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OPTING

A Study of Medicaid Client Need

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OPTING
A STUDY OF MEDICAID CLIENT NEED

PREPARED BY
LEGISLATIVE AFFAIRS AGENCY
DIVISION OF RESEARCH

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Foreword

In the fall of 1972, Alaska entered the national Medicaid program, providing certain of its citizens thereby a limited spectrum of medical care services.

Since this modest beginning, the legislature has increased Medicaid coverage by the addition of a few services above those which the state is required to cover in order to participate in the federal program. These optional services allowed the state to earn addition "matching" federal funds, some of which were a direct one-for-one offset to medical care expenditures that the state itself had been previously paying for in their entirety. Other program additions resulted in increased state expenditures, but provided a more complete medical coverage package.

In order to maximize the benefits from the additional expenditures, optional service additions must undergo careful scrutiny to insure that the options chosen return the greatest level of benefits in terms of meeting the health needs of the approximately seven percent of Alaska's population served by the Medicaid program. During 1976, a number of legislators indicated their desire to have better information upon which to base their decisions concerning the addition (or deletion) of various possible optional services. In order to meet this need, Miss Deborah Behr of the Research Division staff began, in June of 1976, an extensive effort directed at reviewing public assistance eligibility supervisors' perceptions of client requirements, analyzing written denials of additional client service requests, and obtaining information from various states regarding their experience with selected options. The present study is the result of this effort.

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Juneau, Alaska
February, 1977

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OPTING

A STUDY OF MEDICAID CLIENT NEED

PART I. OVERVIEW OF THE MEDICAID PROGRAM

INTRODUCTION TO THE PROGRAM

Medicaid is a program funded jointly by the federal and state governments which aids certain needy Alaskans in providing payments for them to receive medical services. It helps assure that medical services are available to those needy eligible persons when they are ill or injured. It also assists in guaranteeing that the highest quality care of the kind required by the patient's condition is available, by mandating certain medical reviews of patient care and treatment. Medicaid also attempts to make services available by utilizing the present system of private practitioners, facilities, and institutions to provide the care required at the lowest possible cost to the taxpayer.

STATE PLAN FOR MEDICAID

The Medicaid program in Alaska is administered by a single state agency, the Department of Health and Social Services, which is required to submit a state plan to the Secretary of the federal Department of Health, Education, and Welfare for his review and approval.

The state plan is essentially a contract between the state department and the federal Department of Health, Education, and Welfare specifying conditions to be met in order to qualify for federal financial participation. Some topics included in it are:

1. eligibility determination
2. recipient eligibility
3. eligibility verification
4. medical services
5. health care
6. quality control
7. fair hearings
8. methods of administration
9. utilization review
10. fraud

Many of these items are required be included in the plan (mandatory), but others the state may decide whether or not to include (optional). The optional portions allow the state to shape a medical assistance program to the needs and financial resources of its citizens.

DIFFERENCES BETWEEN MEDICAID AND MEDICARE

Medicaid is often confused with the Medicare program in the state. Medicaid is a medical assistance program for certain needy low-income people. In Alaska, Medicaid is administered by the Division of Public Assistance, an agency of the Alaska Department of Health and Social Services. It is authorized under Title XIX of the federal Social Security Act and AS 47.07.010-.080 of the Alaska statutes. States can design their own programs within set federal guidelines to meet the needs and resources of its citizens. Medicaid programs can and do vary from state to state.

In comparison, Medicare is a medical insurance program for those people, rich or poor, covered by Social Security. It is administered by the Social Security Administration of the federal government. The program is the same in all fifty states. Almost everyone over 65 and some younger persons who have been receiving Social Security disability payments for at least two years qualify for the program.

BRIEF HISTORY OF MEDICAID PROGRAM IN ALASKA

On July 6, 1972, Alaska became the 49th state to provide the Medicaid program for its residents. The state had, since the mid-60's, provided for such services under the General Relief - Medical program. Costs had risen from \$1.8 million to \$8.7 million in FY 72. This dramatic increase was due to many factors, the major ones being:

1. The number of eligibles had increased, but the rate of expenditure was increasing at even a faster pace.
2. The scope of the program had been liberalized and expanded with a related increase in utilization of services.
3. Medical care costs were rising at a rate disproportionate to that of other costs of living.

In light of this situation, the administration and the legislature came to basic conclusions that the General Relief - Medical program, which was supported 100% with state monies, had need of administrative controls to review services and, hopefully, reduce health care expenditures. There was a general consensus that either the General Relief - Medical program had to be upgraded or research should be done to investigate the possibility of the implementation of the Medicaid program. In April, 1972, the Department of Health and Social Services contracted with Touche Ross and Company, a public accounting firm, to develop a cost benefit study of the Medicaid program. Budgets were developed and testimony was made to the legislature that session. On June 17, 1972, the enabling bill for the Medicaid program passed the legislature and was later signed into law with an effective date of July 6, 1972. (The history of the program can be traced on Table 1: Medicaid History Timeline.)

TABLE 1

State of Alaska
Medicaid History Timeline

<u>Date</u>	<u>Occurrence</u>
April 10, 1972	Touche Ross & Company begin Medicaid System Design
April 18-June 9, 1972	Departmental Presentation to Legislature
May 10, 1972	Department of Health and Social Services' Steering Committee Established
June 17, 1972	Enabling Bill Passes Legislature
July 6, 1972	Medicaid Becomes Law
September 1, 1972	Medicaid Implemented
September 28, 1972	State Plan Submitted to Federal Department of Health, Education and Welfare
April 4, 1973	Effective date of Intermediate Nursing Home Care Option
May 16, 1974	Effective date of Inpatient Psychiatric Hospital Option for Eligible Persons 55 or Over and Under 22
May 16, 1974	Effective Date of Miscellaneous Minor Eligibility Groups (Primarily needy children under 21 in foster care under supervision by Department of Health and Social Services)
July 13, 1974	Effective date of 60 day limit on filing Medicaid claims
April 15, 1975	New Division of Public Assistance Formed
September 2, 1975	Effective date of Intermediate Nursing Home Care for Mentally Retarded Under 21 who Meet AFDC Need Standards Option
March 12, 1976	Effective date of Eye Glasses and Optometrist Service Options
June 21, 1976	Effective Date of New Nursing Home Group of Eligibles
July 1, 1976	Effective Date of Limited Clinic Services Option (Primarily Community Mental Health Centers and State Operated Mental Centers)
July 1, 1976	Effective date of Treatment of Speech, Hearing, and Language Disorders Option

The Department of Health and Social Services worked during the interim period to provide the necessary procedures and organization to make Medicaid an administrative reality in Alaska. A new Division of Medical Assistance in the Department of Health and Social Services was formed to administer the new program, as well as the remnants of the General Relief - Medical program. On September 1, 1972, the Medicaid program was actually implemented. (The Division continued to administer the program until April, 1975, when the new Division of Public Assistance was formed. This new division combined the eligibility determination, income maintenance, and medical assistance functions into one organizational grouping in the state.) Later that month, the official state plan was submitted to the federal Department of Health, Education and Welfare for its approval.

With the approval of the state plan, Alaska realized the benefits due to implementation of the Medicaid program:

1. Federal matching funds for medical expenditures became 50%, thereby allowing the continuation of the level of medical services without further increase in state general fund expenditure.
2. Federal match for categorical assistance programs under the Social Security Act increased from 30% to 50%.
3. Administrative controls, seen as necessary, were implemented to fulfill Medicaid requirements in order to receive federal financial participation.

When the legislature approved the Medicaid program, it included a restriction in statute mandating that all new services or eligibility group additions must receive its approval. At time of passage, the enabling legislation included those services and eligibility groups mandated by the federal government in order to receive federal financial participation. Since that time, the legislature has added few additional services or eligible groups.

The legislature added the first additional service option in 1973. At that time, intermediate nursing home care was selected. This option permitted the coverage of a lower and less expensive level of nursing home care. This addition allowed many Medicaid recipients in skilled nursing, who did not require that level of treatment, to be properly placed in intermediate nursing care thus "saving" state general fund dollars.

In 1974, the inpatient psychiatric hospital services option was added for eligible persons 65 years of age or over and 21 or under. This allowed the state to claim federal reimbursement for some persons at Alaska Psychiatric Institute, who were eligible for Medicaid coverage and were at that time receiving their care 100% from state monies. Also, other small groups of new eligibles were added at that time. Primarily they consisted of certain needy foster care children under 21 supervised by the Department of Health and Social Services. Prior to

that time these children had, in most cases, received coverage for their health care through the General Relief-Medical program. Also, legislation was passed requiring that medical assistance claims be submitted promptly, no later than six months after date of service or third party payment was received. This permitted more administrative control of expenditures and allowed for greater accuracy in budget projections.

The option to include a new group of needy eligibles under 21 who were in intermediate nursing homes for the mentally retarded became effective in 1975. This permitted a group of children at Harborview Memorial Hospital, Alaska Psychiatric Institute, and Hope Park to receive Medicaid coverage and, hence, additional federal dollars could be earned for their care.

In 1976 the legislature chose to add four new items to the program. A new group of needy persons became eligible for Medicaid coverage for their nursing home care due to an addition of an option. Also, that session, prescription eyeglasses and optometrist's services were added to the program. The legislature also approved the addition of limited clinic services which allowed state operated mental health centers and state approved community outpatient mental health centers receiving grants under A.S. 47.30.520 - 47.30.620 to be covered. This permitted federal funds to be earned in these state general fund supported projects. Also, at that time, the coverage of treatment of speech, hearing, and language disorders was added to the Medicaid program.

The legislature has shown interest in examining and evaluating the available Medicaid options, as seen by the recent history of the program in the state. Many of these options, especially in the case of coverage of nursing home care for certain needy eligible persons, actually "saved" state money. By adding them to the Medicaid program, federal funds could be realized for some of those services, which were being paid at that time 100% from state general funds. Also, by increasing the scope of the service package, a more consistent medical treatment program could be offered to these needy persons. For example, prior to the 1976 addition, eyeglasses were not generally available to all Medicaid eligibles who needed them. Only Medicaid eligible children who had been seen in early screening programs and referred for eyeglasses could be reasonably assured of coverage under the program for their lenses. Needy adults, such as those in nursing homes, had no such guarantee.

Alaska was one of the last states to join the Medicaid program and has been cautious in increasing the scope of the program in the state. In comparison with many other states in the program, Alaska's program is limited, with few service and eligibility group options beyond those basic services and groups required to maintain compliance with the program. This paper will later examine the current scope of the program and the options available under it that the legislature may be called upon to evaluate in 1977 and thereafter.

PART II. CURRENT STATUS OF MEDICAID PROGRAM IN ALASKA

ELIGIBILITY OF CLIENTS

The Alaska Medicaid program provides coverage for certain needy persons receiving or eligible to receive public assistance under:

Federal Supplemental Security Income (SSI),

Alaska Old Age Assistance (OAA),

Alaska Aid to the Blind (AB),

Alaska Aid to the Disabled for Persons who Meet Federal Criteria for Disability (AD), or

Aid to Families with Dependent Children (AFDC),

and certain others (mostly children)

Alaska does not cover the medically needy under its Medicaid program.

In general to be eligible for Medicaid in Alaska, an individual must:

- (1) Be physically present in Alaska at time of application and citizen of U.S. or lawfully admitted alien;
- (2) Not be in a public institution such as a jail (a person may however be in chronic disease facility such as a nursing home);
- (3) Not have more than \$1,500 in non-exempt personal property; this excludes a home (there is no lien requirement), personal belongings, in certain cases, a necessary automobile and some types of income producing property;
- (4) Not have transferred property to qualify for assistance;
- (5) Meet program requirements such as blind, disabled, aged over 65, or dependent child

The Division of Public Assistance examines the financial and living situation to determine if a person is eligible. As a basic rule, if a family of four meets general program requirements, has monthly net income of no more than \$400 earned (excluding reasonable work related expenses) and unearned income, the family would qualify for assistance under Aid to Families With Dependent Children program. There is no geographical differential on the total amounts allowed. The amounts vary for the adult programs (OAA, AB, AD) but generally, if household expenses (excluding fuel) are over \$35 a month and the net income is no more than \$334 a month of earned (excluding reasonable work-related expenses) and unearned income, a single person family would qualify if other program requirements are met. The \$334 figure can vary annually.

in accordance with cost of living adjustments required in AS 47.25.640; 47.25.430; 47.25.810. Eligibility for categorical assistance programs automatically makes one eligible for Medicaid.

SERVICES COVERED UNDER MEDICAID

The State of Alaska covers basically two types of services: mandatory, which the states are required to provide, and optional, which the state may provide and receive federal reimbursement. Alaska provides all mandatory services, but optional services are limited.

Mandatory Services

Alaska must provide the following services: 1) inpatient hospital services; 2) outpatient hospital services; 3) physician's services; 4) x-ray and laboratory services; 5) skilled nursing home services; 6) home health services; 7) early and periodic screening, diagnosis, and treatment of children under 21; and 8) family planning services. Alaska also is required to cover transportation necessary to receive medical service, if unavailable from any other source, but it is not listed as a federal requirement.

Optional Services

In addition to the mandatory services, Alaska provides and receives federal reimbursement for the following services:

- (1) Inpatient psychiatric hospital services for individuals age 65 or older or under age 22
- (2) Intermediate care facility services
- (3) Skilled nursing for those persons under 21 years of age
- (4) Emergency hospital services
- (5) Eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist
- (6) Services for individuals with speech, hearing, and language disorders
- (7) Services through state approved out-patient community mental health clinics which receive grants under AS 47.30.520-47.30.620 and state-operated mental health clinics
- (8) Optometrist's services and limited dental and prosthetic devices as required under EPSDT regulations

Other services that the state could choose to provide for certain of its needy individuals, but which has not yet opted for, include:

- (1) Prescribed drugs
- (2) Dental Services (for persons over 21 not covered under the early screening program)
- (3) Dentures
- (4) Prosthetic devices (for persons over 21 not covered under the early screening program)

- (5) Private duty nursing
- (6) Physical therapy and related services
- (7) Chiropractor's services and other practitioners
- (8) Podiatrist's services
- (9) Care for patients aged 65 or older in Institutions for Tuberculosis
- (10) Other diagnostic services, screening, preventive services, rehabilitative services

Parts III through V of this report deal later with these optional services in more depth, examining the need and aspects to consider in the evaluation of these alternatives to the program.

FINANCIAL PARTICIPATION BY FEDERAL GOVERNMENT

The federal government financially participates in the Medicaid program by means of matching state dollars for allowable administrative and medical expenditures. Services to eligible clients receive 50% reimbursement, except for family planning supplies and services which are matched at 90% level. Administrative costs are generally matched at 50%. Professional medical review staff are reimbursed at 75% level. (Certain other administrative services receive special match rates, such as 100% for certification and survey of nursing homes. These special rates are itemized in federal law and regulation.)

At the present time there is no "ceiling" or set limit for Alaska on the amount of federal funds available for reimbursement. There has, in recent years, been much discussion on the federal level to restrict such reimbursement, as was indicated in President Ford's budget address in January, 1976. At that time, he mentioned the possibility of placing the Medicaid program in a block grant package with other federally assisted health care programs. By this method, a dollar limit would have been set on the available federal funds for those purposes. Generally, though, the prospects for major funding modifications in the Medicaid program appear slim, although tighter management and administrative mechanisms to control fraud and quality of services seems to be a continued interest.

NEW DEVELOPMENTS IN MEDICAID

In the fall of 1976 the federal government placed additional responsibilities on the Medicaid program, through the passage of Public Law 94-437. That bill, known as the Indian Health Care Improvement Act, mandated closer coordination of Medicaid and Indian health services and required that all services for Medicaid eligible Alaska Natives in Indian health facilities be billed to Medicaid. The federal government would then reimburse the state's Medicaid program at 100% for such services. Additional administrative functions would receive normal federal reimbursement rates. The services eligible for reimbursement under Public Law 94-437 are only those included in the approved Medicaid state plan and provided to Medicaid eligible Alaskan Natives.

Total ramifications of the bill are yet unknown. Federal officials report though that Alaska is far ahead of other affected states in implementing the new law. For example, seven of Alaska's nine Indian Health Service hospitals currently meet statutory requirements for participation in Medicaid without further action. State officials note though that unless there is a major shift in procedures for handling people covered under Indian Health Improvement Act, field office work will increase greatly (e.g., issuing medical coupons, arranging necessary transportation, answering client and provider questions). These state officials voiced concern that estimates of the number of new Alaska Native clients attracted to apply for Medicaid coverage are unknown. The attachment of a dollar figure to the cost of medical services for these persons would be just a rough estimation.

PART III. GENERAL INFORMATION REGARDING OPTIONAL SERVICES

CONTROLS THAT STATES MAY IMPOSE ON MEDICAID OPTIONAL SERVICES

Since the addition of optional services is at the discretion of the state, the federal government allows great flexibility for states to determine the scope of the option that they wish to provide for their Medicaid clients. Generally, federal law and regulation define the basic objectives and requirements of the options, all of which must be met in order to obtain federal financial participation. Some of the requirements address equal offering of services to all eligibles, the qualifications of persons providing the services, and degree of supervision required for paraprofessionals. Within those broad parameters states can shape optional services to fit their unique needs and resources.

Alaska can limit optional services by (1) qualifying coverage, (2) requiring prior authorization, (3) limiting usage frequency, (4) requiring clients to share in cost of services, or (5) limiting the amount of provider reimbursement:

(1) Qualifying Coverage

Medicaid law and regulation permit the limiting of coverage of optional services. For example, dentures can be selected as a separate service without having to cover other prosthetic devices such as hearing aids, crutches, etc, or without having to cover other dental services. The Medicaid program does require that the option limitations be applied equally to all eligible clients. (There are certain exceptions to this policy. Some options are defined in federal law to include only specific age groups such as persons under 21 or over 65.) The state, for example, cannot as a general rule limit eligibility for optional service to only those persons receiving aid under a particular program such as Old Age Assistance. If a state chooses an optional service, it must be covered for all groups (except as noted in federal law or regulation) or federal reimbursement will be jeopardized.

(2) Requiring Prior Authorization

States can control inappropriate overutilization of optional services by requiring the client to receive approval from the Medicaid agency prior to obtaining certain medical care. Preauthorization is usually based on medical need for services and appropriateness of the care requested to the condition being treated. The Division of Public Assistance has, since the beginning of Medicaid, required preauthorization of all nursing home placements. This mechanism serves to reduce unnecessary placements, place clients at appropriate levels of care, and suggest alternative, and usually cheaper, methods of treatment.

(3) Limiting Usage Frequency

Optional services can also be limited by restricting client use. This is generally done by limiting the number of treatments or services paid by Medicaid in a specific time period. For example, Maryland limits adults to one eye examination and one pair of eyeglasses every two years. Arkansas limits Medicaid clients to three prescriptions per month. These restrictions must be applied though uniformly to all clients receiving assistance. Limitations of the amount of services should take into account unusual emergency situations. States cannot impose barriers to needed minimum levels of health care, or risk federal sanction.

(4) Requiring Clients to Share in Cost of Services

Some states require Medicaid clients to participate in sharing the costs of certain optional services. Federal regulation sets certain maximum allowable limits on the amount of payment that clients can be required to cover. Those regulations also specify the mechanisms that states can use to allow clients to share in the cost of certain services. Fees are generally limited to small amounts such as \$.50 per prescription drug and \$2.00 per pair of eyeglasses. Originally, this procedure was instituted to control overutilization of services and not to generate funds. California, along with some other states which elected this option, has found that the cost of administration of this mechanism generally did not offset the revenues gained. The charges did not significantly affect client use of services, and the states found that the collecting and controlling of such small fees were bothersome to both client and provider.

(5) Limiting the Amount of Provider Reimbursement

Costs of optional services can also be reduced by limiting the amount of provider reimbursement. Often this comes in the form of reducing reimbursement by a set percentage or by "freezing" payment levels at the current standards. (Medicaid pays "reasonable" rates to its providers. The costs allowable under its definitions often differ greatly from those accepted by Blue Cross and other insurance companies. Fees paid under Medicaid are often lower than fees paid by the general public for the same services.) The state of Michigan, for example, recently implemented an 11% reduction in normal fees paid to practitioners, dentists, laboratories, and other providers. Often such changes receive strong provider reaction and sometimes jeopardize the continued participation of those providers in the program. Federal officials also note the potential use of low bid health providers. For example, the state could solicit bids for a contract to supply Medicaid clients with specific services, such as eyeglasses. The state could select the most advantageous bid and award the contract without jeopardizing federal reimbursement.

OTHER ISSUES TO CONSIDER IN EVALUATING MEDICAID OPTIONAL SERVICES

Although this study focuses primarily on client need, there are other factors that must be considered in evaluating the merits of any given Medicaid option. Three of these major considerations are: availability of funds, costs versus benefits of options, and ease of administration.

The availability of funds plays a major role in the scope of services that a state believes it can provide for its citizens. The high cost of medical care demands an in-depth analysis of cost before any new service is added. Although this study does not discuss this financial issue, it is a major part of any decision to modify the program. Legislators who have a well defined proposal for additional option(s) may request the Research Division of the Legislative Affairs Agency to prepare an analysis of its costs, both direct and administrative.

The costs versus benefits of an option can be an important consideration in deciding whether or not the state should participate in it. For example, certain Medicaid options sometimes "save" state money, if that service is currently paid entirely from state funds or if it allows a client to receive less specialized and less expensive type of service that are more appropriate to this medical condition or problem. In 1976, the Alaska State Legislature added coverage of new limited group of needy eligibles who currently reside in nursing homes. The care for those persons at that time was paid for 100% from state general funds through the General Relief-Medical program. By adding that option, the state was able to claim 50% federal reimbursement for their care. Also, in 1973, the state added the intermediate nursing home care option. By covering this lower and less expensive level of nursing home care, many Medicaid recipients in skilled nursing, who did not require that level of treatment, could be placed in intermediate nursing care. The cost per day for each patient was reduced considerably.

The ease of administration is important also in evaluating the merits of certain options. The drug option, for example, requires that strict payment procedures regarding maximum allowable charges be in place. These are spelled out in some detail in the federal regulations, and the state must meet those requirements or risk loss of federal participation. Federal officials note that many of these cost containment mechanisms would normally be in place in any efficiently administered pharmaceuticals program, regardless of source of funding for it. The transfer of a program from state-only funding to federal assistance should cause minimal additional administrative expenses if adequate cost containment measures are in place in the existing program.

IV. MEDICAID CLIENT NEEDS

QUESTIONNAIRE OF PUBLIC ASSISTANCE SUPERVISORS

In Fall, 1976, a questionnaire was prepared to poll public assistance supervisors (eligibility work supervisors) on their estimation of client need for certain services based on their actual experience in the field. The questionnaire, prior to mailing, was reviewed by both the Division of Public Assistance and Department of Health and Social Services Commissioner's Office. The questionnaires were mailed to nineteen supervisors, many of whom had worked with public assistance clients for a significant period of time. (That sample of supervisors was chosen under the guidance of the Division of Public Assistance's Chief of Field Operations.) Approximately one month after mailing, a follow-up questionnaire was sent.

Fourteen, or 75%, of the supervisors polled responded to the questionnaire. All areas of the State were represented, including Anchorage, Fairbanks, Fort Yukon, Juneau, Kenai, Ketchikan, Nome, and Sitka. Each supervisor was asked specific questions concerning his or her evaluations of client need for Medicaid options not yet selected by the State.

QUESTION #1: In your experience, what optional services currently not covered under Medicaid do you feel your Medicaid eligible clients need most?

Table 2 shows the rank order obtained from the supervisor's responses to question #1. Interestingly, the top four items for each category (Adult Public Assistance and Aid to Families with Dependent Children program recipients) were the same. The ranking for dentures option differed slightly, being seen more necessary for older persons receiving Adult Public Assistance than the younger Aid to Families with Dependent Children recipients.

Since the Medicaid program requires that services included in the State Plan be offered equally to all eligible persons (except for certain specialized programs such as early childhood screening) the similar ranking of need options for both Adult Public Assistance and Aid to Families with Dependent Children Program is particularly meaningful. If it were called upon to evaluate new options, the legislature could be reasonably sure that any of the top four options (prescribed drugs, adult dental services, dentures, and physical therapy and related services) would be "needed" by both categories of clients.

QUESTION #2: On the average, how many Medicaid clients a month ask you if they can receive certain services?

Table 3 shows the responses by the supervisors concerning the requests of Medicaid eligibles for additional services. The responses to question #2 did not match the pattern formed from the supervisor's responses

TABLE 2

Average Ranking of Selected Medicaid
Options by Type of Public Assistance Client

<u>Rank</u>	<u>Recipients of Adult Public Assistance</u>	<u>Recipients of Aid to Families with Dependent Children</u>
1st	Prescribed Drugs	Prescribed Drugs
2nd	Adult Dental Services	Adult Dental Services
3rd	Dentures	Physical Therapy and Related Services
4th	Physical Therapy and Related Services	Dentures
5th	Hearing Aids ¹	Chiropractor's Services
6th	Prosthetic Devices	Hearing Aids ¹
7th	Chiropractor's Services	Prosthetic Devices
8th	Private Duty Nursing	Private Duty Nursing
9th	Podiatrist's Services	Podiatrist's Services
10th	Care for Patients 65 or Over in Tuberculosis Institutions	Care for Patients 65 or Over in Tuberculosis Institutions

¹ Hearing aids, at the time the survey was conducted, were not included in the coverage program offered to all Medicaid clients. An interpretation of Medicaid law and regulation by federal officials allowed hearing aids to be covered as part of the treatment of speech, hearing, and language disorders option. This policy change was implemented by the Division of Public Assistance in November.

to question #1. For example, the Medicaid prescribed drug option which was ranked as needed first for both program categories, received less than 50% of the requests made for adult dental services, which was ranked as needed second by the supervisors. This could be anticipated for Medicaid clients who do not have prior health resources equal or better in coverage to General Relief-Medical automatically receive their drugs through GRM. One Juneau public assistance supervisor noted that for these persons, eligibility for prescription drugs under GRM is automatically determined at the time that Medicaid eligibility is confirmed. Therefore, few Medicaid clients would ask for prescription drugs, since coverage is established at the time they enter the Medicaid program.

Aid to Families with Dependent Children recipients requested fewer services than did the Adult Public Assistance recipients. This was expected, for the recipients of AFDC tend to be young and thus often have less need for diverse health services. Also, many AFDC recipients are eligible for a wider range of treatment service through the Early Periodic, Diagnosis and Treatment Program (EPSDT), a child check-up program. For example, dental care is available to public assistance recipients under 21 as a referral through EPSDT, but currently persons over 21 who are mostly on Adult Public Assistance programs cannot routinely receive preventative dental care under any of the state medical assistance programs.

Many of the Medicaid options available under the federal program do not match with Alaska's availability of services. In rural Alaska, it would be difficult to obtain chiropractor's or podiatrist's services close to home. Also, the option of care for patients 65 or over in tuberculosis institutions is not really relevant to Alaska, since there are no tuberculosis sanatoriums in the State. Care for such conditions would have to be provided in nursing homes, hospitals, and physicians' offices, all of which are currently covered under Medicaid.

The low number of requests in all categories may be due to lack of client awareness that these additional services sometimes can be covered under the state funded medical assistance program, General Relief-Medical. Because of limited funds under that program, the Division of Public Assistance has not actively conducted an outreach program to inform clients of eligibility requirements and services covered. Also, many clients may be reluctant to ask for services, which they feel they stand a likelihood of being rejected. Dentures are a good example of this. Because of funding limitations, dentures can only be covered in extreme hardship situations. Clients often are informed of this policy from their dentists, public health nurses, or social workers, before a formal request is made to the Division of Public Assistance.

SURVEY OF "DENIALS" OF SERVICE RECORDS

The needs of clients were also analyzed through a survey of all denials of requests for additional services for Medicaid clients. Medicaid clients sometimes require services that are not included in the Medicaid

TABLE 3

Total Average Number of Medicaid-Eligibles Requesting
Optional Services Monthly by Program Category

<u>Option</u>	<u>Recipients of Adult Public Assistance</u>	<u>Recipients of Aid to Families with Dependent Children</u>	<u>Total</u>
Adult Dental Services	81.5	88.0	169.5
Dentures	60.5	21.0	81.5
Prescribed Drugs	38.0	39.0	77.0
Physical Therapy and Related Services	20.5	23.0	43.5
Hearing Aids ¹	27.0	16.0	43.0
Prosthetic Devices	25.5	12.0	37.5
Chiropractor's Services	15.5	15.0	30.5
Private Duty Nursing	13.5	5.5	19.0
Podiatrist's Services	4.0	1.5	5.5
Care for Patients 65 or Over in Tuberculosis Institutions	1.0	0.0	1.0
	====	====	====
Total	287.0	221.0	508.0

¹ Hearing aids, at the time of the survey, were not included in the coverage program offered to all Medicaid clients. An interpretation by federal officials of the treatment of speech, hearing, and language disorders options allowed hearing aids to be covered as part of a treatment plan. This policy change was implemented in November.

TABLE 4

Denials of Optional Services for Medicaid-Eligibles
(September 1, 1972 to July 31, 1976) ¹

1.	Dental Services	140 ²
2.	Therapy	63
3.	Dentures	44 ²
4.	Prosthetic Devices	37
5.	Prescription Drugs	28
6.	Hearing Aids	15 ³
7.	Chiropractor's Services	3
8.	Podiatrist's Services	2
9.	Private Duty Nursing	1
10.	Tuberculosis Institution for 65 or Over	0

¹ The figure includes only denials of requests submitted in writing to the Division of Public Assistance, Central Office. That Division also handles numbers of informal telephone requests, which are not included in these figures.

² The figure excludes Delta Dental Corporation denials. Delta Dental Corporation currently reviews and evaluates all public assistance clients requests for care. These records were not readily available in Juneau for the study period. In FY76, Delta Dental denied 454 Medicaid adults for dental services and 20 Medicaid adults for dentures.

³ Hearing aids were added to the Medicaid program as of November, 1976. An interpretation by federal officials of the treatment of speech, hearing, and language disorders option added last session allowed hearing aids to be covered as part of the treatment plan.

program. If the client has no other prior health care resource equal or better in coverage to that of General Relief-Medical (GRM) Program, that client may be able to receive those services through GRM. Since GRM is funded entirely by state general funds, monies are strictly controlled and extremely limited. In order to insure the equitable use of the funds, many services require pre-authorization by the Central Office of the Division of Public Assistance before they can be provided and paid for by the General Relief-Medical Program.

Requests for service can come in two forms: letters and phone calls. The Division of Public Assistance maintains files of only written requests for service. During the month of July, 1976, a tabulation of those records was performed. Table 4 shows the number of denials of optional services which were requested by Medicaid clients during the period September 1, 1972 to July 31, 1976.

Note that the top four options that eligibility work supervisors felt their clients needed appeared within the top five items requested for those clients. Thus, the public assistance supervisors confirm the client perceived need for dental services, therapy, dentures, and prescription drugs. The survey also revealed a client perceived need for prosthetic devices (such as artificial limbs, crutches, canes, etc.).

These tabulations of requests for service represent only written requests. Because of the "emergency" nature of some services and the ease of telephoning for approval, many denials of services are not represented in the written files. Also, many clients will not request a service which they know is unavailable or which they stand a likelihood of being denied. Clearly, then, these figures substantially under-represent client need.

RESULTS OF STUDY

1. Basically State of Alaska eligibility work supervisors feel that their Medicaid-eligible clients most need:

1. Prescription Drugs
2. Adult Dental Services
3. Dentures*
4. Physical Therapy and Related Services*

** The rank order of these services varies by program which client is receiving aid. The adult public assistance clients are seen to need dentures much more frequently than do clients of Aid to Families with Dependent Children.*

2. The top four services that eligibility work supervisors feel that their Medicaid-eligible clients ask for most frequently are:

1. Adult Dental Services
2. Dentures
3. Prescription Drugs
4. Physical Therapy and Related Services

3. Records of "denials" of requests for services to be provided from the General Relief-Medical Program to Medicaid recipients indicate that the following services are requested and denied most frequently:

1. Dental Services
2. Therapy
3. Dentures
4. Prosthetic Devices

4. The records for the number of client requests generally underestimate client need because only written records are available and because many public assistance clients will not request a service which they know is unavailable or which they stand a likelihood of being denied.

PART V. ANALYSIS OF OTHER STATES' EXPERIENCE WITH SELECTED OPTIONS

OVERVIEW OF STATES PARTICIPATING IN SELECTED OPTIONS

The survey of denials of requests for services and tabulation of the responses to the questionnaire sent to the public assistance supervisors point to four service options which clients are perceived as needing most. These are: prescription drugs, adult dental services, dentures, and physical therapy and related services.

These optional services have been elected by many other states. For example--

- 96% of all states and United States protectorates have Prescription Drug Option *
- 64% of all states and United States protectorates have Dental Services Option *
- 60% of all states and United States protectorates have Physical Therapy and Related Services Option *

**Only states participating in Medicaid program are included in total figures. Data are as of June 1, 1976 and were obtained from United States Department of Health, Education and Welfare. (Data are unavailable on the number of states offering denture service to their eligibles.)*

Many states added these services in the mid-1960's when Medicaid first began. However, it was found that some states eliminated or restricted some of these options during the period January 1, 1975 to July 1, 1976. With the skyrocketing cost of medical care and the increasing demand upon state dollars, we decided to review the options that were selected as needed by public assistance supervisors and contact those states that had recently modified them.

QUESTIONNAIRE OF STATES MODIFYING SERVICES

In early December, the Research Division of the Legislative Affairs Agency prepared a questionnaire to ask the views of state Medicaid program administrators regarding the options they had recently restricted. Fourteen states that had recently modified optional services included in this survey were contacted. Eleven states (or 79%) responded to the questionnaire. Since existing federal reports do not pinpoint the number of states modifying their denture coverage, that option was not included in the discussion.

State Experience With
Prescription Drug Option

Of the 51 states providing prescription drugs, 11 states (or 22%) reduced their coverage during the period of January 1, 1975 - July 1, 1976. Seven of those states responded to the questionnaire. The majority of those states reduced coverage of drugs in order to reduce expenditure of state dollars. They noted that it created a hardship, but most clients felt coverage of only certain drugs was better than no coverage at all of them. Basically, controls were maintained by limiting the number of monthly prescriptions any one client could obtain and by limiting the types of drugs covered.

It is interesting to note that one state, Oklahoma, added the drug option during this period. In responding to the questionnaire, the director of the Oklahoma program stated that the option was added at the direction of their legislature. Certain administrative restrictions were imposed when the option was added. Prescriptions were limited to three per client per month and the different categories of drugs were also restricted. The director noted that public reaction to the addition of services has been generally favorable.

State Experience With
Dental Services Option

13% of the states which chose the dental services option eliminated it during the period January 1, 1975 to July 1, 1976. (Recently two states, Massachusetts and New Jersey, have reinstated coverage of this option). Five of the seven states eliminating this option responded to the survey.

Generally, these five states found that the adult dental services option was needed by clients and was easy to administer. Restrictions on the option were basically due to lack of state funds. In one instance, New Hampshire, the legislature set a priority list of services that were to be provided. Since adult dental services received a low priority and funds were limited, the option was dropped. The dropping of the option generated considerable negative client reaction, as evidenced primarily by an increased number of client administrative appeals on this issue.

State Experience With
Physical Therapy and Related Services Option

Michigan was the only one of 32 states which included physical therapy and related services in their programs and chose to modify that option during the period January 1, 1975 to July 1, 1976. The Michigan Medicaid program responded to the questionnaire and noted its experience with the option. The respondent found that the option was needed by clients; however, the cut, an elimination of physical therapy in long term care institutions, was made in response to lack of sufficient funding. To date, this change in the program has not been rescinded.

RESULTS

1. At least 60% of all states participating in the Medicaid program also cover some form of prescription drugs, dental services, and physical therapy and related services options for their clients. These services were among the top four requested by Alaska public assistance clients and seen as needed most for them according to a survey of Alaska public assistance supervisors. (Nationwide data on the numbers of states covering dentures in their programs are not available.)
2. Two of the top four services seen as needed for public assistance clients, prescription drugs and dental services, were also the top two services restricted or eliminated by other states during the period January 1, 1975 - July 1, 1976. (See Part IV for survey results.)
3. Most states modified the options to reduce expenditure of state funds. They did not drop or restrict them because of lack of client need or complexities in administration.
4. Restrictions of service options were generally done in four ways: limiting coverage of service, limiting client access, reducing provider fee payments, and charging clients small fees.
5. Reduction of fees generally brought strong reaction by the provider sector.
6. The states believe that limiting coverage to certain number of services allowable per month and restricting coverage of type of service allowable under the option was generally more acceptable than totally eliminating it.
7. In most cases, states modifying these options chose to restrict prescription drug coverage but they chose to eliminate dental services (except as was required under the early screening program).
8. In some cases states reinstated changes in options a short time after they were made. This was generally due to the strong reaction received from the groups affected.

PART VI. CONCLUSIONS TO THE STUDY

From the responses to the questionnaire sent to public assistance supervisors concerning client need, the survey of denial records of requests for additional services, and the responses from other states regarding their experience with the program, the following conclusions can be drawn:

1. Of Medicaid optional services available that Alaska does not currently provide under its program, public assistance clients appear to need most (in descending order of need):

- (1) Prescription Drugs
- (2) Dental Services
- (3) Dentures*
- (4) Physical Therapy and Related Services*

** The rank order of these services varies by program under which client is receiving aid. The adult public assistance clients are seen to need dentures as a higher priority than do clients of Aid to Families with Dependent Children.*

2. Three of the optional services listed in Item #1 are included by over 60% of the states participating in Medicaid. Prescription drugs, for example, are included in 95% of all state programs. (Data on coverage of dentures are generally unavailable on nationwide basis.)
3. Two of the options that clients "need" most--prescription drugs and dental services--topped the list of options that states reduced or eliminated during the period January 1, 1975 - July 1, 1976. These modifications were done as cost containment measures and not as a response to lack of client need or to complexities of administering the options.
4. Alaska could be reasonably assured that services listed in Item #1 would be needed and used by clients. The choice to include them appears to be a decision based primarily on the state's availability of state funds. The state could choose to cover an option, but restrict that option in many ways to meet funding limitations.

GLOSSARY OF TERMS

AB - See Aid to the Blind.

AD - See Aid to Disabled.

ADC - See Aid to Families with Dependent Children.

AFDC - See Aid to Families with Dependent Children.

APA - See Adult Public Assistance.

APD - See Aid to Disabled. Stands for Aid to Permanently Disabled.

Adult Public Assistance - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education, and Welfare. Designed to provide a state-legislated level of cash assistance to aged, blind, and disabled persons who meet certain income and resource requirements, and who are predominately eligible for Supplemental Security Income (SSI) payments. State administrative costs as well as actual cost payments are 100% state only costs.

Aid to the Blind - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education, and Welfare. Designed to provide a state legislated level of cash assistance to those eligible blind persons who meet certain income and resource requirements, and who are predominately eligible for SSI payments. It is considered an "Adult Public Assistance" program.

Aid to Disabled - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education and Welfare. Designed to provide a state legislated level of cash assistance to those eligible disabled persons who meet certain income and resource requirements and who are predominately eligible for SSI payments. It is considered an "Adult Public Assistance" program.

Aid to Families with Dependent Children - A federal program administered by the state through an approved state plan filed with the U.S. Department of Health, Education, and Welfare. Designed to provide a state-legislated level of cash assistance to dependent children who have been deprived of one or both parents, and who meet certain income and resource requirements. Both administration costs and the actual cash payments provided to recipients are shared equally (50%) by the state and federal government.

Categorical Assistance - Aid, in form of income maintenance, to certain needy persons who receive assistance under Old Age Assistance, Aid to the Blind, Aid to the Disabled, Supplemental Security Income, and Aid to Families of Dependent Children programs.

Compliance - In a federal program, the act of performing certain set program functions in accordance with those requirements outlined in the state plan, federal law, and regulation. Generally, meeting all federal program requirements is necessary to receive federal financial participation in the program.

DHSS - See Department of Health and Social Services.

Department of Health and Social Services - A department of the executive branch designated to be single state agency to administer the Medicaid program for the state of Alaska.

EPSDT - See Early and Periodic Screening, Diagnosis and Treatment.

Early and Periodic Screening, Diagnosis and Treatment - A mandatory service under Medicaid which provides for special check-ups at set intervals for certain needy children, in order to find and treat health problems before they become serious. Coverage includes only those Medicaid eligibles under 21 years of age.

Eligible - A person qualified to receive assistance funded under particular program. Eligibility criteria can vary, so that eligibility must be established on program by program basis.

FFP - See Federal Financial Participation.

Federal Financial Participation - The means by which the federal government assists in supporting certain specific program. The federal government generally provides aid by two methods: 1) matching dollars by set percentage or 2) formula money grants.

GRM - See General Relief-Medical.

General Relief-Medical - A state emergency medical program designed to respond to immediate medical needs of Alaskan families in time of extreme financial crisis. All assistance rendered under this program is in the form of vendor payments to medical providers. State administrative costs as well as actual cash payments to vendors are 100% state only costs.

Intermediate Nursing Care - An optional service available to be provided under Medicaid program. Denotes a less intensive and less expensive level of around-the-clock nursing care, in comparison to skilled nursing.

Mandatory Coverage - A portion of the Medicaid program that is required to be covered by each and every state in the program, in order for the state to be entitled to federal financial participation. Mandatory coverage items concern persons eligible to receive services and the services provided to those persons. States can still administratively "control" mandatory services and not jeopardize federal financial participation by controlling the amount of service available to client, amount of financial participation (deductible required to be paid by client) in order for the client to receive such services, and other mechanisms.

Medicaid - A federal assistance program established by Title XIX of the Social Security Act and administered by the state through an approved state plan filed with U.S. Department of Health, Education, and Welfare. Designed to provide medical coverage for recipients of Aid to Families With Dependent Children; Supplemental Security Income, elderly and blind recipients of Adult Public Assistance and those disabled persons who meet federal definitions of disability; and certain other groups. State administrative costs are shared equally (50%) by the state and federal governments, except for professional medical support personnel who are funded at 75% federal reimbursement. Actual medical vendor payments are shared equally (50%) by the state and federal government, except for family planning which is funded at 90% federal reimbursement.

Medically Needy - An optional group of eligibles for whom federal reimbursement for necessary medical care may be covered under the Medicaid program. Generally includes individuals who have insufficient income and resources to meet the costs of necessary medical or remedial care and services. Presently Alaska does not include the medically needy under its Medicaid program.

Medicare - An insurance program administered solely by the federal government to provide payments for necessary medical care for those people, rich or poor, who receive Social Security payments.

OAA - See Old Age Assistance.

Old Age Assistance - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education, and Welfare. Designed to provide a state legislated level of cash assistance to those eligible persons 65 and over who meet certain income and resource requirements and who are predominately eligible for Supplemental Security Income payments. It is considered an "Adult Public Assistance" program.

Option - A portion of the Medicaid program that is discretionary on the part of the state. Options generally deal with persons eligible for coverage or medical services available for those eligible persons. Options are set out in federal law and regulations and are generally eligible for federal financial participation. Since the choice of options is up to each state, options can generally be designed to fit the state's unique needs and available resources, but each option chosen must meet certain broad federal program requirements.

Public Assistance - A division of Department of Health and Social Services, responsible for administration of the Medicaid, General Relief-Medical, and Income Maintenance programs. This division determines the eligibility of state's residents for such services by carefully reviewing the person's income, resources, and other factors according to state and federal standards.

Quality Control - An office of the Department of Health and Social Services which is assigned the responsibility to verify that

randomly selected cases are eligible to receive services in month that service was rendered. The verification consists of check of files, client contact, and collateral sources.

Recipient - A person receiving income maintenance or assistance services funded under a particular program.

SSA - See Social Security Administration.

SSI - See Supplemental Security Income.

Skilled Nursing Care - A mandatory service required to be provided under the Medicaid program. Denotes highly professional round-the-clock nursing care and monitoring. Generally more expensive and more specialized care than intermediate care.

Social Security Administration - An agency of the federal Department of Health, Education and Welfare assigned the responsibility to administer Social Security, Medicare, and Supplemental Security Income programs.

State Plan - A contract between the single state agency to administer the Medicaid program and the federal Department of Health, Education and Welfare, specifying conditions to be met in order to be eligible for federal financial participation.

Supplemental Security Income - An assistance program funded and administered by federal government which provides payments to certain needy persons who are aged, blind, or disabled and meet program and financial requirements. Payments are uniform nationwide and are based on need.

Title XIX - A portion of the federal Social Security Act which outlines the Medicaid program.

Title XVIII - A portion of federal Social Security Act which outlines the Medicare program.

Utilization Review - Random records check of sample institutional Medicaid billing to insure that services rendered match with those billed to the program. Verifies that institutional records are complete, accurate, and up-to-date. Examines for overuse or misuse of treatment and professional resources and the patient's duration of stay relating to those resources.

Medicaid

Annual

Status

Report

FISCAL YEAR 1977

Jay S. Hammond, Governor
State of Alaska

Helen D. Beima, Commissioner
Department of Health and
Social Services

Richard R. Wilson, Director
Division of Public Assistance

MEDICAID ANNUAL STATUS REPORT

FISCAL YEAR 1977

JAY S. HAMMOND

GOVERNOR

STATE OF ALASKA

HELEN D. BEIRNE

COMMISSIONER

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

RICHARD R. WILSON

DIRECTOR

DIVISION OF PUBLIC ASSISTANCE

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ABSTRACT OF MEDICAID FY 1977
STATUS REPORT

Medical Assistance Budget FY 1977 (not including supplemental appropriations):

Medicaid	\$16,908,500
General Relief-Medical	<u>2,542,100</u>
Total	\$19,450,600

Medical Assistance disbursements for FY 1977 (through February 28, 1978):

Medicaid	\$18,608,568
General Relief-Medical	<u>3,743,128</u>
Total	\$22,351,696 1/

Medicaid	50% federal funding for services and administration
	75% federal funding for professional staff (medical)
	90% federal funding for family planning services
GR Med	100% state funding
Catastrophic Illness	100% state funding

Savings to the State of Alaska through participation in Medicaid (vendor payments only):

Federal financial participation	\$ 9,450,261
State financial participation	<u>9,158,307</u>
Total Medicaid payments	\$18,608,568

Total number of persons receiving Medicaid services FY 1977: 11,815 2/
Total number of persons receiving GR Med services FY 1977: 2,631

Who is eligible for Medicaid? Persons eligible for cash assistance payments under any categorical assistance program: Old Age Assistance, Aid to the Blind, Aid to the Disabled meeting federal disability criteria, Aid to Families with Dependent Children. Additional eligibility criteria exist for persons in nursing facilities and children in foster care or juvenile care situations.

Who is eligible for GR Med? Persons having no prior Medical resources and who meet financial eligibility (need) requirements for the assistance programs listed above but do not meet other qualifications for Medicaid coverage (not blind or disabled under federal definition, under 65, both parents in the home are physically able to work).

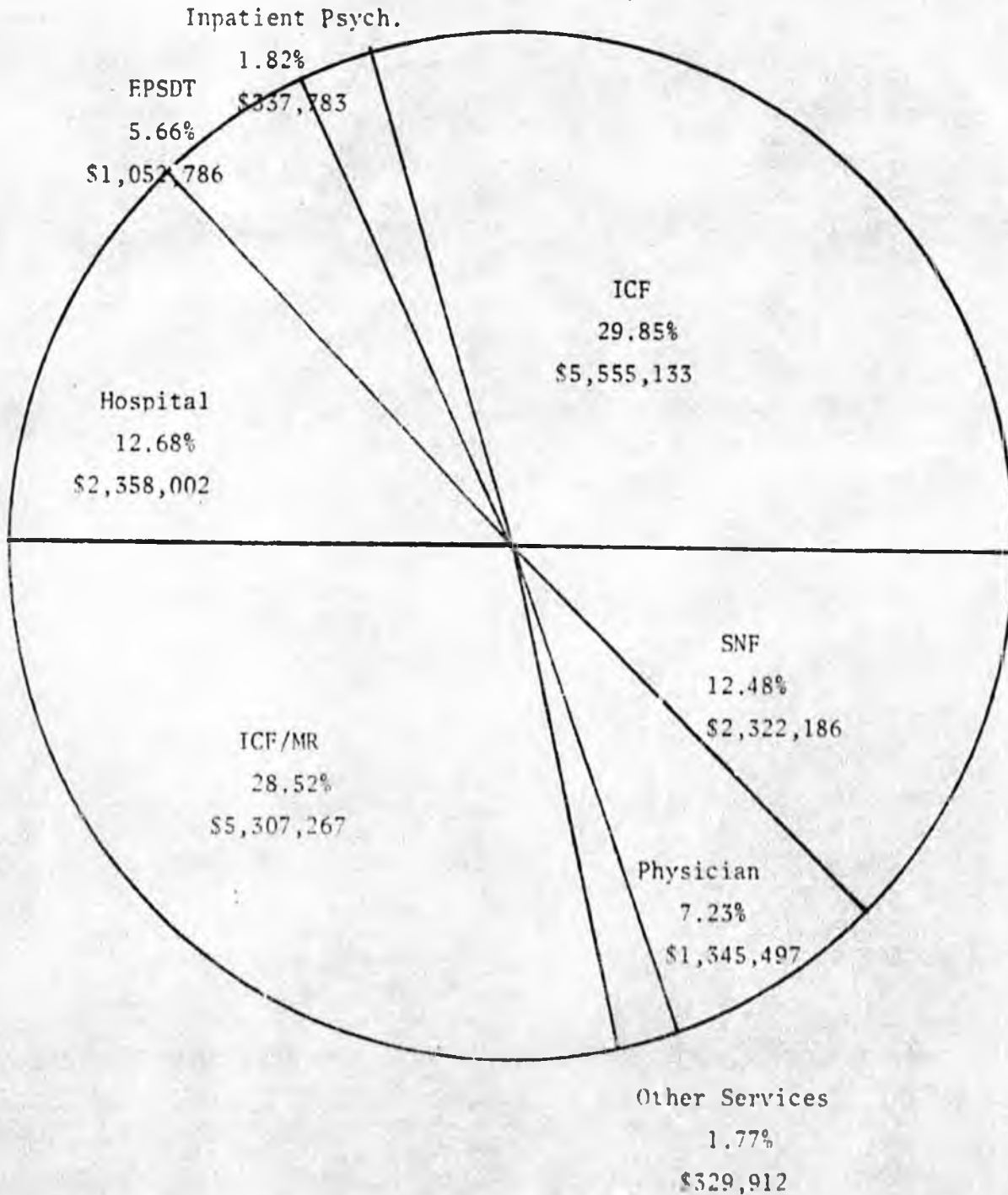
1/ - Not included in these statistics were approximately \$500,000 worth of FY 1977 invoices which had not yet been paid as of 2/28/78, pending decision on the FY 1978 supplemental appropriation request.

2/ - Statistics based on federal report during the federal fiscal year October 1, 1976 to September 30, 1977.

DISTRIBUTION OF MEDICAID PAYMENTS BY TYPE OF SERVICE

BY DATE OF SERVICE

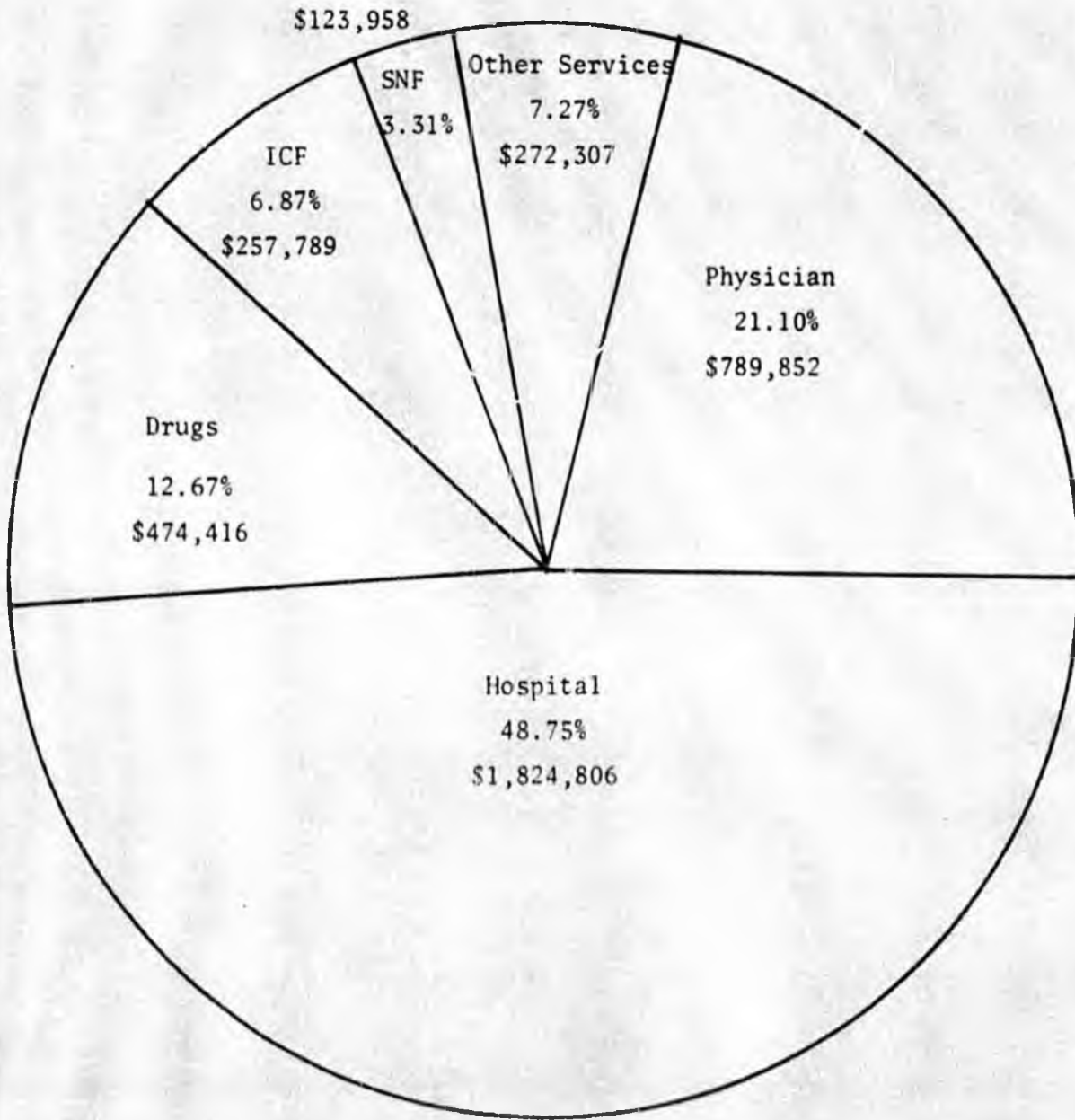
FISCAL YEAR 1977



Total Medicaid Payments

\$18,608,568

DISTRIBUTION OF GR MED PAYMENTS BY TYPE OF SERVICE
BY DATE OF SERVICE
FISCAL YEAR 1977



Total GR Med Payments
\$3,743,128

MEDICAL ASSISTANCE EXPENDITURES - FY 1977 - BY PROVIDER BY DATE OF SERVICE

	MEDICAID	GENERAL RELIEF MED	TOTAL	STATE SHARE TOTAL	FEDERAL SHARE TOTAL
Hospital - Inpatient	\$ 2,047,906	\$ 1,718,698	\$ 3,766,604	\$ 2,742,651	\$ 1,023,953
Outpatient	310,096	106,108	416,204	155,047	261,157
Laboratory & X-ray	13,247	4,279	17,526	10,903	6,623
Skilled Nursing (SNF)	2,322,186	123,958	2,446,144	1,285,051	1,161,093
Intermediate Care (ICF)	5,555,133	257,789	5,812,922	3,035,356	2,777,566
Intermediate Care for Mentally Retarded (ICF/MR)	5,307,267	-0-	5,307,267	2,653,633	2,653,634
Physician Services/Incl. EPSDT	1,353,097	789,852	2,142,949	1,466,400	676,549
Drugs	-0-	474,416	474,416	474,416	-0-
Home Health Services	11,798	-0-	11,798	5,899	5,899
Dental Care EPSDT Serv.	392,704	-0-	392,704	196,352	196,352
EPSDT Admin.	35,552	-0-	35,552	17,776	17,776
Other	-0-	81,828	81,828	81,828	-0-
Transportation/Inc. EPSDT	82,916	16,386	99,302	57,844	41,458
Family Planning	99,917	92,481	192,398	102,473	89,925
EPSDT Admin./RSA	503,913	-0-	503,913	251,956	251,957
Inpatient Psychiatric Hospital	337,783	-0-	337,783	168,891	168,892
Eyeglasses/Inc. EPSDT	160,576	15,725	176,301	96,013	80,288
Prosthetic Devices/Inc. EPSDT	12,244	21,014	33,258	27,136	6,122
Mental Health Clinics	40,151	-0-	40,151	20,075	20,076
Other/Inc. EPSDT	22,082	40,594	62,676	51,635	11,041
TOTAL	\$18,608,568	\$ 3,743,128	\$22,351,696	\$12,901,335	\$ 9,450,261

ALASKA MEDICAID PROGRAM

Medicaid Objectives

Medicaid is based on three basic premises:

- (1) That medical services are available to needy eligible persons when ill or injured;
- (2) That the highest quality care is provided;
- (3) That care is provided at the lowest possible cost to the taxpayers through existing health care providers.

Development of the Program

Medicaid is a state-administered medical assistance program funded by both federal and state sources. The program was implemented in Alaska on September 1, 1972. Since that time Medicaid expenditures have grown tremendously as a result of population growth, inflation, increased availability of services, rising cost of services, and increased utilization of federal revenues for programs that were previously (funded by state revenues alone).

<u>FISCAL YEAR</u>	<u>MEDICAID EXPENDITURES</u>	<u>GR MED EXPENDITURES</u>	<u>ADMINISTRATION AND SUPPORT</u>
1973	\$ 4,447,219	\$ 3,675,277	\$ 481,890
1974	7,876,759	2,607,112	631,129
1975	9,309,702	2,358,080	722,778
1976	14,328,201	2,881,213	1,085,086
1977	18,608,568	3,743,128	1,253,002
1978 1/	25,915,719	6,213,100	1,346,800
1979 2/	38,811,695	6,769,100	1,423,950

1/ Projected expenditures

2/ Total of budget request including supplemental requests--includes \$6,422,300 for Indian Health Care Improvement Act billings by ANHS; this is 100% federal funds.

Medical Care Advisory Committee

The Medical Care Advisory Committee is composed of health care providers, consumers (including Medicaid recipients), and government agency representatives. The committee is mandated by federal Medicaid regulations and deals with issues concerning Medicaid services, performs studies and makes recommendations for action by the Division of Public Assistance or legislature. The purpose of the committee is to provide oversight for implementation of the Medicaid program as well as provide an opportunity for input by both the provider and consumer communities.

Members of the Medical Care Advisory Committee are:

ALASKA'S MEDICAL CARE

ADVISORY COMMITTEE

Charles Rush, Chairman	Anchorage	Pharmacist
Ann Maioriello Vice Chairman	Anchorage	Coordinator Home Health Care
Jimmy Anaver	Kipnuk	Consumer
Gloria Barclay	Juneau	Consumer
Sam Granato	Juneau	Director, Division of Social Services
Rose Davis	Fairbanks	Consumer
Robert Gregovich, MD	Juneau	Program Administrator Developmental Disabilities
J. Ray Langdon, MD	Anchorage	Physician
Sister Kathy McGinty, MD	Ketchikan	Catholic Community Services
Mildred Pelch, RN	Ketchikan	Nursing Home Administrator
Mary Wolcuff	Anchorage	Consumer

Health Care Providers

Health care providers in Alaska must be enrolled with the Division of Public Assistance to be eligible to bill the Division's Medical Assistance programs. Enrollment requires that the provider: (1) be licensed or eligible to provide a service covered under the Division's medical assistance programs; (2) have on file with the Division a signed and approved Division provider agreement form; (3) abide by the regulations and policies governing the Division's medical assistance programs; and (4) comply with Title VI of the Civil Rights Act of 1964.

Medical providers are required to keep records and furnish billing information when requested by state or federal officials for services provided to the Division's medical assistance recipients.

Provider Reimbursement

The Division sets maximum allowable fees for services provided outside of hospitals and nursing facilities. Maximum allowable fees must not exceed Medicare payment for the same service in Alaska. Providers are required to bill the Division for the lesser of: (1) their usual and customary charge to the public, or (2) the Division's maximum allowable fee (or Medicare upper limit, whichever is applicable).

For hospitals (both acute care and psychiatric), skilled nursing and intermediate care facilities and intermediate care for the mentally retarded, payment is based on reasonable cost reimbursement for services rendered. Interim payments are made and, after the close of a facility's fiscal year, settlement is made between the Division and a facility based on the cost report filed by a facility. In order for reasonable cost reimbursement to be effective the following aspects of the Division's Medicaid program must be functioning at maximum efficiency:

- (1) Division policy must be organized and kept current to give adequate notice to providers;
- (2) Utilization review of medical services--both by statistical survey and on-site review;
- (3) Thorough audit of the financial reports and operations of each hospital and nursing facility.

Number of Medical Providers in Alaska

Hospitals	27
Nursing Facilities	14
Physicians	368
Dentists	135
Optometrists	24
Speech, hearing and language therapists	13
Home Health Agencies	1
Laboratories	5
Ambulance services	8
Opticians	12
Community Mental Health Clinics	10
Physical Therapists	16 1/2
Pharmacies	68 1/2
Others	35 1/2

General Relief Medical Program

General Relief Medical (GRM) provides state-only coverage for two distinct classes of recipients: (1) those persons eligible for Medicaid who require services not included under the Alaska Medicaid program; and (2) those financially needy persons not eligible for Medicaid coverage who require medical care.

Under the first group, GRM only provides coverage for those medical services and supplies not covered under Medicaid (such as prescription drugs, prosthetic devices, and medical equipment). For the second group, GRM provides state-only funding for coverage under all Medicaid service categories as well as certain medical services and supplies not covered by Medicaid (drugs, prosthetic devices and medical equipment).

Catastrophic Illness

This program was created by the 1976 legislature to provide post-care financial assistance to Alaskans with large medical bills who did not meet the financial eligibility criteria for Medicaid or GRM at the time the person received the medical care. The Catastrophic Illness Committee is composed of a medical officer of the Department of Health and Social Services, a member of the insurance community appointed by the Governor and a lay member who has previously suffered a catastrophic illness.

SUMMARY OF SERVICES COVERED UNDER THE
ALASKA MEDICAID PROGRAM

Medicaid is a federal-state program administered by the states. As a condition of participation states must provide coverage for a minimum number of services prescribed by federal law. Beyond this minimum, each state has the opportunity to add or delete other "optional services" described in federal regulations.

The advantages of Medicaid optional services are: (1) they allow compensation for services provided by tax-paying providers who may be suffering a loss on services currently provided to low-income customers, and (2) they allow states currently providing services using state-only funds to tap federal money as partial funding for programs funded solely by the state.

The following mandatory and optional services are covered under the Medicaid program in Alaska:

Mandatory Services

(1) Inpatient Hospital services. Public or private facilities, not including hospitals for mental diseases or tuberculosis; services must be physician-ordered; non-emergency out-of-state hospitalization must be prior authorized by the Division.

(2) Outpatient Hospital services. Emergency medical services; on-going ambulatory care; public or private facilities.

(3) Laboratory and X-ray services. Independent facility or one connected with a physician; services must be physician-ordered.

(4) Skilled nursing facility care (SNF). High level nursing and/or rehabilitative care; alternative to extended hospital care; must be prior authorized by the Division.

(5) Physician services. Inpatient and outpatient services performed by private physicians; cosmetic surgery must be prior authorized by the Division.

(6) Home Health Services. Provides an alternative to nursing home care by covering services to clients at home rather than in a nursing facility. Covered services under this category include nursing; medical supplies and equipment; physical, occupational and speech/hearing therapy when provided by a licensed home health agency.

(7) Family planning services and supplies. These services receive 90% federal financial participation; covers hospital and surgical procedures as well as contraceptive devices.

(8) Transportation. To or from a facility or provider of medical services; locally handled by Divisional offices except where cost is in excess of \$250.00 or travel is out-of-state, in which case it must be prior authorized by the Division's Medical Practice Review Officer.

(9) Early Periodic Screening, Diagnosis and Treatment (EPSDT). Currently limited by the Department to federal minimum requirements for covered services; provides screening for all Medicaid-eligibles under 21 years of age; optional at client's choice; as a result of screening, referral is made to physician, audiologist, optometrist, dentist or therapist for further treatment; covered services include all mandatory services plus services for eyeglasses, hearing aids, treatment for visual and hearing defects, and dental services.

Optional Services

(1) Intermediate Care Facilities (ICF). Lower level nursing home care; alternative to skilled nursing and/or hospitalization; requires prior authorization by the Division.

(2) Intermediate Care for the mentally retarded or persons with related disabilities (ICF/MR). Lower level nursing home care for persons with mental retardation or developmental disabilities; requires prior authorization.

(3) Inpatient psychiatric hospital services. Acute care for persons suffering from psychological trauma or impairment; limited to persons under 21 years of age or over 65 years of age; prior authorization is required.

(4) Eyeglasses. Must be prescription glasses; new, repaired or replacement; no photogrey tints; cataract contact lenses must be prior authorized by the Division.

(5) Optometrists. Coverage is provided for both eye care and dispensing.

(6) Clinic services. Currently limited by state statute to state-operated and state-funded outpatient community mental health clinics enrolled for Medicaid; must be supervised by a physician.

(7) Services for speech, language and hearing disorders. Services rendered by speech pathologists or audiologists; requires prior authorization by the Division; must be ordered by a physician.

MEDICAID OPTIONAL SERVICES--INCLUDING THOSE
NOT CURRENTLY COVERED BY THE
ALASKA MEDICAID PROGRAM

The following is a list of all optional services under the Medicaid program. Optional services may be selected by the individual states for inclusion in their Medicaid program if a state decides to make those services available to all categories eligible for the basic Medicaid coverage. A brief description of each option is provided below followed by a comparison of optional services that are offered in Alaska, Idaho, Oregon and Washington, the four states comprising federal Region X. Those services covered in Alaska are indicated.

- (1) Podiatrist services. Manipulation of the feet and treatment of corns, bunions, callous s, etc., by a licensed podiatrist.
- (2) Optometric services. Covered under Alaska Medicaid.
- (3) Chiropractic services. Treatment by a licensed chiropractor limited to manual manipulation of the spine.
- (4) Other practitioner services. Naturopaths, homeopaths, herbalists, faith healers.
- (5) Private duty nursing. Care by a registered nurse or licensed practical nurse under a physician's supervision in home, hospital or nursing facility when a person requires exceptional individual and continuous care.
- (6) Clinic services. Under the Alaska Medicaid program this is currently limited to state-operated and state-funded community mental health clinics. This option could also include such other services as health care clinics, alcoholism treatment centers, ambulatory surgical centers, and rural health care clinics. Rural health clinics are now a mandatory service pursuant to Public Law 95-210.

(7) Physical therapy. Physician-prescribed services provided by a licensed or certified physical therapist (depending upon state licensing procedures).

(8) Occupational therapy. Physician-prescribed services provided by a licensed or certified occupational therapist (depending upon state licensing procedures).

(9) Services for speech, hearing, and language disorders. Included under the Alaska Medicaid program.

(10) Prescribed drugs. Covered by state-only General Relief Medical. Alaska is one of only two states without Medicaid coverage for this option.

(11) Dentures. Replacement of a full or partial set of teeth.

(12) Prosthetic devices. Physician-prescribed replacement, corrective or supportive devices that artificially replace a missing part of the body, to prevent deformity or malfunction, to support a weak or deformed portion of the body.

(13) Eyeglasses. Covered by Alaska Medicaid.

(14) Other diagnostic, screening, preventive and rehabilitative services. Identification of illness, injury or other health deviation; preventive and rehabilitative services to restore patient to functional level.

(15) Services to individuals over 65 years of age in institutions for tuberculosis. Facility providing services could be ICF, SNF or inpatient hospital.

(16) Services to individuals over 65 years of age in institutions for mental diseases. (a) Inpatient psychiatric care for persons over 65 is covered under the Alaska Medicaid program. (b) ICF and SNF care for persons over 65 with mental diseases is not covered in Alaska. Under this provision, it would be possible to provide nursing care for persons with mental disabilities who may not otherwise qualify for nursing care due to a lack of physical health problems requiring nursing home care.

(17) Intermediate care facilities (ICF). Covered under the Alaska Medicaid program.

(18) Inpatient psychiatric services for persons under 22 years of age. Covered by the Alaska Medicaid program.

(19) Transportation. Covered under the Alaska Medicaid program.

(20) Services by Christian Science nurses.

(21) Services by Christian Science Sanatoria.

(22) Skilled nursing facility care (SNF) for persons under 21 years of age. Covered by the Alaska Medicaid program.

(23) Emergency hospital services. Covered under the Alaska Medicaid program.

(24) Dental services. Adult dental services are not covered by Medicaid in Alaska.

(25) Personal care services. Physician-ordered services provided to a person in their home by a non-relative and supervised by a registered nurse.

(26) Intermediate care for the mentally retarded and persons with related conditions (ICF/MR). Covered under the Medicaid program in Alaska.

OPTIONAL SERVICES

<u>OPTIONAL SERVICES</u>	<u>ALASKA</u>	<u>IDAHO</u>	<u>OREGON</u>	<u>WASHINGTON</u>
Podiatrist Services	No	Yes	Yes	Yes
Optometric Services	Yes	Yes	Yes	Yes
Chiropractic Services	No	Yes	Yes	Yes
Other Practitioner Services	No	No	Yes	Yes
Private Duty Nursing	No	No	Yes	Yes
Clinic Services	Yes	Yes	Yes	Yes
Physical Therapy	No	Yes	Yes	Yes
Occupational Therapy	No	No	No	No
Services for Speech, Hearing & Language Disorders	Yes	No	No	Yes
Prescribed Drugs	No	Yes	Yes	Yes
Dentures	No	No	Yes	Yes
Prosthetic Devices	No	No	Yes	Yes
Eyeglasses	Yes	No	Yes	Yes
Other Services				
Diagnostic	No	No	Yes	Yes
Screening	No	No	No	Yes
Prevention	No	No	No	Yes
Rehabilitation	No	No	Yes	Yes
Services to Individuals Over 65 in Institutions for T.B.				
Inpatient	No	No	Yes	Yes
Skilled	No	No	Yes	Yes
ICF	No	No	Yes	Yes
Services to Individuals Over 65 in Institutions for Mental Diseases				
Inpatient	Yes	No	Yes	Yes
Skilled	No	No	Yes	Yes
ICF	No	Yes	Yes	Yes
Intermediate Care Facilities	Yes	Yes	Yes	Yes
Inpatient Psychiatric Services for Under 22	Yes	No	Yes	Yes
Transportation	Yes	Yes	Yes	Yes
Services for Christian Science Nurses	No	No	No	No
Services for Christian Science Sanitoria	No	No	Yes	No
SNF for Under 21	Yes	Yes	Yes	Yes
Emergency Hospital Services	Yes	Yes	Yes	Yes
Dental Services	No	No	Yes	Yes
Personal Care Services	No	No	No	No
ICF/MR	Yes	Yes	Yes	Yes

MEDICAID

A LOOK TO THE FUTURE

The federal government through the Department of Health, Education and Welfare (DHEW) continues to put greater emphasis on cost containment and accountability in the operation of the Medicaid program nationwide. This places added burdens on state-administered Medicaid programs to provide swift and accurate information to DHEW--while providing information about the program and prompt payment to medical providers.

In Alaska, the Division of Public Assistance is attempting to upgrade the overall operation of the Medicaid program in an effort to control costs as well as provide more adequate notice to providers about their rights and responsibilities under the program.

Several tools are necessary to accomplish that end--state administrative regulations, staff operational manual, provider manuals, schedules of maximum allowable fees, and a more efficient mechanized claims payment and data reporting system.

Program Tools

After five and one-half years of Medicaid participation, state administrative regulations are in the drafting stage with hearings tentatively scheduled for the summer of 1978. Federal statutes and federal regulations provide only a broad sketch of the Medicaid program. The Department of Health, Education, and Welfare assumes that states develop the details of the Medicaid program through state administrative regulations and agency policy. Without state regulations it is impossible to begin a program of effective cost containment to insure that improper and excessive utilization does not occur.

Federal law mandates that states have systems for investigation and prosecution of fraud and abuse by Medicaid providers. Without notice to providers through state administrative regulations and provider manuals, it is impossible for the state to control provider fraud and abuse. Broad state statutes and federal laws and regulations lack the detail necessary to insure that providers have specific notice of program requirements and limitations. Additionally, states must have a mechanism that allows providers to appeal decisions on invoices where payment is denied.

Provider manuals offer an organized structure within which notice is given to providers of recurrent changes in the program. Frequent updating of both regulations and manuals help assure that the state and provider are in compliance with federal requirements as well as guarantee that the state receives the maximum allowable federal matching funds afforded to Alaska.

Federal Accountability

Greater emphasis is being placed on state accountability to the federal government. States no longer have the luxury of running their Medicaid programs on an open account. Fraud and abuse control are being emphasized, and overall state management is being scrutinized. During the summer or fall of 1978, DHEW staff will be reviewing the entire Alaska Medicaid program as part of a nationwide management assessment program. Information from this review will be helpful in assessing the deficiencies and operational needs of the Division of Public Assistance, as well as providing DHEW information upon which it can base specific program improvement requests.

Federal budgeting is being revised to require more accurate quarterly expenditure and estimating reports. Revision is being made in part because DHEW is shifting its budgeting from one-year to three-year projection cycles, which places a greater burden on states to arrive at more accurate cost and utilization projections. The Division of Public Assistance must develop more accurate data to fulfill this budgeting requirement; with the present computer system, it will be extremely difficult to insure compliance in Alaska.

Increasing Efficiency in Claims Processing

A new federal statute that will have great impact on the Division's current operation requires that 90% of all "clean claims" (those invoices which require no correction or additional information from providers prior to payment) must be paid within 30 days of receipt. Given the present manual claims payment system, it will be virtually impossible to comply with this requirement.

In an attempt to speed up the claims processing system, the Division is seeking to shift to a schedule of maximum allowable fees for physician services rather than continuing with the present fee profile system. The basic difference between the two is that with maximum allowable fees, an upper limit is established for all providers for a particular medical or surgical procedure. The state pays the lesser of a provider's usual and customary billing or the maximum allowable fee.

With the current fee profile system, the amount paid varies from provider to provider--even within the same city or clinic! Also, with the fee profile system, providers submit invoices with the amount they normally charge for a service. This is then "adjudicated"--that is, reduced--if the charge exceeds the maximum fee for that procedure as established on the physician's fee profile.

A schedule of maximum allowable fees will guarantee: (1) that all physicians receive equal pay for equal work; (2) that they will receive a fair wage for their work; (3) that their invoices will be paid in a more timely manner; and, (4) that they will have notice at the time they perform the medical or surgical procedure of the amount they can expect to be paid.

Fraud and Abuse

More intensive fraud and abuse controls have been mandated by Public Law 95-142. Post-payment utilization review of medical services has been a requirement for several years. The Division is currently computerizing claims payment information and statistical analysis of that information. This computerized system is necessary in order to comply with the reporting and investigative requirements mandated by this new fraud and abuse legislation.

Medicaid Management Information System (MMIS)

Federal law provides for 90% federal funding for development and 75% funding for operation of MMIS. The funding level for a non-MMIS claims payment and information system is only 50%. Alaska has not yet taken advantage of this offer of funding by HEW. All new federal requirements for budgeting, reporting, claims payment, and fraud and abuse are geared to an MMIS operation. Without such a system, or at least the reporting and statistical analysis portion of that system (surveillance/utilization review), the State of Alaska faces several crises in the Medicaid system which could well result in withholding of federal matching money.

It may be possible for the Division to interface with an MMIS operation in another state, and the Division is currently preparing proposals to make this interface possible. This might be the least expensive means of securing an MMIS program. Another alternative would be the purchase of a surveillance/utilization review system to accompany the present claims payment system. If this latter alternative were used, it would allow the state to comply with reporting and budgeting requirements as well as providing statistical information needed for fraud and abuse control.

Indian Health Care Improvement

Public Law 94-437 (the Indian Health Care Improvement Act) provides for reimbursement of services rendered to Medicaid eligible persons by Indian Health Service (IHS) hospitals by allowing the facilities to bill Medicaid. There will be no impact on the State's portion of Medicaid program costs as all money paid to IHS providers will be 100% federal funds. However, there will be an impact on state administration costs as states must pay their percentage of the cost of processing these additional invoices (in Alaska, without MMIS, this is 50% of cost).

In Alaska, IHS has not yet begun to bill the Division for services provided to Medicaid eligible Natives. Start-up has been postponed as IHS is still in the process of establishing billing mechanisms for each of their facilities in Alaska. Several facilities are now ready to begin billing and full implementation of IHS participation may be achieved by July 1978.

Rural Health Clinics

Public Law 95-210 provides for Medicaid and Medicare reimbursement to rural health clinics.

Under P.L. 95-210, states will be required to provide Medicaid coverage for services provided to eligible recipients by a rural health clinic once a clinic has been certified for participation in the federally-administered Medicare program. In Alaska, this certification is performed by the Division of Public Health Office of Certification and Licensing.

Clinics are staffed by nurse practitioners and physicians assistants trained to provide services traditionally performed by physicians. Although there is need for physician supervision, it may be indirect supervision.

The earliest that Medicaid can cover rural health clinic services is July 1, 1978. In order for this required coverage to be implemented in Alaska it will be necessary for AS 47.07.030 to be amended to include rural health clinics. Also, implementing regulations will be needed to allow provision of medical services by physician assistants and nurse practitioners.

Child Health Assessment Program (CHAP)

A bill is presently in Congress (HR 6706 and SB 1392), which, if enacted, would expand eligibility under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program to include a larger number of children through modification of eligibility criteria. Medicaid coverage would be extended to children whose families meet some definition of low income but do not qualify for cash assistance payment as currently required for eligibility under the Medicaid program. Under the CHAP proposal, federal financial participation would be increased to 75% federal funding.

This amendment would greatly expand the EPSDT program beyond its current level of operation in Alaska, though the full impact of the proposal cannot be accurately projected until a decision is made on what age limit will be imposed on the low income children to be added to the program.

The amendment points out the necessity for the Division of Public Assistance to identify more accurately all services provided under the existing EPSDT program. The present billing system does not identify all services provided to children as a result of EPSDT screenings. With passage of the CHAP amendment, states will need to be able to identify all CHAP claims in order to receive the 75% federal matching funds. Changes must be made to allow a child to be "tracked" from the time of screening through completion of services performed by licensed providers for medical problems identified by the screening. This is not being done in Alaska currently.

Summary

The Carter administration's emphasis in medical care is gradually moving toward some form of national health insurance program. It appears that before Congress will take any step in that direction it must be proven that the existing Medicaid/Medicare system will operate efficiently. Rising cost of service, over-utilization, improper utilization and provider fraud and abuse must be controlled.

In order for the State of Alaska to fulfill its role within the nationwide framework of health care, and for the Medicaid program in particular, the following broad goals have been set out for our program.

- (1) Assessment of services covered or potentially covered under Medicaid and General Relief Medical (including the Medicaid "medically needy" option and the state catastrophic illness program);
- (2) Streamlining the claims payment system;
- (3) Updating and expanding computer capability to provide for federal and state requirements in reporting and utilization review;
- (4) Improvement of procedures to give more accurate notice of the existing program and changes as they occur (regulations, provider manuals, staff manual);
- (5) Simplification of structure within the Department of Health and Social Services to allow for more independent operation of the Medicaid program by the Division of Public Assistance;
- (6) Adequate staffing of the Division to allow for control of the medical programs within the framework of good management practice.