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Mary Van Nimwegen

House State Aff.:

March 14 - 1988

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
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January 22, 1988

MEMORANDUM

TO: Representative Curt Menard

ATTN: Tuckerman Babcock

FROM: Heidi Borson-Paine HBP
Legislative Analyst

RE: Cost of Adopting Medicaid's Medically Needy Program
Research Request 88.079

You requested this agency to estimate how much it would cost the State to adopt Medicaid's medically needy option and to include an estimate of the cost of providing the medically needy program solely to disabled persons instead of to all groups eligible for Medicaid. In addition, you posed the following specific questions:

- what are the State's current Medicaid eligibility standards (differentiate between standards for those receiving care inside and outside of institutions); and

- how many Medicaid recipients in Alaska would leave nursing homes if home care was provided through a medically needy program?

This memorandum describes Alaska's current Medicaid eligibility criteria; provides background information on Medicaid's medically needy option; estimates the cost of implementing a medically needy program in Alaska; discusses the possible effects of a medically needy program on the state's nursing home population, and presents other alternatives for providing home and community based services to those who, because of their incomes, are currently eligible only for institutional care.

ALASKA'S CURRENT MEDICAID ELIGIBILITY STANDARDS

Federal regulations require states to cover the "categorically needy" under their Medicaid programs. The categorically needy are defined as persons eligible to receive cash assistance payments under either the Aid to Families with Dependent Children (AFDC) program or the Supplemental Security Income (SSI) program. To qualify for assistance under these programs, applicants must meet certain categorical, income, and resource criteria. The categorical requirements of the AFDC and SSI programs require that recipients be members of families with dependent children (AFDC related) or aged, blind, or disabled (SSI related).

The AFDC resource limit allows up to $1,000 per family real or personal property excluding a home of any value and a car worth $1,500. The SSI resource limits allow: a home of any value, a car worth up to $4,500, personal effects worth $2,000, liquid resources worth $1,900 for individuals and $2,850 for couples, a burial plot and up to $1,500 for burial expenses, and life insurance with a face value of $1,500. A list of Alaska's current AFDC and SSI income standards is provided in Attachment A. However, it should be noted that these standards are not absolute in that applicants are allowed certain exemptions and deductions to bring their incomes down to the eligibility threshold.

In addition to the previously discussed ways of qualifying for Medicaid, persons in institutions may qualify for Medicaid coverage under a special income standard. Federal regulations permit states to use a higher income standard than SSI to determine eligibility for institutionalized individuals (42 CFR 435.231 and .1005). States may set this income standard at up to 300 percent of the SSI monthly benefit amount ($354 for an individual). Persons at this income level are not, however, eligible for Medicaid coverage outside of an institution. Alaska's income standard for aged, blind, and disabled persons receiving care outside institutions is $659 per month, while the monthly income standard for institutionalized recipients is $1,062.

MEDICAID'S MEDICALLY NEEDY OPTION

The medically needy program is a Medicaid option allowing states to provide Medicaid coverage to persons who meet AFDC or SSI categorical requirements but have resources exceeding the eligibility threshold. Under the medically needy program, states may set the income eligibility standard at levels up to 133-1/3 percent of the maximum AFDC cash assistance payment for the same size household.

Federal Medicaid regulations also provide a "spend down" provision under the medically needy program. This provision allows applicants to spend their income on medical expenses in order to qualify for the medically needy program. If an applicant has incurred medical expenses at least

equal to the difference between his or her income and the applicable income standard, the applicant is eligible for Medicaid. Consequently, instituting a medically needy program essentially removes the income eligibility ceiling under Medicaid for those with significant medical expenses.

States may establish a spend down period from one to six months in duration. The spend down period establishes the time frame for incurring medical expenses as well as the duration of the recipient's eligibility for the medically needy program. While the one month spend down is preferable for many Medicaid recipients because it enables them to receive medical care sooner than the six month spend down, it is administratively complex and costly. Under the one month spend down period, State eligibility workers have to compute financial eligibility each month for all recipients.

Currently, Alaska's AFDC income standard for a single adult is $437 per month, while the income standard for aged, blind, and disabled adults is $659 per month. Under the medically needy program, the income standard would be $582 per month if the State set the income standard at the maximum level of 133-1/3 percent of the maximum AFDC cash assistance payment ($437 per month). The income standard for aged, blind, and disabled persons is actually higher under the present system than it would be under the medically needy program. Consequently, aged, blind, and disabled adults who are currently ineligible for Medicaid because of excessive income would not qualify for Medicaid under the medically needy program unless they incurred medical expenses at least equal to the difference between their income and the applicable income standard.

Federal regulations require states electing the medically needy option to provide: 1) maternity care to "all pregnant women during the course of their pregnancy who, but for income and resources, would be eligible for Medicaid as categorically needy"; and 2) ambulatory care for all individuals under the age of 21 (42 CFR 435.301). In addition to these groups, states may elect to extend the medically needy program to any of the following groups: caretaker relatives, aged, blind, and disabled.

Currently, 37 states extend Medicaid coverage to the medically needy. Alaska is one of 13 states which does not participate in the medically needy program. According to John Luehrs, with the National Governor's Association's State Medicaid Information Center, most of the states participating in the medically needy program have much lower income eligibility standards than Alaska. Consequently, other states use the medically needy program to cover the population already covered as categorically needy under Alaska's Medicaid program.

According to State Medicaid Information Center statistics, the average income standard in the 37 states' medically needy programs is approximately 60 percent of the poverty threshold. Currently, Alaska's AFDC and SSI income standards are at 78 and 113.2 percent of the poverty level

respectively. Furthermore, the poverty level for Alaska is set a at higher level than for other states. As of July 1987, the poverty level for a family of three in Alaska and other states was $11,620 and $9,300, respectively.

COST OF IMPLEMENTING A MEDICALLY NEEDY PROGRAM

It is difficult to draw upon the experiences of other states in developing accurate enrollment and cost estimates for a medically needy program in Alaska because of the variation in medical costs, income eligibility standards, covered services, reimbursement rates, and spend down periods. Consequently, the Division of Medical Assistance (DMA) in the Department of Health and Social Services (DHSS), employed medically needy data collected by the U.S. Department of Health and Human Services (DHHS) to estimate the costs of implementing a medically needy program in Alaska.

According to DHHS data, a medically needy program increases the size of a state's Medicaid recipient population by about six to fourteen percent. The per capita costs of medically needy recipients are approximately three times as much as categorically eligible Medicaid recipients, or 1.75 times as much if only the costs of the noninstitutional medically needy are included. Using these data, DMA estimates between 2,542 (six percent) and 5,932 (14 percent) new applicants would be eligible under a medically needy program in Alaska, based on a current Medicaid population of 42,370. The average medical expenditures per person under the medically needy program would be $3,593 if only the noninstitutional population is included or $6,159 including the institutional medically needy population. At the six and fourteen percent levels, this would result in increased medical expenditures of between $9,133,406 and $21,313,676 for the noninstitutional population and between $15,656,178 and $36,535,188 if the institutional population is included.

In addition to medical expenditures, DMA included administrative costs in its cost estimate, such as increases in statewide eligibility technicians and changes to the computer systems currently used by the Division of Public Assistance to track recipient eligibility and process claims. According to DMA's estimates, the total costs of implementing a medically needy program in Alaska would be between $10,684,353 (six percent) and $24,308,971 (fourteen percent) if only the noninstitutional population were included, and between $17,207,125 and $39,530,483 including the institutional population. For a complete breakdown of DMA's, estimate and a discussion of the variables employed by DMA please refer to Attachment B.

You also requested a cost estimate for providing the medically needy program to solely disabled persons instead of all groups of Medicaid eligibles. As discussed earlier, federal law prohibits States from targeting the medically needy program exclusively to the aged, blind or disabled. By law, any medically needy program must include maternity care for pregnant women and ambulatory care for children.

POSSIBLE EFFECTS ON NURSING HOME POPULATION IN ALASKA

You requested an estimate of the number of Medicaid recipients in Alaska who would leave nursing homes if home health care were provided through a medically needy program. According to DHSS statistics, there were 479 Medicaid recipients in Alaska's nursing homes as of October 1987. Of these 479 Medicaid recipients, 452 met the AFDC or SSI income eligibility standards and thus already had the option of receiving Medicaid coverage for out-of-institution services, including home health services. Only 27 recipients qualified for Medicaid under the federal regulation enabling those with incomes over the eligibility threshold to qualify for Medicaid only if institutionalized. Consequently, it does not appear likely that providing home health services under the medically needy option would automatically result in many Medicaid recipients leaving institutions.

On the other hand, adopting the medically needy option could significantly increase the number of people currently in institutions who would qualify for Medicaid. As discussed earlier, the spend down provision enables people to qualify for the medically needy program if they: (1) meet Medicaid's categorical requirements, and (2) incur medical expenses at least equal to the difference between their income and the applicable income standard. According to the American Hospital Association, entering a nursing home is the most common way the elderly spend down their incomes to the eligibility threshold.

Providing institutional care to the medically needy in Alaska would be very expensive given the high cost of nursing home services. According to DHSS data, the per capita cost of institutional care in Alaska ranges from about $3,100 to $8,500 per month. The State could elect not to cover nursing home services under the medically needy option because nursing home services are considered optional benefits under federal regulations.

ALTERNATIVES FOR PROVIDING HOME AND COMMUNITY BASED CARE

This section discusses two alternatives for providing home and community based care to persons who, because of their incomes, are currently eligible for care only if in institutions. The first option, home and community based waivers, provides a mechanism for expanding Medicaid coverage, while the second option provides home and community based services through the federal Title XX Block Grant.

Home and Community Based Services Waiver

The Omnibus Budget Reconciliation Act of 1981 authorized the Department of Health and Human Services (DHHS) to waive certain Medicaid regulations and allow states to provide home and community based services for Medicaid recipients in lieu of nursing home services. Waivers allow states to use the special income thresholds for institutional care (up to 300 percent of the SSI benefit amount) for services provided in the home or community. Waivers can be used to provide alternative services for those aged, blind, or disabled persons who, because of their incomes, currently qualify for Medicaid only if they are in an institution.

Under a waiver, states may limit the provision of home and community based services to specific geographic areas within the state and to certain groups of Medicaid eligibles, such as the disabled. All groups of Medicaid recipients who are at risk of institutionalization, including the aged, disabled, mentally retarded, mentally ill, and disabled children, can receive waiver services. However, separate waiver applications must be submitted for each recipient group. States may also apply for model waivers under which services may be provided to a maximum of 50 recipients. Model waivers must offer at least one additional home and community based service than is covered under the current state Medicaid plan.

The following services may be offered as alternatives to nursing home care under waivers: case management, homemaker, home health aide, personal care attendant, adult day health, habilitation, and respite care. Federal regulations list but do not define these services, consequently, states may use their own definitions. States may also provide other services if the waiver request demonstrates that the services are viable and cost effective alternatives to institutional care.

According to John Luehrs, the waiver application process is time and labor intensive. A state must have the staff to write a waiver application, which is usually about 300 pages in length, as well as staff to manage the waiver if approved. Luehrs estimates that it takes about 18 months for a state to complete a waiver application and get it through the federal review process. Waiver requests must demonstrate that the average per capita expenditure for services under the waiver will not be greater than the cost of services currently available in an institutional setting. In addition, the application must ensure that applicants will undergo an evaluation of the need for nursing home care and will be given a choice between waivered services and nursing home care. Once approved, waivers remain in effect for three years and may be renewed for additional five year periods subject to approval by DHHS.

Forty-six states currently have home and community based service waivers for at least one group (37 states have waivers for the aged and disabled, 25 have waivers for the mentally retarded, and 3 have waivers to serve the chronically mentally ill). Alaska is one of four states without a Medicaid waiver. Alaska applied for a waiver in 1983 to provide home and community based services for the aged, disabled, and mentally retarded. The

application was reportedly denied because the State could not demonstrate that the waiver would result in cost savings or at least limit expenditures to the level under existing institutional services.

Mr. Luehrs contends Alaska is at a disadvantage in proving the cost effectiveness of a waiver because of the state's high medical, transportation, and living costs. He suggests it would be easier to prove the cost effectiveness of a waiver for a specific geographic area of Alaska than for the whole state. He also points out that, for a waiver to succeed, alternative home and community based services must be available and service providers must be willing to participate in the waiver program.

Home and Community Based Services under Title XX Block Grant

Under the Social Security Act, each state receives an annual allotment from the Title XX Block Grant for Social Services. The size of the allotment is based on the state's population. Under Title XX, block grant funded services are to be directed toward the following goals:

1) achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;

2) achieving or maintaining self-sufficiency, including reduction or prevention of dependencies;

3) preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving rehabilitating, or reuniting families;

4) preventing or reducing inappropriate institutional care by providing for community based care, home based care, or other forms of less intensive care; and

5) securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.

Services which may be funded with Title XX Block Grants include, but are not limited to, child care services; protective services for children and adults; services for children and adults in foster care; services related to the management and maintenance of the home; day care services for adults; transportation services; family planning services; training and related services; employment services; information, referral, and counseling services; the preparation and delivery of meals, health support services; and appropriate combinations of services designed to meet the special needs of children, the aged, mentally retarded, blind, emotionally disturbed, and physically handicapped, and alcoholics and drug addicts. States are responsible for deciding how to allocate the grant money between

these or other services which meet the goals of the Title XX Block Grant program.

In FY 87, Alaska received $5,496,669 under the Title XX Block Grant. The Department of Health and Social Services estimates that the FY 87 allotment amount is a reasonable estimate of Alaska's probable FY 88 allotment. Because the amount of block grant funds available to Alaska is far below the cost of funding the range of services provided by DHSS, the State has utilized block grant funds to provide discretionary services while funding mandatory services primarily or exclusively with State General Funds.

For FY 88, DHSS has identified the following services which will be funded with the block grant allotment: adult and child protection homemaker support; child protection day care support; day treatment for adolescents; adult protective services; child protective services; and staff development. Attachment C provides a description of each service, the number of persons to be served, and the projected expenditures.

For the period of July 1987 - July 1988, California received over $300 million under the Title XX Block Grant. The state supplemented these funds with over $170 million in state general funds and $22.9 million in county funds for a total of approximately $500 million. California uses the entire block grant to provide in-home supportive services, which include domestic services, heavy cleaning, nonmedical personal services, accompaniment by a provider during necessary travel, yard hazard abatement, protective supervision, teaching and demonstration directed at reducing the need for other supportive services, and paramedical services which make it possible for the recipient to establish and maintain an independent living arrangement.

According to Terry Jordan, with the California Department of Social Services, the state uses the SSI categorical, income, and resource criteria to determine eligibility for the in-home supportive services program. Those persons who meet the SSI categorical requirements (i.e., they are aged, blind, or disabled) but have incomes above the SSI income standard are required to pay a share of costs for in-home supportive services. A recipient's share of cost is based on his or her income above the standard.

According to Mr. Jordan, approximately 131,000 persons were receiving in-home supportive services as of December 1987. Ninety percent of those served were elderly adults; ten percent were blind or disabled. Given a total expenditure of approximately $500 million on in-home supportive services, the annual per capita cost is approximately $3,800, which is considerably less than the cost of institutional care. Mr. Jordan estimates that the in-home supportive services program saves the state $2 billion per year because most of the recipients would otherwise require nursing home services under the state's MediCal program. He argues that not only is the program cost effective, recipients are also happier receiving care in a home setting.

Alaska could implement an in-home supportive services program similar to the California program, albeit on a much smaller scale. However, it should be noted that any expenditures of Title XX Block Grant funds on new services result in a loss of funding for existing services, which would then require State General Funds. Furthermore, DHSS currently provides services similar to California's in-home supportive services with Title XX Block Grant funds.

According to the attached service descriptions, one of the objectives of adult protective services currently funded with the Title XX allotment is "to provide community-based long term care to maintain independent functioning and when out-of-home care is necessary, to provide placement in the least restrictive setting." Homemaker services which are provided under the adult protection program include: general housekeeping tasks, aiding with personal care tasks, promoting personal and general hygiene, and other services which assist the client in maintaining the highest level of functioning in the home.

I hope this memorandum addresses your concerns. Please contact me if you have any additional questions.

Attachments

HOUSE STATE AFFAIRS COMMITTEE

NEXT COMMITTEE: HESS

BILL: HB 462

CURRENT VERSION: SS HB 462

SCHEDULED: 3/14/88

SPONSOR: MENARD

PHONE NO: 2679

CONTACT FILE: _____

BILL SUBJECT: COVERAGE OF MEDICALLY NEEDY PERSONS UNDER MEDICAID

SPONSOR BACKUP: NOTIFIED 4/10/88

AFFECTED AGENCIES:

DEPARTMENT	CONTACT/PHONE	COMMENT
HESS	JAY LIVEY/3030	

FISCAL NOTES

AGENCY	REQUESTED	DATED	FY 88 AMT	FY 89 AMT
HESS/JAY LIVEY/3030	2/29/88 & 3/10/86	3/14/88	Ø	6928.8

ACTION

DATE	COMMENT
3/14/88	hearing held

HOUSE STATE AFFAIRS COMMITTEE

POSITION PAPER/Department of Health & Social Services

SSHP 462

"An Act relating to coverage of medically needy persons under medicaid; and reordering the priority for elimination of coverage for optional medical services under medicaid."

I. PURPOSE

The purpose of SSHB 462 is to add to the Medicaid program a medically needy component. The medically needy option allows states to provide Medicaid coverage to certain groups of people who meet categorical requirements (that is, they are pregnant, under 21, aged, blind, or disabled) and the resource requirement, but are over the income limits. Pregnant women and children must be covered in order to adopt a medically needy program under federal rules.

Individuals who meet categorical and resource requirements can "spend down" their income on medical expenses in order to qualify for Medicaid. The individual must demonstrate a legal liability for each incurred expense, so medical care costs reimbursed by health insurance, liable third parties, or written off by providers as bad debt or uncompensated care are not counted towards spend down. The accounting period for calculating an individual's spend down would be one month. Each month, the individual would have to meet their spend down amount in order to receive Medicaid coverage for medical expenses incurred during the remainder of that month.

The medically needy income level (MNIL) can be set up to a maximum of 133 1/3% of the Aid to Families with Dependent Children (AFDC) income standards. Eligible individuals with incomes between the AFDC standard and the MNIL attain Medicaid eligibility without spend down. Because the Adult Public Assistance (APA) income standards are higher than 133 1/3% of the AFDC standards, no aged, blind or disabled person will attain this eligibility; in fact, aged, blind and disabled persons will have to spend down to an income level below the APA standards in order to obtain medically needy coverage.

The size of the medically needy population is difficult to estimate since any person meeting categorical and resource requirements is potentially eligible. Non-institutionalized medically needy recipients are twice as expensive as normal Medicaid clients. Only 1/3 of the existing Medicaid population utilizes medical services in a month; the entire medically needy population will apply only because they have used medical services for which they cannot afford to pay.

A medically needy program does not provide coverage for most pregnant women needing pre-natal care coverage or for most children, because the average health care expenses for these groups do not meet their spend down requirement unless the household income is just above the MNIL. Medically needy will cover part of major expenditures for women with difficult deliveries, infants requiring neo-natal intensive care services, and children needing acute care or who have a chronic condition. Aged and disabled persons, the most costly Medicaid recipients in Alaska, will be the majority of the recipients of a medically needy program.

More detailed information on medically needy programs is contained in an issue paper included as an attachment to this position paper.

II. Sectional Analysis

Section 1 — Adds to AS 47.07.070(b), which delineates the optional groups of people who are eligible for Medicaid: pregnant women, persons under age 21 and persons who are aged, blind, and disabled, but not institutionalized, who meet the income standards for the medically needy and the resource standards of the Supplemental Security Income Program to the Medicaid program.

Section 2 — Amends AS 47.07.035 by adding pregnant women, persons under age 21 and persons who are aged, blind, and disabled, but not institutionalized, who meet the income standards for the medically needy and the resource standards of the Supplemental Security Income Program. The purpose of this section is to provide guidance to the department on the order in which optional Medicaid services and optional coverage groups are to be eliminated in the case of inadequate funding for the Medicaid program.

III. RECOMMENDATIONS

1. The Medically Needy program is extremely complex and a significant departure from the present medical assistance programs available in Alaska. Other states have hired consultants to project costs and design the program because the addition of the medically needy option represents a significant funding commitment which is very difficult to estimate. The two divisions involved, Medical Assistance and Public Assistance deliver their services through major computer systems which would be directly involved in the development and implementation of a medically needy program. Estimating the financial cost of systems upgrades is problematic at this time, as the department lacks in-depth knowledge of the demands of the medically needy program. Consequently, the department recommends that, prior to implementing this option, the legislature consider an appropriation allowing the department to contract with consultants who can develop the information needed to construct a reliable estimate of the costs of the option, particularly those relating to eligibility and claims payment systems design and operation.

2. The fiscal notes attached to this position paper represent conservative estimates for the cost of implementing a medically needy program. It projects only a 6% increase in Medicaid eligibles, phased in over a three year period. The department believes there is a potential for much greater costs. The department suggests that the legislature consider the impact of the Permanent Fund Hold Harmless and Alaska Longevity Bonus Hold Harmless statutes in relation to a medically needy program as these two provisions would significantly increase the general fund dollar cost of the program.

POSITION PAPER/Department of Health & Social Services

The Department supports the concept of this coverage, because it provides a mechanism to cover medically indigent Alaskans who currently do not qualify for Medicaid coverage. It also maximizes federal dollars to help offset unpaid medical bills which are currently being borne by health care providers and community health facilities.

However, there are many competing needs for health care financing to assist the 40,000 Alaskans who are currently estimated not to have health care insurance. The Medicaid program itself, currently requires an FY88 supplemental appropriation of $18.5 million. The General Relief Medical Program no longer provides outpatient or preventive health services to the poorest Alaskans since losing 47% of its funding in 1986. The department cannot fully support a major expenditure of health care dollars on the medically needy option until those at the lowest socio-economic levels are guaranteed at least minimal care.

Governor Cowper convened his Interim Commission on Health Care, composed of legislators, health providers and consumers to make recommendations in the better management of costs in the current system, as well as to set priorities for expansion of coverages to improve access. The Commission has debated the medically needy option at length and will be issuing a recommendation on the adoption of this option versus others in its report in May.

Recommended by: Kim Busch
Kim Busch, Director
Division of Medical Assistance

Date: 3-14-88

Recommended by: John Taber
John Taber, Director
Division of Public Assistance

Date: 3-14-88

Approved by: Myra M. Munson
Myra M. Munson, Commissioner
Department of Health and
Social Services

Date: 3-14-88

ISSUE PAPER: THE MEDICALLY NEEDY MEDICAID OPTION

PROGRAM DESCRIPTION

Medically needy is an optional Medicaid program which allows states to provide Medicaid coverage to certain groups of people who meet all the categorical eligibility requirements (that is, they are pregnant women, children, caretaker relatives, aged, blind or disabled) for Medicaid but are over income. The medically needy income standards may be set at levels up to 133 1/3% of the maximum AFDC cash payment for the same size household. 41 states have elected an income standard close to the 133 1/3% level.

Individuals with income above the medically needy standard are allowed to "spend down" their income on medical expenses in order to qualify for the program. Families whose incomes are above the AFDC standard but below the medically needy cutoff are said to fall within the "band" (the income levels which qualify one for coverage) and will become eligible for Medicaid coverage without spending down any income towards medical expenses. Each state may chose the time period for spend down, up to a maximum allowable of six months.

Medically needy programs must include coverage for:

- children up to the age of 18 who qualify for Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI);

- children up to the age of 5 born after September 30, 1983 who would meet AFDC income requirements but live in two parent families;

- pregnant women who meet the AFDC categorical criteria,

- pregnant women who would meet the AFDC categorical criteria when the child is born;

- pregnant women living with the baby's father who would meet the AFDC unemployed parent qualifications once the baby is born; and

- all other pregnant women in two parent families.

Once these groups are covered, the state can choose to cover other groups such as the aged, blind, disabled, caretaker relatives of children.

Based on 1982 statistics, the aged are the group most likely to use the medically needy program, although the disabled are the most expensive medically needy group on a per capita basis.

IT IS VERY IMPORTANT TO NOTE THAT A MEDICALLY NEEDY PROGRAM WILL NOT COVER ALL PEOPLE WITH HIGH MEDICAL EXPENSES, AND WILL NEVER INCLUDE PERSONS CURRENTLY COVERED BY THE GENERAL RELIEF MEDICAL PROGRAM.

"SPEND-DOWN" PERIOD

The spend down period establishes the time frame for incurring medical expenses as well as the duration of medically needy eligibility. The applicant must incur medical expenses in sufficient quantity to reduce their household income to the medically needy level when these expenses are subtracted from their total income. The medical expenses do not have to be actually paid by the applicant, but they cannot include any expenses for which the recipient does not have a legal obligation (medical expenses covered by health insurance, Workers' Compensation, liable third party for an accident or injury, or medical expenses written off by the provider as bad debt or uncompensated care).

An applicant must apply in the same fashion as all other Medicaid applicants, and then must document incurred medical bills during each "spend down" period. For example: let us assume a one month accounting period, and an applicant who must spend down $500 based on the household income. The applicant provides documentation of sufficient medical bills to meet the spend down on the 18th of the month. Medicaid will cover all medical bills for services included in the Medicaid Program from the 19th through the end of the month. At the beginning of the following month, assuming the applicant's financial situation is the same, the applicant must once again incur $500 in medical expenses to receive any Medicaid coverage in that month.

The accounting period that a state selects will have some affect on the number and types of families able to receive medically needy benefits. Generally, families with incomes close to the band are likely to become eligible on the basis of relatively small medical bills. Families with larger incomes must incur more extensive medical bills, and frequently do not meet their spend down requirements unless they enter a nursing home, are hospitalized, or are otherwise treated for a high-cost illness. More of these families would become eligible in a one month spend down period than in a six month period, because the medical expenses that a family would need to qualify would be compared to six times more income and would have to be six times greater. Seasonally employed families may have a greater chance of becoming eligible under a six month period because they would have a longer period in which to incur expenses that were matched against a fluctuating income.

Only children living in families with income close to the band have a chance of obtaining medically needy coverage for regular preventive health care services. Eligibility for the vast majority of low income children is restricted to acute care hospitalizations. For chronically ill children, the likelihood of medically needy eligibility is significantly greater, since they incur more substantial medical bills on a regular basis. For pregnant women, eligibility depends more on the billing methodology of physicians: if the physician charges a global fee, then the pregnant woman would not incur medical expenses until the birth of the baby, attaining eligibility after the delivery, and in greater numbers, under the one month period; if the physician pro-rates the bill on a monthly or semi-monthly basis, then a larger number of pregnant women would become eligible earlier in their pregnancies under a one month accounting period. With this method and a six month period, however, a woman would ordinarily not attain

eligibility until the second trimester, and then lose eligibility again until after the birth of the baby.

Although the one month accounting period is preferable from the standpoint of low income pregnant women and children, it is more expensive in terms of administrative costs. Under the one month scenario, eligibility workers would have to compute financial eligibility for each family each month. Because the one month accounting period results in more accurate eligibility determinations, most states that began a medically needy program with longer accounting periods have switched to a one month period.

RESOURCE CRITERIA

States may develop different resource standards for medically needy programs than those mandated for categorical programs (AFDC resource limit is $1,000 per family excluding a home and a car worth $1,500). The vast majority of states use the Supplemental Security Income (SSI) resource standards (As of January 1, 1988: $1,900 for one person, $2,850 for a couple). Missouri has the lowest resource standard of $1,000 per family regardless of family size. States must consider only resources available during the accounting period, and deduct the value of resources that would be deducted under the appropriate cash assistance program.

SERVICES

A medically needy program need not offer the same services as the regular Medicaid Program. A medically needy program must offer prenatal and delivery services to pregnant women; ambulatory services to children under 18 and individuals entitled to institutional services; home health services to any individual entitled to skilled nursing facility services and medically related transportation.

If the state offers services in an institution for mental diseases for persons age 65 or older or services in an intermediate care facility for the mentally retarded, it must offer to each group of the medically needy: inpatient and outpatient hospital, laboratory and X-ray, skilled nursing facility services to individuals over 21, EPSDT, family planning, physician services and nurse midwife services.

OTHER STATES' EXPERIENCES

Forty one states have medically needy programs. The average medically needy income level is 59.8% of the federal povery level. Alaska does not have a medically needy program. It is important to remember that because Alaska has the second AFDC highest need standard in the country (77.8% of the federal poverty level adjusted for cost of living differences for AFDC, 115% of the federal poverty level for the aged, blind and disabled, and 186% of the federal poverty level for nursing home care). Most other states have such low need standards, that they must add a medically needy program to cover the same groups ordinarily covered here under Medicaid as categorically needy, and still fall short of the coverage provided in Alaska.

In a majority of the states, the AFDC cash payment standards are significantly lower than the federally established poverty level. 34 states provide cash assistance at less than 1/2 of the federal level, 13 states at less than 1/3 of the federal level. In low payment states, the medically needy group is largely comprised of AFDC-type individuals who meet the state's need standards but are ineligible for cash payments because their income exceeds the state's payment level (a state may have two different need standards: one for eligibility determinations and one for payment). The medically needy standard for a family of three in Alaska would span from $779 to $1,038 per month. In contrast, the standard for Mississippi, where payments are the lowest, would be $96 to $128 for a family of three.

PROGRAM COSTS

Administrative costs are much higher for a medically needy program than a Medicaid program, and the chance of making quality control errors is much greater. This is because medically needy programs are more labor intensive than categorical Medicaid programs, as recalculations of each families' spend down must occur in each accounting period, in addition to monitoring all other eligibility requirements that the household is required to meet.

It has been difficult to collect conclusive expenditure data because states report various categories of eligible groups differently (e.g. institutionalized persons and "Ribicoff children" are ordinarily covered as categorical unless a state has a medically needy program). In addition, there is substantial variation in income eligibility standards, covered services, reimbursement rates and spend down accounting periods. These factors make it difficult to draw upon the experience of other states to develop accurate enrollment and cost estimates for Alaska.

Early projections made by states attempting to calculate the cost of medically needy programs had been high, since a person would not qualify for coverage if they did not have medical expenses for which payment was unavailable. However, available data suggests that although medically needy programs have higher per capita costs than Medicaid, they do not increase a state's overall expenditures as much as had been expected. This is primarily because enrollment rates are generally lower than anticipated; potentially eligible individuals are slow to enroll; and the start-up phase before a program may reach its plateau may last from two to five years. Partially, this is caused by the collection of Medicaid data based on the date claims are paid rather than the date costs are incurred.

A Department of Health and Human Services study found that medically needy costs are slightly less than twice those of regular Medicaid recipients when the institutionalized population is excluded from the count. When only children and the related AFDC caretaker relatives are counted, the amount is 1.26 times the expenditure for a regular Medicaid program. When all non-insitutional medically needy are compared to the categorical population, the expenditures average 2 times as much. When the institutional medically needy costs are included, the cost is three times as great. The cost of providing medically needy coverage to children and

pregnant women in 1982 ranged from $4 million (Colorado) to $40 million (Texas) with the per capita costs ranging from $1,000 to $2,831 for pregnant women and $194 to $862 for children.

Expenditure data for 1982 indicate that the medically needy account for 28% of the expenditures even though they are only 14% of the recipients. Different states have experienced dramatically different medically needy expenditures, ranging from a 2.3% population accounting for 2.2% of the expenditures in Louisiana to a 25.1% population using 76.4% of the expenditures in Connecticut.

WHAT WOULD MEDICALLY NEEDY MEAN IN ALASKA?

The income levels for the medically needy in Alaska in the following table are projected at the maximum of 133 1/3% of the AFDC standard. It should be noted that the medically needy income level (MNIL) for the aged, blind and disabled populations is lower than the Adult Public Assistance standards ($659 for one person, $976 for a couple). This means that aged, blind and disabled persons would have to "spend down" below the Adult Public Assistance income standard to receive Medicaid coverage, and that, unlike AFDC-related groups, no one in these categories would fall within the "band" and automatically attain Medicaid eligibility with the enactment of a medically needy program. As stated earlier, the medically needy "band" is the range of income for a household of a particular size which would qualify an applicant for Medicaid coverage without spending down to any particular income level. Only AFDC-related families, pregnant women, and children would attain eligibility by having incomes within the "band".

MONTHLY INCOME STANDARDS

PERSONS	AFDC	MEDICALLY NEEDY BAND	MNIL	APA
1	$437		$582	$659
2	$692		$922	$976
3	$779		$1,038	
4	$866		$1,154	
5	$953		$1,270	
6	$1,040		$1,386	
7	$1,127		$1,502	
8	$1,214		$1,618	
9	$1,301		$1,734	
each add	$87		$116	

Although states have experienced a wide variation in growth of eligibles upon enactment of a medically needy program, studies generally cite a 6 to 14% increase in eligibles (2% if only pregnant women and children are added to the program). Assuming this were true in Alaska, the state could expect between 2,542 (6%) and 5,932 (14%) new eligibles (based upon 42,370 current eligibles). The average cost of the non-institutional medically needy is 1.75% greater than the average cost of the Medicaid categorical recipient, which would equal $3,593 per person, or increased

expenditures between $9,133,406 and $21,313,676. If the institutional population is included, at a cost three times that of the categorical recipient ($6,159 per person), the increased expenditures would range from $15,656,178 to $36,535,188. These costs account for only medical expenditures, not administrative expenditures.

Other costs which would necessarily have to be included for implementation of a medically needy program would include substantial systems changes to the Eligibility Information System (EIS) of the Division of Public Assistance to accomodate management of the new program , and the Medicaid Management Information System (MMIS), the automated claims processing system currently coming on-line in the Division of Medical Assistance.

Increases in the Division of Public Assistance statewide field staff, who determine eligibility and monitor cases, would also be required. Field staff are already operating at maximum capacity in managing the AFDC, APA, Medicaid, Food Stamps, General Relief, General Relief Medical and Energy Assistance Programs. The medically needy program is 4 to 5 times more expensive administratively than a regular Medicaid Program, as the cases demand monthly determinations of eligibility and verification of incurred medical expenses. Additionally, medical expenses must be closely tracked to assure that applicants receive correct credit for expenses, that expenses which are pro-rated are accurately accounted, and that expenses covered by other third parties are not included in the spend down. Medically needy programs are extremely error prone because of the complexity of these computations, so the state would be required to expend the necessary personnel resources in achieving the federally allowable 3% error rate.

Because of the above mentioned factors, a medically needy program would need about a year and a half lead time before the program could actually deliver benefits to recipients.

OTHER FACTORS

The existence of the Permanent Fund Dividend Hold Harmless (PFDHH) and the Alaska Longevity Bonus Hold Harmless (ALBHH) provisions will create further impact on General Fund expenditures. Every medically needy recipient will be eligible for PFDHH annually, for at least a one month period. The statute guarantees four months of hold harmless coverage for each person receiving a PFD, during which time all of their medically needy covered services would be reimbursed out of 100% state dollars. The ALBHH is an on-going hold harmless requiring that every aged person turning 65 after 1985 have their benefits paid from 100% state dollars as long as they lose eligibility because of receipt of the ALB. About one half of the elderly medically needy recipients would qualify for ALBHH, so all of their medical expenses will be paid from 100% state dollars. Over time, the number of elderly qualifying for ALBHH for medically needy will increase because fewer will be recipients in the grandfathered pre-1985 group.

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: SS HB 462
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: ~~An act Relating to the Coverage of Medically Needy~~
Sponsor: ~~Menard~~
Requestor: _____

Agency Affected: ~~Health & Social Services~~
BRU: ~~Public Assistance Admin~~
Components: ~~Eligibility Determination~~
~~PA Data & Word Processing~~

EXPENDITURES REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES	-0-	165.5	224.6	444.9	444.9	444.9
TRAVEL	-0-	-0-	-0-	-0-	-0-	-0-
CONTRACTUAL	-0-	408.0	65.0	95.0	95.0	95.0
SUPPLIES	-0-	-0-	-0-	-0-	-0-	-0-
EQUIPMENT	-0-	10.0	10.0	10.0	10.0	10.0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	-0-	-0-	-0-	-0-	-0-	-0-
MISCELLANEOUS	-0-	583.5	369.6	549.9	549.9	549.9
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-

CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-

REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUND	-0-	291.7	184.8	274.9	274.9	274.9
FEDERAL FUNDS	-0-	291.8	184.8	275.0	275.0	275.0
OTHER	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL	-0-	583.5	369.6	549.9	549.9	549.9

POSITIONS:

FULL-TIME	-0-	5.0	9.0	13.0	13.0	13.0
PART-TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

ANALYSIS: (Attach a separate page if necessary)

See Attached

Prepared by: John R. Taber, Director — Phone: 465-3347
Division: ~~Division of Public Assistance~~ — Date: 3/14/88

Approved by Commissioner: _____ — Date: 3/14/88
Agency: ~~Department of Health & Social Services~~

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

Department of Health and Social Services
Division of Public Assistance

Although states have experienced a wide variation in growth of eligibles upon enactment of a medically needy program, studies generally cite a 6 to 14% increase in eligibles (2% if only pregnant women and children are added to the program). This fiscal note assumes Alaska will experience 6% growth or 2542 new eligibles based upon 42,370 current eligibles. The experience of other states also indicates that participation in a medically needy program gradually increases for 2 to 5 from inception before reaching a stable level of participation. This fiscal note assumes incremental increases of 2% per year over current levels during the first three years of the program.

One time costs which would have to be included for implementation of a medically needy program would include system changes to the Eligibility Information System (EIS) of the Division of Public Assistance to accommodate management of the new program (estimated at $400,000).

Significant increases in the Division of Public Assistance statewide field staff, who determine eligibility, monitor cases, and authorize benefits would be required. Field staff are already operating at maximum capacity in managing the AFDC, Adult Public Assistance, Medicaid, Food Stamps, General Relief and General Relief Medical Programs. The medically needy program is 4 to 5 times more expensive administratively than a regular Medicaid Program, as the cases demand monthly determinations of eligibility and verification of incurred medical expenses. Additionally, medical expenses must be closely tracked to assure that applicants receive correct credit for expenses, that expenses which are pro-rated are accurately accounted, and that expenses covered by other third parties are not included in the spend down. Medically needy programs are extremely error prone because of the complexity of these computations. The state would be required to expend the necessary personnel resources to achieve the federally allowable 3% error rate and effectively manage the caseload.

Public Assistance BRU
Eligibility Determination Component

A. The following identifies the field staff and support resources needed if we assume a Medical Needy program with 3 year service level increase of 6% or 2542 cases. We assume this intake and maintenance caseload level by year three of program operation.

YEAR ONE Eligibility staff resources for intake and maintenance workload of an estimated 847 cases

Position Title	Salary Range	Monthly Cost	# of PFT	FY Cost
Eligibility Tech II	13A	3028	4.0	145,344
Clerk III	8A	1678	1.0	20,136
	TOTAL		5.0	165,480
Contractual line item is for telephone, postage, printing, and office space				8,000
One time equipment outlay for desk, chair, file cabinet and EIS workstation				10,000
One time cost for system changes to the Eligibility Information System necessary to implement and manage the new medical needy program.				400,000
	TOTAL YEAR ONE			583,480

YEAR TWO Eligibility staff resources for intake and maintenance workload of 1694 medical needy cases

Position Title	Salary Range	Monthly Cost	# of PFT	FY Cost
Eligibility Tech II	13A	3028	7.0	254,352
Clerk III	8B	1678	2.0	40,272
	TOTAL		9.0	294,624
Contractual line item is for telephone, postage, printing, and office space				15,000
One time equipment outlay for desk, chair, file cabinet and EIS workstation				10,000
EIS Computer System Operation				50,000
	TOTAL YEAR TWO			369,624

YEAR THREE Eligibility staff resources for intake and maintenance workload of 2542 medical needy cases

Position Title	Salary Range	Monthly Cost	# of PFT	FY Cost
Eligibility Tech IV	15A	3441	1.0	41,292
Eligibility Tech II	13A	3028	10.0	363,360
Clerk III	8B	1678	2.0	40,272
	TOTAL		13.0	444,924
Contractual line item is for telephone, postage, printing, and office space				20,000
One time equipment outlay for desk, chair, file cabinet and EIS workstation				10,000
EIS Computer System Operation				75,000
	TOTAL YEAR THREE			549,924

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: SSHB 462
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act relating to coverage of Medically Needy persons.
Sponsor: _____
Requestor: _____

Agency Affected: Health & Social Services
BRU: Medical Assistance, Medical Assistance Administration
Components: Medicaid Facility, Medicaid Non-Facility, ALBHH, PFDHH; Central Administration, Claims Processing

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES		304.0	322.2	341.6	362.1	383.8
TRAVEL		28.0	29.7	31.5	33.4	35.4
CONTRACTUAL		275.6	133.1	141.1	149.6	158.6
SUPPLIES		9.0	9.5	10.1	10.7	11.4
EQUIPMENT		40.5	-0-	-0-	-0-	-0-
LAND & STRUCTURES						
GRANTS, CLAIMS		6,271.7	13,296.0	21,072.9	22,337.3	23,677.5
MISCELLANEOUS						
TOTAL OPERATING		6,928.8	13,790.5	21,597.2	22,893.1	24,266.7
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND		4,379.0	8,715.6	13,649.4	14,468.4	15,336.5
FEDERAL FUNDS		2,549.8	5,074.9	7,947.8	8,424.7	8,930.2
OTHER						
TOTAL		6,928.8	13,790.5	21,597.2	22,893.1	24,266.7

POSITIONS:

FULL-TIME		7	7	7	7	7
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

SEE ATTACHED FISCAL NOTE ANALYSIS

Prepared by: Kim Busch, Director Kim Busch Phone: 465-3355
Division: Medical Assistance Date: 3-14-88

Approved by Commissioner: Myra Munson Myra Munson Date: 3-14-88
Agency: Department of Health and Social Services

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

FISCAL NOTE ANALYSIS
SSHB 462
DIVISION OF MEDICAL ASSISTANCE

ASSUMPTIONS

The Department has assumed that adoption of a medically needy option will increase the number of Medicaid eligibles by 6% (2,542 individuals) phased in over a three year period. Based on other states experience, the medically needy population is generally made up of 2% pregnant women and children. The remaining eligibles will be equal numbers of aged and disabled persons. Medically needy costs for non-institutional recipients is about double the cost of Medicaid recipients.

The Department assumes that the other 4% of the medically needy population will be equally divided between aged and disabled, and that half of the aged population will qualify for Alaska Longevity Bonus Hold Harmless. The average expenditures for these two populations in the existing Medicaid program is significantly higher than the costs of pregnant women and children.

The cost of the Permanent Fund Dividend Hold Harmless is calculated as the equivalent of one month's medically needy program costs. The Alaska Longevity Bonus Hold Harmless (ALBHH) is calculated by assuming that one half of the elderly medically needy recipients would be eligible for the program as ALBHH state-only recipients.

SERVICES

Medically needy Medicaid recipients will receive all Medicaid covered services except for institutional care services: skilled nursing care, intermediate care, intermediate care for the mentally retarded and inpatient psychiatric for those aged 65 and older. The cost for the medically needy covered services for year one of the program is presented by budget component below:

	MEDICAID FACILITY	MEDICAID NON-FACILITY	ALBHH	PFDHH	TOTAL
	3,081,324	1,540,662	1,127,075	522,641	6,271,702
FFP	1,540,662	770,331			2,310,993
GFM	1,540,662	770,331			2,310,993
GF			1,127,075	522,641	1,649,716

	AVERAGE ANNUAL COST*	X	RECIPIENTS	-3** =	FIRST YEAR COST
PREGNANT WOMEN	$ 6,076		423		856,716
CHILDREN UNDER 21	$ 2,388		424		337,504
DISABLED	$10,000		847		2,823,333

AGED	$ 7,984	847	2,254,149

* Adjusted for other states program experiences which indicates that a medically needy recipient is twice as expensive to serve as the corresponding category of Medicaid recipient.

** Three year program phase-in assumption

	FIRST YEAR COST	SECOND YEAR COST	THIRD YEAR COST
PREGNANT WOMEN	856,716	1,816,238	2,878,566
CHILDREN UNDER 21	337,504	715,508	1,134,013
DISABLED	2,823,333	5,985,466	9,486,399
AGED	2,254,149	4,778,796	7,573,941
TOTAL	6,271,702	13,296,008	21,072,919

The second year costs are calculated by adding a 6% inflation growth amount to the first year's cost and multiplying the amount by 2.

The third year costs are calculated by adding a 6% inflation growth amount for years one and two to the first years cost and multiplying the amount by 2.

MEDICAL ASSISTANCE ADMINISTRATION

JUNEAU - PROGRAM COORDINATION

The addition of a Medically Needy Medicaid Program option will require extensive research into program development; creation of a new Medically Needy Program Manual for eligibility field staff to use in determining eligibility; revision of the Medicaid State Plan with the federal government; drafting of new regulations; on-going policy development; and indepth coordination with the Division of Public Assistance.

Personal Services

Medical Assistance Program Officer Range 21A $3,812/mo. X 31% benefits X 12 months	$59,925
Clerk Typist III, Range 8A $1,631/mo. X 31% benefits X 12 months	$25,639
	$ 85,564

Travel

quarterly district office reviews, stimated at $2,000 each	$ 8,000	
Monthly program reviews with Anchorage staff 1,000 each	$12,000	
		$ 20,000

Contractual

Communication		
centrex line charge	$ 512	
long distance - $200/mo	$ 2,400	
postage $100/mo	$ 1,200	
Advertising for public meetings for regulations changes $200/paper/ 4 papers/3 times/year	$ 2,400	
Printing of: eligibility manuals and periodic updates; public notices about the program, etc.	$ 3,000	
Meeting room rental for public meetings $350 X 3	$ 1,050	
		$10,562

Supplies

Office and Library Supplies for support staff	$ 1,500

Equipment

2 - desks, 2 - desk chairs, 2 - side chairs 1 - bookcase, 1 filing cabinet and 1 - supply cabinet	$ 1,050	
2 microcomputers with laser printer, network connections, and support software	$10,000	
		$11,050
JUNEAU TOTAL		$128,676

ANCHORAGE - PROGRAM IMPLEMENTATION

The addition of the Medically Needy Medicaid program option will require a significant investment of staff time in utilization review functions; development of computer reports; medical review assessments; development of new programming for the Medicaid Management Information System (MMIS, the automated payment system under

development); and interface requirements between MMIS and the Eligibility Information System (EIS) of the Division of Public Assistance.

Medical Review

To support the increased volume and scope of recipients and providers of medical services under a Medically Needy Medicaid option, the medical review function requires the addition of one Nurse position:

1) medical services policy development; coordination of providers involving special cases; out-of-state service requests; evaluation of changing criteria for prior authorization of services to include transportation and escorts;

2) Medical and program coordination with the dozens of agencies, clinics, advocacy groups and facilities which interface with Medicaid operations;

3) agency representation and testimony at fair hearings for recipients and providing of services;

4) identification and follow-up of fraudulent or abusive patterns of service utilization;

5) medical review of hospital and provider billing practices relative to services performed;

6) development and assessment of procedures for adopting new or improved durable medical equipment (DME); new medical/surgical procedures; and pharmaceuticals such as growth hormones, AIDS drugs, and cancer treatments;

7) performance of on-site service reviews for assessment of all components of the Medicaid program such as Personal Care; inpatient hospital; physician visits; rehabilitation services; and mental health programs;

8) preparation and follow up on federal and state performance reviews and audits.

Surveillance/Utilization Review (SURS)

Medicaid consists of thousands of medical procedures, and a wide array of supplies, drugs, diagnosis, and techniques. Research and analysis of the patterns of use of these elements is clearly a requirement of responsible program management.

Analysts will be called upon under major program expansion, to develop and implement research tools and techniques to determine costs by procedure, by provider, by facility and all related combinations, to establish areas of effectiveness, waste, abuse or fraud.

Information requests will increase dramatically as the size and cost of the Medicaid program increases. A well developed research unit with appropriate reports design capability and statistically valid analyst techniques is crucial to program administration. To effectively meet the increased information reporting and demands of both the state and federal government will require the addition of two research analysts to the program. Their responsibilities will include cost/benefit analysis to the service or procedure levels of the program; and pattern analysis of usage throughout the Medicaid program.

These positions will also continually reconcile system edits and audits with the current state plan and regulations; and will prepare documentation for federal funding; and facility rate setting and issue resolution.

System Support

Automation is the basis of health care financing, as it becomes increasingly more complex each year. The state through its fiscal intermediary processes in excess of 350,000 individual claims for medical services annually. Virtually all payments, patient history, provider information and reporting is handled by computer. While contractors or other state agencies bear responsibility for computer operations and mainframe programs, the Division increasingly requires the in-house capability to define program specifications; test coded results; communicate technical requirements; and to download data to agency personal computers for specialized detailed analysis and reports. This has already become a major gap in program administration. There are currently nine major computer systems the division interfaces with in regular operations; and three independent system networks. Staff with the technical background needed to communicate user requirements, computer system limitations, and develop realistic expectations, is a necessity in modern, complex operations. However, this is a specialized area of expertise, and therefore does not lend itself to small, as needed contracts for programs. It is an ongoing responsibility requiring the technical staff with a developed understanding of medical claims processing systems; financial transactions; edits and audits; and reporting requirements to successfully respond to the changing medical environment in Alaska.

Administrative Support

The increased activity and positions for operation will necessitate administrative support beyond typing and reception duties. There will be budget monitoring and reporting for all units in the section; increased scope and complexity of procurements; procedures and follow-up for personnel recruitment actions; documentation systems to be developed and maintained for the claims payments system and for administration manuals and legal materials; and coordination of leases and contracts.

Personal Services

MEDICAL REVIEW

Nurse IV Range 17A

$2,895/mo. X 1.31% benefits X 12	$ 45,509	
SURVEILLANCE/UTILIZATION REVIEW		
Research Analyst III Range 18A $3,113/mo X 1.31% benefits X 12	$ 48,936	
Research Analyst II Range 16A $2,702/mo X 1.31% benefits X 12	$ 42,475	
MEDICAID MANAGEMENT INFORMATION SYSTEM		
Systems Programmer Analyst I Range 18A $3,113/mo X 1.31% benefits X 12	$ 48,936	
ADMINISTRATIVE SUPPORT		
Administrative Assistant III Range 16A $2,072/mo. X 1.31% benefits X 12	$ 32,572	
		$218,428
Travel		
quarterly district office reviews estimate at $2,000 each	$ 8,000	
		$ 8,000
Contractual		
Communications		
Long distance $200/month 1 professional	$ 9,600	
Telephone base system $480/new unit to system	$ 2,400	
Postage $200/month	$ 2,400	
Office Space Rental		
200 square feet per position X 5 positions X $1.25/sq. ft/mo X 12	$ 15,000	
Printing		
Provider bulletins, forms and manuals	$ 4,000	
Data Processing		
Medicaid Management Information System (MMIS) modifications	$200,000	
Contract		
Claims processing costs of MMIS fiscal intermediary 2 claims/yr/		

2,542 recipients X $6.23/claim processing charge	$ 31,673	
		$265,073

Supplies

Office supplies to support program at 1,500 per professional staff	$ 7,500	
		$ 7,500

Equipment

Desk ($300), Office chair ($200), side chair ($100) file cabinet ($150), and book case ($100) for each position = $850 X 5	$ 4,250	
Supply cabinet $200	$ 200	
5 microcomputers with laser printer, network connections and support software	$ 25,000	
		$ 29,450
ANCHORAGE TOTAL		$528,451

MEDICAL ASSISTANCE ADMINISTRATION SUMMARY

	(JUNEAU)	(ADMINISTRATION)	
	Central Administration	Claims Processing	M.A. Administration
Personal Services	85,564	218,428	303,992
Travel	20,000	8,000	28,000
Contractual	10,562	265,073	275,623
Supplies	1,500	7,500	9,000
Equipment	11,050	29,450	40,500
Total MA Administration	128,676	528,451	657,127
Total Services			$6,271,702
		TOTAL FIRST YEAR COST	$6,928,829

Year two and beyond assume a 6% annual inflationary rate of growth. The Medicaid Management Information System modifications of the first year would be

Paralyzed man takes up fight for home care

By ERIC TROYER
Frontiersman staff

WASILLA - A man paralyzed from his neck down is fighting to stay out of a nursing home and save the government some money, but state regulations are leaving him little choice.

Juan D. Gutierrez, injured in a 1978 diving accident, can get funding from the state for nursing-home care, but not to pay for an aide in his home, where he wants to live. The cost of having an aide help him at home is about $3,800 per month less than the cost of living in a nursing home, Gutierrez said, but he is not eligible for a Medicaid in-home care program.

Able to get by on his own much of the time, he says he would be miserable in a nursing home. He wants to live around his friends and family and be able to come and go freely. Around the house he needs only periodic care, spending his time reading, typing and watching television.

It would take an attendant six to eight hours a day to tend to his needs at a cost of about $1,200 a month if he were eligible for reimbursement. He could, however, be placed in a nursing home at the state's expense for about $5,000 a month.

Gutierrez is in the center of a drive to change requirements for handicapped people who require daily care. Fighting with him are Marilyn Bannister, 53, his friend and attendant for eight years, and Chris Chernick, 27, Bannister's daughter. Already the trio has won the support of a Valley legislator.

They are trying to find out how many people are in the same situation as Gutierrez to gain more support to get the laws changed. But nobody in state government seems to have figures on which handicapped people need what care, Chernick said.

"It's like everybody in a wheelchair is hiding at home," she said.

Duane French, of Access Alaska, a non-profit handicap advocacy group, estimates that about 75 people are in the same situation as Gutierrez. The group is pushing for change in the law to help these people.

Gutierrez's problem, simply, is that he makes too much money.

Gutierrez, 33, makes $750 a month from Social Security and Veterans' Administration benefits, which is about $100 too much for him to qualify for the in-home care program. Gutierrez, a veteran, broke his neck in 1978 when diving into shallow water.

"Every last social worker says I'd like to help you, but. . . ." Gutierrez said.

Gutierrez, Bannister and Chernick are trying to get the qualifications changed so Gutierrez, and others like him, can receive financial aid for an attendant instead of having to go to a nursing home.

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With the right equipment Gutierrez can type 15 words a minute.

Home care

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Rep. Curt Menard, R-Wasilla, said he is having legislation drafted that would allow people like Gutierrez to have the state pay for in-home care rather than having to go to a nursing home.

"It just doesn't seem to make good sense to me," he said.

He said he will introduce the bill in the House this session and try to get a similar one introduced in the Senate. The bills will be similar to existing laws in California and Washington.

Until moving up here in August Gutierrez and Bannister were living in California. While there Gutierrez was getting financial aid to pay for Bannister to care for him. California has a share-the-cost program where Gutierrez paid the difference between what he made and the state's poverty level for part of Bannister's care. The rest of Bannister's care was paid for by the state.

"Everybody's told me 'Why don't you move back to California where the system works,'" Gutierrez said.

Nancy Bennett, medical assistance administrator for the Department of Health and Social Services, echoed the advice.

"His options are pretty limited. He can leave Alaska and go somewhere else or he can go to a nursing home," she said.

But Bennett doubts the legislature will vote to change the system once it finds out the consequences.

"We'd be saving money in his particular case, but we'd have to offer it to everybody," she said.

By offering a share-the-cost program many more people, including pregnant needy women and needy children would be eligible for Medicaid programs. The increase would cost the state a lot, she said, though she could not give any estimates.

> "His options are pretty limited. He can leave Alaska and go somewhere else or he can go to a nursing home."

"It's not an oversight. We just have limited funds," Bennett said.

But Gutierrez said the state shouldn't just look at the money element.

"They don't see the moral side of the story," he said.

Gutierrez and Bannister moved to Alaska in August to be with Yvonne, Gutierrez's sister. Yvonne, 16, has been living with Chernick and going to Wasilla High School since last winter.

"We moved up here to be with the ones we love," Gutierrez said.

Before Gutierrez and Bannister came they checked with the Veterans' Administration and the state and were told they would be eligible for at least two programs.

"It wasn't as though we were taking a shot in the dark," Gutierrez said.

After being rejected for funding by a number of government agencies Gutierrez ended up in a hospital and was told he was going to be sent to a nursing home in Seward. Rejecting that Gutierrez moved back in with Chernick temporarily.

Gutierrez, his sister and Bannister would like to move into their own place and Gutierrez is considering going to college. But none of it can happen if Gutierrez is in a nursing home or can't get in-home care funding.

But after a few more phone calls Gutierrez has discovered he may yet be eligible for an in-home care program through veteran's benefits.