ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672

1419 SHESS REVENUE SHARING -MEDICAID

1419

COMPARISON OF NEW HOSPITAL CONSTRUCTION REIMBURSEMENT METHODS
State Revenue Sharing Program (AS 43.18) June 1978

Facility	Number of Beds Constr./Total	Total Construction Cost	Remaining Liability	TOTAL BED METHOD Annual Appropriation	# years	5-YEAR METHOD Annual Appropriation	CURRENT METHOD Annual Appropriation	# years
Fairbanks Memorial Hospital	28/154	$ 9,732,578	$2,275,576	$442,750	5.14	$455,115	$ 80,500	28.27
Alaska Hospital & Medical Center	199/199	16,137,406	2,572,843	497,500	5.17	514,569	497,500	5.17
Providence Hospital	130/253	20,017,000	1,593,102	632,500	2.52	318,620	325,000	4.90
Norton Sound Regional Hospital	22/22	7,082,172	164,965	69,438	2.38	32,993	69,438	2.38
			$6,606,486	$1,642,188		$1,321,297	$972,438	

STATE OF ALASKA
JAY S. HAMMOND, GOVERNOR
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER
POUCH H 01 – JUNEAU 99811

February 9, 1981

The Honorable Charles H. Parr
State of Alaska
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

Enclosed is a copy of our report "Hospital and Health Facility Operation and Construction Assistance" which we recently provided to the Legislature. The appendix materials cited are lengthy and are available upon request.

We hope you will find this report useful as you work with health facility related issues. Please let us know if we can provide additional information or materials.

Sincerely,

Helen D. Beirne

Helen D. Beirne
Commissioner

Enclosure

Report on

Hospital and Health Facility Operation and Construction Assistance

Prepared for

Alaska Legislature

by

Department of Health & Social Services

Helen D. Beirne, Commissioner

February 1, 1981

CONTENTS

Introduction

The report that follows describes the condition of Alaska's health care facilities based on reports and inventories prepared by the Division of State Health Planning and Development. This report examines existing programs of state aid for hospital and health facility construction and operation in Alaska. Options for changes in the program and the rationale and bases for these options follow.

Current Alaska Facilities

Alaska has 17 public and private hospitals, seven of which include an intermediate and/or skilled nursing component. There are also eight facilities (exclusive of the Pioneer Home System) for intermediate care and/or intermediate care for the mentally retarded which are not associated with a hospital. It should be noted that a certificate of need application is currently being reviewed which requests authorization for a specialized hospital. Should this certificate be granted, there will be a total of 18 hospitals in the state (exclusive of Public Health Service and U.S. military hospitals).

Another major provider of care in Alaska is its system of public health clinics scattered throughout the state. The 1981 proposed State Health Plan lists unverified data indicating that 127 clinics, either free-standing structures or existing as a part of a community center or multipurpose building, are located throughout the state. The state has made available through the sale of bonds approximately $3.7 million since 1973 to construct and/or equip clinics in some 38 locations.

Other health care facilities defined by the revenue sharing act include [redacted] (of which there is [redacted] in the state), [redacted] which there are [redacted] in the state according to the 1981 proposed State Health Plan), [redacted] (there are at least [redacted] which receive revenue sharing funds in this category), [redacted] (this capability is noted above, since nursing homes are licensed facilities). In addition, a number of [redacted] receive revenue sharing funds.

Current Status of the Hospital and Health Facility Revenue Sharing Program

The hospital and health facility revenue sharing program was modified during the [redacted] Legislative session to [redacted] (and not to other health facilities). Currently [redacted] (Fairbanks Memorial and Providence Hospital and Alaska Hospital and Medical Center in Anchorage) [redacted] Attachment I, based on data provided by the Department of Community and Regional Affairs, indicates where and in what amounts revenue sharing dollars were distributed in 1980.

Further Changes in the Health Facility Revenue Sharing Program

The health facility revenue sharing program, which was originated to relieve health facilities of financial strains placed on them because of uncollected debts, has undergone changes in support levels and perhaps in its philosophy since it was established in 1971. There have been efforts to increase the minimum amounts available in recent legislative sessions. There is also some interest in tying requirements for specific types of services to the receipt of revenue

sharing funds. It has been suggested, for example, that community hospitals willing to designate psychiatric care beds should receive a revenue sharing incentive for this designation. Such an incentive could relieve the overcrowded situation at the Alaska Psychiatric Institute and perhaps avert the need for constructing other psychiatric hospitals in the state. Yet another interest expressed is in restoring the availability of construction funds to facilities other than hospitals.

DHSS Approach in Developing Report

Recognizing the significant scope of work this report suggests, staff reviewed existing data and accelerated their schedule of inventories for rural hospitals. The revenue sharing program was discussed with staff in the Department of Community and Regional Affairs, the current program administrators. Input was requested as well from recipients of the revenue sharing funds - municipalities, hospitals and other health facilities (see Attachment 2). Several discussions were held with hospital administrators to gain further information regarding the impact of hospital revenue sharing on health care services. Information on current facility status was derived from the 1981 proposed State Health Plan, from reports of deficiencies resulting from annual licensure and certification surveys and from on-site review of the physical plant for architectural condition of hospitals. The inventories focused on the more rural hospitals, and those facilities identified in the proposed State Health Plan as needing immediate attention ([redacted]) were inventoried first. Other rural hospitals with the exception of those at Kodiak and Valdez have been inventoried; the larger, more metropolitan hospitals have not yet been inventoried.

A Review of Current Programs of State Aid for Hospital and Health Facility Construction and Operation

There are three major sources of state aid for hospital and health facility construction and operation in Alaska, as follows:

1) [redacted] -- the current bill provides operation and/or construction support to non-federal, non-state health care facilities. Funds are made available on the basis of facility size (number of beds) and a minimum amount is available per facility.

2) [redacted] -- created by [redacted] to provide financing through the issuance of [redacted] for non-profit facilities to finance capital projects. One major project has been financed to date -- Fairbanks Memorial Hospital in the amount of approximately $12 million. Alaska Hospital and Medical Center in Anchorage is currently working with the Authority to determine the viability of this funding approach to assist them with refinancing their facility and possibly acquiring the adjacent Professional Office Building.

The Medical Facilities Authority is an excellent source of funds for those private non-profit facilities which generate sufficient revenues eventually to repay the loans. However, in communities such as Palmer, and Glenallen where there is little possibility that hospital income

would be sufficient for operational costs as well as loan repayment, the Authority as it is presently structured is not a viable financing option.

3) [redacted] (through the sale of bonds or from general funds to support projects) is the final source of state support for health care facility construction and operation. Since 1973, some $17,882,671 (exclusive of Hill-Burton matching funds) has been made available through the sale of bonds to support 38 clinic construction projects and 12 hospital or other health facility construction projects. This is an important source of funds, especially for rural facilities in more isolated areas. There are several difficulties with this approach. The amount of funds made available is often not adequate to construct an acceptable facility.

In non-hospital facility construction consideration is not always given to the availability of water systems, sewage systems and solid waste disposal systems, all of which are integral to a functional clinic. There is no assessment of the community's need for a clinic, what type and size of clinic should be developed or whether it could be integrated with another community function (part of a multi-purpose facility, for example).

Other sources of funds (a combination of state and federal funds) which have assisted with health facility operation and construction in past years but are no longer available include Hill-Burton funds (Title VI of the Public Health Service

Act), and funds under the Mental Retardation Facilities and Community Mental Health Centers Construction Act c 1963. Hospitals in Kodiak and Homer are receiving final payments under the Hill-Burton Act; no new funds will be available under this Act. Title XVI of the Public Health Service Act authorized federal funds to be used with state funds for health facility construction; to date, no federal funds have been appropriated for this purpose under this title.

Considerations in Determining Appropriate State Support to Health Care Facilities

The State's role in assisting in the construction and operation of health care facilities is an incremental one based, presumably, on its interest in protecting and promoting the health and well being of its citizens. With its vast geographic area, climatic extremes, transportation and communication problems, there is a need for health care facilities in key places to provide at least primary care not only to residents but to seasonal populations and visitors. The need for these facilities is not necessarily related to a community's ability to fully support the facility.

Historically, the state has put funds into health facility construction and/or operation, starting with the Hill-Burton program (established in 1947). The State's construction and operation of the Pioneer Home system is further evidence of a policy to provide health care facilities (and indeed health care services) to its citizens.

While no one would suggest that the state had a responsibility for full construction and/or operational support of all health care facilities in the state, it is clear that many needed facilities are deteriorating and their communities are not financially able to correct these steadily worsening situations. It can be argued that the state has a responsibility for ensuring access to quality care for its citizens when other sources of assistance are non-existant.

[redacted]

Physical plant adequacy is annually determined, as well, by the on-site survey for operational licensure and certification for Medicare and Medicaid reimbursement (which applies primarily to hospitals, skilled nursing and intermediate care facilities). Deficiencies in the facility, particularly those related to patient life and safety, are noted and the facility is required to develop a plan of correction to rectify the situation. [redacted]

[redacted] here currently is [redacted] resources have never been available to inspect current clinics, site-visit areas requesting or needing clinics, or review with communities their proposed program and design for a clinic.

Other dimensions of need, as outlined in Section 14 of Chapter 155, were reviewed in preparing this report. In the area of acute care in a hospital setting, the number of beds available to a service area can be a factor in determining need, since the operating cost of a facility is related to some degree

to the physical plant area within the facility. There are national formulas and data available indicating that generally a maximum of four (4) beds for each 1,000 people will more than adequately make care available. Alaska has overall an average of 2.7 beds per thousand population and there are additional beds authorized through the certificate of need process for future development.

Formulas to determine long term care and other kinds of service needs are much less precise and are not tied to numbers of beds required to provide acceptable levels of service. Much more study and research on a national as well as a local basis needs to occur in this regard.

The occupancy rate of health care facilities can be used to help determine the need for acute care and long term care facilities. The nationally recommended occupancy level for hospitals is 80 percent, for example. In looking at health facility need in Alaska, however, this figure must be used cautiously. Data from the 1981 proposed State Health Plan indicate that only one hospital - Providence in Anchorage - had an average annual occupancy rate even approaching 80 percent (Providence's average was 75 percent average annual occupancy for 1980). The fact that the Valdez Community Hospital average annual occupancy for 1980 was only 14 percent does not necessarily indicate that that facility is unneeded. Geographic location, seasonal population fluctuations, and transportation are only a few of the variables which must be considered in assessing occupancy. Further, a major accident or a natural disaster could quickly fill all beds in a smaller hospital.

The kinds and levels of services provided to determine facility need requires lengthy review and analysis. This process has been underway since June 11, 1980, under the appropriateness review program being conducted by the State's three Health Systems Agencies and the Department. Two services will be reviewed each six-months; end stage renal disease and cardiac catheterization have already been reviewed by the State's three Health Systems Agencies and other institutional services are scheduled for review through 1983. Although the review process is not yet complete, it is clear that there is [redacted] meet a critical need and to avert, if possible, the construction of additional facilities similar to Alaska Psychiatric Hospital.

Alternatives for Making Revenue Sharing Funds Available

The Department reviewed other alternatives to the number of beds option for making revenue sharing funds available. Some of the other options considered included:

- wealth of the community
- population served (including seasonal fluctuations)
- uncompensated care levels at the facilities
- facility occupancy
- health care services offered

While this assessment was not exhaustive in its exploration of possibilities, each option considered had major deficiencies, including:

- creating incentives for providing unnecessary care (i.e., basing a formula on occupancy rate could induce arbitrary raising and lowering of the occupancy rate)

- penalizing good management and rewarding poor management. By no means is a facility's financial status solely the result of management, but establishing a formula only on the basis of a facility's financial status could have this spin-off effect.

- creating a complex operation to administer the program. The concept of revenue sharing can be interpreted to be the provision of some resources to all members in a similar class. Complex formulas incorporating a number of variables would inevitably require additional staff, an audit capability, an application and a review process. This Department interpreted that revenues for a variety of purposes were to be made readily available to facilities through the municipal structure with a minimum of qualifications and strings attached.

Comprehensive Program for Hospital Care and Health Care Services

This report focuses primarily on the assistance which could be provided for hospital and health facility construction and operation. More intensive focus on the state's role in providing or assisting in the provision of health care services can be found in the 1981 (proposed) State Health Plan. These issues as well as financing issues are being extensively reviewed in the current Health Care and Financing Study funded through the Department. The first phase of this

study is scheduled for completion in December 1981 and could provide additional insight into the state's role in assisting municipalities in the provision of hospital care and health care services.

Options for Hospital and Health Facility Operation and Construction Assistance

Access to quality health care at reasonable cost is the aim of Alaska's health care delivery systems. Access and quality are tied to the existence of appropriate facilities which ensure an environment protective of patient life and safety.

The type of facility most appropriate to a given area is outlined in the State Health Plan. This plan articulates a level of care concept identifying minimum facilities and services which should be available in various sized communities in Alaska. This plan, developed in a public forum, guides the certificate of need process so that needed health care facilities and services are approved; unneeded and unnecessarily duplicative services are therefore disapproved. This process offers a safeguard against the proliferation of hospitals and other health facilities subject to review.

The question of the appropriate state role in assisting in the operation and construction needs of existing facilities is a complex one. This report has noted that the state has previously had a role in establishing and/or assisting in the support of the operation of many of these facilities. With the discontinuation of federal funds which had also previously supported health care facilities, the state's role has become less clear and in need of further exploration

and definition. Regardless of the extent of the state's role, the fact remains that many of Alaska' health care facilities, which are deemed to be needed facilities by virtue of the access to services they provide, are in need of renovation, modernization or replacement in order to continue to make quality health care reasonably accessible to Alaskans as well as to the many visitors to this state.

The options for assistance for hospital and health facility operation and construction will be discussed separately to facilitate review and policy development.

Hospital and Health Facility Operation

All health facilities have basic operational costs which must be supported regardless of the volume of patients available to generate revenues. This fact can perhaps best be seen by looking at the minimum requirements for a hospital.

Each hospital, whether rural or urban, must have the following basic areas in its facility through which to provide health care services:

Patient care including:	gross square feet
1 intensive care room	
1 coronary care room	
1 isolation room	
1 psychiatric room	
1 two bed pediatric room	
2 two bed acute care rooms	
1 five crib nursery	5,600

Surgical	2,400
Obstetrics	3,400
Emergency	1,100
Radiology	900
Laboratory	400
Physical therapy	500
Dietary	1,700
Administration	1,600
Central services	400
General storage	300
Laundry	700
Waste disposal	600
Morgue	400
Outpatient	2,000
	22,000

There is a basic cost of operation for this minimum hospital which results from staffing costs, building maintenance, and utilities.

The costs for building maintenance and utilities are almost entirely a function of the area of the hospital. The staffing costs are directly related to the services which are offered by the hospital and comprise the greater part of operating costs. A certain level of minimum staffing for the functions of medical records, dietary, maintenance, housekeeping, laundry, nursing, laboratory, x-ray, etc., is unavoidable and must exist in order for a hospital to provide service. Due to the low population served and thus the low levels of revenue generated, the rural hospitals and nursing homes have difficulty in meeting operating expenses. Many of the rural hospitals subsist only as a result of grants from local government.

All facilities continue to experience operational cost increases as a result of inflation reflected in increased fuel costs, increased salaries and increased costs of supplies. Larger facilities may be able to offset some of these costs by increased charges to patients, but this assumes a constant high occupancy

level within a facility. Such a constant is simply not the case in most Alaska health facilities, and yet the basic operational costs continue to rise. Options currently available to assist health facilities meet some of the operating costs include the health facility revenue sharing program and the municipal assistance program.

The health facility revenue sharing program provides operational costs to facilities on a regular annual basis according to the number of patient care beds available in each facility. Funds are made available to privately owned facilities (owned by a religious order, for example) as well as municipal facilities. These funds have been essential in the support of operational expenses in many Alaska facilities. Current revenue sharing fund levels are not sufficient to provide more than a portion of the operating expense of most hospitals, for example, and this is a key factor for some of the smaller, more rural hospitals in particular. There has been an interest in linking the receipt of revenue sharing funds to the provision of specifically needed services such as psychiatric beds. This option could be further explored.

The second option for operational assistance to health facilities is the municipal assistance program. This option would allow municipalities to increase the amount of operational support to health care facilities in accordance with local determination of need. One aspect of this option requiring further exploration is the eligibility of the six private, non-municipal hospitals and other non municipal health facilities for such assistance.

Hospital and Health Facility Construction

The current health facility revenue sharing program provides construction funds (up to 25% of the costs disbursed over a five-year period) to hospitals only. This program could be modified to provide a greater portion of construction funds for renovation, modernization or replacement of hospitals in communities which have an insufficient tax base to undertake 75% or more of the costs. This program could also be modified to provide up-front money where it is needed when the construction begins. Yet a third modification of this program could be to include facilities other than hospitals as eligible for construction assistance. A consideration for modification of this program might be to include funds for planning and design to ensure the most viable construction alternative.

Municipal assistance is a second option for facility construction. Municipalities which place their health facility needs as a high priority could support needed appropriate construction. Again, the eligibility of non-municipal facilities for such assistance needs to be resolved.

Bond issues offer a third possibility for assistance with health facility construction. Possible bond issues include:

(a) bond issue by an individual community

(b) bond issue by the state for facilities in a number of communities.

(c) municipal bond bank

(d) tax exempt bonds sold by the Alaska Medical Facilities Authority to support construction in nonprofit facilities.

Bond issues by the state for health facility construction provide resources to the community that do not necessarily require community obligation or indebtedness. All other bond issues presume a tax base to support repayment and a bonding capability for the community. Communities which may be approaching the upper limit of bonded indebtedness would be unlikely candidates to support a bond issue.

Health facility construction assistance is presently limited to the above listed alternatives. The likelihood of federal assistance for which Alaska facilities would be eligible any time in the near future is remote. Health facility construction need not be bound by current programs if it is determined that the state has a role in assisting with health facility construction. The state could, for example, establish a program of assistance for health facility construction similar to the now defunct Hill-Burton program. Such a program could include the following features:

- an inventory of all existing health facilities to determine precisely their structural status and need for renovation, expansion, modernization or replacement. This process would not preclude a recommendation for closure of facilities which are no longer providing needed appropriate services.

- DHSS has for many years recognized the need for designated hospitals to provide psychiatric care. AS 47.30.010(b)(1) authorizes the Commissioner of DHSS to designate such hospitals. Alaska Psychiatric Institute is currently the only designated facility in Alaska. This facility is now

experiencing an occupancy rate of 114%. An effective method of providing the needed psychiatric beds is to designate hospitals which would dedicate certain beds for the provision of psychiatric care. This method could, if successful, obviate the need for additional construction and would place psychiatric care into more areas of the state.

- the development of a program of state assistance based on the results of the inventory and the current edition of the State Health Plan. This program could incorporate an initial planning and design component, a community match requirement (based, perhaps, on the size of the community) and the establishment of a representative body to review applications and make recommendations for funding.

All the above options, singly or in combination, have the potential for addressing the needs for health facility construction programs in the state. The age and inadequate status of many of our health facilities make it imperative that a rational system for renovating or replacing deficient facilities be established now to stem the problem. Failure to establish a consistent and timely approach can be expected to result in a plethora of requests from individual communities to the Legislature ---and determining which community should get what level of resources in the absence of a total picture of the state's needs could become a most complex and controversial issue.

APPENDIX

Attachment I - Printout on Distribution of Health Facility Revenue Sharing Funds

Attachment II - DHSS Letter of Request for information to recipients of revenue sharing funds

Attachment III - Structural deficiencies reports:

a. Petersburg General Hospital

b. Wrangell General Hospital

c. Valley Hospital, Palmer

d. Cordova Community Hospital

e. Seward General Hospital

f. Wesleyan Nursing Home, Seward

g. Faith Hospital, Glenallen

HB 164	Equip Kodiak	64,000	(H) finance	Zharoff
HB 244	Wrangell/Petersburg	$1,360,000	(H) Hess	Haugen
HB 349	Nenana	$4,000,000	(H) HESS	Wilson
HB 365	Cordova (feasibility)	$150,000	(H) Hess	Cato
SB 184	Katzehin/N.S. Harb.	[illegible], 000	(S) H&SS	Ferguson
SB 389	AK Navy	$55,000,000	(S) FINANCE	Finance

hospital association
(907) 586-1790
319 Seward St., Juneau, Alaska 99801

Charlie -

This the predraft which final Departmental support but got stuck in its presentation to the Gov's People. The Dept was told To Rewrite To what you recieved

Dennis

MEDICAID

Rod Betit Div. of Pub. Asst.
Bob Ogden
Statute Title 47. 07. 3355
Service 47. 07. 030
Jeff Hubbard 3347 (Pub. Asst)

1AAC-43 725 Ch. 43

Medicaid

Regis. passed Medicaid Clinic
Services - defined as Comm.
operated by State Mental Health Services.
Dir of Health Clinic must file under
Dept. Payee no (where check issued)
in Div and Provider no. (Physician)
Disabilities.
if Regis. passed like
as Clinic services - the
Clinic could be Payee &
Providers.
Clinic - physician services
are Covered — but any
services w/ Clinic other than
Physician not covered.

80% budget to institutional
care. for period of illness

no Medical prevention
no yearly exam / dental

Reagan
5% Cap on services
50% funds from Feds - want
to change reimbursement to
relate to per/capita income.
CETA
Cut reimbursement for
Medicare and upping service.
More people are eligible for
services. More people
eligible in long term care

they can take back money more quickly if they decide not to approve expenditures.

Bill Fed. each quarter for $100,000/services. Can appeal – takes 1½ years. Can take deferral out of budget if guaranteed dem only.

STATE OF ALASKA

THE LEGISLATURE

BUDGET AND AUDIT COMMITTEE

AUDIT DIVISION
POUCH W—ALASKA OFFICE BUILDING

FINANCE DIVISION
POUCH W—STATE CAPITOL

JUNEAU, ALASKA 99811

February 26, 1981

Senator Charles H. Parr
Chairman
Senate Health, Education
and Social Services Committee
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

At the February 24, 1981 meeting, the Legislative Budget and Audit Committee approved for release to the public the attached audit report which may be of interest to your Committee.

If you have any questions on this report, please contact our office.

Sincerely,

Gerald L. Wilkerson

Gerald L. Wilkerson, CPA
Legislative Auditor
Division of Legislative Audit

Enclosure

31-026H

A REVIEW OF THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES DIVISION OF PUBLIC ASSISTANCE MEDICAID BUDGET REQUEST UNIT

For the Fiscal Year Ended June 30, 1980

Commissioner, Department of Health and Social Services	Dr. Helen D. Beirne
Deputy Commissioners, Department of Health and Social Services:	
Management Services	Allen K. Korhonen
Field Operations and Local, State, Federal Liaison	Frederick McGinnis
Program Management	Dean F. Tirador, M.D.

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PURPOSE OF THE REVIEW

In accordance with the provisions of Title 24 of the Alaska Statutes, we conducted a review of the Department of Health and Social Services, Division of Public Assistance, Medicaid Budget Request Unit This component does not include costs for Medicaid administration, or payments made to Harborview or Alaska Psychiatric Institute.

The purpose of our review was to determine:

1. If the financial statements appearing in the State Annual Financial Report for the fiscal year ended June 30, 1980 are fairly presented.

2. The compliance by the Department of Health and Social Services with applicable State statutes and regulations governing fiscal activities.

ORGANIZATION AND FUNCTION

The Medicaid program is organized under the Department of Health and Social Services, Division of Public Assistance. The purpose of the program is to provide health care financial assistance under Title XIX of the Federal Social Security Act. This Title allows medical expenses of eligible Alaskans to be paid with federal and State funds.

All Medicaid expenditures, except those for administration, Harborview, or Alaska Psychiatric Institute, are charged to the Medicaid Budget Request Unit. Medicaid services include the following:

1. Physicians' services.
2. Hospital care.
3. Laboratory and X-ray services.
4. Nursing home care.
5. Early and periodic screening, diagnosis, and treatment for persons under 21.
6. In-patient and psychiatric-home care for the mentally retarded.
7. Transportation if such services are otherwise unavailable.

Medicaid recipients submit coupons as payment to doctors, hospitals, and other health care organizations. The organizations are reimbursed when they submit these coupons to the Division of Public Assistance.

FINDINGS AND RECOMMENDATIONS

Recommendation No. 1

The Department of Health and Social Services (DHSS) should strengthen its internal accounting controls over Medicaid payments.

Internal controls in effect during FY'80 were not sufficient to provide reasonable assurance that accounting records for the Medicaid Budget Request Unit (BRU) are reliable and accurate, and therefore we have disclaimed an opinion on the financial statements. The major findings that led us to this decision are discussed below, along with recommendations where applicable:

A. Over 50% of the FY'80 Medicaid BRU expenditures were charged to the Nursing Home component. DHSS did not perform or contract audits adequate to ensure that billed costs were accurate and/or allowable.

   DHSS should continue its efforts to increase audit staff and should provide the training needed to properly audit long-term care facilities once staff is on board. Further, it should make every effort to audit FY'80 and future cost reports, or contract with a reliable firm to provide this service.

B. DHSS implemented a new claims processing system in January 1980. Approximately the first 35,000 claims are being reprocessed because they include items that were incorrecly paid or recorded. Reprocessing was not completed prior to preparation of the FY'80 financial statments or at the time of our audit.

C. Controls during FY'80 were not sufficient to ensure that claims processed through Computer Sciences Corporation (CSC) were in fact paid. In particular, DHSS did not reconcile the expenditures charged to and the warrants written by the State accounting system (PBA) against the payment tape supplied by CSC. This is an ongoing reconciliation that must be performed each time a payment tape is processed through PBA.

D. Claims received without Medicaid coupons attached were not adequately controlled and accounted for. Even when these claims had been checked for eligibility, they were sometimes processed for payment without adequate proof that this determination had been made.

DHSS now requires that claims checked for eligibility be stamped and initialed by the person making the determination. In addition, systems changes have been planned that would provide greater control over invoices from the time of receipt. We recommend that DHSS implement these changes as soon as possible.

E. Controls during FY'80 were not adequate to prevent duplicate payments. Controls were significantly enhanced with the introduction in late FY'80 of a duplicate edit report for claims processed through CSC. This edit is limited, however, because CSC's history file is incomplete (see Recommendation No. 3).

In addition, DHSS has agreed to make advance payments to certain providers for unresolved FY'80 claims. This was a policy decision and is intended to ease cash flow problems that may be caused by the State's untimely payment of medical bills. It should be noted, however, that duplicate payments will inevitably result, and DHSS will yet again be faced with a major adjustment and reconciliation process.

Recommendation No. 2

DHSS should place greater emphasis on third party liability identification and recovery efforts.

Federal regulations 42 CFR 433.135 specify that federal Medicaid financial participation is not available if a state does not have an adequate third party liability (TPL) identification and recovery program. In response to these regulations, DHSS requested that we review the Department's current TPL program and make recommendations for improvement. Our major findings and recommendations follow:

A. The best source of TPL information is the applicant. We found, however, that application forms for some of the public assistance programs do not ask the right kind of questions and, further, that eligibility workers are not trained to recognize potential TPL resources.

Accordingly, we recommend: (1) DHSS should review the information needs of the various programs affected - Collections, Aid to Families with Dependent Children (AFDC) and Child Support Enforcement Agency (CSEA), Adult Public Assistance, Food Stamps, etc.; (2) forms should be revised to accumulate all necessary information without undue duplication of paperwork; (3) eligibility workers should be made aware of the importance of TPL resources and trained to recognize them; (4) Medicaid manuals, which include information and regulations applciable to TPL, should be distributed to eligibility workers and other appropriate personnel.

B. DHSS employs a one letter "resource code" to record TPL information. For example, "A" designates Blue Cross, "D" designates Commercial Insurance/ Hospital, and "P" designates U.S. Public Health (Alaska Native Health). The resource code is very important because it tells the provider whether a third party must be billed prior to Medicaid and is the basis for certain TPL and control edits.

The codes are too limited, however. Assume, for example, that an applicant is qualified for and is coded as U.S. Public Health (P), but that he or she also has commercial insurance. Unless the provider learns of the insurance and then volunteers that information to the State, DHSS will process the applicant's claims as though no other third party resource exists. If either the provider or the applicant also bills and recovers from the insurance company, DHSS probably will not detect it.

DHSS should correct this systems problem by expanding or modifying its codes to allow the recognition of more than one TPL resource.

C. Trauma or accident claims have a high potential for TPL recovery because they often involve another party who might be legally liable for medical bills. During 1979, DHSS manually screened for trauma claims and forwarded copies to the Collections office in Anchorage for further research. When this practice was discontinued in early 1980, TPL collections dropped and Collections lost one of its major tools for identifying potential TPL recovery.

It would not be practical to re-implement the manual screen for trauma claims. However, we recommend that CSC generate monthly or quarterly listings of these claims. This will at least provide a basis for determining that potential recoveries exist.

D. Most of Alaska's AFDC cases are coded as having no third party resources. However, experience from other states has shown that the AFDC recipient may not know or want to tell about resources available through the absent parent.

To determine whether these resources exist, however, it is necessary to start with the agency working with the absent parent - in this case, CSEA - and work backwards. This is because CSEA is more likely to have the kind of information necessary to cost-effectively identify TPL resources. For example: Parents currently making support payments are more apt to be employed, and parents who are employed are more apt to have insurance that covers the spouse's or children's medical bills. CSEA can identify persons making support payments; DHSS cannot.

We recommend that CSEA and DHSS work together on TPL identification and recovery for AFDC cases. An agreement should be developed that outlines each agency's responsibilities with regard to administration, investigation, and enforcement. Thereafter, cases with high TPL potential should be investigated, resource codes updated, and payment recovery procedures begun.

E. Alaska's medical assistance statutes do not include a subrogation provision empowering the State to recover directly from third parties, nor does DHSS request or require that all medical assistance applicants sign an "assignment of benefits" form. This complicates the process and sometimes negates the cost benefit of seeking reimbursement for medical assistance payments.

We recommend that DHSS work with the Attorney General's office to draft and then submit a subrogation statute for all medical assistance payments. We also suggest that the Department work closely with its Collections manager in this regard, as he has done considerable work in this area over the last two years.

In summary, we found that the Department's support of its TPL program has been minimal. For example, the above recommendations are not new - they have been proposed both by federal Medicaid reviewers and even in a formal report prepared by the DHSS employee responsible for TPL collections. In addition, there is a wealth of TPL literature available. It is time that DHSS gave serious thought as to whether it wants a TPL program that is an integral part of sound fiscal control, or whether it should continue to expend the minimal resources necessary to comply with federal regulations.

Recommendation No. 3

DHSS should data capture all payments onto its medical history file. Medical history file reports should be sorted and formatted to better meet users' needs.

Claims processed through CSC are data captured onto a medical history file. This data is potentially useful to many DHSS offices such as Quality Control, Audit, Collections, Fraud Investigations, Medical Claims, and Public Assistance Administration. We have noted two major problems with the medical history file, however. First, it is incomplete. Second, reports generated from the file are not adequate to meet the various users' needs.

A. The medical history file is incomplete because:

1) The medical data on hand-vouchered payments is not captured. This includes payments to out-of-state providers, nursing homes, dental claims, and many claims that were hand processed prior to implementation of the CSC system in January 1980.

2) When the CSC system was introduced, systems and control problems were extensive. For example, the history file shows payments that were never actually processed; conversely, payments that were processed were erroneously deleted. The extent of these problems is unknown.

3) Previous to July 27, 1979, DHSS had an in-house medical claims system. The history file produced under that system was also inaccurate. In fact, the system is referred to by many DHSS staff as the "black hole" because invoices would enter and then disappear.

DHSS is making efforts to clean up old claims processed through CSC and to improve controls over data currently captured in the medical history file. To fully utilize

the file, however, it must be complete. Therefore, we recommend that hand-vouchered payments also be data captured.

B. However, a complete and accurate medical history file is of little value if data is not sorted and formatted to meet users' needs. The most frequent complaint we heard in this respect is that there is no patient profile report - ie., a listing of medical history data by patient name or case number. This not only inconveniences many offices, it prevents several from doing their jobs effectively. For example:

1) Quality Control (QC) is required to sample eligibility rolls and review payments made on recipients' behalf. QC was unable to do this during FY'80 because it could not get patient payment histories. A run was finally received in the Fall of FY'81 to cover the testing period October 1, 1979 - March 31, 1980, but it had insufficient detail for QC to efficiently conduct its review.

2) Collections is responsible for recovering moneys paid by the State for medical claims that were also paid by or chargeable to some other resource. Because Collections has been unable to access the medical history file for patient payment data, it has had to derive this vital information from other sources (lawyers, providers, etc.). It is inefficient, error prone, and embarrassing to have to ask how much money the State has paid so that the State can then demand it back.

3) The Fraud Investigations unit is similarly handicapped when it comes to assessing the dollar impact of a crime, or whether fraud has indeed occurred. Also, the lack of a complete medical history file is one of the roadblocks to the establishment of a "certified" Medicaid fraud control unit that would be eligible for 90% federal funding.

There are many other ways in which available information can be accessed to create usable information. We stress the need for DHSS to work more closely with all users about the format and content of reports they need, and we make the following recommendations:

1) Patient profiles should be produced at least quarterly. Quarterly provider profiles should continue to be produced.

2) Other listings of data sorted or selected on the basis of specified fields (invoice date, diagnosis code, etc.) should be produced on an as need basis.

3) Reports requiring more sophisticated data manipulation should be evaluated to determine whether they are integral to an office's operations and are cost effective. Management's decision whether to devote programming, computer, and financial resources should be based accordingly.

Recommendation No. 4

Alaska should reconsider the "buy-in" option for Medicare.

Alaska is one of the few states that does not purchase Medicare coverage (ie., "buy-in") for eligible public assistance recipients. This is the result of a decision made many years ago. The State subsequently reconsidered its decision but was told that the option is no longer available. The matter was actively pursued until 1976 but was then more or less dropped.

We believe that the issue of whether the State could and should purchase Medicare coverage deserves reconsideration. The legal issues involved have always been subject to debate and are still so. Moreover, the organizational and personnel makeup of the U.S. Department of Health and Human Services (formerly Health, Education and Welfare) has changed considerably since 1976, and that agency may be more receptive to the State's case. Finally, we have no precise figures, but all indications are that the benefits of a buy-in option would outweigh the costs, and that the benefits would increase over time.

Recommendation No. 5

DHSS should encourage providers to become Medicare eligible.

Medicare, in addition to requiring that individuals be eligible for the program and pay the applicable premiums, also requires that the medical services be performed by Medicare certified providers. Many nursing homes in the

State do not meet this criteria. As a result, the State Medicaid and General Relief Medicine programs pay for care that Medicare would cover.

We believe that the State should make a substantial effort to have providers become Medicare certified and thereby shift the cost of some nursing home care to Medicare. This would be additionally beneficial in that Medicare certified nursing homes have greater review procedures which would benefit recipients and the State.

STATE OF ALASKA

THE LEGISLATURE

BUDGET AND AUDIT COMMITTEE

AUDIT DIVISION
POUCH W—ALASKA OFFICE BUILDING

FINANCE DIVISION
POUCH WF—STATE CAPITOL

JUNEAU, ALASKA 99811

November 3, 1980

Members of the
Legislative Budget and Audit Committee:

We have examined the Statement of Revenues - Budgeted and Actual and the Statement of Expenditures and Encumbrances Compared with Appropriations for the Department of Health and Social Services, Medicaid Budget Request Unit, for the Fiscal Year ended June 30, 1980. As part of our examination, we made a study and evaluation of the agency's system of internal accounting control to the extent we considered necessary to evaluate the system as required by generally accepted auditing standards. The purpose of our review was to determine the nature, timing, and extent of auditing procedures necessary for expressing an opinion on the financial statements and would not necessarily disclose all weaknesses in the agency's internal accounting controls.

However, our study and evaluations disclosed the following conditions:

1. Over 50% of the FY'80 Medicaid Budget Request Unit expenditures were charged to the Nursing Home component. The Department did not perform or contract audits adequate to ensure that billed costs were accurate and/or allowable.

2. The agency implemented a new claims processing system in January 1980. Approximately the first 35,000 claims are being reprocessed because they include items that were incorrectly paid or recorded. Reprocessing was not completed prior to preparation of the FY'80 financial statements.

3. Reviews done by the agency's Quality Control section did not adequately test FY'80 Medicaid payments.

4. Approximately 7,000-10,000 invoices were paid at a flat percentage and then later adjudicated and adjusted. Many of these invoices were charged to the wrong fiscal year.

5. Claims received without Medicaid coupons attached were not adequately controlled and accounted for. Even when these claims had been checked for eligibility, they were sometimes processed for payment without adequate proof that this determination had been made.

6. Controls during FY'80 were not adequate to prevent duplicate payments or to ensure that processed claims were in fact paid.

7. There is no complete medical history file. Furthermore, information that is available is not sorted and formatted in a way that facilitates quality control, fraud investigation, or audit efforts.

In addition, we requested that management furnish us a letter acknowledging responsibility for the financial records and making certain representations regarding the accuracy and completeness of those records. The Department concluded that such a letter would be inappropriate.

As described above, the internal control procedures followed by the Department were not adequate to assure the accuracy of the financial statements, and it was not practicable to attempt to satisfy ourselves by use of extended auditing procedures.

Accordingly, we cannot and do not express an opinion on the financial statements referred to in the first paragraph.

Gerald L. Wilkerson, CPA
Legislative Auditor
Division of Legislative Audit

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE
MEDICAID BUDGET REQUEST UNIT (Note 2)
STATEMENT OF REVENUES - BUDGETED AND ACTUAL
For the Fiscal Year Ended June 30, 1980

Classification	Final Revised Budget	Actual	Over or (Under) Budget
Restricted Revenue			
Federal Grants-in-Aid			
Social Services			
Title XIX	$21,234,500	$16,054,431	$(5,180,069)
Title V	-0-	314	314
Total Social Services	21,234,500	16,054,745	(5,179,755)
Health			
Federal Projects	-0-	60,259	60,259
Total Federal Grants-in-Aid	21,234,500	16,115,004	(5,119,496)
Interagency Receipts			
Health and Social Services	3,347	-0-	(3,347)
Other Restricted Receipts			
Reimbursement and Recovery - Prior Year	-0-	32,321	32,321
Total Restricted Revenue	21,237,847	16,147,325	(5,090,522)
Total Medicaid BRU Unrestricted and Restricted Revenue (Note 3)	$21,237,847	$16,147,325	$(5,090,522)

See Auditor's Disclaimer of Opinion and Accompanying Notes to the Financial Statement.

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE
MEDICAID BUDGET REQUEST UNIT (Note 2)
STATEMENT OF EXPENDITURES AND ENCUMBRANCES
COMPARED WITH APPROPRIATIONS
For the Fiscal Year Ended June 30, 1980

Budget Category	1979 - 1980 Budget Act	Continuations Supplements and Revisions	Total Authorizations	Expenditures	Encumbrances at Close of Year	Unencumbered Balances Continuing Programs (Note 4)	Unencumbered Balances Lapsed
Health Category							
Medicaid	$33,266,700	$ 2,464,695	$35,731,395	$23,887,210	$7,210,540	$196,085	$4,437,560
Total Medicaid Budget Request Unit	$33,266,700	$ 2,464,695	$35,731,395	$23,887,210	$7,210,540	$196,085	$4,437,560
By Object							
Personal Services	$ -0-	$ 6,695	$ 6,695	$ -0-	$ -0-	$ 6,695	$ -0-
Travel and Moving	-0-	-0-	-0-	4,578	458	(5,036)	-0-
Contractual Services	-0-	-0-	-0-	47,669	48,097	(95,766)	-0-
Assistance Grants and Benefits	33,266,700	2,458,000	35,724,700	23,834,963	7,161,985	290,192	4,437,560
Total By Object	$33,266,700	$ 2,464,695	$35,731,395	$23,887,210	$7,210,540	$196,085	$4,437,560

Source of Funds	General Fund	Federal Receipts	Inter-Intra Agency Receipts	Federal Revenue Sharing	Totals
Appropriation Act, Ch. 80, SLA 1979	$ 3,882,300	$20,005,600	$ -0-	$ 9,378,800	$33,266,700
Supplemental Appropriation (Ch. 50, SLA 1980, Sec. 70)	1,229,100	1,228,900	-0-	-0-	2,458,000
Salary Increases	3,348	-0-	3,347	-0-	6,695
Total Source of Funds	$ 5,114,748	$21,234,500	$ 3,347	$ 9,378,800	$35,731,395

See Auditor's Disclaimer of Opinion and Accompanying Notes to the Financial Statement.

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC ASSISTANCE
MEDICAID BUDGET REQUEST UNIT
NOTES TO THE FINANCIAL STATEMENTS

Note 1 - Summary of Significant Accounting Policies

Alaska Statute 37.05.150 requires the State of Alaska to conform to generally accepted accounting principles. The following is a summary of the significant policies applicable to the Department of Health and Social Services.

Bases of Accounting. The accrual basis of accounting is followed, with minor exceptions. The General Fund utilizes the modified accrual basis of accounting. Modifications in such method from the accrual basis and modifications used by the Department are as follows:

1. Revenues are recorded as received in cash except for:

   (a) Revenues susceptible to accrual.

   (b) Material revenues that are not received at the normal time of receipt.

2. Expenditures are recorded on accrual basis except for:

   (a) Certain types of expenses which are considered expenditures at time of purchase:

      (1) Inventory type items.

      (2) Prepaid expenses, such as insurance.

      (3) Interest on long-term debts.

   (b) Encumbrances which represent:

      (1) Valid obligations accrued at June 30, 1980 and paid during the July-August reappropriation period.

      (2) Purchase orders and contract commitments at June 30, 1980 which were recorded by August 31, 1980.

Note 2

The Medicaid Budget Request Unit (BRU) does not include all the costs of the Medicaid program. In general, the Medicaid BRU only includes payments to providers for medical services. It does not include payments to Harborview or Alaska Psychiatric Institute, which are State institutions, nor does it include the administrative costs of the Medicaid program. These costs are also funded in part by the federal Medicaid program and are accounted for in other BRU's within the Department.

Note 3

$9,375,800 of the expenditures reported in the financial statements are offset by Federal Revenue Sharing receipts budgeted to the Medicaid BRU but not reflected in that program's accounts. Instead, these receipts were credited to the Federal Revenue Sharing Fund (#128), and general ledger transfers were periodically made to "replenish" the General Fund for Medicaid expenditures.

Note 4

These funds were appropriated in Ch. 50, SLA 1980, Sect. 70, for the fiscal year ending June 30, 1980, while another section of that act authorizes their use until June 30, 1981. No conflict arose, however, because the agency allowed the funds to lapse on June 30, 1980.

Note 5

At the completion of our audit, there were eight unresolved federal compliance issues that had been identified by federal Medicaid Bureau reviewers. Most issues were procedural in nature and were not associated with specific dollar amounts. If not resolved satisfactorily, however, they could affect the funding or operation of Alaska's Medicaid program.

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

February 24, 1981

Gerald L. Wilkerson, C.P.A.
Legislative Audit Division
Pouch W
Juneau, Alaska 99811

Re: Review of Medicaid, Division of Public Assistance

Dear Mr. Wilkerson:

Although a few areas of disagreement exist, the findings cited in your report are generally accurate and reflect a fair assessment of the problems incurred by the new Medicaid system during its early months of operation. Initial start-up problems were expected as the Department had to design and install a new system within this same time frame. The implementation effort for a new system of this scope and complexity would normally evolve over a period of 12 to 24 months. Unfortunately, the Department's old Medicaid system had already collapsed and the Department simply did not enjoy the normal lead time for system replacement.

The current claims processing system is working with regularity and vendors are being paid within liveable time frames. We are still fine-tuning the system however, and new problems do arise from time to time. To graphically indicate the improvement in the claims processing system, we have attached a graph that shows how the claims payment time has diminished.

The Department's specific remarks to each of the specific audit findings and recommendations are as follows:

RECOMMENDATION NO. 1

A. Audits of Long-Term Care Facilities Inadequate:

We concur with this finding... Contact with Region X federal officials indicates that a number of states have experienced difficulty with Blue Cross contract audits. The Department of Health and Social Services is currently recruiting nationwide to obtain needed audit staff. Every effort will be made to provide comprehensive-professional audits of long-term care facilities.

B. Errors in First 35,000 Invoices Processed Through New System:

As mentioned above, problems were experienced with the first 35,000 invoices processed by the system. Foreseeing the possibility of

such problems, the Department maintained a second complete set of these invoices for reconciliation purposes. This reconciliation is complete as of this writing. All claims have been accounted for and have been paid.

C. Lack of Controls in Claims Processing System:

We disagree some with this finding in that DHSS did identify claims rejected by the PBA system. However, C.S.C. failed to take prescribed actions to delete these claims from the history file then reprocess them for payment. DHSS did fail to monitor this process adequately, a control is now in place.

D. Lack of control over claims received without Medicaid coupons:

The auditors are correct that 25% of all claims are received by the Department without supporting Medicaid coupons. This requires these claims to be separated from all other claims, at the time of receipt, for purposes of eligibility research. The Department has not maintained manual logs for claims in this status simply because it was not possible to do so with the staff resources available to the Department. In fact, it is still out of the question. However, the Department did take measures to bring these claims into a more controlled environment. On October 1, 1980 CSC implemented reporting of all claims (paid, denied, and suspended) on a regular basis to each provider. This marks a significant milestone in Medicaid processing in Alaska as such reporting never occurred before. This system change permits CSC systems to notify medical providers of all claims pending an eligibility check so that they know the claims were received and are in process. This improvement will alert the Department to any claims which might be misplaced during the manual eligibility verification process.

E. Controls to prevent duplicate payments were not in effect during much of FY 80:

Given the compressed time frame within which the Department was forced to implement this system and restore Medicaid claims processing, the Department's primary concern was to make payment on a five month backlog of bills. It became apparent early in the CSC system that the duplicate check subsystem was not functioning properly. Rather than discontinue claims processing entirely, the Department chose to discontinue the duplicate check activity for a temporary period. Duplicate checking was reinitiated several months later and has continued uninterrupted since that time.

RECOMMENDATION NO. 2

Third party liability program improvements:

A. Approximately one year ago DPA introduced a combined application for food stamps and AFDC which collects information on third party medical resources for all AFDC applicants. However, the APA and medical assistance applications have not been revised in the same manner and therefore does not provide the same quality or amount of information. This is particularly a problem in the case of non-institutionalized APA cases. The new Medicaid staff manual with provider directions on Identification of third party resources in a manner not previously available to field staff. The APA and noncash assistance applications will be revised to conform to the Food Stamp-AFDC application at a future date.

B. The BAF manual provides instructions to field staff on the proper coding to create a record of eligibility for cash and medical assistance programs. Section 7002.2, items 24a and 24b were revised in November, 1979 to clarify what the medical eligibility and resource code means and how they are to be used. Because of the limitations of the present eligibility system used by DPA, the Office of Information Systems has informed us that they are unable to make any changes to the system. The revised BAF manual was an atempt to curtail the problem until a new eligibility system is installed. A new eligibility system is currently being developed via a consultant.

C. CSC is at this time sending monthly listings of all claims paid on which a trauma code was indicated. They have sent a similar report covering the period from July 1979 to the present.

D. We are aware of the potential that CSEA offers as a source of information on medical resources, and plan to pursue it at a later date. However the lack of staff to perform existing program functions makes it impossible for DPA to undertake the negotiations and planning necessary to develop an agreement between the two agencies in the near future.

E. Proposed statutory language on subrogation was considered for submittal to the Legislature during the 1981 session, but the proposal was not accepted. We agree that a subrogation law is a vital part of a third party recovery program and plans call for reconsideration of this proposal during the next legislative cycle.

RECOMMENDATION NO. 3

A. There is no complete medical history file:

Because the State did not contract with CSC for payment of all medical claims, some claims paid by the State are not included in the CSC data history file. As the CSC payment systems is scheduled for replacement in earl, 1982, the Department has to live with this situation until then. A major change to the CSC system at this stage of its life expectancy would not be cost-effective.

B. Reports from history files do not meet user needs:

We disagree with this finding at this time. The user reports have been implemented for Quality Control, Collections,, Fraud Investigation as well as various management reports that provide minimal but at least some assistance.

RECOMMENDATION NO. 4

A. The "buy-in" period has just been reopened with the passages of P.L. 96-599. The Department intends to make a decision on this issue during 1981.

RECOMMENDAION NO. 5

A. We strongly agree with your re' mendation. In fact, the Department has introduced State Medicaid regul..ions in August, 1979 which required all skilled Nursing Facilities participating in Medicaid to also participate in Medicare. (See TAAC43.170(1)(A)). This was done to increase third party receipts from Medicare and thereoy reduce costs assessed to Medicaid for nursing home care. It was also done to try to assure that SNF beds are available in Alaska to non-Medicaid individuals with Medicare coverage, rather than being forced to remain in hospitals at a considerably additional expense or having to leave the state for the services. It should be noted that only six of the state's telve nursing homes may receive Medicarre reimbursement, since Medicare coverage is restricted to facilities offering skilled nursing care (SNFO). Additionally, Medicare reimbursement has proven extremely difficult for the nursing homes to recover for seemingly eligible SNF patients. Nakoyia has put considerable effort into its Medicare collections effort and has earned less than 5% of their overall revenue from this source. Alaska is not alone in this regard. In P.L. 97-499, Congr ss required the Secretary of Health and Human Services to look into the question of requiring dual participation and report back within one year.

Sincerely,

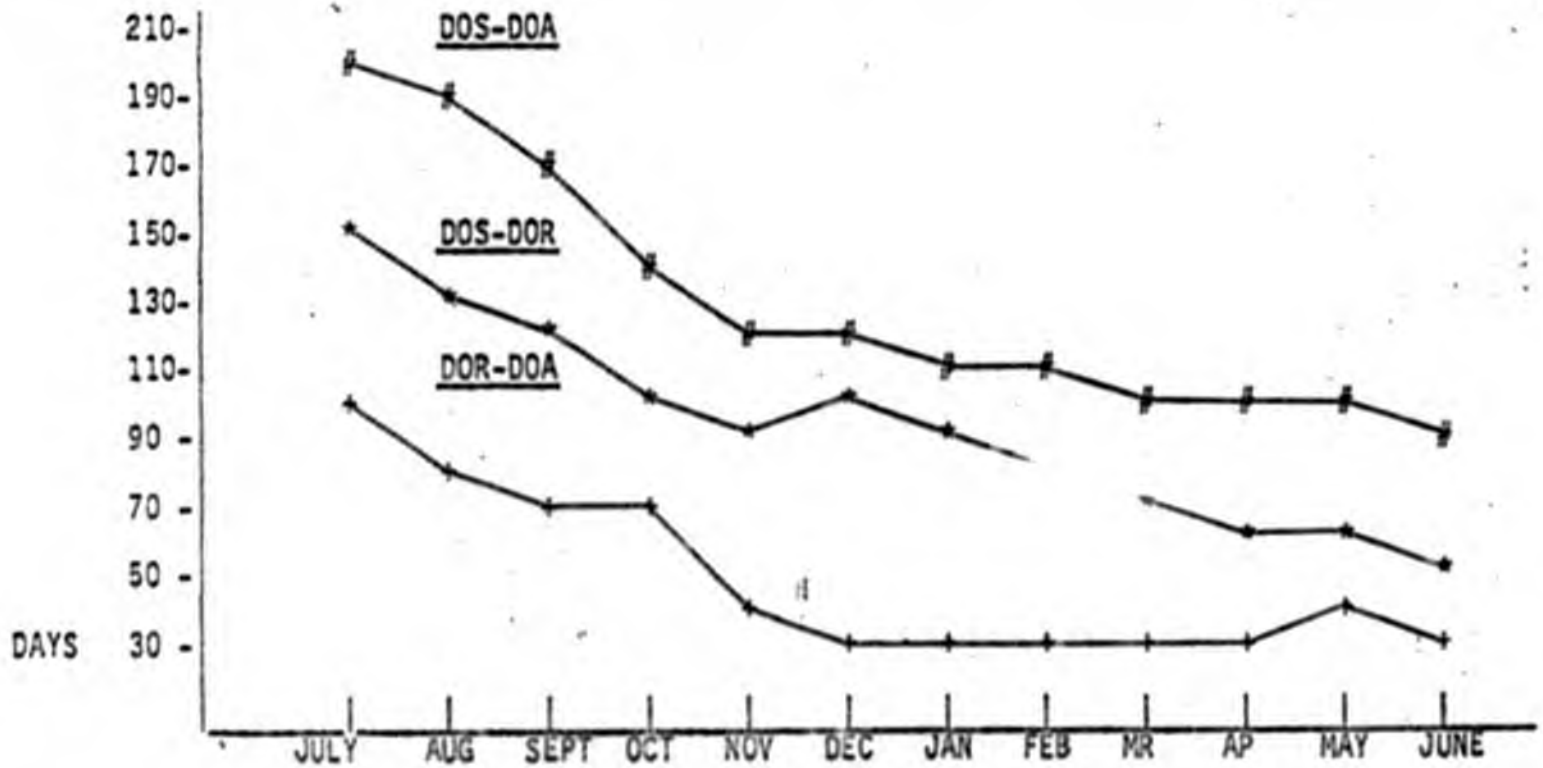
Helen D. Beirne
Commissioner

FY 80

CSC ANALYSIS OF CLAIMS PROCESSING

DATE OF SERVICE-TO-DATE OF RECEIPT-TO-DATE OF ADJUDICATION

AVERAGE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MR	AP	MAY	JUNE
# OF CLAIMS	5331	6570	7232	10974	10519	9291	11141	11768	12387	12698	12195	10894
DATE OF SERVICE TO DATE OF RECEIPT	150	136	125	109	95	100	97	79	71	66	57	54
DATE OF RECEIPT TO DATE OF ADJUDICATION	100	79	71	67	45	28	26	28	31	34	45	31
DATE OF SERVICE TO DATE OF ADJUDICATION	205	194	173	141	123	124	113	107	101	99	102	85



HEALTH CARE FINANCING AMENDMENTS OF 1981 - MEDICAID

1. Limit Federal contributions to Medicaid to $16.4 billion ($100 million less than 1981) allowed to rise with the rate of inflation as measured by the GNP inflator.

2. All Federal requirements for eligibility and benefits for the Medically Needy are eliminated.

3. End AFDC coverage for the 18-20 year olds. Also eliminate the requirements for medicaid coverage to continue four months after AFDC termination.

4. Repeal "freedom of choice" requirements that beneficiaries can choose their own providers.

5. Eliminate Federal requirements for the amount and methods of reimbursement of providers.

6. Eliminate specific methods of utilization and control, effective PSRO's will be funded until 1983. States will establish their own requirements and contract for review.

7. Permit coverage of approved non-medical coverage to prevent institutionalization.

8. The Secretary will provide waivers to states for other provisions:
   a. That all provisions be in effect state-wide.
   b. Cooperative agreements with state health and Vocational Rehabilitation.
   c. Requirements for review of nursing home patients.
   d. Licensing of nursing home administrators.
   e. Prohibitions of co-payments by the categorically needy for outpatient hospital and emergency room services.
   f. Requirements which prevent states from sharing savings with recipients of cost effective care.

9. Repeal Early Periodic Screening notification of AFDC children.

10. Eligibility of non-U.S. citizens take in the income of their sponsors

11. Civil penalties to punish fraud, providers will be fined up to $2,000 and twice the amount of the fraudulent claim.

12. Higher Federal matching for automated eligibility systems. Match state expenditures 90% for system development and 75% for operation.

13. Immediate return of Federal "disallow" funds pending appeal of state claim.

AFDC ADMINISTRATION PROPOSALS FOR 1982

1. Income ceiling at 150% of state standard of need.

2. Dependent children defined to the age of 18.

3. No AFDC to workers on strike.

4. AFDC to pregnant women only in the third trimester.

5. Standardize allowable resources.

6. Count lump-sum income onlyin the month received.

7. Count income of step-parents and other unrelated adults living in the home.

8. Count sponsor's income for aliens.

9. Consider food stamps and housing subsidies as income.

10. Standardize work related income($75/mo.) and child care($50/mo.) 'Income Disregard" of $30 + one third discontinues after 4 months of employment.

11. States required to establish community work experience programs:
    a. Age 16-65 unless in high school, disabled or caring for small children.
    b. divide family AFDC + Food Stamps by minimum wage tc determine the number of hours required to work.
    c. Those attending college required to meet work requirements.

12. Improve Administration:
    a. Prompt correction of over/under payments.
    b. eliminate payments under $10.
    c. Liens on AFDC homes.
    d. AFDC payments based on previous month.
    e. More vendor payments for AFDC.
    f. Information access to government agencies on AFDC cases.
    g. Establish Government recipient information system
    h. State training match 50%

ADMINISTRATIVE PROPOSALS FOR LEGISLATIVE CHANGES TO TITLE II (CSEA)

1. CSEA collects alimony and child support payments.

2. The IRS will collect alimony and child support payments from administrative orders.

3. Repeal bankruptcy declaration to avoid the payment of child support.

4. Charge 10% of support collected for administrative costs.

5. Federal payments to states for AFDC reduced from 15% to 7½%.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

JAY S. HAMMOND, GOVERNOR

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

Document# 125-81

May 6, 1981

The Honorable Charles Parr
Alaska State Senate
Pouch V, State Capitol
Juneau, AK 99811

Dear Senator Parr:

Recently you requested information regarding the status of Delta Dental's Medicaid contract with this Department. Our Director of the Division of Public Assistance has prepared a short briefing paper on this issue which we thought would be of interest to you.

If you have further questions, please do not hesitate to contact me at 465-3030 or Rod Betit, the Director of Division of Public Assistance at 465-3347.

Sincerely,

Helen D. Beirne
Commissioner

Enclosure

DELTA DENTAL CONTRACT

The Department of Health and Social Services currently has a Medicaid/GR Medical Claims processing system wherein responsibility is shared between three parties:

* Computer Science Corporation of Sacramento, California
* Delta Dental Plan of Anchorage, Alaska
* Alaska Division of Public Assistance

Currently, Delta Dental processes all dental billings submitted to the Department's Medicaid and General Relief Medical programs while all other types of claims are processed by Computer Science Corporation (CSC) and the Division of Public Assistance. This current system was designed as an interim solution to claims processing until such time that the Department could develop and install a more efficient claims system for the long term. The Department is presently nearing completion of the general design for this permanent claims system, scheduled for actual implementation in October 1982.

One of the issues facing the Department relative to design of this permanent system was whether to consolidate all claims processing under one contractor, or to continue processing dental claims under separate contract beginning in October 1982. Under either approach the contracts will be awarded on a competitive basis and will require state as well as federal approval of the procurement procedures used.

The Department has decided to release two Request for Proposals (RFP), one for design of a permanent claims processing system for all claims except dental, and one solely for processing of dental claims as is currently the arrangement with Delta Dental of Alaska.

Although this approach will permit Delta Dental to compete effectively for continued processing of dental claims for Medicaid and General Relief Medical beneficiaries after October 1982, it by no means guarantees that Delta Dental will ultimately be selected as the dental claim vendor. This decision will be made based on which vendor submits the lowest price for an acceptable system. It is fully expected that Delta Dental of Alaska will be competing for this contract against some of the largest private firms in the business including Computer Science Corporation, Blue Cross, Electronic Datal Federal System, The Computer Company and Bradford National. Delta Dental will receive a 5% edge over some of these firms since it is an Alaska based business.

It should be noted that the Department has been satisfied with Delta Dental's contract performance to date, and that we intend to continue our current arrangement through September 1982. After that date, however, the Department must operate through the vendor submitting the best technical and cost proposals for the development, installation and operation of the dental claims system over a five year period.

Prepared by:
Division of Public Assistance
Department of Health & Social Services
May 4, 1981

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC ASSISTANCE

POUCH H-07
JUNEAU, ALASKA 99811

November 28, 1980

Senator Charles Parr
S.R. Box 50599
Fairbanks, Alaska 99701

Dear Senator Parr:

On December 12 and 13, 1980, in Anchorage, at the Sheraton Hotel, the Medical Care Advisory Committee will be meeting to review the current operation of the Medicaid program and its future development.

As you may or may not know, this committee is an advisory group to the Commissioner of the Department of Health and Social Services on topics relating to the Medicaid program. I have attached a copy of our agenda in hopes that you will consider attending. I have also enclosed a list of the committee members in case you wish to contact any of them directly.

We would of course be happy to have you attend and participate in the discussions the committee has regarding the over-all operation of Medicaid.

Sincerely,

J. Ray Langdon

J. Ray Langdon, M.D.
Chairman

Enclosure

cc: Helen Bierne
Allen Korhonen
Rod Betit
Bob Ogden

Medical Care Advisory Committee

AGENDA

12/1213/80
Sheraton Hotel

December 12th

9:00 a.m.	Approval of minutes - meeting August 11 & 12, 1980
9:15 a.m.	Review of M.C.A.C. budget as developed by Division of Public Assistance
9:45 a.m.	Development of Alaska Statutory authority for existance of Medical Care Advisory Committee
10:30 a.m.	Break
10:45 a.m.	Development of an E.P.S.D.T. sub-committee
12:00	Lunch
1:00 p.m.	Report on the status of the Medical Health Care Project
2:00 p.m.	Report of the Long Term Care sub-committee
3:00 p.m.	Persons to be heard.

December 13th

9:00 a.m.	Medicaid Operational Review (1) Current claims payment status (2) FY 1979 Reconciliation Project (3) FY 1980 Reconciliation Project (4) Development of permanent claims payment and management reporting system.
10:30 a.m.	Break
10:45 a.m.	Report by David Johnson, M.D. regarding physician pricing issues surfaced during recent visit to Washington D.C.
12:00	Lunch
1:00 p.m.	Usual and customary rates for physicians services under General Relief Medical
2:00 p.m.	Review of Medical Review Section and it's location
3:00 p.m.	Development of Provider Relations Seminars

MEDICAL CARE ADVISORY COMMITTEE

Member & Address	Period of Term
Chairman Dr. J. Ray Langdon 3401 East 42nd Ave. Anchorage, Alaska 99504	June 30, 1980 - 1981
Mr. David L. Swanson P.O. Box 1 Fairbanks, Alaska 99701	June 30, 1980 - 1982
Dr. David E. Johnson 3612 Tongass Ave. Ketchikan, Alaska 99901	June 30, 1980 - 1983
Denise Knapp Delta Dental P.O. Box 3-726 Anchorage, Alaska 99501	June 30, 1980 - 1983
Sister Barbara Haase Administrator Ketchikan General Hospital 3100 Tongass Ave. Ketchikan, Alaska 99901	June 30, 1980 - 1982
Dr. Dave Spence Chief Section of Family Health Division of Public Health Pouch H-06B Juneau, Alaska 99811	June 30, 1980 - 1981
Mrs. Norma Lundy 6 - 520 "H" Street Elmendorf AFB, Alaska 99503	June 30, 1980 - 1982
Principle Division Representative Rod Betit Division of Public Assistance Pouch H-07 Juneau, Alaska 99811	

POSITION PAPER

COMMITTEE SUBSTITUTE FOR HOUSE BILL NO. 330 (Finance) am

For an Act entitled: "An Act relating to payment of the cost of care of pregnant women; and providing an effective date".

CSHB No. 330 provides for the expansion of pregnancy-related health and social services.

a) Section 2 expands the Medicaid Program coverage of medical care services to certain women, who have countable incomes of less than $457 a month; are single, or separated from their spouses; and have no other dependent children living in the home. The provision of the medical services will be financed on a 50/50 matching basis with state and federal revenues.

b) Section 3 of this Act authorizes state funding of the cost of non-medical services for pregnant women experiencing social and economic difficulties during the prenatal and postpartum periods. These services are to include the cost of birthing centers and midwife services, adoption assistance, counseling, transportation, care received in maternity and foster homes, and training in parenting skills.

DISCUSSION

Current Services

The Department of Health and Social Services is one of multiple private and public resources providing pregnancy-related services to Alaskan women. The Department takes an active role in assuring that public health nursing and social services are available throughout the State.

1) The Division of Family and Youth Services provides adoption placement and family counseling for Alaskans.

2) The Division of Public Assistance provides financial, food and medical assistance for low income women through the Aid to Families with Dependent Children, Food Stamp, Medicaid, General Relief Medical and Adult Public Assistance programs.

3) The Division of Public Health provid health care screening, including pregnancy testing and prenatal counseling, education, referral and follow-up through the activities of Public Health Nurses. Nutrition supplement and education is offered to low income pregnant women and their children in 26 communities by the Women, Infant and Children Program. In addition, the Division also sponsors medical care financing for low income and medically high risk women through demonstration projects in Juneau and Fairbanks.

Gaps in Services

Although the Department offers a wide range of public services, many women experience difficulties and hardships in obtaining timely and adequate pregnancy care. These difficulties are associated with economic barriers to private care and the unavailability of many services in rural communities. These gaps in pregnancy related services may be summarized as:

(1) Financial inability of many low income and adolescent women to purchase medical care from private providers, and to pay for travel outside of their communities for medically necessary care.

(2) Fragmentation of the pregnancy care delivery system, that inhibits provision of education, counseling, referral, medical and follow-up services required by many women.

(3) Unavailability of many pregnancy-related services in rural communities.

(4) Lack of appropriate housing near major medical centers, where women from rural communities may stay while obtaining outpatient maternal care services.

(5) Insufficient adoption counseling and placement services.

CSHB No. 330 addresses some of the gaps that occur in the delivery of prenatal care. Section 2 offers medical care coverage to single or separated, low income women who have no dependents living in the home. This Act will effectively provide medical care to certain women (approximately 286), who have not been Medicaid eligible. The state previously had this unborn child coverage in the Medicaid Program, but the legislature eliminated it in 1976 for budgetary reasons.

Section 3 of this Act will expand the types of social and other non-medical services available to maternal clients beyond the present scope of State sponsored activities. The services offered will include birthing center and midwife services, counseling, round trip transportation between a client's residence and maternity or foster home, adoption assistance and training parenting skills to potentially all women experiencing social and economic difficulties associated with childbearing. It is anticipated that provision of maternity and foster home care will be administered through contract arrangements with community based services by the Division of Family and Youth Services.

While Section 3 offers fairly comprehensive social and other non-medical support services, there will continue to be gaps in the medical care services. Many women with countable annual incomes exceeding approximately $5,500 do not qualify for medical assistance. These women often experience more difficulties in purchasing medical care than those who are eligible for public assistance.

In some cases women who are receiving the social and other non-medical services provided by this Act, will continue to be ineligible for medical care assistance that is necessary for a successful pregnancy outcome.

POSITION PAPER/Department of Health & Social Services

RECOMMENDATIONS

Recommendation A:

This Act offers transportation, counseling, adoption assistance and maternity or foster home care to women experiencing economic and social difficulties associated with childbearing. The Bill at the present time does not include specific definitions of "economic and social difficulties associated with childbearing", but allows the department to adopt regulations to define those terms. As part of the adoption of regulations process, we intend to conduct public hearings to assist us in formulating appropriate standards on which to determine eligibility for such aid. At this point, it is perceived that we would draft proposed regulations which would define (1) economic need to be up to 200% of the Federal Community Services Administration's Alaska Non-Farm Poverty Guideline (attached), and (2) social need to include pregnant women who are at risk of being unemployed or under employed, dependent upon welfare, inadequately educated, unable to function socially or having psychiatric problems.

Recommendation B:

Section 3 provides for social and other non-medical services associated with the prenatal and postpartum periods of pregnancy. The House in passing CSHB 330 added a floor amendment to this Section which would cover the cost of midwife and birthing center care. Since these services are primarily associated with medical care, we recommend that CSHB 330 be amended to reflect the medical care status of these services. These amendments would add medicaid coverage for certain needy women for care received from a birthing center or a nurse midwife. By adding these services to medicaid, the state would realize additional federal funds for covering medical care services. To incorporate nurse midwife and birthing center services into the medicaid, the Department recommends the attached amendments.

POSITION

The Department recognizes the value of the needed services that will become available to certain women. We endorse the health promotion concepts of this Bill and feel that it will contribute to the comprehensiveness of pregnancy related services throughout Alaska.

Recommended by: _____
John Pugh, Director
Division of Family and Youth Services

Date: 5/18/81

POSITION PAPER/Department of Health & Social Services

Rod Betit

Rod Betit, Director
Division of Public Assistance

Date: May 18, 1981

David Bruce

David Bruce, Deputy Director
Division of Public Health

Date: May 15, 1981

Approved by: Helen D. Beirne

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

Date: 5/18/81

Community Services Administration
Non-Farm Poverty Income Levels for Alaska

March 5, 1981

Size of Family	Poverty Income	200% Poverty Income
1	$5,410	$10,810
2	7,130	14,260
3	8,850	17,700
4	10,570	21,140
5	12,290	24,580
6	14,010	28,020

Original sponsors: Miller, Martin, Carney, et al

Offered: 4/30/81
Referred: Rules

IN THE HOUSE

BY THE FINANCE COMMITTEE

CS FOR HOUSE BILL NO. 330 (Finance) am
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE - FIRST SESSION
A BILL

For an Act entitled: "An Act relating to payment of the costs of services for pregnant women; and providing for an effective date."

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

*Section 1. LEGISLATIVE FINDINGS AND PURPOSE. The legislature finds that there are insuffi ient maternal and infant care services available to women experiencing so l and economic difficulties associated with childbearing. As a result of these inadequate services, some children may develop health conditions that require state-supported services throughout their lives. In order to promote healthier generations of Alaskan, the legislature wishes to invest in the state's future by providing prenatal care and social services to pregnant women.

*Sec. 2. AS 47.07.020(b) is amended by adding a new paragraph to read:

(8) women who are medically confirmed to be pregnant.

*Sec. 3. AS 47.07.030 is amended to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing hom , physician, home health care services early periodic screening and diagnosis and treatment of persons under 21 years of age, clinic services, <u>nurse midwife</u> treatment of speech, hearing and language disorders, and reasonable transportation to and from the point of medical care. No additional services may be provided unless approved by the legislature.

*Sec. 4. AS 47.07.080(4) is amended to read:

(4) "Clinic services" means services which are restricted state-approved outpatient community mental health services which receive grants under AS 47.30.520 - 47.30.620 and state-operated mental health clinics and birth centers licensed by the state under AS 18.20.010 - 18.20.130

*Sec. 5. AS 47.07.080 is amended by adding a new subsection to read:

(5) "Nurse midwife" means a registered professional nurse who is certified as an advanced nurse practitioner under AS 08.68.410 (a) and authorized to practice as a nurse midwife under regulations adopted in accordance with AS 06.68.410(5).

*Sec. 6. AS 47 is amended by adding a new chapter to read:

CHAPTER 42. PURCHASE OF SERVICES FOR PREGNANT WOMEN.

Sec. 47.42.010. PURCHASE OF SERVICES FOR PREGNANT WOMEN. The Department of Health and Social Services shall pay the cost of prenatal services other than medical services for a pregnant woman experiencing social and economic difficulties, [INCLUDING THE COSTS OF BIRTHING CENTERS, MIDWIFE SERVICES] and transportation to and from a maternity home or a foster home, counseling, adoption assistance, maternity home and foster home care, postnatal care, and parenting skills.

Sec. 47.42.020. LICENSING AND SUPERVISION. (a) A person providing services purchased by the Department of Health and Social Services under this chapter shall be licensed and supervised in the same manner as foster homes, boarding homes, maternity homes, and other agencies and institutions under AS 47.35.010 - 47.35.100.

(b) Nothing in this section requires the licensing of [MIDWIFE AND] transportation services provided to a pregnant woman under this chapter.

*Sec. 7. This Act takes effect immediately in accordance with AS 01.10.070(c).

TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. CS FOR HOUSE BILL NO. 330 (Finance) am
Title "An Act relating to payment of the cost of care for pregnant women"
Requested by House HESS Committee Date May/8, 1981

II. FISCAL DETAIL
Agency Affected Department of Health and Social Services
Program Category Affected Health & Social Services
BRU, Program, or Subprogram(s) Affected Various - See separate fiscal notes attached.
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100	PERSONAL SERVICES		40.7	44.4	48.4	52.7	57.4
200	TRAVEL		1.7	1.9	2.0	2.2	2.4
300	CONTRACTUAL		4.8	5.2	5.7	6.2	6.8
400	COMMODITIES		.4	.4	.5	.5	.6
500	EQUIPMENT		1.2				
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.		2,584.1	2,816.6	3,070.2	3,345.5	3,647.7
	TOTAL		2,632.9	2,868.5	3,126.8	3,408.1	3,714.9

FUNDING (Thousands of Dollars)

GENERAL FUND	2,418.4	3,634.7	2,872.0	3,130.3	3,412.1	
FEDERAL FUNDS	214.5	233.8	254.8	277.8	302.8	
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME	1	1	1	1	1	
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Attached Social and Health Service Analysis.

IV. DATE May 7, 1981 PREPARED BY Dwayne Peeples
AGENCY Department of Health and Social Services
PHONE 465-3100

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named) M&B Approval [signature] Date 5/8/81

33-001 (Rev. 12/80)

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CS FOR HOUSE BILL NO. 330 (Finance) am

Title "An Act relating to payment of the costs of care for pregnant women...."

Requested by House HESS Committee Date May 18, 1981

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services

Program Category Affected Social Services

BRU, Program, or Subprogram(s) Affected

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

		FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100	PERSONAL SERVICES		40.7	44.4	48.4	52.7	57.4
200	TRAVEL		1.7	1.9	2.0	2.2	2.4
300	CONTRACTUAL		4.8	5.2	5.7	6.2	6.8
400	COMMODITIES		.4	.4	.5	.5	.6
500	EQUIPMENT		1.2				
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.		2,155.1	2,349.0	2,560.5	2,790.9	3,042.1
	TOTAL		2,203.9	2,400.9	2,617.1	2,852.5	3,109.3

FUNDING (Thousands of Dollars)

GENERAL FUND		2,203.9	2,400.9	2,617.1	2,852.5	3,109.3
FEDERAL FUNDS		0	0	0	0	0
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		1	1	1	1	1
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

In 1979 there were 9,129 births to Alaskan residents. 1,273 or 14% were births to unmarried women.

1979 Births to Unmarried Women

Age of Mother	Number of Births
Under 15	9
15-19	440
20-24	504
25-29	224
30-34	76
35-39	16
40-44	4
	1,273

IV. DATE 5/18/81 PREPARED BY John R. Pugh, Director

AGENCY Division of Family and Youth Services

PHONE 465-3170

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (Final Legislative Version) M&B Approval Date 6/1/81

33-001 (Rev. 12/80

The Department assumes that the services delineated in this Bill would be utilized mostly by unmarried women. Using this pool as the target group the Department would further assume that the more youthful unmarried women (under 15-24) would be more likely to utilize maternity and foster home care; whereas the older group (25-44) would utilize the community services, such as counseling and adoption assistance.

The younger age group consists of 953 women. The Department estimates that approximately 200 of this group would avail themselves of the services of a maternity home or foster home (75 maternity and 125 foster), another 250 would utilize available counseling and adoption assistance, and 30 would use birthing centers and midwife services.

The older age group consists of 320 women. The Department estimates that approximately 50 women would utilize maternity homes or foster home care (15 maternity and 35 foster homes). An additional 100 would utilize counseling and adoption assistance. The Department estimates 20 would use birthing centers and midwife services.

The Department recommends that the entire range of services be contracted out to local community providers. This would reduce the amount of administrative costs. However, it is recommended that an Associate Coordinator (Range 18) be established to coordinate the program on a statewide basis. This individual would be responsible for planning, program development, preparation of requests for proposals and contracts, and contract monitoring and program evaluation.

Estimated costs are as follows:

Foster Home Care		
160 persons x $422/mo. x 6 mos. =		$ 405,120
Maternity Home Care		
90 persons x $2,250 ($75.00 per day) x 6 mos. =		$1,215,000
Counseling/Adoption Assistance		
350 persons x $1,000 =		$ 350,000
Transportation To and From Placement		
250 persons x $500 average/trip =		$ 125,000
Birthing Centers and Midwife Services		
50 persons x $1,200 =		$ 60,000
	Subtotal	$2,155,120
Associate Coordinator, Range 18		
Personal Services	$40,665	
Travel	1,728	
Contractual	4,798	
Commodities	400	
Equipment	1,230	$ 48,821
	TOTAL	$2,203,941

The costs for Associate Coordinator position includes: Travel - two trips of three day each to perform program reviews; Contractual - telephone rental and long distance of $678, postage of $300, copier usage of $120, printing and advertising of $1,000, and office space rent of $2,700; Commodities - $400 for general office supplies; and Equipment - $1,230.

A 9% inflation rate has been added to future years' estimated costs.

Medical costs will be borne by the Division of Public Assistance.

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CS FOR HOUSE BILL NO. 330 (Finance)am

Title "An Act relating to payment of the costs of care of pregnant women..."

Requested by House HESS Committee Date 5/7/81

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services

Program Category Affected Health

BRU, Program, or Subprogram(s) Affected Medicaid

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
70 GRANTS, CLAIMS, ETC.		429.0	467.6	509.7	555.6	605.6
TOTAL		429.0	467.6	509.7	555.6	605.6

FUNDING (Thousands of Dollars)

GENERAL FUND		214.5	233.8	254.9	277.8	302.8
FEDERAL FUNDS		214.5	233.8	254.8	277.8	302.8
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Approximately 286 pregnant women would be added to the Medicaid program. The addition of this coverage under Medicaid would reduce participation under the General Relief Medical program by approximately 95 women, who would become eligible for Medicaid. The remaining 191 women would be new eligibles who do not receive coverage under the General Relief Medical program because of the method used in counting available income.

The average cost per case is approximately $1500 for FY 82. Because of the reduction in General Relief Medical participation, the cost of the program will also be reduced, making funds available to become the state General Fund matching portion of the Medicaid program coverage. Therefore, new state General Fund matching is 72.0 (214.5 - 142.5 = 72.0).

IV. DATE 5/7/81 PREPARED BY David M. Davidson

AGENCY Division of Public Assistance

PHONE 465-3347

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named) M&B Approval Date 5/7/81

33-001 (Rev. 12/80)

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CS FOR HOUSE BILL NO. 330 (Finance) am

Title "An Act relating to payment of the costs of care of pregnant women..."

Requested by House HESS Committee Date 5/7/81

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services

Program Category Affected Health

BRU, Program, or Subprogram(s) Affected General Relief Medical

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		(142.5)	(155.3)	(169.3)	(184.5)	(201.1)
TOTAL		(142.5)	(155.3)	(169.3)	(184.5)	(201.1)

FUNDING (Thousands of Dollars)

GENERAL FUND		(142.5)	(155.3)	(169.3)	(184.5)	(201.1)
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

IV. DATE 5/7/81 PREPARED BY David M. Davidson

AGENCY Division of Public Assistance

PHONE 465-3347

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named) MSB Approval [signature] Date 5/7/81

33-001 (Rev. 12/80)

Pregnancy Related Health and Social Services

Service Agencies	Eligibility Requirments	Services	Population Served	Service Gaps
Maternal & Infant Care Project - Juneau	pregnant women who resides in the Juneau City and Borough	a. education, and counseling available to all	approx. 125 per year	Limitation of financial assistance to only those women in target area. All other low income women experience difficulties in obtaining care.
	high risk conditions of pregnancy and low income (up to $12,500 for a family of 2) in the city care	b. medical care assistance provided according to a family's ability to pay based on a sliding fee scale	approx. 70 per year	
Improved Pregnancy Outcome Project - Fairbanks	pregnant women who reside in the Fairbanks Borough	a. education counseling, and patient follow-up to all	approx. 250 per year	
	pregnant and low income women (up to $12,500 for a family of 2)	b. Medical care assistance for initial prenatal physician visit. The amount of assistance is provided according to a family's ability to pay based on a sliding fee scale.		Prenatal medical care assistance not available to low income women who are not medically high risk. No inpatient medical care assistance is provided.
	high risk medical conditions of pregnancy and low income (up to $12,500 for a family of 2)	c. Medical care assistance for all outpatient prenatal medical care. The amount of assistance provided according to a family's ability to pay based on a sliding fee scale.	projected 70 per year	

Pregnancy Related Health and Social Services

Service Agencies	Eligibility Requirements	Services	Population Served	Service Gaps
. General Relief Medical	low income (Adult 1 child $4,000 per year) who are not eligible for Medicaid coverage	medical care assistance	approx. 7,000 per month	Those who fall marginally above the income guidelines are not eligible for assistance.
. Catastrophic Illness	those who have suffered a catastrophic illness/injury and who do not have the resources to meet the expenses	medical assistance as determined by a three member committee	approx. 300 per year	Doesn't cover normal pregnancies and limited to "catastrophic illness"
. Medicaid	must be covered by State and categorical programs such as AFDC or Adult Public Assistance	medical care assistance to those individuals eligible for categorical programs	approx. 18000 per month	Low income people not eligible for categorical programs experience difficulties in obtaining medical care.
. of Public Health				
. Public Health Nursing	None	health screening, including pregnancy testing, prenatal education and counseling, post-partum follow-up home visiting and well child clinics	approx. 4,000 visits per month	Lack of unified counseling education and referral services. The unavailability of some services on full-time basis in rural communities.
. Women Infant Children (WIC)	low income (family of 2, up to $12,500) pregnant women and children up to age 5	nutrition supplement coupons and nutrition education and counseling	approx. 1600 per month in 26 communities	Estimated 38000 potentially eligible statewide not being served
. Early, Periodic, Screening, Diagnosis and Treatment (EPSDT)	under 21 years of age, Medicaid eligible	preventive health screening services for children and adolescents, referral to treatment and medical care assistance through Medicaid	approx. 7,000 per year	Low income families who are not qualified for Medicaid do not receive medical treatment services.
. Handicapped Childrens Program	children with physical and handicapping conditions	Medical diagnostic assistance provided to all - medical treatment based upon a sliding fee scale - of a family's ability to pay. Transportation and per diem are also included.	approx. 1800 per year	Premature newborns are not covered by this program.

Pregnancy Related Health and Social Services

Service Agencies	Eligibility Requirements	Services	Population Served	Service Gaps
v. of Family & Youth Svs.				
1. Family Counseling	None	marriage, parenting, family adolescent, and crisis intervention counseling	approx. 1000 per year	Staff time available is limited.
2. Foster Home Care	State must have legal custody of client.	counseling, foster care placement, financial assistance, medical care through Medicaid	approx. 1040 per year	Insufficient foster homes.
3. Adoption Counseling & Placement	State must have legal custody of client to provide adoption placement services. Adoption counseling is available to anyone on request.	counseling, screening and placement	approx. 40 adoption placements per year	Additional counseling services needed.
v. of Public Assistance				
1. Food Stamps	low income ($6,300 for a family of 2)	Food supplement coupons	approx. 38000 per month	There are no regional adjustments cost of living. One income and benefits standard is used statewide which results in inequities of purchasing power.
2. Aid to Families with Dependent Children (AFDC)	low income women($5,500 per year for a family of 2) who are single or separated with dependent children living in the home	income maintenance and medical care assistance through Medicaid	approx. 13000 per month	Women who meet the income and single/separated status but are pregnant with no dependents living in the home are ineligible. Low income women who are married with the spouse living at home are ineligible.
3. Adult Public Assistance	blind, disabled and aged, with income of $5,700 per year for single adults	income maintenance, and medical assistance through Medicaid	approx. 5000 per month	Those blind, disabled and aged pe that are above the income guidelines

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

JAY S. HAMMOND, GOVERNOR

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

June 2, 1981

Document# 152-81

The Honorable Vic Fischer
Alaska State Senate
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Fischer:

Recently you requested information regarding the coverage of three major Alaska Area Native Health Service satellite clinics in Ketchikan, Juneau, and Fairbanks to bill for Medicaid-eligible services and the state to receive 100% federal reimbursement. Representative Clocksin's staff made a similar request, but indicated that they wished to have available to him more limited language to make that necessary statute adjustment. We have prepared a response to that request. We thought it might be of interest to you to see another more limited way to amend the statutes to accomplish the same goal. We have attached it for your reference.

You will not that our estimate of federal fiscal impact due to the passage of such a change to Medicaid has been revised downward from our previous figure. We currently estimate the costs to be about $750,000 to $1,000,000 in the first fiscal year of operation. This is due to the receipt of more current information from AANHS based on its actual billing history.

We appreciate the opportunity to comment on this matter.

Sincerely,

Helen D. Beirne

Helen D. Beirne
Commissioner

QUARTERLY REPORTS

Medicaid UTILIZATION MANAGEMENT PROGRAM

SECTION II

June 1981, No. 17

TABLE OF CONTENTS

A. ACTIVITIES OF THE OFFICE OF QUALITY CONTROL PROGRAMS

MEDICAID QUALITY CONTROL

Administrators of state Medicaid programs are challenged with developing and maintaining adequate management controls to assure the accurate and appropriate expenditure of Medicaid funds. The Medicaid Quality Control (MQC) program is a tool with which the states can monitor the strengths and weaknesses of their MMIS system, and more specifically, the accuracy of eligibility determinations/terminations and state payments/denials. The MQC program also assists in identifying areas requiring corrective action, as well as targeting liable third parties to recover incorrectly expended state funds.

Title XIX of the Social Security Act requires that the Department of Health and Human Services (DHHS) assure proper and efficient administration of the Medicaid program by the states. The MQC program under the direction of the Office of Quality Control Programs, Bureau of Quality Control (BQC) in HCFA, represents this joint state-federal effort to improve program administration, reduce errors and prevent monetary forfeiture. All states participating in the Medicaid program are required to have MQC systems in operation.

The MQC program was designed to identify case and payment errors so that corrective action can be undertaken to prevent repetition. Data collected through the system must be fully analyzed so that strengths and weaknesses can be recognized. Analysis is performed at three levels: state, regional and federal. States are required to investigate a statistically valid sample of eligible Medicaid beneficiaries' cases based on total monthly Medicaid caseload. Both the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) programs established their own individual quality control checks prior to the development of the MQC system. A determination is made as to whether the eligibility and payment status on these claims is accurate. Subsequently, HCFA staff review a representative sampling of these cases to evaluate state determinations. The MQC examiners utilize findings from the quality control systems of the other two programs to obtain information about those beneficiaries who are also covered by Medicaid. Through this integrated system, duplicative reviews are avoided and sample accuracy is increased.

The following fundamental elements are inspected by the MQC program:

- verification of the accuracy of eligibility determinations;
- examination to determine whether the state has taken action to recover monies for which other third parties are liable;
- examination of the accuracy of state payment of Medicaid claims for active cases;
- review of the accuracy of denials and terminations of eligibility; and
- examination of the types of services that may be covered and reimbursement levels.

These reviews are meant to assure that public funds are directed only to beneficiaries who are eligible under state and federal law, that claims are paid only for covered services to eligible providers in the correct amount, and that third party liability (TPL) is fully recognized, thereby assuring Medicaid as the payor of last resort (after other liable parties, such as Medicare, insurance companies, Workers' Compensation plans, absent fathers and estates of deceased persons, have paid their proper share of a beneficiary's medical expenses).

All quality control periods are conducted on six-month cycles from October to March and from April to September. States individually sample approximately 78,000 cases during each semi-annual period out of an estimated monthly list of 9.3 million cases in the Medicaid program. The HCFA staff re-examines approximately 16,000 of these cases to assure the accuracy of the states' findings. The results are then utilized in computing eligibility, claims processing (CP) and TPL error rates for every state for each six-month review period.

Under current regulations, states with error rates above the national average are required to reduce eligibility error rates by approximately 15.7 percent annually. The results of the base review period are compared with results of present periods to determine if states have met the required error rate reduction targets. Federal matching payments are disallowed if performance targets are not met. If this is the case, corrective actions are recommended.

By regulation, all states are required to submit a formal plan each July that specifies what actions are planned to correct problems uncovered through the MQC process. Most states initiate corrective action throughout the year, based on individual case findings or on a pattern of findings that are attributed to system defects. Both state and federal MQC staff participate in planning corrective action and some states and regional offices have established corrective action committees. Federal staff also provide on-site technical assistance to states requesting aid in reducing high error rates.

Medicaid Action Transmittal No. 80-67 (September 1980) clarified the following calendar dates for review completion and reporting deadlines:

1. States are required to report progress in completing their reviews via telephone on a bi-weekly basis.

2. On a monthly basis, states must identify the reviews they have completed and their findings for those cases in a written report.

3. Within eight months of the close of the sample period, states must submit eligibility, TPL and CP data. Therefore, the deadlines are May 31st for the April to September review period and November 30th for the October to March review period.

4. Within ten months of the completion of the April to

September sample period, (or by a deadline of July 31st) states must submit an annual corrective action plan for reducing their error rates. Similarly, January 31st is the deadline for the October to March sample period.

MQC began these reviews with the 1978 base-line period. The first three months of 1979 were set aside as a "grace period" in anticipation of the states' tightening up their programs. Therefore, the first actual review period began in April of 1979. Most states have made considerable improvements in determining Medicaid payments as shown with the following findings for the July to December 1978 and the April to September 1979 review periods:

- The national weighted average eligibility payment error rate (excluding SSI cases) decreased from 6.2 percent in the July to December 1978 base period to 4.9 percent in the April to September 1979 review period.

- The national weighted average eligibility payment error rate for all Medicaid cases decreased from 5.1 percent in the July to December 1978 base period to 4.33 percent in the April to September 1979 review period.

- The national weighted average eligibility payment error rate for Medical Assistance Only (MAO) cases decreased from 6.5 percent to 5.2 percent; for AFDC, decreased from 2.7 percent to 2.3 percent; and for SSI cases, increased from 1.7 percent to 2.1 percent.

- The national weighted average gross TPL payment error rates decreased from 0.5 percent to 0.3 percent and the case error rate decreased from 0.8 percent to 0.7 percent.

- The national weighted average CP gross and unduplicated payment error rates for the April to September 1979 review period was 0.5 percent.

- The deflated national CP payment error rate for the July to December 1978 review period was 1.6 percent (prior to revision of the CP review methodology), and the gross national payment error rate for the April to September 1979 review period was 0.5 percent.

- The total national weighted average gross payment error rate for the April to September 1979 review period was 5.1 percent and the unduplicated rate was 5.0 percent.

Many states are assessing this data in preparation for corrective action planning.

Approximately 1,000 state man-year equivalents consisting of supervisors, reviewers, statisticians, clericals and others comprise the MQC state work force. Over 600 of these state employees are reviewers. Staff turnover is high due to extensive travel requirements. At the federal regional level, there are 147 staff members working on the MQC program. In the central

office there are 29 MQC staff members. The cost of such staffing can be viewed as nominal in contrast with the benefits accrued by the review system in identifying problem areas and system defects, and ultimately recouping monies for which other third parties are liable. (For further cost-benefit information, see the Research Study on thirdy party recovery beginning on page 13 of this issue.)

Numerous clarifications and revisions of instructions and policies have been disseminated as a result of these findings to further assist state Medicaid administrators in utilising the MQC system to their benefit, i.e., calendar dates, to emphasize that reviews must be completed by the required dates, as previously cited.

- Certain specific data entries for complete conveyance of case information have been made optional for the states.
- Corresponding edits for MQC Review Schedule coding have been appended to the regulations.
- More efficient instructions for capturing TPL data have been established.
- A number of proposed editorial changes would facilitate reading of the regulations and are not intended to have any substantive effect on requirements.

These technical changes help to clarify the requirements of the MQC program, provide a better flow of information and promote more efficient management of the Medicaid program. The MQC system represents a systematic approach to monitoring the effectiveness and validity of the Medicaid program.

INTERVIEW WITH JOHN BERRY, DIRECTOR, OFFICE OF QUALITY CONTROL PROGRAMS

To further enhance the understanding of MQC program objectives and the implications of future MQC programs, an interview was recently conducted with Mr. John Berry, Director of the Office of Quality Control Programs. Mr. Berry has been with BQC for two years. Prior to that, he was employed in a variety of management assistance positions in a regional office and earlier with the Department of Defense.

The Office of Quality Control Programs performs the following functions:

- Designs and implements statistically-based reviews to determine the effectiveness of Quality Control Programs operated by carriers, intermediaries, state agencies, the Office of Direct Reimbursement and other related organizations.
- Develops and promulgates policies, standards and guidelines for state MQC programs, state utilization control programs, EPSDT penalty surveys, the Part A Quality Assurance Program, the Part B end-of-line review and other similar formal QC efforts.
- Designs and implements new QC programs (i.e., EPSDT QC) to

assure proper expenditures of federal funds by carriers, intermediaries, state agencies and other HCFA-related organizations.

- Initiates recommendations for financial penalties and disallowances on the basis of formal review results.

- Evaluates regional performance in monitoring QC programs and conducting sample reviews.

- Participates with other HCFA components in developing regulations, policies and procedures for program administration.

- Provides consultation and technical guidance to carriers, fiscal intermediaries, state agencies and regional offices.

QC programs presently in place consist of state MQC programs, the Part A Quality Assurance Program and the Part B end-of-line review. Two programs are presently under review, according to Mr. Berry. These are: the Negative Case Action QC program, which examines Medicaid beneficiaries incorrectly terminated or denied access to program benefits, and the Utilization Review QC program, which examines the decision to place and retain individuals in long-term care facilities. The former may be reduced due to staffing constraints and lack of management involvement; the latter is being reviewed for cost effectiveness.

The EPSDT QC program has been shifted to the Bureau of Program Operations (BPO). BQC ran the first quarter review and then transferred the responsibility to BPO to enhance efficiency. For provider information, Mr. Berry suggested contacting Mr. John Jansak, Director, Office of Standards and Performance Evaluations at (301) 594-8432.

The Cost Report Evaluation Program (CREP) is currently responsible for Medicare hospital cost reporting. This quality control program entails the evaluation of the correct allocation of hospital costs to the Medicare program. The rigorous review program is on its third year run, and HCFA is examining the feasibility of expanding the program to cover Medicaid. This information helps substantiate the costs associated with rendering quality care and can be used to more efficiently examine hospital reimbursement levels. HCFA is "not interested in a sanction right now, but dollars saved," according to Mr. Berry. A pilot program has been initiated this year involving 35 states with Medicaid programs. "Preliminary results will not be available until late this summer and final results early next year," claims Mr. Berry.

QC is one of HCFA's approaches to controlling Medicaid expenditures. According to Mr. Berry, the purpose of the MQC program is "to conserve program dollars for eligible beneficiaries. The QC program's success must be measured by improvements in the overall program." Mr. Berry feels the program is an "attention getter." The states have responsibility for the MQC program and "cooperate to upgrade ideas on how to solve problems." MQC performs top-down reviews,

beginning at the state level, in contrast with MARS and SURS (Validation Office), under which reviews are conducted upwardly, beginning with individual providers. MQC has provided additional input to the MARS reports, whereas MARS data is not a source of feedback for MQC evaluations.

According to Mr. Berry, MQC is attempting to reduce the burden on states while continuing to promote accurate and timely data. The findings for the October 1979 to March 1980 review period have recently been released. This latest published report calls for disallowance of federal funds incorrectly/inappropriately expended in 10 states, but this was suspended in favor of taking corrective action.

State error rates have been found to be inconsistent between review periods. HCFA is looking to reduce samplings where error rates are low and increase samplings where state error rates are high due to a shortage of program funds.

MQC review has been used to encourage the development of the Medicaid Management Information System (MMIS). MQC will become an important tool in examining MMIS contract performance and in expediting evaluation, according to Mr. Berry. As an example, the federal MQC CP review uncovered substantial Medicaid funds that were not being reviewed by a particular state, as well as a major flaw in the contractual relationship between that state and its fiscal agent. The state is renegotiating the terms of the contract to correct these problems.

Federal and state budgets for medical services to the indigent face many constraints. Some states are electing to decrease their benefit packages. "Every state has a different view of the Medicaid program," claims Mr. Berry. MQC efforts can assure that available services are rendered to appropriate beneficiaries. MQC, in its conservation of funds for eligible beneficiaries, has become a vital part of Medicaid management. The most significant contribution to the quality control effort during the 1980's will be the capacity to provide analysis of error-causing factors for managers, as well as to facilitate corrective action, according to Mr. Berry. Through quality control, the Medicaid program will reveal flaws in policy and procedures at the federal and state levels.

The chart on the following page illustrates the MQC process.

B. LEGISLATIVE AND REGULATORY UPDATE

MEDICAID CAP

In recommendations to the House Budget Committee, the House Committee on Energy and Commerce strongly opposed the administration's attempt to use the budget process in effecting major Medicaid program changes. Now that the Administration's budget has been approved, both the House and Senate must determine how and where specific program cuts will be made in order to meet overall budget objectives. For further information, contact Jack McDonald, House Budget Committee, (202) 225-7290.