current Alaska statutes are silent on the department's right to recover medical assistance expenses when it is determined that a third party is liable for those expenses. Almost every claim by the department for reimbursement has been challenged, and, absent a statutory basis for such claims, time-consuming and expensive legal proceedings have been required to obtain reimbursement. Consequently, the department has had to expend excessive amounts of money or forego reimbursement in many cases. The department estimates that at least several hundred thousand dollars every year would be saved if this bill were enacted.

Additionally, the bill provides that the department will reimburse a recipient of medical assistance, in accordance with the rules of court, for the attorney fees incurred in establishing third-party liability for the medical assistance provided.

In the interest of fairness and efficiency, I urge your prompt and favorable consideration of this bill.

Sincerely,

A handwritten signature in cursive script that reads "Bill Sheffield".

Bill Sheffield  
Governor

---

PERSONAL ATTENDANT CARE

---

Alaskans with permanent physical disabilities resulting from accident, illness, or other health conditions may require life-long help to meet basic self-care needs. While today's technology allows for many of these individuals to work and to live outside hospitals and nursing homes, these people cannot live independently in the community without assistance. Personal attendant care provides individual help in bathing, dressing, lifting, eating, and care of physically dependent people who may be paralyzed, have respirators, catheters or other adaptive devices which need frequent monitoring.

Such care is required by people with physical disabilities who may be in their early twenties as well as by older people, or families with a severely health impaired son or daughter.

By amending the state's Medicaid law to include these services, Alaska can obtain 50% of the cost from the federal government and reduce the amount of hospital nursing home care which would otherwise be required.

For the last three years, Alaska has served a small number of physically disabled individuals in Anchorage and Fairbanks through the GR Med program and through special appropriation to the Division of Vocational Rehabilitation.

Without continued funding those people now being served at \$85 per day will be required to move to nursing homes which cost up to \$250 per day.

For F87 the proposed budget deletes use of the GR Med funds for this purpose. However, the Department of Health and Social Services requested \$500.0 in state funds for attendant care and the Council expects legislation to be introduced to amend the Medicaid statute and obtain 50% federal funding for personal attendant care.

RECOMMENDATION:

The Council supports introduction of legislation to amend the state's Medicaid program to include personal attendant care and appropriation of \$500.0 of state funds for program implementation in F87.

~~Personal services without position~~  
**STATE OF ALASKA 1986 LEGISLATIVE SESSION**  
**FISCAL NOTE**

Revision Date: 12/26/85

**REQUEST**

Bill/Resolution No.: CSHR 98  
 Title: An Act relating to medical assistance; and providing for an effective date.  
 Sponsor: Governor  
 Requestor: \_\_\_\_\_  
 Date of Request: \_\_\_\_\_

**FISCAL DETAIL**

Agency Affected: Health & Social Services  
 BRU: Medical Assistance  
 Components: Medical Assistance - Non Facility

**EXPENDITURES/REVENUES : (Thousands of Dollars)**

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES		45.2	47.0	48.8	50.8	52.8
TRAVEL		8.6	8.9	9.3	9.7	10.1
CONTRACTUAL		8	8	9	9	9
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS		1,000.0	2,419.9	2,516.7	2,617.4	2,722.1
MISCELLANEOUS						
<b>TOTAL OPERATING</b>		<b>1,054.6</b>	<b>2,476.6</b>	<b>2,575.7</b>	<b>2,678.8</b>	<b>2,785.9</b>

CAPITAL						
---------	--	--	--	--	--	--

REVENUE						
---------	--	--	--	--	--	--

**FUNDING : (Thousands of Dollars)**

GENERAL FUND		527.3	1,238.3	1,287.8	1,339.4	1,392.9
FEDERAL FUNDS		527.3	1,238.3	1,237.9	1,339.4	1,392.9
OTHER						
<b>TOTAL</b>		<b>1,054.6</b>	<b>2,476.6</b>	<b>2,525.7</b>	<b>2,678.8</b>	<b>2,785.9</b>

**POSITIONS :**

FULL-TIME		1.0	1.0	1.0	1.0	1.0
PART-TIME						
TEMPORARY						

**ANALYSIS :** Attach a separate page if necessary

See the attached.

Prepared by: *Red Bell*  
 Division: Medical Assistance

Phone: 465-3355  
 Date: 12/26/85

Approved by Commissioner: *John A. G...*  
 Agency: DHSS

Date: 12/31/85

Distribution (by Agency preparing fiscal note):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

Committee Substitute House Bill 98  
Assumptions

This projection for personal care services is based on the following:

- (a) personal care services can be divided into two categories of allowed Title XIX services (personal care and medically related home care).
- (b) Oregon showed an average of 21.2 hours personal care and 38.12 hours of home care per case per month.
- (c) unit cost is based on 1 hour of work.
- (d) recipient utilization figures for the Oregon personal care services program showed total utilization equal to 8.6% of the Aged, Disabled, and Blind eligibles. Alaska has approximately 5,200 APA recipients of which 455 is the estimated number of recipients of this program.
  - 1. 30% Personal Care (PC) reimbursed at \$11.90 per hour. (Oregon's hourly rate multiplied by 1.25).
  - 2. 70% Home Care (HC) at \$8.13. (Oregon's hourly rate multiplied by 1.25)

Projected Cost Personal Care Services

	<u>Hours</u>	<u>Rate</u>	<u>Cost</u>
Single recipient PC/mo.	11.2	x 11.90 =	\$133.28
Single recipient HC/mo.	<u>38.1</u>	x 8.13 =	<u>309.92</u>
Single recipient PC&HC/mo.	49.3		\$443.20
Single recipient yearly	591.6		5,318.40
Total 455 recipients	<u>269,178</u>		<u>\$2,419,872.00</u>

While the analysis projects a total annual cost of \$2,419,872, the Division estimates the first year cost at \$1,000,000. The Division anticipates that both a 10/1/86 program start date, as well as client unfamiliarity with the program will reduce the programs first year cost.

Committee Substitute House Bill 98

Division of Medical Assistance

Personal Services:

1 - New Medical Assistance Administrator position  
at range 17A \$2,895 x 12 months x 30% benefits = \$45,162

Travel:

Semi-annual travel to personal care sites by Medical  
Assistance Administrator to monitor the personal care  
services each client is receiving.  
Estimate transportation 7,000  
Estimate per diem, 20 days at \$80 per day 1,600

Contractual:

Printing and advertising for personal care services 800

Increases from fiscal year to fiscal year are budgeted at 4% for all lines.

STATE OF ALASKA 1985 LEGISLATIVE SESSION  
FISCAL NOTE

Revision Date: \_\_\_\_\_

**REQUEST**  
 Bill/Resolution No.: SB91  
 Title: An Act relating to recovery of Medical Assistance expenses  
 Sponsor: Governor  
 Requestor: \_\_\_\_\_  
 Date of Request: 1/23/85

**FISCAL DETAIL**  
 Agency Affected: Health & Social Services  
 Program Category Affected: \_\_\_\_\_  
 BRU, Program or Subprogram(s) Affected: Medical Assistance

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
<b>OPERATING</b>						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS						
800 MISCELLANEOUS						
<b>TOTAL OPERATING</b>	-0-	-0-	-0-	-0-	-0-	-0-
<b>CAPITAL</b>	-0-	-0-	-0-	-0-	-0-	-0-
<b>REVENUE</b>	250	270	292	315	340	367

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
<b>TOTAL</b>						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

**ANALYSIS:** Attach a separate page if necessary

This bill would redirect approximately 1,000 man hours of effort per year currently utilized due to a lack of clear State authority to have first right of collection. These redirected man hours are estimated to generate recoveries at a rate of approximately \$250 per hour. A 3% escalator was added to reflect increases in health care costs from one year to the next.

Prepared By: Rod Betit, Director *RPB 2/6/85* Phone: 465-3355  
 Division: Medical Assistance Date: \_\_\_\_\_

Approved by Commissioner: *John G...* Date: 2/15/85 *JCC*  
 Agency: HEALTH & SOCIAL SERVICES

Distribution (by Agency preparing fiscal note):  
 Legislative Finance  
 Legislative Sponsor  
 Requestor  
 Office of Management and Budget

# FOR DISCUSSION

1 BILL

2 IN THE LEGISLATURE OF THE STATE OF ALASKA

3 LEGISLATURE

4 A BILL

5 For an Act entitled: "An Act relating to payments to health  
6 facilities."

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

8 \* Section 1. 47.07.040 is amended to read:

9 Sec. 47.07.040. STATE PLAN FOR PROVISION OF MEDICAL  
10 ASSISTANCE. The department shall prepare a state plan in  
11 accordance with the provisions of 42 U.S.C. 1396 -- 1396p  
12 (Title XIX, Social Security Act, Medical Assistance) and  
13 submit it for approval to the United States Department of  
14 Health and Human Services. The plan shall designate that  
15 the Department of Health and Social Services is the single  
16 state agency to administer this plan. The department shall  
17 act for the state in any negotiations relative to the  
18 submission and approval of the plan. The department,  
19 including the medicaid rate commission, may make those  
20 arrangements, or regulatory changes, not inconsistent with  
21 law, as may be required under federal law to obtain and  
22 retain approval of the United States Department of Health  
23 and Human Services to secure for the state the optimum  
24 federal participation under the provisions of 42 U.S.C. 1396  
25 -- 1396p (Title XIX, Social Security Act, Medical Assis-  
26 tance). In addition, the department shall provide a report  
27 to the legislature no later than March 15 of each year  
28 concerning the status of this program and recommendations,  
29

1 with supporting fiscal data, as to any changes in the  
2 coverage of eligible persons or services to be provided.

3 \* Sec. 2. 47.07.070(a) is amended to read:

4 Sec. 47.07.070(a). PAYMENT TO HEALTH FACILITIES. (a)

5 The Commission shall determine prospectively the rate of  
6 payment to a health facility under this chapter and  
7 AS 47.25.120 - 47.25.300 based on a fixed rate, not to  
8 exceed the facility's customary charges, for reasonable  
9 costs incurred by the facility. The commission shall by  
10 regulation list the factors it considers in making its rate  
11 determinations under this section.

12 \* Sec. 3. 47.07.070 is amended by adding new subsections:

13 Sec. 47.07.070(d) In determining rates of payment to  
14 health facilities, the commission shall consider the appro-  
15 riation limit set by the legislature for the department's  
16 programs under this chapter and under AS 47.25.120 --  
17 47.25.300. The commission shall set rates for facilities in  
18 the state so that, taking into account projected rates of  
19 utilization, the aggregate state payments to health facil-  
20 ities will not exceed the budgeted amounts for the state  
21 fiscal year.

22 (e) For the state fiscal year 1987, beginning July 1,  
23 1986, the commission may establish new prospective payment  
24 rates for any facility whose rate for any part of state  
25 fiscal year 1987 was set before the effective date of this  
26 amendment, if a new rate is necessary to allow the commis-  
27 sion to carry out the intent of subsection (d) above.

28 \* Sec. 4. 47.07.180 is amended to read:  
29

1                   Sec. 47.07.180. DUTIES. (a) The commission shall  
2 review proposed payment rates [AND BUDGETS] of health  
3 facilities and establish payment rates for health facilities  
4 under this chapter and AS 47.25.120 -- 47.25.300.

5                   (b) The commission shall consult with the department  
6 on the state plan as it relates to health facilities, and  
7 shall coordinate the payment rate methods used by the  
8 commission with the state plan and with the administrative  
9 needs of the department's medical assistance payment  
10 program.

11                   (c) The commission will make available facility-  
12 reported budget data to any health facility which has need  
13 of budgeting or management assistance, including assistance  
14 by the commission in a facility's request to the United  
15 States Department of Health and Social Services for a waiver  
16 of federal reimbursement rules or limits.

17                   (d) By March 1 of each year, the commission shall  
18 adopt a target dollar amount estimating Medicaid  
19 utilization, revenues, and payment rates of facilities for  
20 the state fiscal year beginning the next July 1. The  
21 methodology used by the commission to develop the target  
22 shall be the basis used for establishing payment rates for  
23 the facilities during the applicable state fiscal year.

# health association of alaska

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

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South Peninsula Hospital  
Homer

Chairman-Elect  
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Charter North Hospital  
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Alternate Delegate to the  
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Hospital Governing  
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Sharon Jean  
Central Peninsula  
General Hospital  
Soldotna

Physician Member of  
the Board  
Morris Horning, M.D.  
Anchorage

President  
Dennis DeWitt  
Juneau

January 30, 1986

Senator Bettye M. Fahrenkamp  
Alaska State Legislature  
Pouch V (MS 3100)  
Juneau, Alaska 99811

Dear Senator Fahrenkamp,

Thank you for the opportunity to review a draft bill proposal that I understand the Department of Health and Social Services has ask the Senate HESS committee to consider, titled "An Act relating to payment to health facilities". I will be in Washington D.C. the full week of February 3-7 thus will not be able to attend the committee session Tuesday February 4. I would appreciate any possible consideration in the committee not acting on this measure until I return. I will be distributing this draft to the Executive Committee of the Health Association of Alaska so that we can develop and communicate a formal position to you. In the interim I will offer preliminary comments.

Section 1. This appears somewhat simple, however it could well cause the demise of many nursing homes in Alaska. The current fight is over whether the current costs of nursing homes in Alaska are reasonable in spite of the fact that most exceed federal limits. We believe that this is because we treat a heavier case load than is typical in the other states. We believe that many patients in Alaskan nursing homes would be in hospitals in other states. This section gives the state the clear direction to back away from that fight. We believe that it would be disastrous to the quality of patient care. Perhaps the first step to the problems we read about in other states but as yet not in Alaska.

Section 2. While this seems simple and equitable, it is not. We have to consider the payment structure developed by the Medicaid Rate Commission (MRC) and how it is compared to the customary charges of a facility. Currently every acute facility in Alaska is on a cafeteria style charge structure but the Medicaid program through the MRC has chosen to pay on a per diem basis. The second problem is that the typical outcome of this language is to take advantage of any discount price but not pay the higher charge in other areas to offset the loss. This gives the state the ability to shop in a very different manner than any other purchaser.

FORMERLY

alaska  
state  
hospital  
association

Senator Fahrenkamp  
January 30, 1986  
Page two

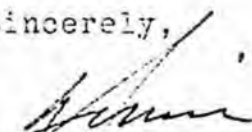
Section 3. This issue is addressed in House Bill 93 which is the outcome of negotiations between this association and Commissioner Pugh last year. This is their original position. At best this, in my opinion, shows poor judgement of the process. As I have told them in the past, the Federal law provides that rates of payment must reflect rates which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. I would refer you to 42 U.S.C. Section 1396a(a)(13)(A) and 42 C.F.R. Section 447.252 and Nebraska Health Care Association, Inc. v. Dunning, 575 F. Supp. 176 (D. Neb. 1983).

There seems to be a notion in this section that legislative appropriation is per se an aggregate reasonable and adequate cost determinate. I suggest that that would not survive any test. The subsection (e) is your basic "Kings X". Gosh guys we really didn't mean your rate and the legislature agrees!

Section 4. The new verbiage is somewhat of a mystery. I am not sure that it is necessary or beyond the ability of the MRC currently. The omission of the words "and budgets" is quite a different issue. That takes the discussion of the impact of MRC decisions off the table. The MRC then has the ability to determine that an arbitrary rate is justified based on national criteria, for example, and ignore the impact it might have in Petersburg, Glennallen or Home.

I have attempted to get this to you quickly so that you will be aware that these proposals are not "technical" but are substantive. I appreciate your courtesy in sharing this proposal. It would be well for the proponents to consider the same level of courtesy.

Sincerely,

  
Dennis L. DeWitt  
President

cc: Executive Committee  
Comissioner Pugh  
Ray Gillespie

under the federal aid to families with dependent children program, but who do not qualify because they are not dependent children:

(9) women who are pregnant.

(c) Receipt of medical assistance under this chapter is considered to be an additional benefit to these individuals and does not affect other assistance payments, federal or state, for which the recipient is eligible.

(d) Additional groups may not be added unless approved by the legislature.

(e) Notwithstanding (b) (4) of this section, a person is not eligible for medicaid benefits until a final determination is made on the eligibility of that person for benefits under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act). (§ 1 ch 182 SLA 1972; am § 1 ch 105 SLA 1974; am § 1 ch 117 SLA 1975; am § 1 ch 221 SLA 1976; am § 1 ch 11 SLA 1978; am § 1 ch 132 SLA 1982; am § 13 ch 138 SLA 1982)

Effect of amendments. — The first 1982 amendment added paragraphs (b) and (9) to subsection (b). The second 1982 amendment added subsection (e).

Sec. 47.07.030. Medical services to be provided. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, 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, physical therapy, occupational therapy, prosthetic devices and medical supplies, long-term care noninstitutional services, and reasonable transportation to and from the point of medical care. Additional services may not be provided unless approved by the legislature. (§ 1 ch 182 SLA 1972; am § 1 ch 35 SLA 1973; am § 2 ch 105 SLA 1974; am § 1 ch 12 SLA 1976; am § 2 ch 221 SLA 1976; am § 1 ch 82 SLA 1978; am § 25 ch 40 SLA 1981; am § 2 ch 132 SLA 1982)

Effect of amendments. — The 1981 amendment added "nurse midwife" following "skilled and intermediate nursing home, physician" in the first sentence. The 1982 amendment inserted "physical therapy, occupational therapy, prosthetic devices and medical supplies, long-term care noninstitutional services" near the end of the first sentence.

Sec. 47.07.035. Priority of services. If the funding in a fiscal year is inadequate to finance the total medical assistance program under this chapter, the department shall, to the extent that federal law and funding permits, provide medical assistance in the following order:

§ 47.07.040 WELFARE, SOCIAL SERVICES AND INSTITUTIONS § 47.07.040

- (1) aged, blind, or disabled persons who
  - (A) do not receive supplemental security income under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) because they do not meet income and resources requirements; and
  - (B) are eligible to receive an optional state supplementary payment;
- (2) persons in a medical or intermediate care facility
  - (A) whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act); and
  - (B) who would not be eligible for an optional state supplementary payment if they left the facility;
- (3) persons under 21 years of age
  - (A) who are under the supervision of the department;
  - (B) whose maintenance is paid in whole or in part from public funds; and
  - (C) who are in foster homes or private child-care institutions;
- (4) persons under 21 years of age who
  - (A) receive treatment in a psychiatric hospital; and
  - (B) are financially eligible as determined by the standards of 42 U.S.C. 601 — 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children);
- (5) persons under 21 years of age who are
  - (A) in an institution designated by the department as an intermediate care facility for the mentally retarded; and
  - (B) financially eligible as determined by the standards of the federal aid to families with dependent children program;
- (6) women who are pregnant;
- (7) persons under 21 years of age who do not qualify for benefits under the federal aid to families with dependent children program because they are not dependent children;
- (8) intermediate nursing home services;
- (9) eye examinations by an ophthalmologist or optometrist; or eyeglasses prescribed by a physician skilled in the diseases of the eye or by an optometrist;
- (10) treatment of speech, hearing, or language disorders;
- (11) physical or occupational therapy;
- (12) care at an intermediate care facility for the mentally retarded;
- (13) care at an inpatient psychiatric facility;
- (14) community mental health clinic services;
- (15) surgical care center services;
- (16) nurse midwife services;
- (17) medical supplies and equipment;
- (18) long-term care noninstitutional services. (§ 3 ch 132 SLA 1982)

**Sec. 47.07.040. State plan for provision of medical assistance.**  
The department shall prepare a state plan in accordance with the

provisions of 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act, Medical Assistance) and submit it for approval to the United States Department of Health and Human Services. The plan shall designate that the Department of Health and Social Services is the single state agency to administer this plan. The department shall act for the state in any negotiations relative to the submission and approval of the plan and may make those arrangements, not inconsistent with law, as may be required under federal law to obtain and retain approval of the United States Department of Health and Human Services to secure for the state the provisions of 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act, Medical Assistance). In addition, the department shall provide a report to the legislature no later than March 15 of each year concerning the status of this program and recommendations, with supporting fiscal data, as to any changes in the coverage of eligible persons or services to be provided. (§ 1 ch 182 SLA 1972)

**Sec. 47.07.050. Implementation of the medical assistance program.** The department shall take the steps necessary to adopt those regulations, prepare necessary documentation for the state and providers and undertake the systems design that may be necessary to implement the provisions of this chapter on or before November 1, 1972. Implementation of the medical assistance program shall include appropriate controls and reporting capabilities as required by the United States Department of Health and Human Services, and the department shall make those necessary reports as required by that federal agency or as requested by the legislature. (§ 1 ch 182 SLA 1972)

**Sec. 47.07.060. Receipt of federal money.** The Department of Administration shall accept and receive all grants of money awarded to the state under 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act, Medical Assistance). All money received shall be deposited by the Department of Administration in a special account of the general fund and shall be used by the state exclusively for medical assistance and the administration of medical assistance under the provisions of this chapter. This money shall be paid from the account on a certified disbursement voucher from the department. (§ 1 ch 182 SLA 1972)

**Sec. 47.07.070. Payment to health facilities.** (a) The commission shall determine prospectively the rate of payment to a health facility under this chapter and AS 47.25.120 — 47.25.300 based on a fair rate for reasonable costs incurred by the facility. The commission shall by regulation list the factors it considers in making its rate determinations under this section.

(b) In determining a rate of payment to a health facility under this section, the commission shall consider the proportionate share of the facility's financial requirements for patient care for

(1) costs of current operations, including salaries and wages, purchased services, supplies, insurance, leases, depreciation, taxes, inter-

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est expense, maintenance and other health facility operating expenses:  
and

(2) education, research, and appropriate capital development.

(c) In determining a rate of payment to a health facility under this section, the commission may consider whether the rate of utilization of the facility has been reduced because of improvident or careless development of the facility. (§ 1 ch 182 SLA 1972; am § 3 ch 95 SLA 1983)

**Cross references.** — For legislative findings and policy relating to ch. 95, SLA 1983, see § 2, ch. 95, SLA 1983, in the Temporary and Special Acts.

**Effect of amendments.** — The 1983 amendment rewrote this section.

**Editor's notes.** — Section 8, ch. 95, SLA

1983, provides: "INTERIM PROSPECTIVE PAYMENT SYSTEM. The department shall establish an interim system of prospective payments for health facilities under this Act for the period July 1, 1983, to June 30, 1984."

**Sec. 47.07.071. Reports by health facilities.** Not later than 120 days after the end of each fiscal year of a health facility, the facility shall submit to the commission a report on the facility's financial performance during the fiscal year. (§ 4 ch 95 SLA 1983)

**Sec. 47.07.072. Report by the commission.** Not later than September 30 of each year, the commission shall submit to the governor a report on the prospective payments made under this chapter during the current fiscal year and an estimate of the prospective payments that will be made during the remainder of the current fiscal year and the next fiscal year. The report shall state the assumptions that are used as a basis for the estimates. (§ 4 ch 95 SLA 1983)

**Sec. 47.07.073. Uniform accounting, budgeting, and financial reporting.** (a) The commission by regulation shall require a uniform system of accounting, budgeting, and financial reporting for health facilities receiving prospective payments under this chapter. The regulations shall provide for reporting revenues, expenses, assets, liabilities, and units of service. The commission shall specify the date the system becomes effective for each health facility.

(b) In adopting regulations under this section, the commission shall consider

(1) accounting, budgeting, and financial reporting procedures used by health facilities;

(2) variations among health facilities in the types of health care services provided by health facilities;

(3) the size and organizational structure of health facilities;

(4) the methods used by health facilities to obtain payments; and

(5) other factors the commission considers relevant.

(c) The commission may waive or modify a requirement for accounting, budgeting, or financial reporting for a health facility if waiver or modification is

**I. PURPOSE OF HB98**

There are six major components of HP98 as passed out of Senate HESS.

1. A provision clarifying the Legislature's intent regarding the six-month limitation placed on medical providers for filing medical billings (SECTION 1).
2. A provision strengthening the Department's ability to recover medical payments made on behalf of a recipient who subsequently was awarded an insurance or court settlement (SECTION 2).
3. A provision amending Alaska Medicaid Statutes making technical changes to bring them into conformance with federal law (SECTION 3).
4. A provision adding personal care services, chiropractor services, and adult dental care under Medicaid (SECTION 4).
5. A provision clarifying the order in which optional Medicaid services will be deleted by the Department in the event of funding difficulties (SECTION 5).
6. A provision clarifying the relationship between the Medicaid Rate Commission and the Department's annual budget (SECTION 6, 7 and 8).

**II. SECTIONAL ANALYSIS**

**. SECTION 1**

This section amends the filing deadlines on claims, for Medicaid and General Relief Medical, to eliminate inequities that result under the current six month rule. Under existing AS 44.77.010(b), the Department of Health and Social Services may only pay a claim for Medicaid or General Relief Medical services if the claim is filed "promptly". "Promptly" is defined for these purposes as within six months after the date that the service was rendered or third-party payment was received.

SECTION 1 would correct the following inequities:

- (1) Those situations where the third-party payor was so late in responding to the claim that more than six months elapsed before the medical provider received the negative response. The medical provider cannot then "promptly" file the claim, and is left with no recourse. The bill would eliminate this inequitable result by amending the definition of "promptly" to mean within 12 months after the date of service in those situations where a third-party is involved.
- (2) Another inequitable situation arises where a person has been found ineligible for Medicaid or General Relief Medical, and then successfully appeals that finding through a judicial or adminis-

trative proceeding only to discover that more than six months have elapsed since the medical services were provided. SECTION 1 would correct this inequity by permitting a medical provider to file claims within six months after the date upon which a court or administrative hearing officer finds that a person was improperly found to be ineligible for Medicaid or General Relief medical. Further, this section would make it the responsibility of the recipient to inform his or her medical provider(s) of the judicial or administrative decision.

- (3) Finally, SECTION 1 recognizes that some claims are filed late for good reasons. Under current statutes, the Commissioner has no discretion to consider "good cause" for late filings. SECTION 1 authorizes the Commissioner of Health and Social Services to approve payment, at no more than 50 percent of the allowed charges, of a claim not "promptly" filed, if the medical provider shows "good cause" for the failure to meet the filing deadline. "Good cause" does not include a recipient's failure to timely inform the provider of a judicial or administrative reversal of the department's finding of ineligibility.

The estimated state fund impact of SECTION 1 is \$14.6 in additional expenditures annually.

#### . SECTION 2

SECTION 2 gives the Department of Health & Social Services clear statutory basis for undisputed "first right" to recovery of medical assistance expenses from any insurance or court settlement awarded to a Medicaid recipient. Current Alaska statutes are silent on the Department's right to first recovery of medical assistance expenses, and as a result, many Department claims are challenged requiring time-consuming and expensive legal proceedings to obtain recovery.

The estimated state fund impact of SECTION 2 is (\$125.0) savings through increased revenue.

#### . SECTION 3

SECTION 3 clarifies the optional groups of needy persons covered under the Alaska Medicaid Program.

Alaska statutes specify the groups that are federally mandated to cover under AS 47.07.020(a). These groups include, among others, recipients of Aid to Families with Dependent Children, Old Age Assistance, Aid to the Blind, Aid to the Disabled, certain children not eligible for AFDC, and pregnant women. A complete list of mandatory groups is shown in Attachment A.

In addition to these mandatory groups, AS 47.07.020(b) sets out the optional groups the Alaska Legislature has elected to cover. Of the 10 optional groups, Alaska covers 5.

The purpose of SECTION 3 is simply to recognize that parts of two optional groups have been made mandatory by Congress in 1984. No

optional groups are being added or deleted from the program under SECTION 3.

There is no state fund impact as a result of SECTION 3.

. SECTION 4

As with the eligible groups, the State must also offer certain "mandatory" medical services, and may elect to offer certain "optional" medical services (see Attachment B).

Of the 28 optional Medicaid services, the Alaska Legislature has elected to offer 13 under Medicaid. Two of the remaining 15 services have been offered to Medicaid recipients under the 100% state funded General Relief Medical program (dental services and prescribed drugs).

SECTION 4 would pick up two additional optional services for Medicaid recipients that have not previously been offered under either Medicaid or General Relief Medical (personal care services and chiropractor services), and one service previously offered under GR Medical (adult dental care). A brief explanation of each follows:

A. Personal Care

Personal care services are those services necessary to "accommodate long-term maintenance or supportive care, at a skill level less than most duties included under home health care as performed by Home Health Aides." Personal care would include such tasks as assistance with personal hygiene, dressing, eating, using the toilet, and getting in or out of a bed or chair. Attachment C also gives one case example of when personal care would be appropriate, and two examples of when it would not be.

The cost estimate for adding personal care was derived using an average of 50 hours per month. However, the Division proposal would allow up to 170 hours of personal care per month per recipient.

The estimated state general fund cost to add personal care is \$1.2 million. However, an October 1, 1986 start date, client unfamiliarity with the service, and lack of personal care providers will reduce the program's first year's costs to \$527.3.

B. Adult Dental Care

Adult emergency dental care has been offered to Medicaid recipients under the General Relief Medical program since 1972. The Governor's FY87 budget eliminates adult dental services effective July 1, 1986. Section 5 would restore adult dental services under Medicaid rather than GR Medical where 50% federal funding can be earned. Adult dental care would be limited to the relief of "pain and acute infection" as has been the practice under GR Medical. Preventative dental services and dentures will not be covered.

Approximately 2716 adult Medicaid recipients will receive services in FY87 at an average per person cost of \$331.63 for a total estimated cost of \$900.7 (450.3 state and 450.4 federal).

C. Chiropractor Services

Chiropractor services would be a new service limited to manual manipulation of the spine and necessary x-ray, the only services reimbursable under Medicaid rules. This provision of CSCSHB98 (HESS) is identical to that contained in CSSB109 (HESS) which has passed the Senate and is awaiting House floor action.

Approximately 600 Medicaid recipients will receive services in FY87 at an average per person cost of \$255 for a total cost of \$153.00 (76.5 state and 76.5 federal).

. SECTION 5

SECTION 5 identifies the order in which optional medical services and optional eligible groups would be deleted if the program encountered funding difficulties. The present statute is unclear and therefore, open to misinterpretation. The present statute also includes services which are now mandatory for Medicaid coverage under federal laws, and may no longer be deleted if funding difficulties arise.

There is no state fund impact as a result of SECTION 5.

. SECTIONS 6, 7 and 8

These sections seek to create equitable consideration by the Medicaid Rate Commission between the financial needs of Alaska's health facilities, and the financial constraints of the Department budget.

The Medicaid Rate Commission is an independent body which was established in 1983 to set Medicaid rates for Alaska health facilities. Members are appointed by the Governor to three year terms.

As an example of the problem addressed by SECTION 6, the Department advised the Medicaid Rate Commission in February 1985 that only 7.5% was budgeted for facility price increases in FY85. However, data available to the Department indicates that the Medicaid Rate Commission approved a rate process that resulted in FY85 price increases averaging 16% for hospitals and 13% for nursing homes. This has not only created an over expenditure situation for FY85, but has placed the Department out-of-compliance with the state plan filed with federal Medicaid officials. The state plan is essentially a contract between the state and federal government describing the operation of Medicaid in Alaska. The state plans for FY85 and FY86 have not been approved by federal officials because there are significant differences between what federal rules permit, and what the Rate Commission has adopted as rate setting policies. Failure to remedy these differences could lead to significant reductions in federal funding, and worse case, total withdrawal of federal Medicaid funding in Alaska.

The potential problems addressed by Section 6 are significant, and if not adopted, could result in a major adverse impact on the Department's budget. The Department urges additional language further strengthening the legislative expectation that the Medicaid Rate Commission establish rates which, in the aggregate, are affordable within the Department's appropriated funds each fiscal year. The Department also urges an additional section requiring the Medicaid Rate Commission to reset any facility fiscal year 86 rates which extend into State Fiscal Year 1987, if new rates are necessary so that commission-set rates for Fiscal Year 87 do not exceed the final FY87 legislative appropriation. The present language of Section 6 in CSCSHB98 is an improvement over the present statute, but still leaves open the possibility of the Medicaid Rate Commission to exceed budgeted funds as occurred for FY85. (The final outcome for FY86 is not yet known.) The Department therefore urges the insertion of the language in Attachment D.

. SECTIONS 9 AND 10

These sections clarify one existing term, and add definitions for new terms introduced by CSHB98 (Senate HESS). These new terms are found in AS 47.07.030 and in AS 47.07.035.

. SECTION 11

This section deletes the existing six month billing provisions being replaced by Section 1 of Senate CS for CS HB98 (HESS).

DEPARTMENT POSITION

The Department supports CSCSHB98 (HESS) as written, but strongly recommends further strengthening of Section 7 to prevent a funding shortfall in FY87. The additional language recommended is included in Attachment D. CSCSHB98 has become an omnibus medical assistance measure of considerable importance to the Department. The net state general fund impact of CSCSHB98, with the proposed program additions in SECTION 4, is \$968.3 in FY87.

Recommended By:

*Rod Betit*

Rod Betit, Director  
Division of Medical Assistance

Date:

*3/12/86*

Approved By:

*John R. Pugh*

John R. Pugh, Commissioner  
Department of Health & Social  
Services

Date:

*3/12/86*

# STATE OF ALASKA 1986 LEGISLATIVE SESSION FISCAL NOTE

Revision Date : \_\_\_\_\_

**REQUEST**

Bill/Resolution No. : SCS CSHB98 (HESS)  
 Title : An act relating to Medical Assistance  
 Sponsor : Rules/Governor  
 Requestor : \_\_\_\_\_  
 Date of Request : 3/5/86

**FISCAL DETAIL**

Agency Affected : Health & Social Services  
 BRU : Medical Assistance Non-Facility  
 Components : Medicaid Non-Facility

**EXPENDITURES/REVENUES : (Thousands of Dollars)**

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES		45.2	47.0	48.8	50.8	52.8
TRAVEL		8.6	8.9	9.3	9.7	10.1
CONTRACTUAL		20.8	.8	.9	.9	.9
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS		2112.3	3612.5	3757.0	3907.2	4063.6
MISCELLANEOUS						
<b>TOTAL OPERATING</b>		<b>2186.7</b>	<b>3669.2</b>	<b>3816.0</b>	<b>3968.6</b>	<b>4127.4</b>

CAPITAL						
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REVENUE		250.0	270.0	292.0	315.0	340.0
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**FUNDING : (Thousands of Dollars)**

GENERAL FUND		968.3	1599.6	1762.0	1826.8	1893.7
FEDERAL FUNDS		968.4	1699.6	1762.0	1826.8	1893.7
OTHER						
<b>TOTAL</b>		<b>1936.7</b>	<b>3399.2</b>	<b>3524.0</b>	<b>3653.6</b>	<b>3787.4</b>

**POSITIONS :**

FULL-TIME		1.0	1.0	1.0	1.0	1.0
PART-TIME						
TEMPORARY						

**ANALYSIS :** Attach a separate page if necessary

- (1) Funding is net after revenue to program.
- (2) Grants inflated by 4% after FY88.
- (3) See attached detailed financial ~~summary~~.

Prepared by : Rod Betit, Director *R. Betit*  
 Division : Medical Assistance

Phone : 465-3355  
 Date : 3/5/86

Approved by Commissioner : John R. Poy  
 Agency : Department of Health & Social Services

Date : 3/12/86

Distribution (by Agency preparing fiscal note):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

Fiscal Note  
 Summary SCS (SHB98 (HESS)  
 FY87

<u>Section</u>	<u>Subject</u>	<u>FY87 Total</u>	<u>FY87 State</u>
I	Six Month Law	29.2	14.6
II	Subrogation	(250.0)	(125.0)
III	Optional Needy Groups	-0-	-0-
IV	Optional Medical Services	2157.5	1078.7
A. <u>Personal Care</u>			
	(a) 190 recipients X 600 hours X \$9.00/hour =	1,029.2	Total
	(b) New position and associated costs =	54.6	Total
B. <u>Chiropractor</u>			
	(a) 600 recipients X \$255 average =	153.0	Total
	(b) One time computer costs =	20.0	Total
C. <u>Adult Dental</u>			
	(a) 2716 recipients X \$331.63 =	900.7	Total
V	Priority Medical Services	-0-	-0-
VI	Medicaid Rate Commission	<u>-0-</u>	<u>-0-</u>
	Total \$ Impact	1936.7	968.3

Attachment A

MEDICAID  
ELIGIBLE GROUPS

A. Mandatory Eligible Groups:

- .AFDC Recipients
- .Deemed Recipients of AFDC
- .Families that lost AFDC because of employment
- .Individuals ineligible for AFDC because of requirements inapplicable under Medicaid
- .Individuals eligible for AFDC except for the SSA increase in 1972
- .Qualified pregnant women and children under 5 born after 9/30/83
- .Newborn children of Medicaid - eligible women
- .Children for whom adoption assistance or foster care maintenance payments are made under Title IV-E
- .The Aged, Blind, or Disabled under SSI
- .Individuals ineligible for SSI or State supplements because of requirements inapplicable under Medicaid
- ."Grandfathered" individuals

Win  
MMR

B. Optional Eligible Groups Covered in Alaska

11. Individuals under 21 who cannot qualify for AFDC because they are not dependent children
12. Institutionalized individuals under a special income eligibility level
13. Individuals who do not receive SSI but qualify for Adult Public Assistance
14. Pregnant women
- \* Individuals eligible for financial assistance but not receiving it
- \* Individuals eligible for financial assistance except for institutional status (not listed in draft bill under .035)

C. Optional Eligible Groups Not Covered

- .Noninstitutionalized disabled children
- .Noninstitutionalized individuals receiving home and community based service under a special income eligibility level
- .The medically needy
- .Individuals who could qualify for AFDC if AFDC were as broad as federally allowed
- .Individuals eligible for assistance under AFDC if child care costs were paid from earnings

\* These optional services and eligible groups are not currently listed in AS 47.07.035 but have been included in the revision proposed in HB98.

February 27, 1986

Senator Bettye Fahrenkamp, Chair  
Senate H.E.S.S. Committee  
Pouch V  
Juneau, AK 99811

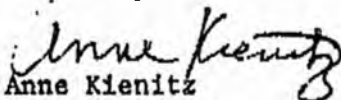
Madame Chairperson:

My name is Anne Kienitz. I am employed by Sitka Community Hospital and one of my duties is to assist patients in obtaining financial assistance for both elective and emergent medical care.

I feel there is a group of truly needy Alaskans not covered by the scope of this bill or present statutes. That group is the adult population over the age of 21 and not yet of Medicare age, and who are not suffering any permanent disability. While these persons are eligible under the State's General Relief Medical Program, the resource ceiling for individual applying for this assistance is \$300/month; a level unchanged since 1975, I believe. A person unemployed due to illness or injury who, for instance, draws a minimum unemployment check is rendered ineligible for assistance. The insurance crisis in this country has left many uninsured persons in this position. These persons then contribute to higher hospital costs to absorb revenue losses.

My concern is that the House address the lack of assistance for these persons--possibly through a resolution to Congress and a review of the State's current funding and eligibility requirements for medical assistance outside federal programs.

Sincerely,

  
Anne Kienitz  
Sitka Community Hospital  
209 Moller Drive  
Sitka, AK 99835

from DHS

ATTACHMENT D

- (1) Add at end of paragraph (d), line 21, page 7, Section 7 of CSCSHB98 (HESS).

The Commission shall set rates for facilities in the State so that, taking into account projected rates of utilization, the aggregate state payments to health facilities will not exceed the budgeted amounts for the state fiscal year.

- (2) Add between lines 22 and 23, page 7, as a new paragraph under Section 7 of CSCSHB98 (HESS).

- (e) For the state fiscal year 1987, beginning July 1, 1986, the commission may establish new prospective payment rates for any facility whose rate for any part of state fiscal year 1987 was set before the effective date of this amendment, if a new rate is necessary to allow the commission to carry out the intent of subsection (d) above.

# health association of alaska

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

Chairman of the Board  
Michael Herring  
South Peninsula Hospital  
Homer

Chairman-Elect  
R. Dale Reynolds  
Charter North Hospital  
Anchorage

Immediate Past Chairman  
Edward Zeine  
Cordova Community  
Hospital  
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Secretary/Treasurer  
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Central Peninsula  
General Hospital  
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Providence Hospital  
Anchorage

Alternate Delegate to the  
American Hospital Assoc.  
Sister Barbara Haase  
Ketchikan General Hospital  
Ketchikan

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Health Care Association  
Tom Boling  
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Care Center  
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of Western Hospitals  
C. Keith Campbell  
Seward General Hospital  
Seward

Alternate Delegate to the  
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Hospitals  
Jane Sabes  
Norton Sound Regional  
Hospital  
Nome

Delegate to the National  
Congress of Hospital  
Governing Boards  
Maxine Robertson  
Ketchikan General Hospital  
Ketchikan

Alternate Delegate to the  
National Congress of  
Hospital Governing  
Boards  
Sharon Jean  
Central Peninsula  
General Hospital  
Soldotna

Physician Member of  
the Board  
Morris Horning, M.D.  
Anchorage

President  
Dennis DeWitt  
Juneau

February 25, 1986

John Pugh, Commissioner  
Department of Health and Social Services  
Pouch H-01  
Juneau, Alaska 99811

Dear Commissioner Pugh,

I have reviewed the amendments you have proposed to HB 98 concerning rate setting for health facilities. We will be opposing them and any chances at this time.

We will submit the attached amendments for consideration by the committee if it feels compelled to move in the direction indicated by the amendments you have proposed.

I want to thank you for the time your staff has spent working on this issue with me. While we have not been able to reach agreement, we do better appreciate each other's position.

Sincerely,

Dennis L. DeWitt  
President

cc: Senator Bettye Fahrenkamp

FORMERLY

alaska  
state  
hospital  
association

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Dennis DeWitt  
Juneau

FORMERLY

alaska  
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## TESTIMONY BEFORE SENATE HESS COMMITTEE FEBRUARY 27, 1986

### STATEMENT ON DEPARTMENT AMENDMENTS TO HOUSE BILL 98

Madame Chair and members of the Senate Health, Education and Social Services Committee.

I am Dennis L. DeWitt, President of the Health Association of Alaska which represents over 30 hospitals and nursing homes in Alaska. I am before you this afternoon to address proposed amendments to House Bill 98, amending the development of rates for health facilities by the Medicaid Rate Commission. Specifically, we oppose the amendments to AS 47.07.070 and AS 47.07.130 as proposed by the Department of Health and Social Services.

In 1983 this association worked with the Department of Health and Social Services to develop a prospective payment system for the medical assistance program that would fairly compensate vendors (health facilities) and permit the department to better forecast the budgetary needs of the program to the Legislature. We believe that these amendments simply retreat from the notion of fairness back to a process of balancing the state budget on the back of health facilities.

It is important to review the statute, the intent language, and some of the activities that have brought us to these amendments. First let's look at the intent language found in Section 2 of Chapter 95 SLA 1983.

"The legislature acknowledges the need to pay health facilities for services provided to beneficiaries of state programs at a level that will meet the proportionate share of the total financial requirements of the facilities that are attributable to those programs given prudent and cost-effective management and operations of such facilities. The legislature finds that, because Medicaid is a joint state and federal program and because federal Medicaid funds have been and are likely to continue to be reduced dramatically, a

ATTACHMENT A

Section 47.07.070(d) is amended by adding new subsections:

(d) Payment to facilities shall be adjusted pro rata on July 1 to reflect any difference between budget appropriation for the state fiscal year beginning that date and the forecast of medical assistance payments to facilities made pursuant to Section 47.07.180. In the event that payment to facilities is reduced below the rate approved by the commission, the commission shall calculate the estimated aggregate amount of reduction and report that amount to the governor and legislature by February 1 following any adjustment made pursuant to this section.

(e) If the forecast exceeds the actual expenditures, any funds remaining from the legislative appropriation shall be paid to facilities on a pro rata basis up to 100% of the approved rate.

Section 47.07.180 is amended by adding a new subsection:

(b) By March 1 of each year, the commission shall develop an annual forecast for the fiscal year starting the next July 1, of medical assistance program expenditures in facilities under the jurisdiction of the commission. The forecast shall consider anticipated utilization and payment rates for each facility. The methodology used by the commission to develop the forecast shall be consistent with the regulations governing the commission's rate-setting process. The report shall include reporting of any reduction in payment to facilities in the current fiscal year and the amount necessary to fully fund the rates approved by the commission.

*assumption - 40% increase in rates  
isn't reasonable*

*DHSS - tie rate setting process to budget  
Dennis - tie payment process to budget*

*develop reasonable  
payment rate +  
pro rata fund*

*concern: rural hospitals absorb loss?*

*fed. concern - directly ties rates to budget apppr.  
Fed reqs. say rates must be reasonable per efficiently  
run facility - pro rating won't accomplish this.*

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February 27, 1986  
Page two

"retrospective payment system no longer serves as an appropriate method of compensation, nor does it respond with appropriate flexibility to continued federal cutbacks. A prospective payment system is necessary to prudently address payments to health facilities under the medicaid and general relief medical assistance programs."

Clearly the legislative intent was to assure that facilities received appropriate compensation for services provided rather than the type of discounting that was taking place at that time in Alaska and even more so in most other states. The intent to be a good business partner is as evident in this statute as it is in House Bill 30 which the governor just signed which requires the state to make prompt payment or pay interest just like the rest of us. The concepts in Chapter 95 SLA 1985 are the same in that they say that the state is not entitled to take a discount from its vendors just because it is an easy way to balance its budget, or it wants to buy more than the dollars it is willing to appropriate will allow. Neither you nor I have this luxury, neither should the state.

The current law, Section 47.07.070(b) states

"In determining a rate of payment to a health facility under this section, the commission shall consider the proportionate share of the facility's financial requirements for patient care for..."

We believe that this clearly states that the rates paid to facilities must fairly consider the costs of operating the facility. It does not suggest a rate based on the volume of services the state wishes to purchase divided by the amount the state wishes to appropriate for the medical assistance program.

There seems to be little question that the legislature knew that the federal financial participation was being reduced, that historically facilities had not been reimbursed fairly in any business sense and the need to address that situation. We believe that these factors were important considerations in the move to a new payment system.

We further believe that the legislature felt that an independent commission should be the judge of just what was a fair rate of payment to health facilities. The governor was given the authority to appoint five commissioners to do that.

*this assumes rates are reasonable & appropriate*

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Page three

The commission has done its work and reported its recommended rates back to the department. The aggregate payments which will result from these rates exceed projected budget limits that were established in the past fiscal years, because the system, which has been struggling, is not yet prospective. We have been assured that the process should be prospective by July 1986. This association is more hopeful than anyone that that time table is kept. It is through a true prospective system that you will be better able to make budget decisions and we will be better able to make management decisions. The legislature will know the price and can then make an informed decision on what and how much health facility services it intends to purchase.

Let us come back to the rate increases that seem to be the concern of the department in these amendments. We must object to the notion that this industry is somehow inherently dishonest because the budget forecasts and the approved rates are not the same. I dare say that we would not be having this discussion if the appropriation exceeded the aggregate rates. But such is not the case.

This industry has been attempting to deal with conflicting directions from commission staff. We have been trying to play prospective while our rates are set one and two years after the fact. Add to this the fact that there have been delays in payments from the program at the level of approved rates once they were set. We have acted with great restraint and devoted countless hours of facility staff time to doing and redoing forms as requested by the commission staff. We believe that the new Executive Director is the "light at the end of the tunnel" in terms of reasonableness in the "process" part of the commission activity. We still believe that a prospective rate determined by an independent commission is in the best interests of all concerned.

We believe that we have subjected ourselves to intense public review in the form of Medicaid Rate Commission public hearings and public rate setting. We have struggled with the regulations and worked to assure that they accurately reflected the financial needs of health facilities, so that we would not continue to be required to subsidize Medicaid patients through hidden taxes on the private pay patient or in many cases a tax on the municipality which owned the facility. We believe that the Legislature should look beyond the raw numbers of aggregate budget or specific percentage of rate increase. We believe that the legislature should look to see if in fact the previous rates and payments were a

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prime cause of the deterioration of the physical plants in many of our rural settings. Perhaps we should ask if the rates charged at Careage North and Nakoyia were directly related to the problems found in licensing surveys and whether the rates at Denali Center and Our Lady of Compassion Care Center result in the excellent quality of care now found in those facilities.

The notion of an independent commission was developed because it was thought that the unbiased nature of such an entity could develop answers for the Legislature. We hoped that the Legislature and the department would not "shoot the messenger" but rather consider the realities that it presents and deal with the question of how much you wish to purchase.

If it is the intent of the department to recommend and the Legislature to accept rates tied to the state budget appropriations then we have an alternate proposal with which we are prepared to live. The language (Attachment A) provides a process which has four steps:

1. The Medicaid Rate Commission forecasts the appropriation needed to pay facilities at the rates the commission approves for the volume the department expects;
2. The budget becomes law;
3. A percentage is derived by dividing budget appropriation by the forecast. Payments to facilities are then made at that percentage of the facility's approved rate. If the forecast proves to be high the facilities are reimbursed from the "surplus" up to 100% of the approved rate.
4. The commission will report to the governor and legislature the amount needed in a supplemental appropriation to fully fund the approved rates.

We believe that this process preserves the concept of an independent agency fairly determining rates based on the financial requirements of facilities. The department's current proposal simply divides the ~~the~~ budget up among facilities without regard to the reality of financial requirements. We believe the department amendments change the intent and effect of the prospective payment system, and return it to a budget-driven system without any real attention to financial requirements.

ATTACHMENT A

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# Medically Needy & Adult Dental

## Assumptions

A. Medicaid served 14880 children in FY85 and performed 1105 deliveries in 1984.

B. FY85 recipient count is 25,422 recipients.

C. FY85 cost per recipient: (based on FFY85 hCFA 2082)

	<u>Children</u>	<u>Adults</u>
1. institutionalized care	736.89	1558.00
2. ambulatory care	604.17	864.57
3. total	1,341	2423

D. The cost per recipient for MN is 1.26 greater than the cost per Medicaid recipient. Memorandum from Jarriette B. Fox)

E. The MN will increase total recipients by 6% or 1525 recipient. (25422 X .06 = 1525).

F. Of the 1525 recipients 7.4% or 113 will be pregnant women the remaining 1412 will be children. (1105 + 14880)

The cost of MN children equals 1.26 times the number of children times the average cost per child for ambulatory service only.

$$(1412)(1.26)(604.17) = \$1,074,890.33$$

The cost for pregnant women equals 1.26 multiplied by the number of pregnant women multiplied by the average cost per all recipients for total care \*.

$$113 (1.26)(2423) = \$344,986.74$$

G. Summary - Projected expenditures for a limited medically needy program.

	<u>\$</u>	<u>Recipients</u>
Total	1,419,877	1,525
FFP	709,938	

\* You may wish to include the complicated pregnancy related cost of the Cat Illness Program.

Diagnosis divided into categories:

Primary Diagnosis	# of Cases	% within category	cost to program	% of cost to program
Complicated Pregnancy & Premature Births	43*		1,372,924.33	
a. pregnancy related cost	31	42	1,35,333.75	10
b. premature related cost	38	58	1,237,590.58	90
Other Medical	64	14	900,067.00	22.5
a.respiratory/asthma/COPD	9		200,428.46	
b.digestive disorders/ulcers chrones/liver/gall bladder	19	30	166,884.66	18.5
c.meningitis,encephalitis	5	7.5	163,135.56	18
d.bone & orthopedic	12	19	158,211.12	17.5
e.diabetes	4	6.5	79,414.41	9
f.blood disord.,clots,hemorrhage	5	7.5	50,222.52	5.5
g.appendectomy	8	12.5	36,821.62	4
h.AIDS	1	1.5	33,994.76	3.5
i.seizure disorders	1	1.5	10,953.89	1.5
Trauma	33		378,539.82	
a.falls(other accident)	15	46	118,978.97	31.5
b.motor vehicle accident	11	33	117,140.02	31
c.burns	5	15	104,778.16	27.5
d.self-inflicted	2	6	37,642.67	10
Cardiovascular (coronary bv-dass, heart disease)	18		253,085.69	
Cancer (leukemia/Hodakins)	15		192,573.18	
Other GYN (hysterectomy/ectopic preg/urinary)	18		59,694.68	

\*Compl. preg. and premature birth: 26  
 Premature only: 12  
 Complicated pregnancy only: 5

## Cost Projection for Adding Adult Dental Services to Medicaid

### A. Assumptions for Cross Over

1. The ratio of nonnative to native children using dental services under Title XIX is 2.5 : 1. (based on unduplicated count FFY85 HCFA 2082).
2. The ratio of non native to native adults using dental services under the GRM programs is 11.6 : 1. (based on unduplicated count FFY85 HCFA 2082).
3. Total number of natives and non native adults using the GRM Dental services in FY85 was 162 and 1874 respectively (unduplicated count from HCFA 2082).
4. The difference in the ratio of users between Title XIX and GRM is due mainly to the availability of PHS to cover the adult native dental care. The number of native adults who would use Title XIX dental services is estimated to be 1874 divided by 3.5 or 535 recipients. I calculated this number by assuming that the ratio of adult natives to adult non native users should be the same as the children ratio in A1.
5. The average cost per recipient for FFY85 for GRM dental was 303.16.

6. We could expect at least \$162,190.06 in new dental bills from cross over and 535 recipients. Some portion of this would come through PHS at 100% FFP.
7. Overall the same GRM limitations on adult dental services would be applied to the Medicaid program. Dental coverage would be limited to emergency services for relief of pain and infection only.
8. The GRM non Medicaid adults accounted for 25% of the GRM dental expenditures and recipients. These clients would lose services when and if dental services are no longer covered under GRM. A savings of \$195,757. This may not be true, an individual in pain and infection may show up at the hospital for treatment.
9. GRM Dental FY86 Projection (without change)

State Expenditures	783,030
Recipients	3,526
Claims	4,649
Units of Service	12,786

Based on monthly MR-0-112 as of 12/86. Please note recipient count is not duplicated.

10. FY86 Project X 75% plus cross over = Medicaid Projected Expense  
from GRM transfer

Expenditure	587,272	+	162,190.06	=	749,462.60
Recipients	2,644	+	535	=	3,179
Claims	3,486	+	706	=	4,192
Units	9,586	+	1,942	=	11,528
Federal Share			374,731		
State Share			374,731		

11. Increased Coverage

3. In North Carolina and Connecticut dental services represented 2.02% and 9% of total expenditures respectively. Total dental expenditures for adults was 1.26 to 1.75 that of children.

			<u>\$</u>	<u>Recipient</u>	<u>\$/Recipient</u>
1.	Per the FY85 HCFA 2082.	Medicaid	1.422 mil	5857	\$242.95
		GRM	671,806	2216	303.16

2. In FY86 the Division was authorized \$1,583,500 for EPSDT Dental
4. Based on the ratio in B1 the total dental services cost for adults is assumed to be 1.26 times as great as the childrens total expenditures (1.26 X 1,583,500 = 1,995,210).
5. The dollar amount due to increased utilization would be \$1,995,210 minus the dollar amount transferred from GRM or (1,995,210 - 749,462 = 1,245,748)
6. Based on the cost per recipient in B1, total number of new recipients based on increased utilization would be 1,245,748 ÷ 303.16 = 4109

7. Native population represent 31% of the total Medicaid recipients. Thus of the 6478 new recipients 2,008 are native. Some of these will utilize IHS facilities which are reimbursed at 100% federal.

C. D. Summary

1. Dental services will now be provided to all Medicaid recipients through Title XIX.
2. All adult non emergency services must be prior authorized, preventive services and dentures are not covered.

	Current Title XIX	Utilization Factors +	GRM Transfer =	Total
Dental Recipients	5,857	4,109	3,394	15,729
Dental Expenditures	1,583,500	1,245,748	749,462	3,578,710
FFP	791,750	1,135,552	374,731	1,789,355
				TOTAL
	5,857	3,394	3,394	9,251
	1,583,500	688,974	754,019	
			1,442,993	

Approved *R. Ball* 2.24.86

*negs: 1/11/86  
HB 611: Pharmacy  
sub. can't  
save costs  
until 5/86  
Pharmacy  
sub. can't  
save costs  
until 5/86*

BILL NUMBER	DESCRIPTION OF ACT	SPONSOR(S)	ADDED STATE FUND (SAVINGS)	DEPARTMENT POSITION	LEGISLATIVE STATUS
HB98	This is now an Omnibus bill which 1) clarifies mandatory and optional services under Medicaid and the priority in which optional services will be deleted, 2) makes changes to the six month billing limit, 3) adds provision of SB91, 4) adds personal care services and 5) clarifies the role of the Medicaid Rate Commission.	Governor	416.9	Support	Passed House. Currently in Senate HESS. 1st hearing held on February 4. Next hearing is February 25. Will have to go back to House because of major changes.
HB209	Moves payment for proscribed drugs for Medicaid recipients from GR Medicaid into Medicaid, and mandates generic drug substitution for all Alaskans.	Governor	1,100.0	Support	Passed House during 1985 session. Currently in Senate HESS. No 1986 hearings held yet.
HB320	Permits substitution of JCAH inspections for those performed by the Department.	Koponen Sund et al	-0-	Support	Being held in Committee in view of SB45.
HB372	Prohibits the use of State money to pay for abortions.	Marrow Martin et al	-0-	Oppose	Currently in House HESS. No 1986 hearing held yet.
HB574	Authorizes a drug supplemental for FY86, and moves funds from FY84 to FY85 to pay liabilities.	Governor	896.9	Support	Currently in House Finance No 1986 hearings held yet.
HB641	Mandates generic drug substitution for all Alaskans.	Gruenberg	-0-	Support	Currently in House Labor and Commerce. No 1986 hearings held yet.
HB675	Creates a new basic health care program for low-income persons not eligible for other assistance.	Koponen Clocksin Hurley	Unknown	Being Reviewed	Currently in House HESS. No 1986 hearings held yet.
HB678	Gives DASS the authority to redefine the GR Medicaid program to operate within the \$5 million FY87 budget.	Governor	-0-	Support	Currently in House HESS. No 1986 hearings held yet.
HB687	Creates a special fund to pay for neonatal care. Companion bill to HB691.	Koponen Gruenberg Taylor	1,500.0	Support	Currently in House HESS. No 1986 hearings held yet.
HB691	Prohibits coverage of neonatal care under Catastrophic illness and creates a special neonatal care program.	Koponen Gruenberg Taylor	-0-	Support	Currently in House HESS. No 1986 hearings held yet.
HJR58	Urging the United States Department of Health and Human Services to ease the restrictions on the granting of Medicaid 1915(c) waivers.	House HESS	-0-	Support	Passed Legislature and signed by Governor.
SB33	Renames and expands the functions of the Medicaid Rate Commission to make it an all payor system.	V. Fischer	-0-	Oppose	No Activity yet. Currently in Senate HESS.
SB45	Permits substitution of JCAH inspections for those performed by the Department.	Falks	-0-	Support	Passed Senate. Currently in House Finance.
SB91	Expands the Department's third party collections powers.	Governor	(125.0)	Support	No Activity yet. Currently in Senate HESS. Also included in HB98.
SB109	Adds chiropractic services under the Medicaid program.	Josephson Abood Fahrenkamp	87.0	Support	Passed Senate and House Finance.
SB117	Relating to Alzheimer's disease and related disorders.	Fischer Josephson	253.8	Support	Passed Senate currently in House Finance.
SB364	Makes changes to the 6 month billing limit.	DeVries	14.6	Support	1st hearing in Senate Judiciary held 2/20.
SJR25	A Resolution opposing federal Medical funding reduction.	Senate HESS	-0-	Support	No activity yet. Currently in Senate Rules.

## [¶ 14,581] Dental Services

"Dental services" are defined as any diagnostic, preventive, or corrective procedures administered by or under the supervision of a dentist in the practice of his profession. Such services include treatment of the teeth and other structures of the oral cavity, and of disease, injury, or impairment that may affect the oral or general health of the recipient. The term "dentist" means an individual licensed to practice dentistry or dental surgery. See ¶ 14,551 concerning dental care under EPSDT.

.01 Sources.—Soc. Sec. Act § 1905(a) (10), ¶ 17,335. Reg. 42 CFR § 440.100, ¶ 21,553.

.21 Dental consultants to state agency.—*North Carolina.* The two part-time dental consultants to the Medical Services Section of the North Carolina Division of Social Services, who presently share in the responsibility for making decisions relating to prior approvals of dentures, requests for inpatient admission for dental extractions, and payment of individual claims which do not fall within the "norms," may not be assigned provider numbers for purposes of participating in the Medicaid program as providers of dental care because such an arrangement does not fall within the bounds of propriety. Absolute freedom is required to render completely disinterested decisions, and the fact that each consultant would review the other's provider activities leads to the conclusion that decisions in this regard may not be completely free of bias, however subconscious.

*Atty Gen Op.*, Nov. 25, 1974. [This decision was originally reported at NEW DEVELOPMENTS ¶ 27,212.]

.23 Dentures.—See ¶ 14,591.16.

.25 EPSDT dental care requirements.—See ¶ 14,551.13.

.29 Failure to provide.—*New York.* In a suit by a group of Medicaid recipients seeking an order to require the state to make dental care and services available to all persons who qualify, no merit was found to the recipients' contention that there were three bases on which the court could assert jurisdiction: (1) civil rights, (2) federal question jurisdiction, and (3) suits arising under Acts of Congress regulating commerce. (All of the claims were based on statutory or regulatory violations, there being no claim of constitutional violations.) Furthermore, the complaint was dismissed because the claimants failed to exhaust their administrative remedies, i.e., the Medicaid fair hearing procedures.

*Duffany v. Van Lare*, USDC (ND N. Y.), 393 F. Supp. 1060 (1973). [This decision was originally reported at NEW DEVELOPMENTS ¶ 27,050.]

.49 Licensing.—*Mississippi.* There is nothing in the statute authorizing the licens-

ing of dentists that automatically allows a U. S. Public Health dentist, who does not have a state license, to participate in the state's Medicaid program as a provider. A dentist may provide services and be reimbursed only for such dental care as is rendered within the scope of his authorized practice, as determined by the State Board of Dental Examiners.

*Atty. Gen. Op.*, Oct. 9, 1979. [This opinion was originally reported at NEW DEVELOPMENTS ¶ 30,074.]

.58 Opinion of attending dentist, effect of.—*Mimicola.* Although the state agency need not leave the determination of medical necessity up to the attending dentist, due consideration should have been given to his opinion as opposed to the opinion of a consulting dentist who has never seen the patient. Furthermore, the agency may not deny treatment requested by the attending dentist unless the denial is supported by substantial evidence. Therefore, a determination denying authorization to obtain a single tooth bridge for a 17-year-old recipient is reversed where the only evidence in the record to support the agency was an opinion letter authorized by the agency's consulting dentist.

*Wuori v. Noot*, Minn. Dist. Ct., No 20383. June 23, 1980. [This decision was originally reported at NEW DEVELOPMENTS ¶ 30,898.]

.61 Periodontia.—*Connecticut.* The state of Connecticut lawfully refused Medicaid coverage of periodontia, even though its Medicaid program covers other dental services.

*Laurence v. Maher*, USDC (Conn.), Civ. No. N-75-217, Mar. 21, 1977. [This decision was originally reported at NEW DEVELOPMENTS ¶ 28,478.]

.64 Prior authorization requirement.—*New York.* Even though New York regulations require prior authorization before dental work is rendered, a recipient was entitled to reimbursement for dental services performed without prior authorization where the agency knew that the services were necessary to alleviate a serious health problem.

*Klein v. Blum*, N. Y. Sup. Ct., App. Div., 78 A. D. 2d 768 (1980). [This decision was originally reported at NEW DEVELOPMENTS ¶ 30,904.]

### 11. Noninstitutionalized Disabled Children

A state's Medicaid plan may cover disabled children of age 18 or younger who are living at home but do not qualify for SSI or state supplementary payments because of their parents' income or resources, provided that: (a) they would qualify for SSI or state supplementary payments if they were in a medical institution; (b) they need a hospital, SNF, or ICF level of care; (c) home care is medically and otherwise appropriate; and (d) the cost of home care would not exceed the cost of appropriate institutional care.

This option, which was added to the federal Medicaid law at § 1902(e)(3) by § 134 of the 1982 Amendments, is explained further under .44, below.

### 12. The Medically Needy

A state's Medicaid program may cover individuals who are "medically needy" (see Reg. § 435.301). As mentioned at GUIDE ¶ 14,211, these are individuals whose income and/or resources may be too high to qualify as categorically needy but who, in the view of the state or territory, cannot afford to pay their medical bills. The regulations (Reg. § 435.4) define the medically needy as aged, blind, or disabled individuals, or as families and children, who are otherwise eligible for Medicaid, who are not categorically needy, and whose income and resources are within limits set under the state's Medicaid plan.

Thus, a state's Medicaid program may set income and resource eligibility levels for the medically needy that are no lower than the levels for comparable groups of categorically needy individuals, but no higher than allowed by federal regulations. Furthermore, applicants must be allowed to "spend down" to the medically needy income eligibility level by incurring medical expenses. Details concerning these and other aspects of financial eligibility for the medically needy are explained at ¶ 14,311 in the GUIDE.

When a state's Medicaid program covers any individual in one of the following groups, it must cover all individuals who are eligible to be members of that group. Also, there are these rules and options concerning coverage of the following groups as medically needy:

(a) *Pregnant women.*—Coverage of the medically needy must include all pregnant women during the course of their pregnancy if they would be eligible for Medicaid as categorically needy except for their income and resources (see Reg. §§ 435.1, 435.301, and 436.301). It may include other pregnant women who meet the financial eligibility standards for the medically needy. (See Social Security Act §§ 1902(a)(10)(C) and 1905(a)(viii) and Public Law 97-248 § 137.)

(b) *Individuals under age 18.*—Coverage of the medically needy must include individuals under age 18 who would be eligible for AFDC or SSI except for their higher income or resources. (See Social Security Act § 1902(a)(10)(C)(ii)(I) and Public Law 97-248 § 137.)

(c) *Individuals under age 21.*—Coverage of the medically needy may include financially eligible individuals who are not included in (b), above, if they are under age 21, or under age 20, 19, or 18 as the state provides. (See Reg. §§ 435.1, 435.301, 435.308, 436.301, and 436.308.)

(d) *Caretaker relatives.*—Caretaker relatives may be covered as medically needy if they meet the AFDC definition of a caretaker relative caring for someone determined to be a dependent child according to criteria in the state's AFDC plan (see Reg. §§ 435.1, 435.301, 435.310, 436.301, and 436.310).

### ¶ 14,595] Other Diagnostic, Screening, Preventive, and Rehabilitative Services

The law (Law § 1905(a)(13)) calls these services "other diagnostic screening, preventive, and rehabilitative services." The regulations (Reg. § 440.130) omit the word "other" and describe them as follows:

"Diagnostic services," other than those for which provision is made elsewhere in the regulations, include any medical procedures or supplies recommended for a patient by his physician or other licensed practitioner of the healing arts within the scope of his practice as defined by state law, to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in the recipient.

"Screening services" consist of the use of standardized tests performed under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify suspects for more definitive studies.

"Preventive services" are those provided by a physician or other licensed practitioner of the healing arts, within the scope of his practice as defined by state law, to prevent illness, disease, disability and other health conditions or their progression, to prolong life, and to promote physical and mental health and efficiency.

"Rehabilitative services," except as otherwise provided in the regulations, include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level. See also .71, below.

Consult the Medicare Topical Index for references to discussion of these services under Medicare.

.01 Sources.—Soc. Sec. Act § 1905(a)(13), § 17,335. Reg. 42 CFR § 440.130, ¶ 21,556.

.71 **Rehabilitative services.**—*Wisconsin.* Treatment provided by a psychiatric social worker to whom the recipient was referred by her psychiatrist does not constitute "other medical [rehabilitative] services" under Medicaid because this treatment was not "prescribed" as required by

federal regulations. The referral was not an adequate prescription because the treatment was provided in an unstructured setting without the supervision of a psychiatrist.

*Hildebrand v. Department of Health and Social Services of State of Wisconsin.* Wis. Cir. Ct., Dane County, No 138-351, Aug 15, 1973 [This decision was originally reported at NEW DEVELOPMENTS ¶ 26,804.]

### ¶ 14,601] Hospital and Nursing Home Services for Aged Persons in Mental Disease Institutions

The federal Medicaid law (§ 1905(a)) provides for "inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases." The law (§ 1902(a)(44)) requires a physician's certification of need for inpatient mental hospital care, periodic recertification by appropriate medical personnel, and a plan of care established and periodically evaluated and reviewed by a physician. As explained at ¶ 14,729, such services are subject to utilization control requirements.

The regulations (§ 440.140) require inpatient hospital services for individuals 65 or older in institutions for mental diseases to be provided under the direction of a physician in an institution for mental diseases that meets the requirements in § 405.1035 and 405.1036 of the Medicare regulations, except for certain admission review and utilization review requirements. An institution for mental diseases (under

# STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

BILL SHEFFIELD, GOVERNOR

POUCH H-07  
JUNEAU, ALASKA 99811

PHONE: (907)  
465-3355

February 6, 1985

The Honorable Jim Duncan  
Pouch V  
Juneau, Alaska 99811

Attn: Roxanne Stewart

Dear Representative Duncan:

This is in response to your recent request for a program description and financial assessment related to adding personal care under the Alaska Medicaid Program.

In order to explain more clearly our plans for FY86, it is necessary to clarify the three different categories of personal care that could be offered by the State in FY86. These are:

- 1) Personal care associated with preventing an individual's placement in a nursing home. Here personal care services would typically be combined with home health, homemaker, physician and other services to address the individual's medical problems.
- 2) Personal care associated with enabling an individual to gain employment and become more independent. Here personal care would typically be combined with vocational rehabilitation services.
- 3) Personal care services associated with an individual's recovery from a major illness, or to provide on-going assistance to a person not in need of nursing home care, but in need of assistance with personal hygiene, dressing and other health related activities. In these cases if personal care services are not available, these needs would typically be met by relatives, friends or volunteer groups. In some areas of the State home health aide services are available on a limited basis to meet a part of these needs.

For the last two years, the Department has selectively offered the services described in category #1 as Commissioner's exceptions through the State funded General Relief Medical program. The Department does not believe it appropriate to continue this practice as limited FY86 funding does not

permit equal access to all persons eligible for this alternative program. Given the potential number of eligible persons, this service should be managed under Medicaid where federal funds can be earned, and all eligible persons have equal access to it. Therefore, this Administration has submitted a Medicaid waiver to formally establish this alternative program and make it available on a statewide basis to the extent the services are available to purchase in each community. The outcome of this Medicaid waiver application will not be known until late March 1985.

In addition, the Administration is committing \$100,000 as a transfer from the Department of Health & Social Services to the Department of Education for persons who need the second category of service described above.

The third category of personal care described above is the "personal care" addition that we have priced for you to consider. Again, these are typically individuals who do not require so much personal care that they are in danger of "imminently needing nursing home care", nor are they participating in a vocational rehabilitation program. Personal care is in fact a "gap" in our continuum of medical services at the present time. Again, while home health aide services are available in some communities, the units of services available are limited and it should not be viewed as a substitute for personal care.

Table I displays a continuum of service ranging from simple homemaker to acute medical care in skilled and intermediate nursing facilities. The second row in the chart denotes the level of care provided in each component. An increasing level of medical need is assumed as one moves from left to right on the chart. Also, the service components on the right hand side of the chart generally include those on the left hand side. The reverse is not true. For example, a nursing home client is provided housekeeping, physical therapy, personal care, nursing and residential services by the institution while a person with homemaker services does not need or receive the same level of services provided in a nursing home. Lines three and four show the expected funding source and state agency responsible for the specific service on the continuum.

Our estimated cost to add personal care coverage under Medicaid is \$2.4 million annually (\$1.2 million in State funds). Based on other states' experience we estimate approximately 455 Medicaid recipients monthly would use this service if offered. Table II gives our assumptions and analysis in arriving at these estimates.

Just as the Medicaid Waiver program would limit the cost of services to no more than 90% of nursing home care, personal care should also be limited. The Division's analysis assumes that services will be limited to a maximum of 170 hours per month, or 50% of the average nursing home rate. This maximum reimbursement level would include the cost of home health, personal care and homemaker services. Programmatically any individual whose care exceeds 50% of the nursing home rate would still be served but under the Medicaid waiver rather than the personal care option.

All states that offer personal care limit the amount of personal care services available. Examples include: Minnesota, 200 hours per month;

Nevada, 40 hours per week; Nebraska, 40 hours per week; others limit the reimbursement: New Hampshire, \$40 per day; Montana, minimum wage + 15%; Nebraska, minimum wage; Maryland, \$10 per day.

If I may provide any additional information, please let me know.

~~Sincerely,~~

A handwritten signature in cursive script that reads "Rod Betit".

Rod Betit  
Director

TABLE I

Continuum of Care	Homemaker	Personal Care	Home Health Care	Foster Care	Residential Care	Medicaid Waiver	Medicaid Institutional Care
Level of Care	non-medical	medical support & maintenance	medical rehabilitation	non-medical	non-medical	intermediate nursing	skilled & intermediate & acute
Funding Agency	FYS Public Health	DVR DMA	DPH DMA	FYS	DFYS DPB	DMA	DMA DPB
Funding Sources	SGF Social Services block grant XIX?	SGF XIX	XIX	SGF Social Services block grant	SGF	Medicaid	Medicaid GRM
Type of Service	housekeeping chore service laundry meal preparation	personal care	nursing home health aide PT/OT	room & board personal care	room & board housekeeping	foster care day care respite care home health personal care residential homemaker nursing	room & board nursing PT/OT personal care homemaker

DVR - Div Voc Rehab, DOE  
DMA - Div Med Assit, DHS  
SGF - St. Gen Fund

Table II  
Assumptions

This projection for personal care services is based on the following:

- (a) personal care services can be divided into two categories of allowed XIX services (personal care and medically related home care).
- (b) Oregon showed a average of 21.2 hours personal care and 38.12 home care per case per month.
- (c) unit cost is based on 1 hour of work.
- (d) recipient utilization figures for the Oregon personal care services program showed total utilization equal to 8.6% of the Aged, Disabled, Blind eligibles.
  - 1. 30% Personal Care (PC) reimbursed at \$11.90 per hour. (Oregon's hourly rate multiplied by 1.25)
  - 2. 70% Home Care (HC) at \$8.13. (Oregon's hourly rate multiplied by 1.25)
- (e) Alaska has approximately 5200 APA recipients.

<u>Projected Cost Personal Care Services</u>	
<u>Hrs.</u>	<u>\$</u>
Single recipient PC/mo.	11.2 133.28
Single recipient HC/mo.	38. 508.94
Single recipient PC&HC/mo.	49.2 442.22
Single recipient yearly	509.4 5,306.664
Total 455 recipients	2,686.32 2,414,521.20

not qualify as a Medicare or Medicaid provider of inpatient or outpatient hospital services (see Reg. § 440.170(e));

*Personal care services in a recipient's home.*—See details in Reg. § 440.170(f) and .70 below.

*Ambulatory surgical center services.*—HCFA's *State Medicaid Manual* provides that ambulatory surgical center services may be covered as clinic services (GUIDE § 14,575) or as "any other medical care . . . recognized under state law, specified by the Secretary" (see .09, below).

.01 Sources.—Soc. Sec. Act § 1905(a) (18), § 17,335. Reg. 42 CFR § 431.53, § 21,017; § 440.170, § 21,560.

.09 Ambulatory surgical center services.—A. *Background.*—Ambulatory surgical center (ASC) services are currently coverable as clinic services under regulations at 42 CFR 440.90. They may also be covered under section 1905(a)(18) of the Social Security Act as ". . . any other medical care, and any other type of remedial care recognized under state law, specified by the Secretary."

B. *Limitations and Payment.*—ASC services provided under this benefit must meet the following requirements:

1. They must be provided by a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization;
2. They must be furnished to outpatients;
3. They must be furnished by a facility that meets the requirements in sections 42 CFR 416.25-416.49; and,
4. They must be recognized under state law.

*State Medicaid Manual*, HCFA-Pub. 65-4, § 4570.

.21 Christian Science nurses and practitioners.—*New York.* A U. S. district court properly dismissed (for lack of jurisdiction) a Medicaid claim for Christian Science nurse and practitioner services while the issue was pending in a state court. New York state courts have consistently held, in cases involving this claimant, that these services are not available under the state's Medicaid program. Moreover, the U. S. Supreme Court has dismissed the claimant's appeal for want of jurisdiction.

*Winters v. Levine*, CA-2, 574 F. 2d 48 (1978). [This decision was originally reported at NEW DEVELOPMENTS § 28,204.]

*New York.* A request for Medicaid to pay the cost of Christian Science nursing care was properly denied and such denial is affirmed. Aside from the fact that a Christian Science nurse is not classified as a registered nurse under Education Law § 6901 *et seq.*, the claimant has not demonstrated that she is entitled to Medicaid pursuant to Social Services Law § 365-a since there is insufficient evidence in the record to indicate

either the nature of her illness or the treatment she received.

*Winters v. Commissioner*, N. Y. Sup. Ct., App. Div., First Dept., 373 N. Y. S. 2d 604 (1975), appeal dismissed and cert. denied, U. S. Sup. Ct. (1978). [This decision was originally reported at NEW DEVELOPMENTS § 27,587.]

.70 Personal care services in a recipient's home.—

#### Manual Provisions

C. *Introduction.* Personal care services are medically-oriented tasks having to do with a patient's physical requirements (as opposed to housekeeping requirements) which enable a patient to be treated by his physician on an out-patient, rather than on an in-patient or institutionalized basis. The purpose of this care is to accommodate long-term maintenance or supportive care, as opposed to the short-term skilled care required for some acute illnesses. Since the level of care is of a supportive or maintenance type, the tasks encompassed require less skill than some of the duties included in home health care performed by Home Health Aides. In many instances personal care services and home health care services overlap as to the particular duties included. The distinction which applies is the requirement that home health care services must be provided through a Home Agency, while personal care services need not.

The personal care provider should perform such tasks as assisting the patient with personal hygiene, dressing, feedings or transfer or ambulatory needs. Any household tasks performed should be purely incidental to the patient's health care needs. Personal care services should usually be prescribed only in cases where the patient needs no highly skilled or technical care. Personal care services should not be used as a substitute for Home Health Aide care, or for the care usually provided by a registered nurse, licensed practical nurse, or therapist.

Basic homemaker services are not reimbursable under title XIX, just the same as other basic needs; i. e., food, heat, clothing, etc., are not reimbursable under the

Medicaid program because they are not medical needs.

**D. Limitations, and Examples of Personal Care Services.** (1) Personal care services vary, depending on the needs and requirements of each individual patient, and based on the judgment of the patient's attending physician and/or assigned registered nurse. Generally, personal care services may include the following:

Basic personal care and grooming, including bathing, care of the hair, and assistance with clothing.

Assistance with bladder and/or bowel requirements or problems, including helping the patient to and from the bathroom, or assisting the patient with bed pan routines.

Assisting the patient with medications which are ordinarily self-administered, when ordered by the patient's physician.

Assistance with food, nutrition, and diet activities, including the preparation of meals, when required, if incidental to a medical need.

Performing such household services (if related to a medical need) as are essential to the patient's health and comfort in his home. Examples of such activities would be the necessary changing of bed linens or the rearranging of furniture to enable the patient to move about more easily in his home. Accompanying the patient to clinics, physician office visits, or other trips which are made for the purpose of obtaining medical diagnosis or treatment. Costs for both the patient and the personal care provider are reimbursable under title XX and may include such methods of transportation as: public transportation (bus, subway, etc.); taxi fare; medical transportation when necessary (ambulance, etc.); or payment to the personal care provider for gasoline and mileage when the provider has used his or her personal automobile.

(2) Personal care services should never be confused with services of a higher level which clearly should be performed by persons with the proper professional training. Services which are not appropriate as personal care are as follows:

Insertion and sterile irrigation of catheters.

Irrigation of any body cavities which require sterile procedures.

Application of dressings, involving prescription medication and aseptic techniques, including care of mild, moderate, or severe skin care.

Giving of injections of fluids into veins, muscles, or skin.

Administering of medicine (as opposed to assisting with a self administered medication).

(3) Personal care services should also not be confused with services which would more appropriately be provided by persons who provide chore services in the home. Examples of chore services which are clearly not to be regarded as personal care are as follows:

Cleaning of floor and furniture in areas not occupied by the patient. For example, cleaning of the entire living area if the patient occupies only one small room.

Laundry, other than that incidental to the care of the patient. For example, laundering of clothing and bedding for the entire household, as opposed to simple laundering of the patient's bed smock or gown.

Shopping for groceries or household items other than items required specifically for the health and maintenance of the patient. This would not preclude a personal care provider's shopping for items needed by the patient but also used by the rest of the household.

(4) Following are examples of a case in which personal care should be authorized and cases when personal care services would be inappropriate and should not be authorized.

**Case Example #1:** Mrs. R. is a 90-year old woman who lives alone. She has been diagnosed as having cardiac insufficiency and has a weakened heart. Mrs. R. suffers from shortness of breath and frequently has trouble with swollen ankles which prevent her from getting around well. She is on a low-salt diet and takes regular medication. Mrs. R. requires assistance with bathing, meal preparation, light housekeeping, and taking and maintaining her medication. Her pulse must be taken at regular intervals to monitor the effect of her heart medication, and in addition she requires assistance in getting to and from the periodic visits to her physician. Personal care services are appropriate in this case.

**Case Example #2:** Mrs. K. is a 33-year old woman with two school-aged children. She has just been discharged from a hospital where she had a cancerous pancreas removed. During her absence from the home her two children remained at home under the care of a homemaker (title XX). Now that she has been discharged she suffers from severe diabetes and requires insulin injections and other medications, as well as assistance with the application of dressings. Authorization of personal care services would be inappropriate in the case, since Mrs. K. requires more skilled medical services.

*Case Example #3:* Mr. J. is a 78-year old man who lives alone in a small apartment. He suffers from cardiovascular heart disease and is not able to lift or sweep. Mr. J. is able to prepare his own meals and handle his daily grooming. Twice each week a housekeeper comes to the apartment where she does the laundry and cleans the apartment. She also goes out to the store to purchase groceries and other supplies in accordance with Mr. J.'s instructions. These services are not medically-oriented, despite the fact that Mr. J. has a medically diagnosed illness. Personal care services should not be authorized in this case.

*E. Plan of Care.* Personal care services are provided to prevent inappropriate institutionalization, but only if the patient does not require skilled nursing care. FFP is available for personal care services only when prescribed by a physician, and provided in accordance with each patient's individual plan of care. The plan of care is a course which is based on the physi-

cian's orders, and which typically reflects the patient's physical, psychosocial, emotional, environment(al), and personal care needs. Under current widely accepted procedures, a registered nurse will list the specific personal care tasks required to maintain the patient in his own home. The plan of care should state the expected outcome of the care, and should be reviewed by a registered nurse at a minimum interval of every sixty days.

*F. Minimum Standards for Training.* (1) Although the regulations require that a provider of personal services be "qualified", the term is not defined. It is suggested that some criteria be developed, and that it might include a training course of at least forty hours in some or all of the following areas:

Basic personal care procedures such as grooming, etc.

Bowel and bladder care.

Food, nutrition, diet planning, etc.

EXHIBIT ASurgical Necessity - Procedures

The following require prior authorization for the surgical necessity of the procedure to be performed:

<u>Procedure Name</u>	<u>ICD-9-CM Code</u>	<u>Requires Level of Care Authorization</u>
Antireflux Procedure (Hill, Nissen, etc.)		no
Arthroscopy of Knee	80.26	no
Bunionectomy		yes
Bunionectomy w/osteotomy first MT.	77.51	yes
Bunionectomy w/athrodesis	77.52	yes
Bunionectomy w/soft tissue correction	77.53	yes
Excision Bunionette	77.54	yes
Bunionectomy NEC	77.59	yes
Cataract Extraction		
Intra caps extract lens by temp.	13.11	yes
intra caps lens ext. NOS	13.19	yes
Linear extracarpal lens ext.	13.2	yes
Simple aspiration lens ext.	13.3	yes
Phacoemulsif and aspiration	13.41	yes
Phacogragment and asp. cataract by post route	13.42	yes
Phacofragment and other aspiration cataract	13.43	yes
Extra caps extraction lens by Temp. Inf. route	13.51	yes
Other extra caps extraction lens	13.59	yes
Discussion of primary membrane cataract	13.61	yes
Discussion of secondary membrane cataract	13.65	yes
Excision of primary mambrane cataract	13.62	yes
Mechanical fragment of prim membrane cataract	13.63	yes
Secondary	13.65	yes
Other cataract extraction	13.69	yes
Insertion of prosthetic lens, NOC	13.70	yes
Insertion of prosthetic at time of cataract ext.	13.71	yes
Carotid Indarterectomy	38.12	no
Cesarean Sections - elective	74.0	
(emergency within 24° of procedure)	74.1	
	74.2	
	74.3	
	74.4	
Coronary Bypass	36.10	no
Cholecystectomy	51.21	no
	51.22	
Deviated septum - septoplasty	21.88	yes
	21.5	

<u>Procedure Name</u>	<u>ICD-9-CM Code</u>	<u>Requires Level of Care Authorization</u>
Dilation and curettage	69.02	no
	69.09	
Hemorrhoidectomy	49.4	yes
Hemorrhoid Cauterization	49.43	yes
Hemorrhoid Destr-Cryotherapy	49.44	yes
Hemorrhoid Ligation	49.45	yes
Hemorrhoid Excision	49.46	yes
Evacuation of thrombosed hemorrhoids	49.47	yes
Other procedures on hemorrhoids	49.49	yes
Hysterectomy		
Subtotal abdominal hysterectomy	68.3	no
Total abdominal	68.4	no
Vaginal hysterectomy	68.5	no
Radical abd. hysterectomy	68.6	no
Radical vag. hysterectomy	68.7	
Femoral popliteal bypass		
Laminectomy		
Ligation and stripping of varicose veins		
Leg	38.57	yes
Arm	38.53	yes
Mastectomy	85.4	no
	85.41-48	no
Meniscectomy, knee	80.6	no
Obesity surgery	44.69	no
Prostatotomy - TURP	60.2	
Tonsillectomy/Adenoidectomy		
Tonsillectomy without adenoidectomy	28.2	no
Tonsillectomy with adenoidectomy	28.3	no
Adenoidectomy without Tonsillectomy	28.6	no
Excision of tonsil tag	28.4	no
Total hip replacement (except with hip fracture)	81.51	no
	81.59	no

Medical Diagnoses/Symptoms - Treatments

The following require prior authorization for the medical necessity of the admission to an acute care facility:

<u>Diagnosis/Symptom</u>	<u>ICD-9-CM Code</u>
Abdominal pain for diagnostic work-up	
Depression	
Depression disorder/state	311
Major depressive - disorder single episode	296.20
Major depressive - mild	296.21
Major depressive - moderate	296.22
Neurotic depression	300.4
Brief depressive reaction	309.0
Diagnostic work-ups	
Observation for suspected mental conditions	V.71.01 (adult) V.71.02 (child) V.71.09 (unspec)
Special investigation and examinations	V.72
Eyes/vision	V.72.0
Ears/hearing	V.72.1
Dental	V.72.2
Gynecological	V.72.3
Pregnancy exam	V.72.4
Radiological	V.72.5
Laboratory	V.72.6
Diagnostic skin & sensitization tests	V.72.7
Other specified exams	V.72.8
Unspecified exams	V.72.9
Dysmenorrhea	625.3
Psychogenic	306.52
Back pain - chronic	
- unspecified	724.5
- psychogenic	307.89
Benign hypertension	401.1 401.9
Diabetes Mellitus	
- non-insulin dependent w/o complication	250.00
- insulin ddependent w/o complication	250.01
Gastroenteritis	558.9
Headaches	784.0
Migraines	346.0, 346.1 346.2, 346.8 346.9
Tension	307.81
Impacted cerumen	380.4

# STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

MEDICAID RATE COMMISSION

*Medicaid*  
BILL SHEFFIELD, GOVERNOR

670 WEST FIREWEED LANE  
SUITE 228  
ANCHORAGE, ALASKA 99503  
PHONE: (907) 277-5982

January 16, 1986

## REPORT TO THE COMMISSION

### INTRODUCTION

Since coming to the Commission on December 1, 1985, I have conducted a review of the system for budget reporting and review, internal operating procedures and the report provided by Wolfe & Associates on cost containment. The Commission is still operating behind schedule. There are eight of the twenty-seven facilities that have not had rates approved for the 1985 fiscal year, including one facility whose stub period for the 1984 fiscal year has not been set and one facility who has a formal appeal on their 1984 rate. Several facilities' rates have been set subject to decisions on Providence Hospital's 1985 rate. A few 1986 rates have been reviewed.

The rate setting process was slowed considerably by numerous appeals for the 1984 budget cycle and late adoption of reporting and rate setting criteria for the 1985 cycle. In late 1984, facilities were required to resubmit budgets based on a newly designed budget review format. On January 25, 1985, the Commission changed the units of payment for the facilities thus requiring additional reporting and budget changes. The rate setting process for the 1985 fiscal year did not actually begin until mid-1985.

The budget review process is tailored after reporting requirements from the State of Washington. The State of Washington is a rate-regulated state and sets rates for facilities licensed as hospitals.

The budget review and rate setting process used by the Medicaid Rate Commission is a total budget review process. The operating procedures used by staff resemble more a total facility rate setting process rather than a process for determining a payment rate for Medicaid. There has been little attention paid to services covered by Medicaid, utilization of the facility by Medicaid, or costs associated with Medicaid.

## STATE PLAN AND THE MEDICAID RATE COMMISSION

States participating in the Medicaid and Medicare programs must submit on an annual basis state plans. These plans identify programs and methodologies used by the state to provide payment and services for the Medicaid program. With the changes in legislation that resulted in the establishment of the Medicaid Rate Commission, significant changes in the state plan occurred. The State of Alaska has had approval from the Health Care Financing Administration for the 1984 State Plan which ended June 30, 1984. However, the 1985 and 1986 State Plans have not been approved.

The Health Care Financing Administration (HCFA) would not accept components of the rate setting process in this state. These components include bad debt, charity, contractual adjustments or discounts taken by Medicare and the Veterans Administration as allowable expenses to be built into the Medicaid payment system. Other areas such as the audit function, payments higher than charges, and assurances that the federal government would not be asked to participate in greater than its share of cost reimbursement are still unresolved issues.

There has been substantial confusion about the state plan and the rate setting system in this state. Components that the federal government would not participate in were deleted from the state plan with the misconception that the state could then proceed to include these elements within the rate setting and not ask for federal participation. This is not the case. The state plan is to be a reflection of the actual process for rate setting. The state does not have the latitude to participate in the Medicaid program operating under a system different than that approved by HCFA. The state must also have an approved plan.

This has left the state in the awkward situation of operating in an out-of-compliance condition. The result of such an out-of-compliance condition will be substantial reduction in federal payments as it is determined which components of our rate setting process the federal government will participate in and which components will not be accepted. If the situation is not corrected, the state does run the risk of losing all state funds. It is somewhat unclear what would happen if HCFA rejected our state plan. Ultimately federal funds could be withheld in the entirety. Although state representatives met with the HCFA representatives in Region X in Seattle and was given assurances that this process could be worked out, the ultimate decision will be made in Baltimore.

While the State of Alaska may be able to adjust the state plan to gain approval from HCFA, operating out of compliance cannot be a permanent situation. The operating procedures and rate setting process within the Medicaid Rate Commission must be the same as that state plan.

#### THE BUDGET REVIEW RATE-SETTING PROCESS

The budget review and rate setting processes evolved as one of a total budget concept. After considerable discussions with staff, it is apparent that the process is to determine what a facility needs in the rate setting process. The process has moved from the development design and determination of payment system for services covered by a third party payer to a budget and rate setting process. Staff operates as though they are actually approving a budget for a hospital rather than setting a payment rate for Medicaid.

The process is extremely detailed, setting up general standards of percentage increases. The process uses different units of measure depending upon whether it is a hospital, a long term care facility, or a combination. Therefore, there is no way to compare acute care services among all hospitals or long term care services among all facilities with an aggregate measurement. There has been no review of the previously approved rate to determine standards of reasonableness.

Apparently no requirement or evaluation of whether the report is in conformance with the reporting manual is made by staff. There are several discrepancies in the budgets that have been reviewed since December 1, 1985. A review process is one that requires an enormous amount of additional detail from the facility including line item explanations of cost increases, reclassification of costs, staffing levels, and small minute expenditure items. Staff has no standards by which to determine whether any of these expenses are reasonable or unreasonable. This left staff in the position of recommending what he or she feels is appropriate.

There is no summary data that has been tabulated by staff. No national or regional statistics have been brought together to compute averages for comparative purposes. No attempt has been made to require a hospital to provide data in any consistent format.

The operating standards of the staff have been to provide

budget reviews before the hearings. Timelines and deadlines were not a consideration in processing budgets. The process has evolved to the point where it is nearly impossible to review a budget within the sixty days allowed by regulation. It is an involved, letter-writing, one-question-at-a-time process. In short, there is no budget review system except as an individual analyst interprets the data. The operating and performance standards were to have a budget review delivered to the Commission before the hearing or placed on the hearing table.

### REPORTING FORMS

The reporting forms as they exist deal strictly with hospital budgets. They are a rough draft form that have been copied out of the Reporting and Accounting Manual. The forms have not been adjusted for units of measure as adopted by the Commission nor do they contain adequate information to determine return on investment as adopted by the Commission. There are no forms for the freestanding nursing home or the various outpatient service entities that are to be regulated by this Commission.

### THE MEDICAID REPORTING AND ACCOUNTING MANUAL

The Reporting and Accounting Manual developed for the use of the Medicaid Rate Commission is a hospital accounting manual. It was tailored after the State of Washington's reporting and accounting manual for hospitals. There is nothing contained in it to assist nursing homes or combined facilities in accurately preparing budgets. There is no datum or reporting for the various outpatient facilities. There are several errors in the accounting manual and in the budget forms and reporting instructions. There has been no adjustment to include the units of measure as adopted by the Commission for payment. This leaves staff and the facilities in the position of arguing which methodology the individual facility or staff thinks should be appropriate.

## UNITS OF MEASURE USED TO PAY FACILITIES

The Commission adopted units of measure for the facilities to include per day for nursing homes, per day or per diem for hospital acute care services, and per visit. Presently, there are no definitions for these units of measure. The facilities have had no instructions as to how to cost find for developing a per unit cost for a rate request. Staff has no guidelines and no definitions. As a result, staff accepts any data submitted by the hospital and argues if he or she does not think it looks right.

As a more significant result of no definition for units of measure, no standard methodology for cost finding, and no requirement that hospitals actually provide data in the format as found in the accounting manual, there has been a tremendous process of argumentation through the rate setting process. The budgets as submitted appear to be riddled with errors and in some cases expenses are moved to maximize reimbursement. This is an especially critical problem for the combined facilities. There are cases where what requirements that are in the accounting manual have been disregarded by the facility. Expenses are moved from one cost center to another to resulting in much higher costs in the long term care cost center. Cost centers such as central services where supplies are sold and pharmacy are being moved around providing higher reimbursement in the nursing homes.

There is also no standard requirement that facilities provide data consistently between years. A review of budgets show change in allocation methodology and change in costs that have been gathered in specific revenue centers from one year to the next. It appears that this is more than simply a learning process and a refinement of the budget review process. Since there is no audit or review function, these problems simply perpetuate from year to year.

## RATES APPROVED BY THE COMMISSION

The budget review and rate setting process is currently in its third year of operation. There are still several facilities from the 1985 or second year of operation that have been set by the Commission. Recapped below is the activity on the twenty-one facilities that have been set for the 1984 and 1985 years. The chart is for illustration purposes only and does not have adjustments for increased utilization.

	1982/3	1984	1985
	=====		
Psych	\$10,841,662	\$11,711,575	\$13,092,884
From 1983		8.02%	20.76%
From 1984			11.79%
LTC	\$16,552,508	\$17,274,859	\$20,569,635
From 1983		10.41%	24.25%
From 1984			12.56%
Hospital only	\$14,045,491	\$16,877,586	\$19,708,487
From 1983		20.16%	40.32%
From 1984			16.77%

The aggregate is 40.3% for hospitals, long term care 24.3%, and the psychiatric institutes 20.8% over a two year period of time. Based on the budget submittals for the remainder of the 1985 and 1986 budget cycles, there appears to be little slowing of the requested rate increases.

The next exhibit summarizes Commission activity and contrasts it to the Medicaid budget. The estimate aggregate utilization is based on what was in the budget. The inflation assumptions are based on hospital requests and Commission actions to date.

## COMPARISON BUDGET TO MRC ACTIVITIES (000)

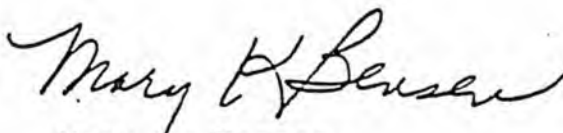
	HOSPITALS			LONG TERM CARE		
	Budget	MRC	Diff	Budget	MRC	Diff
1984	\$23,754.4	\$20,305.7	\$3,448.7	\$22,514.7	\$23,576.8	(\$1,062.1)
1985	25,156.1	24,550.8	605.3	25,512.1	26,247.5	(735.4)
1986	26,796.7	29,719.9	(2,923.2)	23,587.8	28,871.6	(5,283.8)
			\$1,130.8			(\$7,081.6)

If the rate of increase continues, the Medicaid budget will be \$8 million over for the 1986 fiscal year. The overage will be nearly \$3 million in hospitals and \$5.3 million in nursing homes. This calculation does not include the disallowances from the federal government when they will not participate in costs greater than prescribed in the state plan. A major cause of the increases is inflation assumptions of 8% in 1984 and 1985 and 5% in 1986. The rate of increase approved by the Medicaid Rate Commission has been averaging over 15% a year.

## STAFF RECOMMENDATIONS

1. That the Medicaid Rate Commission through the Executive Director develop a new relationship with the Division of Medicaid Assistance to secure approval of the state plan.
2. That the Executive Director provide detailed information to the Commissioners on the progress of approval of the state plan and what changes if any the Medicaid Rate Commission should consider to assure no loss of federal funds to the State of Alaska.
3. Evaluation and redesign of the accounting and reporting manual to include all facilities regulated by the Medicaid Rate Commission.
4. Development and redesign of new reporting forms including an abbreviated reporting form as soon as possible.
5. A complete review of the regulations for conformity with the legislation and proposed changes for consideration in draft form by March 1986 for adoption in April 1986.
6. The design of a comparative analysis system for the 1987 review cycle to identify efficiency and inefficiency in facility requests.

7. Identification of facilities not yet brought under the regulation of the Medicaid Rate Commission and notify such facilities of the reporting requirements by the 1987 review cycle.
8. Evaluation of staffing and functions within the agency to the Commission by February 1986 with recommendations for internal requirements.
9. Immediate adherence to all regulations as they exist including timely notice on budget reviews and scheduling.



Mary K. Bensen  
Executive Director

MKB/ss

# STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

MEDICAID RATE COMMISSION

670 WEST FIREWEED LANE  
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## COST CONTAINMENT REPORT November 1985

The following is an analysis of the recommendations provided by Wolfe & Associates concerning activities that may foster cost containment.

RECOMMENDATION #1: Establish peer groups to facilitate comparative institutional financial analysis and cost containment.

The report identified the need for peer groups and comparison of facility costs. This is a standard methodology used in rate setting for identifying high cost or high priced facilities. A comparative analysis of operating costs and requested prices would give staff additional tools with which to evaluate reasonable and prudent costs.

The application of the standard peer group methodology in the State of Alaska must be adjusted because of the small number of institutions, a diversity of types of institutions, and the varying cost of living in regions within the State of Alaska.

A standard peer grouping methodology assumes that there is a sufficient number of facilities in which to cluster by like services, physical characteristics of the facility, and external components. In the State of Alaska we have four psychiatric hospitals, seventeen acute care hospitals and twelve skilled nursing departments or hospitals that provide skilled nursing services. A standard peer grouping will not work because of the small number of facilities within the state. Cost of living indexes range over 30% depending upon location. This would not preclude a comparative analysis of services by major category but would require institutional adjustments.

One recommendation that I would not use is the classification of facilities separating the acute care hospitals from hospitals that provide acute care services and long term care. It is highly questionable if there can be any justification to assume that acute care hospitals with long term care should have distinctively different costs on the acute care side than an institution that does not have long term care.

The cross-comparison of expenses among the facilities will be proposed for the guidelines for the 1987 cycle. While the scope of comparison will be more limited than a traditional peer grouping system, it will assist staff in evaluating reasonable cost by institution. The 1987 guidelines will be prepared over the next several weeks and presented for Commission consideration in March 1986.

**RECOMMENDATION #2:** Identify in general and by facility those costs which will be borne by the Medicaid program.

This recommendation is a critical issue that has been before the Commission on several occasions. It is primarily the issue of whether rates paid by Medicaid should be related to prices charged to other purchasers of health care services. While the approach in Recommendation #2 is a discussion of offsetting expenses with other available sources of revenue such as local taxes and revenue sharing, a more fundamental issue is contained within their recommendation. The issue is whether the Medicaid rate system unit of payment should be based on charges billed by the facilities or whether the Commission should in fact develop a unit of payment at a fixed rate which in most cases is exceeding the charges billed by the facility.

Our current system identifies an inpatient per diem, an outpatient visit, and a long term care patient day. The long term care patient day rate has been a standard unit of payment for several years. However, the per diem inpatient rate and the visit rate are two units of measure adopted by the Medicaid Rate Commission. As was mentioned earlier in this report, we have no current definitions for our acute care and outpatient per units of measure.

The point that Wolfe & Associates brings up concerning a proportionate share of Medicaid to the total revenue generated by the facility is a valid point. Staff would recommend that the Medicaid Rate Commission return to a billed charge system calculating maximum rates that a facility may charge and appropriate discounts where costs have been disallowed by the Medicaid Rate Commission.

This approach would tie immediately to the revenue billed by the facility. It would be a simpler approach than developing a per unit measure and ratioiding it down based on costs exceeding charges. It would also relate Medicaid payments to services provided to Medicaid patients. The current system of aggregate per diem and outpatient visit in the acute care is only coincidentally related to the services received by Medicaid patients.

**RECOMMENDATION #3: Take advantage of the impact of competition.**

While Wolfe & Associates does reference the potential benefits of tying in with negotiated rates, the practicality of this approach is questionable. With the exception of Anchorage, all facilities are either in rural areas. There is only competition of any substance in the Anchorage area.

Another point that should be considered is that competition and negotiated rates assumes a billed charge system. The present unit of payment would not be compatible with negotiated rates. The recommendation that the Medicaid Rate Commission require all contractual agreements to be provided by the facilities is most probably in excess of the Medicaid Rate Commission's statutory authority. The Medicaid Rate Commission was established to determine the appropriate payment rate for Medicaid services. It is not an all-inclusive rate setting agency with broad authority. Other states required legislative change to receive negotiated rate agreements.

Staff also questions whether the lowest rate paid by a payer other than Medicaid would in fact have any relationship to the Medicaid rates paid. It would also require the establishment of two rate review systems: one for facilities that have negotiated rates and another for facilities that do not. This would lead to inequity in methodology.

**RECOMMENDATION #4: Improve Medicaid Rate Commission analytical tools and operations.**

The recommendation and subrecommendations made by Wolfe & Associates are well-taken. The development of a data base, financial impact analysis prior to decision making, and a regulatory image must be implemented if there is to be any cost containment and equity of payment for the Medicaid payment program. In-house procedures are already being implemented to strengthen the Medicaid Rate Commission and provide analytical tools for determination of reasonableness.

RECOMMENDATION #5: Consider statutory changes.

The report cited three areas of potential legislative change. The first is to tie the level of payment made by DHSS to available funds. While on the surface this may seem particularly advantageous to the State budget, there are several areas which must be further explored. First, input price increases in conjunction with utilization are the determinant for a state budget. The Medicaid Rate Commission has control over input prices, not utilization factors. The requirements of the federal participation would not allow a rate setting system that did not consider both input prices and utilization factors. If there are substantial changes in utilization, the state does not have the option to adjust its methodology to reduce payment levels on those Medicaid services with federal participation.

The federal requirements are to develop a methodology and remain consistent through a fiscal year. Areas such as input inflation could be tied to the assumptions made by the legislature when they pass the budget. It should be noted that the guidelines used by the Medicaid Rate Commission have been consistently lower than the inflation factors established by the legislature. The areas which resulted in substantial rate increases are centered around unit of payment, expansion to the rate base including recognizing inflation higher than the guidelines, and new construction expenditures.

The second statutory change recommended in the report is to change the facilities' fiscal years to the state fiscal year. While it is possible to do this for nursing homes, it is seriously questionable whether it is possible to do it for acute care facilities. It would place an onerous burden on facilities as they would be producing two year-end reports, one for the Medicaid Rate Commission and one for everyone else. The ability to measure the changes would be limited since the facilities would remain on their existing fiscal years. Hospitals do not have the option of changing their fiscal years to match a state program as the federal requirements for Medicare participation would not allow such a change. The cost increases that would result from the double reporting would far outway the benefits that might be gained. Appropriate analytical techniques would be far more beneficial to the rate setting process than changing a facility's fiscal year for computation ease.

The third area in which the report recommended statutory change was separating the rate setting process for acute

care and long term care facilities. The legislation passed is very general and requires consideration of specific financial requirements based on Medicaid's proportionate share of those financial requirements. There is nothing to prohibit the Medicaid Rate Commission from developing compatible but separate methodologies for acute care facilities and long term care facilities. There are several other entities contained within the legislation such as rural health clinics, home health care, and surgery centers. Each of these require a different approach to rate setting. The recommendation does not require legislative change.



Rod Belit  
1-30-86

	<u>FY86 SGF</u> <u>Authorized</u>	<u>FY87 SGF</u> <u>Authorized</u>	
Medicaid	33,216.7	9,480.8	NF Medicaid
GR Med	11,149.1	27,022.9	F Medicaid
		-0-	
		5,000.0	F GR Med
Cat. Illness	2,312.6	1,312.6	
ALBHH	413.8	880.5	
<i>long bonus</i>			
	47,092.9	43,696.8	
		✓	
		- 73%	

27,022.9  
9,480.8  

---

36,503.7

split  
47% state \$  
53% federal \$

Facility  
Non-Facility  
separated  
- out transfer  
money from NF  
to F so if rate  
Commissioner doesn't  
get facility  
rates under  
control  
pull \$ from  
NF to  
meet the  
expenses

Introduced: 2/17/86  
Referred: Health, Education &  
Social Services, Judiciary  
and Finance

BY THE RULES COMMITTEE BY  
REQUEST OF THE GOVERNOR

1 IN THE HOUSE

2 HOUSE BILL NO. 678

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FOURTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to the general relief assistance  
7 program; and providing for an effective date."

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

9 \* Section 1. AS 47.25.130 is amended to read:

10 Sec. 47.25.130. AMOUNT OF ASSISTANCE. (a) The amount of assis-  
11 tance for a needy person must [SHALL] be determined by the department  
12 with regard to the resources and needs of the person and the condi-  
13 tions existing in each case. Where possible, assistance shall be  
14 sufficient to provide the applicant with reasonable subsistence ac-  
15 cording to standards of assistance established by the department.  
16 However, the amount of the assistance for subsistence needs may not  
17 exceed \$120 a person a calendar month.

18 (b) To determine the amount of assistance for a needy person  
19 under (a) of this section, the department may consider the income and  
20 resources of all persons who reside with the needy person and are  
21 either related to the needy person by blood, marriage, or adoption, or  
22 would benefit directly from the financial assistance given under  
23 AS 47.25.120 -- 47.25.300.

24 (c) The amount of assistance paid to or on behalf of a needy  
25 person for medical care services may not exceed \$25,000 per year.

26 (d) The department shall, by regulation, establish the cat-  
27 egories of medical care services which the department may provide to a  
28 needy person under AS 47.25.120 -- 47.25.300, any conditions applica-  
29 ble to those services, and a priority listing of which categories of

1 service may be reduced or eliminated if the department finds that such  
2 action is necessary in order to ensure that, taking into consideration  
3 projected use, the medical assistance program does not exceed the  
4 funds appropriated for the program.

5 \* Sec. 2. AS 47.25 is amended by adding a new section to read:

6 Sec. 47.25.135. LIABILITY OF NEEDY PERSON FOR A PORTION OF  
7 MEDICAL CARE EXPENSES. (a) The department may require a needy person  
8 who is eligible for assistance under AS 47.25.120 to pay for a portion  
9 of the medical care expenses incurred by the needy person, except that  
10 the liability of the needy person may not exceed (1) \$50 for each day  
11 of inpatient stay or \$200 per hospital admission, whichever is less,  
12 or (2) \$20 for each outpatient visit.

13 (b) If a needy person is required under (a) of this section to  
14 pay for a portion of the medical care expenses, the department shall  
15 deduct the required portion owed by the needy person from the amount  
16 of assistance paid to the medical provider under AS 47.25.120 --  
17 47.25.300 on behalf of the person.

18 \* Sec. 3. AS 47.25.195 is amended by adding a new subsection to read:

19 (d) If insufficient money is appropriated to fund medical assis-  
20 tance under AS 47.25.120 -- 47.25.300 when taking into consideration  
21 projected use and the health facility payment rates established in  
22 accordance with (b) of this section, the department may, by regula-  
23 tion, establish at any time in the fiscal year a prospective pro rata  
24 reduction of the facilities' payment rates that will be paid by the  
25 department for services provided by facilities under AS 47.25.120 --  
26 47.25.300.

27 \* Sec. 4. AS 47.25.250 is amended to read:

28 Sec. 47.25.250. TEMPORARY RELIEF. When a needy person is not  
29 entitled to assistance under AS 47.25.120 -- 47.25.300 and has no

1 relatives in the state liable for support under AS 47.25.230 and  
2 47.25.240, the needy person may receive temporary assistance in the  
3 form and amount which the department considers necessary. Temporary  
4 assistance for needs other than [TRANSPORTATION AND] medical care may  
5 not exceed \$120 per person per month.

6 \* Sec. 5. AS 47.25 is amended by adding a new section to read:

7 Sec. 47.25.262. MEDICAL CARE REPAYMENT. The department may  
8 require a needy person to repay the full amount of assistance received  
9 under AS 47.25.120 -- 47.25.300 for medical care, if the needy person,  
10 within two years after the receipt of assistance, receives income and  
11 resources sufficient to cover the payment of the assistance. The  
12 commissioner may adopt regulations necessary to implement this sec-  
13 tion.

14 \* Sec. 6. AS 47.25.252 is repealed.

15 \* Sec. 7. This Act takes effect July 1, 1986.

16

HB 677

HOUSE BILL NO. 677 by Marrou and Navarre by request, entitled:

"An Act relating to the Seldovia Native Association land exchange; and providing for an effective date."

was read the first time and referred to the Resources and Finance Committees.

HB 678

HOUSE BILL NO. 678 by the Rules Committee by request of the Governor, entitled:

"An Act relating to the general relief assistance program; and providing for an effective date."

was read the first time and referred to the Health, Education & Social Services, Judiciary and Finance Committees.

A zero fiscal note was attached.

The Governor's transmittal letter, dated February 19, 1986, appears below:

"Dear Representative Grussendorf:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill relating to persons in need of financial assistance. This bill proposes the amendment of current statutes governing the general relief assistance program administered by the Department of Health and Social Services.

Section 1 of the bill proposes that in making general relief assistance eligibility determinations the Department of Health and Social Services take into account the income and resources of persons who reside with the needy person and who either are related to the needy person or who would benefit directly from assistance given to the needy person. In addition, the maximum amount of assistance that can be received for medical care would be \$25,000 per year per person. The amendments in sec. 1 of the bill also require the department to establish, by regulation, categories of medical care services and any applicable conditions, and establish priorities for reducing services if the department anticipates that requests for assistance under the assistance program will not exceed the program's appropriations.

Section 2 of the bill proposes that the needy person pay for the first \$50 of expenses incurred for each day of a hospital stay, to a maximum of \$200 per hospital admission.

HB 678

The needy person will also be liable for \$20 for each outpatient visit. The needy person's liability will be deducted from any assistance for medical care that is paid to a medical provider on behalf of a needy person.

Section 3 of the bill adds a new subsection to provide that when there is insufficient money for medical assistance, the department may by regulation establish a prospective pro rata reduction of a health facilities' payment rates.

Section 4 of the bill amends AS 47.25.250 to provide that temporary general relief assistance for transportation may not exceed \$120 per month. Under the amendment, only medical care temporary assistance may exceed the \$120 limit.

Section 5 of the bill requires repayment of medical assistance under certain conditions.

Section 6 of the bill repeals the department's authority to give discretionary assistance to a needy person not entitled to such assistance under the general relief program.

Sincerely,

/s/

Bill Sheffield  
Governor"

HB 679

HOUSE BILL NO. 679 by the Rules Committee by request of the Governor, entitled:

"An Act relating to the purchase of Alaska products; and providing for an effective date."

was read the first time and referred to the State Affairs, Judiciary and Finance Committees.

Three fiscal notes were attached and appear in House Supplement No. 87.

The Governor's transmittal letter dated, February 19, 1986, appears below:

"Dear Representative Grussendorf:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill requiring that, whenever practicable, Alaska products be used in construction projects financed with state money. This bill also provides an economic incentive for contractors who promise to use Alaska products as components in these construction projects.

DEPARTMENT OF LAW

POUCH K - STATE CAPITOL  
JUNEAU, ALASKA 99811  
PHONE: 1907) 465-3600

OFFICE OF THE ATTORNEY GENERAL

February 5, 1986

Honorable Bettye Fahrenkamp  
Chairman, Senate Health, Education  
and Social Services Committee  
Alaska State Senate  
P. O. Box V  
Juneau, Alaska 99811

Re: HB 98 (medical assistance)  
Our file nos.: 377-058-86  
& 377-065-86

Dear Senator Fahrenkamp:

I understand that the attached language amending the filing deadlines on claims for medicaid and general relief assistance has been furnished to your committee by the Department of Health and Social Services. I also understand that your committee has already agreed to incorporate it into your committee substitute for CSHB 98(Fin). This new language for the bill eliminates inequities that result under the current six-month rule for those claims.

In discussing this with your staff yesterday afternoon, it appeared that it would be helpful for your committee to have the explanation of the proposed AS 44.77.015 in final, rather than draft, form. And I strongly urge your committee to use this explanation, along with appropriate parts of the governor's January 29, 1986 letter to you regarding other changes in the bill, to prepare a committee report (or "letter of intent") for inclusion in the Senate Journal. The report would provide valuable evidence of legislative intent.

The proposed statute (AS 44.77.015) has three substantive components. It redefines "promptly" for the purpose of filing medicaid and general relief assistance claims; gives the commissioner of health and social services, upon a showing of good cause, discretion to approve partial payment of claims not promptly filed; and defines "beneficiary" and "medical provider" as used in that section. The amendment to the bill also repeals the existing subsection (AS 44.77.010(b)) on that subject. The substance of that repealed subsection, in amended form, is transferred to the proposed AS 44.77.015(a).

Under existing AS 44.77.010(b), the Department of Health and Social Services may only pay a claim for medicaid

Honorable Bettye Fahrenkamp  
Chairman, Senate Health, Education  
and Social Services Committee

February 5, 1986  
Page 2

(AS 47.07) or general relief assistance (AS 47.25.120 -- 47.25.-300) services if the claim is filed "promptly." "Promptly" is defined for these purposes as within six months after the date that the service was rendered or third-party payment was received.

An inequitable situation results when no third-party payment is ever received, but the potential third-party payor was so dilatory in responding to the claim that more than six months elapsed before the medical provider received the negative response and could file a claim for medicaid or general relief assistance. The medical provider cannot then "promptly" file the claim, and is left with no recourse. The proposed statute would eliminate this inequitable result by amending the definition of "promptly" to mean within 12 months after the date of service for claims in which third-party payment was sought. AS 44.77.015(a).

Another inequitable situation can arise under the present definition of "promptly." If a person found by the department to have been ineligible for medicaid or general relief assistance appeals that finding and obtains a favorable judicial or administrative decision, the person's medical provider may only file claims for services provided to that person during the period in which the person was erroneously considered ineligible if no more than six months have elapsed since those services were provided. If the appeal takes longer than six months, the medical provider may not be able to "promptly" file claims for all of the services provided. (The earlier claim that prompted the finding of ineligibility would be considered as having been promptly filed.) Although the provider did not file claims for the subsequent services because the earlier claim for services provided to the same person was denied based on ineligibility, the provider now has no recourse. The provider must seek payment from the person cared for, or bear the loss, for services for which a "prompt" claim cannot be filed.

The proposed statute would eliminate this inequitable result by redefining "promptly" in new AS 44.77.015(a) and (b) to mean that a claim filed later than six months after a service was provided may still be considered promptly filed if the medical provider can show that the claim was not filed earlier because the provider believed the person was ineligible, and that this belief was reasonable. A belief is reasonable, for example, if it was based on the denial, due to ineligibility, of an earlier claim filed by the provider for services rendered to the same person. To be considered "promptly" filed under AS 44.77.015(b), a medical provider must file claims within six months after the date upon which a court or administrative hearing officer finds that a person was improperly found to be ineligible for medicaid

Honorable Bettye Fahrenkamp  
Chairman, Senate Health, Education  
and Social Services Committee

February 5, 1986  
Page 3

or general relief assistance.

In addition, proposed AS 44.77.015(b) provides that when a court or administrative hearing officer reverses a finding of ineligibility, it is the responsibility of the successful appellant to inform his or her medical provider of the judicial or administrative decision. Placing the responsibility on the appellant is appropriate because the Department of Health and Social Services has neither access to the records of all medical providers, nor the ability to freely publicize eligibility determinations. It cannot contact all medical providers who may have claims affected by a successful appeal. Moreover, a person in debt to a medical provider for services rendered has an incentive to inform his or her creditor of the judicial or administrative decision so that the creditor can obtain payment and relieve the person of his or her debt.

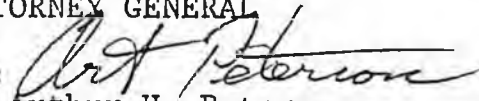
The second substantive component of the proposed statute authorizes the commissioner of health and social services to approve payment of no greater than 50 percent of the covered charges in a claim not "promptly" filed if the medical provider shows good cause for the failure to meet the relevant statutory deadline. AS 44.77.015(c). "Good cause" does not include a successful appellant's failure to inform the provider of a judicial or administrative reversal of the department's finding of ineligibility.

Finally, proposed AS 44.77.015(d) defines "beneficiary" and "medical provider," as used in AS 44.77.015.

Passage of the bill with these changes will eliminate inequities that result under the current law.

Sincerely,

HAROLD M. BROWN  
ATTORNEY GENERAL

By:   
Arthur H. Peterson  
Assistant Attorney General

HMB:AHP:md

cc: Hon. John Pugh, Commissioner  
Dept. of Health & Social Services

Jim Ayers, Director  
Legislative Relations  
Governor's Office

Honorable Bettye Fahrenkamp  
Chairman, Senate Health, Education  
and Social Services Committee

February 5, 1986  
Page 4

George Edwards  
Assistant Attorney General  
Human Services Section  
Juneau

1 \* Section 7. AS 44.77 is amended by adding a new section to read:

2       Sec. 44.77.015. CLAIMS FOR MEDICAL SERVICES. (a) For the  
3 purposes of filing claims for medical services provided under AS 47.07  
4 or 47.25.120 -- 47.25.300, "promptly", in AS 44.77.010(a), means (1)  
5 within six months after the date of service, or as provided in (b) of  
6 this section, if there is no third-party claim, or (2) within 12  
7 months after the date of service if there is a third-party claim.  
8 Except as provided in (c) of this section, a claim may not be paid if  
9 it is not filed promptly; an inference to the contrary may not be  
10 drawn from AS 09.10.050, AS 09.50.250 -- 09.50.300, or AS 37.25.010.

11       (b) In accordance with (a) of this section, a claim may be con-  
12 sidered to be filed promptly if (1) the claim was filed more than six  
13 months after the date of service because the medical provider had  
14 reason to believe that the beneficiary was ineligible for service  
15 under AS 47.07 or AS 47.25.120 -- 47.25.300; (2) a court of competent  
16 jurisdiction or an administrative hearing officer finds that the  
17 beneficiary was eligible for service under AS 47.07 or AS 47.25.120 --  
18 47.25.300 on the date of service; and (3) the claim is filed within  
19 six months after the date that the court or administrative finding is  
20 rendered. The beneficiary is responsible for notifying the medical  
21 provider of the judicial or administrative finding.

22       (c) The commissioner of health and social services may authorize  
23 payment to a medical provider of a claim not promptly filed, upon good  
24 cause shown. Payments under this subsection may not exceed 50 percent  
25 of the allowable charges presented in the claim. "Good cause" does  
26 not include a beneficiary's failure to notify a provider of a judicial  
27 or administrative finding of eligibility.

28       (d) For the purposes of this section,

29       (1) "beneficiary" means a person who is found to be eligi-

1 ble to receive medical services under AS 47.07 or AS 47.25.120 --  
2 47.25.300;

3 (2) "medical provider" means a person, firm, corporation,  
4 association, or institution that, on the date of service, was approved  
5 to provide medical assistance, in accordance with regulations adopted  
6 by the Department of Health and Social Services.

7 \* Sec. 2. AS 44.77.010(b) is repealed.  
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Sec. 47.25.140. **Residence in institution.** Payment under AS 47.25.120 — 47.25.300 may not be made to or in behalf of an individual who is a resident of the Alaska Pioneers' Home or other public institution, except as a patient in a public medical institution, or an individual who is a patient in a public or private institution for tuberculosis or mental disease. A resident of the Alaska Pioneers' Home or other public institution who is otherwise eligible to receive an allowance under AS 47.25.120 — 47.25.300 may apply for the allowance instead of the support and maintenance provided in the home or public institution. (§ 4 ch 110 SLA 1953)

Sec. 47.25.150. **Application for assistance.** A person requesting assistance shall apply for it, either personally or through another person, upon forms furnished and under regulations adopted by the department. (§ 5 ch 110 SLA 1953)

Sec. 47.25.160. **Investigation of applicant.** The department shall promptly investigate each applicant to determine the applicant's eligibility. (§ 6 ch 110 SLA 1953)

Sec. 47.25.170. **Granting of assistance.** Upon the completion of its investigation, the department shall decide whether the applicant is eligible for and should receive assistance promptly under AS 47.25.120 — 47.25.300, the amount of assistance, the manner of paying or providing it, and the date on which the assistance shall begin. The department shall notify the applicant of its decision. (§ 7 ch 110 SLA 1953)

Sec. 47.25.180. **Appeal.** An applicant whose application is not acted upon or is denied, discontinued, or modified by the department shall be granted an opportunity for fair hearing before a representative of the department appointed for that purpose. The hearing shall be held within a reasonable time after demand for it. A representative designated to conduct the hearing shall be governed by the regulations adopted for that purpose by the department. (§ 8 ch 110 SLA 1953)

Sec. 47.25.190. **Payment to guardians.** When a guardian is appointed by the court for a person receiving assistance, the department may pay the assistance to the guardian. (§ 9 ch 110 SLA 1953)

Sec. 47.25.195. **Payment to health facilities for treatment of needy persons.** (a) The department may make payments to a health facility for the treatment of a needy person.

(b) A health facility receiving a payment under this chapter is subject to the requirements of AS 47.07.070 — 47.07.075.

(c) For purposes of this section, "health facility" includes a hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally-retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic. (§ 7 ch 95 SLA 1983)

Sec. 47.25.280. *Obtaining assistance by fraud.* [Repealed, § 42 ch 143 SLA 1982.]

Sec. 47.25.290. *Penalty for violation.* A person who violates a provision of AS 47.25.120 — 47.25.300 is guilty of a misdemeanor and upon conviction is punishable by a fine of not more than \$1,000 or by imprisonment for not more than one year, or by both. (§ 19 ch 110 SLA 1953; am § 2 ch 116 SLA 1975)

Sec. 47.25.300. *Definitions.* In AS 47.25.120 — 47.25.300

(1) "assistance" means financial assistance to or on behalf of a needy person, including subsistence (food, shelter, fuel, clothing, and utilities) and transportation, medical needs (including, but not limited to, hospitalization, nursing, and convalescent care), burial, and other determined needs;

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

(3) "needy person" means a needy resident of the state who is not eligible for aid from another public agency or department providing similar services in the state;

(4) "public medical institution" means a public hospital or medical institution, except an institution for the treatment of tuberculosis or mental disease. (§ 1 ch 110 SLA 1953; am § 2 ch 32 SLA 1971; am § 6 ch 104 SLA 1971)

NOTES TO DECISIONS

A statutory prohibition of welfare benefits to residents of less than a year creates a classification which constitutes an invidious discrimination denying such

residents equal protection of the laws. *Shapiro v. Thompson*, 394 U.S. 618, 89 S. Ct. 1322, 22 L. Ed. 2d 600 (1969).

Article 3. Aid to Families with Dependent Children Act.

Section

- 310. Eligibility for assistance
- 320. Amount of assistance
- 330. Duties of department
- 340. Application for assistance
- 350. Investigation of application
- 360. Granting of assistance
- 365. Retraining of parent or family member

Section

- 370. Appeal
- 380. Reconsideration and alteration of assistance
- 395. Alienation and attachment
- 400. Purpose
- 410. Definitions
- 420. Short title

Sec. 47.25.310. *Eligibility for assistance.* The department shall grant assistance to the family of each dependent child and each pregnant woman it determines is eligible for assistance under AS 47.25.310 — 47.25.420, or to employers under a work incentive program established by AS 23.15.650, and by 42 U.S.C. 633(e)(1) (Social Security Act, Win Program), as amended. (§ 51-2-32 ACLA 1949; am § 2 ch 57 SLA

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**7 AAC 47.190. EXCEPTIONS TO FINANCIAL ELIGIBILITY CRITERIA.** Persons who do not meet the financial eligibility criteria of 7 AAC 47.150 and 7 AAC 47.160, but whose income and resources are inadequate to meet their medical expenses, may apply to the Catastrophic Illness Program (7 AAC 48) for determination of eligibility for coverage of part or all of their medically related costs. (Eff. 3/23/78, Reg. 65)

Authority: AS 47.05.010  
AS 47.25.120

**7 AAC 47.200. GENERAL RELIEF MEDICAL COVERAGE.** The General Relief program provides payment on behalf of needy persons who are eligible under the provisions of this chapter for the following services:

- (1) hospital – inpatient and outpatient;
- (2) skilled nursing facility;
- (3) intermediate care facility;
- (4) physician services;
- (5) laboratory and X-ray services;
- (6) visual care services and dispensing;
- (7) ophthalmic materials;
- (8) dental care – limited to emergency treatment for relief of pain and acute infection;
- (9) medical transportation;
- (10) services for speech, language, and hearing disorders;
- (11) family planning services;
- (12) prescribed drugs;
- (13) physical and occupational therapy;
- (14) prosthetic devices and medical supplies;
- (15) outpatient surgical center services. (Eff. 3/23/78, Reg. 65; am 5/2/79, Reg. 70; am 5/17/82, Reg. 82; am 5/25/82, Reg. 82; am 9/23/84, Reg. 91; am 8/1/85, Reg. 95)

Authority: AS 47.05.010  
AS 47.25.195

Editor's Note: Emergency amendments of 7 AAC 43.005(c), 7 AAC 47.030, 7 AAC 47.050, 7 AAC 47.060, 7 AAC 47.070, 7 AAC 47.110, 7 AAC 47.180, 7 AAC 47.200, 7 AAC 47.210, 7 AAC 47.220 and 7 AAC 47.900, filed on 4/15/82 (effective 5/17/82), were repealed on 5/25/82 and are therefore not being printed. The text of these provisions appears as it did before the emergency amendments.

**7 AAC 47.210. EXCLUSIONS FROM GENERAL RELIEF MEDICAL PROGRAM.** Notwithstanding any other provisions contained in this chapter or 7 AAC 43, medical payment may not be made under the General Relief Medical program for any expense

(1) which is not reasonably necessary for the diagnosis or treatment of illness or injury or for correction of an organic system as determined by the attending health care professional or a professional standards review organization or upon review by the division's medical practice review section:

(2) if the expense is for inpatient hospital or nursing home care which does not meet the criteria in (1) of this section:

(3) if the expense is for items and services not properly prescribed or determined necessary by a health care practitioner:

(4) if the expense is incurred for an evaluative or periodic checkup, examination, or immunization not in connection with the participation or enrollment in a program or activity of the division;

(5) if the expense is for or in connection with cosmetic therapy or cosmetic surgery, except that coverage will be available when required for repair of accidental injury, for the improvement of the functioning of a malformed body member, or for the correction of a visible disfigurement which would materially affect the beneficiary's acceptance in society, and when performed within the normal course of treatment or otherwise beginning no later than one year after the event which caused the need for the corrective action;

(6) if the expense constitutes a charge imposed by a friend or relative of a beneficiary except when payment is made for medical transportation;

health  
association  
of alaska

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

January 30, 1986

Senator Bettye M. Fahrenkamp  
Alaska State Legislature  
Pouch V (NS 3100)  
Juneau, Alaska 99811

Dear Senator Fahrenkamp,

Thank you for the opportunity to review a draft bill proposal that I understand the Department of Health and Social Services has ask the Senate HESS committee to consider, titled "An Act relating to payment to health facilities". I will be in Washington D.C. the full week of February 3-7 thus will not be able to attend the committee session Tuesday February 4. I would appreciate any possible consideration in the committee not acting on this measure until I return. I will be distributing this draft to the Executive Committee of the Health Association of Alaska so that we can develop and communicate a formal position to you. In the interim I will offer preliminary comments.

Section 1. This appears somewhat simple, however it could well cause the demise of many nursing homes in Alaska. The current fight is over whether the current costs of nursing homes in Alaska are reasonable in spite of the fact that most exceed federal limits. We believe that this is because we treat a heavier case load than is typical in the other states. We believe that many patients in Alaskan nursing homes would be in hospitals in other states. This section gives the state the clear direction to back away from that fight. We believe that it would be disastrous to the quality of patient care. Perhaps the first step to the problems we read about in other states but as yet not in Alaska.

Section 2. While this seems simple and equitable, it is not. We have to consider the payment structure developed by the Medicaid Rate Commission (MRC) and how it is compared to the customary charges of a facility. Currently every acute facility in Alaska is on a cafeteria style charge structure but the Medicaid program through the MRC has chosen to pay on a per diem basis. The second problem is that the typical outcome of this language is to take advantage of any discount price but not pay the higher charge in other areas to offset the loss. This gives the state the ability to shop in a very different manner than any other purchaser.

Chairman of the Board  
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South Peninsula Hospital  
Homer

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Charter North Hospital  
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Cordova Community  
Hospital  
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Providence Hospital  
Anchorage

Alternate Delegate to the  
American Hospital Assoc.  
Sister Barbara Haase  
Ketchikan General Hospital  
Ketchikan

Delegate to the American  
Health Care Association  
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Our Lady of Compassion  
Care Center  
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Association  
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Seward

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Hospitals  
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Hospital  
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Delegate to the National  
Congress of Hospital  
Governing Boards  
Maxine Robertson  
Ketchikan General Hospital  
Ketchikan

Alternate Delegate to the  
National Congress of  
Hospital Governing  
Boards  
Sharon Jean  
Central Peninsula  
General Hospital  
Soldotna

Physician Member of  
the Board  
Morris Horning, M.D.  
Anchorage

President  
Dennis DeWitt  
Juneau

FORMERLY

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Senator Fahrenkamp  
January 30, 1986  
Page two

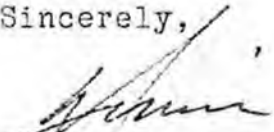
Section 3. This issue is addressed in House Bill 98 which is the outcome of negotiations between this association and Commissioner Pugh last year. This is their original position. At best this, in my opinion, shows poor judgement of the process. As I have told them in the past, the federal law provides that rates of payment must reflect rates which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. I would refer you to 42 U.S.C. Section 1396a(a)(13)(A) and 42 C.F.R. Section 447.252 and Nebraska Health Care Association, Inc. v. Dunning, 575 F. Supp. 176 (D. Neb. 1983).

There seems to be a notion in this section that legislative appropriation is per se an aggregate reasonable and adequate cost determinate. I suggest that that would not survive any test. The subsection (e) is your basic "Kings X". Gosh guys we really didn't mean your rate and the legislature agrees!

Section 4. The new verbiage is somewhat of a mystery. I am not sure that it is necessary or beyond the ability of the MRC currently. The omission of the words "and budgets" is quite a different issue. That takes the discussion of the impact of MRC decisions off the table. The MRC then has the ability to determine that an arbitrary rate is justified based on national criteria, for example, and ignore the impact it might have in Petersburg, Glennallen or Home.

I have attempted to get this to you quickly so that you will be aware that these proposals are not "technical" but are substantive. I appreciate your courtesy in sharing this proposal. It would be well for the proponents to consider the same level of courtesy.

Sincerely,

  
Dennis L. DeWitt  
President

cc: Executive Committee  
Comissioner Pugh  
Ray Gillespie



- (1) aged, blind, or disabled persons who
  - (A) do not receive supplemental security income under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) because they do not meet income and resources requirements; and
  - (B) are eligible to receive an optional state supplementary payment;
- (2) persons in a medical or intermediate care facility
  - (A) whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act); and
  - (B) who would not be eligible for an optional state supplementary payment if they left the facility;
- (3) persons under 21 years of age
  - (A) who are under the supervision of the department;
  - (B) whose maintenance is paid in whole or in part from public funds; and
- (C) who are in foster homes or private child-care institutions;
- (4) persons under 21 years of age who
  - (A) receive treatment in a psychiatric hospital; and
  - (B) are financially eligible as determined by the standards of 42 U.S.C. 601 — 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children);
- (5) persons under 21 years of age who are
  - (A) in an institution designated by the department as an intermediate care facility for the mentally retarded; and
  - (B) financially eligible as determined by the standards of the federal aid to families with dependent children program;
- (6) women who are pregnant;
- (7) persons under 21 years of age who do not qualify for benefits under the federal aid to families with dependent children program because they are not dependent children;
- (8) intermediate nursing home services;
- (9) eye examinations by an ophthalmologist or optometrist; or eyeglasses prescribed by a physician skilled in the diseases of the eye or by an optometrist;
- (10) treatment of speech, hearing, or language disorders;
- (11) physical or occupational therapy;
- (12) care at an intermediate care facility for the mentally retarded;
- (13) care at an inpatient psychiatric facility;
- (14) community mental health clinic services;
- (15) surgical care center services;
- (16) nurse midwife services;
- (17) medical supplies and equipment;
- (18) long-term care noninstitutional services. (§ 3 ch 132 SLA 1982)

**Sec. 47.07.040. State plan for provision of medical assistance.** The department shall prepare a state plan in accordance with the

provisions of 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act, Medical Assistance) and submit it for approval to the United States Department of Health and Human Services. The plan shall designate that the Department of Health and Social Services is the single state agency to administer this plan. The department shall act for the state in any negotiations relative to the submission and approval of the plan and may make those arrangements, not inconsistent with law, as may be required under federal law to obtain and retain approval of the United States Department of Health and Human Services to secure for the state the provisions of 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act, Medical Assistance). In addition, the department shall provide a report to the legislature no later than March 15 of each year concerning the status of this program and recommendations, with supporting fiscal data, as to any changes in the coverage of eligible persons or services to be provided. (§ 1 ch 182 SLA 1972)

**Sec. 47.07.050. Implementation of the medical assistance program.** The department shall take the steps necessary to adopt those regulations, prepare necessary documentation for the state and providers and undertake the systems design that may be necessary to implement the provisions of this chapter on or before November 1, 1972. Implementation of the medical assistance program shall include appropriate controls and reporting capabilities as required by the United States Department of Health and Human Services, and the department shall make those necessary reports as required by that federal agency or as requested by the legislature. (§ 1 ch 182 SLA 1972)

**Sec. 47.07.060. Receipt of federal money.** The Department of Administration shall accept and receive all grants of money awarded to the state under 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act, Medical Assistance). All money received shall be deposited by the Department of Administration in a special account of the general fund and shall be used by the state exclusively for medical assistance and the administration of medical assistance under the provisions of this chapter. This money shall be paid from the account on a certified disbursement voucher from the department. (§ 1 ch 182 SLA 1972)

**Sec. 47.07.070. Payment to health facilities.** (a) The commission shall determine prospectively the rate of payment to a health facility under this chapter and AS 47.25.120 — 47.25.300 based on a fair rate for reasonable costs incurred by the facility. The commission shall by regulation list the factors it considers in making its rate determinations under this section.

(b) In determining a rate of payment to a health facility under this section, the commission shall consider the proportionate share of the facility's financial requirements for patient care for

(1) costs of current operations, including salaries and wages, purchased services, supplies, insurance, leases, depreciation, taxes, inter-

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est expense, maintenance and other health facility operating expenses:  
and

(2) education, research, and appropriate capital development.

(c) In determining a rate of payment to a health facility under this section, the commission may consider whether the rate of utilization of the facility has been reduced because of improvident or careless development of the facility. (§ 1 ch 182 SLA 1972; am § 3 ch 95 SLA 1983)

**Cross references.** — For legislative findings and policy relating to ch. 95, SLA 1983, see § 2, ch. 95, SLA 1983, in the Temporary and Special Acts.

**Effect of amendments.** — The 1983 amendment rewrote this section.

**Editor's notes.** — Section 8, ch. 95, SLA

1983, provides: "INTERIM PROSPECTIVE PAYMENT SYSTEM. The department shall establish an interim system of prospective payments for health facilities under this Act for the period July 1, 1983, to June 30, 1984."

**Sec. 47.07.071. Reports by health facilities.** Not later than 120 days after the end of each fiscal year of a health facility, the facility shall submit to the commission a report on the facility's financial performance during the fiscal year. (§ 4 ch 95 SLA 1983)

**Sec. 47.07.072. Report by the commission.** Not later than September 30 of each year, the commission shall submit to the governor a report on the prospective payments made under this chapter during the current fiscal year and an estimate of the prospective payments that will be made during the remainder of the current fiscal year and the next fiscal year. The report shall state the assumptions that are used as a basis for the estimates. (§ 4 ch 95 SLA 1983)

**Sec. 47.07.073. Uniform accounting, budgeting, and financial reporting.** (a) The commission by regulation shall require a uniform system of accounting, budgeting, and financial reporting for health facilities receiving prospective payments under this chapter. The regulations shall provide for reporting revenues, expenses, assets, liabilities, and units of service. The commission shall specify the date the system becomes effective for each health facility.

(b) In adopting regulations under this section, the commission shall consider

(1) accounting, budgeting, and financial reporting procedures used by health facilities;

(2) variations among health facilities in the types of health care services provided by health facilities;

(3) the size and organizational structure of health facilities;

(4) the methods used by health facilities to obtain payments; and

(5) other factors the commission considers relevant.

(c) The commission may waive or modify a requirement for accounting, budgeting, or financial reporting for a health facility if waiver or modification is

(page 3, line 20)

*Superseded*

Hein  
2/1/86

Original sponsor: Rules/Governor

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IN THE HOUSE

BY THE HEALTH, EDUCATION AND  
SOCIAL SERVICES COMMITTEE

SENATE CS FOR CS FOR HOUSE BILL NO. 98 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

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

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

\* Section 1. AS 44.77 is amended by adding a new section to read:

Sec. 44.77.015. CLAIMS FOR MEDICAL SERVICES. (a) For the purposes of filing claims for medical services provided under AS 47.07 or 47.25.120 - 47.25.300, "promptly," in AS 44.77.010(a), means (1) within six months after the date of service, or as provided in (b) of this section, if there is no third-party claim, or (2) within 12 months after the date of service if there is a third-party claim. Except as provided in (c) of this section, a claim may not be paid if it is not filed promptly; an inference to the contrary may not be drawn from AS 09.10.050, AS 09.50.250 - 09.50,300, or AS 37.25.010.

(b) In accordance with (a) of this section, a claim may be considered to be filed promptly if (1) the claim was filed more than six months after the date of service because the medical provider had reason to believe that the beneficiary was ineligible for service under AS 47.07 or AS 47.25.120 - 47.25.300; (2) a court of competent jurisdiction or an administrative hearing officer finds that the beneficiary was eligible for service under AS 47.07 or AS 47.25.120 - 47.25.300 on the date of service; and (3) the claim is filed within six months after the date that the court or administrative finding is rendered. The beneficiary is responsible for notifying the medical provider of the judicial or administrative finding.

1 (c) The commissioner of health and social services may authorize  
2 payment to a medical provider of a claim not promptly filed, upon good  
3 cause shown. Payments under this subsection may not exceed 50 percent  
4 of the allowable charges presented in the claim. In this subsection,  
5 "good cause" does not include a beneficiary's failure to notify a  
6 provider of a judicial or administrative finding of eligibility.

7 (d) In this section,

8 (1) "beneficiary" means a person who is found to be eligi-  
9 ble to receive medical services under AS 47.07 or AS 47.25.120 -  
10 47.25.300;

11 (2) "medical provider" means a person, firm, corporation,  
12 association, or institution that, on the date of service, was approved  
13 to provide medical assistance, in accordance with regulations adopted  
14 by the Department of Health and Social Services.

15 \* Sec. 2. AS 47.05 is amended by adding a new section to read:

16 Sec. 47.05.070. SUBROGATION. (a) If the department provides or  
17 pays for medical assistance for injury or illness under this title,  
18 the department is subrogated to the rights of the recipient of that  
19 medical assistance for any claim arising from the injury or illness  
20 and to the proceeds of an insurance policy covering the injury or  
21 illness to the extent of the value of the medical assistance provided.

22 (b) If a recipient of medical assistance under this title set-  
23 tles a claim or obtains an award or judgment arising from the injury  
24 or illness for which the medical assistance was received, the depart-  
25 ment shall reimburse the recipient for attorney fees and costs commensurate  
26 with the amount of the settlement, award, or judgment to which  
27 the department is entitled under (a) of this section. Regardless of  
28 the manner in which the amount of the attorney fees is derived, reim-  
29 bursement of attorney fees shall be in accordance with the applicable

1 rules of court governing the award of attorney fees in civil matters.

2 \* Sec. 3. AS 47.07.020(b) is amended to read:

3 (b) In addition to the persons specified in (a) of this section,  
4 the following optional groups of persons for whom the state may claim  
5 federal financial participation are eligible for medical assistance:

6 (1) persons eligible for but not receiving assistance under  
7 any plan of the state approved under 42 U.S.C. 601 - 615 (Title IV-A,  
8 Social Security Act, Aid to Families with Dependent Children) or 42  
9 U.S.C. 1381 - 1383c (Title XVI, Social Security Act, Supplemental  
10 Security Income);

11 (2) persons in a general hospital, skilled nursing facility  
12 or intermediate care facility, who, if they left the facility, would  
13 be eligible for assistance under one of the federal programs specified  
14 in (1) of this subsection;

15 (3) persons under age 21 who are [YEARS OF AGE] under  
16 supervision of the department, for whom maintenance is being paid in  
17 whole or in part from public funds, and who are in foster homes or  
18 private child-care institutions;

19 (4) aged, blind, or disabled persons, who, because they do  
20 not meet income [REDACTED] requirements, do not receive supple-  
21 mental security income under 42 U.S.C. 1381 - 1383c (Title XVI, Social  
22 Security Act), and who do not receive a mandatory state supplement,  
23 but who are eligible, or would be eligible if they were not in a  
24 [GENERAL HOSPITAL OR] skilled nursing facility or intermediate care  
25 facility to receive an optional state supplementary payment;

26 (5) persons under age 21 who are [YEARS OF AGE] in an  
27 institution designated as an intermediate care facility for the men-  
28 tally retarded and who are financially eligible as determined by the  
29 standards of the federal aid to families with dependent children

1 program;

2 (6) persons in a medical or intermediate care facility  
3 whose income while in the facility does not exceed 300 percent of the  
4 supplemental security income benefit rate under 42 U.S.C. 1381 - 1383c  
5 (Title XVI, Social Security Act) but who would not be eligible for an  
6 optional state supplementary payment if they left the hospital or  
7 other facility;

8 (7) persons under age 21 who are [YEARS OF AGE] receiving  
9 active treatment in a psychiatric hospital and who are financially  
10 eligible as determined by the standards of 42 U.S.C. 601 - 615 (Title  
11 IV-A, Social Security Act, Aid to Families with Dependent Children);

12 (8) persons under age 21 and not covered under (a) of this  
13 section, [YEARS OF AGE] who would be eligible for benefits under the  
14 federal aid to families with dependent children program, except that  
15 they have the care and support of both their natural and adoptive  
16 parents [BUT WHO DO NOT QUALIFY BECAUSE THEY ARE NOT DEPENDENT CHILD-  
17 REN];

18 (9) [WOMEN WHO ARE] pregnant women not covered under (a) of  
19 this section and who meet the income and resource requirements of the  
20 federal aid to families with dependent children program.

21 \* Sec. 4. AS 47.07.030 is repealed and reenacted to read:

22 Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. (a) The de-  
23 partment shall offer all mandatory services required under 42 U.S.C.  
24 1396 - 1396p (Title XIX of the Social Security Act).

25 (b) In addition to the mandatory services specified in (a) of  
26 this section, the department may offer only the following optional  
27 services: personal care services in a recipient's home; emergency  
28 hospital services; long-term care noninstitutional services; medical  
29 supplies and equipment; clinic services; inpatient psychiatric

1 facility services for individuals age 65 or older and individuals  
2 under age 21; physical therapy; occupational therapy; treatment of  
3 speech, hearing, and language disorders; prosthetic devices and  
4 eyeglasses; optometrists' services; intermediate care facility  
5 services, including intermediate care facility services for the  
6 mentally retarded; skilled nursing facility services for individuals  
7 under age 21; and reasonable transportation to and from the point of  
8 medical care.

9 \* Sec. 5. AS 47.07.035 is repealed and reenacted to read:

10 Sec. 47.07.035. PRIORITY OF MEDICAL ASSISTANCE. If the depart-  
11 ment finds that the cost of medical assistance for all persons eligi-  
12 ble under this chapter will exceed the amount allocated in the state  
13 budget for that assistance for the fiscal year, the department shall  
14 eliminate coverage for optional medical services and optionally eligi-  
15 ble groups of individuals in the following order:

- 16 ~~(1)~~ personal care services in a recipient's home;
- 17 ~~(2)~~ emergency hospital services;
- 18 ~~(3)~~ long-term care noninstitutional services;
- 19 ~~(4)~~ medical supplies and equipment;
- 20 ~~(5)~~ clinic services;
- 21 ~~(6)~~ inpatient psychiatric facility services;
- 22 ~~(7)~~ intermediate care facility services for the mentally  
23 retarded;
- 24 ~~(8)~~ physical therapy and occupational therapy;
- 25 ~~(9)~~ treatment of speech, hearing, and language disorders;
- 26 ~~(10)~~ prosthetic devices and eyeglasses;
- 27 ~~(11)~~ optometrists' services;
- 28 ~~(12)~~ intermediate care facility services;
- 29 ~~(13)~~ individuals age five and over, but under age 21, who are

1 not eligible for benefits under the federal aid to families with  
2 dependent children program because they do not meet the definition of  
3 dependent children;

4 (14) individuals under age 21 under supervision of the de-  
5 partment, for whom maintenance is being paid in whole or in part from  
6 public money and who are in foster homes or private child-care insti-  
7 tutions;

8 (15) individuals in a health facility whose income while in  
9 the facility does not exceed 300 percent of the supplemental security  
10 income benefit rate under Title XVI of the Social Security Act, and  
11 who would not be eligible for the optional state supplementary payment  
12 if they left the facility;

13 (16) aged, blind, and disabled individuals who, because they  
14 do not meet the income and resource requirements, do not receive  
15 supplemental security income under Title XVI of the Social Security  
16 Act, and who are not eligible to receive a mandatory state supplement  
17 but who are eligible, or would be eligible if they were not in a  
18 general hospital or skilled nursing facility or intermediate care  
19 facility, to receive an optional state supplementary payment;

20 (17) skilled nursing facility services for persons under age  
21 21.

22 \* Sec. 6. AS 47.07.070 is amended by adding a new subsection to read:

23 (d) Notwithstanding (a) - (c) of this section, the commission  
24 shall also consider available state and federal revenue when making  
25 rate decisions.

26 \* Sec. 7. AS 47.07.900(1) is amended to read:

27 (1) "clinic services" means services provided by state-  
28 approved outpatient community mental health clinics that receive  
29 grants under AS 47.30.520 - 47.30.620, state-operated community mental

1 health clinics, outpatient surgical care centers, and physician  
2 clinics;

3 \* Sec. 8. AS 47.07.900 is amended by adding new paragraphs to read:

4 (7) "emergency hospital services" means services that

5 (A) are necessary to prevent the death or serious  
6 impairment of the health of the individual; and

7 (B) because of the threat to the life or health of the  
8 individual, necessitate the use of the most accessible hospital  
9 available that is equipped to furnish the services, even if the  
10 hospital does not currently meet

11 (i) the conditions for participation under Medi-  
12 care; or

13 (ii) the definitions of inpatient or outpatient  
14 hospital services under 42 C.F.R. secs. 440.10 and 440.20.

15 (8) "personal care services in a recipient's home" means  
16 services prescribed by a physician in accordance with the recipient's  
17 plan of treatment and provided by an individual who is

18 (A) qualified to provide the services;

19 (B) supervised by a registered nurse; and

20 (C) not a member of the recipient's family.

21 \* Sec. 9. AS 44.77.010(b) is repealed.

22 \* Sec. 10. This Act takes effect immediately in accordance with AS 01.-  
23 10.070(c).

# Proposed

## Prioritization of Services

occupational & physical therapy were combined in existing statute

Medicaid recipients at non-enrolled hospitals who

	Annual Cost (Mil)	Recip.	
1.		New	Emergency hospital services
2.	.1	26/mo.	Treatment of speech, hearing and language disorders
3.	.4	386	Optometrists services and eyeglasses
4.	.1	5/mo	Occupational therapy <i>small motor development</i>
5.	.1	17/mo	Prosthetic devices <i>diabetic supp</i>
6.	.3	53/mo	Medical supplies and equipment <i>diabetic supplies, wheelchairs</i>
7.	.9	1300	Clinic services <i>commun MH, physician clinics</i>
8.	.1	25/mo	Physical therapy <i>gross motor</i>
9.			Personal care services in a recipient's home
10.	N/A	Waiver	Long term care non-institutional services <i>if community based waiver granted</i>
11.	1.0	34/mo	Inpatient psychiatric facility services <i>mainly API also Charter North 1-2 patients only</i>
12.	9	130	Intermediate care facility services M/R
13.	17	530	Intermediate care facility services
14.	4.2	1753	Individuals under 21 who are not eligible for AFDC because they are not deprived of one or more of their natural or adoptive parents
15.	1	4	Skilled nursing services for persons under 21
16.	9.3 8.9	1200 aged 1100 disabled	Aged, blind, and disabled who because they do not meet the income requirements, do not receive SSI but who are eligible or would be eligible if they were not in skilled nursing facility or intermediate care facility, to receive an optional state supplement
17.	1.1	36	Individuals in a hospital or SNF or ICF whose income while in the facility does not exceed 300 percent of the SSI benefit rate under Title XVI of the SS Act but who because of income are not eligible for the optional state supplementary payment
18.	.1	153	Individual under 21 under supervision of the department for whom maintenance is being paid in whole or in part from public

Hospital Association  
not in agreement

Dept needs Sec. 1  
and sec. 3(b) -  
state plan  
must be in compliance  
with fed. requirements

1 BILL

2 IN THE LEGISLATURE OF THE STATE OF ALASKA

3 LEGISLATURE

4 A BILL

5 For an Act entitled: "An Act relating to payments to health  
6 facilities."

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

8 \* Section 1. 47.07.040 is amended to read:

9 Sec. 47.07.040. STATE PLAN FOR PROVISION OF MEDICAL  
10 ASSISTANCE. The department shall prepare a state plan in  
11 accordance with the provisions of 42 U.S.C. 1396 -- 1396p  
12 (Title XIX, Social Security Act, Medical Assistance) and  
13 submit it for approval to the United States Department of  
14 Health and Human Services. The plan shall designate that  
15 the Department of Health and Social Services is the single  
16 state agency to administer this plan. The department shall  
17 act for the state in any negotiations relative to the  
18 submission and approval of the plan. The department,  
19 including the medicaid rate commission, may make those  
20 arrangements, or regulatory changes, not inconsistent with  
21 law, as may be required under federal law to obtain and  
22 retain approval of the United States Department of Health  
23 and Human Services to secure for the state the optimum  
24 federal payment under the provisions of 42 U.S.C. 1396 --  
25 1396p (Title XIX, Social Security Act, Medical Assistance).  
26 In addition, the department shall provide a report to the  
27 legislature no later than March 15 of each year concerning  
28 the status of this program and recommendations, with  
29

1 supporting fiscal data, as to any changes in the coverage of  
2 eligible persons or services to be provided.

3 \* Sec. 2. 47.07.070 is amended by adding new subsections:

4 Sec. 47.07.070(d) In determining rates of payment to  
5 health facilities, the commission shall consider the appro-  
6 priation limit set by the legislature for the department's  
7 programs under this chapter and under AS 47.25.120 --  
8 47.25.300. The commission shall set rates for facilities in  
9 the state so that, taking into account projected rates of  
10 utilization, the aggregate state payments to health facil-  
11 ities should not exceed the budgeted amounts for the state  
12 fiscal year.

13 (e) For the state fiscal year 1987, beginning July 1,  
14 1986, the commission may establish new prospective payment  
15 rates for any facility whose rate for any part of state  
16 fiscal year 1987 was set before the effective date of this  
17 amendment, if a new rate is necessary to allow the commis-  
18 sion to carry out the intent of subsection (d) above.

19 \* Sec. 3. 47.07.180 is amended to read:

20 Sec. 47.07.180. DUTIES. (a) The commission shall  
21 review proposed payment rates and may review budgets of  
22 health facilities and establish payment rates for health  
23 facilities under this chapter and AS 47.25.120 -- 47.25.300.

24 (b) The commission shall consult with the department  
25 on the state plan as it relates to health facilities. The  
26 commission may not change the unit of payment without the  
27 written consent of the department.

28 (c) By March 1 of each year, the commission shall  
29 develop an annual estimate for the fiscal year starting the

1 next July 1, of medical assistance program expenditures in  
2 facilities under the jurisdiction of the commission. The  
3 estimate shall consider anticipated utilization and payment  
4 rates for each facility. The methodology used by the  
5 commission to develop the estimate shall be consistent with  
6 the regulations governing the commission's rate-setting  
7 process.

HB 98 RELATING TO MEDICAL ASSISTANCE

A DRAFT COMMITTEE SUBSTITUTE HAS BEEN PREPARED.

TO TESTIFY:

COMMISSIONER PUGH/ROD BETIT, DEPT. HEALTH AND SOCIAL SERVICES  
MARY BENSON, EXECUTIVE DIRECTOR, MEDICAID RATE COMMISSION  
BOB FRANKEN, GOVERNOR'S COUNCIL ON HANDICAPPED AND GIFTED

HJR 58 URGING THAT RESTRICTIONS ON THE GRANTING OF MEDICAID WAIVERS  
BE EASED.

TO TESTIFY:

REPRESENTATIVE MAX GRUENBERG, SPONSOR  
COMMISSIONER PUGH/ROD BETIT, DEPT. HEALTH AND SOCIAL SERVICES

=====

HB 98 1) ALLOWS DEPT. TO PAY "PAST DUE" (MORE THAN 6 MO. OLD) MEDICAID  
CLAIMS UNDER CERTAIN CIRCUMSTANCES.

2) GIVES DEPT. 1st RIGHT TO RECOVERY OF MEDICAID EXPENSES FROM  
INSURANCE COMPANIES OR COURT SETTLEMENTS.

3) MAKES CHANGES NECESSARY FOR CONFORMANCE WITH FEDERAL LAW

4) ADDS MEDICAID COVERAGE FOR PERSONAL CARE ATTENDANTS

5) REQUIRES MEDICAID RATE COMMISSION TO TAKE INTO ACCOUNT  
AVAILABLE REVENUES WHEN SETTING HOSPITAL RATES.

ISSUES: - NUMBER OF HOURS OF CARE A PERSONAL ATTENDANT MAY PROVIDE IN  
A MONTH. DEPT'S FISCAL NOTE IS BASED ON 50; GOVERNOR'S COUNCIL WANTS  
120. THE MORE HOURS THE GREATER THE COST. FISCAL NOTE IS NOW \$1 MILLION.

DEPT'S ABILITY TO RESTRICT RATE COMMISSION'S AUTHORITY. DEPT.  
FEELS A NEED TO GET A CONTROL ON HOSPITAL RATES. HOSPITAL ASSOCIATION  
OPPOSES; DENNIS DeWITT IS UNABLE TO ATTEND TODAY.

PERSONAL CARE ATTENDANTS RANKING IN NUMERICAL PRIORITIZATION.

AS PROPOSED, THEY'D BE FOR THE FIRST OPTION TO GO IN A FUNDING SHORTFALL.

JAN 31 1986

# Alaska State Legislature

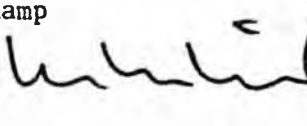


## House of Representatives

House Judiciary Committee

MEMO: Jan. 30, 1986

TO: Sen. Bettye Fahrenkamp

FROM: Rep. M. Mike Miller 

RE: Medicaid coverage of podiatry services

Pouch V  
State Capitol  
Juneau, Alaska 99811  
(907) 465-4990

Attached is a copy of a public opinion message I received recently from a Fairbanks podiatrist in regard to coverage of podiatrists under Medicaid.

Another podiatrist practicing here in Juneau recently brought the same question to the attention of one of my staff informally.

Frankly, I did not know that podiatrists were not eligible for Medicaid reimbursement, nor has it ever been an issue as far as I can remember. However, I can understand how such services might indeed be important to people covered by Medicaid. I do know that the Juneau podiatrist visits other communities in Southeast Alaska, and trades services for elderly patients in the Ketchikan pioneers home in return for use of office space for other patients. So, apparently there may be a need.

Since HB 98 will soon be coming to your committee, you may want to ask about this. At the same time, getting enough information on which to base a decision whether to include podiatrists or not may take longer than we have time in the current session.

This memo is informational only; I don't have an opinion one way or another, but rather thought that you might want to ask some questions since you will be hearing a bill addressing the overall issue of medical assistance.

If you are interested in further information, you may want to contact Dr. Frank Mesdag here in Juneau at 789-0405.

\*\*\*\*\*  
\*  
\* DELIVER TO: JPOH  
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\* ORIGINAL  
\* SENT: 01/20/86 TIME: 12:42  
\* FROM: ANITE NEUBAUER  
\* SUBJECT: POH/FAIRBANKS  
\* PRINT DATE: 01/20/86 TIME: 12:42  
\*  
\*\*\*\*\*

2

**RE: MIKE M. MORGER**

FROM: MARLENE H. LEAK, D.P.M., 771 8TH AVE., FAIRBANKS 99701

PHONE: 452-1015

RE: MEDICAID COVERAGE OF PODIATRY SERVICES

SINCE THE STATE OF ALASKA LICENSES PODIATRISTS TO PRACTICE, IT SHOULD REIMBURSE THOSE SERVICES COVERED BY MEDICAID. OTHER PHYSICIANS ARE REIMBURSED FOR PROVIDING THE SAME SERVICES PODIATRISTS PERFORM SO COST IS NOT THE ISSUE. IT IS NOT THE FUNCTION OF THE STATE OF ALASKA TO FAVOR ONE GROUP OF PHYSICIANS OVER ANOTHER MONETARILY WHEN IT RECOGNIZES BOTH PROFESSIONALLY.

*Sandra*



TO: BETTYE  
FROM: SANDRA

HB 98 RELATING TO MEDICAL ASSISTANCE

DRAFT C.S. HEARD FEB. 4:

1. ADMINISTRATIVE CHANGES TO MEDICAID (PAYMENT OF CLAIMS, 3rd PARTY PAYMENTS). DENNIS DeWITT WILL PROPOSE TO PLACE RESPONSIBILITY ON DEPT., RATHER THAN PATIENT, TO NOTIFY PROVIDERS WHEN ELIGIBILITY DECISIONS ARE MADE.
2. CHANGES TO CONFORM TO FEDERAL LAW
3. ADD PERSONAL CARE SERVICES

NEW C.S. ADDS:

1. NEW PRIORITY OF OPTIONS (BASED ON DEPT. ADVICE)
2. TIES HOSPITAL/NURSING HOME RATE-SETTING PROCESS TO LEGISLATIVE APPROPRIATIONS. DEPT. AND DENNIS WERE UNABLE TO AGREE. DENNIS WILL PROPOSE TO LEAVE RATE SETTING PROCESS AS IS BUT ALLOW PRORATING OF PAYMENTS IF UNDERFUNDING OCCURS.
3. ADDS NO NEW OPTIONS. COMMITTEE MEMO OUTLINES COST OF ADDING ADDITIONAL PROGRAMS TO MEDICAID.

REMEMBER: ADDING SERVICES TO MEDICAID WILL RELIEVE SOME OF THE PROBLEM CREATED BY THE GENERAL RELIEF MEDICAL CUT (FROM \$12 MILLION TO \$5 MILLION) BUT BECAUSE ELIGIBILITY CRITERIA DIFFER, WILL STILL HAVE AN UNSERVED POPULATION. GOVERNOR INTRODUCED HB 678 -- COST SAVINGS TO G.R.M. THROUGH CO-PAYMENT, PRO-RATING REIMBURSEMENT TO FACILITIES AND PHYSICIANS, ALLOWING DEPT. TO PRIORITIZE SERVICES.

NOTE: INDICATIONS ARE SENATE FINANCE WILL SUPPORT PERSONAL CARE SERVICES, PERHAPS AS BUDGET AMENDMENT. NO INDICATION THEY'LL SUPPORT ADDITIONAL FISCAL NOTES.

# Alaska State Legislature

f. HB 98

BETTYE FAHRENKAMP, Chairman  
ARLISS STURGULEWSKI, Vice Chairman  
JOE JOSEPHSON  
PAUL FISCHER  
EDNA ARMSTRONG-DE VRIES



P O BOX V  
STATE CAPITOL  
JUNEAU, ALASKA 99811  
(907) 465-3834  
(907) 465-3762

## Senate Committee on Health, Education and Social Services

March 6, 1986

Senator John Sackett, Co-Chairman  
Senator Jan Faiks, Co-Chairman  
Senate Finance Committee  
P.O. Box V  
Juneau, AK 99811

Dear Senator Faiks and Senator Sackett:

SCS CSHB 98 (HESS) proposes revisions to the administration of the Medicaid program, adds additional services under Medicaid, and gives the Medicaid Rate Commission explicit direction to consider the level of legislative appropriations in its rate setting process.

Section 4 of the bill, which adds personal care services, adult dental services and chiropractic services to the range of Medicaid services offered by the state, carries a fiscal impact of \$1,057,352 in state general fund monies. Personal care and adult dental services are currently being provided under the state's General Relief Medical (GRM) program at a combined cost of \$925,546.

	FY 87 ESTIMATED GRM COST	FY 87 ESTIMATED MEDICAID COST (STATE SHARE)
PERSONAL CARE SERVICES	\$200,000	\$527,000
ADULT DENTAL SERVICES	\$725,546	\$450,352
CHIROPRACTIC SERVICES	--	\$ 80,000


The Governor's FY 87 budget proposes reducing GRM funding from \$12 million to \$5 million, which would severely restrict the program's ability to meet the medical needs of the 16,690 Alaskans it served last year. Placing personal care and adult dental services under Medicaid will ensure that these services continue to be provided and will effect an overall cost savings

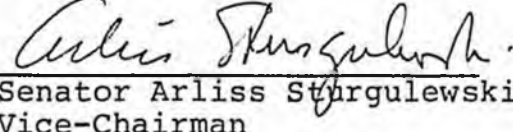
to the state, as the federal government will pick up 50% of the program's costs. In addition, expansion of the Medicaid program as proposed in HB 98 may prove beneficial to the state should a federal Medicaid "cap" be applied.

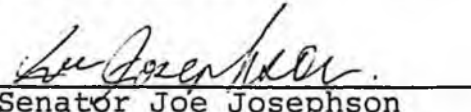
The Senate Committee on Health, Education and Social Services considered SCS CSHB 98 (HESS) on February 4 and February 27. While testimony on the addition of services was supportive, there is recognition that funding for all of the proposed services may not be available. It is therefore the recommendation of the committee that, should a prioritization of the three services be necessary, personal care services be given highest consideration.

Senators, thank you for taking these comments into consideration. We would be pleased to assist you in any way during your deliberations.

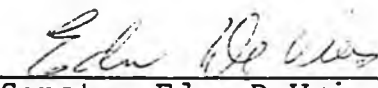
Sincerely,

  
\_\_\_\_\_  
Senator Bettye Fahrenkamp  
Chairman

  
\_\_\_\_\_  
Senator Arliss Sturgulewski  
Vice-Chairman

  
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Senator Joe Josephson

  
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Senator Paul Fischer

  
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Senator Edna DeVries

# Alaska State Legislature

BETTYE FAHRENKAMP, Chairman  
ARLISS STURGULEWSKI, Vice Chairman  
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## Senate Committee on Health, Education and Social Services

### SECTIONAL ANALYSIS

### SCS CS HB 98 (HESS) RELATING TO MEDICAL ASSISTANCE

MARCH 3, 1986

- Sec. 1 Extends the 6 month filing period for Medicaid and general relief medical assistance claims under certain circumstances.
- Sec. 2 Gives the state statutory basis for "first right" to recovery of medical assistance expenses from any insurance or court settlement awarded to a Medicaid recipient.
- Sec. 3 Amends the Medicaid statute to bring it into conformance with federal law.
- Sec. 4 Adds to the state's optional Medicaid programs personal care attendant services, adult dental services, and chiropractic services.
- Sec. 5 Provides the order in which optional services are to be deleted if the Medicaid program runs into funding difficulties.
- Sec. 6 Requires the Medicaid Rate Commission to work within the state's Medicaid plan.
- Sec. 7 Requires that in determining payment rates to health facilities the Medicaid Rate Commission consider the amount of state and federal funds available.
- Sec. 8 Clarifies the Medicaid Rate Commission's responsibility to set rates prospectively.
- Sec. 9 & 10 Defines the new services added in Section 4.
- Sec. 11 Repeals existing language relating to payment of claims.
- Sec. 12 Immediate effective date.

**DRAFT**

- 1 - payment of claims
- 2 - 3rd party payments
- 3 - conform to federal law
- 4 - personal care, adult dental, chiropractic
- 5 - prioritization of options

Hein  
3/3/86 ✓

Original sponsor: Rules/governor

- 6-8-Medicaid Rate Commission
- 9-10-definitions
- 11 - old language on payment
- 12 - effective date

IN THE HOUSE

BY THE HEALTH, EDUCATION AND  
SOCIAL SERVICES COMMITTEE

SENATE CS FOR CS FOR HOUSE BILL NO. 98 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

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

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

\* Section 1. AS 44.77 is amended by adding a new section to read:

Sec. 44.77.015. CLAIMS FOR MEDICAL SERVICES. (a) For the purposes of filing claims for medical services provided under AS 47.07 or 47.25.120 - 47.25.300, "promptly," in AS 44.77.010(a), means (1) within six months after the date of service, or as provided in (b) of this section, if there is no third-party claim, or (2) within 12 months after the date of service if there is a third-party claim. Except as provided in (c) of this section, a claim may not be paid if it is not filed promptly; an inference to the contrary may not be drawn from AS 09.10.050, AS 09.50.250 - 09.50,300, or AS 37.25.010.

(b) In accordance with (a) of this section, a claim may be considered to be filed promptly if (1) the claim was filed more than six months after the date of service because the medical provider had reason to believe that the beneficiary was ineligible for service under AS 47.07 or AS 47.25.120 - 47.25.300; (2) a court of competent jurisdiction or an administrative hearing officer finds that the beneficiary was eligible for service under AS 47.07 or AS 47.25.120 - 47.25.300 on the date of service; and (3) the claim is filed within six months after the date that the court or administrative finding is rendered. The beneficiary is responsible for notifying the medical provider of the judicial or administrative finding. The department

1 shall make a good faith effort to notify the medical provider of the  
2 judicial or administrative finding if the department has reason to  
3 believe that services have been provided to the beneficiary.

4 (c) The commissioner of health and social services may authorize  
5 payment to a medical provider of a claim not promptly filed, upon good  
6 cause shown. Payments under this subsection may not exceed 50 percent  
7 of the allowable charges presented in the claim.

8 (d) In this section,

9 (1) "beneficiary" means a person who is found to be eligi-  
10 ble to receive medical services under AS 47.07 or AS 47.25.120 -  
11 47.25.300;

12 (2) "medical provider" means a person, firm, corporation,  
13 association, or institution that, on the date of service, was approved  
14 to provide medical assistance, in accordance with regulations adopted  
15 by the Department of Health and Social Services.

16 \* Sec. 2. AS 47.05 is amended by adding a new section to read:

17 Sec. 47.05.070. SUBROGATION. (a) If the department provides or  
18 pays for medical assistance for injury or illness under this title,  
19 the department is subrogated to the rights of the recipient of that  
20 medical assistance for any claim arising from the injury or illness  
21 and to the proceeds of an insurance policy covering the injury or  
22 illness to the extent of the value of the medical assistance provided.

23 (b) If a recipient of medical assistance under this title set-  
24 tles a claim or obtains an award or judgment arising from the injury  
25 or illness for which the medical assistance was received, the depart-  
26 ment shall reimburse the recipient for attorney fees and costs commen-  
27 surate with the amount of the settlement, award, or judgment to which  
28 the department is entitled under (a) of this section. Regardless of  
29 the manner in which the amount of the attorney fees is derived,

1 reimbursement of attorney fees shall be in accordance with the appli-  
2 cable rules of court governing the award of attorney fees in civil  
3 matters.

4 \* Sec. 3. AS 47.07.020(b) is amended to read:

5 (b) In addition to the persons specified in (a) of this section,  
6 the following optional groups of persons for whom the state may claim  
7 federal financial participation are eligible for medical assistance:

8 (1) persons eligible for but not receiving assistance under  
9 any plan of the state approved under 42 U.S.C. 601 - 615 (Title IV-A,  
10 Social Security Act, Aid to Families with Dependent Children) or 42  
11 U.S.C. 1381 - 1383c (Title XVI, Social Security Act, Supplemental  
12 Security Income);

13 (2) persons in a general hospital, skilled nursing facility  
14 or intermediate care facility, who, if they left the facility, would  
15 be eligible for assistance under one of the federal programs specified  
16 in (1) of this subsection;

17 (3) persons under age 21 who are [YEARS OF AGE] under  
18 supervision of the department, for whom maintenance is being paid in  
19 whole or in part from public funds, and who are in foster homes or  
20 private child-care institutions;

21 (4) aged, blind, or disabled persons, who, because they do  
22 not meet income requirements, do not receive supplemental security  
23 income under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act),  
24 and who do not receive a mandatory state supplement, but who are  
25 eligible, or would be eligible if they were not in a [GENERAL HOSPITAL  
26 OR] skilled nursing facility or intermediate care facility to receive  
27 an optional state supplementary payment;

28 (5) persons under age 21 who are [YEARS OF AGE] in an  
29 institution designated as an intermediate care facility for the

1 mentally retarded and who are financially eligible as determined by  
2 the standards of the federal aid to families with dependent children  
3 program;

4 (6) persons in a medical or intermediate care facility  
5 whose income while in the facility does not exceed 300 percent of the  
6 supplemental security income benefit rate under 42 U.S.C. 1381 - 1383c  
7 (Title XVI, Social Security Act) but who would not be eligible for an  
8 optional state supplementary payment if they left the hospital or  
9 other facility;

10 (7) persons under age 21 who are [YEARS OF AGE] receiving  
11 active treatment in a psychiatric hospital and who are financially  
12 eligible as determined by the standards of 42 U.S.C. 601 - 615 (Title  
13 IV-A, Social Security Act, Aid to Families with Dependent Children);

14 (8) persons under age 21 and not covered under (a) of this  
15 section, [YEARS OF AGE] who would be eligible for benefits under the  
16 federal aid to families with dependent children program, except that  
17 they have the care and support of both their natural and adoptive  
18 parents [BUT WHO DO NOT QUALIFY BECAUSE THEY ARE NOT DEPENDENT CHILD-  
19 REN];

20 (9) [WOMEN WHO ARE] pregnant women not covered under (a) of  
21 this section and who meet the income and resource requirements of the  
22 federal aid to families with dependent children program.

23 \* Sec. 4. AS 47.07.030 is repealed and reenacted to read:

24 Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. (a) The de-  
25 partment shall offer all mandatory services required under 42 U.S.C.  
26 1396 - 1396p (Title XIX of the Social Security Act).

27 (b) In addition to the mandatory services specified in (a) of  
28 this section, the department may offer only the following optional  
29 services: personal care services in a recipient's home; emergency

1 hospital services; long-term care noninstitutional services; medical  
2 supplies and equipment; clinic services; inpatient psychiatric facili-  
3 ty services for individuals age 65 or older and individuals under age  
4 21; physical therapy; occupational therapy; chiropractic services;  
5 treatment of speech, hearing, and language disorders; adult dental  
6 services; prosthetic devices and eyeglasses; optometrists' services;  
7 intermediate care facility services, including intermediate care  
8 facility services for the mentally retarded; skilled nursing facility  
9 services for individuals under age 21; and reasonable transportation  
10 to and from the point of medical care.

11 \* Sec. 5. AS 47.07.035 is repealed and reenacted to read:

12 Sec. 47.07.035. PRIORITY OF MEDICAL ASSISTANCE. If the depart-  
13 ment finds that the cost of medical assistance for all persons eligi-  
14 ble under this chapter will exceed the amount allocated in the state  
15 budget for that assistance for the fiscal year, the department shall  
16 eliminate coverage for optional medical services and optionally eligi-  
17 ble groups of individuals in the following order:

- 18 ✕(1) chiropractic services;
- 19 ✕(2) adult dental services;
- 20 (3) emergency hospital services;
- 21 (4) treatment of speech, hearing, and language disorders;
- 22 (5) optometrists' services and eyeglasses;
- 23 (6) occupational therapy;
- 24 (7) prosthetic devices;
- 25 (8) medical supplies and equipment;
- 26 (9) clinic services;
- 27 (10) physical therapy;
- 28 ✕(11) personal care services in a recipient's home;
- 29 (12) long-term care noninstitutional services;

1 (13) inpatient psychiatric facility services;

2 (14) intermediate care facility services for the mentally  
3 retarded;

4 (15) intermediate care facility services;

5 (16) individuals under age 21 who are not eligible for  
6 benefits under the federal aid to families with dependent children  
7 program because they are not deprived of one or more of their natural  
8 or adoptive parents;

9 (17) skilled nursing facility services for persons under age  
10 21;

11 (18) aged, blind, and disabled individuals who, because they  
12 do not meet the income requirements, do not receive supplemental  
13 security income under Title XVI of the Social Security Act, but who  
14 are eligible, or would be eligible if they were not in a skilled  
15 nursing facility or intermediate care facility, to receive an optional  
16 state supplementary payment;

17 (19) individuals in a hospital, skilled nursing facility, or  
18 intermediate care facility whose income while in the facility does not  
19 exceed 300 percent of the supplemental security income benefit rate  
20 under Title XVI of the Social Security Act, but who, because of in-  
21 come, are not eligible for the optional state supplementary payment;

22 (20) individuals under age 21 under supervision of the  
23 department, for whom maintenance is being paid in whole or in part  
24 from public money and who are in foster homes or private child-care  
25 institutions.

26 \* Sec. 6. AS 47.07.040 is amended to read:

27 Sec. 47.07.040. STATE PLAN FOR PROVISION OF MEDICAL ASSISTANCE.  
28 The department shall prepare a state plan in accordance with the  
29 provisions of 42 U.S.C. 1396 1396p (Title XIX, Social Security Act,

1 Medical Assistance) and submit it for approval to the United States  
2 Department of Health and Human Services. The plan shall designate  
3 that the Department of Health and Social Services is the single state  
4 agency to administer this plan. The department shall act for the  
5 state in any negotiations relative to the submission and approval of  
6 the plan. The department, including the Medicaid Rate Commission,  
7 [AND] may make those arrangements or regulatory changes, not inconsis-  
8 tent with law, as may be required under federal law to obtain and  
9 retain approval of the United States Department of Health and Human  
10 Services to secure for the state the optimum federal payment under the  
11 provisions of 42 U.S.C. 1396 - 1396p (Title XIX, Social Security Act,  
12 Medical Assistance). In addition, the department shall provide a  
13 report to the legislature no later than March 15 of each year concern-  
14 ing the status of this program and recommendations, with supporting  
15 fiscal data, as to any changes in the coverage of eligible persons or  
16 services to be provided.

17 \* Sec. 7. AS 47.07.070 is amended by adding a new subsection to read:

18 (d) In determining a rate of payment to a health facility under  
19 this section, the commission shall consider the appropriation limit  
20 set by the legislature for the department's programs under this chap-  
21 ter and under AS 47.25.120 - 47.25.300, and available federal revenue.

22 \* Sec. 8. AS 47.07.180 is repealed and reenacted to read:

23 Sec. 47.07.180. DUTIES. (a) The commission shall review pro-  
24 posed payment rates for health facilities under this chapter and  
25 AS 47.25.120 - 47.25.300.

26 (b) The commission may review budgets of, and shall establish  
27 payment rates for, health facilities under this chapter and AS 47.-  
28 25.120 - 47.25. 300.

29 (c) The commission shall consult with the department on the

1 state plan as it relates to health facilities. The commission may not  
2 change the unit of payment without the written consent of the depart-  
3 ment.

4 (d) By March 1 of each year, the commission shall develop for  
5 the fiscal year starting the next July 1 an annual estimate of medical  
6 assistance program expenditures in health facilities under the jurisdic-  
7 tion of the commission. The estimate shall consider anticipated  
8 utilization and payment rates for each facility. The methodology used  
9 by the commission to develop the estimate shall be consistent with the  
10 regulations governing the commission's rate-setting process.

11 \* Sec. 9. AS 47.07.900(1) is amended to read:

12 (1) "clinic services" means services provided by state-  
13 approved outpatient community mental health clinics that receive  
14 grants under AS 47.30.520 - 47.30.620, state-operated community mental  
15 health clinics, outpatient surgical care centers, and physician clin-  
16 ics;

17 \* Sec. 10. AS 47.07.900 is amended by adding new paragraphs to read:

18 (7) "adult dental services" means minimum treatment for the  
19 immediate relief of pain and acute infection provided by a licensed  
20 dentist;

21 (8) "chiropractic services" includes only services that are  
22 provided by a chiropractor licensed under AS 08.20 that consist of  
23 treatment by means of manual manipulation of the spine and x-rays  
24 necessary for treatment;

25 (9) "emergency hospital services" means services that

26 (A) are necessary to prevent the death or serious  
27 impairment of the health of the individual; and

28 (B) because of the threat to the life or health of the  
29 individual, necessitate the use of the most accessible hospital

1 available that is equipped to furnish the services, even if the  
2 hospital does not currently meet

3 (i) the conditions for participation under Medi-  
4 care; or

5 (ii) the definitions of inpatient or outpatient  
6 hospital services under 42 C.F.R. secs. 440.10 and 440.20.

7 (10) "personal care services in a recipient's home" means  
8 services prescribed by a physician in accordance with the recipient's  
9 plan of treatment and provided by an individual who is

10 (A) qualified to provide the services;

11 (B) supervised by a registered nurse; and

12 (C) not a member of the recipient's family.

13 \* Sec. 11. AS 44.77.010(b) is repealed.

14 \* Sec. 12. This Act takes effect immediately in accordance with AS 01.-  
15 10.070(c).