SB

41

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE MCGUIRE
TO: CSSS SB 41(FIN)

Page 3, following line 28:

Insert:

"(f) The procedures authorized under this section shall be conducted in accordance with applicable state and federal laws and regulations to protect the privacy of individual medical assistance recipients."

Page 8, following line 4:

Insert:

"(b) The procedures authorized under this section shall be conducted in accordance with applicable state and federal laws and regulations to protect the privacy of individual medical assistance recipients."

Explanation:

This language is an assurance that the privacy of individuals' health information will be fully protected to the extent of the law. Specifically, the Health Insurance Portability and Accountability Act of 1996 required the establishment of federal regulations to protect individuals regarding the use and disclosure of individually identifiable health information. 45 CFR 164 sets forth those regulations in detail.

AMENDMENT

OFFERED IN THE HOUSE
TO: CSSB SB 41(FIN)

BY REPRESENTATIVE MCGUIRE

Page 4, line 19, following "record":

Insert: "knowing that the person lacks the authority to do so"

Explanation:

This amendment conforms the language to AS 11.56.820(a)(2) "Tampering with public records in the second degree," which is also a Class A Misdemeanor. This is the statutory basis upon which the Department of Law crafted the criminal statute for SB 41.

State of Alaska Department of Health and Social Services
NOTICE OF USE OF PRIVATE HEALTH CARE INFORMATION

Effective Date April 14, 2003

For Your Protection

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Health Care Information Is Private

We understand that information we collect about you and your health is personal. Keeping your health care information private is one of our most important responsibilities. We are committed to protecting your health care information and following all laws about its use. You have the right to discuss with the privacy officer your concerns about how your health care information is shared. The law says:

1. We must keep your health care information from others who do not need it.
2. You may ask us not to share certain health care information. Sometimes, we may not be able to agree to your request.

Who Sees And Shares My Health Care Information?

Your health caregivers, such as nurses, doctors, therapists and social workers may see, use and share your health care information to determine your plan of care. This use may cover health care services you had before now or may have later.

We review your health care information and bills (claims) to make sure that you get quality care and that all laws about providing and paying for your health care are being followed. We may also use your information to remind you about appointments or to tell you about treatment alternatives.

How Is Payment Made?

We may share your health care information with health plans, insurance companies, tribal or government programs to help you get your benefits and so that we can be paid or pay for your health care services.

May I See My Health Care Information?

In most cases, you may see your health care information. There may be legal reasons or safety concerns that may limit the amount of information that you may see. You may ask in writing to receive a copy of your health care information. We may charge a small amount for copying costs.

If you think some of your health care information is wrong, you may ask in writing that we correct or add to it. You may ask that the corrected or new information be sent to others who have received your health care information from us. You may ask us for a list of where we sent your health care information.

What If My Health Care Information Needs To Go Somewhere Else?

You may ask to have your health care information sent to others. You will be asked to sign a separate form, called an authorization form, permitting your health care information to go to them.

The authorization form tells us what, where and to whom the information must be sent. You can stop or limit the amount of information sent at any time by letting us know in writing.

Note: If you are younger than 18 years old **and, by law, you are able to give consent for your own health care,** then your health care information is kept private from others unless you sign an authorization form.

Could My Health Care Information Be Released Without My Authorization?

We follow laws that tell us when we have to share health care information, even if you do not sign an authorization form. We always report:

1. contagious diseases, birth defects and cancer;
2. firearm injuries and other trauma events;
3. reactions to problems with medicines or defective medical equipment;
4. to the police when required by law;
5. when the court orders us to;
6. to the government to review how our programs are working;
7. to a provider or insurance company who needs to know if you are enrolled in one of our programs;
8. to Workers Compensation for work related injuries;
9. birth, death and immunization information;
10. to the federal government when they are investigating something important to protect our country, the President and other government workers;
11. abuse, neglect and domestic violence, if related to child protection or vulnerable adults.

We may also share health care information for permitted research purposes, for matters concerning organ donations and for serious threats to public health or safety.

May I Have a Copy of this Notice?

This notice is yours. You may ask for a copy at any time. If there are important changes to this notice, you will get a new one within 60 days if you are enrolled in a health plan, such as Medicaid. An electronic version of this notice is available at www.hss.state.ak.us.

Questions or Complaints?

If you have questions or feel your privacy rights have been violated you can contact the Department Privacy Official by calling 907-465-2150, or by writing to State of Alaska, DHSS Privacy Official, PO Box 110650, Juneau, AK 99811-0650, or by e-mailing PrivacyOfficial@health.state.ak.us.

You can also complain to the federal government Secretary of Health and Human Services (HHS) or to the HHS Office of Civil Rights. **Your health care services will not be affected by any complaint made to the Department Privacy Official, Secretary of Health and Human Services or Office of Civil Rights.**

Privacy Issues:

Public Law 104-191, August 21, 1996 = HIPAA
Sec. 264. Required the Secretary of Health and Human Services to make recommendations on standards with respect to the privacy of individually identifiable health information, and to establish regulations addressing: 1) the rights than an individual should have regarding their health information; 2) the procedures established for the exercise of such rights; and 3) the uses and disclosures of such information that should be authorized or required.

This same section provides that federal regulation shall not supercede state law if the state law imposes more stringent requirements. If a state does not have more stringent requirements, then federal regulations apply.

45 CFR 164 Subpart E – Privacy of Individually Identifiable Health Information
There is a ream of federal regulations here that govern individuals' privacy. In brief:

Section 164.501 Definitions:

Required by law means a mandate contained in law that compels a covered entity to make a use or disclosure of protected health information and that is enforceable in a court of law....including, but not limited to.....statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

Section 164.510 Uses and disclosures requiring an opportunity for the individual to agree or to object.

This is where a Medicaid recipient would have signed a form in order to participate in the program that allows the disclosure of health information for the purposes of administering the state plan.

Section 164.512 Uses and disclosures for which consent, an authorization, or opportunity to agree or object is not required.

"...to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law."

42 CFR Part 431 – State Organization and General Administration

Subpart F – Safeguarding Information on Applicants and Recipients
Sec. 431.301-302. A State plan must provide for the safeguarding of information and restriction of use to purposes directly connected with the administration of the plan that includes:

1) Establishing eligibility;
2) Determining the amount of medical assistance;
3) Providing services for recipients; and
4) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan.

Subpart C – Administrative Requirements: Provider Relations
Sec. 431.107. Requires the State plan must provide for an agreement between the Medicaid agency and each provider....that agrees to keep any records necessary to disclose the extent of services the provider furnishes to recipients.

7 AAC 43.030 specified that providers are required to keep the following records for seven years from the date the service is provided:

1) patient information;
2) financial information; and
3) a clinical record

Alaska State Medical Association

cc: Traci

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

05/06/2003

Honorable Lyda Green
State of Alaska
Senate
State Capitol, Room 516
Juneau, AK 99801

Transmitted by Fax:
907-465-3805

RECEIVED
MAY 06 2003

Re: SB 41

Dear Senator Green:

You have not heard from The Alaska State Medical Association (ASMA) regarding SB 41 until now because it has struggled with formulating a position. ASMA cannot support SB 41 because serious unintended consequences may result. The potential lack of access to care is the most significant unintended consequence.

Attached is a copy of a letter to Representative Lesil McGuire dated 4/14/03, in which ASMA's Executive Director relayed some of the experiences related to the FY 98 Medicaid Audits involving 70 physicians. A number of physicians are no longer seeing Medicaid patients due to the manner in which those audits were conducted.

The criminalization of honest mistakes is also a concern. The payment methodology (RBRVS) and coding schema (CPT) for Medicaid in Alaska is the same as for Medicare. With the Medicare program, honest coding mistakes and legitimate differences of opinion about coding have occurred and will continue to occur. The coding for many treatments is not an exact science. Coding questions posed to Medicare administrative personnel have not resulted in either consistent or accurate answers. It is my understanding that neither Medicaid officials nor its contractors will provide responses to individual questions regarding coding. When a physician cannot get a definitive answer from the administering agency, how can she/he know that they won't be charged criminally for an honest mistake or a legitimate difference in opinion over proper coding?

The above uncertainty, the experiences of the FY 98 audits, and the relative low level of payment provides the basis for an easy decision not to see Medicaid patients. ASMA's concern remains the same as it was during the whole FY 98 audit process – access to care for Medicaid patients.

Until SB 41 positively addresses the above concerns, ASMA cannot support it.

Sincerely,

Jeanne Bonar

By: Jeanne Bonar, MD, President
For: Alaska State Medical Association

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

04/14/2003

Honorable Lesil McGuire
State of Alaska
House of Representatives, Room 118
Juneau, AK 99801-1182

Transmitted by Fax:
907-465-6592

Re: SB 41

Dear Representative McGuire:

It is my understanding that you will be "carrying" this bill in the House. Also, you have asked for input regarding SB 41. To date, ASMA has not taken a position on this bill. ASMA has repeatedly stated that anyone committing medical assistance fraud needs to be removed from the system and appropriately punished.

Because ASMA has not taken a position on SB 41, I cannot comment on the bill. However, I will share with you the experiences that physicians had with the Department of Health and Social Services in regards to Medicaid audits begun in FY 98.

The physician community was used as the test group for audits done under contract with DHSS by the accounting firm Deloitte and Touche. Audits of 70 physicians were begun in FY 98. Unfortunately, some of the audits are still in process. In general, the experience of those initial audits was that DHSS was slow in completing the administrative process. The process was slow to be started but even slower to complete (e.g. to get to a point of giving a "clean" audit result or to make a formal charge of inappropriate billing, etc).

Below, I will share some of the common complaints about the audit process that have been made by physicians:

- Do not like any overpayments found being extrapolated over their entire Medicaid patient base. (Regulations provide for extrapolation.)
- Had to wait too long for the audit results.
- No requests for additional time to produce records were honored. (Regulations require production within a specific time period, but for the department to grant extension in its discretion.)
- Inappropriate requests were made for records of non-Medicaid patients.
- Some settings are not appropriate for "on-site" audits. For example, a stranger (an auditor) in the office of a psychiatrist is disruptive for some patients.

- Go after the "outliers" and do not waste time auditing those that fall within pre-set parameters.
- The "hassle factor" with Medicaid is reaching the levels of the Medicare program.

As per usual, the "devil is in the details". My concern during the whole FY 98 audit process and now is the same – access to care for Medicaid beneficiaries. As has happened across the country with Medicare, a combination of "hassle factor" elements and low payment to physicians is resulting in our elderly having a difficult time finding a doctor. Its not that physicians don't want to treat them, its that they can't treat them when the payment rates don't come near to covering office overhead.

Please let me know if you have any questions.

Sincerely,

James J. Jordan
Executive Director

Cc: Board of Trustees
Thyes Shaub

STATE OF ALASKA
OFFICE OF VICTIMS' RIGHTS

Representative Lesil McGuire, Chair
Representative Tom Anderson, Vice-Chair
House Judiciary Committee
State Capitol Building
Juneau, AK 99801

May 12, 2003

Re: CS For Sponsor Substitute For Senate Bill No. 41 (FIN) – "An Act relating to medical care and crimes relating to medical care, including medical care and crimes relating to the medical assistance program, catastrophic illness assistance, and medical assistance for chronic and acute medical conditions."

Dear Representatives McGuire and Anderson:

On behalf of the Alaska Office of Victims' Rights, I offer this written testimony in support of SB 41 and would ask that it be included as part of the record when your committee convenes to consider this milestone legislation. The Senate unanimously passed this Bill on April 22, 2003.

Approximately 18 months ago I appeared before Senator Green's HES committee in Wasilla to testify about the role of the Alaska Medicaid Fraud Control Unit, and some of the difficulties facing prosecutors who wish to investigate Medicaid health care providers in this state. When I addressed that committee on November 8, 2001, I had been the director of the Alaska Medicaid Fraud Control Unit for some 2 ½ of my 27-year career as a prosecutor and knew all too well the problems health care prosecutors face in Alaska.

What I said then is equally true today: unscrupulous Medicaid providers can easily cheat Alaska's Medicaid program through fraudulent or inflated billings and the problem of waste and mismanagement in the program itself continues to cost the public millions of dollars each year. For example, Alaska's Medicaid costs have escalated an average of 15% a year over the last 6 years and the FY 2004 proposed

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budget is approaching $1 billion. In this era of declining state revenues, one has to wonder where the money will come from?

One big reason for the rapid escalation of such health care costs is due to theft, waste and mismanagement in the administration of Alaska's Medicaid programs that divert limited dollars that ought to be spent to treat sick Alaskans. As I explained in detail to Senators Green, Senator (then Representative) Dyson, Senator Taylor and the other HES Committee members present that day, it is very easy under present Alaska statutes for dishonest practitioners to steal from the Medicaid program and there is a critical need for new statutes specifically tailored to combat such unnecessary losses.

Alaska is the only state that has *no* specific health care criminal theft statutes on the books. As a result, prosecutors must use non-specific criminal statutes to prosecute healthcare professionals who operate in a highly technical field and are able to mount expensive and well-financed (and often successful) defenses. Consequently, the record shows that there have been very few prosecutions-far less than one would expect-given the hundreds of millions of dollars which flow through Alaska's Medicaid program each year to less than 10,000 participating Medicaid providers. For example, between 1995 and 2000 a total of $1.99 *Billion* has passed through the Division of Medical Assistance (DMA) to a relatively small number of providers yet there have been far less than a dozen criminal prosecutions.

I retired from the Criminal Division of the Department of Law in January 2002 and in May the Alaska legislature confirmed my appointment to be the Director of the newly created Alaska Office of Victims' Rights (OVR) whose purpose is to help victims of crime. It is in that capacity that I write this letter to this committee for I believe that when limited funds earmarked to be spent on needy patients are diverted from the Medicaid program due to theft, waste and mismanagement, the public is victimized and the suffering of patients is unnecessarily prolonged.

Based on my training and experience I have worked with Senator Green and members of the departments of law and health and social services, to fashion a comprehensive package of new statutes, and amendments to existing statutes, which are all designed to address Medicaid fraud and mismanagement in our Medicaid program. The following is a brief overview of some of the highlights of SB 41, which is now before you.

1. <u>PROPOSED AMENDMENT TO AS 17.30.080</u>

All states, including Alaska, (and the federal government) have drug laws that say that prescriptions for controlled substances (medications) may *only* be issued by practitioners such as doctors, dentists, etc. when there is present a <u>legitimate medical purpose</u>, e.g. controlled substances and prescriptions may *only* be issued in order to treat a patient's illness or medical condition. If the required medical purpose is

absent, then the doctor is treated under AS 17.71 the same way as any drug dealer who delivers controlled substances. All the controlled substances in Alaska are classified in AS 11.71.140-.190 on the basis of how dangerous they are. Thus, the only factor that exempts doctors from criminal liability is the presence of a medical purpose when he or she writes prescriptions. If it's absent, the doctor, dentist, etc. is subject to prosecution.

Problem With The Present Law:

In Alaska we have a number of problem practitioners who issue vast numbers of prescriptions without a real and legitimate medical need (or where the claimed medical need is very questionable). Usually, the "patients" are drug dependent and drug seeking individuals, who simply want to get high or sell their prescription drugs on the street to get cash in order to purchase illicit street drugs they can't obtain from a pharmacy such as cocaine, crack, heroin, etc. Most of these "patients" are on Medicaid so the Medicaid fund is impacted twice: Once when the doctor bills for a service claimed to have been rendered (the office visit) and again when the "patient" presents the prescription to a pharmacist and the drugs are dispensed. After you multiply this several thousand times over a year the amount of money is substantial.

The drafters of present AS 17.30.080, attempted to protect the public and prevent this from happening but the way they tried to do so has proved very ineffective. They incorporated the requirement that there exist a legitimate medical necessity by inserting the words "medical purpose." However, the legislature never defined exactly what that term means. The statute simply says that practitioners need a "medical purpose" to stay out of trouble.

The result is that Alaska prosecutors are very reluctant to accept cases for prosecution because of this ambiguity, and this has been my personal experience as well. I would always run into big problems with this key statute whenever I prosecuted health care practitioners because what is or isn't a "medical purpose" is vague in the absence of a statutory definition. And because there have been very few health care criminal prosecutions in Alaska, there are no cases from our appellate courts interpreting this term.

When cases against doctors are not accepted for prosecution by prosecutors it doesn't take too long for the drug enforcement authorities to re-focus their limited resources to other more "traditional" crimes. This lack of prosecutorial-police oversight and enforcement has emboldened dishonest Alaska practitioners and increased abuse of the Medicaid fund.

The Solution To This Problem

The proposed amendment to AS 17.30.080 contained in Section 2 of SB 41 [page 2 starting at line 11] will make it easier to convict unethical practitioners because the requirement of medical necessity will now be defined in that statute. The amendment provides that controlled substances may only be delivered or prescribed for a purpose that is "solely medical" which is defined as being "...reasonably necessary for treatment of a person's illness, injury, or physical or mental health, and that is provided by a practitioner while acting within the usual course of professional practice or research and in accordance with a standard of care generally recognized and accepted within the medical profession in the United States." This amendment will make it easier to effectively investigate and prosecute professional abuses.

2. NEW SUBSECTION AS 17.30.080 REQUIRES NOTICE BY THE A.G.

This new subsection is found in Section 1 [at page 1 starting at line 11] and will impose an affirmative obligation on the Attorney General to notify the Commissioner of Health and Social Services whenever a Medicaid provider is charged with any drug offense under AS 11.71. Upon receiving that notice, the Commissioner is required to "...immediately undertake a review of all unpaid claims or requests for reimbursements attributable to services claimed to have been provided by the person charged."

This much needed change will require DMA to take a hard look at providers who are facing criminal drug charges. It has been my experience that when a provider is charged with a drug crime, DMA takes no action to scrutinize that person's billing history. I know this from cases I have prosecuted. And, if the defendant posts bail so as to be able to continue to provide services while awaiting trial, Medicaid continues to conduct business as usual.

Pre-trial delays can take many months, and even years because such cases involving medical practitioners involve thorny questions regarding "medical necessity" and "quality of care" issues where thousands of documents are involved, prosecutors have little experience in medicine and pharmacology so are forced to hire medical experts to help them understand the evidence and prepare for trial. Under this amendment, a provider's billings would be subject to a review by those who administer Alaska's Medicaid fund during that entire period, which is presently not the case.

3. PROPOSED AMENDMENT TO THE PURPOSE LANGUAGE INAS 47.07.010

This amendment to the "Purpose" statute in title 47 (the title which contains the Medicaid statutes) can be found in Section 4 on page 7 [starting at line 12] of the

bill. It embodies the legislature's declaration that the Medicaid fund is a limited resource and, that to conserve that limited resource for the benefit of indigent patients, providers must conduct themselves "...honestly, responsibly, and in accordance with applicable laws and regulations in order to maintain the integrity and fiscal viability of the state's medical assistance program, and that those who do not operate in this manner should be held accountable for their conduct. It is vital that the department administer this chapter in a manner that promotes effective, long-term cost containment of the state's medical assistance expenditures while providing medical care to recipients."

It reaffirms the concept that, those in state government who administer the fund have a special duty, as well as a firm public responsibility, to employ effective cost containment measures to safeguard this limited fund for the benefit of all needy recipients and to reverse annual increases in the Medicaid budget.

This amendment will give Medicaid administrators a much needed directive about which way the Medicaid program must go: effective and long term cost containment. This will also provide the legislature the means, in the months and years to come, to measure DMA's performance and conduct in managing the Medicaid program regarding whether this legislative philosophy has been observed.

4. CREATION OF AS 47.05.200 WILL NOW REQUIRE ANNUAL AUDITS

The language of this new statute may be found on page 2 [starting at line 20]. It would require the Commissioner of Health and Social Services to undertake annual statewide audits of Medicaid providers, similar to the successful Deloitte & Touche audits conducted in 1998-2001. The number of audits each year would be based upon 0.75 percent of all enrolled providers in the Medicaid program adjusted annually but the number of audits could not be less than 75. The audits must include both on-site as well as desk audits and must be of a variety of provider type. The D&T audits not only served a deterrent purpose to unethical Medicaid providers, but they were very cost effective. For example, the D&T audits cost the Division of Medical Assistance $477,250 annually for three years and identified more than $20 million dollars in overpayments. $2.1 million dollars of that amount was recovered by the Alaska Medicaid Fraud Control Unit and returned to the Medicaid fund during my tenure in that office. The amendment also permits the legislature to appropriate a portion of recovered funds to pay for the annual audits.

This statute would also require DMA to commence administrative procedures to recoup overpayments identified in the audits and to "...allocate the reasonable and necessary financial and human resources to ensure prompt recovery of overpayments..." In time, it is probable that the recovered funds will more than pay

for the audits, as was the case with the Deloitte & Touche audits conducted in 1998-2001.

5. AS 47.05.210 WILL CREATE CRIMINAL STATUTES SPECIFICALLY DESIGNED TO PROSECUTE MEDICAL ASSISTANCE FRAUD

Problem With The Present Law:

At the beginning of this letter I characterized SB 41 as "milestone legislation" for good reason. Alaska is the only state that has no criminal statutes that are specific to health care crimes. This bill closes that door. Currently, prosecutors must use the traditional theft statutes contained in AS 11.46.100-.295 that are non-specific and unsuited to health care crime prosecutions. This is primarily due to the high culpable mental state (the highest in Alaska's criminal code)) that is specified in such statutes. They require the state to prove beyond a reasonable doubt that the defendant acted "intentionally." This term is defined in the law (AS 11.81.900(a)(1)) to require the state to prove the defendant had a "conscious objective" to steal.

This standard makes it exceedingly difficult to convict health care providers because such crimes are all circumstantial in nature. For example, unlike most "regular" crimes there is no crime scene in a health care crime case nor is there any physical evidence to send to a crime lab for analysis. There are seldom any witnesses to crimes of dishonesty and health care crimes are in a league of their own in terms of specialization. Those who commit such crimes are intelligent, well educated and able to afford the best criminal defense. They also work in very specialized areas involving health care and are no match for most police officers or prosecutors.

Often, such crimes depend on a showing by the state through expert testimony that medical services were not provided in accordance with complex Medicaid rules and Regulations. This raises thorny issues regarding the quality of care provided by a practitioner to his patient, something juries find difficult to understand. In fact, these crimes are so difficult to investigate and prosecute that most states, including Alaska, have a special office to prosecute health care providers who cheat the Medicaid fund. In Alaska we have the Medicaid Fraud Control Unit within the Office of Special Prosecutions and Appeals within the Criminal Division of the Department of Law. The problem is that they lack the appropriate tools to be effective. With its new criminal statutes, SB 41 will help overcome that handicap.

The Solution To This Problem

The statutes proposed in this section will make it easier to prosecute health care crimes because they criminalize conduct by providers who "knowingly" (as opposed to "intentionally") make false statements and engage in dishonest behavior.

The term "knowingly" is defined in AS 11.81.900(a)(2) and "is established if a person is aware of a substantial probability" of a fact (as opposed to crimes where the mental state is "intentionally" e.g. where prosecutors have to show a "conscious objective" to steal).

The range of conduct criminalized is appropriately broad because there are many ways to cheat the Medicaid program, e.g. making false statements, concealing material facts, and solicitation of others to do so.

When the Attorney General files criminal charges, a new statute, AS 47.05.220 [page 5 starting at line 7] would require him to notify the HES commissioner. Upon receiving such notice, the commissioner "...shall immediately undertake a review of all unpaid claims or requests for reimbursement" from the provider.

6. EXCLUSION FROM MEDICAL ASSISTANCE PROGRAMS

Another new statute, AS 47.05.240, will permit the HES commissioner, in the exercise of his or her discretion, to exclude an applicant to the Medicaid program or to disenroll a Medicaid provider, for a period of up to 10 years following the person's unconditional discharge on a conviction for medical assistance fraud or a drug conviction in a court of this state or another state or federal court.

7. SB 41 PROVIDES MANY NEEDED DEFINITIONS FOR PROSECUTORS

Finally, this bill provides prosecutors with needed definitions regarding a variety of legal terms of art used in this new package of laws. The definitions permit all participants to the criminal justice process, as well as the Medicaid practitioners in this state, to gain a clear understanding of what is prohibited under the law. It will likewise assist appellate courts that, hopefully, will now be called upon more frequently to decide appeals by convicted defendants. Such appeals will result in appellate decisions that will provide further guidance to practitioners in this field.

CONCLUSION

In sum, the provisions of SB 41 will load prosecutors' guns with real ammunition in a state that is presently all but defenseless against unscrupulous Medicaid providers. For the first time, Alaska will join the rest of the country and will have a set of workable and effective health care criminal statutes on her books. In future years, the benefit of experience will tell us if and how these statutes should be amended to correct problems presently unseen.

The proposed statutes will also mandate annual audits that will uncover crimes. If there is a commitment on the part of the executive to allocate prosecution resources within DOL's Medicaid Fraud Control Unit, those audits will result in investigations, prosecutions, convictions, and recovery of audit expenses. The sentences will be commensurate with the seriousness of the crimes involved. Convictions will allow for recovery of stolen Medicaid funds through restitution ordered by the court. The combination of annual financial audits and convictions will have a decidedly deterrent effect on dishonest Medicaid practitioners.

Happily, as you can see from the fiscal notes prepared by Commissioner Gilbertson, the Federal Medicaid match is calculated at 75% for the costs associated with this legislation

I want to close by offering my thanks and appreciation to Senator Green's staff and to the very capable professionals of the Department of Law and the Department of Health and Social Services with whom I worked on this legislation over the last several months. I will be present telephonically at the hearing before your committee and would be glad to answer questions. As you consider these proposed Medicaid cost reform statutes and amendments I hope that you will permit me to be a continuing resource to your committee. For the above reasons I urge all committee members to vote for passage of SB 41 as drafted

Respectfully,

Stephen E. Branchflower, Director
Office of Victims' Rights

CC: Senator Lyda Green
Attorney General Gregg D. Renkes
Commissioner Joel S. Gilbertson

DMA notes on ASMA SB 41 comments

- A number of physicians are no longer seeing Medicaid patients due to the manner in which those audits were conducted.
  While some physicians have indicated that they were going to stop treating Medicaid patients, there is no evidence to indicate that this has occurred to any significant degree. Access to care has not been negatively impacted. (It is worth noting that some of the ASMA concerns might have resulted from MFCU investigations.)

- It is my understanding that neither Medicaid officials nor its contractors will provide responses to individual questions regarding coding
  If this statement refers to inquiries to First Health Provider Services staff or DMA staff in regard to choosing the most appropriate code to bill, the statement is correct. It is DMA policy to adhere to American Medical Association's Current Procedural Terminology, Healthcare Common Procedure Coding System, American Dental Association and other industry guidelines and standards. However when DMA has specifically prohibited code usage, or has a stricter or different requirement, the policy is outlined in the Provider billing manual and/or Remittance Advice messages. It is expected that providers deliver and bill for services in the same manner as they serve the general public.

- Do not like any overpayments found being extrapolated over their entire Medicaid patient base. (Regulations provide for extrapolation.)
  Current regulations do allow the division to use its discretion in the use of statistical sampling in audits or overpayment calculations. As the regulations are not specific, provider's concerns are understandable. It would be beneficial to undertake new audits using standard published protocols.

- Had to wait too long for the audit records.
  This is true. Timelines should be established and followed.

- No requests for additional time to produce records were honored. (Regulations require production within a specific time period, but for the department to grant extension in its discretion.)
  In the DMA audits, providers were sometimes given additional time to produce records. However, not all requests were honored. Again protocols in regard to timeframes and circumstances which would be considered should be addressed before audits are initiated.

- Inappropriate requests were made for records of non-Medicaid patients.
  The DMA audits only requested records on claims and Medicaid recipients which our system had record of. However, in a few instances the financial

• privacy issues

records which were requested included financicl records of family members who were not recipients. Also in a few instances, the claim was billed under a Medicaid recipient's ID, but the service was actually provided to another individual who was not a recipient. These circumstances are unavoidable. (This also could have occurred with some other type of investigation.)

- Some settings were no appropriate for "on-site" audits. For example, a stranger (an auditor) in the office of a psychiatrist is disruptive for some patients.
  DMA staff did give providers a window of time in which the audit had to be scheduled. The audit team attempted to perform the reviews in a manner and at a time which was least disruptive. For example, the auditors used a corner office or a room across the hall. In some cases records were copied and reviewed offsite. There should be consideration given to improving the process. Possibly giving the providers the opportunity to do the reviews after business hours or on weekends.

- Go after the "outliers" and do not waste time auditing those that fall within pre-set parameters.
  The method for choosing audits should be published –random or those meeting specified parameters. The audit process must be established in an efficient manner so providers are informed timely and effort is not wasted on marginal cases.

- The "hassle factor" with Medicaid is reaching the levels of the Medicare program.
  Audits are required and inevitable, but should be conducted in a reasonable, fair and efficient manner.

ALASKA STATE LEGISLATURE

Interim:
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SENATOR LYDA GREEN

Memorandum

To: Representative Lesil McGuire, Chair
House Judiciary Committee

From: Senator Lyda Green, Sponsor
Senate Bill 41

Date: 4/24/2003

Re: Scheduling Request for House Judiciary Committee

Attached is a committee packet for Senate Bill 41 relating to Medicaid costs and crimes. This bill passed the Senate by unanimous vote and I very much look forward to having it heard in the House. Included in the committee packet are the following:

1) The current version of the bill, CSSS SB 41(FIN).
2) Two fiscal notes, one from DHSS and one from Law.
3) My sponsor statement.
4) A sectional analysis.
5) Relevant statutes.
6) Supporting background information.

It is crucial this legislation be heard as soon as possible to ensure its passage this session. I appreciate your support and respectfully request SB 41 be scheduled for a hearing in the House Judiciary Committee at your earliest convenience.

Please call Traci Carpenter, at 465-3841, if she can be of assistance. Thank you for your consideration.

Attachments

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CS SS SB 41 (HES)
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: MEDICAL CARE AND MEDICAID FRAUD
BRU: Medical Assistance Admin
Component: Health Purchasing Group

Sponsor: GREEN
Requester:

Component No.: 243

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Personal Services	66.5	65.7	66.9	68.1	69.4	70.7
Travel						
Contractual		1,024.9	1,045.4	1,066.3	1,087.6	1,109.3
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	66.5	1,090.6	1,112.3	1,134.4	1,157.0	1,180.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts	49.9	818.0	834.2	850.8	867.8	885.0
1003 GF Match	16.6	272.6	278.1	283.6	289.2	295.0
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
TOTAL	66.5	1,090.6	1,112.3	1,134.4	1,157.0	1,180.0

Estimate of any current year (FY2003) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time	1	1	1	1	1	1
Part-time						
Temporary						

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

This bill creates more accountability from providers, recipients, and the Department of Health and Social Services (DHSS) in the administration of the Medicaid and CAMA programs, primarily through provider audits. The department is ordered to contract for independent financial audits in order to identify overpayments and criminal violations. This bill establishes named criminal acts for medical assistance fraud and corresponding degrees of felony or misdemeanor crimes. This bill provides for disenrollment of a health care provider for fraud or misconduct involving a controlled substance.

Prepared by: Kevin Henderson — Phone 465-5821
Division: Medical Assistance — Date/Time 03/17/2003
Approved by: Joel S. Gilbertson, Commissioner — Date 03/17/2003
Agency: Department of Health and Social Services

STATE OF ALASKA
2003 LEGISLATIVE SESSION

BILL NO. CS SS SB 41 (HES)

ANALYSIS CONTINUATION

ESTIMATED EXPENDITURES

The department has limited experience with contracting for provider audits. Audits for which DHSS has contracted in the past did not include the search for illegal activity required by this bill. Factoring in our limited experience, we make the following assumptions:

The .75% sample of all enrolled providers required by this bill means at least 75 providers would have to be audited each year. We estimate that two of the provider audits would be medical facilities, which require a more complex audit. The remaining 73 providers chosen by the contractor would be a cross section of provider types who exhibited characteristics that indicate recovery was likely.

To estimate the cost of an audit, we started with the historical cost of both facility and non-facility audits and increased that amount by 50%. This increase is to compensate for the added requirements of this bill, including the search for illegal activity, using a contractor with attorney staff, and the higher cost of short term contracting with a firm large enough to complete the complexity and number of audits required. The FY04 base cost of a facility audit is $26,100 per audit and there would be at least 2 of these completed per year. The base cost of a non-facility audit is $13,050 and there would be at least 73 of these per year.

DMA would require one full-time auditor (Range 16) to coordinate the non-facility audits, assist in management of the contract, and coordinate fair hearings as a result of DMA recovery enforcement. Additional administrative costs of equipment, supplies, office space, travel, etc are factored in.

Expenditures are anticipated to grow at an annual rate of 2%. Federal Medicaid match is calculated at 75%.

STATE OF ALASKA
2003 LEGISLATIVE SESSION

BILL NO. CS SS SB 41 (HES)

ANALYSIS CONTINUATION

ESTIMATE OF RECOVERIES

Of the 75 providers audited each year, we estimate that 75% of them will result in a claim for recovery. We estimate a 1 to 2 ratio of audit costs to recoveries. Historically, for every 1$ of the cost of an audit we recovered $2.

Annual growth in recovery of Medicaid and CAMA is estimated at 4%, which is a balance between inflationary growth in medical costs and a reduction in the frequency of provider violations and related recoveries as the program matures. We anticipate no recovery in FY04, because that year will be needed to develop, advertise, and award a contract for audit and recovery functions. In addition, some regulations changes will be needed in order to make a clear distinction between rate-setting audits and financial/misconduct audits.

Estimated recovery is shown below:

FY04	FY05	FY06	FY07	FY08	FY09
$0	$1,567.5	$1,630.2	$1,695.4	$1,763.2	$1,833.8

Section 3: AS 47.05.200(c) requires recovered overpayments obtained because of an audit to be deposited with the Department of Revenue.

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 41
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Law
Title "An Act relating to medical care and crimes relating to medical care, including . . . medical assistance program."
BRU Criminal Division; Civil Division
Component Criminal Appeals/Special Litigation; Human Services
Sponsor Senator Green
Requester Senate HESS Committee
Component No. 2203;2208

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2003) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

This bill establishes new crimes specifically addressing Medicaid fraud, including misconduct involving the prescription and dispensing of controlled substances. The bill further requires a specified percentage of financial/misconduct audits be performed by the Department of Health and Social Services each year.

The Department of Law does not anticipate many new cases will result from the criminal provisions contained in the bill and so does not anticipate a fiscal impact.

Prepared by: Joan M. Kasson
Phone (907) 465-5370
Division Attorney General's Office
Date/Time 2/25/03 12:10 PM
Approved by: Kathryn Daughhetee for Gregg D. Renkes, Attorney General
Date 2/25/2003
Agency Department of Law

(Revised 9/2002 OMB)

ALASKA STATE LEGISLATURE

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SENATOR LYDA GREEN

COMMITTEE SUBSTITUTE FOR SPONSOR SUBSTITUTE FOR SENATE BILL 41

SPONSOR STATEMENT

"An Act relating to medical care and crimes relating to medical care, including medical care and crimes relating to the medical assistance program, catastrophic illness assistance, and medical assistance for chronic and acute medical conditions."

Since 1999, the costs of the Medicaid program have risen throughout the nation at an average rate of 11 percent per year. Alaska's Medicaid program has averaged annual increases of 20 percent, or more than $100 million per year, bringing the total projected program costs in FY2004 to just under $1 billion ($695 million in federal funds and $289 million in state funds).

Factors such as increased participant enrollments, increased use of health services, and the increasing costs of pharmaceuticals and long-term care are the greatest contributors to the rise in Medicaid program costs. While we have limited ability to contain these cost factors, we can control program integrity by targeting waste and fraud.

Nationally, the error rate of overpayments in the Medicare program is 7 percent, a number that could be inferred to the Medicaid program as well. In addition, the commonly held perception of the amount of fraud committed against the Medicaid program nationwide is 10 percent. Whether these two numbers are inclusive of one another or should be compounded, they represent a sizeable amount of spending -- between $70 and $170 million -- in Alaska's Medicaid program on activities that are, at best, questionable and at worst, criminal.

To preserve the integrity and fiscal viability of Alaska's Medicaid program, the system should be held to rigorous controls and frequent scrutiny. Relevant laws should be in place to prosecute those who commit fraud and abuse related to medical care. Alaska has no specific health care criminal theft statutes. Currently, in order to prosecute those who commit Medicaid fraud, prosecutors must use criminal statutes related to actions coincidental to the misconduct. Alaska theft statutes require proving the conduct was intentional, a very high standard to meet for a crime where there is no crime scene or physical evidence. Consequently, there have been relatively few prosecutions. Senate Bill 41 provides the legal tools for the fiduciaries of the Medicaid program to establish program integrity and maintain maximum fiscal control.

The legislation establishes the crime of medical assistance fraud, defines the elements that constitute the fraud, and classifies the crime committed as either a felony or a misdemeanor. It requires independent financial audits to identify errors, overpayments, and criminal violations made to, or by, Medicaid providers and requires administrative action within 90 days of receipt of each audit. It completes the loop between the Department of Health and Social Services and the Department of Law by requiring copies of all audits be provided to the Attorney General and by directing the Attorney General to notify the Department of Health and Social Services of any charges of misconduct filed against a Medicaid provider. Such notice requires the Department to undertake a complete review of any outstanding claims of that provider. Finally, Senate Bill 41 provides that financing of the audits may be made from the recovery, due to the audits, of misspent funds.

It is vital that the State of Alaska administer its Medicaid program in a manner that ensures effective, long-term cost containment while providing needed medical care to its intended recipients. Medicaid providers must operate honestly, responsibly and in accordance with the law. Those who do not should be held accountable. Senate Bill 41 provides the State with the means to better implement this philosophy.

SB 41: ***"An act relating to medical care and crimes relating to medical care, including medical care and crimes relating to the medical assistance program, catastrophic illness assistance, and medical assistance for chronic and acute medical conditions."***

Note: throughout this document, the references to "commissioner" and "department" mean the commissioner of the Department of Health and Social Services.

Section 1.

AS 17.30.080 (b) is amended to require the attorney general to notify the commissioner of health and social services when a medical assistance provider is charged with misconduct involving a controlled substance.

Section 2.

AS 17.30.080(c) is added to require the commissioner of health and social services to undertake a complete review of any outstanding claims of a medical assistance provider charged by the attorney general with misconduct involving a controlled substance.

AS 17.30.080(d) is added to provide definitions for: "claims"; "medical assistance provider"; "medical purpose"; and "practitioner".

Section 3.

Adds new sections to AS 47.05 regarding medical assistance fraud.

AS 47.05.200. Annual audits. Subsection (a) requires the department of health and social services to contract for annual independent audits of a sample of all medical assistance providers in order to identify overpayments and criminal statute violations.

Audit parameters:

- The number of audits contracted annually shall be .75 percent of all enrolled medical assistance providers, but may not be fewer than 75.
- The audits must include both on-site and desk audits.
- The audits must be of a variety of provider types.

This subsection also gives general direction to the department as to the qualifications of the successful contractor.

Subsection (b) requires the department to begin administrative proceedings to recoup identified overpayments within 90 days of receiving each audit report. It also requires the commissioner to provide copies of all audit reports to the attorney general for purposes of screening for criminal violations.

Subsection (c) indicates legislative intent that the State's share of recovered overpayments are accounted for separately under AS 37.05.142 (accounting for program receipts), a portion of which may be appropriated to the department to pay for the annual audits.

Subsection (d) allows for audit and inspection of the records of a medical assistance provider that are pertinent to providing services to a medical assistance recipient.

Subsection (e) provides clarification that the department is not prohibited from performing other audits that are allowed or required under other laws.

AS 47.05.210. Medical assistance fraud. This section establishes new criminal statutes with penalties ranging from a class B felony to a class B misdemeanor. In the interests of brevity, the crimes are paraphrased below.

A person commits the crime of medical assistance fraud if the person:

1) knowingly and recklessly submits a claim to a medical assistance agency for which the claimant is not entitled;
2) knowingly and recklessly prepares or assists in the preparation of a claim to a medical assistance agency for providing services for which the claimant is not entitled;
3) requires payment for a referral to another health care provider;
4) requires payment for providing health care to a medical assistance recipient in addition to the payment by a medical assistance agency;
5) fails to produce medical assistance records to a person authorized to request them;
6) knowingly makes false entry in or falsely alters a medical assistance record;
7) knowingly damages, conceals, or otherwise impairs a medical assistance record.

AS 47.05.220. Notice of charges. Like its counterparts under sections 1 and 2 of this bill, this section is added to require the attorney general to notify the department when a medical assistance provider is charged with medical assistance fraud, and to require the commissioner to immediately undertake a complete review of any outstanding claims of that provider.

AS 47.05.230. Determination of value; aggregation of amounts. This section provides that the value of property shall be determined in accordance with AS 11.46.980, which essentially defines the value of property as market value at the time of the crime, or replacement value if market value cannot be determined. It also allows for aggregation of the amounts in order to determine the degree or classification of a crime under AS 47.05.210.

AS 47.05.240. Exclusion from medical assistance programs. This section allows the commissioner of health and social services to exclude a medical assistance provider from participating in the medical assistance programs under AS 47.07 and AS 47.08 if that provider was convicted for medical assistance fraud or misconduct involving a controlled substance.

- It includes persons convicted under both Alaska statutes and in a U.S. court or the court of another state for similar crimes.
- The period of exclusion may be up to 10 years following unconditional discharge from sentence served, including probation and parole.
- After a period of exclusion, an applicant for enrollment in the medical assistance programs may not participate until they establish to the commissioner of health and social services that they are qualified to participate.

Section 4.

AS 47.07.010. Purpose (of the medical assistance program for needy persons).

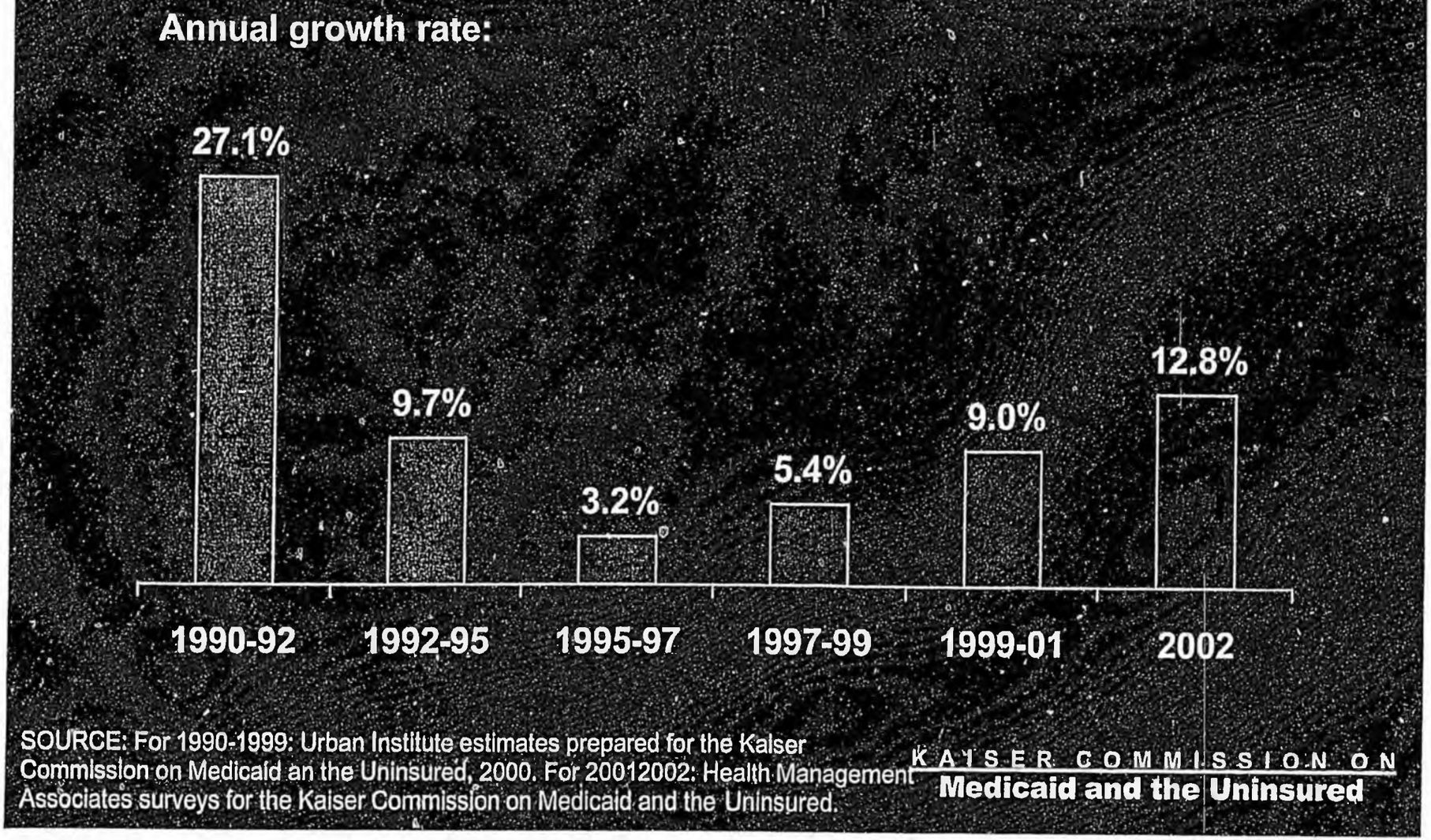
The purpose is amended to clarify the philosophy that care provided to needy persons at public expense must be appropriate and cost-effective; that providers of care to such persons must operate with honesty and integrity and be held accountable if they do not; and that the department of health and social services administer this chapter in a manner to promote effective, long-term cost containment while providing medical care to its intended recipients.

Section 5.

AS 47.07.074 is specific to health facilities. Subsection (a) is amended to clarify that *all* the records pertinent to providing services to a medical assistance recipient must be available for inspection, not just the financial records. This brings the statute into accord with the like audit provisions under the proposed AS 47.05.200(d).

Figure 13

Average Annual Growth Rates of Total Medicaid Spending



SOURCE: For 1990-1999: Urban Institute estimates prepared for the Kaiser Commission on Medicaid an the Uninsured, 2000. For 20012002: Health Management Associates surveys for the Kaiser Commission on Medicaid and the Uninsured.

KAISER COMMISSION ON
Medicaid and the Uninsured

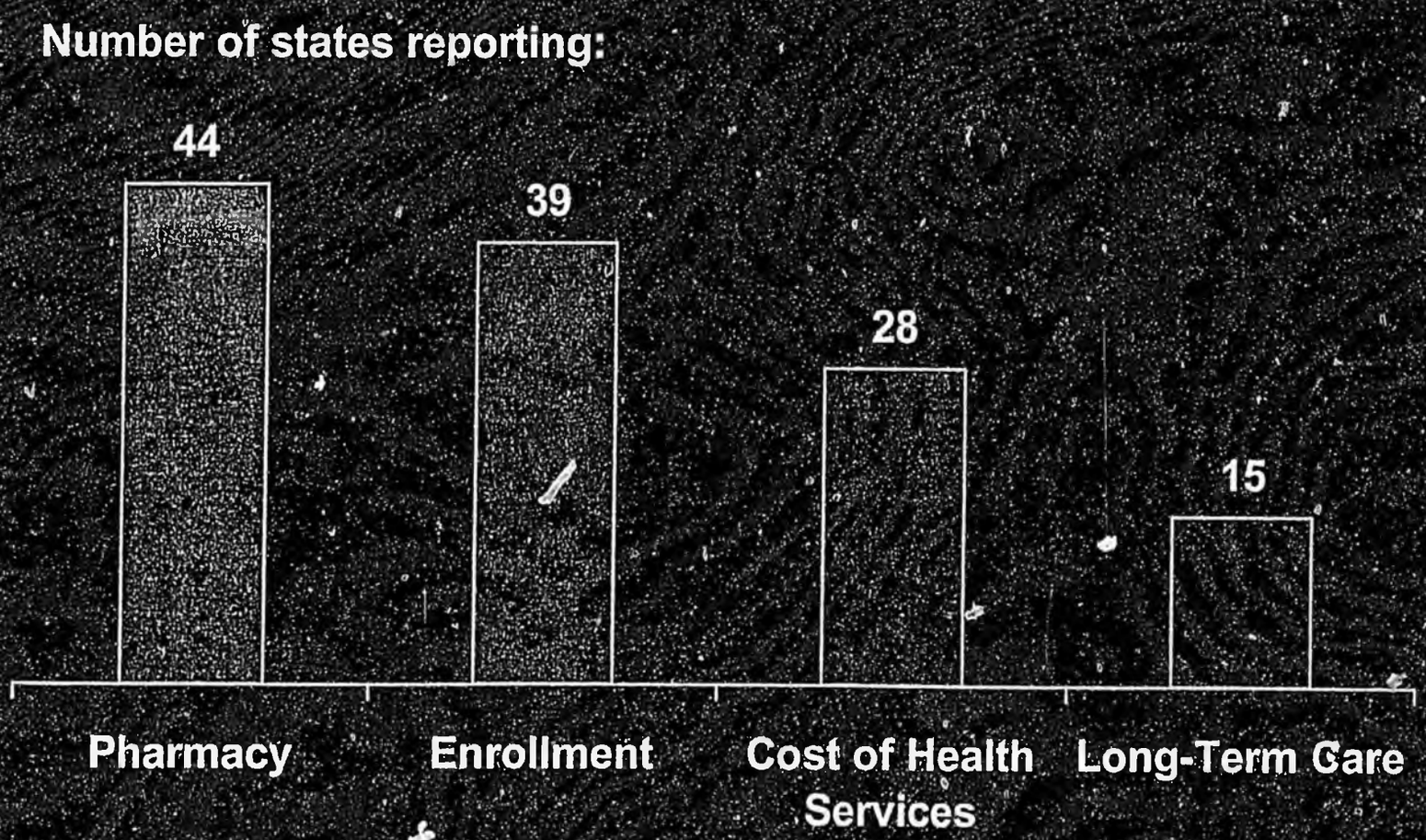
ALASKA MEDICAID PROGRAM EXPENDITURES ~ RECENT HISTORY							
Numbers and Language							
	Actuals	Actuals	Actuals	Actuals	Actuals	Enacted	Projected
	FY98	FY99	FY00	FY01	FY02	FY03	FY04
Medical Assistance							20% increase
Medicaid	**366,536.5**	**395,689.5**	**470,709.0**	**583,893.6**	**693,679.7**	**820,036.5**	**984,043.8**
General Purpose	129,731.2	131,522.9	145,514.7	152,791.1	192,921.5	173,294.8	207,953.8
Federal	231,329.7	261,315.7	307,508.4	387,431.9	461,846.9	579,552.0	695,462.4
Other	5,475.6	2,850.9	17,685.9	43,670.6	38,911.3	67,189.7	80,627.6
Total	**366,536.5**	**395,689.5**	**470,709.0**	**583,893.6**	**693,679.7**	**820,036.5**	**984,043.8**
% Increases from Prior Year		7.95%	18.96%	24.05%	18.80%	18.22%	20.00%
Total Medicaid Expenditures FY 99 - FY 02:				2,143,971.8			
Average annual increase between FY 99 and FY 02				20.60%			

Source: figures obtained from Legislative Finance Division
Presented by T. Carpenter of Senator Green's staff

2/24/2003

Figure 15

Factors States Reported as Among the "Top Three" Increasing Medicaid Spending

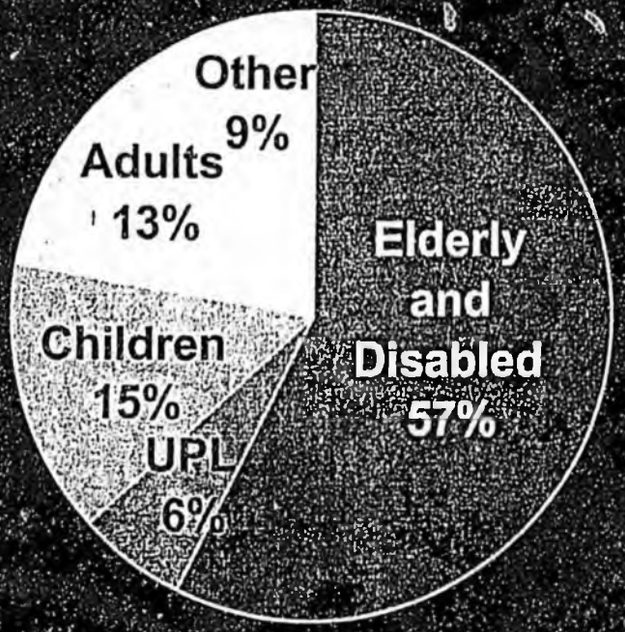


SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002.

KAISER COMMISSION ON
Medicaid and the Uninsured

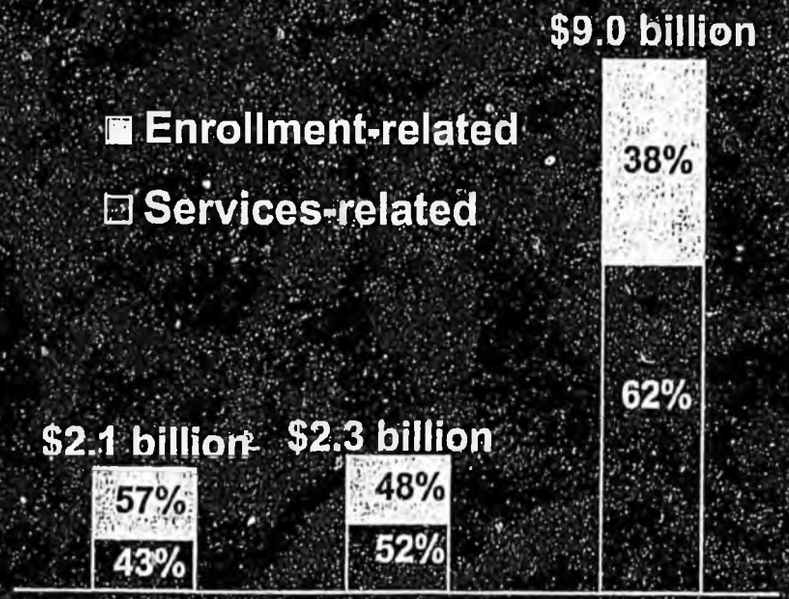
Figure 16

Sources of Growth in Federal Medicaid Expenditures, 2001-2002



Total Increase = $15.7 billion

Factors Behind Expenditure Growth for Beneficiaries

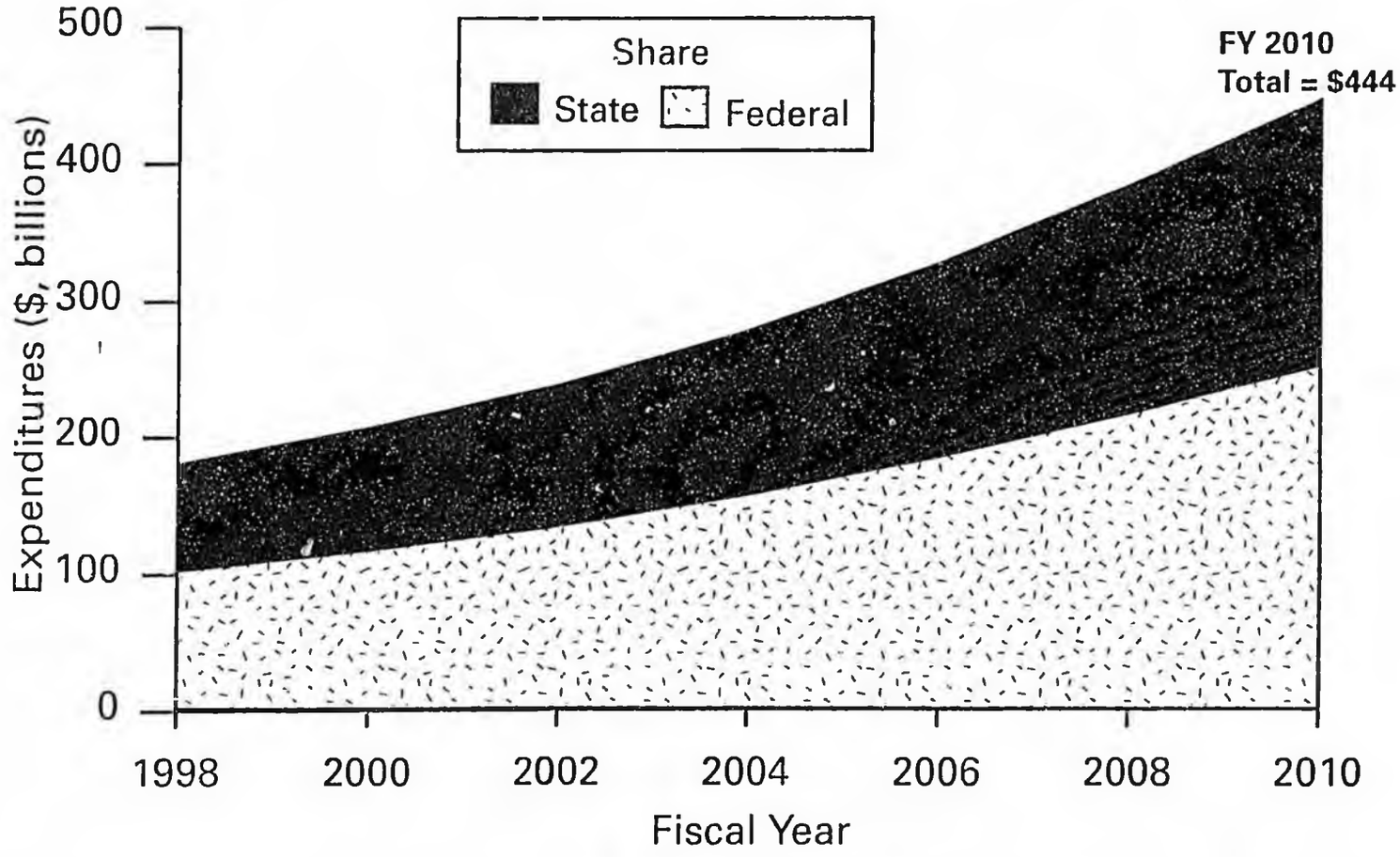


SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of CBO Medicaid baseline, March 2002.

KAISER COMMISSION ON Medicaid and the Uninsured

Figure 2.5 Projected Medicaid Expenditures, Fiscal Years1998-2010

Spending is projected to grow to $444 billion in FY 2010.

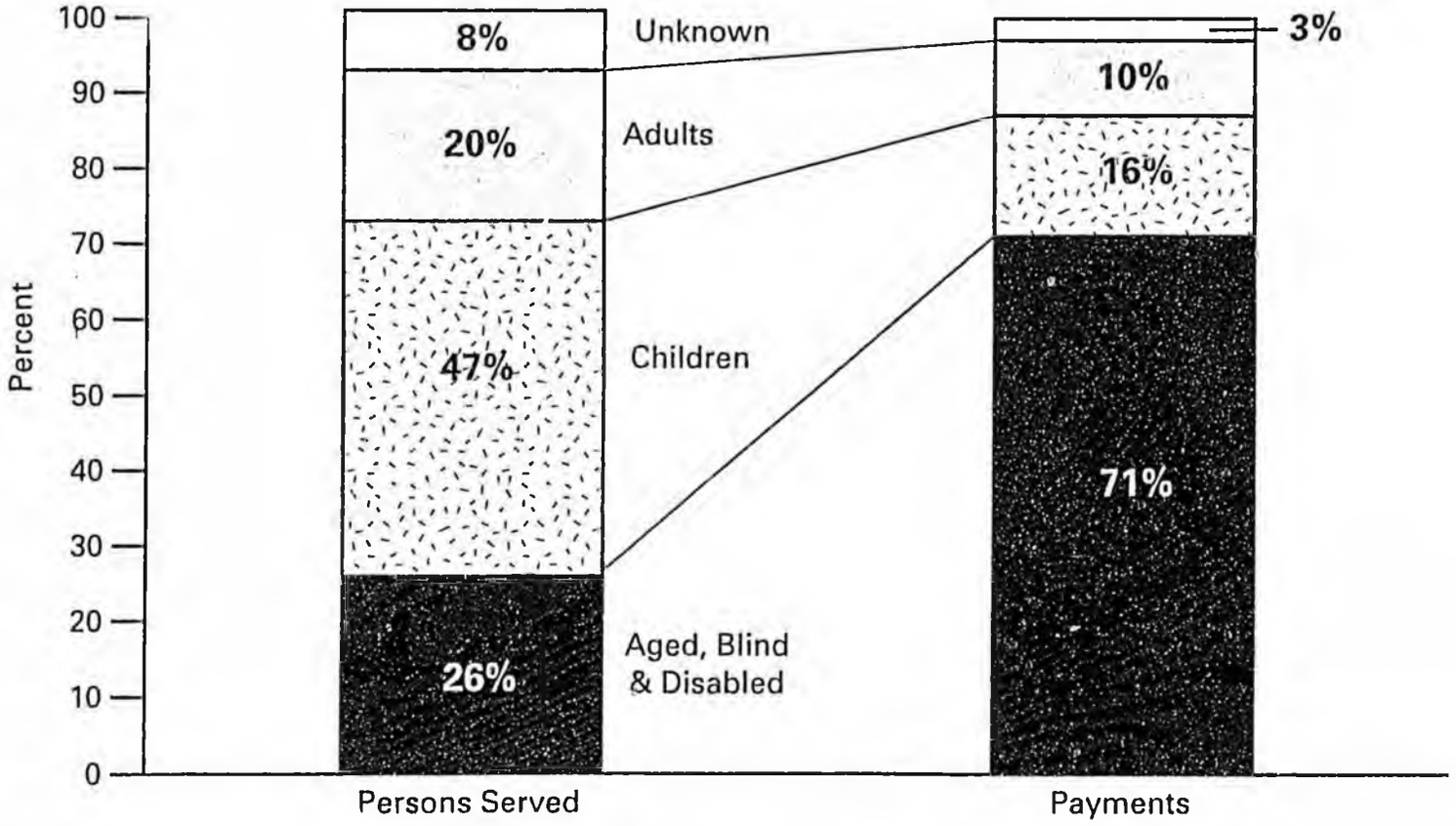


Note: (1) The projected increase in Medicaid expenditures can be explained by the following factors — case load accounts for about one-sixth of the increase, inflation one third, and the balance can be explained by spending-per-enrollee in excess of inflation; (2) data shown above are expressed in nominal terms.

Source: HCFA/Office of the Actuary, President's Fiscal Year 2001 baseline budget.

Figure 2.10 Distribution of Persons Served Through Medicaid and Payments by Basis of Eligibility, Fiscal Year 1998

Payments for the elderly, blind and disabled account for 71 percent of total payments.

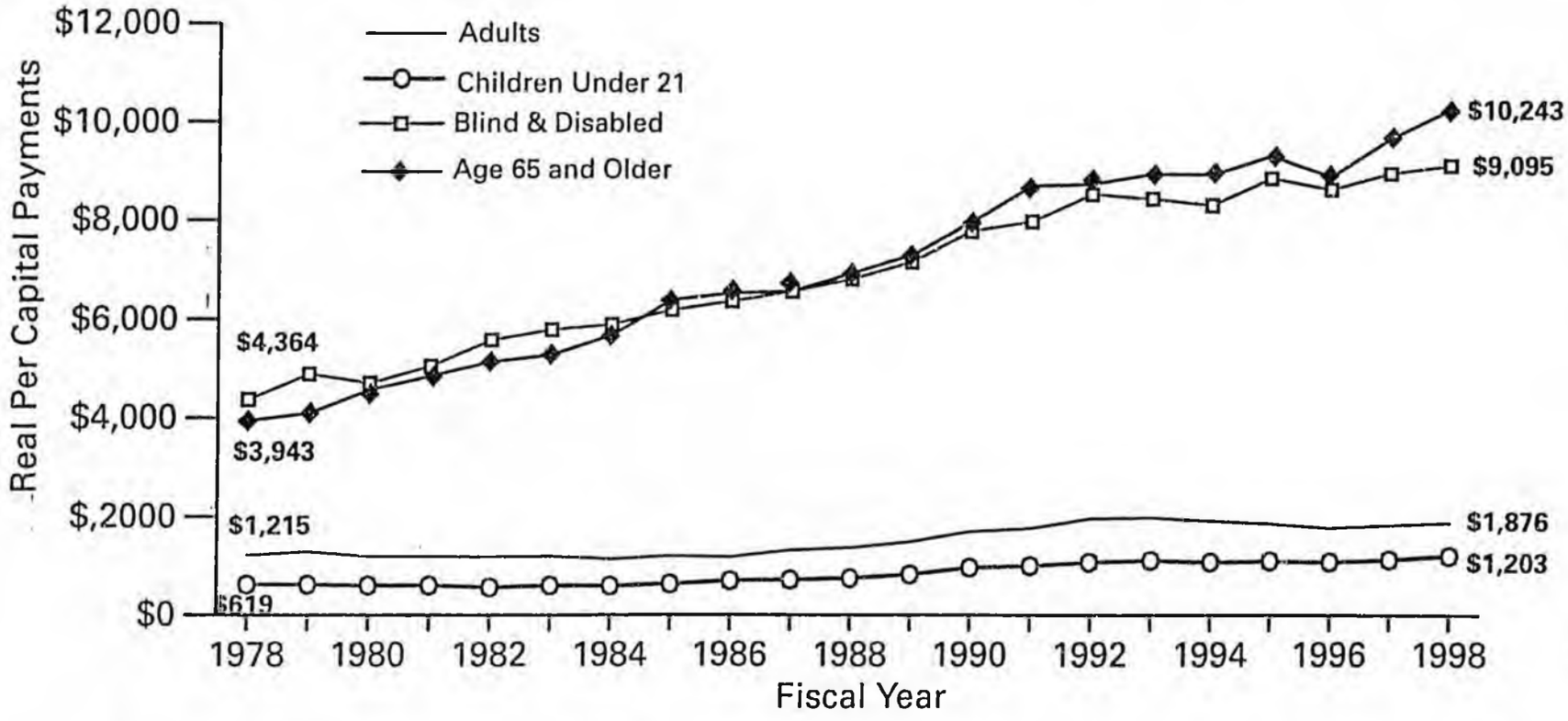


Note: (1) Totals may not equal 100% due to rounding; (2) "Payments" describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude DSH payments, Medicare premiums and cost sharing on behalf of beneficiaries dually enrolled in Medicaid and Medicare); (3) disabled children are included in the aged, blind & disabled category shown above.

Source: HCFA-2082.

Figure 2.12 Average Real Medicaid Payments per Person Served, Fiscal Years 1978-1998

Per capita payments for the elderly, blind and individuals with disabilities more than doubled while per capita payments for children and adults had modest growth rates.



Note: (1) Data shown above are expressed in 1998 dollars; (2) for FY 1998 "payments" describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude DSH payments, Medicare premiums and cost sharing on behalf of beneficiaries dually enrolled in Medicaid and Medicare), while data from previous years only include direct vendor payments; (3) the term "adults" as used above refers to a category of non-elderly, non-disabled adults; (4) disabled children are included in the blind & disabled category shown above.

Source: HCFA Form 2082.

ALASKA MEDICAID FRAUD CONTROL UNIT

Message Hotline to Report Medicaid Fraud 1-907-269-6279

The Alaska Medicaid Fraud Control Unit (MFCU) has been part of the Attorney General's Office since January 1992. The unit is located in Anchorage and has statewide jurisdiction. It has the responsibility for investigating and prosecuting Medicaid fraud and the abuse, neglect or financial exploitation of patients in any facility that accepts Medicaid funds. The Director of the MFCU is Assistant Attorney General Donald R. Kitchen, a career criminal prosecutor with more than a quarter centry of experience in the criminal justice system. There are 47 MFCU's across the U.S.

Although the vast majority of health care providers are honest and dedicated to providing the highest quality health care to their patients, Medicaid provider fraud costs American taxpayers hundreds of millions of dollars annually and threatens the integrity of the Medicaid program. Nationally, it is estimated that Fraud, Waste and Abuse account for 10 to 20 percent of the payments made by Medicaid. If the National trends hold true for the State of Alaska, these percentages equate to 30 million to 70 million Medicaid dollars annually, resulting in a substantial reduction in moneys available to provide necessary medical services to needy Alaskans.

Fraud is "intentional" deception or misrepresentation which results in an "unearned benefit", usually in the form of an excess payment. While health care fraud can take many forms, the most common involves billing for services not performed or billing for more expensive services than those actually provided. Medicaid patients may not suspect fraud, as they are seldom made aware of the procedures or dollar amounts billed to Medicaid. An unscrupulous provider can generate a fraudulent Medicaid payment simply by filing a false claim with an eligible recipient's identification number and a valid procedure code.

Examples Of Fraud Schemes In Health Care

- BILLING FOR SERVICES NOT RENDERED
- BILLING FOR HIGHER LEVEL OF SERVICES THAN ACTUALLY PERFORMED
- BILLING FOR MORE SERVICES THAN ACTUALLY PERFORMED
- CHARGING HIGHER RATES FOR SERVICES TO MEDICAID THAN OTHERS
- CODING BILLINGS TO GET MORE REIMBURSEMENT

- PROVIDING AND BILLING FOR UNNECESSARY SERVICES
- MISREPRESENTING AN UNALLOWABLE SERVICE IN A MEDICAID BILLING
- FALSELY DIAGNOSING SO MEDICAID WILL PAY FOR MORE SERVICES

ALASKA DIVISION OF MEDICAL ASSISTANCE	HCFA News	ALASKA DEPARTMENT OF LAW

If you suspect Medicaid health care fraud or patient abuse, do your part to protect the integrity of the Medicaid program and the public resources that fund it! Contact the Medicaid Fraud Control Unit Hotline at 1-(907) 269-6279 and ask to speak to an investigator or simply leave a message. Our fax is 1-(907) 269-6202. Or call the Crimestoppers Hotline at 1-(907) 561-7867. You need not give your name and you may be eligible for a reward.

Alaska Medicaid Fraud Control Unit
Office of Special Prosecutions and Appeals
310 K Street, Suite 308
Anchorage, AK 99501

E-MAIL at medfraud@law.state.ak.us

Testimony
Before the Finance Committee
United States Senate

Improper Payments

Statement of
Michael F. Mangano
Acting Inspector General

April 25, 2001

Office of Inspector General
Department of Health and Human Services

Good morning Mr. Chairman. My name is Michael F. Mangano. I am the Acting Inspector General for the Department of Health and Human Services (HHS). It is my pleasure to be here today to give you an update on our work with regard to improper payments in Departmental programs.

Today, I will provide an overview of the types of payment errors revealed by our most recent Health Care Financing Administration (HCFA) audit. Over the past five years, the Office of the Inspector General (OIG) has undertaken audits of Medicare's fee-for-service claims to estimate the extent of payments that did not comply with Medicare laws and regulations. These payment errors, comprised of improper provider billings, make up the largest category of inappropriate payments in the Medicare program. These errors can include simple billing mistakes as well as fraudulent billings. We continue to believe that most health care providers do their best to provide high quality care and are honest in their dealings with Medicare. At the same time, we must be concerned about all errors, even those which are totally innocent. Our annual measurement of Medicare payment errors not only allows HCFA to focus on the areas where increased compliance is needed, but also enables HCFA to identify approaches to building a better Medicare program.

I will also describe instances of specific inappropriate payments made as a result of the complex, antiquated, and incompatible technology environment in which Departmental programs operate. These examples include Medicare and Medicaid payments made on behalf of deceased or incarcerated beneficiaries, as well as Temporary Assistance for Needy Families (TANF) payments made to fugitive felons. Taken together, these problems indicate systemic vulnerabilities which could lead to much more serious losses of funds if not remedied.

MEDICARE PAYMENT ERROR RATE

We recently released our report *Improper Fiscal Year 2000 Medicare Fee-for-Service Payments* (A-17-00-02000) in which we present the results of our review of Fiscal Year (FY) 2000 Medicare fee-for-service claims. Based on our statistical sample, we estimate that improper Medicare benefit payments made during FY 2000 totaled $11.9 billion, or about 6.8 percent of the $173.6 billion in processed fee-for-service payments reported by HCFA. It is important to note that this is an error rate estimate and not a fraud estimate. These improper payments could fall on a continuum anywhere from simple inadvertent mistakes to outright fraud and abuse.

When the sampled claims were submitted for payment to Medicare contractors, they contained no visible errors. We found that the contractors' claim processing controls were generally adequate for: (1) ensuring beneficiary and provider Medicare eligibility; (2) pricing claims based on information submitted; and (3) ensuring that the services as billed were allowable under Medicare rules and regulations. However, their controls were not effective in detecting the types of errors we found. Instead, reviews of patient records by medical professionals detected 92 percent of the improper payments. Our historical analysis of payment errors from FY 1996 through FY 2000 identified four major payment error categories: medically unnecessary services, unsupported services, coding errors, and noncovered services.

Medically unnecessary services, the largest error category this year, amounted to $5.1 billion in improper payments. This category covers situations in which the medical review staff found enough documentation in the medical records to make an informed decision that the medical services or products received were not medically necessary. The following is an example of services that were determined not medically necessary:

- A physician was paid $3,305 for 40 hypnotherapy sessions with an Alzheimer's patient. The medical records stated that the patient was neither attentive nor cooperative during the initial mental status exam. Since the patient could not participate in that exam, the medical reviewer determined that hypnotherapy treatment was not medically necessary, reasonable, or appropriate for a 95 year old Alzheimer's patient.

Unsupported services represented the largest error category in three of the last 5 years. In FY 2000, they accounted for an estimated $4.3 billion in improper payments. Such services include those where there is insufficient documentation to determine the patient's overall condition, diagnosis, and extent of services performed ($2.3 billion) or where there was no documentation to support the services provided ($2 billion). An example of unsupported services follows:

- A hospital was paid $722 for outpatient radiation therapy services. The medical records contained no documentation to support the provision of these services. After repeated unsuccessful attempts to obtain such documentation, the claim was denied.

Coding errors represented $1.7 billion in improper payments (the net of upcoding and downcoding errors). For most of the coding errors found, the medical reviewers determined that the documentation submitted by providers supported a lower reimbursement code. Physician and inpatient Prospective Payment System (PPS) claims accounted for over 90 percent of the coding errors over the 5 years reviewed. An example of incorrect coding includes:

- A hospital was paid $19,452 for providing a diagnostic related group service to a patient admitted with a chronic inflamation of the membrane lining the abdominal wall. The principal diagnosis code was shown as another infection. The medical reviewers concluded that the diagnosis code should have been related to an infection due to a dialysis catheter. As a result, $7,125 was denied.

Noncovered services and other errors consistently constituted the smallest error category. Noncovered services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. Such services include most routine physical examinations; eye and ear examinations to prescribe or to fit glasses or hearing aids; and, most routine foot care.

Since we developed the first error rate for FY 1996, HCFA has closely monitored Medicare payments and has instituted appropriate corrective actions. The HCFA has also worked with provider groups to clarify

reimbursement rules and to impress upon healthcare providers the importance of fully documenting services. Additional initiatives on the part of the Congress, HCFA, the Department of Justice, and the Office of Inspector General have focused resources on preventing, detecting, and eliminating fraud and abuse. All of these efforts, we believe, have contributed to reducing the improper payment rate by almost half -- from $23 billion, or about 14 percent of Medicare program expenditures, in FY 1996 to $11.9 billion, or about 6.8 percent of the $173.6 billion in Medicare payments, in FY 2000.

The decrease in improper payments has had a positive effect on Medicare's financial situation. From 1991 to 1996, the Congressional Budget Office (CBO) reported that Medicare's rate of inflation averaged 10.9 percent per year. In FY 1998, the rate of inflation for the Medicare fee-for-service program dropped to the lowest in the program's entire history (since 1965) -- 1.5 percent. Overall, CBO calculated the average Medicare inflation rate for FY 1997 to FY 2000 at 3.2 percent. CBO commented that: "Most of the decline can be explained by a strong effort to ensure compliance with payment rules." (The Budget and Economic Outlook: Fiscal Years 2002-2011, CBO, January 2001)

As of 1996, the Trustees of the Medicare Part A Trust Fund projected that the Trust Fund would be insolvent in 1999. However, over the past 5 years, the Trustees have extended their estimate of the financial life of the Trust Fund by 30 years, from 1999 until 2029. One of the primary contributing factors cited by the Trustees has been "the continuing efforts to combat fraud and abuse." (Status of the Social Security and Medicare Programs, Trustees Annual Report, March 1999). We believe that these positive economic findings with respect to the financial integrity of the Medicare program, which will positively impact on both taxpayers and beneficiaries, are due in large part to the fact that the vast majority of health care providers are engaged in submitting accurate claims to HCFA and providing high quality, medically necessary services.

INAPPROPRIATE MEDICARE AND MEDICAID PAYMENTS

Numerous OIG audits and investigations have revealed instances where antiquated and complex computer systems have resulted in inappropriate payments being made on behalf of Medicare beneficiaries and Medicaid recipients. Several recent OIG audits and inspections examined whether the Medicare or Medicaid programs were being billed for services which occurred after the date of a beneficiary's death and whether these programs were paying for such services. We have also recently completed work to identify inappropriate payments made on behalf of incarcerated Medicare beneficiaries.

Payments Made on Behalf of Deceased Beneficiaries

Medicare Services: In our inspection, *Medicare Payments for Services After Date of Death* (OEI-03-99-00200), we found that Medicare paid an estimated $20.6 million in 1997 for services that started after a beneficiary's date of death. These payments were made because of several system problems. Approximately $12.6 million was paid because Medicare had not yet received beneficiary date of death information from the Social Security Administration (SSA) Master Beneficiary Record at the time the claim was processed. For example, for one beneficiary who died in May 1997, HCFA did not receive the date of death information until October 1997. This delay allowed three months of rental payments for a nebulizer to be paid in June, July, and August 1997.

The remaining $8 million was paid for services where the beneficiary's date of death was in its system at the time the claim was processed and approved for payment, but HCFA's Common Working File system, the system used by fiscal intermediaries and carriers to process fee-for-services claims, did not prevent the claims from being paid. Over half of the $8 million was for durable medical equipment claims. For example, for one beneficiary who died in November 1997, HCFA received the date of death information in

that same month. However, in January 1998, HCFA paid claims on behalf of that beneficiary for durable medical equipment items with service dates in December of 1997.

We also found some payments for services where HCFA's Enrollment Database, which contains entitlement data for Medicare beneficiaries, and the Common Working File contained different dates of death. In one example, a beneficiary received four services relating to ambulance transport on May 12, 1997. Although data from the Enrollment Database indicated that the beneficiary died on May 9, 1997, the Common Working File contained a different date of death of May 13, 1997. In such examples, we found no indication of which file contained the accurate date of death and therefore do not know whether or not the claims were paid in error.

As a result of our findings, we recommended that HCFA require contractors to conduct annual post-payment reviews to identify and recover payments made for services after death; revise their Common Working File system edit to ensure that durable medical equipment payments are not made for deceased beneficiaries; and periodically reconcile date of death information between the Enrollment Database and Common Working Files. In January 2001, HCFA implemented the system change necessary to revise the Common Working File edits to prevent payment of durable medical equipment services billed after the beneficiary's date of death. HCFA has also recently issued instructions to Medicare contractors requiring them to conduct the necessary post-payment review activities to identify payments made on behalf of deceased beneficiaries. However, HCFA indicated that there is no way to systematically compare the Enrollment File and Common Working File to determine which date of death is accurate without a manual review; therefore, they will need to take into account contractor workload while implementing this recommendation.

Medicaid Services: In 1994, the OIG began an initiative to work more closely with State Auditors in reviewing the Medicaid program. Through this initiative, the OIG/State Audit Partnership Plan was developed to expand Medicaid program audits and allow State Auditors to apply methodologies we have successfully used in our Medicare audits. As an example, the State of Ohio's Office of the Auditor examined whether Medicaid was paying for services on behalf of deceased recipients (*Payments for Medicaid Services to Deceased Recipients*, A-05-00-00045). The audit determined that, during a period of almost 6 years, the Ohio Department of Human Services (ODHS) paid $82 million for services to Medicaid recipients after the recipients' date of death. This amount consisted of 115,000 payments to over 4,000 different providers for services provided to almost 27,000 apparently deceased recipients. The average time to discover and recover an overpayment was just over five months after the recipient's date of death. About 93 percent of the unrecovered payments were in four categories of service: skilled nursing facility (75 percent of the unrecovered payments), intermediate care facility (7 percent), pharmacy (6 percent), and durable medical equipment (5 percent).

Subsequent analysis by the Ohio Department of Human Services confirmed that information in the Medicaid recipient master file is not always accurate. Ohio auditors determined that almost 30 percent of 34,330 Medicaid recipients who died during 1997, according to the Ohio Department of Health's Vital Statistics file, did not have a date of death entered on the recipient master file (meaning that providers could still bill and be reimbursed for Medicaid services). Moreover, 4.6 percent of the 24,463 recipients who had a date of death on the recipient master file had a death date that differed from the Vital Statistics death date by more than one day.

The Office of the Auditor recommended that the Ohio Department of Human Services recover the outstanding amount when feasible and cost effective, make corrections to prevent additional overpayments from being made for deceased recipients, and seek legislative authority to develop and apply sanctions against providers who do not timely report a recipient's death or who bill for or retain unearned

reimbursements. The State has now recovered all of the overpayments identified in this audit.

Payments Made on Behalf of Incarcerated Beneficiaries

Medicare Payments: We are currently conducting a series of audits on Medicare payments provided on behalf of beneficiaries who were in the custody of Federal, State, or local law enforcement agencies at the time services were provided. Under current Federal law and regulations, payments for such services are generally unallowable. The State or other government component operating the prison is presumed to be responsible for the medical needs of its prisoners.

The rules for determining whether Medicare will pay are complex and administratively cumbersome. Under sections 1862(a)(2) and (3) of the Social Security Act, the Medicare program will not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. Regulations at 42 Code of Federal Regulations (CFR) 411.4(b)(1) and (2) state the Medicare program may not pay for services provided to beneficiaries who are in the custody of penal authorities *unless* the authorities require that all individuals pay for such services and enforce that requirement by pursuing collection for repayment. The State or other Government component operating the prison is presumed to be responsible for the medical needs of its prisoners. According to HCFA's procedural manuals for its contractors, this is a rebuttable presumption that may be overcome only at the initiative of the Government entity. The entity must establish that it enforces the requirement to pay by billing and seeking collection from all individuals in custody, whether insured or uninsured, with the same vigor it pursues the collection of other debts. It must pursue collection, including the filing of lawsuits to obtain liens against an individual's assets outside the prison and income from non-prison sources.

The Social Security Administration, on the other hand, has a simple rule regarding payments to prisoners. A person's Social Security benefits are suspended if he/she is incarcerated for a month or more.

In our report *Review of Medicare Payments for Services Provided to Incarcerated Beneficiaries*(A-04-00-05568), we found that the Medicare program is vulnerable to improper payments for services provided to incarcerated beneficiaries. According to data provided to us by the SSA, there were 38,600 Social Security beneficiaries entitled to Medicare who were incarcerated as of July 2000. We used this data to determine whether Medicare claims have been paid on behalf of any of these beneficiaries during Calendar Years 1997 through 1999. To date, we have identified $32 million in Medicare fee-for-service payments on behalf of 7,438 incarcerated beneficiaries during Calendar Years 1997 through 1999. We also found that some incarcerated beneficiaries were enrolled in Medicare managed care plans during their incarceration.

We are in the process of determining the amount of Medicare payments made on behalf of incarcerated beneficiaries which may be improper. We are concerned, however, because, in general, no Medicare payments should be made for services rendered to prisoners unless certain strict conditions are met by the government component (i.e., Federal, State, or local) which operates the prison. We are now determining if the government components operating prisons meet the strict conditions for Medicare payments to be allowable. The development underway includes researching State laws to determine if prisoners are required to repay their medical expenses. If such a law exists, the government entity must then prove that it enforces this requirement. Examples we are investigating include:

- Medicare paid $25,423 for services to an inmate charged with killing his mother.
- In another State, Medicare paid a facility $97,283 on behalf of nine inmates who were incarcerated

for various crimes including arson, attempted assault, breaking and entering, and burglary.

The HCFA does not identify Medicare beneficiaries who are in prison, making it virtually impossible for Medicare contractors to prevent improper payments. To minimize this risk, we recommend that HCFA formalize its efforts to obtain additional data from SSA in the daily transmission of enrollment data, which identifies incarcerated beneficiaries, and design and implement system controls in the Enrollment Database and Common Working File to alert contractors when a Medicare claim is submitted for services for an incarcerated beneficiary. We recognize that implementing the routine transfer of necessary information from SSA and making the necessary system enhancements will take time. In the interim, we recommend that HCFA periodically obtain a file on incarcerated beneficiaries for post-payment reviews from SSA similar to the file we obtained during our review.

Medicaid Payments for Inmates of Public Institutions: We are in the process of reviewing Medicaid payments for services provided to inmates of public institutions. Our involvement began with information received from the Louisiana Office of Legislative Auditor. The Auditor was concerned that the Louisiana Department of Health and Hospitals was including the cost of services provided to inmates in determining its Medicaid net uncompensated care costs for disproportionate share hospital payments made to State operated hospitals. The Louisiana Office of Legislative Auditor had interpreted that neither disproportionate share hospital payments nor Federal financial participation payments are allowable for services provided to inmates of public institutions, specifically prisoners in a penal institution.

Based on audit work to date, we found that HCFA has not established a definitive coverage policy that is consistent with the intent of the governing statute that generally prohibits Federal financial participation payments for inmates of public institutions. The current Medicaid coverage policy contains a provision allowing for Federal financial participation payments for services provided to inmates of public institutions when the inmate is an inpatient in a medical institution. We believe this provision is contrary to the intent of the Medicaid statute. We believe the intent was to ensure that Medicaid funds are not used to finance care that has traditionally been the responsibility of the State and local governments. Also, HCFA has no specific guidance on the availability of disproportionate share hospital payments to hospitals for uncompensated care provided to inmates. We expect to complete our review this summer.

Other OIG Work

In addition to the improper payments described above, we have also done extensive work through audits and inspections to identify duplicate payments made in the Medicare and Medicaid programs. For example, we have examined if Medicare fee-for-service payments were made on behalf of beneficiaries enrolled in Medicare managed care plans. This work involves identification of specific overpayments, as well as identification of the system vulnerabilities, which have allowed such payments to occur. Additionally, we have work underway to identify whether Medicare payments are being made on behalf of deported aliens. Preliminary results indicate that such payments are being made.

TANF BENEFICIARIES WHO ARE FUGITIVE FELONS

The problems of ensuring the appropriateness of payments in a complex program environment are not limited to Medicare and Medicaid. This is illustrated in the following account of income assistance payments which we discovered were being made to fugitive felons.

The U.S. Department of Health and Human Services, Administration for Children and Families, Office of Family Assistance, oversees the Temporary Assistance for Needy Families (TANF) program. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 increased the flexibility of the States in

operating the TANF program. The Act allows States to provide assistance so that children may be cared for in their own home; promote job preparation, work and marriage; prevent and reduce the incidence of out-of-wedlock pregnancies; and encourage the formation and maintenance of two parent families. Section 408 of the Act identifies prohibitions and other requirements for the TANF program including a requirement that States not use any part of the grant to provide assistance to any individual who is fleeing to avoid prosecution, custody or confinement after conviction for a felony, as defined under the laws of the place from which the individual flees.

Project Cornhusker is an initiative of our Office to reduce fraudulent TANF payments in the metropolitan area of Omaha, Nebraska. This is the first such joint project we have undertaken with local law enforcement to identify individuals with felony fugitive warrants who are recipients of federal assistance in violation of the Welfare Reform Act of 1996. As part of this effort, the active felony warrants for Douglas County, including Omaha, were matched with the active TANF beneficiary files maintained by the Nebraska Department of Health and Human Services. This computer match produced 64 wanted individuals.

On March 21 and 22, 2001, OIG agents assisted the Douglas County Sheriff's Office and the Omaha Police Department in the arrest of 24 individuals wanted for felonies committed in their jurisdiction. These arrests were made possible because of the cooperation of the Nebraska Department of Health and Human Services, local police and OIG. Twelve additional arrests were made without OIG assistance.

The majority of the arrested subjects were wanted for non-violent crimes, such as felony theft, bad checks, burglary and crimes against property. Three subjects were arrested on warrants for assault, one with a deadly weapon. Specific information concerning some of the arrests are identified below:

- A subject was arrested and found to have three Social Security cards in another individual's name. He also had a birth certificate in that subject's name with two passport photos of himself. This information was sent to the Social Security Administration, Office of Inspector General, Office of Investigations.

- An individual was arrested and found to be in possession of black tar heroin.

- Upon request, an individual present during the arrest of a TANF recipient produced identification. A check of law enforcement records showed that the individual was currently wanted in Louisiana for failure to pay court ordered child support. He was subsequently arrested on that charge.

Because of the success of this effort, we are considering replicating this type of joint initiative in the future.

MODERNIZING DEPARTMENT INFRASTRUCTURE

The Secretary of the Department of Health and Human Services has named reforming the management of the Department's operations as one of his top priorities. Specific priorities include improving the management of HCFA and making appropriate investments in Department management and infrastructure.

Improve the Management of the Health Care Financing Administration:. The demands on HCFA have grown dramatically in the last few years. On the one hand, the agency needs adequate resources to successfully administer the Medicare, Medicaid, and State Children's Health Insurance programs; on the other hand, it must be recognized that patients, providers and States have legitimate complaints about the scope and complexity of the regulations and paperwork that govern these programs. The Department has

therefore begun a thorough examination of HCFA's missions, its competing demands, and its resources.

Invest in Department Management and Infrastructure: The Secretary has noted that one of the major challenges in a large, decentralized Department such as HHS is finding ways to bring together diverse activities and to develop coordinated systems for managing its programs.

In the area of financial management, the Secretary has proposed an additional $50 million investment in a unified financial accounting system. The OIG has found major problems with the Department's current system structure, which involves separate accounting systems operated by multiple agencies. Department plans to replace these antiquated systems with one or two unified financial management systems should help to increase standardization, reduce security risks, and allow HHS to produce timely and reliable financial information needed for management decision-making, and provide accountability to the external customers.

In the information technology arena, the Secretary has proposed $30 million to improve information technology systems through investments in the Information Technology, Security and Innovation Fund. As seen in my examples today, these systems are highly antiquated, incompatible, and vulnerable to exploitation. The Secretary has proposed that funds would be used to implement an Enterprise Infrastructure Management approach across the Department that would minimize vulnerabilities while maximizing cost savings and the ability to share information

We fully support these proposals and continue to promote adequate departmental resources to ensure efficient and effective claims processing, policy development and regulation, and quality assurance. We remain concerned that the currently inadequate internal controls leave the Medicare program vulnerable to potential loss of funds, misstated financial statements, disclosure of sensitive information, and disruption of critical claim processing. Further, out of-date and overly complex computer systems are not adequately preventing inappropriate program payments.

Over the past 5 years, the Trustees have extended their estimate of the financial life of the Trust Fund by 30 years, from 1999 until 2029. The expanded solvency projection provides a window of opportunity to develop a departmental technology infrastructure for the 21st century. Over time, such an investment will lead to further savings -- by reducing payment errors of all types and by making program operations more efficient.

This concludes my testimony. I would be happy to answer any questions.

ALASKA STATE LEGISLATURE
SENATE HEALTH, EDUCATION & SOCIAL SERVICES COMMITTEE
Health Care and Welfare Subcommittee Hearing
Mat-Su Legislative Information Office
November 8, 2001
9:00 a.m.

MEMBERS PRESENT

Senator Lyda Green, Chair
Senator Bettye Davis

See pp. 37-49
Testimony of S. Branchflower

MEMBERS ABSENT

Senator Jerry Ward

OTHER LEGISLATORS PRESENT

Senator Robin Taylor
Representative Fred Dyson
Representative Sharon Cissna

SUBCOMMITTEE CALENDAR

The future of health care costs and welfare reform in Alaska.

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ACTION NARRATIVE

TAPE 01-47, SIDE A
Number 001

CHAIRWOMAN LYDA GREEN called the Senate Health, Education & Social Services Subcommittee meeting to order at 9:00 a.m. Present were Senators Davis, Taylor, and Chairwoman Green. Chairwoman Green announced that the subcommittee is meeting to consider in what direction Alaska should go regarding Medicaid coverage and possible legislation. She noted that priorities regarding services to be covered under Medicaid have changed since the events of September 11. She pointed out that one item on the agenda today is rural health care. When looking through the budget last year, Senate Finance Committee members noticed there would be a budget item to provide a service at the state level that other groups were providing. They tried to find as many funding sources coming into rural health care sites to get them aligned and not duplicative. She asked a representative

from the Denali Commission to present to the committee.

MR. KRAG JOHNSON, the Alaska Legislature's staff representative on the Denali Commission, introduced Joel Neimeyer, the Commission's rural health expert. He distributed an update on Denali Commission activities to committee members and the public. The update contains a generalized list of projects the Denali Commission has been working on and funding levels for those projects. He noted Mr. Neimeyer came to the Denali Commission after 17 years with the Indian Health Service and has worked with the Alaska Native Tribal Health Consortium.

MR. JOEL NEIMEYER, program manager for the Health Facilities Program, informed the committee that since September of 1999, he has been working with the Denali Commission on infrastructure, originally with rural energy projects. When the health care program started developing, it was consuming so much time he became the Health Facilities Program Manager.

CHAIRWOMAN GREEN asked Mr. Neimeyer if he spent all 17 years with the Indian Health Service (IHS) in rural Alaska.

MR. NEIMEYER said all but three years, which he spent in Western Washington. He noted that he would address four bullets issues, one being the role of the state and federal government, the Denali Commission and Native non-profit health corporations in rural health care.

First, the Denali Commission was created by federal legislation in 1998 to look at training, economic development, and infrastructure development. The legislation allows the Commission to work with many different partners in many different areas. The legislation established an administrative cap at 5 percent, which does not allow the Commission to run its own program. That cap forces the Commission to find partners who are already doing the work and have the same mission.

CHAIRWOMAN GREEN asked who a typical partner would be.

MR. NEIMEYER said that varies by interest. In the Denali Commission's health care program, its two primary partners are the State of Alaska and the Alaska Native Tribal Health Consortium. In the Commission's rural energy program, it primarily partners with the Alaska Energy Authority and the Alaska Village Electric Authority. He said in 1999, Congress passed legislation [P.L. 105-277] that amended the Denali Commission act and focuses it particularly on health care programs. It gives the Commission the authority to plan, design

and construct hospitals, mental health facilities, elder care, childcare, and primary care facilities.

MR. NEIMEYER said one of the first things the Denali Commission did when that legislation passed was to put together a steering committee to do a needs assessment of primary care. Its original partners were the Alaska Native Tribal Health Consortium and Indian Health Service. The goal of the needs assessment was to quantify what the primary care needs are across the state. They chose to look at 288 communities without an in-patient care facility at the hospital and more than 20 year-round residents. The study results determined a need for $253 million to address primary care facilities statewide.

CHAIRWOMAN GREEN asked him to describe some typical communities identified in the study.

MR. NEIMEYER stated that some communities have no health clinics, but many have very small clinics. The Steering Committee found that many clinics were built based upon available funds from HUD community development block grant funds and State of Alaska community development block grant funds. The Steering Committee found the small facilities restrict the amount of health care programs offered in the community so that health care access is restricted by capital funds, not by health program services that can be offered. The Steering Committee decided to change its perspective and requirement of a community for primary care services based upon geographic isolation and population size.

When the Steering Committee put together the needs assessment, it found that it could not compare the health care needs of large and small communities and felt it was unfair to make communities compete with one another. The outcome was to develop three funding processes as demonstrated in the following chart. Large clinics work for communities with a population larger than 750 or communities that serve as a sub-regional clinic or a multi-community clinic. Small clinics work in communities where that clinic is a "stand alone" clinic for that community. The third funding process is for the repair or renovation of existing clinics.

MR. NEIMEYER pointed out that none of the Denali Commission's projects to date have required a Certificate of Need but that will be incorporated into the program in case one is needed.

Where the Commission goes with funding these projects will be guided by the Health Care Steering Committee. That Committee was organized in early 2000 and is made up of four agencies: the

Denali Commission, the IHS, the Alaska Native Tribal Health Consortium and the State of Alaska. Over time, more partners were added: the Alaska Primary Care Association, the Alaska Mental Health Trust, the University of Alaska and the Alaska Native Health Board. The Steering Committee took on the responsibility for developing the Request for Proposals process for capital funding of health care facilities. Recently, the Committee was restructured so that it takes a more policy advisory role and less of a work-group function. Karen Perdue will represent the University of Alaska.

CHAIRWOMAN GREEN asked for a description of the Alaska Primary Care Association.

MR. NEIMEYER explained that it is a non-profit member organization made up of about 40 or 50 members, located in Anchorage.

MR. NEIMEYER informed the subcommittee that Karen Pearson is the chair of the Steering Committee.

CHAIRWOMAN GREEN noted the presence of Senator Taylor.

MS. KAREN PEARSON informed the committee that the primary role of the Alaska Primary Care Association (APCA) is to support its membership, which is made up predominantly of the rural community health centers and the two larger ones in Fairbanks and Anchorage. The APCA helps them to do joint purchasing and to help with board development.

CHAIRWOMAN GREEN asked if the APCA has any members from the private sector.

MR. NEIMEYER said several decisions were made about who would have a seat on the Steering Committee, one being that each seat would be filled by a representative from a statewide organization. The concern was that if a regional organization was selected, other regional organizations would fear that funds would be steered toward that region. The Steering Committee gives advice to the seven commissioners on the Denali Commission about what the Commission should be doing in the health care arena. The Steering Committee gets its advice from the seven member organizations.

CHAIRWOMAN GREEN asked how a conflict of interest is avoided if the Steering Committee is funding organizations that belong to it.

MS. PEARSON said that is a question the Steering Committee has grappled with and was partly responsible for the restructuring of the board. She pointed out the State of Alaska, University of Alaska and Native Health Board will not receive funding and all members work very hard to be cognizant of that issue.

MR. NEIMEYER said once decisions are made, it has to find partners because it has a 5 percent limit on administrative costs.

CHAIRWOMAN GREEN asked for an explanation of the administrative costs.

MR. NEIMEYER said administrative costs include utilities, staff, and whatever else it takes to run an operation. To put projects on the ground in rural Alaska takes more than five percent, so the Steering Committee finds partners to help. In the health care arena, the State (the Department of Health and Social Services - DHSS) is the pre-award partner. Ms. Pearson and her staff assist the Steering Committee in getting the RFPs out and in putting together evaluation teams to review the applications. Once the decision has been made about what projects should be funded, the Steering Committee works with its post-award partner, the Alaska Native Tribal Health Consortium (ANTHC), on small clinic projects and repair projects. The ANTHC represents the Steering Committee's interests in the individual communities. The Steering Committee found that many of the proposals for large clinics are from large organizations.

CHAIRWOMAN GREEN asked for an example of a large organization.

MR. NEIMEYER replied that the Steering Committee funded a large clinic through the Yukon Kuskokwim Corporation (YKC). YKC has a health facility manager, professional engineer, and several staff who run the project. The Steering Committee funded SEARHC projects in Angoon and Haines, who also have health facilities managers and contracting departments, so they are capable of putting the projects on the ground. The Steering Committee entered into agreements with those organizations for the large clinic funding. Routinely, small clinics are built in smaller communities.

CHAIRWOMAN GREEN asked if Mr. Neimeyer is referring to the large clinic in Kotzebue.

MR. NEIMEYER said he was not and that, in general, a small clinic is about 1,500 to 2,500 square feet. Large clinics are 2,500 to 10,000 square feet.

CHAIRWOMAN GREEN asked if, in general, a clinic is a 24-hour, overnight stay facility.

MR. NEIMEYER said they are not. He explained that ANTHC represents the regional health corporations, such as YKC and the Tanana Chiefs Conference (TCC). When the Steering Committee selected ANTHC, it required ANTHC to agree to represent all communities in the state that the Denali Commission funds.

CHAIRWOMAN GREEN asked if ANTHC was pre-ordained to participate from the beginning.

MR. NEIMEYER said it was not. The Steering Committee looked into what different organizations could be program partners and everything pointed to ANTHC as being the organization most ready to take on this work. ANTHC agreed to serve all communities that the Steering Committee recommends projects in.

CHAIRWOMAN GREEN asked if they are audited regularly.

MR. NEIMEYER said they are; they fall under the federal single audit act so they are monitored regularly. He said this past fiscal year, the Steering Committee put 12 projects on a fast-track process; ANTHC represented the Steering Committee on those projects. Mr. Neimeyer told the committee that if the Denali Commission decides to expand its program to include health facilities other than primary care facilities, such as hospitals, it will have to explore the question of who to partner with.

CHAIRWOMAN GREEN asked if totally different standards would apply to a hospital program.

MS. PEARSON said that is correct and that is the reason the Denali Commission has not gone into that arena. The Denali Commission is only looking at communities that do not have a hospital. Primary care includes, in addition to physical care, mental health and substance abuse services. With the maturation of this process, communities are thinking about their total primary care needs.

CHAIRWOMAN GREEN asked if the Haines clinic, a one-person outfit, is an example of a primary care health care facility. She pointed out that managing a one-person clinic is a very stressful job.

MS. PEARSON said the Haines clinic is an example of a primary care facility. The Steering Committee is approaching the design of these facilities in a systematic way that focuses on physical

care first, but will build a one-person mental health facility so that residents will have total access to primary care.

CHAIRWOMAN GREEN asked Ms. Pearson if her participation is outside of her job at the Division of Public Health so that she wears two hats.

MS. PEARSON said that is correct.

CHAIRWOMAN GREEN asked Ms. Pearson how she considers both perspectives when she works on the division's budget.

MS. PEARSON said she believes it was a wise decision on the part of the Denali Commission to have the director of the Division of Public Health chair this group because to have the facility development work happen separate from the question of how to pay for services would not have worked well. All participants do the planning for the facilities and the services together in a coordinated fashion.

CHAIRWOMAN GREEN stated that she would like to have a follow-up session, perhaps in April, to update the committee on the impact of the Steering Committee's work on the budget.

ME. NEIMEYER continued his presentation. For projects managed by ANTHC, communities have six funding-construction options. A community, regional health corporation or ANTHC can manage a project using a force account or by contract. If a community wants to take the lead, it can, if it can demonstrate that it has the ability to do so. The Steering Committee has found that when it partners with ANHTC, it receives quarterly status reports, it manages the funds, and it has engineers in the field. In fiscal year 2000, the Steering Committee put $1,000,000 into four demonstration projects and learned to have the construction plans in hand and to do site control. Those lessons were applied in fiscal year 2001, when the Steering Committee had $20 million to spend. In fiscal year 2002, the Steering Committee has committed $12.5 million for small clinics. It plans to have $20 to $30 million so it is developing mechanisms to select projects.

TAPE 01-47, SIDE B

MR. NEIMEYER explained that the Steering Committee had to devise a way to translate services to square footage. Emergency Medical Services categories are used; the first of three being an isolated community, which includes most of the 288 communities, and the two highway communities. Based upon isolation and population, the Steering Committee decided how large a facility

should be. For example, a community relatively close to a large urban center with a hospital and other health care service was deemed to not need as much space as a community far from an urban center. The Steering Committee designated clinic sizes as small, medium and large within the small clinic program. A small clinic is 1500 square feet, a medium is 2000 square feet, and a large clinic is 2500 square feet. The Steering Committee found, when developing these guidelines, access to inpatient services became a much more important factor in the health care needs of larger communities. For that reason, the Steering Committee created two categories so that those communities would have to compete individually and demonstrate their service delivery needs.

CHAIRWOMAN GREEN asked Ms. Pearson if any of the Division of Public Health's budget is used for the administrative costs of the Denali Commission.

MS. PEARSON said it does not. The Steering Committee worked out an arrangement whereby it has about $300,000 that it can tap into as needed for support activities. It has worked very hard to dovetail this program with programs already in place, which is why the Denali Commission asked the division to be the pre-award partner. The division administers a lot of grants every year and has a process established that can easily be duplicated. Ms. Pearson noted that during the past year, the Steering Committee worked very hard, with support from Senator Stevens' office, to access federal community health money (Section 330 money). While the Steering Committee was successful in partnering with certain clinics to get money directly to communities, it was also successful in persuading the federal Health Resource Services Administration (HRSA) that the State of Alaska needs an ongoing stream of funds to ensure that communities get the necessary support to compete for Denali Commission dollars or for other federal dollars. The Steering Committee received $250,000 for that purpose. That will support the additional work it takes to support the Denali Commission without using any state funds.

SENATOR TAYLOR referred to the Denali Commission's needs assessment, which projects a need for $253 million, and asked if that amount will provide a full clinic in every community in the state.

MR. NEIMEYER said that amount will provide a full clinic in 288 communities. He pointed out that communities with fewer than 20 year-round residents and communities with hospitals are not on the Commission's "radar screen."

SENATOR TAYLOR asked if communities are expected to participate

in the needs assessment.

MR. NEIMEYER said there is a required cost share match in legislation of 25 or 50 percent, depending on the economic status of the community and the Steering Committee has found that to be a barrier to getting communities funded.

There was no further testimony from, or questions for, Mr. Neimeyer.

Number 958

MS. CYNTHIA NAVARRETTE, President and CEO of the Alaska Native Health Board (ANHB), stated that Sally Smith, the ANHB Chair, was unable to present to the committee today because of a schedule conflict. She clarified that the ANTHC is a member organization of ANHB, which is a privately owned, non-profit organization. It advocates on behalf of health organizations throughout the state of Alaska. ANHB was established in 1968 with the sole purpose of promoting the spiritual, physical, mental, social and cultural well-being and pride of Alaska Native people. The Board of Directors include Alaska Native regional and village health providers from across the state. In most cases, these organizations are the only health care providers in the communities and, in fact, they not only serve Native people but they serve all community members. She informed the committee she would present her testimony in four parts: an overview of the Alaska Native health system; an overview of the funding providing to operate the programs, functions, activities and services; an overview of Medicaid; and the effects of the IHS beneficiaries in the use of the Medicaid program.

Overview of The Alaska Native Statewide Health Care Delivery System

The heart of the Alaska Native Health System is the 468 Community Health Aides working in 178 village clinics throughout rural Alaska. The IHS beneficiaries in remote villages do not have daily access to physician care. They rely on the medical attention of the Health Aide.

There are six regional hospitals operated by the following Native regional organizations: Maniilaq, Inc. located in Kotzebue, Yukon-Kuskokwim Health Corporation located in Bethel, Norton Sound Health Corporation located in Nome, Bristol Bay Area Health Corporation located in Dillingham, Arctic Slope Native Association located in Barrow, and Southeast Alaska Regional Health Consortium located in Sitka.

The Alaska Native Health Care Delivery System consists of both consortiums and individually operated service units. A typical consortium infrastructure includes village clinics, possibly several sub-regional clinics, and a regional hospital. The rural health organizations typically serve areas as sole community providers. They may also serve the entire population, regardless of race.

The Alaska Native Medical Center (ANMC) is located in Anchorage and provides essential tertiary care, acute care and specific statewide health services for all Indian Health Service beneficiaries. The Alaska Native Tribal Health Consortium and Southcentral Foundation jointly manage the facilities that provide the full continuum of care within the Alaska Native Health Campus.

The Alaska Native Health System reflects levels of care available within the village, the regional hospitals, and the Alaska Native Medical Center (ANMC), located in Anchorage. The Medivac is essential to receive the next step up of care from the village to the regional hospital. If the case is deemed serious enough, a Medivac can be directed from the village straight to ANMC. There are Medivac call-outs from regional hospitals to ANMC, and also from ANMC to more specialized hospitals in the lower-48.

Overview of Funding

With the construction of the new Alaska Native Medical Center and the Primary Care Center, there is a perception that Alaska Native Health Services are amply funded. The reality is that the system is significantly under-funded. Indian people have long experienced disproportionately low health status and a large gap in health care resources compared to other Americans. Recently, Congress requested a health status and resource deficiency report for each Indian tribe or service unit. The IHS charged a Level of Need Funded (LNF) Workgroup to develop the necessary methodology. This report, published April 2001, states that Alaska is only funded at 61% of the total need compared to the Federal Employee Health Benefits Package. It is important to know that the Medicaid reimbursement funding is included in this percentage.

Overview of Medicaid

The Medicaid Program is not out of control. It is a large cost in every state, second only to public schools. To save the Alaska Legislature money by reducing the Medicaid Program would actively harm people receiving care - either by eliminating services for adults, or cutting reimbursement to providers, which will reduce access. Medicaid provides insurance to individuals and families that have no other access to health care services. Reducing the program would be a huge detriment to the health of Alaskan

citizens.

Additionally, there is the economic impact that would be imposed on private health care providers to consider. Seventeen percent of the employees within the private sector are funded due to the Medicaid Program. Realistically, Medicaid within the State of Alaska is not a comparatively generous program. Other states in our nation provide more services and that should be the direction in which the Alaska Legislature heads as well.

The Effects of IHS Beneficiaries' Use of the Medicaid Program

IHS beneficiaries are a large user of the Medicaid Program. However, the fiscal reality this imposes on the Medicaid Program is not what one would think. The State of Alaska receives 100% reimbursement from the federal government for IHS beneficiaries that utilize Medicaid. This results in broader user access to a non-IHS beneficiary population. Additionally, the IHS beneficiary who utilizes the Medicaid Program actually has a positive impact on our State's economy. The federally reimbursed dollars create jobs in the private health care sector that may not be otherwise available.

The Alaska Native Health Care Delivery System encourages the Alaska State Legislature not to cut the Medicaid Program and lower the wellness of Alaskans for the benefit of fiscal conservation.

MS. SANDRA MIRONOV, health administrator for the Yukon Kuskokwim Health Corporation, made the following comments. Last spring, the Legislature had some questions about a budget request unit and how the money was used. A budget request unit is direct funding from the State of Alaska to different organizations across the state. It was established about 20 years ago to develop services in rural areas to provide better access to Alaskans that had no services. She noted that she distributed to members an overview of the Yukon Kuskokwim Health Corporation's (YKHC) use of the budget request unit and testimony from consumers in the region, prepared for the Legislature last April.

She provided the following highlights of the handouts. The budget request unit currently funds about one-third of the services of all mental health and substance abuse services in the region provided by YKHC. It also funds a significant portion of our community health services and the health aide program. It is the core of YKHC's services. Page 2 contains a graph showing how much of the actual services are covered by Medicaid that are provided in the region. The YKHC's concerns about the budget request unit are that if this funding was cut from the state budget, YKHC would be put at a very unfair disadvantage in a

rural community. YKHC does not have the capacity to write competitive grants in the rural communities that are often available to people in urban areas. The population in rural villages does not provide the skills necessary. If services are lost in rural communities, other communities would have to provide those services. YKHC is concerned that people might not seek services if they are not available until they get into a crisis situation, at which time they would have to be transported several hundred miles from home to get the necessary services. In addition, those people will have no follow-up services when they return home.

CHAIRWOMAN GREEN informed participants that today's hearing is not a budget hearing.

MS. MIRONOV said she understood but that the budget request unit is a very important income stream to YKHC and she wanted to get the information on the table for the committee's consideration throughout its deliberations on Medicaid.

CHAIRWOMAN GREEN asked Ms. Mironov if she is referring to the non-competitive grants.

MS. MIRONOV's answer was indiscernible.

CHAIRWOMAN GREEN noted that when the non-competitive grant process began, outline units were not billing or collecting all reimbursements or co-payments. That circumstance no longer exists. The Legislature is trying to figure out what to do with those facilities that are not built [billed], those without insurance, those without co-pay, yet have the same responsibilities of YKHC. Many of the larger facilities have the ability to bill Medicaid. The Legislature needs to decide how to use that pocket of money to serve those people who have no ability to get reimbursed. She pointed out the competitive grant process would still be available for more sophisticated organizations.

MS. MIRONOV concluded by saying there is still a significant population in rural Alaska that is not covered by Medicaid. The budget request unit funding stream helps those people access services in rural Alaska. It is very important as a supplement to the Medicaid program for rural Alaskans.

MR. DAN WINKELMAN, legal counsel to the YKHC, gave the following testimony.

Good afternoon Chair and Subcommittee members. My name

is Dan Winkelman, I am Legal Counsel for the Yukon-Kuskokwim Health Corporation located in Bethel. Thank you for this opportunity to participate at this Subcommittee meeting, to discuss the future of our State's health care and welfare.

YKHC is comprised of 58 federally recognized tribes operating pursuant to a compact with the federal government under the Indian Self-Determination Education and Assistance Act. We operate the only hospital in Bethel as well as 49 village-based clinics staffed with community health aide practitioners and 3 sub-regional clinics staffed with community health aide practitioners, registered nurses and mid-level practitioners.

YKHC urges this Subcommittee, when considering Medicaid cost-containment measures for the next fiscal year, to understand that under the Indian Health Care Improvement Act, the Federal government subsidizes 100% of the cost of providing medical services to Medicaid-eligible Alaska Native patients through Alaska Native tribe or tribal health organization facilities. Alaska's Federal Match Percentage, otherwise known as the Federal Medical Assistance Percentage or "FMAP", is 100% for health care services provided to Medicaid-eligible Alaska Native patients. Indeed, when Congress enacted this law, the U.S. Senate Select Committee on Indian Affairs stated in its Senate Report, and I quote:

> Thus, the Federal Government would pay for 100% of the reimbursements to tribally-owned health facilities for services provided to Medicaid-eligible Indian patients. *This, in turn, would reduce the states' current share of Medicaid expenditures to 0% for these same facilities.* As a result, Native Americans will have better access to health care services and will be able to more fully utilize third party resources to which they are entitled.

Therefore, 100% of Medicaid costs for Alaska Native patients is 100% federal pass-through monies resulting in a State Medicaid expenditure of 0%. Accordingly, any reduction in Medicaid rates proposed by this Subcommittee would be a reduction of federal, not state monies for Medicaid eligible Alaska Native patients resulting in a decrease of health care services to Alaska Natives and contrary to Congress' intent. For

the foregoing reasons, YKHC strongly urges this subcommittee to *not* reduce the state's Medicaid Program.

Lastly, I would like to invite the Subcommittee to personally tour YKHC and meet with your rural constituents *before* the Subcommittee proposes health care legislation that would negatively [affect] rural Alaska.

Thank you.

CHAIRWOMAN GREEN announced that the committee would hear from a representative from Senator Murkowski's office.

MR. JOEL GILBERTSON, legislative director for U.S. Senator Frank Murkowski, stated that today's meeting could not be more timely because the Senate Finance Committee will be doing a mark-up of the economic stimulus package as put forth by Senator Baucus. He did not expect the economic stimulus package to have too much to do with state health care and welfare programs, but right now the committee is debating a bill that will provide $75 to $80 billion, to be paired up with $20 billion of direct spending from floor amendments. Of that, provisions will affect states that administer Medicaid programs, unemployment insurance, and formula adjustments for the FMAR program. Those provisions were unexpected and may have an uphill fight once the bill reaches the Senate floor.

MR. GILBERTSON said when he first prepared his remarks to the committee, he focused on bills that have been pending at the federal level and the prospects for any true changes to some of the formula-driven, state administered health and welfare programs. That focus has changed in the last week because of the adjustment to what will be included in Senator Baucus's economic stimulus package. Originally, he thought there would be very few changes made at the federal level. A number of proposals have been brought forth to address issues with federal [indisc.] rates, and issues of what Medicaid expansions will be made optional for states, additional services, and modernization of the CMS infrastructure in Washington that replaced HCRA. Those issues were considered to be in a low priority category at the beginning of this year on the federal level. However, the events of September 11 have presented new priorities to Congress: aviation security; the economic stimulus package; a bio-terrorism bill; a few measures to fight against terrorism; and increased appropriations for the defense industry and the military. That put a lot of the health and welfare programs on a back burner and has created a lot of uncertainty as to what direction will be taken within the committee of jurisdiction on the Senate side and the Finance Committee under the new chairman, Senator Baucus. He

pointed out that two days ago, Senator Baucus included the following provisions:

- temporarily extend and broaden unemployment insurance benefits,
- create a new federal subsidy of 75 percent for COBRA continuation coverage,
- give new authority to states to expand the Medicaid program to cover displaced workers and their families,
- enhance the CHIP match rate for states,
- give states the option to use Medicaid funds at the CHIP match rate to subsidize the remainder of COBRA premiums for low-income individuals,
- adjust the federal medical assistance percentage (FMAP) for all states - it was originally drafted to hold harmless all states scheduled for an FMAP reduction in the coming year,
- provide a one point bonus for all states, and
- classify all states with an undefined level in the increase of unemployment debts an additional one point bonus. Last night that was expanded to a 1½ percent bonus for all states and another 1 1/2 percent bonus for states deemed to have an enhanced amount of unemployment as the result of a compromise with Senator Bingaman.

MR. GILBERTSON said everything has changed in the last 24 hours so he will answer questions to the best of his ability. In addition, the bill is undergoing a mark-up in the Senate Finance Committee right now. He informed the committee that over 140 amendments have been filed and Senator Murkowski has not yet expressed how he will vote on some of these issues.

MR. GILBERTSON said that Senator Murkowski is very sensitive to the unfair treatment that the current Medicare formula has created for rural states, particularly Alaska. The FMAP formula itself, from Senator Murkowski's position, was poorly drafted and has not been adjusted to reflect new data that shows that looking solely at per capita income and ignoring the cost of providing services is an inaccurate way to determine how states should be reimbursed for providing health care services. Senator Murkowski is not supportive of the proposal put forth by Senator Bingaman that was incorporated into Senator Baucus's bill to give an across-the-board FMAP increase to all states. Some states already receive more than they should while others receive less. That is one reason Senator Murkowski pushed a $200 billion five-year adjustment last year of the states' FMAP rate. Unfortunately, it was followed up by a change in the Bureau of Economic Analysis's definition of "per capita income," which led to an artificial decrease.

MR. GILBERTSON repeated that Senator Murkowski does not believe

an across-the-board increase in the FMAP rate is the right approach. First it is only for one year. Second, after it sunsets, it does nothing to address the underlying problem. The formula itself has never been adjusted or modified to affect the realities of preventive care in Alaska. Senator Murkowski has informed the committee that this approach will waste billions of federal dollars and delay, for one year, the debate that needs to occur, that being to focus on fixing the formula so that it reflects the high cost of providing services in rural areas.

CHAIRWOMAN GREEN pointed out the latest outcome on the FMAP issue is certainly more optimistic than what she expected from their conversation several weeks ago.

MR. GILBERTSON said that obviously, if the current language passes, Alaska will benefit and that, 99 percent of the time, is the standard Senator Murkowski uses to decide whether to support legislation. The problem is that it is tied in with many things that are bad for the program, for example, to bring in a COBRA subsidy at the federal level to put pressure on states to expand coverage for displaced workers. He pointed out that this method of handling the COBRA subsidy issue would create an inefficient system. The Administration and the Republicans on the committee feel it is much more efficient to look toward national emergency grants already established under the energy program system to distribute funds to states pursuant to Department of Labor policies developed back in 1982 and refined in 1998. Those policies allow governors to step in, submit an application, and certify that the events are September 11 related. The states can use that money without having to provide matching funds to establish emergency assistance programs in communities that are disproportionately harmed. By instead providing a COBRA subsidy, funds will have to be distributed to the states only after the Departments of Transportation and Labor promulgate regulations to set up a program. In addition, states will have to establish infrastructure capable of administering the funds. New mandates will be put on states to identify and certify who is COBRA-eligible. It will require states to make payments to those recipients or to the insurance carrier. In addition, states may have to subsidize the cost of COBRA premiums as well. Again, Senator Murkowski believes a temporary across-the-board FMAP rate increase is not the right approach to fix Alaska's problem. That temporary boost will prevent the Senate Finance Committee from working on the problem over the next year, therefore it will be placed into another political cycle and will start from ground zero again.

SENATOR TAYLOR commented that Senator Murkowski has been the lead person in the Alaska delegation on the rewrite of the FMAP formula. He stated he appreciates the work of the staff members who helped with that project.

MR. GILBERTSON noted this has always been an uphill battle and that delegation members have done well channeling their energies within their areas of jurisdiction. The state was looking at some very difficult financial hardships going into 1997. At that time the match rate was 50/50. Senator Murkowski's first effort was to raise and get a three-year extension of the Alaska FMAP rate at 59.8 percent and, after that expired to secure another extension. He was able to put a five-year extension on to that which decreased Alaska's per capita income by five percent before being inserted into the formula. That will generate an extra $40 million for the state over the next five years. Senator Murkowski's concern is what will happen in 2005 when that extension expires, which is why he feels it is most appropriate to fix the FMAP formula now.

CHAIRWOMAN GREEN thanked Mr. Gilbertson for his briefing.

MR. BOB LABBE, Director of the Division of Medical Assistance, presented a power point presentation on Alaska's Medicaid program to the commission, of which highlights follow.

TAPE 01-48, SIDE A

MR. LABBE discussed the following overview of the Medicaid program.

•Administered by each State under a host of federal rules, with both sharing in the cost of the program.
•Eligible groups per federal law
-Mandatory: Family Medicaid; Newborns and Children in Lowest Poverty Levels; SSI recipients
-Optional: APA recipients; Denali Kid Care; Pregnant women
•Services allowed per federal law
-Mandatory
-Optional
•Federal law requires each State to have a committee (MCAC) to advise the Medicaid agency in order to obtain federal matching funds.
•Established by the Social Security Act Amendments of 1965 to pay for medical assistance for certain individuals and families with low incomes and resources.

He explained that those the state is required to cover under Medicaid are temporary assistance recipients, recipients of Supplemental Security Income (SSI), pregnant women with incomes below 133 percent of the federal poverty level, and children who fall at different income levels depending on age. In addition, optional groups of people can be served. Currently, children whose family income is up to 200 percent of the poverty level are eligible, as well as certain aged and disabled recipients that

fit state-only cash assistance grants. About 40 different Medicaid-eligible categories exist; states must cover certain services but can elect to cover others. States are required to have a medical care advisory committee to receive federal funds.

The Alaska statutes that authorize DHSS to participate in the Medicaid program fall under AS 47.07 (.020, .030, .035).

MR. LABBE reviewed the eligibility criteria on the following chart and pointed out, for reference, that DHSS would be required to cover a pregnant woman in a family of three with an income under $24,000.

Eligible Persons

Federally mandated groups include:
- Family Medicaid
- Newborns and children at lowest poverty levels
- SSI recipients
- Children at lower poverty levels
- Pregnant women at lower poverty levels

Optional groups include:
- Some APA recipients
- Children at higher poverty levels
- Pregnant women of higher poverty levels

Eligibility: In Simpler Terms...

Aged
Blind
Disabled
A Child
A Caretaker of a Child
A Pregnant Woman

CHAIRWOMAN GREEN asked if the SSI program is a federal program.

MR. LABBE said it is 100 percent federally funded and operated. States are required to provide a state supplement, which in Alaska, is the adult public assistance payment (APA). SSI recipients are then eligible for Medicaid. Some of the groups who receive APA payments are required by federal law, some are optional. The SSI program started in 1974. Prior to that, the program was administered by states and required a state match.

MR. LABBE pointed out that Alaska's Medicaid program does not cover everyone who is low-income. Some states have special grants and demonstration waivers to cover low-income groups that are excluded from Alaska's program.

REPRESENTATIVE DYSON commented that hospitals must spread the cost of treating folks without coverage. He asked if other jurisdictions have figured out how to solve that problem.

MR. LABBE replied that some states have concluded that making sure that everyone is covered in some way reduces the cost shifting. That is the theory behind Oregon's health plan that moved toward universal coverage. That program provides coverage in several ways; part-Medicaid, buy-in programs, part-insurance. The idea behind it is that if everyone has coverage, some level of payment takes place so there is less subsidization from cost-shifting.

REPRESENTATIVE DYSON asked if those states have seen the costs to third party payers decrease since cost subsidization isn't happening within institutions.

MR. LABBE said he does not have the answer to that question but can look into it. He added that he is not aware of any state in which everyone is fully covered but Hawaii and Tennessee seem to have the broadest programs.

CHAIRWOMAN GREEN recognized the arrival of Representative Cissna.

REPRESENTATIVE CISSNA pointed out, in reference to Representative Dyson's question, that the costs of health care have accelerated so quickly so that everyone is scrambling to keep up with the costs while nothing has been done to stabilize those costs. She asked if that is a correct assessment of what has been happening.

MR. LABBE said the fact that costs have accelerated rapidly is correct and is a national issue. He noted the rate of increase slowed down for a few years but it is now accelerating again.

MR. LABBE provided the following chart of federally mandated services. He pointed out that for children, all the services are mandatory as the result of a modification of the federal law in 1989. That modification required states to provide necessary services for a child to correct a condition, even if that service is not covered in general by the state's Medicaid program. An example would be physical therapy, which is not listed as a mandatory service.

Federally Mandated Services - Mandatory Services: Sec. 1905, Social Security Act

Inpatient hospital services
Outpatient hospital services
Prenatal care
Vaccines for children
Physician services
Nursing facility services

Family planning services and supplies
Rural health clinic services
Home health care for persons eligible for skilled-nursing services
Laboratory and x-ray services
Pediatric and family nurse practitioner services
Nurse-midwife services
Federally qualified health-center (FQHC) services
Early and periodic screening, diagnostic, and treatment (EPSDT)

Children's Services

All medically necessary health care services must be covered for eligible children.

-Within the scope of mandatory or optional services under Federal law.
-Even if those services are not included as part of the covered services in that State's plan.

MR. LABBE then discussed the following optional services that states may elect to cover.

Optional Services
AS 47.07.030
(◗ Selected by the Alaska Legislature for coverage)

◗ Ambulatory surgery center services
◗ Case management services
Chiropractic
Christian Science sanatorium
Clinic services
Community supported living arrangements
◗ Dental *(adults limited to emergency treatment for pain and infection)*
Dentures
Diagnostic services
◗ Durable medical equipment
Emergency hospital services (for hospitals not enrolled)
◗ Home and community care
◗ Home health
◗ Hospice services
◗ Intermediate Care Facility for the Mentally Retarded (ICF/MR)
◗ Services in an inpatient psychiatric facility for age 65 and older
◗ Medical supplies
◗ Occupational therapy
Optometrist services
◗ Personal care services
◗ Physical therapy
Podiatry
◗ Prescription drugs
Preventive services
Private duty nursing
◗ Prosthetics and orthotics
◗ Rehabilitation services *(mental health and substance abuse)*
Respiratory therapy
Screening services
◗ Speech, language and hearing services
◗ Vision services

MR. LABBE said some of the eligibility groups are up through age 18, but a disabled person who is 20 would be considered a child for the purpose of the Medicaid package.

CHAIRWOMAN GREEN asked how a minor who is a ward of the state would be treated.

MR. LABBE said the state currently covers 19 and 20 year olds under that system. He clarified that home and community based services are not considered medical services typically so the state is not required to cover those services for children but it does have waivers specific to disabled children.

MR. LABBE showed the following list of priority services in statute.

AS 47.07.035 Priority of medical assistance

Priority	**Type of Service**	**FY01**	
		Recipients	Cost
1	Clinical Social Workers Services	0	$0
2	Psychologists Services	0	$0
3	Chiropractic Services	0	$0
4	Advanced Nurse Practitioner Services	0	N/A
5	Adult Dental Services	4,798	$1,699,255
6	Emergency Hospital Services	0	$0
7	Midwife Services	0	N/A
8	Treatment of Speech, Hearing, and Language Disorders	1,686	$920,912
9	Optometrists Services and Eyeglasses	9,407	$1,135,807
10	Occupational Therapy	292	$404,894
11	Mammography Screening	928	$33,733
12	Prosthetic Devices	285	$248,949
13	Medical Supplies and Equipment	1,874	$2,564,022
14	Targeted Case Management Services	0	$0
15	Rehabilitative Services for Substance Abusers and Emotionally Disturbed or Chronically Mentally Ill Adults	735	$2,507,124
16	Clinic Services	4,005	$42,516,123
17	Physical Therapy	9,316	$918,404
18	Personal Care Services in a Recipient's Home	1,198	$6,251,068
19	Prescribed Drugs	26,664	$27,659,154
20	Hospice Care	5	$7,494
21	Long-Term Care Noninstituticnal Services	2,246	$55,495,465
22	Inpatient Psychiatric Facility Services	490	$13,845,681

23	Intermediate Care Facility Services for the Mentally Retarded	0	$0
24	Intermediate Care Facility Services	0	$0

Source: MMIS MARS MR-O-12 Reports

MR. LABBE said the big costs begin with clinic services, which are the community mental health clinics. The costs are borne by total fund dollars, not only general fund dollars which pays about 33 percent.

CHAIRWOMAN GREEN asked if Mr. Labbe has any suggestions regarding the list.

MR. LABBE said he does not; he showed the list to point out that when people talk about going down the list, the program will have to cut one dollar to save 33 cents, and a number of services will be eliminated, such as medical supplies and equipment. When he has looked at that approach in the past, the question of whether the Medicaid program will no longer cover mental health services or prescription drugs is the kind of question that has to be answered. He feels that approach is draconian.

REPRESENTATIVE DYSON asked Mr. Labbe to clarify what he meant by this approach.

MR. LABBE said he was referring to reducing costs by cutting services. He stated some services cannot be cut; so, to save $50 million in general funds for example, the program would have to no longer provide prescription drug coverage and other services.

REPRESENTATIVE CISSNA said another way to look at that is to figure out what the real cost is. When the legislature looks at any kind of cuts, it needs to know the total cost because the state will lose if it cuts certain things.

MR. LABBE pointed out the list only shows what DHSS spent in a particular service. Several years ago, perhaps in 1994, adult dental services were added back into the program. At that time, DHSS found it was spending quite a bit of money on outpatient hospital services because people who could get no dental care would show up there when they had a dental emergency. He said although the Adult Dental Services program is not comprehensive, it provides relief from pain and infection and reduces the outpatient service cost. He said his point is that if something is cut, the cost will show up elsewhere.

CHAIRWOMAN GREEN asked if the amounts on the priority list reflect the amounts actually paid.

MR. LABBE said that is correct.

CHAIRWOMAN GREEN asked how the list of 24 services was prioritized.

MR. LABBE said the first service on the list would be the first to go so that the list is in reverse order of the importance of services. He noted the first three items on the list are not currently provided. He explained that number 23 refers to payments to Harborview and number 24 refers to nursing home payments. DHSS had no expenditures on FY 01. He indicated that number 24 should probably be removed from the statute since nursing facility services are mandatory.

CHAIRWOMAN GREEN asked if the first expenditure is number 22.

MR. LABBE said number 22 would be the last service cut.

CHAIRWOMAN GREEN asked, if DHSS ran out of money, would it quit paying for services for numbers 22, 21, and 20.

MR. LABBE said it would not happen that way and that this is a difficult issue. When he met with the Finance Committee over the last several years on this question, they discussed making this decision before the end of session. The discussion has revolved around whether it is better to project expenses low and come back for supplemental funding if necessary. He has found that DHSS cannot cut services without promulgating regulations and giving clients notice. In addition, some payments are in the "pipeline" and there is a payment lag. Therefore, to make a cut effective and generate the dollar, DHSS has to have this in place at the first of the fiscal year or shortly thereafter. Once the fiscal year begins, the regulation process, the client notice process, and the payment lag run into the next year.

SENATOR TAYLOR commented that legislators have been told during the session that DHSS will have to cut out adult dental services and other services if the legislature does not act immediately. However, that does not occur.

MR. LABBE said that happens when DHSS presents a budget and is told the program will only be funded at a certain level. DHSS then does an impact analysis and that is what it would have to do. He noted that changing the benefit package would not happen without a discussion with the legislature.

CHAIRWOMAN GREEN asked Mr. Labbe if he is prohibited from pro-rating payments if he foresees a shortage.

MR. LABBE said he believes there is a federal problem with pro-ration but he would have to research that further. He said DHSS has state authority to adjust payment rates but certain rules

apply and the adjustments are not typically across the board. For example, Alaska statute requires DHSS to pay a fair rate for health facilities. The same requirement does not exist for physician rates. He knows in the past, when states have tried to do across the board cuts, the federal agency says a program cannot be driven by budget.

REPRESENTATIVE DYSON said he assumes DHSS cannot pro-rate the qualifying family income.

MR. LABBE said that is correct. Moving on with the presentation, Mr. Labbe explained each state is required to have a medical care advisory committee (MCAC), composed of six health care providers and six consumer representatives. DHSS has aimed for a fair geographic distribution as well as representatives from the different user groups and medical fields.

CHAIRWOMAN GREEN asked if a charge of the medical care advisory committee is to review Medicaid provisions and agencies and whether it comes up with proposed programs or changes.

MR. LABBE said the committee makes recommendations to DHSS for regulatory changes and on operational issues. He told committee members that the MCAC hears from the public and tries to advocate for all participants, both providers and consumers.

CHAIRWOMAN GREEN asked if the MCAC is supposed to act as an advocate or lobby.

MR. LABBE said he would not characterize the MCAC that way. He believes its members are very interested in health care but their primary role is to make sure the system is working well. For example, DHSS developed a survey of providers, which the MCAC reviewed and gave DHSS practical feedback and advice.

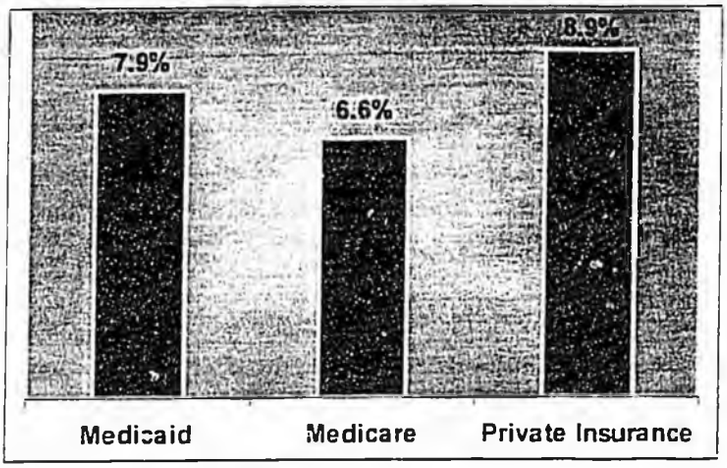
REPRESENTATIVE DYSON said he believes, by definition, the role of the MCAC is advocacy.

MR. LABBE said he brings the MCAC a lot of material for review..

CHAIRWOMAN GREEN asked if the MCAC's role is to advise DHSS or the legislature.

MR. LABBE thought the federal government envisioned the MCACs to advise the program and to allow program managers to have some input into the process.

REPRESENTATIVE CISSNA said she felt compelled to say that it is "sticky" because every single person in Alaska wants to advocate for help. Therefore, it is difficult to determine when one group may be asking too much.



MR. LABBE said his next chart speaks to what is happening nationally.

Nationwide Medicaid Expenditure Growth
Converging Trends are Causing
Medicaid Expenditure Growth

- Increasing Inflation in Health Care Market
  - -Pressure to increase provider payments
  - -Higher costs for brand and generic prescription drugs
- Changing Health Care Utilization
  - -Reliance on home & community based services
  - -Greater use of prescription drugs, new technology
- Expanding Enrollment
  - -Eligibility expansions
  - -Growth of the disabled population in Medicaid
  - -Use of Upper Payment Limit (UPL) Arrangements

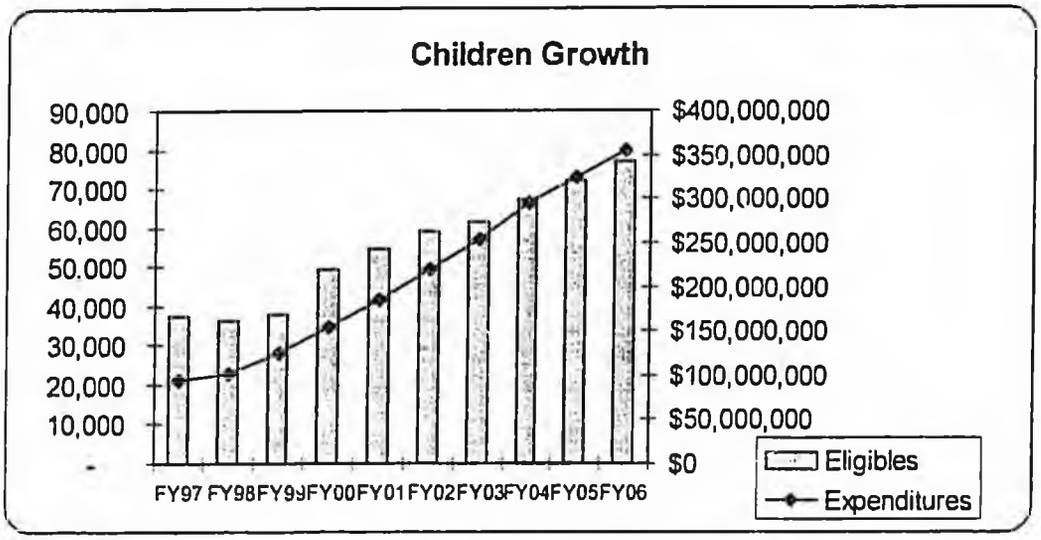
MR. LABBE said, regarding inflation, costs were fairly flat for awhile but are beginning to increase again. The big issue nationally is prescription drugs. He thought Mr. Gilbertson might discuss prescription drugs but he believes that agenda is on the back burner with Congress right now. He noted states would benefit if prescription drugs for seniors were covered.

National Projected Average Annual Growth Rate in Medicaid, Medicare, & Private Health Insurance, 2000-2005

MR. LABBE stated:

> I think if you look at the next page where it shows the growth rates projected - Medicaid, Medicare and private insurance - the one that I thought was interesting here was that Medicare was lower than Medicaid and private insurance and I think the Medicare, again, the areas like prescription drugs, which they don't cover, are one of the biggest drivers in Medicaid so Medicaid will go up. The other thing that Medicare doesn't really do much of is long-term care. It's a very short stay following hospitalization. They say up to 100 days but it's typically 8 to 10 days that Medicare will pay for

and then if the person stays in a nursing facility, the primary payer tends to become the Medicaid program, which is state match. The same thing in the home and community based services. Medicare does cover some home health benefit. Again that's more short term but if you get the longer term supports - personal care attendant services, some of these things, essentially it's a state Medicaid business. So I think that's partly - those areas are growing in Medicaid and the basic - the hospital and the doctor stuff is probably



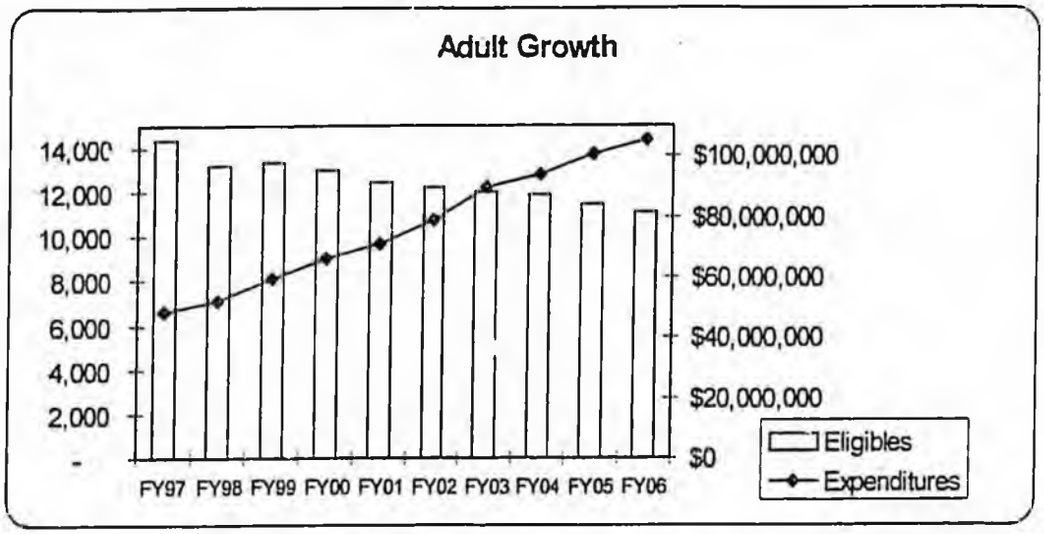
the same but when you add these prescription drugs, home care, nursing home care, Medicaid will be growing.

MR. LABBE then discussed the information on the following chart.

- **Children's eligible recipient numbers**
  - FY01 eligible numbers represent 24% of Alaska's total population ages 0 - 18
  - Average increase in eligible growth over last 4 years has been 10.4%
  - Children's eligible recipient rate of growth decreased by more than 50% in FY 01
  - FY01 average cost per month per eligible child was $280

- **Children's expenditures**:
  - 35% of total FY01 Medicaid expenditures are attributed to Alaska's children.
  - Over the past 4 years, Medicaid's total rate of expenditure growth has averaged 15%
  - Over the past 4 years, the average increase in expenditure growth for children has been 18.8%
  - 55% of FY 01 expenditure growth was attributable to increased eligibles

FY04 through FY06 total projections are based on a simple linear trend with a 7.1%



health spending growth rate applied. Source of Rate: March 2001 Center for Medicare & Medicaid Services' "National Health Care Expenditures Projections: 2000-2001". These projections assume no changes to the existing program.

MR. LABBE explained the chart projects the growth of the Denali Kid Care program through FY 06. The rate of growth increased more than 50 percent in FY 01; the future rate of growth is projected to be lower. DHSS expanded Medicaid services in the early 1990s when it began to cover children and pregnant women at a higher income level. DHSS served 77,422 children last year, about 24 percent of Alaska's children.

REPRESENTATIVE DYSON asked if any jurisdiction, other than private health, figured out how to reward and encourage healthy behaviors.

MR. LABBE said some programs encourage pregnant women to access prenatal care sooner but he did not think DHSS could reward certain behaviors.

REPRESENTATIVE CISSNA noted that Native health agencies are putting a lot of effort into education because many people do not know what healthy habits are.

SENATOR TAYLOR pointed out that the number of eligible participants will be less than the funding by FY 06. He asked for clarification.

MR. LABBE said when the program was implemented, that some of the costs per person dropped. The later years show that once the population is well covered, the costs will increase as health care costs increase so that expenditures will exceed the number of eligible people. He added that same scenario is more evident on the next chart with the adult population, where the population is decreasing but the expenditures are increasing.

He pointed out the adult population is made up, primarily, of the temporary assistance population and pregnant women. DHSS expanded coverage several years ago so that pregnant women with a

higher income level were eligible. At the same time, temporary assistance cases have been lower cost because those clients receive coverage based on the fact they receive cash grants: they do not necessarily apply for the purpose of health coverage. People move off of the temporary assistance program so that those who remain are those with the most difficulties in moving into the work force and frequently have more health problems and use more services. Consequently, the cost per person has increased while the caseload has dropped.

SENATOR TAYLOR said one of his concerns regarding the previous chart is how many of the 77,000 children are also covered by the Public Health Service or private insurance. He noted Medicaid has become the first payer.

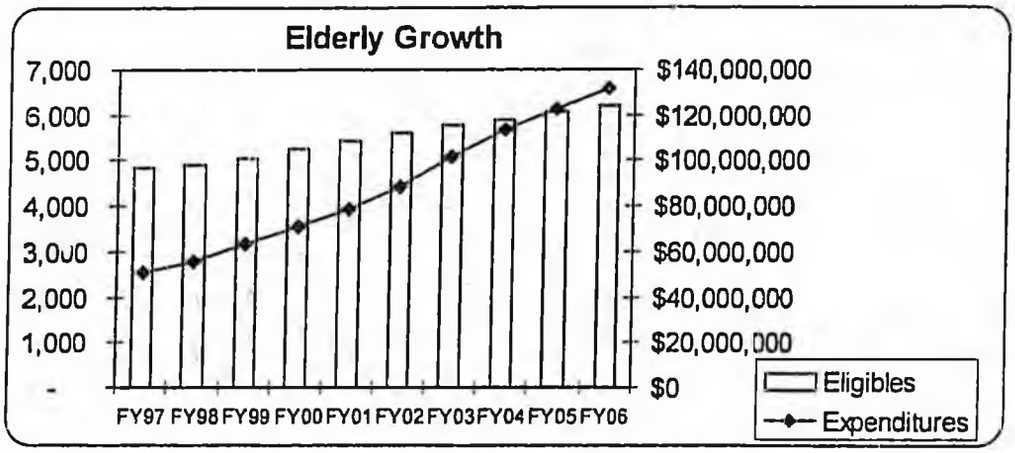
MR. LABBE explained that some children have other health insurance but that is not a factor that makes a person ineligible for the Medicaid program. If a client has other insurance, Medicaid acts as the last payer. In addition, the Medicaid program may offer some benefits that private insurance does not, for example dental services. He noted that many seniors are eligible for both Medicare and Medicaid. Medicare pays first but it does not cover prescription drugs so those drugs are paid through Medicaid. Payments for Medicare and Medicaid services are coordinated so that, for example, Medicare may pick up 80 percent of the costs while Medicaid pays the other 20 percent. He informed members that if private insurance is available, DHSS has a unit that goes after the insurance company and recovers for the state.

SENATOR TAYLOR asked why the Medicaid program would cover a bill for someone who is eligible for and fully covered by a Native health service. He questioned why, if the Native program is fully paid for with federal funds, the state should get a bill for any services for that person.

MR. LABBE said his understanding is that the federal law directs states to enroll and allow tribal programs to bill as a way to help supplement declining appropriations. However, when the state pays those providers, it claims that payment at 100 percent federal funds so no general fund payment is being made.

MR. WINKELMAN, legal counsel for the YKC Health Corporation, explained that Congress views the Alaska Native citizen as a citizen of Alaska and the United States, and a citizen with a trust relationship with the federal government. Therefore those citizens are entitled to both Medicare and Medicaid. The federal government pays 100 percent for their health care under the FMAP so no state funds are being expended for Alaska Native Medicaid-eligible patients.

MR. LABBE continued his presentation by describing Alaska's elderly in regard to the Medicaid program.



FY04 through FY06 total projections are based on a simple linear trend with a 7.1% health spending growth rate applied. Source of Rate: March 2001 Center for Medicare & Medicaid Services' "National Health Care Expenditures Projections: 2000-2001". These projections assume no changes to the existing program.

MR. LABBE pointed out the growth of Alaska's senior population in the Medicaid program has been very consistent. In terms of

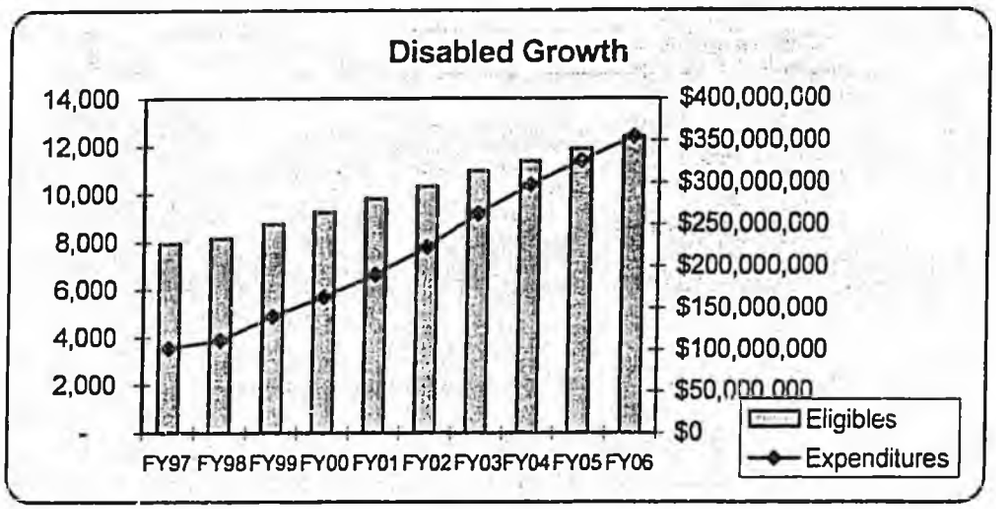
- **Elderly Eligible Recipient Number:**
  - Elderly eligible growth has averaged 3% for the past 4 years
  - Elderly Rate of growth is Medicaid's most consistent
  - FY01 average cost per month per eligible elderly person was $1,209
- **Elderly Expenditures**
  - Expenditure growth for the elderly has average 12% for 3 years
  - 29% of FY01 expenditure growth was attributable to increased eligibles

demographics, he believes the general population is growing at a lower rate than the senior population. There has been concerned expressed about long-term care needs in 20 years because of a large number of seniors who will be over age 85. However, the population that is aging in Alaska typically has more assets and higher income so they will not qualify for these programs until they are in need of nursing home services. The growth is very predictable. Services for Alaska's elderly comprise a fairly

expensive portion of the Medicaid caseload. Last year, Medicaid served 7,159 elderly individuals at a cost of $70 million. However, the services they need are expensive, such as prescription drugs and long-term care. If those clients did not have Medicare coverage, Alaska's cost would be very high. DHSS is required to pay premiums for low-income Medicare beneficiaries. The federal government matches that payment.

CHAIRWOMAN GREEN asked where the costs for the assisted living services show up.

MR. LABBE said assisted living services fall under the home and community based waivers. He noted the charts show aggregate costs and that he would provide more detail later.



MS. RYNNIEVA MOSS, staff to Representative Moss, noted that assisted living homes take in vulnerable adults and apply for Medicaid waivers. Often, they provide medical services three months before the waiver is approved and they cannot be reimbursed for those three months. It is her understanding that could be changed at the federal level because assisted living homes are in the unique position of not being able to be reimbursed retroactively. She asked Mr. Labbe if he has talked to the federal government about those possible changes, which, to her understanding, will have to be made legislatively.

MR. LABBE said he has not talked to anyone in the federal government about retroactive payments. That issue has been under discussion in the Department of Administration. He stated the issue is that a person cannot be put on a home and community based waiver retroactively. If the services begin before a person has a level of care determination, those services cannot be paid prior to the date of determination. He said he has no new information on that issue but will find out.

CHAIRWOMAN GREEN announced that the committee would break in 20 minutes for lunch and reconvene at 1:30 p.m.

MR. LABBE continued his presentation and discussed the disabled clients in Alaska's Medicaid program. He referred to the following chart and stated that last year, the Medicaid program served 12,194 clients, both children and adults with disabilities.

- **Disabled Eligible Recipient Number:**
  - ↘ Disabled eligible numbers have maintained a steady increase of about 5% for 4 years
  - ↘ FY01 average cost per month per disabled recipient was $1,624
- **Disabled Expenditures:**
  - ↘ Expenditure growth has averaged more than 17% for 4 years
    28% of FY01 expenditure growth was attributable to increased eligibles

CHAIRWOMAN GREEN stated the Mat-Su Valley is growing faster than any other area of the state, population-wise. She asked Mr. Labbe if his charts take that growth into account.

MR. LABBE said the projections are from DHSS data.

CHAIRWOMAN GREEN said the projections could be an underestimate.

MR. LABBE said they could go either way and, in fact, DHSS has been looking into the growth rate in the number of disability clients. A researcher suggested the disability growth for the adult public assistance population followed the birth rate plus 18 years. He suspects that as the birth rate dropped, the rate could level out. He pointed out this category is the most expensive on a per person basis. About 50 percent of these clients also receive Medicare.

REPRESENTATIVE DYSON commented, regarding Senator Taylor's question about expenditures increasing at a higher rate than enrollees, the services should be based on the needs of the people rather than what is available. He asked:

> How do we keep new people providing services from being salesmen who are saying, oh my goodness, there's another program you can sign up for - you need to do this - just because the program is available as opposed to the needs of the client or patient?

MR. LABBE replied in the medical service area, DHSS is quite dependent on the physician prescribing services. DHSS also has case management programs to monitor utilization and to assist families in finding a more efficient use of services. He pointed out that one of the factors that is driving up the cost of prescription drugs nationally is not only new technology but direct advertising. He noted DHSS has a committee that works on these issues, including education.

REPRESENTATIVE DYSON said he is on a crusade to create a process where every person who receives assistance from the state only has to deal with one agency and minimal paperwork. He asked Mr. Labbe if he believes that is an impractical goal.

MR. LABBE said he believes it is an ambitious goal but it may not be impractical, especially in some areas. The Division of Medical Assistance does not directly interact with consumers, for the most part. Clients submit a public assistance application. During that process, a client may encounter multiple agents.

REPRESENTATIVE DYSON said he is aware of people who receive temporary assistance and, in addition, need child care assistance. Those people have to recap all of their information and comply with schedules that are very difficult, particularly in light of the fact that they are dealing with child care and transportation problems. He said he longs for the day when those people can fill out one form that would qualify them for several programs and in which one person acts as the broker for the family. He asked if any jurisdiction in the country uses such a process.

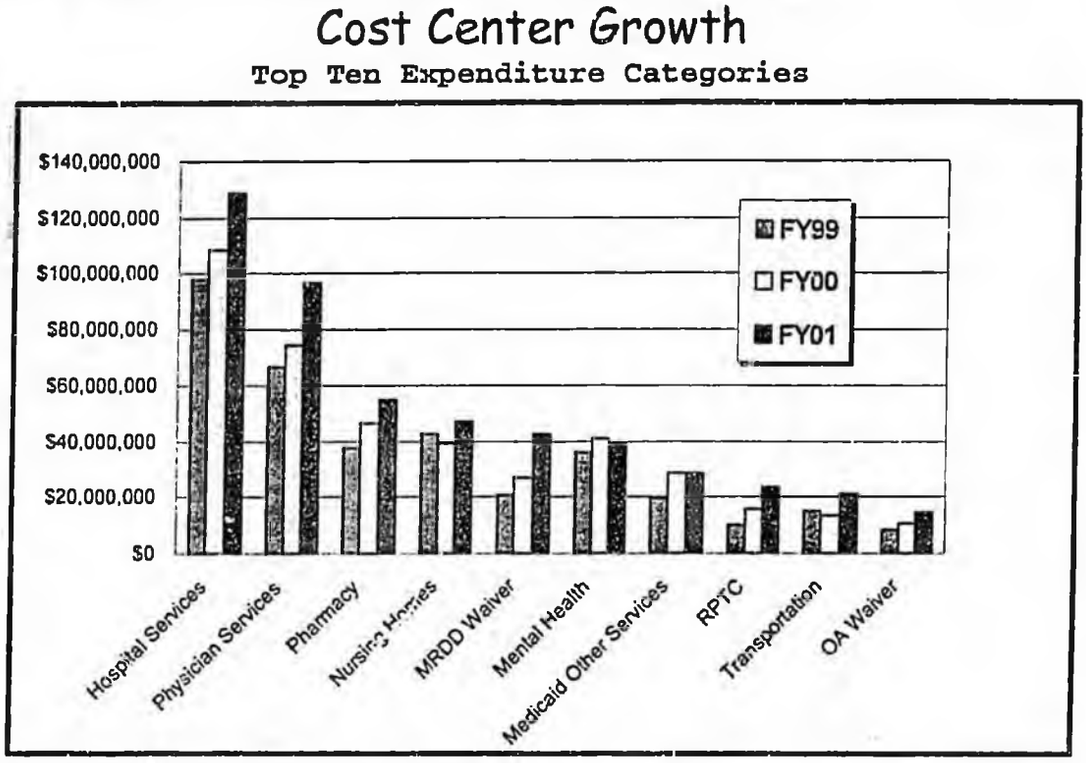
MR. LABBE said the State of Oregon is moving into that model and he believes one or two other states are moving in that direction.

REPRESENTATIVE DYSON said if the state made it work better for recipients, the delivery of services would become more efficient and possibly reduce costs.

MR. LABBE pointed out the Division of Public Assistance has a web page but he has not been involved in that project.

REPRESENTATIVE CISSNA said she did some volunteer work for a program for the long-term mentally ill that was established by the California State Legislature to find a solution similar to what Representative Dyson suggested. Funding stays with the client so that if money is saved by hospitalization so that, for example, some of the clients were able to receive college educations with the extra funds saved. She felt such a program is worth looking at.

MR. LABBE drew attention to the following chart.



Categories include Indian Health Services

He explained that the category entitled "Medicaid Other Services" includes lab work, x-rays, medical supplies, vision, home health, family planning, physical and speech therapy, and personal care attendants. He noted that clearly, the largest expenditure categories are for hospital and physician services. He said the one area that has remained fairly level is the nursing home category.

SENATOR TAYLOR asked why such a dramatic increase in hospital services in two years.

MR. LABBE said that reflects an increase in the caseload of children.

SENATOR TAYLOR asked if that is due to Denali Kid Care.

MR. LABBE said it is. DHSS has added about 18,000 to 20,000 children since 1999. DHSS has also added a new group of disabled workers that can buy into the program. In addition, costs have increased.

SENATOR TAYLOR said he is floored by the almost 50 percent increase in costs of physician services over three years and asked how that can be rationally budgeted for in the next three

years.

REPRESENTATIVE CISSNA maintained that insurance costs are rising in the same manner.

SENATOR TAYLOR disagreed and said insurance costs have not increased 50 percent in two years.

MR. LABBE pointed out the chart shows the total dollars expended, including Indian Health Service costs. The tribal programs have had an increasing ability to bill the Indian Health Service so the data is coming in now. In addition, there have been some rate increases from the federal government.

SENATOR TAYLOR asked Mr. Labbe if those factors may have skewed those categories a bit.

MR. LABBE said they have.

CHAIRWOMAN GREEN felt the rate of growth should be fairly static and that the chart is reflective of what she saw on the Finance Committee last year - a $40 to $60 million increase in one year in Medicaid participation. That amount equals half of the Department of Public Safety's budget. She said that regardless of how endearing these programs are, the legislature has to ask if this is the best way to provide those services.

MR. LABBE presented four pie charts to demonstrate service use by the four population groups. He noted the population group of children includes newborns; he would prefer to split the group in two because expenses are much higher for the first year of life.

CHAIRWOMAN GREEN asked Mr. Labbe if he would prefer to separate out the high incidence children.

MR. LABBE said yes and, similarly, he would like to separate out costs for pregnant women from the adult category. He plans to split the groups because the current categories mask what is going on.

REPRESENTATIVE DYSON asked what percentage of the total state population are disabled, what percentage are children, and what percentage is classified as adult.

MR. LABBE offered to get that information from the Census Bureau data.

CHAIRWOMAN GREEN announced the committee would recess until 1:30 p.m.

CHAIRWOMAN GREEN called the subcommittee back to order at 1:40

p.m. and announced the next item on the agenda was an overview of Medicaid fraud.

MR. STEVE BRANCHFLOWER, Director of the Alaska Medicaid Fraud Control Unit (MFCU), informed subcommittee members that he distributed a handout that he prepared in May of 2000 for the Medical Care Advisory Committee. He explained the essential difference between Medicaid and Medicare is that Medicaid is a health care program for low income and disabled people, funded by the state and federal government, while Medicare is 100 percent federally funded and provides medical benefits for retired people. State participation in Medicaid is optional. If states decide to participate, they must provide certain minimum health care services, establish a payment structure, and provide for oversight of the providers. Alaska's split was 50/50 until Senator Murkowski was able to enact legislation that changed the split to 60/40. Alaska's statutory scheme for its Medicaid program is embodied in AS 47.

MR. BRANCHFLOWER explained that each state that participates in Medicaid must have a Medicaid fraud control unit to investigate and prosecute crimes against the Medicaid fund. The MFCU is a separately identifiable legal entity. Although it functions as part of the Department of Law, it is separate from the Division of Medical Assistance.

The MFCU has three objectives:

- to conduct a statewide program to investigate and criminally prosecute providers who steal money;
- to investigate fraud in the administration of the program;
- to review complaints of abuse and neglect against patients in health care facilities receiving Medicaid funding.

The MFCU was created in 1992. It is funded with 75 percent federal funds and 25 percent state funds. The office is staffed with two investigators, an internal auditor, and Mr. Branchflower. He is cross-designated, meaning he can prosecute in either state or federal court. Alaska's criminal statutes are not tailored to the investigation or prosecution of health care crimes, therefore he often prosecutes in federal court.

REPRESENTATIVE DYSON asked Mr. Branchflower if he recommends changing Alaska's statutes.

MR. BRANCHFLOWER said he believes there is a lot of room for improvement and offered to provide suggestions.

REPRESENTATIVE CISSNA maintained that the cost factor of statutory changes should be taken into consideration.

MR. BRANCHFLOWER informed the subcommittee that the MFCU is located in the Office of Special Prosecution and Appeals within the Department of Law. He provided the following statistics to show the rising costs per participant:

In FY 99 -
- the total number of participating providers was 3,787
- the total number of recipients was 79,777
- the number of claims lines processed equaled 3,091,484
- the total reimbursements paid equaled $378,451,845 equaling $4,783.87 per recipient.

In FY 00 -
- the number of providers escalated to 10,345
- the number of recipients increased to 92,103
- the claims lines processed jumped to 4,683,421
- the total reimbursements paid was $467 million which equates to $5070 per recipient.

He pointed out the total expenditures progressed from $257 million in FY 95 to $467 million in FY 00. From 1995 to the present, the Medicaid claims paid amounts to almost $2 billion. HCRA reports that, nationally, approximately 10 to 20 percent of health care dollars spent go to fraud, waste and abuse, amounting to a considerable amount of money.

MR. BRANCHFLOWER explained that DMA contracts with the First Health Services Corporation, to conduct the day-to-day business of DMA. They enroll Medicaid providers. He pointed out that any business that provides a service to a recipient can become an enrolled provider, such as an airline, hotel, or taxi cab company. First Health Services Corporation also processes Medicaid claims. DMA has a term contract with the First Health Services Corporation, which will soon be up for renewal.

TAPE 01-49, SIDE A

MR. BRANCHFLOWER told the subcommittee that providers can submit bills to First Health Services Corporation either on paper or electronically. More and more providers are submitting claims electronically because the reimbursement process is much faster. Essentially, a recipient goes to a provider who provides services and submits a bill to the First Health Services Corporation. The claim is processed and, if approved, a check is deposited directly in the provider's checking account. The turnaround time is relatively short and can take a matter of days. Because of the high volume of service and claims, the system does not allow for a check on whether or not services were actually provided. The whole system runs on good faith. It is only after the fact,

if an effort is made to reconcile the billings with patient charts, can fraud be found. Many checks have been put into the system, but the ability to steal large amounts of money in a short period of time is there.

CHAIRWOMAN GREEN asked if that is the case nationwide.

MR. BRANCHFLOWER said it is. He then noted that Alaska has what is called a "fee for service" program, as opposed to health maintenance organizations (HMOs). In the HMO scenario, the government gives a group of doctors a certain amount of money to provide services under a contract. Recipients may complain that the services are not being provided so the HMO is underutilized. Alaska is one of three states with a fee for service program. The problem here is over-utilization because anyone who provides a service gets paid for it.

REPRESENTATIVE DYSON maintained that with a fee for service system, services may outweigh demand.

MR. BRANCHFLOWER agreed. He said a reasonable medical necessity must be associated with the service but, from time to time, the MFCU sees over-utilization with no justification, for example over prescribing, over testing, and over medication.

REPRESENTATIVE DYSON asked if that occurs in non-profit organizations.

MR. BRANCHFLOWER said it does. He then went on to explain that the major components of a Medicaid claim are:

- a recipient number
- a provider number
- date of service
- diagnosis
- procedure code for the treatment provided
- reimbursement

He exhibited a chart of four columns: a description of services, such as whether the patient is new or established or the appointment was a consultation; the CPT code; the service category, which ranges from minimal to comprehensive; a description of the services provided; and the Medicaid reimbursement rate. He pointed out that if a doctor codes a bill for a comprehensive exam when in actuality the doctor only renewed a prescription, the doctor will be reimbursed at a much higher rate. In a case that he recently tried, a doctor billed Medicaid for consultations for almost 80 percent of all of his billings, which are reimbursed at a higher rate. His billings equaled $180,000. This doctor did not have the training to

qualify as a consultant, no other physician had referred any patients to him for a consultation, and no consultation took place. He maintained that trusting providers to act in good faith works most of the time, but some people take advantage of the system.

CHAIRWOMAN GREEN asked if the time lag has always been the case with Medicaid.

MR. BRANCHFLOWER replied, "I think it's in the nature of the system because when you have hundreds of hundreds of thousands, there's no way that you can have a bureaucracy that would ever require proof of services provided."

He said it is difficult for him to accept because most people are used to receiving a service before it is paid for.

REPRESENTATIVE DYSON said he assumes the medical profession has not been proactive about weeding out the charlatans.

MR. BRANCHFLOWER said these cases are very tough to investigate and prosecute compared to rape and murder cases because there is no crime scene, no physical evidence, no eye witnesses and no lab evidence. In addition, everyone is opposed to rape and murder and jurors have no difficulty understanding the law in those areas. In Medicaid fraud cases, there is no crime scene, no witnesses, no physical evidence, and juries are dealing with issues they are not familiar with, such as quality of care. These fraud cases end up being a battle of the experts. Often, medical experts within the state do not want to get involved.

REPRESENTATIVE DYSON asked Mr. Branchflower if the medical profession is doing much to police itself, for example does the Alaska Medical Association's disciplinary process work well.

MR. BRANCHFLOWER said he sees a very high level of professionalism in Alaska's medical community but he does not know whether the profession is policing itself in an effective manner. He indicated that the medical board has been very cooperative.

REPRESENTATIVE DYSON asked if doctors report to the MFCU when they see fraudulent activity.

MR. BRANCHFLOWER said they do not. He acknowledged that reports can be made anonymously.

REPRESENTATIVE CISSNA asked if proving whether services have been provided is part of the problem.

MR. BRANCHFLOWER said it is. He informed the committee that in

1997, the DMA contracted with Deloitte and Touche to do some random audits over a three-year period. Of the 70 audits done, 40 were on-site. In an on-site audit, the auditing team visits the provider's office and looks at the patient charts to reconcile the patient chart entries with the billings. As a condition of enrollment in the Medicaid program, doctors must agree to make patient files available. Correspondingly, Medicaid recipients must waive their doctor-patient privilege. The patient populations of the doctors are usually considerable. So to do a full audit would be very costly and ineffective. Instead, the auditing firm consulted with a statistician about its findings and projected the loss to the entire patient population. A total of 164 were done. He maintained the single most effective deterrent to fraud and abuse of Medicaid funds would be to continue the audits. The total cost of the three-year audit was $1,431,750. He has collected and put back into the state treasury $2,741,126 since July of 1998. Of the total collected, $2,112,980 came directly from the audits. In addition, he has eight audits sitting on his desk, which could bring in an additional $18 million. One provider would be liable for $16 million.

CHAIRWOMAN GREEN asked if the audits began after Mr. Branchflower became employed.

MR. BRANCHFLOWER said the first audit contract was let in October, 1997; he began in July of 1998. When he began, the audits were complete and he was the beneficiary of a great amount of information.

CHAIRWOMAN GREEN asked if the money collected comes through the court system.

MR. BRANCHFLOWER said he can do one of two things: he can either prosecute a person criminally, in which case he would ask for a jail term with restitution. He acknowledged that does not often happen because these cases are difficult to investigate and prove. More often he does civil recoveries. After he reviews an audit, he meets with the provider and his attorney and share the information in the audit. Usually, once they have reviewed the findings they find they have been overpaid. Regulations governing the Medicaid program require participants to reimburse for overpayments. Depending on the conduct of the provider, MFCU can employ a range of options, for example treble damages or filing a false claim act. He often, when settling a case, asks for double the reimbursement amount; recovery of investigative costs, plus interest.

CHAIRWOMAN GREEN asked what happens if the doctor settles but does not pay.

MR. BRANCHFLOWER said they always pay. He said many bad things can happen to providers, one being disenrollment from the program. If a hospital that is part of a national chain is disenrolled, the entire chain might be disenrolled. He indicated that most providers want to make restitution because many times the problems are caused by billing or human errors.

SENATOR DAVIS asked if the settlement money goes directly to the state or whether it is shared with the federal government.

MR. BRANCHFLOWER said that depends on the settlement but usually a portion goes to the federal government. In actuality, MFCU sends the check to the Division of Medical Assistance where the apportionment is made. Sometimes he also settles with the federal government in which it keeps the money. In one case, a national hospital chain settled a national case, which was filed by the federal government with help from the states. He received a check from which the federal portion had already been subtracted.

REPRESENTATIVE CISSNA indicated that Mr. Branchflower said it is incumbent upon the providers to know the rules but she expressed concern that when she was more actively involved in the Medicaid program in the early 1990s, the standards were a moving target. She maintained that many providers are small non-profit agencies.

MR. BRANCHFLOWER agreed that many providers are very unsophisticated regarding the rules and regulations.

REPRESENTATIVE CISSNA said that to be a player, a provider almost has to be affiliated with a national group to be safe and not make mistakes because of the sophistication that is required.

MR. BRANCHFLOWER responded that the larger the provider, meaning the more services that are provided, the greater the risk that when something goes wrong it will involve a major chunk of change. For that reason, those people hire experts to do their billing. On the other hand, the "mom and pop" business cannot afford to do that. That is a legitimate problem because all are required to play by the same rules. One of the ways the Medicaid program aids all providers is by drafting a provider manual. Every enrollee receives one of these "how to" books, depending on provider type. In his estimation, those manuals need to be revised. They are out-of-date and lack specificity. He suggested once revised, the manuals should be reviewed by a lawyer or someone who could be called upon to prosecute a case. He cautioned that provider manuals are often an abbreviated form of the regulations and he believes the manuals should be more "in sync." He feels a lawyer who might be called upon to prosecute someone should have a hand in reviewing the provider manual because a common defense is that the information in the provider

manual was unclear.

MR. BRANCHFLOWER felt another issue that merits follow-up is the fact that no record is kept when a provider calls First Health Services Corporation for clarification or information. Consequently, when he questions a provider about not following a procedure in the manual, he is told the provider called First Health Services Corporation and was told what he was doing was acceptable. The First Health Services Corporation provides assistance; however, it needs to document those calls.

REPRESENTATIVE CISSNA asked if e-mail responses to questions would be considered proof in court.

MR. BRANCHFLOWER said it would and that a copy of the message should be placed in the provider's file.

SENATOR TAYLOR asked what the acronym CPT represents.

MR. BRANCHFLOWER said it is an acronym for a current procedural terminology code. Providers agree to use a universal language of services. Each service is assigned a particular number so that instead of having to fully describe each service, a number can be assigned.

SENATOR TAYLOR asked if it was derived from the California code.

MR. BRANCHFLOWER said it was derived from the American Medical Association.

SENATOR TAYLOR commented:

> Which was a code that they had to come up with when they first came up with the system because the gross abuse and thievery within the system and compounding of bills was so out of control that they actually went to California and other places in the United States tried to figure out what the average high price [indisc.] was for all services and then said to the doc, you're going to get to bill this amount for this procedural service.

CHAIRWOMAN GREEN asked who writes the manuals.

MR. LABBE answered, "First Health drafts the manual - it's kind of a joint effort."

CHAIRWOMAN GREEN asked if the manual is a regulatory interpretation of state law.

MR. BRANCHFLOWER said it is a summary of statutes and

regulations. He then explained that a major glitch in the system is that DMA does not send explanation of benefit (EOB) forms to every recipient. EOB forms are a way of informing recipients of the services providers are claiming to have performed. Medicaid patients almost never get an explanation of benefits. A random sample of 400 EOBs are sent out on a monthly basis by DMA, even though there are thousands of recipients and recipients are not required to respond and return the EOBs. Historically, DMA receives very few responses. Requiring Medicaid recipients to respond, as a condition of eligibility, would provide another layer of protection.

CHAIRWOMAN GREEN asked if such a requirement would require legislation.

MR. BRANCHFLOWER thought that could be done administratively.

CHAIRWOMAN GREEN recalled that in days past, when patients were expected to pay the bill at the time of service, the patient would notice when costs increased and payment acted as a form of approval. She felt that another condition of eligibility could be to require patients to fill out a form at the time of service.

MR. BRANCHFLOWER said he attends Medicaid conferences nationwide and is aware of what other states provide. He feels Alaska provides a "Cadillac" system in the level of services provided to recipients. He believes if recipients were required to answer EOBs and the number of EOBs is increased, that action would have a chilling effect on the ability of providers to file fraudulent claims.

CHAIRWOMAN GREEN asked Mr. Branchflower if the subcommittee could look at other states' models regarding what is required of recipients in relation to verification of services.

MR. BRANCHFLOWER said it could, and recipient responses would be successful especially if the form is one page and postage paid envelopes are provided. He noted an added benefit would be that those who do not respond could be tracked.

CHAIRWOMAN GREEN asked if that would require legislation.

MR. BRANCHFLOWER was not sure. He went on to explain that the Medicaid program does exclude payment for certain services, those being:

- expenses not reasonably necessary to the diagnosis and treatment of an illness;
- items and services not properly described;
- school check-ups;

- cosmetic surgery;
- telephone consultations;
- sex change operations;
- services for inmates who are in custody; and
- weight loss therapy.

MR. BRANCHFLOWER informed the committee that the federal laws are much more comprehensive than the laws of the State of Alaska. Federal laws include the False Claims Act, statutes dealing with false statements, mail fraud, wire fraud, money laundering, specific statutes that deal with Medicaid and Medicare fraud, the RICO statutes, the Health Insurance Portability and Accountability Act (HIPAA), conspiracy, theft of government property, obstruction of justice and anti-kickback statutes. In contrast, Alaska has theft statutes that are "one size fits all," and statutes dealing with forgery, scheme to defraud, falsifying business records, and misconduct involving a controlled substance statutes.

CHAIRWOMAN GREEN asked if Alaska statutes should specifically address welfare fraud.

MR. BRANCHFLOWER said he believes so. He noted Alaska has no statutes tailored toward health care crimes.

TAPE 01-49, SIDE B

MR. BRANCHFLOWER said he has been surveying statutes from all 50 jurisdictions during the last few days and when he retires in June, he plans to go through all of the statutes and come up with a model statutory scheme. He then listed the following common rip-offs used in Medicaid fraud:

- billing for goods and services not provided;
- billing for phantom patient visits;
- upcoding;
- unbundling;
- double billing;
- billing for medically unnecessary services;
- billing for non-covered services;
- billing Medicaid higher than other payers; and
- kickbacks.

In terms of crimes against persons and patient abuse, Alaska has a very good statutory scheme that deals with crimes of violence and endangering a welfare or vulnerable patient. He noted he prosecuted a doctor in Fairbanks earlier this year who was exchanging prescriptions with some of his female patients for

sex. The doctor was billing Medicaid for "services" that he was not actually providing and Medicaid was paying for the prescriptions.

MR. BRANCHFLOWER reviewed several slides that [illegible] investigative tools available to him. Federal law requires DMA and the Department of Law to have a memorandum of understanding. The original memorandum of understanding dated back to 1992; in 1999 it was redrafted and renewed. He then informed the subcommittee that as of this morning, MFCU has 51 investigations open. He then reviewed a chart of the investigative process.

CHAIRWOMAN GREEN asked about the MFCU budget.

MR. BRANCHFLOWER said that MFCU spent $460,000 last year and the unit was able to bring in over $2 million. In addition, the MFCU budget is comprised of 75 percent federal funds and 25 percent state funds.

CHAIRWOMAN GREEN noted that if 10 to 20 percent of the Medicaid budget is used fraudulently, it would not take many years to add up to a few billion dollars. She then asked if anyone has been administratively sanctioned.

MR. BRANCHFLOWER said that DMA has a regulatory system that provides for sanctions, meaning the equivalent of an accusation is filed against a provider and a hearing is held to determine whether the accusation has merit. The provider can be disenrolled. He explained that it is similar to the adjudicatory process but is done at the administrative level.

CHAIRWOMAN GREEN asked if that is a common occurrence.

MR. BRANCHFLOWER stated that, to his knowledge, DMA has sanctioned one provider since 1995.

CHAIRWOMAN GREEN asked what happened to the others.

MR. BRANCHFLOWER deferred to Mr. Labbe for an answer to that question. He then indicated that of the 164 Deloitte and Touche audits, he has taken over less than 20. Federal law says that if the MFCU refers a case to DMA in which a loss has been identified, then DMA is required by law to institute an action to recover the identified overpayment.

CHAIRWOMAN GREEN asked if DMA reports back to the MFCU when cases have been resolved.

MR. BRANCHFLOWER said it does not. He said in the last three years, he has identified; with the assistance of the Deloitte and Touche audits, $22,300,000 in overpayments. He has sent letters

to DMA in each case citing the federal statutes and asking DMA to undertake administrative hearings to recover that money. He does not know the status of those cases.

CHAIRWOMAN GREEN asked how many people work in the recovery effort at DMA.

MR. BRANCHFLOWER said he knows of one person.

CHAIRWOMAN GREEN asked if the federal agency acts as a watchdog to make sure overpayments are collected or whether that is a state function.

MR. BRANCHFLOWER said the watchdog agency is the Office of the Inspector General. Alaska is one of the only states that office does not have a presence in. In terms of requirements, states are required to follow federal regulations as a condition of funding the Medicaid program. One of those regulations says that if the MFCU refers a case to the DMA for recovery, DMA is required to try to get the money back. He repeated in the last three years he sent 140 letters to DMA, amounting to over $22 million. He referred them to DMA because the cases are not sufficiently strong in terms of evidence for him to pursue in court. Those cases are better suited to be handled on an administrative basis. Different standards of proof, rules of evidence and rules of procedure apply.

CHAIRWOMAN GREEN asked why the Office of the Inspector General does not have an office in Alaska.

MR. BRANCHFLOWER said it seems to him that Alaska has a sufficient volume of dollars to merit its presence but he is not aware of the reason.

REPRESENTATIVE CISSNA asked if, regarding the audits, an appeal procedure exists.

MR. BRANCHFLOWER said that when he refers a case to DMA, they meet with the provider and offer them an opportunity to review the audit. Oftentimes there are explanations for [illegible] perhaps an x-ray was missing from a patient's file, so there are corresponding reductions in the overpayments. The findings are calculated on the basis of 100 patients. Perhaps the auditor finds a lack of documentation for $150 worth of services. The mathematician then extrapolates to the entire patient population the probability that there are undocumented services throughout the patient population based upon that number. That formula motivates providers to get the first figure lowered.

REPRESENTATIVE CISSNA asked if a filtering process exists to separate those who may have made a mistake from those who

intentionally commit fraud.

MR. BRANCHFLOWER said that Representative Cissna put her finger on one of the most difficult jobs of his agency. They must judge the strength of evidence and decide which cases involve egregious conduct. It is very difficult to prove these cases in court because they often involve questions of medical necessity and medical judgment. He said defining fraud is also a matter of semantics. The problem occurs when one gets away from the extreme cases. Many of those cases lend themselves well to administrative hearings.

REPRESENTATIVE DYSON asked if he gets any referrals from the Ombudsman.

MR. BRANCHFLOWER said he does not. He said his jurisdiction is limited by institutions funded by federal dollars so he is not involved with the Pioneers' Homes. He noted that most of the MFCU's work deals with conduct of providers; recipient problems are investigated by another lawyer in the Department of Law.

CHAIRWOMAN GREEN asked how to go about continuing the audits.

MR. BRANCHFLOWER said he is unaware of the mechanics of the initial audits. He thought it was done via an executive decision.

SENATOR TAYLOR asked Mr. Branchflower when he will "run out" of new audits.

MR. BRANCHFLOWER said he just finished looking at the last [illegible] of 33; of those he kept about 8. When he finishes working [illegible] those, the "grist for his mill" will be gone.

CHAIRWOMAN GREEN asked what percentage Deloitte Touche would have and how many prosecutors would be needed.

MR. BRANCHFLOWER said the first year Deloitte Touche did 70 and about 30 the second year. He pointed out that is a realistic number because a lot of factors are considered when selecting providers. He meets with the auditors once per month to discuss provider issues and fraud issues. If certain names continue to come up, an audit may be planned. He surmised that the audits have a high deterrent value on all providers.

SENATOR TAYLOR told Mr. Branchflower that the Senate Judiciary Committee would introduce legislation for him. He then asked Mr. Branchflower his opinion of using partial payment of claims as another tool to get recipients to respond to the EOBs. He pointed out if the patient must pay 5 percent of the cost of a visit, the patient may pay more attention to the amount [illegible]

bill.

MR. BRANCHFLOWER said he feels that is a political question. He does not disagree with that approach, but said that some recipients are very poor.

CHAIRWOMAN GREEN thanked Mr. Branchflower for his presentation and asked Mr. Labbe to complete his.

MR. LABBE continued with his power point presentation (page 19) and discussed the ten fastest growing categories of service over the last three years. The number of persons on the "Adults With Physical Disabilities waiver (APD) grew rapidly, based on pent up demand.

CHAIRWOMAN GREEN asked when that category of individuals began to receive services.

MR. LABBE said it was in 1993 or 1994. The first year about 50 people were eligible for the APC waiver and then it went way up.

CHAIRWOMAN GREEN asked what has caused such an increase between 1999 and 2001.

MR. LABBE said that for a number of years the program was administered by the Division of Mental Health and Developmental Disabilities and the adult disabled were "submerged" into the much larger waiver for the developmentally disabled. The program was moved to the Division of Senior Services where people became more aware of the backlog. He said in addition, the Supreme Court issued a decision that stimulated a lot of interest in community-based services for people with disabilities. He said he does not believe the same level of growth will continue.

MR. LABBE explained the second fastest growing category of service is for residential psychiatric treatment centers (RPTC) for children. Two facilities are located within the state. Last year about 596 clients were served. Alaska clients are also being served in about 15 out-of-state facilities. DMA has been working with the Alaska Mental Health Board on a project to investigate how Alaska children ended up in out-of-state facilities. At one point in time, about 75 percent of those children were in state custody but the opposite is true now. DMA and the Alaska Mental Health Board are also looking at whether enough in-state capacity exists.

CHAIRWOMAN GREEN asked for a description of the type of child who would need these services.

MR. LABBE said these children are generally between 10 and 18 with serious emotional disturbances. They are sometimes

dangerous to themselves.

SENATOR TAYLOR asked, "Usually they are not in the custody of the state anymore, but the numbers have gone up. That's bizarre."

MR. LABBE said at one point that category was made up predominantly of children in custody and now about 75 percent are not in custody. That is one of the issues being studied and whether there are better ways to approach that.

REPRESENTATIVE DYSON noted that the residential treatment centers can be very expensive, up to $700 to $800 per day.

MR. LABBE said there have been a few at that level but now the rates are more uniform. The maximum rate for out-of-state facilities paid by the state is $330 per day. Costs out-of-state are typically lower than in state.

REPRESENTATIVE CISSNA asked Mr. Labbe if there are other costs, such as educational fees.

MR. LABBE said he believes the Department of Education and school districts pay for educational costs of children in residential facilities.

REPRESENTATIVE CISSNA clarified that the school district in which the parents reside pay for the cost. She stated that legislators need to know the total cost of sending clients to residential facilities.

CHAIRWOMAN GREEN asked about the CCMC waiver category.

MR. LABBE explained it represents children with complex medical coverage, such as a child who requires a ventilator. He then referred to page 20 and explained that it compares waiver and nursing home costs. Looking at the demographics, Alaska can expect to have a large segment of its population in need of these kinds of services in the future. The legislative Long Term Care Task Force discussed that issue quite a bit. The chart illustrates the issue of developing community-based services as an alternative to more expensive institutional services. The condition to qualify for elderly community-based waiver service is the same as the condition to qualify for a nursing home. The chart demonstrates the cost-effectiveness or cost-avoidance of using community-based services waivers.

SENATOR TAYLOR said that waiver has only been in place for about two years, as he co-sponsored legislation to create it. He asked about the status of regulations for that waiver and then clarified that he was referring to the adult assisted living program.

MR. ELMER LINDSTROM, Deputy Commissioner, Department of Health and Social Services (DHSS), said an assisted living licensure bill first passed in about 1993. Facilities were licensed as assisted living facilities from that point forward and at this time, there are more beds in assisted living homes than in nursing homes. However, the funding mechanism is complicated because there are some private pay individuals, people who receive general relief, which is paid with general fund dollars, and people who receive some reimbursement for assisted living services through the Medicaid waiver. The bill that passed several years ago, Senator Mike Miller's bill, increased the general relief payment, which is outside of the jurisdiction of DMA. He noted regulations were promulgated with some provisions relating to licensing requirements and background checks. One phase of those regulations have been filed; another portion is still being reviewed internally and have not yet been adopted. Another set of general relief regulations pertain to general relief reimbursement. During the public comment period, many comments were received and a number of changes were proposed by the agency. The draft regulations then went out again for public comment. The comment period is now closed and the Departments of Administration and Health and Social Services are still reviewing the comments.

CHAIRWOMAN GREEN said one issue she believes will continue to surface is the concern that licensure falls under the jurisdiction of DHSS.

MR. LINDSTROM said it is particularly complex when two agencies are involved. The Department of Administration licenses assisted living homes primarily for the senior population. DHSS licenses assisted living homes under the same law and regulations for mentally ill individuals residing in assisted living homes.

TAPE 01-50, SIDE A

SENATOR TAYLOR said he believes the assisted living home amount needs to be increased three or four times.

MR. LABBE said, according to the 2000 Census, Alaska's total population is 626,932. The number of children under 18 is 190,587. The number of adults 18 to 65 equals 400,610. The number of elderly Alaskans over 65 equals 35,735.

MR. LINDSTROM told subcommittee members that the 2000 Census does contain disability status for the civilian non-institutionalized population in Alaska. He was not aware of what definition of "disability" was used. The Census designated approximately 12 percent of Alaska's population disabled, amounting to 75,735 individuals. That category does not contain a breakdown for

children under the age of 5, but the number of disabled aged 5 to 20 years was 12,387; the number of disabled aged 21 to 64 was 47,357; and the number over the age of 65 was 15,991.

REPRESENTATIVE DYSON asked if the folks that pay their own costs are included in the chart.

MR. LABBE said they are not; the chart only represents Medicaid clients. He pointed out the standard used for eligibility for the disability category is tied to the Social Security Administration's disability definition, which is fairly rigorous. Therefore, many people are disabled who do not meet that standard.

MR. LABBE referred to page 21 of his power point presentation and said on average, states spent 14.7 percent of their general fund expenditures on their Medicaid programs in FY 01 while Alaska spent 10.8 percent. Alaska was 46th in the nation for state fund spending during FY 98. In terms of total expenditures, Alaska ranks low because it has a small population.

CHAIRWOMAN GREEN asked if Alaska's number is skewed upward because it does not have a county system.

MR. LABBE said in terms of state Medicaid programs, a few states have a county share but most programs are centrally administered. He offered to provide more back-up material from the reports these numbers were generated from.

SENATOR TAYLOR expressed concern that when comparisons are made with Alaska's general fund expenditures,

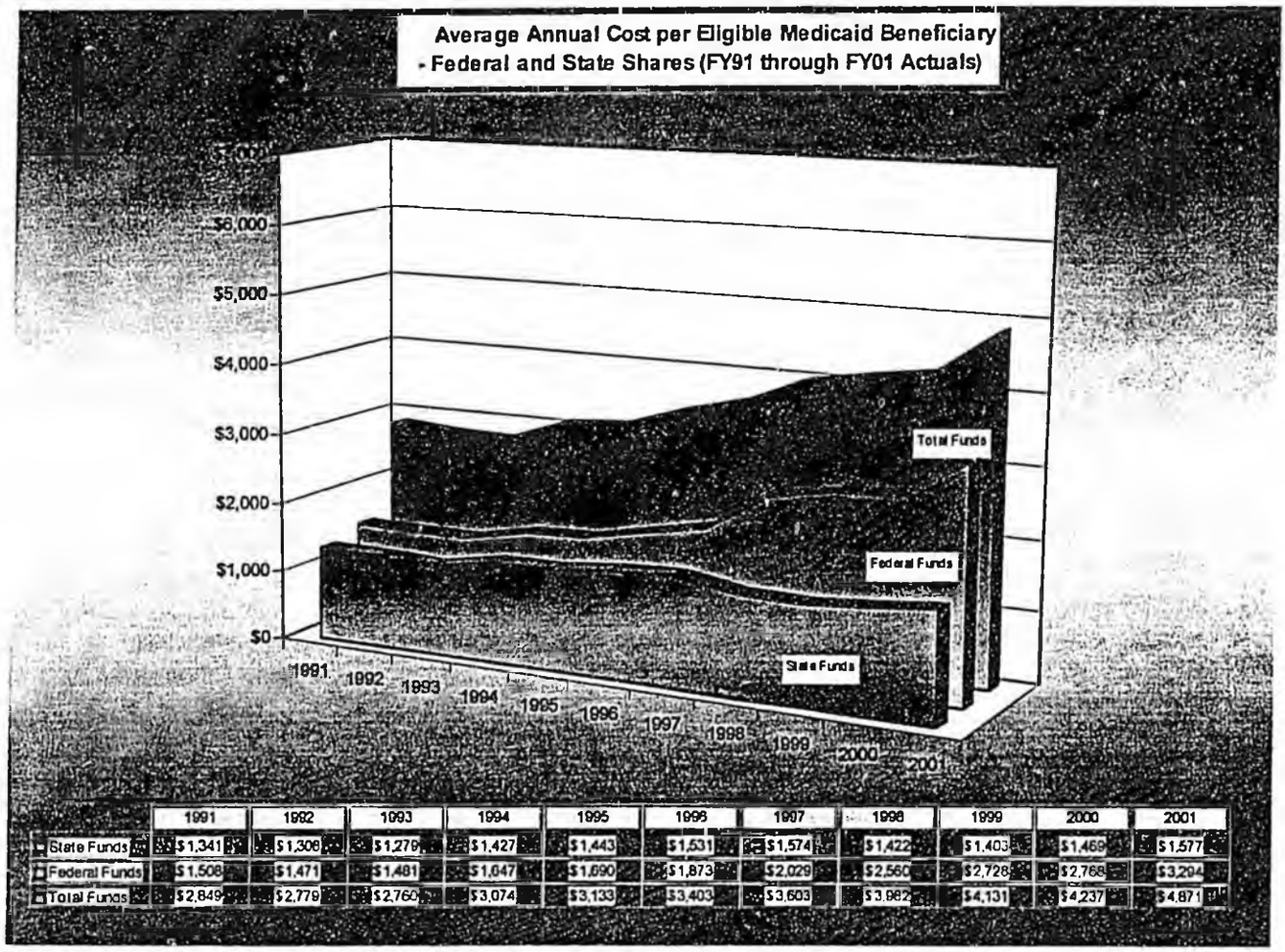
> ... for the last - gosh I don't know how many years now - we've been involved in an exercise in Juneau creating other quote, special funds. And every time a department or agency wanted to go out and [indisc.] a little more income for their agency, they went out and created a new fee schedule and their new fee schedule became part of their specific fund base for their agency - whether it was $5 bucks additional per license for every person who wanted to catch a king salmon so the fish and game department got a significant increase. And rather than have the budget reflect the [indisc.] Department of Fish and Game had gone up, what we did was we called that other funds - not general funds, other funds. And that other funds [indisc.] we make certain it's not dedicated of course, we make certain it goes to the Department of Fish and Game. So their budget actually went up $5 million bucks but does that reflect as a general fund? No, the general fund budget didn't go up. So when I see a comparison being

made between what is stated as general fund allocation, and a comparison is then made up of what our expenditures are either per capita or on a national level, it really is becoming less and less of a meaningful comparison is all I'm getting at....

MR. LABBE stated that would lower Alaska's percentage.

SENATOR TAYLOR said it should, and that is what he was getting at.

MR. LABBE referred to the following chart and said the purpose of



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
State Funds	$1,341	$1,308	$1,279	$1,427	$1,443	$1,531	$1,574	$1,422	$1,403	$1,469	$1,577
Federal Funds	$1,508	$1,471	$1,481	$1,647	$1,690	$1,873	$2,029	$2,560	$2,728	$2,768	$3,294
Total Funds	$2,849	$2,779	$2,760	$3,074	$3,133	$3,403	$3,603	$3,982	$4,131	$4,237	$4,871

the graph is to show that over the last 10 years, the general fund outlay has not been extreme in terms of increases. Although the total cost of the program has increased, most of the increase has been with federal funds. He noted between 1994 and 1999, the average general fund increase was about 3 percent per year. The federal increase was 16 or 17 percent per year. He felt that was

primarily due to the match rate change, but also Alaska has been progressive in maximizing the 100 percent IHS reimbursement and in taking other cost containment measures. He said he is always concerned about the cost of the general fund. He stated that a 3 percent increase per year per person is not too bad. Essentially, the state is cost shifting and trying to avoid cost shifting by the federal government.

CHAIRWOMAN GREEN said if one looks at the increase from 1991 to 2001 in total funds, it amounts to about a 75 percent increase. She said she is concerned about accepting a prior year increase as the norm and that the federal match rate will continue because at some point, the state will have no control over the cost.

MR. LABBE said he agrees with Mr. Gilbertson's concern that Congress needs to take an honest look at that match rate. DMA has been doing some work internally to help support Senator Murkowski's effort by providing data and looking at what other private payers pay in Alaska relative to what they pay in other states. DMA now has access to a program that provides expenditures by codes in other areas and has started to compile information that shows that Alaska's payment per beneficiary is higher than most states. It is also higher for Blue Cross or Aetna by a similar percentage. He felt that demonstrates that costs are higher in Alaska, not that the state is overpaying.

SENATOR TAYLOR said:

> You are living in a world that is so Alice in Wonderland, none of us are in Kansas anymore. As your local hospital what the bill is for a room for a day. Do you know what the answer is you're going to get back? You will find out that that local hospital has probably six or seven schedules for what that room is worth. It's worth this much if you're a Medicare patient, it's worth this much if you're a Medicaid patient, it's worth this much if you're Blue Cross. You'll find that's right at the top because everybody else has some advocacy group that comes in and negotiates with that hospital to set rates. Probably the most controversial thing I got my little nose stuck into for the last two or three years was when I took on you guys on the issue of the revolving door on rate hearings and when we were going to make some decisions and how are we going to set them and then Torgy jumped in too and says, look, if you don't want to just take care of part of the problem, I'll take care of all of it and I'll set your rates for you. All of a sudden people decided to get to the table.

I can guarantee you, the marketplace has absolutely nothing to do with anything going on out there. It's all bureaucracy and you as bureaucrats get to negotiate with hospitals what you're going to pay and they negotiate back with you guys and then the insurance industry shows up and they try and do some of the same stuff. There's literally a rate out there for the guy who has no insurance but has a business and can pay his bills. Then there's a separate rate, a different one for the insurance company and a different rate for each state agency so why take and compare based on zip codes what somebody may be paying in Arkansas? It's just that the Arkansas docs and the hospitals haven't raped their people down there yet but believe me, they're coming around the corner just like you guys have so badly in California that when the federal government started this whole process, they had to go down there and take an average because they were seeing a cost - or bills coming in from doctors, where in a six month period the price of the same process in surgery and so on had gone up 200 percent with the same doc because he was bidding each time to see, well, he'd tell the guy he's playing golf with, well gosh, I got $200 for an appendectomy last week and the other guy said, well by gosh George, you get $200, my appendectomy is worth $300 so he would charge three and the next week the other guy charges four and it just kept evolving up.

So, I don't know where any of that gets us - what it gets me - it gets me very frustrated that we have an awful lot of state and federal bureaucrats involved in the process of setting rates which we then have to fund in the form of a budget that's going to cap out within the next year or two at a billion dollars just for this state....

SENATOR TAYLOR said he really believes that if we don't pay attention to this and find a solution, we will find a lot of people relying on services that the state will not be able to provide.

MR. LABBE said that across the nation Alaska ranks number 47 in total expenditures for Medicaid. He explained that a Supreme Court decision regarding the Americans With Disabilities Act said that the state would be required to provide services that would permit individuals to live in the community rather than an institution. The case called Olmstead involved a couple of women in Georgia who were in a state hospital. Their medical providers felt could leave the hospital, but the state wasn't moving them

out.

The plaintiffs won that and since that time, there has been quite a bit of work around the country. His division was told by the federal Medicaid Agency (HCFA) that the Medicaid Program can help states comply with the Supreme Court decision, because the federal government will help share in the expense with community based services. Alaska has moved further along than many states in terms of our community base care program and closed Harbor View, consistent with the view that people aren't inappropriately institutionalized and that there are options. They are still waiting lists of issues for services and significant capacity problems in terms of people providing supports in the community, especially in smaller communities. Medicaid can help these issues and that's what they have been doing through the home and community based waivers.

CHAIRMAN GREEN thanked him for his testimony and further discussions would be needed.

MR. LABBE added that there were several things that Steve Branchflower mentioned and he wanted to respond to one comment that was misunderstood. When he said we were only one of three states that operate in the fee for service Medicaid Program and all the rest have HMOs, every state has a fee for service program. Many of them also have an HMO. You have the same dynamic in 50 states of providers billing and some states have a percentage of their population signed up on the prepaid plan, but it's still less than 50% of the total national Medicaid population involving HMOs.

SENATOR TAYLOR said a Sitka constituent had a question about what an alcohol counselor can be called and how they get reimbursed based upon that. The legislature passed a law or there was a regulation saying that a person needed to have a master's degree or better to be in alcohol counseling.

MR. LABBE responded that the Mental Health has that kind of rule, but he didn't think that was required for alcohol.

SENATOR TAYLOR asked him to look into it and he agreed.

SENATOR DAVIS asked him to address the building manual and the audits.

MR. LABBE replied that they were directed by the legislature in '97 to initiate a series of cost containment actions, one of which was the provider audits. They have to work through backlogs.

SENATOR DAVIS asked if they have administrative procedures for

prosecution and how many people are working in that area. She also wanted to know how many cases he had been able to get funds for.

An unidentified woman responded that just doing this in the spirit of prosecution is sometimes a negative way to look at it, because there were built-in improvements.

MR. LABBE said that the focus was particularly on the patient and one of the problems with the $22 million is what Mr. Branchflower perceives are the draft reports from the contractor concurrently with the state. The state had to make a number of policy changes, which is a lengthy process.

> For the most part, we didn't do the extrapolation because this was like our first time really going out. What we are doing is working on compliance and correction...If you look at our physician expenditures, they're practically flat for about three years before we expand the populations. So, I believe the attempt of the legislature was to slow the growth of the program. It was not aimed so much at the recovery mode...We had some problems with it, too.

SENATOR TAYLOR thanked him for his excellent presentation and said they would next take public testimony.

4:09

MR. BILL HOGAN, Executive Director, Lifequest Regional Health Center, said he is also a member of the Alaska Community Mental Health Services Association, which is the mental health providers association. Today he is speaking for the Alaska Mental Health Board. He said:

> Programs such as Alaska Temporary Assistance program, Adult Public Assistance and General Relief provide basic support for many Alaskans, helping them to meet fundamental expenses such as food, shelter, clothing and transportation. Whether transitional or long-term in nature, these programs allow participants to live as independently as possible and with dignity in their community of choice. These programs also help Alaskans avoid homelessness and minimize higher costs, more restrictive settings, including hospitalization, nursing home placement and incarceration.
>
> The Board asked that the subcommittee as they review programs, do so based on the following principles:

- All Alaskans have the basic human need to achieve and maintain the highest possible level of independence.
- The State has a responsibility to address the basic human needs of individuals who do not have other means to meet those needs on either a short or long-term basis.
- Support levels should be sufficient to allow individual to live with dignity in the community
- Programs should be readily accessible to eligible applicants.
- Programs and services should be managed to promote efficiency and maximize resources.

MR. HOGAN recommended they review the programs in a thoughtful manner.

- None of the proposed changes have a negative impact on the ability of participants to meet basic living needs.
- Review of the programs should be on a program-by-program basis.
- No major changes should be made without meaningful input from the program recipients.

MR. HOGAN said he firmly believes that as a provider they have an obligation to the taxpayers of Alaska and the legislature to make sure they are getting the best bang for the buck. He said they are concerned about access.

> In many instances publicly funded programs are the only source of health care for many Alaskans and that's not entirely true for a number of folks who have no insurance at this point. Without Medicaid and other publicly funded health care programs, many persons would have nothing.

He emphasized the importance of treating mental illness and mental health care in a similar way to physical health. The Surgeon General's Report on Mental Health from 1999 - 2000 advocates strongly for states passing mental health parity legislation and the federal government just passed a mental health parity law.

He wanted to comment on Representative Dyson's suggestion to begin looking at integrating primary care mental health and substance abuse. Most mental health and substance abuse providers feel that makes a lot of sense and many communities need a one-

stop shop where people can go and get everything they need without being shuffled.

Also, many mental health providers have undertaken an effort to develop corporate compliance plans in regards to Medicaid and Medicare fraud. They have had at least one consultant up from down south to help mental health centers begin to develop their compliance limits. The Medicaid regulations are very complicated and they are equally complicated for providers to comply with.

As a Mental Health Board member, they are concerned about out-of-state placement for kids. There are about 250 kids for about $14 million.

> We are committed to develop in-state capacity to keep kids in Alaska close to their own homes. It's pretty difficult to do family therapy with a kid and try to reunite a child with their family of natural origin if the kid is in Idaho or Montana…

MR.HOGAN next commented on the disabled and his best guess at prevalence of mentally disabled in Alaska is about 24,000 individuals or about 4% of the population. If the 75,000 figure is accurate, it might be safe to say about a third of those are mentally disabled.

An unidentified person asked how many were related to fetal alcohol syndrome.

MR. HOGAN guessed about 10 - 15 percent, but it could be higher.

MS. LILA BERRY, Manager, Circle of Care, said she wanted to discuss care coordination. She explained that Circle of Care began about 12 years ago in response to a community tragedy where an elderly woman who lived by herself had many people involved in her care, but no one really knew about her day-to-day activities. So there was no coordination. She died and was found several days later.

MS. BERRY said that geriatric care coordinators can be found in all parts of the United States and many parts of the world. They assist seniors and adults with physical disabilities with doing screenings, consultation and assessments to help people get through mazes of eligibility. She helps them problem solve and obtain services so that they stay as safe and healthy as possible. This may mean assisting seniors who cannot afford their current housing, their food or their medication and protect them from financial exploitation.

TAPE 01-50, SIDE B

MS. BERRY continued:

> Hundreds of seniors and disabled person benefit from the choice waiver program and as our senior population is rapidly growing and is predicted to continue to grow, we need to enhance and improve our menu of services for seniors and for those with adult physical disabilities, but there are gaps in services for people with chronic illnesses. The safety net for people who are chronically ill is inadequate to meet the needs of our residents. There is the person who might be $10 over Medicaid or have a chronic illness that's not covered by the PMO. For example, if you have a respiratory illness, you're out of luck. You're not covered. Or there might be the person who hasn't worked enough quarters to be eligible for disability under [indisc].
>
> Oregon is one example of innovative ways to meet the needs of the chronically ill who might not be eligible for traditional Medicaid. I am asking that some consideration be given to this population with one area, the people with respiratory illnesses who are not currently eligible for Medicaid.

MS. KRIS MOORE, Wasilla parent, said she has four children, two have been adopted from within the family. She said that parents should plan to have their children and make sure they have coverage before they have children. Neither she nor her husband have jobs that offer reasonable health insurance and she was recently unexpectedly laid off. "Many families experience these kinds of unexpected transitions…In the case of a medical emergency or for the necessary basic care during these times, we would be set back financially for years were it not for Denali Kid Care coverage."

CHAIRMAN GREEN asked if she had received a message about Denali Kid Care.

MS. MOORE replied that she hadn't specifically heard anything.

CHAIRMAN GREEN said that tomorrow's discussion was going to be about how to find alternative methods of health insurance and get coverage in places. She did not think the Denali Kid Care model is the ideal model. She said it might need to be retooled where people have the ability to participate in the selection, the types of coverage and phase into a regular health insurance policy. She did not want to strip the Denali Kid Care. She said, "The CHIPS Program is in probably going to be changed. What does that do to Denali Kid Care when it comes down from the feds to

us? I don't know. It's a dilemma."

MS. MOORE responded that her point is that they need to make sure they are considering the resources parents and families receive in these programs. She urged them to find a way to deal with the fraud issues.

MS. ELAINE MANNING said she has a Medicaid waiver. Before it came, she and her husband didn't know if they could stay in their home where they want to be. "If we could keep, for instance, 100 people in their home where they want to be, we would save our state millions of dollars and I think we're going in the right direction…"

MS. MONTA FAYE LANE, President, Alaska Caregivers Association, said the assisted living homes are far more cost effective than they realize. SB 73 had a lot of support in the legislature, but now it seems that people want to change the intent, which was to give providers a raise in the daily room and board rate they receive for taking care of indigent and elderly people, alcoholics, chronically mentally ill, etc. She explained that when she worked with Senator Mike Miller on this bill, they were receiving $34.50 per day room and board to care for these people and they figured it should be $150 per day. There was no Medicaid money at that time. It was increased to $50 per day in 2000. In 2001 it went up to $60 and in 2002 it will be $70. She said that the State wants to take away 60 percent of that. "That's going to make us receive for room and board for these people less than the 1982 $31.90."

Additionally, people are being kicked out of hospitals quicker and sicker than they ever have before in the history of the United States. She said, "I can't see why they can't figure out what a savings assisted living is to the State of Alaska when you set and look at the numbers."

MS. LANE told the committee that she was taking care of a quadriplegic patient for $3,500 a month and he was kicked out of a nursing home that was charging $15,000. He was an alcoholic and there was no way to recover any damages he did to their home. She couldn't just kick him out and continues to take his abuse. She asked that the legislature:

> Redefine the way they handle the Medicaid Program of the PA numbers. When I talk about PA numbers, I'm talking about getting paid that little $68.41 a day. I had to wait 180 days to get my money and I think that's atrocious. I'm supposed to carry the State of Alaska on my back?

MS. MARY OLSON, physical therapist, said she worked for 25 years

with children and serves on the National Board of the American Physical Therapy Association's Pediatric Section. She got an e-mail stating the committee was going to address the Denali Kid Care Program and she sees the importance of the program to the Medicaid waivers. Her first job as a physical therapist was in a boarding school for kids 5 - 21 years old because they had a physical disability. The requirement was that they had a physical disability, but intellectually normal. She has since worked with other families where the Medicaid waivers have made it possible for patients to be at home.

> The important thing is that the services be financially accessible to all children, particularly. I'm a strong believer in early intervention. That's where were going to make a difference and a kids life…and to pregnant women…Stop these problems before they occur…If they are there, get these kids on as soon as possible doing the best they can.

MS. OLSON said in her private practice that regulation and paperwork are two-thirds of her cost. "If I would just get paid for the work I do and I love to do, I would be thoroughly satisfied, but you've got to pay me for that other stuff you make me do."

MS. OLSON asked if Medicaid in schools had been addressed. She said there are many ways people receive assistance and there was no coordination or any one to take ultimate responsibility.

MS. SUE DROVER said she was not representing anyone and wanted to talk about Denali Kid Care. Her son tried to commit suicide 14 months ago and the doctors said he needed long-term care. She would have had to take him home where he would have to be watched all the time, because she could not afford to send him to a long-term facility. Fortunately, he qualified for Denali Kid Care allowing him to get the treatment and round-the-clock care that he needed and she felt that was the only reason he was alive today. She requested that they fund an in-state residential treatment center. She said there is no alcohol or drug abuse involved in her son's case.

CHAIRMAN GREEN asked someone from the Department if he knew of any those facilities were being planned. He answered that there are two facilities in-state that are long-term - North Star Behavioral Health and Alaska Children's Services Center - and Providence in short-term.

CHAIRMAN GREEN asked if the two long-term facilities were residential. He answered that they are and added that they have vacancies.

MS. DROVER said that at the time it may have been an availability issue at the time, but now he is so ingrained with the treatment and doing well in Utah that he wouldn't want to leave.

CHAIRMAN GREEN thanked her for coming in and added that she thought they would be hearing more about these facilities.

MS. DROVER added that if anything happens outside of the facility, that their regular medical insurance takes care of it. Denali Kid Care covers the residential facility fees which are about $9,000 per month.

MS. RUTH TITLER said she is a 61-year old diabetic and had been dependent on insulin for 52 years. She has other major complications directly related to the diabetes. About three years ago, her physician requested that Circle of Care evaluate her needs at home. It was determined that she needed additional help with showers, cooking and laundry. Once she was approved by the Choice Labor Program, life became better. Her care coordinator contacts her at least twice a month - one of them is a face to face visit; they monitor how her outside help is doing. Her family lives in the Lower 48 and Circle of Care has given her emotional support as well, which is very important in a person's outlook on life.

MS. TITLER said because the state opted out of the Social Security System, she is denied disability and doesn't qualify for Medicare until she is 65. "If it was not for a Choice waiver, Medicaid and Circle of Care, I believe I would not be able to maintain independent living…"

She supported continuing Medicaid money to those who need it most.

DR. DAVID ALEXANDER, physician member of the Medical Care Advisory Committee (MCAC), said he faxed them a copy of his comments. The main thing is that the State Medicaid Program has been closely reviewed by the MCAC with Bob Labbe meeting with them for two days four times a year. This Committee came up with some recommendations. The first one was: "It ain't broke; so don't try to fix it. Beyond that, it can clearly be tweaked and improved."

As an example, he said there is money spent for disaster dental care for adults, but if you're going to do that, there should be some way to fund preventive care as well, because it's a lot cheaper in the long run. He said second, the issue of payment for transportation charges needs review; it's unclear why the state is trying to be fiscally conservative and insist on paying top dollar for air tickets, because tickets can only be purchase if

they are totally refundable so they have to wait until the last minute to buy it.

Speaking as a pediatrician, he said the federal government is proposing cost neutral health insurance flexibility and accountability waivers that will allow coverage for more adults, but only contracting the amount that's available to children (because it has to be cost neutral). In addition, some of the current Medicaid money would have to go to set up the program, which is complex. He thought it was poor economic policy to drop people from the program when they finally get just above the poverty level.

MR. DENNIS DUNN, Principal at Kenai Alternative High School, said that he is here to represent the voiceless. He has about 75 kids and about a third of them a different times qualify as homeless and well over half of his population utilize the Denali Kid Care Program.

> Without this program, it's unquestionably clear that they would not get the medical services that they are now providing. Now these students have access to vision services, general medical care and mental health care. In addition, some of our students are also parents that have children. In many cases both the student and our school as well as their child is a recipient of the Denali Kid Care. I just cannot emphasize the difference this is making in the lives of these kids. These are kids who have nowhere to go, no access to any kind of health care, whatsoever until this program came along.

MR. DUNN said a couple of problems he had with his kids is that several providers are reluctant to take Denali Kid Care, in particular dentists. He said some psychologists are now being allowed to bill. Also, many of his kids are on their own, but they can't be seen unless they have someone who is over 18. If they have a Denali Kid Care card, it would help if they could go without someone 18 years old. He strongly supported continuing the program.

CHAIRMAN GREEN thanked him and said that emancipation was another issue they would have to deal with.

SENATOR TAYLOR said, "There's a whole series of things we need to take up, Madam Chairman. When it comes to parental responsibility, the idea of a throw away kid in Alaska is more than offensive to me…"

CHAIRMAN GREEN thanked everyone for their testimony and adjourned the meeting at 5:05 p.m.

Alaska State Medical Association

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05/07/2003

Honorable Lesil McGuire
State of Alaska
House of Representatives, Room 118
Juneau, AK 99801-1112

Transmitted by Fax:
907-465-6592

Re: SB 41

Dear Representative McGuire:

Previously you inquired of ASMA's executive director, Jim Jordan, as to ASMA's position on SB 41. At the time of his response, ASMA had not arrived at a position. Now it has and ASMA cannot support SB 41 unless it is amended to alleviate some potentially serious unintended consequences.

In his letter to you dated 4/14/03, Mr. Jordan pointed out some of the problems that occurred during FY 98 audits of physicians. I am aware of a number of physicians who, due to those problems experienced, are no longer seeing Medicaid patients. The potential lack of access to care is the most significant unintended consequence that could occur.

The criminalization of honest mistakes is also a concern. The payment methodology (RBRVS) and coding schema (CPT) for Medicaid in Alaska is the same as for Medicare. With the Medicare program, honest coding mistakes have occurred and will continue to occur. The coding for many treatments is not an exact science. Coding questions posed to Medicare administrative personnel have not resulted in either consistent or accurate answers. It's my understanding that neither Medicaid officials nor its contractors will provide any responses to individual questions regarding coding. When a physician cannot get a definitive answer from the administering agency, how can she/he know that they won't be charged criminally for an honest mistake or a legitimate difference in opinion over proper coding?

The above uncertainty, the experiences of the FY 98 audits, and the relatively low level of payment provides the basis for an easy decision to not see Medicaid patients

Until SB 41 positively addresses the above concerns, ASMA cannot support it.

Sincerely,

Jeanne Bonar

By: Jeanne Bonar, MD, President
For: Alaska State Medical Association

Alaska State Medical Association

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TO: Representative Lesil McGuire # Pages 2

FROM: Jeanne Bonar, MD President

DATE: 05/07/03

SUBJECT: SB 41

Alaska State Legislature

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Juneau, AK 99801
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Representative Lesil McGuire

Chair, Judiciary Committee

MEMORANDUM

To: House Judiciary Committee
From: Rep. Lesil McGuire, Chair – Judiciary
Date: May 15, 2003
Re: Waiver request for House Judiciary Committee referral for SB 41 – *"An Act relating to medical care and crimes relating to medical care, including medical care and crimes relating to the medical assistance program, catastrophic illness assistance, and medical assistance for chronic and acute medical conditions."*

Given our extraordinarily full committee schedule for the remainder of the session, and the fact that we have heard this bill once before on May 12th, I am requesting that we waive SB 41 from the House Judiciary Committee. Because of the sizeable fiscal note attached to this bill, I believe our colleagues on the House Finance Committee are better to address the policy implications of this bill. This bill currently has a Finance referral following Judiciary.

AGREEMENT TO WAIVE SB 41 FROM THE HOUSE JUDICIARY COMMITTEE

Rep. Lesil McGuire (Chair)_____

Rep. Tom Anderson (Vice-Chair)_____

Rep. Les Gara_____

Rep. Max Gruenberg_____

Rep. Jim Holm_____

Rep. Dan Ogg_____

Rep. Ralph Samuels_____

MEMO

DATE: 5/15/2003

To: House Judiciary Committee
Representative Lesil McGuire
Attn: Vanessa Tondini

From: Representative Jim Holm

RE: Request for Waiving SB41
"Medicaid Costs and Crimes"

I am consenting to have Senate Bill 41, "Medicaid Costs and Crimes," from House Judiciary.

Representative Jim Holm

5/15/03
Date

"(D) shall be responsible generally for advising the Secretary and the Congress on the status of the implementation of part C of title XI of the Social Security Act."; and

(5) by adding at the end the following:

"(7) Not later than 1 year after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, and annually thereafter, the Committee shall submit to the Congress, and make public, a report regarding the implementation of part C of title XI of the Social Security Act. Such report shall address the following subjects, to the extent that the Committee determines appropriate: Reports.

"(A) The extent to which persons required to comply with part C of title XI of the Social Security Act are cooperating in implementing the standards adopted under such part.

"(B) The extent to which such entities are meeting the security standards adopted under such part and the types of penalties assessed for noncompliance with such standards.

"(C) Whether the Federal and State Governments are receiving information of sufficient quality to meet their responsibilities under such part.

"(D) Any problems that exist with respect to implementation of such part.

"(E) The extent to which timetables under such part are being met.".

SEC. 264. RECOMMENDATIONS WITH RESPECT TO PRIVACY OF CERTAIN HEALTH INFORMATION. 42 USC 1320d–2 note.

(a) IN GENERAL.—Not later than the date that is 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the Committee on Labor and Human Resources and the Committee on Finance of the Senate and the Committee on Commerce and the Committee on Ways and Means of the House of Representatives detailed recommendations on standards with respect to the privacy of individually identifiable health information.

(b) SUBJECTS FOR RECOMMENDATIONS.—The recommendations under subsection (a) shall address at least the following:

(1) The rights that an individual who is a subject of individually identifiable health information should have.

(2) The procedures that should be established for the exercise of such rights.

(3) The uses and disclosures of such information that should be authorized or required.

(c) REGULATIONS.—

(1) IN GENERAL.—If legislation governing standards with respect to the privacy of individually identifiable health information transmitted in connection with the transactions described in section 1173(a) of the Social Security Act (as added by section 262) is not enacted by the date that is 36 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall promulgate final regulations containing such standards not later than the date that is 42 months after the date of the enactment of this Act. Such regulations shall address at least the subjects described in subsection (b). Regulations.

(2) PREEMPTION.—A regulation promulgated under paragraph (1) shall not supercede a contrary provision of State

law, if the provision of State law imposes requirements, standards, or implementation specifications that are more stringent than the requirements, standards, or implementation specifications imposed under the regulation.

(d) CONSULTATION.—In carrying out this section, the Secretary of Health and Human Services shall consult with—

(1) the National Committee on Vital and Health Statistics established under section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)); and

(2) the Attorney General.

Subtitle G—Duplication and Coordination of Medicare-Related Plans

SEC. 271. DUPLICATION AND COORDINATION OF MEDICARE-RELATED PLANS.

(a) TREATMENT OF CERTAIN HEALTH INSURANCE POLICIES AS NONDUPLICATIVE.—Section 1882(d)(3)(A) (42 U.S.C. 1395ss(d)(3)(A)) is amended—

(1) in clause (iii), by striking "clause (i)" and inserting "clause (i)(II)"; and

(2) by adding at the end the following:

"(iv) For purposes of this subparagraph, a health insurance policy (other than a Medicare supplemental policy) providing for benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual is not considered to 'duplicate' any health benefits under this title, under title XIX, or under a health insurance policy, and subclauses (I) and (III) of clause (i) do not apply to such a policy.

"(v) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy) is not considered to 'duplicate' health benefits under this title or under another health insurance policy if it—

"(I) provides health care benefits only for long-term care, nursing home care, home health care, or community-based care, or any combination thereof,

"(II) coordinates against or excludes items and services available or paid for under this title or under another health insurance policy, and

"(III) for policies sold or issued on or after the end of the 90-day period beginning on the date of enactment of the Health Insurance Portability and Accountability Act of 1996 discloses such coordination or exclusion in the policy's outline of coverage.

For purposes of this clause, the terms 'coordinates' and 'coordination' mean, with respect to a policy in relation to health benefits under this title or under another health insurance policy, that the policy under its terms is secondary to, or excludes from payment, items and services to the extent available or paid for under this title or under another health insurance policy.

"(vi)(I) An individual entitled to benefits under part A or enrolled under part B of this title who is applying for a health insurance policy (other than a policy described in subclause (III)) shall be furnished a disclosure statement described in clause (vii) for the type of policy being applied for. Such statement shall be

Subparts B–D [Reserved]

Subpart E—Privacy of Individually Identifiable Health Information

AUTHORITY: 42 U.S.C. 1320d–2 and 1320d–4, sec. 264 of Pub. L. 104–191, 110 Stat. 2033–2034 (42 U.S.C. 1320(d–2(note)).

SOURCE: 65 FR 82802, Dec. 28, 2000, unless otherwise noted.

Subpart A—General Provisions

§ 164.102 Statutory basis.

The provisions of this part are adopted pursuant to the Secretary's authority to prescribe standards, requirements, and implementation standards under part C of title XI of the Act and section 264 of Public Law 104–191.

EFFECTIVE DATE NOTE: At 67 FR 53266, Aug. 14, 2002, §164.102 was amended by removing the words "implementation standards" and adding in its place the words "implementation specifications", effective Oct. 15, 2002.

§ 164.104 Applicability.

Except as otherwise provided, the provisions of this part apply to covered entities: health plans, health care clearinghouses, and health care providers who transmit health information in electronic form in connection with any transaction referred to in section 1173(a)(1) of the Act.

§ 164.106 Relationship to other parts.

In complying with the requirements of this part, covered entities are required to comply with the applicable provisions of parts 160 and 162 of this subchapter.

Subpart B–D [Reserved]

Subpart E—Privacy of Individually Identifiable Health Information

AUTHORITY: 42 U.S.C. 1320d–2 and 1320d–4, sec. 264 of Pub. L. 104–191, 110 Stat. 2033–2034 (42 U.S.C. 1320d–2(note)).

§ 164.500 Applicability.

(a) Except as otherwise provided herein, the standards, requirements, and implementation specifications of this subpart apply to covered entities with respect to protected health information.

(b) Health care clearinghouses must comply with the standards, requirements, and implementation specifications as follows:

(1) When a health care clearinghouse creates or receives protected health information as a business associate of another covered entity, the clearinghouse must comply with:

(i) Section 164.500 relating to applicability;

(ii) Section 164.501 relating to definitions;

(iii) Section 164.502 relating to uses and disclosures of protected health information, except that a clearinghouse is prohibited from using or disclosing protected health information other than as permitted in the business associate contract under which it created or received the protected health information;

(iv) Section 164.504 relating to the organizational requirements for covered entities, including the designation of health care components of a covered entity;

(v) Section 164.512 relating to uses and disclosures for which consent, individual authorization or an opportunity to agree or object is not required, except that a clearinghouse is prohibited from using or disclosing protected health informa ion other than as permitted in the business associate contract under v hich it created or received the pr tected health information;

(vi) Section 164.532 relating to transition requirements; and

(vii) Section 164.534 relating to compliance dates for initial implementation of the privacy standards.

(2) When a health care clearinghouse creates or receives protected health information other than as a business associate of a covered entity, the clearinghouse must comply with all of the standards, requirements, and implementation specifications of this subpart.

(c) The standards, requirements, and implementation specifications of this subpart do not apply to the Department of Defense or to any other federal agency, or non-governmental organization acting on its behalf, when providing health care to overseas foreign national beneficiaries.

EFFECTIVE DATE NOTE: At 67 FR 53266, Aug. 14, 2002, in §164.500, remove "consent," from paragraph (b)(1)(v), effective Oct. 15, 2002.

§164.501 Definitions.

As used in this subpart, the following terms have the following meanings:

Correctional institution means any ponal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. *Other persons* held in lawful custody includes juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial.

Covered functions means those functions of a covered entity the performance of which makes the entity a health plan, health care provider, or health care clearinghouse.

Data aggregation means, with respect to protected health information created or received by a business associate in its capacity as the business associate of a covered entity, the combining of such protected health information by the business associate with the protected health information received by the business associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.

Designated record set means:

(1) A group of records maintained by or for a covered entity that is:

(i) The medical records and billing records about individuals maintained by or for a covered health care provider;

(ii) The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

(iii) Used, in whole or in part, by or for the covered entity to make decisions about individuals.

(2) For purposes of this paragraph, the term record means any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated by or for a covered entity.

Direct treatment relationship means a treatment relationship between an individual and a health care provider that is not an indirect treatment relationship.

Disclosure means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

Health care operations means any of the following activities of the covered entity to the extent that the activities are related to covered functions, and any of the following activities of an organized health care arrangement in which the covered entity participates:

(1) Conducting quality assessment and improvement activities, including

outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;

(2) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;

(3) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of §164.514(g) are met, if applicable;

(4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(5) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

(6) Business management and general administrative activities of the entity, including, but not limited to:

(i) Management activities relating to implementation of and compliance with the requirements of this subchapter;

(ii) Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer.

(iii) Resolution of internal grievances;

(iv) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and

(v) Consistent with the applicable requirements of §164.514, creating deidentified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required as described in §164.514(e)(2).

Health oversight agency means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.

Indirect treatment relationship means a relationship between an individual and a health care provider in which:

(1) The health care provider delivers health care to the individual based on the orders of another health care provider; and

(2) The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual.

Individual means the person who is the subject of protected health information.

Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and:

(1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

(2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

(i) That identifies the individual; or

(ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Inmate means a person incarcerated in or otherwise confined to a correctional institution.

Law enforcement official means an officer or employee of any agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, who is empowered by law to:

(1) Investigate or conduct an official inquiry into a potential violation of law; or

(2) Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

Marketing means to make a communication about a product or service a purpose of which is to encourage recipients of the communication to purchase or use the product or service.

(1) *Marketing* does not include communications that meet the requirements of paragraph (2) of this definition and that are made by a covered entity:

(i) For the purpose of describing the entities participating in a health care provider network or health plan network, or for the purpose of describing if and the extent to which a product or service (or payment for such product or service) is provided by a covered entity or included in a plan of benefits; or

(ii) That are tailored to the circumstances of a particular individual and the communications are:

(A) Made by a health care provider to an individual as part of the treatment of the individual, and for the purpose of furthering the treatment of that individual; or

(B) Made by a health care provider or health plan to an individual in the course of managing the treatment of that individual, or for the purpose of directing or recommending to that individual alternative treatments, therapies, health care providers, or settings of care.

(2) A communication described in paragraph (1) of this definition is not included in marketing if:

(i) The communication is made orally; or

(ii) The communication is in writing and the covered entity does not receive direct or indirect remuneration from a third party for making the communication.

Organized health care arrangement means:

(1) A clinically integrated care setting in which individuals typically receive health care from more than one health care provider;

(2) An organized system of health care in which more than one covered entity participates, and in which the participating covered entities:

(i) Hold themselves out to the public as participating in a joint arrangement; and

(ii) Participate in joint activities that include at least one of the following:

(A) Utilization review, in which health care decisions by participating covered entities are reviewed by other participating covered entities or by a third party on their behalf;

(B) Quality assessment and improvement activities, in which treatment provided by participating covered entities is assessed by other participating covered entities or by a third party on their behalf; or

(C) Payment activities, if the financial risk for delivering health care is shared, in part or in whole, by participating covered entities through the joint arrangement and if protected health information created or received by a covered entity is reviewed by other participating covered entities or by a third party on their behalf for the purpose of administering the sharing of financial risk.

(3) A group health plan and a health insurance issuer or HMO with respect to such group health plan, but only with respect to protected health information created or received by such

health insurance issuer or HMO that relates to individuals who are or who have been participants or beneficiaries in such group health plan;

(4) A group health plan and one or more other group health plans each of which are maintained by the same plan sponsor; or

(5) The group health plans described in paragraph (4) of this definition and health insurance issuers or HMOs with respect to such group health plans, but only with respect to protected health information created or received by such health insurance issuers or HMOs that relates to individuals who are or have been participants or beneficiaries in any of such group health plans.

Payment means:

(1) The activities undertaken by:

(i) A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or

(ii) A covered health care provider or health plan to obtain or provide reimbursement for the provision of health care; and

(2) The activities in paragraph (1) of this definition relate to the individual to whom health care is provided and include, but are not limited to:

(i) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

(ii) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(iii) Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;

(iv) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

(v) Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and

(vi) Disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement:

(A) Name and address;

(B) Date of birth;

(C) Social security number;

(D) Payment history;

(E) Account number; and

(F) Name and address of the health care provider and/or health plan.

Plan sponsor is defined as defined at section 3(16)(B) of ERISA, 29 U.S.C. 1002(16)(B).

Protected health information means individually identifiable health information:

(1) Except as provided in paragraph (2) of this definition, that is:

(i) Transmitted by electronic media;

(ii) Maintained in any medium described in the definition of *electronic media* at §162.103 of this subchapter; or

(iii) Transmitted or maintained in any other form or medium.

(2) *Protected health information* excludes individually identifiable health information in:

(i) Education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g; and

(ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv).

Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. *Psychotherapy notes* excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Public health authority means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has

granted authority, that is responsible for public health matters as part of its official mandate.

Required by law means a mandate contained in law that compels a covered entity to make a use or disclosure of protected health information and that is enforceable in a court of law. *Required by law* includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

Research means a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

Use means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

EFFECTIVE DATE NOTE: At 67 FR 53266, Aug. 14, 2002, amend § 164.501 in the definition of "health care operations" by removing from the introductory text of the definition ", and any of the following activities of an organized health care arrangement in which the covered entity participates" and revising paragraphs (6)(iv) and (v); by removing the definition of "individually identifiable health information"; by revising the definition of "marketing"; in paragraph (1)(ii) of the definition of "payment," by removing the word "covered"; by revising paragraph (2) of the definition of "protected health information"; by removing the words "a covered" and replace them with "an" in the definition of "required by law", effective Oct. 15, 2002. For the convenience of the user, the revised text is set forth as follows:

§ 164.501 Definitions.

* * * * * *

Health care operations means * * *

(6) * * *

(iv) The sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and

(v) Consistent with the applicable requirements of § 164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.

* * * * * *

Marketing means:

(1) To make a communication about a product or service that encourages recipients of the communication to purchase or use the product or service, unless the communication is made:

(i) To describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the covered entity making the communication, including communications about: the entities participating in a health care provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits.

(ii) For treatment of the individual, or

(iii) For case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual.

(2) An arrangement between a covered entity and any other entity whereby the covered entity discloses protected health information to the other entity, in exchange for direct or indirect remuneration, for the other entity or its affiliate to make a communication about its own product or service that encourages recipients of the communication to purchase or use that product or service.

* * * * * *

Protected health information means * * *

(2) *Protected health information* excludes individually identifiable health information in:

(i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g;

(ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and

(iii) Employment records held by a covered entity in its role as employer.

* * * * *

§ 164.502 Uses and disclosures of protected health information: general rules.

(a) *Standard.* A covered entity may not use or disclose protected health information, except as permitted or required by this subpart or by subpart C of part 160 of this subchapter.

(1) *Permitted uses and disclosures.* A covered entity is permitted to use or disclose protected health information as follows:

(i) To the individual;

(ii) Pursuant to and in compliance with a consent that complies with § 164.506, to carry out treatment, payment, or health care operations;

(iii) Without consent, if consent is not required under § 164.506(a) and has not been sought under § 164.506(a)(4), to carry out treatment, payment, or health care operations, except with respect to psychotherapy notes;

(iv) Pursuant to and in compliance with a valid authorization under § 164.508;

(v) Pursuant to an agreement under, or as otherwise permitted by, § 164.510; and

(vi) As permitted by and in compliance with this section, § 164.512, or § 164.514(e), (f), and (g).

(2) *Required disclosures.* A covered entity is required to disclose protected health information:

(i) To an individual, when requested under, and required by § 164.524 or § 164.528; and

(ii) When required by the Secretary under subpart C of part 160 of this subchapter to investigate or determine the covered entity's compliance with this subpart.

(b) *Standard: Minimum necessary.* (1) *Minimum necessary applies.* When using or disclosing protected health information or when requesting protected health information from another covered entity, a covered entity must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

(2) *Minimum necessary does not apply.* This requirement does not apply to:

(i) Disclosures to or requests by a health care provider for treatment;

(ii) Uses or disclosures made to the individual, as permitted under paragraph (a)(1)(i) of this section, as required by paragraph (a)(2)(i) of this section, or pursuant to an authorization under § 164.508, except for authorizations requested by the covered entity under § 164.508(d), (e), or (f);

(iii) Disclosures made to the Secretary in accordance with subpart C of part 160 of this subchapter;

(iv) Uses or disclosures that are required by law, as described by § 164.512(a); and

(v) Uses or disclosures that are required for compliance with applicable requirements of this subchapter.

(c) *Standard: Uses and disclosures of protected health information subject to an agreed upon restriction.* A covered entity that has agreed to a restriction pursuant to § 164.522(a)(1) may not use or disclose the protected health information covered by the restriction in violation of such restriction, except as otherwise provided in § 164.522(a).

(d) *Standard: Uses and disclosures of de-identified protected health information.*(1) *Uses and disclosures to create de-identified information.* A covered entity may use protected health information to create information that is not individually identifiable health information or disclose protected health information only to a business associate for such purpose, whether or not the de-identified information is to be used by the covered entity.

(2) *Uses and disclosures of de-identified information.* Health information that meets the standard and implementation specifications for de-identification under § 164.514(a) and (b) is considered not to be individually identifiable health information, *i.e.*, de-identified. The requirements of this subpart do not apply to information that has been de-identified in accordance with the applicable requirements of § 164.514, provided that:

(i) Disclosure of a code or other means of record identification designed to enable coded or otherwise de-identified information to be re-identified constitutes disclosure of protected health information; and

(ii) If de-identified information is re-identified, a covered entity may use or disclose such re-identified information only as permitted or required by this subpart.

(e)(1) *Standard: Disclosures to business associates.* (i) A covered entity may disclose protected health information to a business associate and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurance that the business associate will appropriately safeguard the information.

(ii) This standard does not apply:

(A) With respect to disclosures by a covered entity to a health care provider concerning the treatment of the individual;

(B) With respect to disclosures by a group health plan or a health insurance issuer or HMO with respect to a group health plan to the plan sponsor, to the extent that the requirements of § 164.504(f) apply and are met; or

(C) With respect to uses or disclosures by a health plan that is a government program providing public benefits, if eligibility for, or enrollment in, the health plan is determined by an agency other than the agency administering the health plan, or if the protected health information used to determine enrollment or eligibility in the health plan is collected by an agency other than the agency administering the health plan, and such activity is authorized by law, with respect to the collection and sharing of individually identifiable health information for the performance of such functions by the health plan and the agency other than the agency administering the health plan.

(iii) A covered entity that violates the satisfactory assurances it provided as a business associate of another covered entity will be in noncompliance with the standards, implementation specifications, and requirements of this paragraph and § 164.504(e).

(2) *Implementation specification: documentation.* A covered entity must document the satisfactory assurances required by paragraph (e)(1) of this section through a written contract or other written agreement or arrangement with the business associate that meets the applicable requirements of § 164.504(e).

(f) *Standard: Deceased individuals.* A covered entity must comply with the requirements of this subpart with respect to the protected health information of a deceased individual.

(g)(1) *Standard: Personal representatives.* As specified in this paragraph, a covered entity must, except as provided in paragraphs (g)(3) and (g)(5) of this section, treat a personal representative as the individual for purposes of this subchapter.

(2) *Implementation specification: adults and emancipated minors.* If under applicable law a person has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, a covered entity must treat such person as a personal representative under this subchapter, with respect to protected health information relevant to such personal representation.

(3) *Implementation specification: unemancipated minors.* If under applicable law a parent, guardian, or other person acting *in loco parentis* has authority to act on behalf of an individual who is an unemancipated minor in making decisions related to health care, a covered entity must treat such person as a personal representative under this subchapter, with respect to protected health information relevant to such personal representation, except that such person may not be a personal representative of an unemancipated minor, and the minor has the authority to act as an individual, with respect to protected health information pertaining to a health care service, if:

(i) The minor consents to such health care service; no other consent to such health care service is required by law, regardless of whether the consent of another person has also been obtained; and the minor has not requested that such person be treated as the personal representative;

(ii) The minor may lawfully obtain such health care service without the consent of a parent, guardian, or other person acting *in loco parentis*, and the minor, a court, or another person authorized by law consents to such health care service; or

(iii) A parent, guardian, or other person acting *in loco parentis* assents to an agreement of confidentiality between a covered health care provider and the minor with respect to such health care service.

(4) *Implementation specification: Deceased individuals.* If under applicable law an executor, administrator, or other person has authority to act on behalf of a deceased individual or of the individual's estate, a covered entity must treat such person as a personal representative under this subchapter, with respect to protected health information relevant to such personal representation.

(5) *Implementation specification: Abuse, neglect, endangerment situations.* Notwithstanding a State law or any requirement of this paragraph to the contrary, a covered entity may elect not to treat a person as the personal representative of an individual if:

(i) The covered entity has a reasonable belief that:

(A) The individual has been or may be subjected to domestic violence, abuse, or neglect by such person; or

(B) Treating such person as the personal representative could endanger the individual; and

(ii) The covered entity, in the exercise of professional judgment, decides that it is not in the best interest of the individual to treat the person as the individual's personal representative.

(h) *Standard: Confidential communications.* A covered health care provider or health plan must comply with the applicable requirements of §164.522(b) in communicating protected health information.

(i) *Standard: Uses and disclosures consistent with notice.* A covered entity that is required by §164.520 to have a notice may not use or disclose protected health information in a manner inconsistent with such notice. A covered entity that is required by §164.520(b)(1)(iii) to include a specific statement in its notice if it intends to engage in an activity listed in §164.520(b)(1)(iii)(A)–(C), may not use or disclose protected health information for such activities, unless the required statement is included in the notice.

(j) *Standard: Disclosures by whistleblowers and workforce member crime victims.* (1) *Disclosures by whistleblowers.* A covered entity is not considered to have violated the requirements of this subpart if a member of its workforce or a business associate discloses protected health information, provided that:

(i) The workforce member or business associate believes in good faith that the covered entity has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the covered entity potentially endangers one or more patients, workers, or the public; and

(ii) The disclosure is to:

(A) A health oversight agency or public health authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions of the covered entity or to an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by the covered entity; or

(B) An attorney retained by or on behalf of the workforce member or business associate for the purpose of determining the legal options of the workforce member or business associate with regard to the conduct described in paragraph (j)(1)(i) of this section.

(2) *Disclosures by workforce members who are victims of a crime.* A covered entity is not considered to have violated the requirements of this subpart if a member of its workforce who is the victim of a criminal act discloses protected health information to a law enforcement official, provided that:

(i) The protected health information disclosed is about the suspected perpetrator of the criminal act; and

(ii) The protected health information disclosed is limited to the information listed in §164.512(f)(2)(i).

EFFECTIVE DATE NOTE: At 67 FR 53267, Aug. 14, 2002, §164.502 was amended by revising paragraphs (a)(1)(ii), (iii), and (vi) and (b)(2)(ii); redesignating paragraphs (b)(2)(iii) through (v) as paragraphs (b)(2)(iv) through

plan sponsor consistent with the requirements of this subpart.

* * * * *

(iii) The group health plan, or a health insurance issuer or HMO with respect to the group health plan, may disclose to the plan sponsor information on whether the individual is participating in the group health plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the plan.

* * * * *

§ 164.506 Consent for uses or disclosures to carry out treatment, payment, or health care operations.

(a) *Standard: Consent requirement.* (1) Except as provided in paragraph (a)(2) or (a)(3) of this section, a covered health care provider must obtain the individual's consent, in accordance with this section, prior to using or disclosing protected health information to carry out treatment, payment, or health care operations.

(2) A covered health care provider may, without consent, use or disclose protected health information to carry out treatment, payment, or health care operations, if:

(i) The covered health care provider has an indirect treatment relationship with the individual; or

(ii) The covered health care provider created or received the protected health information in the course of providing health care to an individual who is an inmate.

(3)(i) A covered health care provider may, without prior consent, use or disclose protected health information created or received under paragraph (a)(3)(i)(A)–(C) of this section to carry out treatment, payment, or health care operations:

(A) In emergency treatment situations, if the covered health care provider attempts to obtain such consent as soon as reasonably practicable after the delivery of such treatment;

(B) If the covered health care provider is required by law to treat the individual, and the covered health care provider attempts to obtain such consent but is unable to obtain such consent; or

(C) If a covered health care provider attempts to obtain such consent from the individual but is unable to obtain such consent due to substantial barriers to communicating with the individual, and the covered health care provider determines, in the exercise of professional judgment, that the individual's consent to receive treatment is clearly inferred from the circumstances.

(ii) A covered health care provider that fails to obtain such consent in accordance with paragraph (a)(3)(i) of this section must document its attempt to obtain consent and the reason why consent was not obtained.

(4) If a covered entity is not required to obtain consent by paragraph (a)(1) of this section, it may obtain an individual's consent for the covered entity's own use or disclosure of protected health information to carry out treatment, payment, or health care operations, provided that such consent meets the requirements of this section.

(5) Except as provided in paragraph (f)(1) of this section, a consent obtained by a covered entity under this section is not effective to permit another covered entity to use or disclose protected health information.

(b) *Implementation specifications: General requirements.* (1) A covered health care provider may condition treatment on the provision by the individual of a consent under this section.

(2) A health plan may condition enrollment in the health plan on the provision by the individual of a consent under this section sought in conjunction with such enrollment.

(3) A consent under this section may not be combined in a single document with the notice required by § 164.520.

(4)(i) A consent for use or disclosure may be combined with other types of written legal permission from the individual (*e.g.*, an informed consent for treatment or a consent to assignment of benefits), if the consent under this section:

(A) Is visually and organizationally separate from such other written legal permission; and

(B) Is separately signed by the individual and dated.

(ii) A consent for use or disclosure may be combined with a research authorization under § 164.508(f).

(5) An individual may revoke a consent under this section at any time, except to the extent that the covered entity has taken action in reliance thereon. Such revocation must be in writing.

(6) A covered entity must document and retain any signed consent under this section as required by §164.530(j).

(c) *Implementation specifications: Content requirements.* A consent under this section must be in plain language and:

(1) Inform the individual that protected health information may be used and disclosed to carry out treatment, payment, or health care operations;

(2) Refer the individual to the notice required by §164.520 for a more complete description of such uses and disclosures and state that the individual has the right to review the notice prior to signing the consent;

(3) If the covered entity has reserved the right to change its privacy practices that are described in the notice in accordance with §164.520(b)(1)(v)(C), state that the terms of its notice may change and describe how the individual may obtain a revised notice;

(4) State that:

(i) The individual has the right to request that the covered entity restrict how protected health information is used or disclosed to carry out treatment, payment, or health care operations;

(ii) The covered entity is not required to agree to requested restrictions; and

(iii) If the covered entity agrees to a requested restriction, the restriction is binding on the covered entity;

(5) State that the individual has the right to revoke the consent in writing, except to the extent that the covered entity has taken action in reliance thereon; and

(6) Be signed by the individual and dated.

(d) *Implementation specifications: Defective consents.* There is no consent under this section, if the document submitted has any of the following defects:

(1) The consent lacks an element required by paragraph (c) of this section, as applicable; or

(2) The consent has been revoked in accordance with paragraph (b)(5) of this section.

(e) *Standard: Resolving conflicting consents and authorizations.* (1) If a covered entity has obtained a consent under this section and receives any other authorization or written legal permission from the individual for a disclosure of protected health information to carry out treatment, payment, or health care operations, the covered entity may disclose such protected health information only in accordance with the more restrictive consent, authorization, or other written legal permission from the individual.

(2) A covered entity may attempt to resolve a conflict between a consent and an authorization or other written legal permission from the individual described in paragraph (e)(1) of this section by:

(i) Obtaining a new consent from the individual under this section for the disclosure to carry out treatment, payment, or health care operations; or

(ii) Communicating orally or in writing with the individual in order to determine the individual's preference in resolving the conflict. The covered entity must document the individual's preference and may only disclose protected health information in accordance with the individual's preference.

(f)(1) *Standard: Joint consents.* Covered entities that participate in an organized health care arrangement and that have a joint notice under §164.520(d) may comply with this section by a joint consent.

(2) *Implementation specifications: Requirements for joint consents.* (i) A joint consent must:

(A) Include the name or other specific identification of the covered entities, or classes of covered entities, to which the joint consent applies; and

(B) Meet the requirements of this section, except that the statements required by this section may be altered to reflect the fact that the consent covers more than one covered entity.

(ii) If an individual revokes a joint consent, the covered entity that receives the revocation must inform the other entities covered by the joint consent of the revocation as soon as practicable.

EFFECTIVE DATE NOTE: At 67 FR 53268, Aug. 14, 2002, §164.506 was revised, effective Oct. 15,

(i) The individual's right to revoke the authorization in writing, and either:

(A) The exceptions to the right to revoke and a description of how the individual may revoke the authorization; or

(B) To the extent that the information in paragraph (c)(2)(i)(A) of this section is included in the notice required by §164.520, a reference to the covered entity's notice.

(ii) The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization, by stating either:

(A) The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations in paragraph (b)(4) of this section applies; or

(B) The consequences to the individual of a refusal to sign the authorization when, in accordance with paragraph (b)(4) of this section, the covered entity can condition treatment, enrollment in the health plan, or eligibility for benefits on failure to obtain such authorization.

(iii) The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by this subpart.

(3) *Plain language requirement.* The authorization must be written in plain language.

(4) *Copy to the individual.* If a covered entity seeks an authorization from an individual for a use or disclosure of protected health information, the covered entity must provide the individual with a copy of the signed authorization.

§164.510 Uses and disclosures requiring an opportunity for the individual to agree or to object.

A covered entity may use or disclose protected health information without the written consent or authorization of the individual as described by §§164.506 and 164.508, respectively, provided that the individual is informed in advance of the use or disclosure and has the opportunity to agree to or prohibit or restrict the disclosure in accordance with the applicable requirements of this section. The covered entity may orally inform the individual of and obtain the individual's oral agreement or objection to a use or disclosure permitted by this section.

(a) *Standard: use and disclosure for facility directories.* (1) *Permitted uses and disclosure.* Except when an objection is expressed in accordance with paragraphs (a)(2) or (3) of this section, a covered health care provider may:

(i) Use the following protected health information to maintain a directory of individuals in its facility:

(A) The individual's name;

(B) The individual's location in the covered health care provider's facility;

(C) The individual's condition described in general terms that does not communicate specific medical information about the individual; and

(D) The individual's religious affiliation; and

(ii) Disclose for directory purposes such information:

(A) To members of the clergy; or

(B) Except for religious affiliation, to other persons who ask for the individual by name.

(2) *Opportunity to object.* A covered health care provider must inform an individual of the protected health information that it may include in a directory and the persons to whom it may disclose such information (including disclosures to clergy of information regarding religious affiliation) and provide the individual with the opportunity to restrict or prohibit some or all of the uses or disclosures permitted by paragraph (a)(1) of this section.

(3) *Emergency circumstances.* (i) If the opportunity to object to uses or disclosures required by paragraph (a)(2) of this section cannot practicably be provided because of the individual's incapacity or an emergency treatment circumstance, a covered health care provider may use or disclose some or all of the protected health information permitted by paragraph (a)(1) of this section for the facility's directory, if such disclosure is:

(A) Consistent with a prior expressed preference of the individual, if any, that is known to the covered health care provider; and

(B) In the individual's best interest as determined by the covered health care provider, in the exercise of professional judgment.

(ii) The covered health care provider must inform the individual and provide an opportunity to object to uses or disclosures for directory purposes as required by paragraph (a)(2) of this section when it becomes practicable to do so.

(b) *Standard: uses and disclosures for involvement in the individual's care and*

notification purposes. (1) *Permitted uses and disclosures.* (i) A covered entity may, in accordance with paragraphs (b)(2) or (3) of this section, disclose to a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual, the protected health information directly relevant to such person's involvement with the individual's care or payment related to the individual's health care.

(ii) A covered entity may use or disclose protected health information to notify, or assist in the notification of (including identifying or locating), a family member, a personal representative of the individual, or another person responsible for the care of the individual of the individual's location, general condition, or death. Any such use or disclosure of protected health information for such notification purposes must be in accordance with paragraphs (b)(2), (3), or (4) of this section, as applicable.

(2) *Uses and disclosures with the individual present.* If the individual is present for, or otherwise available prior to, a use or disclosure permitted by paragraph (b)(1) of this section and has the capacity to make health care decisions, the covered entity may use or disclose the protected health information if it:

(i) Obtains the individual's agreement;

(ii) Provides the individual with the opportunity to object to the disclosure, and the individual does not express an objection; or

(iii) Reasonably infers from the circumstances, based the exercise of professional judgment, that the individual does not object to the disclosure.

(3) *Limited uses and disclosures when the individual is not present.* If the individual is not present for, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the covered entity may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the protected health information that is directly relevant to the person's involvement with the individual's health care. A covered entity may use professional judgment and its experience with common practice to make reasonable inferences of the individual's best interest in allowing a person to act on behalf of the individual to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

(4) *Use and disclosures for disaster relief purposes.* A covered entity may use or disclose protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entities the uses or disclosures permitted by paragraph (b)(1)(ii) of this section. The requirements in paragraphs (b)(2) and (3) of this section apply to such uses and disclosure to the extent that the covered entity, in the exercise of professional judgment, determines that the requirements do not interfere with the ability to respond to the emergency circumstances.

EFFECTIVE DATE NOTE: At 67 FR 53270, Aug. 14, 2002, in §164.510 revise the first sentence of the introductory text, and remove the word "for" from paragraph (b)(3), effective Oct. 15, 2002. For the convenience of the user, the revised text is set forth as follows:

§ 164.510 Uses and disclosures requiring an opportunity for the individual to agree or to object.

A covered entity may use or disclose protected health information, provided that the individual is informed in advance of the use or disclosure and has the opportunity to agree to or prohibit or restrict the use or disclosure, in accordance with the applicable requirements of this section. * * *

* * * * *

§ 164.512 Uses and disclosures for which consent, an authorization, or opportunity to agree or object is not required.

A covered entity may use or disclose protected health information without the written consent or authorization of the individual as described in §§ 164.506 and 164.508, respectively, or the opportunity for the individual to agree or object as described in § 164.510, in the situations covered by this section, subject to the applicable requirements of this section. When the covered entity is required by this section to inform

the individual of, or when the individual may agree to, a use or disclosure permitted by this section, the covered entity's information and the individual's agreement may be given orally.

(a) *Standard: Uses and disclosures required by law.* (1) A covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

(2) A covered entity must meet the requirements described in paragraph (c), (e), or (f) of this section for uses or disclosures required by law.

(b) *Standard: uses and disclosures for public health activities.* (1) *Permitted disclosures.* A covered entity may disclose protected health information for the public health activities and purposes described in this paragraph to:

(i) A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority;

(ii) A public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

(iii) A person subject to the jurisdiction of the Food and Drug Administration:

(A) To report adverse events (or similar reports with respect to food or dietary supplements), product defects or problems (including problems with the use or labeling of a product), or biological product deviations if the disclosure is made to the person required or directed to report such information to the Food and Drug Administration;

(B) To track products if the disclosure is made to a person required or directed by the Food and Drug Administration to track the product;

(C) To enable product recalls, repairs, or replacement (including locating and notifying individuals who have received products of product recalls, withdrawals, or other problems); or

(D) To conduct post marketing surveillance to comply with requirements or at the direction of the Food and Drug Administration;

(iv) A person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if the covered entity or public health authority is authorized by law to notify such person as necessary in the conduct of a public health intervention or investigation; or

(v) An employer, about an individual who is a member of the workforce of the employer, if:

(A) The covered entity is a covered health care provider who is a member of the workforce of such employer or who provides a health care to the individual at the request of the employer:

(*1*) To conduct an evaluation relating to medical surveillance of the workplace; or

(*2*) To evaluate whether the individual has a work-related illness or injury;

(B) The protected health information that is disclosed consists of findings concerning a work-related illness or injury or a workplace-related medical surveillance;

(C) The employer needs such findings in order to comply with its obligations, under 29 CFR parts 1904 through 1928, 30 CFR parts 50 through 90, or under state law having a similar purpose, to record such illness or injury or to carry out responsibilities for workplace medical surveillance;

(D) The covered health care provider provides written notice to the individual that protected health information relating to the medical surveillance of the workplace and work-related illnesses and injuries is disclosed to the employer:

(*1*) By giving a copy of the notice to the individual at the time the health care is provided; or

(*2*) If the health care is provided on the work site of the employer, by posting the notice in a prominent place at

the location where the health care is provided.

(2) *Permitted uses.* If the covered entity also is a public health authority, the covered entity is permitted to use protected health information in all cases in which it is permitted to disclose such information for public health activities under paragraph (b)(1) of this section.

(c) *Standard: Disclosures about victims of abuse, neglect or domestic violence.* (1) *Permitted disclosures.* Except for reports of child abuse or neglect permitted by paragraph (b)(1)(ii) of this section, a covered entity may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence:

(i) To the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law;

(ii) If the individual agrees to the disclosure; or

(iii) To the extent the disclosure is expressly authorized by statute or regulation and:

(A) The covered entity, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the individual or other potential victims; or

(B) If the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

(2) *Informing the individual.* A covered entity that makes a disclosure permitted by paragraph (c)(1) of this section must promptly inform the individual that such a report has been or will be made, except if:

(i) The covered entity, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm; or

(ii) The covered entity would be informing a personal representative, and the covered entity reasonably believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

(d) *Standard: Uses and disclosures for health oversight activities.* (1) *Permitted disclosures.* A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of:

(i) The health care system;

(ii) Government benefit programs for which health information is relevant to beneficiary eligibility;

(iii) Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or

(iv) Entities subject to civil rights laws for which health information is necessary for determining compliance.

(2) *Exception to health oversight activities.* For the purpose of the disclosures permitted by paragraph (d)(1) of this section, a health oversight activity does not include an investigation or other activity in which the individual is the subject of the investigation or activity and such investigation or other activity does not arise out of and is not directly related to:

(i) The receipt of health care;

(ii) A claim for public benefits related to health; or

(iii) Qualification for, or receipt of, public benefits or services when a patient's health is integral to the claim for public benefits or services.

(3) *Joint activities or investigations.* Nothwithstanding paragraph (d)(2) of this section, if a health oversight activity or investigation is conducted in

conjunction with an oversight activity or investigation relating to a claim for public benefits not related to health, the joint activity or investigation is considered a health oversight activity for purposes of paragraph (d) of this section.

(4) *Permitted uses.* If a covered entity also is a health oversight agency, the covered entity may use protected health information for health oversight activities as permitted by paragraph (d) of this section.

(e) *Standard: Disclosures for judicial and administrative proceedings.*

(1) *Permitted disclosures.* A covered entity may disclose protected health information in the course of any judicial or administrative proceeding:

(i) In response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order; or

(ii) In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if:

(A) The covered entity receives satisfactory assurance, as described in paragraph (e)(1)(iii) of this section, from the party seeking the information that reasonable efforts have been made by such party to ensure that the individual who is the subject of the protected health information that has been requested has been given notice of the request; or

(B) The covered entity receives satisfactory assurance, as described in paragraph (e)(1)(iv) of this section, from the party seeking the information that reasonable efforts have been made by such party to secure a qualified protective order that meets the requirements of paragraph (e)(1)(v) of this section.

(iii) For the purposes of paragraph (e)(1)(ii)(A) of this section, a covered entity receives satisfactory assurances from a party seeking protecting health information if the covered entity receives from such party a written statement and accompanying documentation demonstrating that:

(A) The party requesting such information has made a good faith attempt to provide written notice to the individual (or, if the individual's location is unknown, to mail a notice to the individual's last known address);

(B) The notice included sufficient information about the litigation or proceeding in which the protected health information is requested to permit the individual to raise an objection to the court or administrative tribunal; and

(C) The time for the individual to raise objections to the court or administrative tribunal has elapsed, and:

(*1*) No objections were filed; or

(*2*) All objections filed by the individual have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution.

(iv) For the purposes of paragraph (e)(1)(ii)(B) of this section, a covered entity receives satisfactory assurances from a party seeking protected health information, if the covered entity receives from such party a written statement and accompanying documentation demonstrating that:

(A) The parties to the dispute giving rise to the request for information have agreed to a qualified protective order and have presented it to the court or administrative tribunal with jurisdiction over the dispute; or

(B) The party seeking the protected health information has requested a qualified protective order from such court or administrative tribunal.

(v) For purposes of paragraph (e)(1) of this section, a qualified protective order means, with respect to protected health information requested under paragraph (e)(1)(ii) of this section, an order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that:

(A) Prohibits the parties from using or disclosing the protected health information for any purpose other than the litigation or proceeding for which such information was requested; and

(B) Requires the return to the covered entity or destruction of the protected health information (including all copies made) at the end of the litigation or proceeding.

(vi) Nothwithstanding paragraph (e)(1)(ii) of this section, a covered entity may disclose protected health information in response to lawful process described in paragraph (e)(1)(ii) of this

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TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES--(Continued)

PART 431--STATE ORGANIZATION AND GENERAL ADMINISTRATION--Table of Contents

Subpart F--Safeguarding Information on Applicants and Recipients

Sec. 431.301 State plan requirements.

A State plan must provide, under a State statute that imposes legal sanctions, safeguards meeting the requirements of this subpart that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

Revision: HCFA-AT-87-9 (BERC) OMB No.: 0938-0193
AUGUST 1987

State/Territory: ALASKA

Citation	4.3 Safeguarding Information on Applicants and Recipients
42 CFR 431.301 AT-79-29	Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.
52 FR 5967	All other requirements of 42 CFR Part 431, Subpart F are met.

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CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES--(Continued)

PART 431--STATE ORGANIZATION AND GENERAL ADMINISTRATION--Table of Contents

Subpart F--Safeguarding Information on Applicants and Recipients

Sec. 431.302 Purposes directly related to State plan administration.

Purposes directly related to plan administration include--
(a) Establishing eligibility;
(b) Determining the amount of medical assistance;
(c) Providing services for recipients; and

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(d) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan.

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TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES--(Continued)

PART 431--STATE ORGANIZATION AND GENERAL ADMINISTRATION--Table of Contents

Subpart F--Safeguarding Information on Applicants and Recipients

Sec. 431.306 Release of information.

(a) The agency must have criteria specifying the conditions for release and use of information about applicants and recipients.

(b) Access to information concerning applicants or recipients must be restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the agency.

(c) The agency must not publish names of applicants or recipients.

(d) The agency must obtain permission from a family or individual, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of medical assistance payment under section 1137 of this Act and Secs. 435.940 through 435.965 of this chapter.

If, because of an emergency situation, time does not permit obtaining consent before release, the agency must notify the family or individual immediately after supplying the information.

(e) The agency's policies must apply to all requests for information from outside sources, including governmental bodies, the courts, or law enforcement officials.

(f) If a court issues a subpoena for a case record or for any agency representative to testify concerning an applicant or recipient, the agency must inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.

(g) Before requesting information from, or releasing information to, other agencies to verify income, eligibility and the amount of assistance under Secs. 435.940 through 435.965 of this chapter, the agency must execute data exchange agreements with those agencies, as specified in Sec. 435.945(f).

(h) Before requesting information from, or releasing information to, other agencies to identify legally liable third party resources under Sec. 433.138(d) of this chapter, the agency must execute data exchanges agreements, as

specified in Sec. 433.138(h)(2) of this chapter.

[44 FR 17934, Mar. 29, 1979, as amended at 51 FR 7210, Feb. 28, 1986; 52 FR 5975, Feb. 27, 1987]

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TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES--(Continued)

PART 431--STATE ORGANIZATION AND GENERAL ADMINISTRATION--Table of Contents

Subpart C--Administrative Requirements: Provider Relations

Sec. 431.107 Required provider agreement.

(a) Basis and purpose. This section sets forth State plan requirements, based on sections 1902(a)(4), 1902(a)(27), 1902(a)(57), and 1902(a)(58) of the Act, that relate to the keeping of records and the furnishing of information by all providers of services (including individual practitioners and groups of practitioners).

(b) Agreements. A State plan must provide for an agreement between the Medicaid agency and each provider or organization furnishing services under the plan in which the provider or organization agrees to:

(1) Keep any records necessary to disclose the extent of services the provider furnishes to recipients;

(2) On request, furnish to the Medicaid agency, the Secretary, or the State Medicaid fraud control unit (if such a unit has been approved by the Secretary under Sec. 455.300 of this chapter), any information maintained under paragraph (b)(1) of this section and any information regarding payments claimed by the provider for furnishing services under the plan;

(3) Comply with the disclosure requirements specified in part 455, subpart B of this chapter; and

(4) Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in part 489, subpart I, and Sec. 417.436(d) of this chapter.

[44 FR 41644, July 17, 1979, as amended at 57 FR 8202, Mar. 6, 1992]