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HHESS

STATE HEALTH INSURANCE

(FILE NO. 1)

STATE  
HEALTH  
INSURE.

#1

HOUSE RESEARCH AGENCY  
Pouch Y - State Capitol  
Juneau, Alaska 99811  
465-3991

MEMORANDUM

March 18, 1980

TO: Representative Bill Parker  
Attn: Mr. Jim Erickson

FROM: Jack Kreinheder, Issues Analyst *JK*

RE: State Health Care Programs  
Research Request No. 61

You have asked that we: (1) provide any available studies on Medicaid, state health insurance, and the State's health care program in general; and (2) determine whether the State could provide medical care for low-income groups in medically underserved areas of the state. The enclosed materials represent all the relevant materials we were able to locate, with the exception of past copies of the State Health Plan and the Medicaid Annual Status Report. These reports were not included because of their bulk and uncertain value to you; should you wish to review these documents, please let us know.

Our major findings with regard to direct State delivery of medical services are the following:

1. There appear to be no legal reasons why the State could not hire doctors to treat low-income groups or any other class of people; however, four major practical difficulties with such an approach were raised during the course of our research. The first problem is that everyone we contacted believed the medical community would oppose the competition which direct State participation in the delivery of medical services would represent. Second, the State would need to purchase malpractice insurance for doctors in its employment, thus incurring substantial costs. Third, if the legislature approved funding for such a program, and later discontinued it, or if State physicians' services were to be provided on a temporary basis, the problem of "medical abandonment" could result in lawsuits against the State unless adequate arrangements were made for the further treatment of patients handled under the program. Fourth, it appears that medical services provided by State physicians would not be eligible for federal Medicaid funds

except on a temporary or special situation basis; therefore, the State would have to bear the full cost of the program unless State-provided services were demonstrated to qualify for a waiver from the usual federal Medicaid requirements.

2. Withdrawal from the Medicaid program is not, however, a prerequisite to the establishment of a State physician program. My understanding of the alternative health care system you are considering is that the State would not necessarily provide all the medical services now administered by private physicians under the Medicaid program, but would instead make State doctors available in areas which are medically under-served either because of the lack of physicians, the lack of specific medical services, or because of the refusal of available physicians to accept Medicaid patients. It is clear that the State could continue to receive federal Medicaid funds for medical services provided by private physicians; and, in addition, it appears that funds could also be received for State-provided services if a federal waiver from certain regulations could be obtained. The State currently receives over \$22 million per year in federal Medicaid funds.
3. It may be possible to improve medical care for low-income persons by means other than, or in addition to, direct State health care delivery, and without opting out of the Medicaid program. The principal problem with the Medicaid program, from the recipient's point of view, appears to be that many doctors in Alaska refuse to accept Medicaid patients. This reluctance to take Medicaid patients is, in turn, largely attributable to the extensive paperwork requirements and the extremely slow payment process of the current Medicaid system in Alaska. However, these problems are not inherent in the federal Medicaid system, and it appears that more rapid and efficient reimbursement of medical providers could substantially improve low-income access to medical care by encouraging more doctors to participate in the program. Of course, there may be other problems with the Medicaid program which might make withdrawal from the system desirable.
4. The expanded use of fiscal intermediaries may be one option for making more doctors available to low-income persons. Delta Dental Plan of Alaska is currently the only organization of this type in Alaska and handles only dental services, but all parties involved--the Department of Health and Social Services, the participating dentists, and the Medicaid recipients--seem to be very satisfied with the program. About 96 percent of the dentists in Alaska are members of Delta Dental and 95 percent of these participate in Medicaid. The fact that reimbursement to dentists by

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Delta Dental for Medicaid cases usually occurs within two weeks, as compared to up to several months for other Medicaid claims handled by the State, is the main reason for the almost universal acceptance of Medicaid cases by Alaska dentists.

In an administrative review of the Alaska Medicaid program completed in 1979, HEW officials recommended that the Division of Public Assistance contract with a fiscal intermediary for Medicaid processing. The Division is planning to solicit within the next six months requests for proposals for the processing of all Medicaid claims by a fiscal intermediary, although H&SS may still elect to process claims in-house. Robert Ogden, Chief of Medical Assistance for the Division, stated that a fiscal intermediary handling all Medicaid claims could probably process claims as rapidly as Delta Dental currently does for dental claims, thus improving the prospects for physicians accepting Medicaid patients. However, the choice between the use of a fiscal intermediary and processing the Medicaid claims in-house will depend on administrative decisions made within the department.

Each of the four points summarized above will now be discussed in more detail.

#### State Medical Care

According to the sources we contacted, the basic answer to your second question is yes, the State could hire doctors to treat low-income groups. Eligibility could be determined in a number of ways and would not need to parallel the federal Medicaid system. Placement of the State-employed doctors throughout the state could be based on whatever criteria were deemed appropriate by the State.

The State already provides direct delivery of medical services to a limited degree. Nurses employed by the Division of Public Health administer the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) for children throughout the state. The program is small in comparison to other medical services, but it does provide a precedent on the State level for direct delivery of services.

Political resistance by the medical community was cited by several persons with whom we spoke as the greatest obstacle to the direct employment of doctors by the State. Our contacts believed that many doctors would view such an action as State competition with the private sector,

and as "socialization" of the medical profession. The apparent acceptance by the medical community of the EPSDI program suggests that opposition to the State physician approach would not be as strong if the approach were used only in a few selected areas or were clearly temporary in nature. For example, if the State adopted a procedure similar to that which was employed by the federal Department of Health, Education, and Welfare (HEW) to identify and designate the low-income population of Anchorage as a Critical Health Manpower Shortage Area (see Attachment A), doctors might be more willing to accept the State delivery approach than if it were part of a comprehensive, state-wide system.

Under the HEW system, which is authorized by section 332 of the Public Health Service Act, an area or population group of an area may be designated as a Health Manpower Shortage Area if the population-to-primary care physician ratio exceeds a certain level. An area is also given a degree-of-shortage classification based on this ratio. The population-to-physician ratio takes account of physician accessibility, rather than simply dividing the population by the number of physicians. For example, in Anchorage, the ratio of Medicaid eligible persons to all primary care practitioners is estimated at 161:1, but when HEW adjusted for the fact that most of these physicians do not accept Medicaid patients, the final population-to-primary care physician ratio was determined to be 3,041:1.

This ratio qualified the low-income population of Anchorage as a degree-of-shortage group 4, which makes the area eligible to: (1) apply for placement of National Health Service Corps (NHSC) physicians; (2) be an eligible service area for purposes of repayment of health professions student loans and for the NHSC scholarship program; and (3) apply for grant funds under various sections of the Public Health Act.

A similar approach to improving medical care for medically underserved areas or population groups could be utilized by the State. Designation under the program might qualify an area for the placement of State-hired physicians, for grants to improve health care delivery, or perhaps for a special streamlined Medicaid process which would encourage doctors to accept Medicaid patients. The latter option might be effective in a case like Anchorage's, in which the number of practicing physicians in an area is sufficient to meet the medical needs of the population, but the physicians will not accept Medicaid patients because of dissatisfaction with the reimbursement system.

Attachment B, which is a letter to Representative Martin from Commissioner Beirne, suggests other questions which should be considered if the State elects to provide medical care directly and/or withdraw from the Medicaid program. As Duncan Read indicated in his earlier memo, Dr. Frederick McGinnis, Deputy Commissioner of H&SS, has proposed a major study of health care financing options which would address questions relating to

Representative Bill Parker  
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State provision of health care, such as who would be eligible for the program, and what services should be provided. Dr. McGinnis has apparently expanded the scope of the proposed study and is attempting to obtain about \$170,000 for the project. If the study is conducted, the results would be submitted to the 1981 legislature.

If the State physician health delivery system is to be pursued, the problems of malpractice insurance and medical abandonment must be considered. Neither of these problems would prevent the State from hiring doctors, but their cost and legal implications may have some bearing on the issue. The State currently carries a small amount of malpractice insurance for doctors employed in administrative capacities, apparently in the event that they are called upon in an emergency situation. To fully insure doctors employed by the State who regularly provided medical services would require a substantial expenditure. The magnitude of the insurance cost would depend on the number of doctors employed the service provided, and the scope of the program, but the cost could be significant.

Medical abandonment appears to be a relatively easy problem to avoid, but it could present legal problems if it is not considered in the design of any State-provided medical care program. Under state and federal law, physicians are responsible for arranging for continued medical care for their patients if, for any reason, they discontinue their treatment. A doctor not fulfilling this responsibility may be sued by a patient. The two ways in which the issue of medical abandonment could arise are: (1) if the legislature suddenly discontinued funding for the program, and (2) if the program were discontinued in an area because it was determined that the private physicians in the area could now adequately serve the population. In both instances, the problem of medical abandonment could be avoided by ensuring that adequate arrangements were made for the continuing treatment of patients after the State ceased providing service directly.

A final point to be considered regarding direct State delivery of medical care is the Medicaid funding question. I contacted officials with the Northwest regional office of the HEW Medicaid Bureau in Seattle to determine if federal Medicaid funding could be provided for medical services delivered by State-employed physicians. A firm answer could not be secured within the time frame of this project, but it appears that a waiver from certain federal regulations pertaining to reimbursement procedures and other matters would be required for federal funding to be given for State-provided services. The necessary conditions for such a waiver are also unclear at this time, but HEW officials indicated that the designation of an area or population group having a severe shortage of medical care might meet the waiver requirements.

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You have indicated an interest in the possibility of the State withdrawing entirely from the Medicaid program, and the question of Medicaid support for State-provided services may therefore not be a major concern. However, the State currently receives over \$22 million each year in federal Medicaid funds. It may, therefore, be desirable to retain these funds if a State medical care program could meet, or be exempted from, the necessary federal regulations without compromising the program. Please let us know if you would like a more concrete response to the Medicaid funding question. A written request to HEW would be required and their response could take two weeks or more, but we would be glad to pursue this issue if you would like.

#### Medicaid Issues

Although we were not asked to specifically address the Medicaid program in this memorandum, we obtained information on Medicaid during our research which may be of value to you in considering health care options. The greatest problem with the current Medicaid program in Alaska is that the claims processing system is inefficient, requires excessive paperwork, and results in long delays in provider reimbursement. It is the paperwork and the payment delays which have been the primary cause of Alaska physicians refusing to accept Medicaid patients. Attachments C and D provide a physician's perspective on the problems of the Medicaid system. In many cities, most notably Anchorage, the number of physicians seems to be adequate, but a Medicaid patient cannot see a doctor because the majority of physicians refuse to take Medicaid cases. It therefore appears that a more efficient and rapid claims processing system could do much to alleviate the difficulty of obtaining medical care for low-income Alaskans.

The current program of Medicaid dental services lends strong support to this premise. Medicaid claims for dental care do not go through the State system used for other medical services, but instead are handled by the Delta Dental Plan of Alaska, which acts as a fiscal intermediary between the providers and the State. The pertinent statistics regarding Medicaid participation by dentists were cited in the findings section, but the importance of Delta Dental in this discussion is that the vast majority of the state's dentists accept Medicaid patients. The two-week Medicaid reimbursement time which Delta Dental provides for dentists is the primary reason for the high degree of cooperation by Alaska dentists with the Medicaid program.

The obvious question, then, is if Delta Dental is so efficient, why doesn't the State use Delta or another fiscal intermediary to process all its Medicaid claims. There are a number of reasons why fiscal intermediaries do not represent an easy solution to the Medicaid and low-income health care problems.

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The first is that Delta Dental does not appear eager, and may not have the capability to take on the processing of medical claims. Attachment D is a letter from the Pediatricians' Association to Representative Martin suggesting that the State contract with Delta Dental for payment of Medicaid claims for pediatric services. However, I spoke with Denise Knapp, Executive Director of Delta Dental, and she indicated that Delta has not agreed to process pediatric claims and is still only discussing the idea. Robert Ogden, Chief of Medical Assistance for H&SS, stated that while he has been very pleased with Delta's performance, he is not sure if Delta could handle the large volume of Medicaid claims for medical services, and knows of no other in-state firms who could.

A second possible problem with the expanded use of fiscal intermediaries is cost. Each claim processed by Delta Dental costs the State an average of more than \$14, while the medical claims processed under the current system cost only about \$1.45 each. However, Mr. Ogden was quick to point out that the current system does not meet federal requirements, and meeting these requirements is likely to increase the cost of processing claims whether a fiscal intermediary is used or not. In addition, Delta's cost is much higher than would be that of a fiscal intermediary handling all medical claims, because the fixed costs of the Delta claims processing system are spread over a relatively small number of claims (8,000 per year). A fiscal intermediary handling all Medicaid claims for medical services would process about 144,000 claims per year; cost per claim would therefore be much lower, perhaps in the \$2.50 range, according to Mr. Ogden.

HEW has mandated that the Division of Public Assistance implement a new claims processing system by September, 1980. In an administrative review completed a year ago, HEW officials recommended that the Division contract with a fiscal intermediary for the processing of all Medicaid claims. (See Attachment E, Chapter 7, for more detail on this recommendation.) However, it is still uncertain whether this recommendation will be followed. The Division plans to solicit requests for proposals (RFP) for claims processing within the next six months. At least six to eight firms are expected to bid on the contract, but it appears that the decision to use a fiscal intermediary or to process Medicaid claims in-house will be more dependent on administrative decisions within H&SS than on the results of the RFP process.

We hope the information we have provided is useful to you. This memorandum is a brief treatment of a complex subject, so please let us know if you would like additional research, or if we may be of further assistance in any other way.

JK/dp

cc: Representative Terry Martin

Attachments:

- A. HEW designation of Anchorage as a Health Manpower Shortage Area, from the Anchorage Neighborhood Health Center.
- B. Letter from Commissioner Beirne to Representative Martin on Medicaid/State Health Care issues.
- C. Letter from Dr. Lillibridge to HEW discussing Medicaid problems.
- D. Letter from Dr. Lillibridge to Representative Martin on Medicaid problems and the Delta Dental program.
- E. HEW administrative review of the Alaska Medicaid program.
- F. H&SS task force recommendations on the Medicaid program.
- G. Information supplied by Delta Dental on their program.
- H. Alaska and National Health Insurance--report by Dr. McGinnis of H&SS.
- I. Third Party Health Coverage in Alaska--1978 report by the former Legislative Affairs Research Division.
- J. Opting-A Study of Medicaid Client Need--1977 report by the former Research Division.
- K. H&SS 1977 Medicaid Annual Status Report.
- L. January, 1980 State Health Plan.



# ANCHORAGE NEIGHBORHOOD HEALTH CENTER

1217 EAST 10<sup>TH</sup> AVENUE • ANCHORAGE, ALASKA 99501 • 907-279-9586



February 18, 1980

Duncan Read, Director  
House Research Agency  
Pouch "Y"  
State Capital Building  
Juneau, Alaska 99811

Dear Mr. Reed:

As per request from your staff person, Carol Biggs, I am sending you a copy of the application which I submitted to the Bureau of Health Manpower, which resulted in a Critical Health Manpower Shortage Area designation for the low income population of Anchorage. Also enclosed, is a letter from the Bureau, in which they accepted the evidence we presented in the application, thus making the designation.

Sincerely,

A handwritten signature in cursive script that reads 'Don Bantz'.

Don Bantz  
Executive Director

DB/jw  
Enclosures

**RECEIVED**  
FEB 22 1980

HOUSE RESEARCH AGENCY



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
PUBLIC HEALTH SERVICE  
HEALTH RESOURCES ADMINISTRATION  
HYATTSVILLE, MARYLAND 20782

BUREAU OF HEALTH MANPOWER

JAN 17 1980

Mr. Don Bantz  
Executive Director  
Anchorage Neighborhood Health Center  
1217 East 10th Avenue  
Anchorage, Alaska 99501

Dear Mr. Bantz:

We have reviewed your request as amended for designation of the low-income population of Anchorage as a population with a shortage of primary medical care manpower. In addition, we have contacted the Health Systems Agency for your area, the State Health Planning and Development Agency, and the Governor's office for their comments.

From this review, we have determined that the area appears to be rational for the delivery of primary medical care, and it has a population-to-primary care physician ratio of 3,034:1 and has unusually high needs for primary medical care services.

Therefore, we are designating the low-income population of the Municipality of Anchorage as a population group with a shortage of primary medical care manpower, under the authority of section 332 of the Public Health Service Act. The designated population is defined to include:

<u>County</u>	<u>Parts</u>
Anchorage Division	Municipality of Anchorage- low-income population

This area is assigned to degree-of-shortage group 4, as defined in the regulations for Designation of Health Manpower Shortage Areas.

As you probably know, designation under section 332 makes this area (1) eligible to apply for placement of National Health Service Corps personnel, (2) an eligible service area for purposes of repayment of health professions student loans, (3) an eligible obligated service area under the National Health Service Corps Scholarship Program, and (4) eligible to apply for (or to receive preference for) grant funds under various sections of the Public Health Service Act.

Page 2 - Mr. Don Bantz

Applications for NHSC personnel are available from Dr. Art Lagace, NHSC Regional Program Consultant, in Seattle.

We appreciate your efforts to assist us in identifying health manpower shortage areas.

Sincerely yours,

*Howard V. Stambler*

Howard V. Stambler  
Director  
Division of Manpower Analysis

cc:  
Office of the Governor  
Health Systems Agency  
State Health Planning and Development Agency

APPLICATION FOR THE MUNICIPALITY OF ANCHORAGE  
FOR DESIGNATION OF THE LOWER INCOME POPULATION  
AS A CRITICAL HEALTH MANPOWER SHORTAGE AREA GROUP

In April of 1977, the Municipality of Anchorage was designated as a Medically Underserved Area. This designation was based upon four indices:

- 1) percentage of population below the poverty level.
- 2) percentage of population over age 65,
- 3) infant mortality rate, and
- 4) primary care physicians per 1,000 population.

It is the contention now that the lack of access to primary care practitioners for the low income population group of Anchorage qualifies this group to be designated as a Critical Health Manpower Shortage group.

This application includes the following:

- 1) population methodology
- 2) primary care practitioners
  - (a) background
  - (b) primary care practitioner summary
  - (c) Anchorage Human Resources Department survey
  - (d) Anchorage Neighborhood Health Center survey
  - (e) adjustments of the ratio: population group to primary care practitioners serving them
- 3) additional documentation
- 4) appendices

## POPULATION METHODOLOGY

According to the Municipality of Anchorage Human Resource Planning Department, the population of Anchorage is 202,101 persons. Subtracting the Alaska native and military populations from this total leaves a non-federal population of 165,517 persons:

202,101
- 28,500 military
- 8,084 Alaska native
<u>165,517</u>

The 1978 Population Profile prepared by The Municipality of Anchorage lists the distribution of annual household incomes for Anchorage but the data is not broken down by number of persons in the household.

Table 1. DISTRIBUTION OF  
INCOME OF ENTIRE HOUSEHOLD  
BY SUBCOMMUNITY

Annual Household Income	Total Popu- lation
\$ 0-\$ 9,000	10.0%
\$10,000-\$14,999	9.2
\$15,000-\$19,999	9.5
\$20,000-\$24,999	10.9
\$25,000-\$29,999	10.1
\$30,000-\$34,999	12.2
\$35,000-\$39,999	7.7
\$40,000-\$49,999	12.8
\$50,000-\$59,999	9.0
\$60,000 & Above	8.6
<hr/>	
(n)	(1,177)
Mean	32,998
Median	30,155
Standard Deviation	20,555

The median household size in Anchorage is 3.0. (Population Profile - Municipality of Anchorage, Page 4 table 1-1).

The Medicaid eligible population of Anchorage can be estimated by using the poverty guidelines for Alaska, issued by the Community Services Administration on May 7, 1979 in the Federal Register. (For a complete breakdown of these figures, see Appendix).

By these guidelines a family of 3 persons who makes \$7,008 per year or less is Medicaid eligible. Using the

household incomes in Table 1, approximately 8% of the 165,517 non-federal population of Anchorage, 13, 241 persons, live below the poverty levels and are Medicaid eligible.

#### PRIMARY CARE PRACTITIONERS

There are, at present, 82 practicing primary care non-federal physicians in the Anchorage Municipality. The breakdown is as follows:

Family practice/general practice	42
Pediatrician	14
OB/GYN	17
Internists	9
Total	<u>82</u>

Source: Alaska State Medical Association. 1978-9 Medical Directory.

#### Background

The State of Alaska's Medicaid Program has experienced problems with its reimbursement system to the degree that a nine month lag in physician reimbursement is not uncommon. The Alaska Medical Society, at their annual meeting in 1979 went on record as rejecting any mandatory medical obligation to care for people who cannot pay. This resolution was written and sponsored by the Anchorage Medical Society (see attached newspaper article). It appears that this resolution was directed at efforts by the State to legally prohibit doctors from refusing to treat poor patients in retaliation to tardiness in paying Medicaid bills.

This has lead to the situation whereby Medicaid patients are being denied access to primary care practitioners in Anchorage. This has been documented by a number of independent surveys conducted by various health agencies in Anchorage during the past year. The situation is particularly acute with regards to prenatal care. The initial survey was done by the South Central Health Planning and Development Agency who concluded that a "shortage of OB services does exist, and that the economically disadvantaged patients are those who are most likely to directly experience that shortage" (December 12, 1978).

#### Anchorage Human Resources Department Survey

The Anchorage Human Resources Planning Department surveyed 38 of the 42 Family Practice physicians in March, 1979 and 33% responded that they do not accept Medicaid patients for any type of services. In a further study commissioned for the Human Resources Planning Department, the Anchorage Urban Observatory found that the primary care physicians have on an average 57 Medicaid patients per practice. This

would indicate that approximately 4731 Medicaid patients (57 x 83 physicians) are being seen on a regular basis by Anchorage primary care physicians. This represents about 36% of the Medicaid eligible population in Anchorage, and would seem to indicate that 64% of the Medicaid eligible population in Anchorage is not being seen regularly by primary care practitioners except for the two physicians at the Anchorage Neighborhood Health Center.

#### ANHC Survey

To further clarify the situation, the Anchorage Neighborhood Health Center conducted its own telephone survey in October, 1979. ANHC called 17 OB physicians, 36 family practice physicians, and 14 pediatricians in Anchorage.

Summary of results (see appendix for complete survey results).

1) Five OB practices are completely closed to new OB patients or Medicaid patients.

2) Six OB practices accept new OB patients but do not accept Medicaid patients.

3) The remaining four OB practices all require cash payments by the patients, up front, before they will be seen, thus limiting access to low income patients. Further, they will only accept a limited number of Medicaid patients.

4) None of the 36 family practice physicians accept new OB Medicaid patients.

5) Twelve of the fourteen pediatricians will not accept Medicaid patients. Two pediatricians who accept Medicaid patients do so on an extremely limited basis.

#### Adjustments To Primary Care Practitioners

1)	Beginning Ratio	<u>13,241</u> 82
2)	Adjusting for physicians with closed practices to Medicaid patients.	<u>13,241</u> 21
	11 obstetricians (ANHC Survey - see appendix)	
	12 pediatricians (ANHC Survey - see appendix)	
	38 family practice (Anchorage Municipal Human Resource Planning Survey)	
3)	a) Adjusting for limited access to Medicaid patients - 36% of Medicaid eligible population, currently has access to primary care practitioners. This means that the 4,766 Medicaid eligible persons have access to the 21 remaining primary care physicians.	<u>4,766</u> 21

b) The remaining 64% (8,475) of the Medicaid eligible population, in effect, has a total of 2 physicians (Anchorage Neighborhood Health Center) available to them on a full-time basis.

$$\frac{8,475}{2} = 1:4,236$$

Thus, according to the data presented, a Critical Health Manpower Shortage area ratio exists in the Anchorage low income population. For the reasons outlined in this report, we are requesting that the Bureau of Health Manpower provide this designation immediately. A critical need in the area of prenatal care is particularly apparent, and the Anchorage Neighborhood Health Center intends to apply for a Family Practice National Health Service Corp Physician to help alleviate this problem.

ADDITIONAL DOCUMENTATION  
IN SUPPORT OF THIS APPLICATION

There is some evidence that the group above the Medicaid eligible population of Anchorage also lacks regular access to primary care practitioners. This "medically indigent" category is not well defined. However, using the HUD "Section 8" guidelines (the most generally accepted income guidelines for Anchorage), low and moderate income levels and target populations can be enumerated.

Table 2. HUD Section 8 Income Guidelines for Anchorage, July 31, 1979\*

Number in Family	Low Income	Moderate Income	Median Income
1	8,960	11,200	14,000
2	10,240	12,800	16,000
3	11,520	14,400	18,000
4	12,800	16,000	20,000
5	13,600	17,000	21,250
6	14,400	17,800	22,500
7	15,200	19,000	23,750
8	16,000	20,000	25,000

\* Source: Al Robinson, HUD Economist, Anchorage

According to HUD figures, an Anchorage family of 3 that makes \$11,520 or less is considered to be low income. Referring again to Table 1, approximately 4% of the total Anchorage population falls above the poverty level, yet below the low income level (extrapolation of the 2 categories 0-9,000 and 10,000-14,999 per year). By this calculation, there are about 6,620 persons who fall within this medically

indigent category. end: 8876

Again, using the HUD figures, the moderate income level population can be estimated. This amounts to approximately 7%, or 11,586 persons in the low to moderate income range.

In summary, the income populations are shown below.

Anchorage Target populations

Poverty level (Medicaid eligible)	13,241
Low income	6,620
Moderate income	<u>11,586</u>
Total	31,447

Lack Of Access To Medical Care Services

Another indicator of the problem is the emergency room utilization. Providence Hospital had 27,000 emergency room visits during the past year. According to the administration office at Providence, 60% to 80% of these visits were non-emergency problems. This is one of the major indicators of the lack of access to a regular physician by a large segment of the Anchorage population.

Perceived Needs

The perceived needs of Anchorage health consumers seems to support the physician access problem. In a recent survey done for the Anchorage Municipality, the Anchorage Urban Observatory\* found that 25.4% of the persons surveyed had difficulty paying for the uninsured cost of medical care.

\*Ender, Richard. "Anchorage Health Needs Assessment Study: A Consumer's Health Survey", May, 1979.

# STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

JAY S. HAMMOND, GOVERNOR

POUCH H 81 - JUNEAU 99811

February 6, 1980

The Honorable Terry Martin  
Alaska State Representative  
Pouch V  
Juneau, Alaska 99811

Dear Mr. Martin:

Recently you requested information regarding key questions that might be addressed in a study analyzing the advantages and disadvantages of State of Alaska withdrawing from the federal Medicaid and Aid to Families with Dependent Children (AFDC). Our primary information sources for your request were Deputy Commissioner Frederick McGinnis, who has been designated to coordinate a special project on health care financing, and members of the Division of Public Assistance. They offered the following list of pertinent questions:

## Medicaid Issues

1. What would be the impact of withdrawing from Medicaid without withdrawing from AFDC?
2. Which option services (such as eyeglasses) and mandatory services (such as doctor's visits) would be advantageous to the State to continue in a state designed and financed medical program?
3. Who would be eligible for the state replacement program? Would the State be interested in expanding its eligible group to cover certain needy or middle income persons now not routinely eligible for state assistance?
4. How would the issue of prior medical resources (Indian Health Service, Blue Cross coverage, etc) be handled? Would the state only cover those persons with no other available resource to pay for or provide care? As is the case currently with General Relief Medicaid program.
5. Should the Medicaid requirement of "free choice of provider" be continued under any new state medical assistance program?
6. Would the services be offered in all areas of the state in the same manner? Or would regional planning and delivery of services be utilized?

7. How will National Comprehensive Health Insurance or National Catastrophic Medical Insurance programs now discussed on federal fronts impact the design of this program?
8. Other points to consider regarding loss of federal Medicaid funds if the State withdrew from Medicaid:
  - a. 50% federal funds for medical services covered under Medicaid for persons eligible for a cash payment under AFDC, SSI and/or APA.
  - b. 50% to 90% federal funds for medical services covered under Medicaid for persons not eligible for a cash assistance payment but who are in state institutions, in long-term care facilities and hospitals, and children in foster homes and private child-caring institutions.
  - c. 100% federal funds which flow through the Medicaid program to the Alaska Area Native Health Services to provide funds to raise the quality of care of those facilities under the Indian Health Care Improvement Act.
  - d. 75% to 90% federal funds for the development and operation of a computerized Medicaid claims payment and management information system to provide prompt payment of medical providers and detailed information necessary to do adequate budget projections.
  - e. 75% to 100% federal funds for program management safeguards to assure that cost effective payment is being made to licensed providers for medically necessary services through a professional standards review organization for hospital care, medical utilization review for long term care and outpatient medical services and supplies, and medical provider fraud investigation.
  - f. 75% to 100% federal funds for certification and licensing of health care facilities under Medicare and Medicaid to assure adequate care is being provided in safe and sound facilities.
  - g. 50% to 75% federal funds to the Division of Public Health for nursing services provided to Medicaid eligible children for the detection, identification and treatment of diseases and deformities.
  - h. 100% federal funds for federal program oversight, technical assistance, and program review to assist the Department in an effort to provide payment for cost-effective, high quality medical care.
  - i. 50% to 90% federal funds for program administration costs claimable by the Department for the department-wide and

statewide cost allocation system designed to maximize federal receipts to offset state general fund expenditures.

AFDC Issues

An exhaustive study of this subject was completed by the former Research Division, Legislative Affairs Agency. The Department participated actively in this research project and has reviewed the draft. The Legislative Affairs Agency's Research Division was disbanded before the final report was approved for printing. We recommend you obtain a copy of this report to determine whether your current initiative may duplicate the massive effort required in the project.

Though the draft report discussed the features of the AFDC program that may make it desirable for Alaska to opt out and upon the costs of dropping the program, considerable attention was given to possible alternatives to replace AFDC. Among the topics covered in the study were:

- (1) history of Alaska's assistance programs;
- (2) problems in administering a federal program in Alaska;
- (3) federal welfare reform proposals and their potential effects on Alaska;
- (4) fiscal impact of withdrawal;
- (5) alternatives to AFDC (including negative income tax and a universal child allowance);
- (6) legislative and administrative alternatives and options within the current federal AFDC program; and
- (7) work requirements for welfare recipients.

You may wish to contact Deputy Commissioner McGinnis directly at 278-4668 (Anchorage) and Rod Betit, Director of the Division of Public Assistance at 465-3355, for further clarification. For your information, Deputy Commissioner McGinnis has just begun the planning for a study with the Governor's approval to take a comprehensive look at the total health care financing picture in Alaska, of which Medicaid is a vital part. He plans to submit the results of his study to the 1981 Legislature.

We appreciate the opportunity to offer some input on your possible project.

Sincerely,



Helen D. Beirne  
Commissioner

The Children's Clinic  
3300 Providence Drive  
Anchorage, Alaska 99504

907/279-8571

October 12, 1979

Mr. Leonard D. Schaeffer, Administrator, HCFA  
Department of HEW  
Mary E. Switzer Building, Room 5006  
330 "C" Street, S.W.  
Washington, D.C. 20201

Dear Mr. Schaeffer:

The purpose of this letter is to outline the difficulties The Children's Clinic has experienced in dealing with the Medicaid system in the State of Alaska. In addition, we are outlining some of the recommendations that would alleviate some of these problems.

- (1.) Failure of Medicaid to pay anything in less than four months, with many accounts unpaid in 16 months. An example is given in Table 1.
- (2.) The cost of processing Medicaid paperwork is excessive. For example, The Children's Clinic pays \$1,700.00 in combined staff salaries to process Medicaid paperwork. The current disallowance rate pays us \$ .62 for each \$1.00 billed. In the month of September 1979 our doctors each made an average of 1,355 patient visits in the hospital and office. Thirty-eight percent of these visits or procedures are for Medicaid recipients. After correcting for the disallowed rate, the secretarial time to process paperwork, less office overhead of 55%, net receipts was \$489.00. The average net is \$3.62 to the doctors per patient procedure or visit. If this is converted into a net hourly rate, the amount is \$4.31 per hour for Medicaid patients. Compare this with the net income per doctor per visit or procedure of \$19.29 per visit or \$28.30 per hour for patients having private insurance.
- (3.) The fact that a doctor will be reimbursed \$3.62 nine months after he provides the treatment is not conducive to his opening his practice to any new Medicaid patients. The fact that a Medicaid coupon is relatively worthless from the financial viewpoint means the Medicaid patient is, in effect, a second-class citizen in his attempts to obtain medical care.
- (4.) The Medicaid office has repeatedly failed to advise the providers of changes in the system prior to the change taking place. This results in a great waste of time for the State employees, the providers, staff, and the Medicaid patient in generating and processing outdated forms.

Mr. Leonard Schaeffer  
October 12, 1979  
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- (5.) The Medicaid office fails to keep Medicaid recipients notified of coverage to which they are entitled and the system by which they are to obtain these benefits.
- (6.) The supervisory and clerical staff in Juneau change very often. A supervisor with whom we might have discussed various cases is no longer there when we telephone back a month later. The people who are now handling the account know nothing of what is going on and they request reapplication of the entire account. After a particular invoice is handed from one clerk to another, 6 months may have elapsed. If the paperwork must be resubmitted, coupons for the service provided 6 months ago cannot be provided by Medicaid. The patients themselves do not keep old coupons.
- (7.) Although private insurance carriers will coordinate benefits between one another, when the patient has coverage by more than one company, Medicaid expects the doctor's office to do this. The physician's offices are skilled at providing Medicaid care, but not for employing insurance personnel for this type of activity.
- (8.) The Medicaid office is not verifying whether or not the Medicaid recipients have insurance coverage. The social worker will determine that a divorced mother is working for a company that has insurance available. Many of these mothers choose not to have the insurance as it will reduce their take-home pay. This mother will be recorded by the Medicaid office as having private insurance when, in actual fact, no private insurance exists. It takes an average of 5 months of letter writing between the insurance company, employer, and the doctors to prove that no insurance coverage existed at the time. Again, when 5 months have elapsed, the patient does not have a coupon covering the appropriate time period. The Medicaid office refuses to provide the coupons or authorize payment for those services.
- (9.) The Medicaid office in Juneau requires a separate coupon be obtained for each provider. When the patient comes to the hospital in the middle of the night for an emergency, often times the patient forgets to bring the coupon. The hospital will be reimbursed on a basis of a coupon number typed on the emergency room services sheet. The private physician who provides the service at the time of the visit is expected to obtain a coupon rather than use the same system as the hospital.
- (10.) Payment vouchers are presently identified only by invoice numbers. They lack corresponding patient names. Transition errors are being made by Medicaid personnel in typing invoice numbers on the vouchers, consequently the doctors cannot find the invoice that should be credited with the payment. We need patient names included as well as the invoice numbers.

Mr. Leonard Schaeffer

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Page Three

- (11.) Lump sum payemnts are made, which do not give Explanation of Benefits that state what services are being paid and what date. For example, we will have provided 20 services for a family over a period of one year. Because of the reimbursement for Medicaid being delayed 6 to 12 months - some services are disallowed, others are questioned, and others are paid - we cannot properly credit the lump sum payment to the proper services. This particular procedure is necessary because invoices are constantly being lost in Juneau and we must reapply two or three times. We must have an itemization accompanying each payment voucher so that accounts can be properly credited and duplicate charges will not be submitted in error.
- (12.) A mother who is pregnant is not permitted to get a coupon for the unborn child until after the birth of the child. In this office an average of 2 months elapses following the birth of a child before the mother can provide us with a coupon for that child. Medicaid mothers are a high risk for having premature infants and newborns with a high degree of sickness. The whole process of initiating paperwork to obtain reimbursement is delayed an additional two months, in addition to the five or six months already mentioned. If the social worker thinks that the mother has maternity benefits from her employer, the situation stretches out for a year.
- (13.) Medicaid recipients only recieve 5 coupons per month which may be used in 2 visits to the doctor (one coupon for the doctor, one for the lab, one for the x-ray, and one for the pharmacy). Recipients tell us they go to the Medicaid office, but are unable to get any more coupons; as a result, patient care suffers.

The following recommendations are offered to IMPROVE MEDICAID.

- (1.) It is time for the state and federal government to get out of the insurance business. The CHAMPUS program work very satisfactorily in Alaska. In Alaska, private insurance companies competitively bid to obtain one-year contracts for the CHAMPUS funds. The companies compete with one another to provide the government with more health care for less dollars. The insurance carriers are already very good at coordinating benefits for recipients having multiple coverage, and consistently accompany the voucher with the explanation of benefits for each individual patient. We would strongly urge that the federal government look at the actual cost in dollars per service to the patient, including the overhead for the cumbersome duplicating, inefficient system we have in Alaska. If the Medicaid in Juneau was to bid competitively with Blue Cross, Aetna, Metropolitan to obtain federal funds for the administration of reimbursement for medical care, the Medicaid would either shape up or lose the contract to a private carrier.

Mr. Leonard Schaeffer  
October 12, 1979  
Page Four

- (2.) An alternative system to do away with reimbursing doctors altogether: Doctors would simply document the services provided and apply the patient fees for Medicaid patients as a tax credit to the Internal Revenue Service. The IRS already has an effective system of cross-checks and could audit office records simply and avoid suspicion of fraud on the part of the doctors. The amount of monies saved by doing away with salaries, equipment and rent for the Medicaid system could be reallocated into education, food, etc.
- (3.) We understand from Mr. William Collings, of the D.H.E.W., that the Medicaid office in each state is to have a medical advisory committee in each state. The committee has not been functional in Alaska to our knowledge. The Alaska American Academy of Pediatrics and the Anchorage Medical Society have doctors who are knowledgeable and are willing to contribute their time and efforts to such a committee. These representatives could report back any changes in the system to the doctors in the communities.
- (4.) To curbe the current widespread abuse of the Medicaid system by the patient, each patient should be required to make "token" payments in cash (\$2.00) each visit. Children are being brought into the doctor's office for hang nails, etc., because they are on Medicaid and think they must be seen. If they paid \$2.00 of their own slender dollars they would think carefully before going to the doctor or health clinic unnecessarily.

To prevent user abuse of the hospital emergency room, patients would be required to make a cash payment of \$20.00 in advance if the emergency triage nurse determined that this visit is not an emergency. It is not unusual for a Medicaid mother to bring a 4-year-old to the emergency room at 3 a.m. because he has been crying for two weeks and cannot sleep. If his mother had to pay \$20.00 in cash prior to the service she would make more efficient use of her Medicaid coupon and the medical services available to her. Thus, Medicaid would be charged only \$28.00 for an office visit, instead of \$100.00 for an emergency room visit.

- (5.) As an interim measure, move the state Medicaid offices from Juneau to Anchorage or Fairbanks. These are the areas where the majority of the recipients live and the majority of the care is provided. This would facilitate communications between recipients, providers and administrators. Each area must have a strong manager who has the authority to authorize payment, issue coupons, etc.. locally.

Mr. Leonard Schaeffer  
October 12, 1979  
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The pediatricians of The Children's Clinic appreciate the opportunity to bring their ideas and concerns for caring of the Medicaid recipients to you at the Annual Meeting of the American Academy of Pediatrics. We hope that this type of dialogue will continue to benefit the Nation's Medicaid children.

Sincerely,

(Signed)

Clinton Lillibridge, M.D.—  
The Children's Clinic  
3300 Providence #112  
Anchorage, Ak. 95504

cc: James Nesbitt, M.D. ✓  
Gerry Schriever, M.D. ✓  
Dion Roberts, M.D. ✓  
Elizabeth Hatton, M.D. ✓

CL/pkd  
(Retyped 10/22/79 -AAP-  
AAP - TPR/ms)  
(Attachments)



CHAIRMAN  
MARIAN T. WITT, M.D.  
3300 PROVIDENCE DRIVE  
ANCHORAGE, ALASKA 99504

ALASKA CHAPTER  
American Academy of Pediatrics

February 6, 1980

Representative Terry Martin  
Pouch V  
Juneau, Alaska 99811

Dear Sir:

By way of introduction, I am the alternate chairman of the Alaska chapter of the American Academy of Pediatrics. The Academy represents 90 per cent of all of the pediatricians in Alaska. We have been struggling to develop new solutions to the Medicaid problems. It is our desire to provide excellent care for every child in Alaska, regardless of the ability to pay.

Many physicians (including some pediatricians) have refused to accept Medicaid patients simply because the entire fee for the office visit is expended in clerical time to process the paper work. To add insult to injury, after processing (and reprocessing) the paper work, payment is not forthcoming. From a financial standpoint, we would be better off to see Medicaid patients for free and not bother to process any paper work.

If we do this, however, an ethical problem arises with the patients who have jobs (and thus are not eligible for Medicaid) but do not earn enough to pay for medical care. If we give free care to one part of the population, we are ethically bound to do that for others. With no end in sight, this is not a viable solution.

We have been impressed with the capability of Delta Dental as an intermediary for handling Medicaid payments for dentists. We would strongly recommend that pediatric care, including handicapped children, and early screening for Medicaid recipient patients be contracted through Delta Dental.

Representative Jerry Martin

Page 2

February 6, 1980

Our experience with third party payers who are out of state has been dismal. Close and frequent communication is mandatory to facilitate understanding between the provider of care and the third party payer. This is simply impossible when the offices are out of state.

The carriers very effectively can set aside or delay payment, knowing there is no effective way we can communicate with them. As a result, our clerical costs are quite high and the costs to the system (because they do not understand what is going on in our offices, or any of Alaska for that matter) are quite high. It may seem on the surface that an outside carrier would be cheaper, but this is only in the short run. A close working relationship with open communications will greatly reduce costs, in the long run. Delta Dental has proven itself to be effective, and even if they have higher costs than an outside carrier, we firmly believe that the cost to the system will be much lower with Delta Dental carrying Medicaid for pediatrics.

Enclosed is a letter which gives you background information. It was originally presented for our discussions with Mr. Leonard Schaeffer of HEW.

Dr. James Nesbitt and I are willing and prepared to help you understand what is going on with the Medicaid program as it presently exists and would like to work with you in developing new solutions so that needy children in our state can receive proper care and physicians can be reimbursed for the care they provide.

Sincerely yours,

*Clinton B. Lillibridge*

Clinton B. Lillibridge, M.D.  
Alternate Chairman  
Alaska Chapter  
American Academy of Pediatrics

CL:sh

Enclosure

*It's a shame that in a state as rich as ours, a lot of children receive poor medical care, simply because the State Does NOT PAY ITS Bills !*

*CL*

THE FOLLOWING DOCUMENT(S) MAY NOT FILM  
LEGIBLY BECAUSE OF POOR QUALITY OF THE  
ORIGINAL.

REPORT ON  
REGION X REVIEW OF MEDICAID OPERATIONS

DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
STATE OF ALASKA



Prepared by  
MEDICAID MANAGEMENT BUREAU  
HEALTHCARE FINANCING ADMINISTRATION  
REGION X, SEATTLE  
MARCH 1979

THE PRECEDING DOCUMENT(S) MAY NOT FILM  
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CHAPTER I

EXECUTIVE SUMMARY

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## I. EXECUTIVE SUMMARY

### Introduction

This is a report of a review of Alaska's Medicaid program conducted during the week of January 15-20, 1979 by members of the Region X Medicaid Bureau staff. This review was conducted at the request of the Division of Public Assistance.

Chapters II through VII present the major findings, conclusions, and recommendations of the review. These are summarized in the next pages. Detailed reports from the members of the review team follow Chapter VII.

### Summary of Findings, Conclusions, and Recommendations

Any review of this type tends to focus on weaknesses of present operations. At the same time, it must be recognized that, despite very considerable difficulties of staff turnover, budget limitations, and the problems of travel and communication within Alaska, the State's staff have made valiant efforts to keep the program functioning and to be responsive to recipients and providers.

There is no doubt, however, that Alaska's Medicaid program has very serious problems. Staff turnover, staff shortages, and the need to deal with day-to-day crises have combined to place the program in a situation in which there are few controls over costs and the program is seriously vulnerable to fraud or human error.

The major changes recommended in the next six chapters cover:

- reorganization of the Division of Public Assistance to establish a clearly defined Medical Assistance Unit
- addition of staff in eligibility determination, medical policy, third-party liability areas, claims processing (unless fiscal agent employed), Medicaid quality control, and medical surveillance unit
- more emphasis on training efforts

- contracting for development of manuals and procedures
- improvements in accounting controls
- enhancement of the TPL collection function
- improvements in the maintenance of the claims history file
- improvements in control over provider enrollment
- establishment of a provider training program
- development of closer relationships with the provider community
- development of eligibility determination procedures and associated training
- improvements in gathering eligibility data, including a new Basic Eligibility Form
- implementation of a reasonable cost-related reimbursement system, incorporating a 90 percent minimum occupancy level
- re-establishment of admission review for API cases
- renegotiating the memorandum of understanding with APRO and developing an associated monitoring system
- increased emphasis on alternatives to institutional long-term care
- contracting for development of a new provider manual and claims processing procedures
- development of, or contracting for, a new claims processing system (preferably through use of a fiscal agent or facilities manager who would also operate the system)

### Implementation Plan

Three of the recommendations potentially involve the use of contractors. Given the seriousness of the Alaska Medicaid program's problems, this is

an appropriate approach, since it provides some assurance that changes can be accomplished at a known cost, without dependence on the very limited -- and desperately busy -- existing staff of the Division of Public Assistance. The recommendations are for use of outside organizations to:

- develop manuals and procedures for providers, claim examiners, eligibility workers, etc.
- develop training materials
- develop a new claims processing system (preferably through use of a fiscal agent or facilities manager, who would also operate the system)

Contracting for the first should be done immediately. Contracting for the second should be done as soon as the manuals and procedures are developed. The feasibility of using a fiscal agent should be investigated immediately.

All the recommendations are urgent. Those involving adding staff should be examined immediately so that personnel can, if funds are available, be hired. Responsibilities for implementation of each recommendation should be assigned as rapidly as possible and detailed schedules and cost estimates developed.

## II. ADMINISTRATION AND MANAGEMENT

### Overview

This chapter discusses the administration and management of Alaska's Medicaid program in terms of organization, staffing, hiring, training, and operational procedures. The next five sections of this chapter present findings, conclusions, and recommendations for these five areas.

### Organization

Alaska's Medicaid program is administered by the Department of Health and Social Services through the Public Assistance Division, which is designated as the State's Medical Assistance Unit. Other components of the Department with significant involvement in Medicaid administration are the Office of Information Systems, the Office of Internal Review, the Division of Public Health, the Division of Mental Health and Developmental Disabilities, and the Division of Administrative Services.

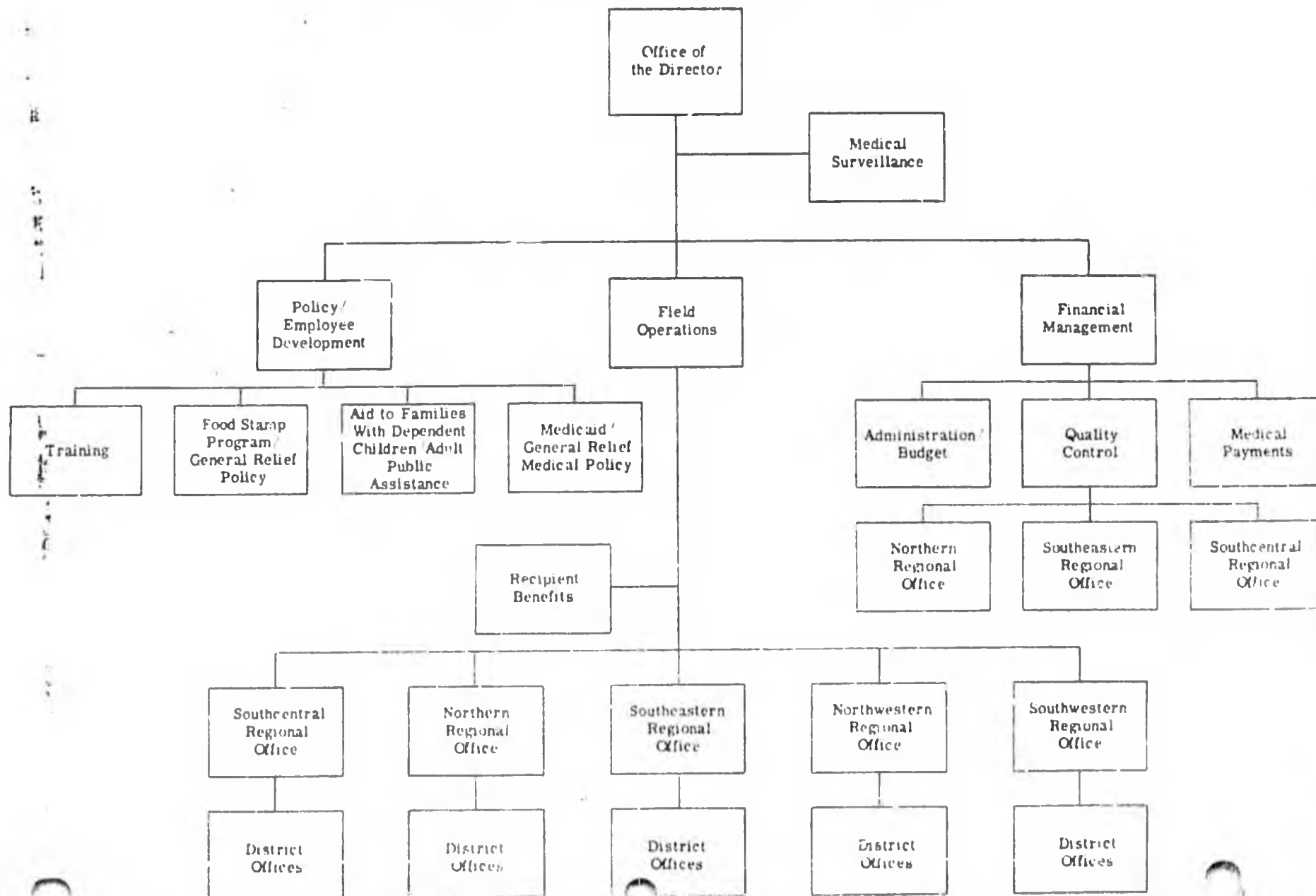
### Major Findings and Conclusions

While the Department's organization structure is comparable to that of other states, the Division of Public Assistance's organization is significantly different and appears to result in a number of problems:

- The definition of the Public Assistance Division as the State's Medical Assistance Unit appears not to comply with the relevant Federal regulations (45 CFR 205.101 (b) and (c) and Part 2-49 of the Medical Assistance Manual), since the Division and its Director are responsible for a variety of other programs in addition to Medicaid. Thus it is doubtful that the Division meets the requirement that a State Medical Assistance Unit "provide a central point of responsibility for professional and technical aspects of medical services and medically related programs of the agency". The present organization is shown in Exhibit 1.

EXHIBIT 1

DHSS - DIVISION OF PUBLIC ASSISTANCE  
UNIT ORGANIZATION CHART - JANUARY 1979



From an organizational point of view, the dispersing of Medicaid functions, including policy-making, through a division which also administers other important programs, leads to a lack of direction of the Medicaid program. There is no part of the Division of Public Assistance whose sole responsibility is Medicaid policy. In practice, Medicaid policy decisions are made by the Medical Surveillance Section, the Medicaid/General Relief Medical Policy Section, and the Medical Payments Section. Each section performs a variety of other functions as well as Medicaid policy-making. Medicaid functions must compete with the AFDC, Adult Payment, Catastrophic Illness, and Food Stamp programs for the time and attention of the Division Director as well as for other Division resources. Directing and coordinating the varied elements of the Medicaid program is extremely difficult in this organizational arrangement.

Responsibility for Medicaid claims processing is split between the Division of Public Assistance and the Division of Administrative Services. This leads to difficulties in controlling service utilization and in developing accurate financial and statistical data for the program. (This problem is discussed further in Chapter VII, Claims Processing.)

### Recommendations

Restructure the organization of the Division of Public Assistance to establish a clearly identifiable Medical Assistance Unit with responsibility only for Medicaid administration. The Medical Assistance Unit should be established either as a separate division or, preferably, as a major subdivision of Public Assistance co-equal with Field Operations and Financial Management. The Medical Assistance Unit should include the following present groups:

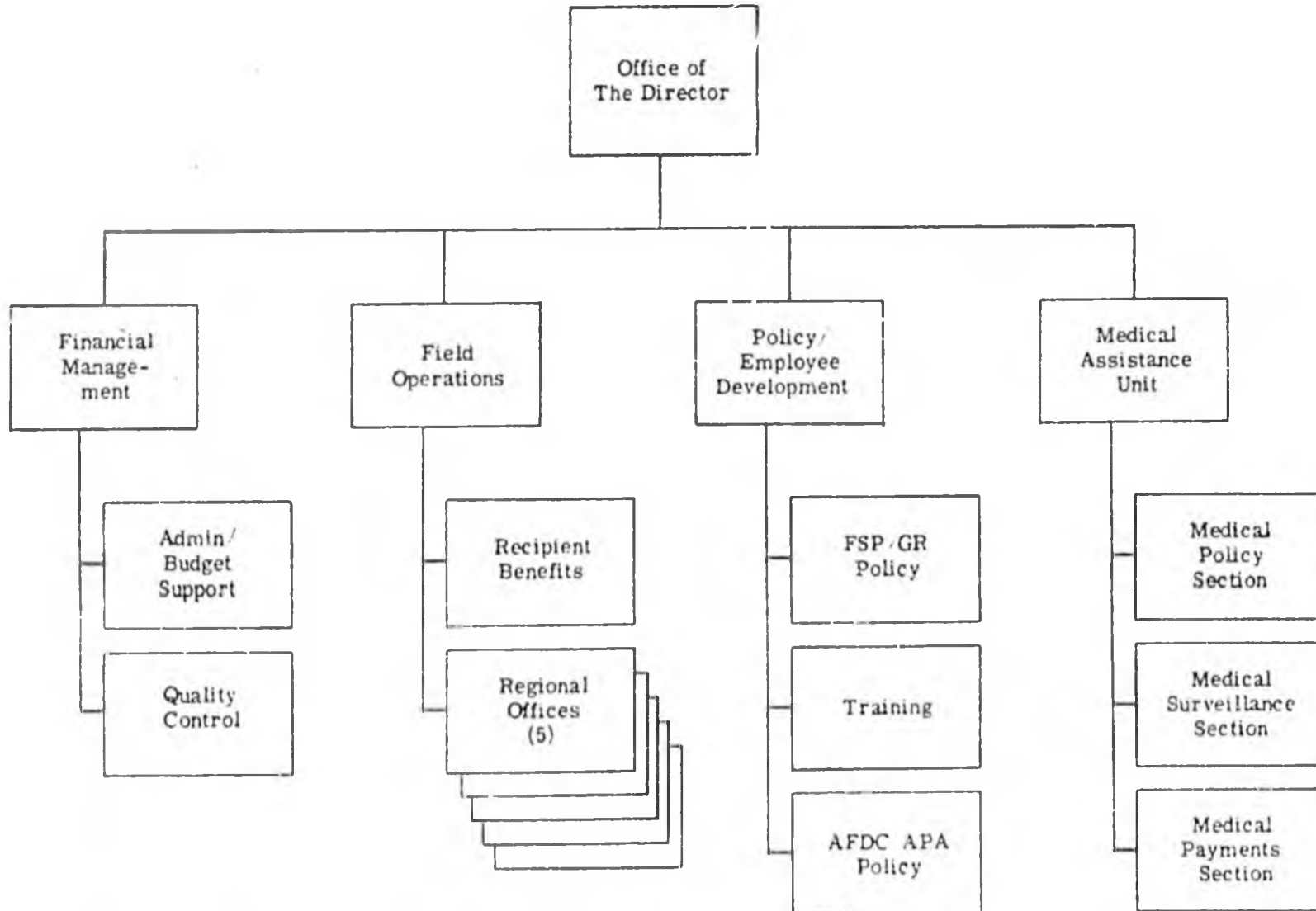
Medicaid/General Relief Medical Policy Section  
Medical Surveillance Section  
Medical Payments Section  
Medical Assistance Administrator (Anchorage  
Regional Office)

The proposed organization structure is shown in Exhibit 2.

EXHIBIT 2

DIVISION OF PUBLIC ASSISTANCE

PROPOSED ORGANIZATION STRUCTURE FOR MEDICAL ASSISTANCE UNIT



- Provide clear definitions of policy-making and other responsibilities within the revised structure. Policy-making functions should be located in one section, not dispersed through the Medical Assistance Unit.
- Contain all Medicaid claims processing functions in one unit.

### Staffing

Any examination of staffing in DHSS must take into consideration two factors: first, the State of Alaska is in a period of considerable budgetary constraint; second, most State agencies and many private sector businesses in Alaska experience problems of high staff turnover.

At the time of the review (January 6, 1979), the authorized versus actual staffing of the Division of Public Assistance was as follows:

<u>Authorized</u>	<u>Actual</u>
<u>163</u> full-time	<u>133</u> full-time
(plus 11 part-time)	(plus 8 part-time and 15 temporary)

It should be noted, however, that the 163 authorized positions are not fully funded; that is, some vacancies are assumed.

### Major Findings and Conclusions

The effectiveness of Alaska's Medicaid program is currently hampered by insufficient staffing in some key areas and by high levels of staff turnover.

- DPA management anticipates a considerable staff shortage in the eligibility determination area in FY

1980, due to expected increases in numbers of eligibles without a corresponding staff increase. The staffing formula used by DPA indicates a need for an additional ten FTE personnel for eligibility determination.

- The Medicaid/GR Medical Policy Section is severely understaffed. At present, a program officer and an administrative assistant are responsible for developing Medicaid policy, GR Medical policy, and catastrophic illness program policy, provider enrollment, fair hearings, writing the Alaska Medicaid program regulations, drafting a Medicaid eligibility manual, consulting to field offices, and other ad hoc administrative activities.
- Only one person is currently assigned to third-party liability collection. Since Alaska's experience to date (borne out by that of other states) is that this is a highly cost-effective activity, there is a need for increased staffing to provide additional recoupment from third parties.
- High levels of staff turnover have undoubtedly contributed to problems in Medicaid administration. An analysis of two BRUs within DPA showed turnover rates of 44 percent within each during FY 1978. This is assumed to have resulted in too low experience levels in too many positions within the Division.

#### Recommendations

- Examine ways of increasing the eligibility determination staff for FY 1980. Possible approaches include:
  - a supplemental request to the Governor's Office for ten eligibility positions
  - use of CETA positions in District and Regional offices to carry out eligibility and/or clerical duties
  - use of temporary hires in the District and Regional offices (the least desirable approach)

- Examine ways of increasing effectiveness of the eligibility determination staff. Possible approaches include:
  - enhancement of automated systems for eligibility determination
  - provision of additional training (discussed in a later section)
  - provision of improved procedure manuals (discussed in a later section)
- Add one professional and one clerical position to the Medicaid/GR Medical Policy Section. It may be possible to add the professional position through reassignment of a vacant position elsewhere in the Division. One function of the new positions should be maintenance of manuals and procedures.
- Reassign the position of Medical Assistance Administrator from the Anchorage Regional Office to the Medicaid/GR Medical Policy Section in Juneau, since, although the Anchorage position is currently needed, implementation of other recommendations will allow its elimination.
- Add up to three additional positions to the third-party liability collection function in order to increase third-party reimbursement of Medicaid payments. Additional staff may be required to maximize these reimbursements.
- Examine ways of reducing staff turnover, including:
  - acceleration of the Department of Administration's planned classification review of eligibility positions to the earliest possible date in 1979
  - provision of improved training throughout DPA (discussed in a later section)
  - provision of improved procedure manuals so that tasks are easier to perform and job pressures are somewhat eased (discussed in a later section)

## Hiring

Hiring for new or vacant positions presents some unique problems in Alaska State government. The practical difficulties of attracting state personnel, combined with a policy of preference for State persons, and a limited State population, considerably constrains the availability of persons qualified for open positions. It is important, then, that Division of Public Assistance hiring problems be examined in the light of these constraints.

### Major Findings and Conclusions

At least in part for the reasons noted above, DPA has and is experiencing hiring problems.

- There have been some delays in filling positions, particularly in view of the high turnover rate. Currently the average time to fill an existing position is one month, and for new positions is up to six months.
- There has been a tendency to promote staff with minimal experience in their existing jobs, with new personnel hired only at low levels. While this has some positive aspects, it can lead both to "inbreeding" and to inadequately experienced supervisory staff.

### Recommendations

There are obvious practical difficulties in solving DPA's hiring problems. The following recommendations, however, should alleviate the problems to some extent.

- Work with DHSS personnel staff and Department of Administration personnel staff to reduce the length of time to fill vacant positions.
- Aggressively utilize the "flexible" staffing authority for filling eligibility worker positions.
- For managerial positions, ensure the position requirements are sufficiently specific to allow recruitment of qualified employees.

## Training

The preceding sections indicate weaknesses in staffing which might be, at least partly, alleviated by more extensive training. In fact, as discussed below, DPA's training efforts have been much reduced as a result of other pressures on the Division.

### Major Findings and Conclusions

- The position of Training Specialist is currently filled only in name, since the incumbent is temporarily assigned to management of the Southeast Regional Office.
- Partly as a result of this temporary assignment, minimal training activities are currently being performed.
- As discussed earlier, the high level of staff turnover, combined with inadequate or nonexistent manuals and procedures, makes the need for training very urgent.

### Recommendations

- Fill the Training Specialist position on a full-time basis.
- Contract for development of Medicaid training courses for Division staff.

### Operational Procedures

The Medicaid Program is one of considerable complexity, and its proper administration depends on the availability of current, accurate, and understandable manuals and procedures for use by State and provider personnel. These manuals and procedures should meet the needs of providers, claims examiners, policy-makers, and management.

## Major Findings and Conclusions

Development and maintenance of Medicaid manuals and procedures has suffered due to staff shortages and the need to deal with more immediate critical problems. Specifically:

- Medicaid regulations have been drafted but have not yet been adopted. Implementation is anticipated in May 1979.
- The Provider Manual is not current. The version available to providers was developed in 1974.
- There is no current eligibility worker manual for Medicaid.
- There are no procedures for use by claims examiners.
- There is no medical policy or staff operational manual for use by DPA management and staff.

## Recommendations

- Complete the current review process and hearing on draft program regulations and implement by March 1979.
- Contract with a consulting firm to develop:

provider manual(s)  
claims examiner desk procedures  
medical policy manual  
Medicaid eligibility manual

At least the provider manual(s), claims examiner desk procedures, and medical policy manual should be completed by July 1, 1979.

- Establish a position in the Medicaid/GR Medicaid Policy Section to be responsible for maintenance of manuals and procedures (recommended also under Staffing).

## Summary

The major changes recommended in the preceding sections cover:

- reorganization to establish a clearly defined Medical Assistance Unit
- addition of staff in eligibility determination, medical policy, and third-party liability areas
- more emphasis on training efforts
- contracting for development of manuals and procedures

In terms of costs, the reorganization should have minimal impact, the staff additions and training efforts (except for TPL) will increase costs in the short run but should contribute toward a more effective and better controlled program, and the development of manuals and procedures should pay for itself in reducing claims payment errors.

### III. FINANCE AND ACCOUNTING

#### Overview

This chapter discusses the accounting systems and controls relevant to the Medicaid program, the third-party liability collection function, contracts management, and financial reporting.

#### Accounting Systems and Controls

Accounting systems and controls for the Medicaid program are the responsibility of three groups within the Department of Health and Social Services: Financial Management Section (Division of Public Assistance), Finance Operations (Division of Administrative Services), and Office of Information Systems. Certain functions are also performed by the Department of Administration, which provides computer services and operates the Statewide accounting system (PBA).

#### Major Findings and Conclusions

Possibly in part because of the ongoing staffing problems, and more urgent situations such as claims backlogs, there are a number of weaknesses in accounting for the Medicaid program.

- There is a lack of control over Medicaid claims documents and over the entire claims payment process (discussed in more detail under Claims Processing).
- Specific weaknesses include: payment vouchers can be completed and certified by the same individual, provider enrollment can be completed without certification by an independent person, there is no system for verifying that recipients actually receive the services billed, remittance advices do not necessarily match warrants, batch integrity is not maintained over claims in data entry, and the PBA file does not match claims history file.

- While most Medicaid invoices are processed by the Division of Public Assistance, certain invoices (State institutions, other State agencies, certain non-medical claims) are processed by the Division of Administrative Services. The systems of controls, document storage, and invoice-to-warrant reconciliation processes used by the two divisions are all dissimilar. More important, the invoices paid by Administrative Services do not become part of the claims history file and are not checked for overlapping or duplicated services against the invoices processed by DPA. This fragmentation of processing makes projecting Medicaid costs extremely difficult.

### Recommendations

- Provide organized secure storage for all accounting documents (medical coupons, invoices, vouchers, etc.).
- Eliminate the practice of persons certifying vouchers they have prepared.
- Implement a batch control system to provide complete batch integrity.
- Implement a system to provide reconciliation of warrants versus invoices.
- Contain payment of all Medicaid claims within one unit.
- Post all claims payments to the claims history file (discussed also under Claims Processing).
- Request a full-scope audit by the Office of Internal Review of the Title XIX program with specific emphasis on internal controls.

### Third-Party Liability Collection

Third-party liability collection efforts provide an opportunity to achieve significant reductions in Medicaid program costs by collecting from (or

redirecting claims to) other medical insurers or a liable party in an accident case.

### Major Findings and Conclusions

Alaska's TPL Collection function has only recently been established and is only beginning development. Limitations of the function include:

- Eligibility workers may not obtain details of other coverage from a newly eligible person.
- Only some claims are examined (manually) for possible third-party liability.
- Neither the eligibility nor claims processing computer systems are used in TPL detection.
- Insufficient staff are available to handle the potential volume of TPL collections.

Despite these limitations, over \$30,000 has been recovered by the one person currently assigned in the short time this function has been in existence.

### Recommendations

- Provide training to eligibility workers to enable them to obtain details of any other coverage.
- Add edits to claims processing computer system to identify potential TPL cases.
- Increase TPL collection staff to two professional and one clerical.

(The experience to date suggests that further cost-benefit analysis may justify a greater increase than this.)

## Contracts Management

The contracts management function covers contracts with fiscal agents, consultants, and other contractors. The function is the responsibility of the Division of Public Assistance, although routine processing is performed by the Department of Administrative Services.

### Major Findings and Conclusions

Comprehensive written policies regarding contracts management have recently been developed by the State. These policies are generally satisfactory. A few minor weaknesses are noted in the corresponding Detailed Review Report.

## Financial and Statistical Reporting

Three groups of financial reports are prepared by the State which have relevance to the Medicaid program: monthly and annual reports of disbursements (generated by the Department of Administration's PBA System), internal State reports (prepared by DHSS), and Federal reports (prepared by DHSS). Only the Federal reports were reviewed in detail during the review, so the following findings and conclusions are limited to Federal reporting.

### Major Findings and Conclusions

- Financial reports are out of phase with statistical reports.
- Expenditures by eligibility category are incorrectly reported.
- Expenditure projection reports are incomplete and inaccurate.

### Recommendations

- Adopt written procedures covering preparation of Federal reports.

- Consolidate all claims processing in the Division of Public Assistance, to eliminate multiple sources of financial and statistical data (discussed elsewhere).
- Modify the claims processing system to provide a claims history file which reflects warrants issued, not merely claims adjudicated (recommended also under Claims Processing).

### Summary

The major changes recommended cover:

- improvements in accounting controls
- enhancement of the TPL collection function
- improvements in the maintenance of the claims history file

Each of these changes involves increased expenditures. Each is important. The accounting control improvements are essential to avoid fraud and protect the integrity of the program. The additional staffing of the TPL collection function should more than pay for itself, based on other states' experience. The changes to claims history file maintenance are essential to provide proper controls and reporting.

## IV. PROVIDER RELATIONS

### Overview

This chapter discusses provider enrollment, provider education and training, and other provider relations activities.

### Provider Enrollment

New providers are enrolled in the Medicaid program by the completion by provider, and the signing by the State, of a provider application and agreement, in accordance with 42 CFR 431.107.

### Major Findings and Conclusions

The provider enrollment process is generally straightforward and effective except that:

- Under some conditions a fictitious provider could be enrolled.
- Out-of-State providers are not enrolled, nor is there any verification of the validity of their participation.
- Three different provider application/agreement forms are used: for mental health clinics, for audio/speech therapists, and for all other providers. These forms do not reflect all current Federal regulation citations.

### Recommendations

- Direct the Department of Administration's Pre-Audit Unit to reject provider updates without an appropriate countersignature. (This is generally done now, but has not been formally or consistently applied.)
- Establish a verification process for out-of-State providers, including obtaining of state license number and social security or employer ID number.

- Consolidate the three provider application forms into a single common form, and update the references to Federal regulations.

### Provider Education and Training

An ongoing program of provider education and training is important to the Medicaid program to ensure new (and existing) providers understand the requirements and constraints of the program and to help maintain good provider relations.

### Major Findings and Conclusions

Alaska's Medicaid provider education and training is extremely limited:

- In the six months prior to the review only two training sessions, each for specific providers, were given.
- Responsibility for provider training is not clearly assigned to any one group.

### Recommendations

- Establish an ongoing provider training program with more frequent provider workshops throughout the State.
- Assign responsibility for provider training to a specific unit in the Division of Public Assistance.

### Other Provider Relations Activities

Other provider relations activities include attendance at professional society meetings, publication of newsletters, etc.

### Major Findings and Conclusions

- Because of limited staff availability and the pressures of more immediate and urgent problems, few other provider relations activities have been performed.

### Recommendation

- Develop closer relationships with the provider community, through participation in professional meetings, etc.

### Summary

The major changes recommended cover:

- improvements in control over provider enrollment
- establishment of a provider training program
- development of closer relationships with the provider community

The cost increase associated with these changes is probably equivalent to the addition of one person. The result should be improved controls against fraud and a provider community with a better understanding of the program and its constraints.

## V. ELIGIBILITY

### Overview

This chapter discusses eligibility organization, eligibility policy, and eligibility procedures.

### Eligibility Organization

The Medicaid eligibility organization consists of eligibility workers in district and regional offices, a central Recipient Benefits section, and a network of fee agents in the villages.

### Major Findings and Conclusions

Alaska's eligibility program has some unique aspects. The fee agent network covers some 90 percent of the villages and provides an efficient mechanism for identifying potential eligibles and assisting in the application process.

In common with other parts of the Division, the eligibility organization suffers from the problems of high turnover and lack of training, identified in Chapter II. Since these problems are covered there, further details and recommendations are not presented here.

### Eligibility Policy

Clear and correct understanding of Medicaid eligibility policy is essential to Medicaid cost control, to compliance with Federal regulations, and to ensure that potential Medicaid eligibles receive appropriate benefits.

### Major Findings and Conclusions

For reasons similar to those for other problems -- lack of staff, high turnover, more urgent problems -- a number of weaknesses exist in the area of eligibility policy.

- Current Medicaid eligibility determination forms and manuals do not exist.
- Determination of eligibility appears to be based almost entirely on AFDC, SSI, and Adult Supplement eligibility, although Federal law and regulations provides many eligibility provisions peculiar to the Medicaid program. Thus, for persons not receiving cash grants, eligibility may be determined incorrectly.
- Particular misunderstandings of eligibility policy appear to exist for Alaska Psychiatric Institute cases, for which no Medicaid agency review of a need for admission (as required by 42 CFR 456.171) was occurring.

#### Recommendations

- Assign one person the responsibility of developing Medicaid eligibility policy. This is at least a half-time job on a continuing basis because of the frequent changes in Federal policy. This function could be combined with responsibility for training staff in Medicaid eligibility policy.
- Develop (or contract for) a Medicaid eligibility manual reflecting current State and Federal laws and regulations (also discussed in Chapter II).
- Develop a training plan for Medicaid eligibility training to be given to each eligibility worker within the first six months of employment, and for refresher courses.

#### Eligibility Procedures

Eligibility procedures must be adequate to ensure that eligibility is rapidly and accurately determined and the information correctly incorporated in appropriate files.

### Major Findings and Conclusions

- The Basic Action Form used to convey information from the field to the State Office is in need of updating. Combined with the absence of up-to-date written procedures, the form is liable to be incorrectly completed.
- The Office of Information Systems, which has responsibility for the data processing system used for maintaining and reporting eligibility, has little documentation for the system and no one designated as responsible for its maintenance.
- For Alaska Psychiatric Institute cases, a form other than the Statement of Income and Resources normally used for AFDC eligibility was being used for gathering information. So little financial information is gathered via this other form that the eligibility of many children in API must be considered suspect.

### Recommendations

- Update the Basic Eligibility Form and develop adequate instructions for using the new form.
- Designate an individual within the Office of Information Systems to be responsible for the eligibility system. Improve the quality of documentation of the system.
- Use the form used to gather eligibility data from AFDC recipients to gather data for children at API, or use some other form with adequate questions regarding financial status.
- Update the written instructions for determining the eligibility of children at API.

## Summary

The major changes recommended cover:

- development of eligibility determination procedures and associated training
- improvements in gathering eligibility data, including a new Basic Action Form

The costs are a one-time cost for new procedures (already noted in Chapter II) and the addition of one staff person to have ongoing responsibility for maintenance of eligibility policy and related training. Savings should result from more accurate eligibility determination.

## VI. UTILIZATION CONTROL AND RATE SETTING

### Overview

This chapter discusses details of Alaska's rate-setting processes for long-term care, monitoring of appropriateness of care, utilization control, and the development of alternatives to long-term care.

### Rate Setting for Long-Term Care

Long-term care costs represent the largest single component of Alaska's Medicaid costs. The generally high costs of labor, goods, and services in Alaska and the desirability of availability of long-term care in major communities present some constraints to cost reductions; nevertheless, any reductions which can be achieved will have a significant impact on overall program costs.

### Major Findings and Conclusions

Long-term care costs in Alaska are very high, ranging from \$40 to \$170 per day with a weighted average daily rate of \$75-80 per day. The following appear to be the major non-economic causes of the high rates.

- Responsibilities for interim rate setting are not clearly defined. This has led to at least one situation in which interim reimbursement rates were approved which included unallowable costs.
- There has been no systematic approach to rate setting, nor do any detailed procedures currently exist. Interim rates, in particular, have been approved as requested.
- Field audits have not always been performed. Settlement activity has been inadequate and has generally been a "rubber stamping" of reported costs.
- Current occupancy levels in SNF/ICF facilities average 70 percent. No occupancy minimums are included in the State reimbursement process.

## Recommendations

- Define interim rate setting responsibilities clearly and provide adequate staffing.
- Implement a reasonable cost-related reimbursement system, incorporating a 90 percent minimum occupancy level. Because of the extent of the disparity currently existing, it may be necessary to phase in this occupancy level requirement.
- Expand the Medicaid Audit Section to ensure that, at least for the next three years, field audits of all facilities are performed annually.

## Appropriateness of Care

From the viewpoints both of the Medicaid recipients and the State and Federal governments, it is important to ensure that recipients receive appropriate levels of care.

## Major Findings and Conclusions

The State is currently in the process of developing Medicaid regulations which would include enforceable policies regarding levels of care determination and the placement of patients in long-term care. Accordingly, at least some of the following problems may be expected to be resolved with implementation of the new regulations.

- Generally, the approval process for admission to nursing homes works well and appears to be effective in ensuring appropriate care. However, there is currently no admission review for eligibles entering Alaska Psychiatric Institute. This is the responsibility of the Division of Mental Health and Developmental Disabilities but has not been done following the resignation of the psychiatrist assigned to the function.
- Monitoring of continued stays involves both periodic monitoring of patients' long-term stays and an annual review by the Medicaid Surveillance Unit of all patient

records in long-term care facilities. Both functions appear to be generally effective, except that patients have not been sent "adequate notice" of changes in their level of care as specified in 45 CFR 205.10(a)(4)(14).

### Recommendations

- Re-establish admission reviews for API, either by having the Medicaid Surveillance Unit reassume responsibility or by development of a clear memorandum of understanding with the Division of Mental Health and Developmental Disabilities. If the latter is chosen, some form of periodic monitoring by the Medicaid Surveillance Unit should occur.
- Ensure that adequate notice is sent to Medicaid recipients whenever a change is made in their level of care.

### Utilization Control

Utilization control for Medicaid patients in acute care hospitals in Alaska is delegated to the Alaska Professional Review Organization (APRO). Utilization control for patients in long-term care facilities is the responsibility of the Medical Surveillance Unit and is covered in part in the preceding section.

### Major Findings and Conclusions

Utilization control activities are performed for both hospital and nursing home patients. Weaknesses are listed in the following paragraphs:

- There is some indication that APRO's review procedures are inadequate and tend to "rubber stamp" hospital physicians' decisions. A current proposal by APRO to move to "sample review" could intensify the problem.
- The Division of Public Assistance has no mechanism for monitoring the APRO review process.

- The State is not performing the review of a sample of hospital claims agreed to in the memorandum of understanding with APRO.
- Long-term care utilization control is partly covered under the previous section on appropriateness of care. Utilization control efforts in nursing homes appear to be very much limited by staffing availability and the absence of procedures.

### Recommendations

- Renegotiate the current memorandum of understanding with APRO, to specify relative responsibilities, assurances that APRO will carry out a full review, and the monitoring system to be used by the State in reviewing APRO activities.
- Develop the monitoring system for reviewing APRO performance.
- Perform a review of a sample of hospital claims.
- Increase staffing in the Medical Surveillance Unit to enhance long-term care utilization control efforts.

### Alternatives to Long-Term Care

The costs of long-term care in Alaska are such that, if alternatives can be developed, substantial savings could result.

### Major Findings and Conclusions

The State has recognized the need to develop alternatives to long-term care and has recently established a committee to work on the issue. At present, however, the only possible alternative covered by the Medicaid program is home health agency services (available only in Anchorage). Use of these services appears to be discouraged by two factors:

- Many Medicaid recipients are Alaska natives, who have tended to use the Indian Health Services Hospital in Anchorage, which was until recently not subject to professional standards review and did not actively discourage long-term stays.
- There is an excess of ICF and SNF beds, which suggests there is a tendency to admit patients to long-term facilities although they could be served in their homes by an HHA.

### Recommendations

- Continue to develop alternatives to long-term care, and critically examine any further plans to certify additional long-term care beds until plans are in place to offer a continuum of care which includes non-institutional placements.

### Summary

The major changes recommended cover:

- implementation of a reasonable cost related reimbursement system, incorporating a 90 percent minimum occupancy level
- re-establishment of admission reviews for API cases
- renegotiating the memorandum of understanding with APRO, and developing an associated monitoring system
- increased staffing in the Medical Surveillance Unit
- increased emphasis on alternatives to institutional long-term care

Each change should have a significant impact on program costs. Only the fourth item involves an ongoing cost increase, of one staff member's salary. The other items will each take considerable short-term effort to achieve, however.

## VII. CLAIMS PROCESSING

### Overview

This chapter discusses the entire claims processing function, including plans for an improved data processing system and the use of AMOEBA.

### Hospital, Physician, HHA, and Pharmacy Claims Processing Flow

Medicaid claims from hospitals and physicians (including crossover claims), home health agencies, and General Relief/Medical claims from pharmacies follow essentially the same overall claims flow:

- Claims are received in the DHSS mail room, normally with eligibility coupons attached, stamped with date of receipt, and passed to the claims receipt area in the Division of Public Assistance.
- Claims are checked for eligibility coupon. If coupon is attached, information will be transferred from coupon to claim. If there is no coupon, the on-line eligibility file is accessed to obtain eligibility data. If the recipient is not on file, the claim is returned to the provider.
- Claims are sorted by type of service and passed to a claims examiner for adjudication (they may be temporarily filed in the examiner's area).
- Adjudication is performed manually. Payment allowed is based on:
  - lowest of actual charge, median charge, and Medicare reasonable charge (for physicians)
  - percentage of charges (for hospitals)
  - amount billed (for pharmacies)
- Claims are batched, "certified", and forwarded to data entry.

- Following data entry to diskette, the claims data is read into the Department of Administration computer system and processed through the Claims Processing System.
- The outputs from the Claims Processing System include remittance advices, an updated claims history file, punched cards for entry to the PBA accounting/warrant system, and various reports.
- Warrants are produced from the PBA system, matched with the remittance advices, and mailed to the providers.

### Major Findings and Conclusions

There are significant problems with the present claims processing operations:

- No record is currently made of the number and type of claims received, making workload scheduling very difficult.
- The on-line eligibility file is for inquiry only and will not supply historical data on eligibility. If no coupon is attached, and the recipient is now eligible but was not at the time of service, the claim will be paid in error.
- Procedure coding is converted from 1969 RVS or 1974 RVS to 1964 RVS for comparison with Medicare profiles. The conversion and subsequent adjudication process is complex, time-consuming, and error-prone.
- There are no procedure manuals for claims processing.
- Where services are limited (e.g., x services per year), the manual system cannot determine when the limitation is met.
- Crossover claims are paid even when a Medicare EOB is not provided. This may result in overpayments.
- The experience level of the claims processing staff is low. The senior examiner has one year of experience, the other examiners only two to three months. (It is generally accepted that six months' experience is necessary for a claims examiner to become accurate and efficient).

- No validation of the reasonableness of pharmacy claims is made. (This finding applies to the GR/Medical program only.)
- Data entry is performed from the less legible carbon copies of the claims.
- Claims may be altered or removed from a batch during the data entry process.
- Data may be substituted in a field in data entry if the data is missing from the claim.
- The claims history file is updated before it is known that warrants can be or have been issued. Moreover, PBA cards created by the claims processing system may be altered prior to processing through PBA. Thus the claims history file does not reflect claims paid.
- The claims processing system does not provide an acceptable level of duplicate checking, does not verify coverage of procedures or services, and does not check for recipient eligibility.

### Recommendations

Generally, the problems listed above have obvious solutions. Each problem must be eliminated if Alaska is to have a workable claims processing operation. The major changes which must be made are:

- Contract for development of adequate claims processing procedures (see also Chapter II).
- Contract for development of a new provider manual to reduce the errors created by providers.
- Develop, or contract for (preferably through use of a fiscal agent or facility manager), a new claims processing system incorporating automated claims pricing and adjudication.
- Update the claims history file with amount paid after the warrant is created by PBA.

- Examine the feasibility of turning over the entire claims processing function to a fiscal agent or facility manager. The feasibility would depend on:

availability of interested qualified companies

potential cost

political acceptability

### Claims Flow for Other Claims Types

Other types of Medicaid claims which do not follow the typical claims flow are nursing home claims, EPSDT screening claims, State institutional claims, transportation claims, other miscellaneous services claims, and out-of-State claims. The major exceptions to the claims flow described in the preceding section are noted in the following paragraphs:

- Nursing home claims are checked for prior authorization, a voucher prepared and forwarded via data entry to the PBA system, without editing, to create a warrant. Nursing home claims data is added to the claims history file at a later date, without processing through the full claims processing system.
- EPSDT screening claims are processed by the Nursing Section of the Division of Public Health. Except for screenings performed by a physician, no claim is submitted, only details of screening results. Screenings performed by Public Health nurses (95 percent of the total) are reimbursed on the basis of an annual time study. Nurse screenings are not added to the claims history file.
- Claims for miscellaneous services (e.g., wheelchairs, oxygen), some transportation claims (those not processed by the Division of Administrative Services), and out-of-State claims, generally follow the claims flow for hospital and physician claims.

### Major Findings and Conclusions

The most important conclusion regarding processing of these other claims types is that the fragmentation of claims processing leads to inaccurate claims history and the possibility of incorrect payment.

Many of the problems identified for hospital and physician claims processing are valid for these other types also.

### Recommendations

The same recommendations listed for hospital and physician claims flow apply to the other types of claims. In addition, the following recommendation made also in Chapter II is extremely relevant:

- Consolidate all claims processing in a single area.
- Ensure that all adjudicated claims update the claims history file.

### Claims Data Processing System

The preceding sections have identified some problems with the present claims data processing system. The Office of Information Systems has developed plans for, and has programmed part of, a new claims processing system. The following findings and conclusions relate primarily to the possible new system, or to some alternative system.

### Major Findings and Conclusions

- The new system which has been partially developed by OIS is based on the use of a schedule of maximum allowables which has been rejected by the provider community.
- The new system, as currently designed with a single fee schedule, is anticipated to be completed in December 1979, based on a development group of three analysts/programmers (two present staff plus one planned). However, the forthcoming conversion of the State's computers may delay this schedule.
- The present design for the new system, while offering substantially enhanced capabilities, does not provide for processing of all claims types.

- Whether or not the new system is implemented, there will be a substantial increase in computer processing costs for Medicaid as the Department of Administration installs a new larger computer and implements a charge-back system.

### Recommendation

- The problems with the present claims processing system are so serious that development of a new system, whether that planned by OIS, or a system designed and developed by a contractor, must be a major priority.

### Use of AMOEBA

The State has been considering for some time the use of AMOEBA, a set of computer programs designed to list questionable claims and identify symptoms of unusual utilization.

### Major Findings and Conclusions

To date, one pilot run of AMOEBA has been made using the claims history file for a 30-month period. The experience leads to the following findings and conclusions:

- To use AMOEBA properly requires a significant amount of training and experience, particularly the latter. Without an understanding of the AMOEBA system, the output is likely to be so voluminous and misdirected as to be useless.
- Use of AMOEBA requires staff to be available to conduct detailed research of the claims listed by the system.
- AMOEBA should not be used by anyone not totally familiar with State Medicaid policy.
- If the preceding constraints can be overcome, AMOEBA can be extremely valuable.

### Recommendation

- Use of AMOEBA should be delayed until plans for a new claims processing system are finalized. However, such plans should, at least tentatively, involve the use of AMOEBA once the new system is stabilized and provided adequate support staff can be provided.

### Summary

The major changes recommended are:

- contracting for development of a new provider manual and claims processing procedures
- development of, or contracting for, a new claims processing system (preferably through use of a fiscal agent or facilities manager who would also operate the system)

Costs for new manuals and procedures are discussed in Chapter II.

DHSS MEDICAID TASK FORCE RECOMMENDATIONS

- I. Authority: By memorandum dated May 4, 1979, Deputy Commissioner Catherine M. Lloyd appointed a task force specifically to develop recommendations to correct identified deficiencies in the Medicaid payments system. This task force was comprised of the following persons:

Rod Betit, Director, DPA  
Tom Haas, Chief of Financial Management, DPA  
Chris Dooley, Accountant IV, DPA  
Lloyd Pukis, EDP Supervisor, Information Systems  
Doug Goldbach, Finance Officer, Div. of Admin. Services  
Ken Sather, Office of Inter al Review.

- II. Overview: The Medicaid payments system has been a constant source of problems for several years now. When originally installed the system was adequate to meet the billing demands of Medicaid/GR Med providers statewide. However, since 1972 billing demand has steadily grown to the point that the present manual system cannot keep current with billing activity. For purposes of the task force's review, "current" was defined as making payment in 30 days or less from the date of receipt of a billing. This 30 day timeframe is required by current federal regulations. At the time of review, processing timeframes were averaging 49 days and increasing.

Given this situation, the Division of Public Assistance requested and received a complete review of all Medicaid operations by representatives of the federal Medicaid agency in DHEW. This review generally disclosed no startling discoveries; but rather reinforced conclusions already reached by the Division with respect to what was wrong, and what was needed to correct the problem. The recommendations that follow come from careful consideration of the DHEW report, individual experiences from different agency representatives and consideration of the fact that additional manpower and funding were not made available by the Legislature to deal with the problem.

III. Task Force Recommendations

Recommendation #1

The Department should adopt regulations effecting a shift from the current profile pricing method to a schedule of maximum allowances. Adoption of a schedule is viewed the only viable means of reaching the target processing timeframe of 30 days. This recommendation is also most desirable for the following additional reasons; 1) timeliness of implementation will permit on-line operation by August 1 at the latest due to previous start-up work already completed, and 2) many of the deficiencies noted in the DHEW report would be corrected concurrent with installation of a schedule of maximum allowances. Other alternatives considered by the task force included:

- Contracting with a fiscal intermediary. This would provide no short-term relief to payment difficulties and could not be purchased without additional funds. With adequate funding committed, this would be a viable long term alternative.
- Contracting with Aetna Insurance, the current fiscal intermediary for Medicare claims processing. Discussions with Aetna data processing staff indicate that their system, although similar to what we desire for Medicaid claims processing, would not be readily convertible to the needs of a Medicaid processing system in terms of invoice handling, audits, and controls. Any potential for this alternative would require the expenditure of time and money for a long-range benefit. Again, no immediate benefits would be derived from this alternative.
- Automation of the current individual profile pricing system in-house. The work required of DHSS Information Systems to program such a system is estimated at approximately 12 man months. This would not bring immediate relief to the payment problem, nor would the final product be as maintenance free as a schedule of maximum allowances. Again, this could be a viable long term alternative.
- Adapting Aetna's claims processing system to Alaska's needs. The time involved in converting the programs and the expense of purchasing the software from Aetna would be prohibitive under our current budget constraints. Again, the needed expenditure of time and energy would prevent any short range benefits.

Recommendation #2

Although implementation of a schedule of maximum allowances would permit sending invoices directly to Data Processing's keypunch center, it is recommended that DPA maintain responsibility for batch control of all billing documents. This will leave the burden of batch accountability, provider relations and records retention with the Division of Public Assistance.

Recommendation #3

It is expected that the Department could potentially recover the time of two full time adjudicators with transition to a schedule of maximum allowances. It is recommended that one of these two positions be reclassified as a Third Party Liability Technician, and the other an Administrative Assistant II to provide support to the Medicaid Program Officer.

Recommendation #4

Until the current card-deck payment system can be replaced with a tape payment system, written procedures should be developed to place the card-deck system under tighter security controls. This may require a Memo of Agreement between DHSS and the Department of Administration.

Recommendation #5

That the Department renegotiate the Delta Dental contract for FY80 and not attempt to take this responsibility in-house until at least FY81, thereby permitting time to clean-up current operations once the schedule of maximum allowances is adopted.

Recommendation #6

That the Department locate funds to purchase development of new providers manuals and a staff manual for field workers on a contract basis. The present burden on DPA Medicaid staff is such that other critical projects will have to be deferred unless such a contract is arranged. Even then, a staff manual could not be produced prior to October 1, 1979.

Recommendation #7

That the Department should consolidate payment of all DHSS medical bills in the current DPA Medicaid Payments Section. Currently, medical payments are made throughout the Department with little or no system integration.

Recommendation #8

That the office of Information System should draw up an APD to request 90/10 match from DHEW to pay for completion of the new Medicaid DP system.

Recommendation #9

That installation of the new Medicaid system and any funds necessary to purchase hardware such as computer terminals receive top DHSS priority. This determination should be made immediately to permit purchase of needed equipment, and to insure DP staff concentration on installation of the new Medicaid system.

6/15/79

DATE

TASK FORCE MEMBERS

*Rod Betit*

Rod Betit

*Tom Haas*

Tom Haas

*Christine L. Dooley*

Christine Dooley

*Lloyd Pukis*

Lloyd Pukis

*Douglas L. Goldbach*

Doug Goldbach

*Ken Sather*

Ken Sather

- I. History: Delta was organized in 1973, selected as fiscal intermediary for State Medicaid programs in 1973.
- II. Participation: 96% of the dentists in the State are members of Delta, and 95% of these participating in the Medicaid program.
- III. Significance to dentists for Delta in fiscal intermediary role.
  - A. Prompt payment; bi-monthly.
  - B. Payment on usual fee; not to exceed 75% percentile.
  - C. Dental profession has a direct voice in program through Delta.
  - D. Direct government intervention is avoided.
- IV. Significance to State of Alaska for Delta in fiscal intermediary role.
  - A. Professional dental services in providing review (pre- and post-operative) and quality assurance.
  - B. Local processing, using Alaska employees who invest in Alaska to improve Alaska economy.
  - C. Higher utilization by and satisfaction of patients through cooperation of the dental profession to allow free choice.
  - D. Increased efficiency of processing and payment.
  - E. Cost containment (verification made with dentists' fees on file) and utilization checks and balances.
  - F. Provider agreements between Delta and the dentists.

## V. Claims Cost Information:

	<u>No. Claims</u>	<u>Total Amount</u>	<u>Av. Cost Per Claim</u>	<u>No. Eligibles</u>
1975	1900	\$250,600	\$132	11,500
1978	7100	\$887,000	\$125	15,000



*From: Report presented by Fredrick McGinnis  
at the Future Frontiers Conference.*

## ALASKA AND NATIONAL HEALTH INSURANCE

From time to time, as many as ten or twelve measures have been introduced simultaneously in the United States Congress proposing a variety of national health insurance programs. For a number of years, Alaska health leaders have been concerned with regard to the fragmentation of health delivery systems within Alaska as well as the escalating costs for all health services in the state. Delays have been encountered in active planning for an improved financing system for Alaska health programs because of the prospect of a national health insurance program being enacted by the federal Congress. Numerous discussions continue to go forward with regard to a national health insurance program for the entire United States. It now appears that the enactment of and implementation of such a plan are receding further and further into the future. Three of the more popular approaches to national health insurance have been those which have been introduced into the federal Congress by President Carter, Senator Edward Kennedy and Senator Russell Long. Appendix Number One at the end of this document outlines the "Three Approaches to National Health Insurance" as set forth by these national leaders. The topics covered in the table include coverage, benefits, administration, financing, cost, cost controls and timing for implementation of the respective plans.

There are several reasons why Alaska should consider developing, as rapidly as good planning will permit, a model health system for all the citizens of our state. With our extremely small population and with the numerous extensive health delivery plans in place already, it would seem that Alaska could adjust its present programs and add thereto in order to create a truly comprehensive and effective health system for Alaska. It will take bold, creative and extensive work to develop such a system.

Governor Jay S. Hammond, Lieutenant Governor Terry Miller, and the Commissioner of the Department of Health and Social Services, Helen D. Beirne, have expressed strong support for a revised and improved model health plan for Alaska. The Department of Health and Social Services leaders are taking certain initiatives at the present time in order to explore further the possibilities of changes within the present systems. In due course, numerous parties within the government and in the private sector will be invited to participate in the creation of a new health services financing system, as far as outlays of the state government are involved or will be involved in the future.

## Recommendations:

- 1) It is recommended that the health planning organizations in the state, as well as the health agencies and providers in the state, embark on a joint program to make reasonable efforts at cost containment of health services. A detailed examination should be made for the reasons of the dramatic increases in hospital charges to patients and third-party payers, as well as the escalation in rates of physician fees, prescription drugs, and nursing home rates. Efforts at cost containment, while notable, have not been effective to any substantial degree. Ceilings proposed from time to time applied to specific parts of the health care system do not appear to be equitable, since all of the goods and services related to the delivery of health care have not been proposed for inclusion in the cost ceilings. One of the more urgent matters facing Alaskans, as well as the citizens of other states, is the rapid escalation of health service costs. Detailed attention should be given to any cost of a health service in the state of Alaska which begins to exceed approximately 60% over and above what the average for such cost would be elsewhere in the nation.
  
- 2) The Alaska Revenue Sharing Program provided by Alaska Statutes, as it relates to health services, hospitals, health facilities and construction aid, should be reviewed with the possibility of major revisions in order to create a more equitable revenue sharing basis as related to other municipal services. In some communities in Alaska where the local government is responsible for the operation of hospitals, the generous revenue sharing dollars flowing to those hospitals seem to be well justified. In some of the urban areas, in cases where hospital income dramatically is excessive over operational expenditures, an adjustment may be found to be in order. In those cases, the local government should have the freedom to utilize the revenue sharing dollars for those health services deemed to be the local government's priorities for expenditures.

- 3) A detailed study should be undertaken in Alaska of the 458,305 third-party coverages or non-fee for service coverages when projected on a population base of 411,211 in 1977. The cost benefit ratio of the double coverages should be examined in some length in some depth. At the same time, data seem to reveal that numerous Alaskans are not covered by any third-party coverage or non-fee for service program at all. Scientific research and detailed studies which may be undertaken with regard to the possibility of a model health system for the state could include the study recommended herein.
- 4) That a detailed review be made of the medicaid eligibles, medicaid coverages and medicaid expenditures in an effort to determine whether or not Alaska wishes to continue the escalation of covered groups, covered services and financial outlays experienced from 1973 to 1979. From a basic coverage of eight services in 1973, the coverage services have gone to 17 services. Minor changes in covered groups have been made by federal and state laws since 1973 and the initially covered groups have contributed substantially to the increase in financial outlays.
- 5) In the event studies are undertaken with regard to the covered services and the covered eligible groups under medicaid, consideration is recommended with regard to the cost effectiveness of implementing the "medically needy option" under the medicaid program. If Alaska is going to improve health financing assistance to the medically needy, if provided under the medicaid program, the federal government would match all expenditures on the basis of 50% federal and 50% state funds.
- 6) Regardless of what may develop in the near term with regard to other changes in medicaid, general relief medical coverage or under a model health system, immediate attention should be given to expanding coverage for catastrophic illnesses for Alaskans. This could be accomplished with an amendment to the present catastrophic statute, as well as additional appropriations for the catastrophic illness program.

The design of any amended catastrophic illness program should be undertaken in such a way as to fit in with the State's goal of a comprehensive revision of its health financing plans.

- 7) That immediate detail and urgent study be continued with regard to broadening the range of services to prevent premature institutionalization in long-term care facilities and more appropriate placements for some who may at present be institutionalized in nursing homes.
- 8) That the State of Alaska move ahead as rapidly as good planning will permit to develop a model health services financing program geared to the needs of Alaskans, whether or not such a revised program includes the federal medicaid program. In the event it is not possible for the State to carry out an extensive study and mature plans to revise its present financing programs for medical assistance, as a minimum it is recommended that the State consider dropping the medicaid program and rebuild a program with the State's current 50% of medicaid dollars furnished to the State, combined with the State's general relief medical funds, and thereby render services to the limit of funds available to a revised group of eligibles based on new priorities.
- 9) That the State consider a revised plan of reimbursement for physician services and hospitals in the early part of the 1980's, whether or not the medicaid program remains or is dropped. Strong emphasis should be placed then upon the free enterprise and competitive systems in order the market forces will be generally operable in the health care field as is demanded in all other fields of endeavor.