

ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672

1420 SHESS MEDICAID - DAY CARE : CORRESPONDENCE

MEDICAID ELIGIBILITY

A bill has been introduced (S.667) by Senator Alan Cranston (D-Ca.) to amend the Social Security Act, extending Medicaid eligibility to low-income pregnant women and newborn children under specific circumstances. Considering proposed federal expenditures, this places a further burden on tight state finances, particularly because no incentives have been developed to encourage the expectant mother to apply to the local welfare office for medical assistance for her unborn child. For further information, contact Senator Cranston's office, (202) 224-3553.

TERMINATION OF ELIGIBILITY

Representative Richard Shelby (D-Ala.) has introduced H.R.2423 that would amend Title XIX of the Social Security Act to permit states to terminate Medicaid eligibility for up to one year for program abusers. For further information, contact Rep. Shelby's office, (202) 225-2665.

ASSETS UTILIZED IN DETERMINING SSI

P.L. 96-611 requires that any possessions transferred within a prior twenty-four month period by parties being considered for SSI eligibility be computed as assets. The proposed rule for Medicaid eligibility, which appeared in the Federal Register in April 1981 is currently going through the requisite comment period. States have the option of establishing their own regulations concerning these assets when determining Medicaid eligibility, providing

they are not more restrictive than those governing SSI eligibility. For further information, contact Richard Cody, Acting Director, Division of Medicaid Eligibility Policy, Bureau of Program Policy, HCFA, (301) 594-9050.

BLIND OR DISABLED INDIVIDUALS RECEIVING SSI

Effective January 1, 1981, Section 201 of P.L.96-265 provides that under certain conditions severely impaired blind or disabled individuals be eligible for SSI benefits even if their income exceeds the income limits. States have the option of augmenting these benefits. States are expected to obtain updated TPL information from these individuals or their employers. HCFA will be responsible for making available to SSA information concerning the initial and updated threshold amount figures for Medicaid. Eligibility for this special SSI status will be re-evaluated at least annually. For further information, contact Richard Cody, HCFA, (301) 594-9050.

NURSING HOME RESIDENTS

A bill has been introduced (H.R. 2421) by Rep. Richard Shelby (D-Ala.) to permit relatives of Medicaid eligible nursing home residents to make payments to a state fund for services rendered. For further information, contact Rep. Shelby's office, (202) 225-2665.

REIMBURSEMENT FOR NURSING HOMES

Section 962 of P.L.96-491 has deleted Medicaid reimbursement for nursing homes on a reasonable cost-related basis. The substituted

requirement specifies that nursing home rates meet the costs of "efficiently and economically operated homes" according to applicable federal and state standards.

HOME HEALTH CARE SERVICES

A bill has been introduced (H.R.2414) by Rep. Guy Molinari (R-N.Y.) to encourage the establishment of home health care programs and to amend the Social Security Act to provide expanded coverage of home health care services under Medicaid and Medicare. The Senate Committee on Labor and Human Resources has held hearings on the legislation. The Committee plans to hold further hearings in June and to begin mark-up in the fall. For further information, contact Rep. Molinari, (202) 225-3371.

CERTIFICATE OF NEED

P.L.96-538 provides for a one year extension for states to bring their certificate of need laws into compliance with federal requirements established by the Health Planning Amendments of 1979. The effective compliance date is one year from the start date of each state's 1981 legislative session.

MEDICARE DEDUCTIBLE

A bill has been introduced (H.R.2223) by Rep. C.W. Bill Young (R-Fla.) which would amend the Social Security Act to reduce the Medicare inpatient hospital deductible to its 1978 level. The bill was referred to the Ways and Means Committee. If this bill passes, state Medicaid agencies would be responsible for a larger portion of hospital bills for

Medicaid recipients who are also Medicare beneficiaries. For further information, contact Rep. Young, (202) 225-5961.

CERTIFICATION FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

42 CFR 442.115 has been amended to authorize a state survey agency, in specified circumstances, to certify intermediate care facilities for the mentally retarded in those cases where the facility has not met the July 18, 1980 compliance deadline. Plans to correct deficiencies must be completed by July 18, 1982. Extensions will be granted beyond the deadline where, under limited circumstances, litigation has caused delay. For further information, contact Dr. Wayne Smith, Health Standards and Quality Bureau, HCFA, (301) 594-7651.

PREPARATION OF THE QUARTERLY REPORT OF ABORTIONS

Reporting requirements have been established for the preparation of the quarterly report of abortions for the Medicaid program (Sections 1903a5 and 1905a4c of the Social Security Act). For the quarter ending December 31, 1980, and all subsequent quarters until superseded, the revised form HCFA 74.9b is the abortion reporting document to be completed by the states. The submission of these forms will be thirty days after the conclusion of each quarter (i.e., April 30, July 30, October 30 and January 30).

All abortions performed between September 20, 1980 and December 31, 1980, meeting Hyde Amendment criteria should appear in section A of the report with an appropriate

explanation. Those abortions not meeting Hyde Amendment criteria are not allowable for federal funding and should not be included in the report. Appropriate revisions should be reported on current submissions if any incorrect expenditures or number of abortions were included on reports already submitted.

C. NEWS

INFLATION AND HEALTH CARE COSTS

Controlling Medicaid costs will be the predominant health care issue facing most of the states in 1981. Many states are reporting significant budget problems with their Medicaid programs, finding it necessary to consider Medicaid eligibility and services limitations.

Additionally, President Reagan has proposed to cap federal funding of the Medicaid program and to decentralize welfare responsibility, thereby forcing states to reassess health care benefits for their indigent population. The nation's governors are strenuously opposed to Reagan's proposal, believing that Medicaid should remain largely a federal responsibility.

State budget forecasts reflect the seriousness of the current fiscal situation. Massachusetts wants to cut more than \$200 million from its program. New Jersey, Maryland, and Tennessee would like to cut \$50 million from each of their programs. Virginia is facing a \$27 million deficit, California's shortage could reach \$800 million, Wisconsin will need \$174 million over the next two years and the District of Columbia will have a deficit of up to \$20 million.

Medicaid programs have become the single most expensive item in many state budgets. The program consumes approximately 10 to 15 percent of state general funds. The mounting fiscal pressures are generating numerous inquiries regarding the goals and accomplishments of Title XIX programs. An efficient MQC program (see lead article) can pinpoint unwarranted program costs and lay the groundwork for corrective action.

PREPAID MEDICAID SERVICES IN FLORIDA

Florida has become the first southern state to contract for Medicaid services on a prepaid basis. Medicaid recipients are enrolling for a prepaid health plan on January 1, 1981, under an agreement between the state Medicaid program and the Palm Beach County Health Department. The plan offers comprehensive health services, including inpatient care. The state will pay a flat fee for each Medicaid enrollee, with the County Health Department assuming financial responsibility for all designated health services used by plan members. The fees have been set for six eligibility categories based on the historical cost of each, and will be updated at contract renewal on July 1, 1981.

MARYLAND LIMITS HOSPITAL SERVICES

In Maryland, the number of Medicaid inpatient hospital days in 1980 was 15 percent higher than in 1979. Several measures have been instituted to reduce Medicaid expenditures for hospital services, including a coverage limit of 20 days per spell of illness per year.

After the 20th day, the hospital cannot receive Medicaid reimbursement for further services. In addition, there must be a discharge period of 15 consecutive days for a second stay to be covered. By imposing these limitations, it is anticipated that physicians will be encouraged to hospitalize their patients only for the period that is medically necessary. Data on the cost impact are not available yet since the program only became effective January 1, 1981.

NEW JERSEY PLANS TO COVER MEDICAID DEFICIT

The New Jersey State Legislature will transfer surplus dollars to offset the projected \$57 million deficit in the state's Medicaid program. Had this not been approved, the state's Commissioner of Human Services had planned to terminate funding for pharmaceutical, dental, vision, chiropractic, orthopedic, hearing aid and convalescent care services. New Jersey and the federal government will expend approximately \$1 billion during the 1981-1982 fiscal year on Medicaid services to state beneficiaries.

CHANGES IN MEDICAID TAKEOVER FORMULA

New York Governor Hugh Carey has revised his proposed program, whereby the state would take over the counties' responsibility for Medicaid funding. The original proposal called for counties to transfer into property tax reduction 90 percent of the savings gained through the proposed state takeover of local Medicaid expenditures. As revised, the legislation would allow counties to keep 25

percent of the Medicaid savings until 1985. The final proposal would also permit counties to recoup, in property taxes, any savings transferred to city, town and village governments within their boundaries. The legislation is still pending until the disposition of the President's proposed Medicaid cap on federal funds to states has been determined.

PHYSICIANS ASK FOR MEDICAID PAY RAISE

The New Hampshire Department of Welfare has been asked by physicians to either increase reimbursement for services rendered to Medicaid recipients or to set up a system of tax credits whereby their contributions to the state government would be recognized. The New Hampshire Medical Society claims that physicians are being reimbursed at rates established ten years ago (approximately 50 cents for every dollar of care rendered). The medical society is seeking just compensation for physicians' services to Medicaid recipients, preferably through a formula utilizing inflation and the demand for services as a basis, i.e., the Medicare formula. The state Health and Welfare Department's budget request for the next two years entails reimbursement for physicians at approximately 32 percent of their bill to Medicaid recipients. Another proposal entails increasing the figure to 38 cents on the dollar.

HMOs PROMOTING MEDICARE AND MEDICAID

HCFA's Office of Demonstrations and Evaluations is sponsoring five projects designed to increase Medicare and Medicaid enrollment in

HMOs and promote cost effectiveness and competition in the health care field. HHS will evaluate the effect of alternative HMO risk reimbursement methods, rather than the current cost-based approaches. Any savings achieved through these programs are to be applied toward increased benefits and reduced cost sharing. Enrollment is in various stages in these HMOs.

NEW HHS UNDERSECRETARY

David Swoap was sworn in March 23 as HHS Undersecretary. His nomination by President Reagan in early February to the second ranking HHS post was confirmed by the Senate on March 17.

HCFA APPOINTMENTS

Dr.Carolyn K. Davis was sworn in as Administrator of HCFA by HHS Secretary Richard Schweiker on March 2. Prior to her appointment, Dr. Davis was Associate Vice President for Academic Affairs at the University of Michigan and a professor in the Schools of Nursing and Education since 1975. She received her Ph.D. in higher education from Syracuse University, as well as a B.S. in nursing from Johns Hopkins University.

Paul R. Willging, Ph.D., formerly acting as Deputy Administrator, has been officially appointed to that position. Previously, he was Deputy Director of the HCFA Bureau of Program Operations and, before the reorganization, was Deputy Director of the Medicaid Bureau.

James Scott has been appointed Director of the HHS Office of Intergovernmental Affairs, HCFA, effective May 1, 1981. Mr. Scott

was vice-president of the Kansas Hospital Association.

Patrice Hirsch Feinstein has been appointed as Director, Office of Legislation and Policy, HCFA. Ms. Feinstein has co-authored several publications including National Health Insurance Issues: The Adequacy of Coverage and Project Hope Report on the Consequences of Hospital Cost Containment Regulation. Other experience includes serving as the former editor of the Roche Medicaid Utilization Management Program.

D. MMIS STATUS IN THE STATES

Currently, 34 states (one partially) have received approval for 75 percent federal financial participation for operation of a mechanized claims processing and information retrieval system. Four states and several regions in New York State are anticipating approval during federal fiscal year 1981. The chart on the following page shows the current status of MMIS development in the states and territories.

E. RESEARCH STUDIES

AN EFFECTIVE APPROACH TO THIRD PARTY RECOVERY OF TITLE XIX FUNDS

A demonstration project was undertaken in Region X due to that region's concerns in identifying third party liability resources. While it dealt specifically with a proposed approach to Medicaid Quality Control review and development, it was designed to include procedures that could be used routinely in front-end eligibility review.

STATUS OF MMIS IMPLEMENTATION BY STATE

| | Inactive | Development Stage | Requesting Certification | Certified |
|---------------------------|----------|-------------------|--------------------------|-----------|
| Alabama..... | | | | X |
| Alaska..... | | X | | |
| Arkansas..... | | | | X |
| California..... | | | | X |
| Colorado..... | | | | X |
| Connecticut..... | | X | | |
| Delaware..... | X | | | |
| District of Columbia..... | | X | | |
| Florida..... | | | | X |
| Georgia..... | | | | X |
| Hawaii..... | | | | X |
| Idaho..... | | | | X |
| Illinois..... | | X | | |
| Indiana..... | | | | X |
| Iowa..... | | | | X |
| Kansas..... | | | | X |
| Kentucky..... | | X | | |
| Louisiana..... | | | | X |
| Maine..... | | | | X |
| Maryland..... | | X | | |
| Massachusetts..... | | X | | |
| Michigan..... | | | | X |
| Minnesota..... | | | | X |
| Mississippi..... | | | | X |
| Missouri..... | | | | X |
| Montana..... | | | | X |
| Nebraska..... | | | | X |
| Nevada..... | | X | | |
| New Hampshire..... | | | | X |
| New Jersey..... | | | | X |
| New Mexico..... | | | | X |
| New York..... | | | partially | X |
| North Carolina..... | | | | X |
| North Dakota..... | | | | X |
| Ohio..... | | | | X |
| Oklahoma..... | | | | X |
| Oregon..... | | X | | |
| Pennsylvania..... | | | X | |
| Rhode Island..... | X | | | |
| South Carolina..... | | | X | |
| South Dakota..... | | | X | |
| Tennessee..... | | | | X |
| Texas..... | | | | X |
| Utah..... | | | | X |
| Vermont..... | | | | X |
| Virginia..... | | | | X |
| Washington..... | | | | X |
| West Virginia..... | | | X | |
| Wisconsin..... | | | | X |
| Wyoming..... | X | | | |
| <u>Territories:</u> | | | | |
| Guam..... | X | | | |
| N. Mariana Islands..... | X | | | |
| Puerto Rico..... | X | | | |
| Virgin Islands..... | X | | | |

The report identified the major reason for shortcomings in the third party recovery process to be failure to obtain correct and sufficient information at the time of eligibility determination. Current procedures depend on the recipients to supply information on TPL, but the recipient is not always fully aware of the health insurance benefits for which he or she is qualified. Another problem is that the information may not enter into the processing system due to errors and oversights in transmitting data among the various agencies. Therefore, in this study, case reviewers received specific instructions for review procedures to include thorough investigations and intensive interviews.

PROJECT APPROACH

The project plan was to re-examine sample cases in two states, Idaho and Oregon. After a review of all MQC sample cases for the review period October to December 1978, selection of project cases was accomplished in a series of steps. First, the basis chosen for projections consisted of those cases for which there were claims paid for services rendered during the first review month. These cases were then screened for the following:

1. easily accessible locations; and
2. likelihood of producing a good lead.

This latter screen involved prioritizing cases according to a tentative TPL profile developed by the project team and used in the Idaho project; the profile was

refined and finalized for use in Oregon. The factors used included:

- . AFDC eligibility with deprivation based on continued absence of either parent;
- . Evidence of established paternity in AFDC cases;
- . Established whereabouts of an absent parent;
- . Established legal responsibility for health care or coverage on the part of an absent parent or other relative;
- . Employment of an absent parent or other relative;
- . Known health coverage held by an absent parent or other relative;
- . Evidence of accident/trauma related medical services (e.g., no-fault);
- . Employment of recipient(s);
- . Indications of military service in disability or blindness cases;
- . A disabled or blind minor who is a member of a mainstream family with gainfully employed parents; and
- . Indications of military retirement benefits in any type of case (e.g., CHAMPUS, CHAMPVA).

During the final screen, if it was not possible to locate recipients with a reasonable amount

of effort or if recipients refused to cooperate, the cases were omitted from the survey. All cases not completely reviewed would be assumed to contain no new TPL information. However, states should realize that these omitted cases would be just as likely to yield positive results if these new procedures had been applied at recipient application.

The reviews consisted of two approaches. The first was done by the project staff in researching cases, developing leads, and following them up to establish positive verification of available TPL. This included extracting useful information from the MQC case record, visiting the local welfare office responsible for the case (including SSI eligibles, examined by the District office and AFDC cases, examined by the state's child support enforcement agency), personal interviews with recipients or any other sources of information discovered during the review, and finally verification of potential coverage with insurance companies or liable persons.

The second approach in the review involved asking five major health insurance carriers to match the names of the recipients in the project sample against their own files. This served to validate the effectiveness of review procedures used by the staff. In some instances, this type of approach provides additional leads to TPL at relatively low cost.

ANALYSIS AND FINDINGS

The project base included 148 cases from the Region X states of Idaho and Oregon. After dropping

25 cases, 123 total reviews were completed with 68 new TPL sources identified. Of these identified cases, 37 (54 percent) were from AFDC absent parent leads which were obtained from information routinely collected by child support enforcement agencies, and 15 cases (22 percent) were related to employment of AFDC mothers.

Table 1 on page 20 presents a breakdown of all cases selected in each state's sub-base of MQC sample cases with paid claims in the original MQC review month. The totals for each state are less meaningful than the stratum figures because the numbers of AFDC and MAO cases are not in proportion to their relative sizes in the states' total Medicaid populations. Additionally, the AFDC and MAO strata have different Medicaid utilization rates and claim dollar distributions.

Calculations were made for recoverable dollar amounts from the "hit" cases or those with positive results. Before inclusion of a case, verification of TPL was obtained from liable persons and the five major health insurance carriers who cooperated with the study. Then all claims for the recipient(s) were collected. Deductible computations were performed using two different assumptions. First, to compute an extremely conservative estimate of the amount recoverable, it was assumed that all individual deductible amounts had to be net before any claims could be paid (this was referred to as "Comp 1"). Since the coverage groups encountered tended to involve several people from one family unit, a more realistic estimate would assume that where family

maximum deductible amounts applied, each recipient would probably not have had to meet his full individual deductible. "Comp 2" assumes that each recipient would have had to satisfy 50 percent of the individual deductible in those situations. Deductible computations in the review month were based on the average utilization rate seen over the full year's utilization of coverable Medicaid services. Based on that utilization rate, it was estimated whether the entire deductible would have been satisfied by the review month.

Recoverable dollar amounts based on a full year's utilization treat the period July 1978 through June 1979 as though it were a calendar year for purposes of computing deductibles. Within that period, only those months during which coverage was actually in effect (and the case remained in the states' Medicaid active files) were included in the computations. Therefore, the full year's utilization yielded savings that were less than the review month savings multiplied by twelve. For Oregon, the recoverable dollar amount was about \$10,800 using Comp 1 (with \$635.30 average dollars per hit case) and \$12,500 using Comp 2 (\$521.57 average). For Idaho, the Comp 1 recoverable dollar amount was about \$2,300 (an average of \$386.53 per case) and Comp 2 revealed a recoverable dollar amount of \$3,000 (an average of \$376.51 average).

In presenting projections, the study cautioned that although assumptions were made to assure that any projections would be underestimated, there is still uncertainty in projecting such a small study, particularly against

national expenditures. Many states have realized great savings from expanding their TPL recovery systems with similar efforts in front-end eligibility review and supplementing MQC data with information and verification from liable persons and health insurance carrier files, as well as unemployment insurance files, inquiries from attorneys, and various codes indicating trauma or accident.

Savings were projected to the states' Medicaid populations using both Comp 1 and Comp 2 and also using two different sample universes. Universe 1 is defined as the number of AFDC claims in the MQC sample period with paid claims in the review month. Universe 2 is less conservative, because it compensates for those cases which were omitted due to geographical location (beyond the limited resources of the study). In Idaho, out of 77 AFDC cases in the complete three month sample, 58 had claims in the review month, and 57 fell within the geographical region selected for review. In Oregon, out of 407 total AFDC cases, 268 had claims in the review month and 193 satisfied the geographical requirement.

Statewide projected figures for the two states combined are as follows:

| | <u>Comp 1</u> |
|------------|---------------------|
| Universe 1 | \$1,903,631 or 3.1% |
| Universe 2 | \$2,541,543 or 4.2% |

| | <u>Comp 2</u> |
|------------|---------------------|
| Universe 1 | \$2,244,751 or 3.7% |
| Universe 2 | \$2,984,777 or 4.9% |

The above percentages are of Medicaid program expenditures for

APDC families for the period July 1978 through June 1979 (\$10,881,862 for Idaho and \$49,817,337 for Oregon).

During the period July 1978 through June 1979, total Medicaid expenditures nationwide were \$18.5 billion of which \$6.66 billion were attributed to APDC families. Thus, for that time period, nationwide projected savings range from \$206.5 million to \$326.3 million. Projections for the following fiscal year, based on projected Medicaid program expenditures of \$26 billion, yield estimates for savings in the APDC category from \$190.2 million to \$458.6 million. Finally, the MAO savings in the demonstration amounted to 9.4 percent of the APDC savings. Including this amount, total savings were projected between \$317.5 million and \$501.8 million for the entire Medicaid program nationwide.

CONCLUSIONS

The study revealed that a significant amount of TPL goes undetected under the current system employed by Region X and that it is relatively easy to identify good leads as other states have proven (e.g., Michigan - see May 1980 Special Report issue). There is enough financial incentive to justify a major effort along the lines of this project for those states that have not increased efforts in TPL recovery.

This project prompted the following recommendations:

- to replicate this demonstration in states radically different from Idaho and Oregon. In addition to being

useful to the individual states, it will help yield better estimates of national TPL recovery potential.

- to undertake an intensive effort to train eligibility workers and QC reviewers about the importance of TPL and the subtleties of its identification.
- to develop closer ties between child support enforcement agencies, medical assistance units and local offices, and an effective flow of information to state Medicaid claims processing systems.
- to develop a set of instructions aimed at developing TPL information during eligibility reviews; and to change TPL review procedures to capture more useful information.

This demonstration project prompted a number of activities in Region X with the potential of producing substantial savings:

1. Insurance carriers are working with the state of Oregon to identify alternative coverage for Medicaid recipients prior to the payment of claims submitted to the state. Wherever possible, printouts of child support records and current employment data are accessed. Thus, all current information from the sources shown to be productive in this study are utilized prior to state payment of claims.

2. A team of Region X staff was organized to establish a series of TPL training sessions in the states for attendance by those responsible for training eligibility and medical assistance workers.
3. Alphabetised master lists of all Region X employee groups by state, identifying the health insurance carrier in each case, were produced and distributed to the local offices and claims processing units in the states. All health insurance carriers have been requested to provide the Region with regularly updated lists of the employers whose policies they currently hold.
4. A TPL task force was formed in the regional office to handle all recovery issues which arise in the region. The task force is comprised

of financial management specialists, program specialists, QC staff, and the regional corrective action specialist to assure maximum coordination and communication.

A choice is presented then for states to make a concerted effort to identify and collect TPL resources through expansion of the front-end eligibility review and supplementing MQC data with information from insurance carriers and other resources, or to continue as they do at present. Many states have undertaken such efforts, but the availability of data quantity and quality reveals significant diversity in data collection practices within each state. Comparison can be made to identify problem areas and methodologies. As this study indicates, TPL recovery warrants more substantive efforts to fully realise all TPL resources and ultimately to reallocate these otherwise misspent Title XIX funds.

Table 1

Summary of Project Findings

| | AFDC | Idaho MAO | TOTAL | AFDC | Oregon MAO | TOTAL |
|---|------|--------------|-------|------|---------------|-------|
| No. of MQC cases with paid claims in the MQC review month | 58 | 71 | 129 | 268 | 89 | 357 |
| No. of cases selected for review | 32 | 17 | 49 | 84 | 15 | 99 |
| No. of cases dropped during review | 7 | 4 | 11 | 13 | 1 | 14 |
| No. of recipient interviews conducted | 24 | 11 | 35 | 55 | 14 | 69 |
| No. of reviews completed | 25 | 13 | 38 | 71 | 14 | 85 |
| Total No. of hits found (possibly more than one hit per case) | 17 | 7 | 24 | 41 | 3 | 44 |



HOFFMANN-LA ROCHE INC
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HOUSE RESEARCH AGENCY
Pouch Y - State Capitol
Juneau, Alaska 99811
465-3991

MEMORANDUM

February 15, 1980

TO: Representative Terry Martin

FROM: Duncan L. Read, Director *DLR*

RE: Proposed Study on Medicaid and Alternative Health Care
Financing Programs (Research Request No. 72)

Attached are a draft resolution and a draft appropriations measure pertaining to a study on medicaid and health care financing alternatives. Billy Barrier suggested that a resolution and an appropriations measure in combination would be more appropriate as legislative vehicles than a bill. We have transmitted them to the Division of Legal Services for formal drafting and introduction by the personal bill deadline, February 18. In the process of gathering information necessary for the drafting of the resolution and the appropriation, we did compile some materials and data that you may find of interest. After we have reviewed them, we shall forward any of significance to you.

DLR/dp

cc: Representative Hayes

IN THE HOUSE

BY REPRESENTATIVE MARTIN,
HAYES

HOUSE CONCURRENT RESOLUTION NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

Directing the Legislative Council
to conduct an evaluation of the
State of Alaska's medicaid and
general medical relief programs
and alternative means of meeting
the health care needs of the
state's citizens.

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

WHEREAS an estimated \$400,000,000 is spent annually on health care
in Alaska; and

WHEREAS a projected amount in excess of \$50,000,000 will be expended
for the State's medicaid and general relief medical programs this fiscal
year; and

WHEREAS costs of these programs by Fiscal Year 1981 will have
increased over 300 percent in the past five years; and

WHEREAS there are continuing operational problems in expeditiously
reimbursing health care providers for treatment provided medicaid clients
and associated difficulties of Medicaid clients in securing services;
and

WHEREAS existing State medical services record systems do not
provide adequate information on the extent and nature of medical care
provided; and

WHEREAS many Alaskans are medically underserved, while others may have dual coverage of their health care needs; and

WHEREAS other states are exploring options to participation in the federal medicaid program and some have recently taken innovative steps to assure that their citizens' health care needs are better served and that health care financing is more cost efficient;

BE IT RESOLVED by the Alaska State Legislature that under provisions of AS 24.20.090 and Uniform Rule 48(c) the Legislative Council is directed to conduct a study that would evaluate:

- (1) the health care needs of Alaskans, the services currently available to meet them, and the present means of financing those services;
- (2) the cost implications of the State of Alaska withdrawing, in part or in whole, from the federal medicaid program;
- (3) the feasibility of other means of health care financing in Alaska, including, but not limited to, expanded private insurance coverage and State delivery of services to medically underserved citizens, either directly or indirectly through private, non-profit corporations; and be it

FURTHER RESOLVED that major parties of interest, including private health care providers and insurance carriers and the federal government as well as the State Department of Health and Social Services, be involved in the study; and be it

FURTHER RESOLVED that a report containing the study's findings and options for legislative action be transmitted to members of the Alaska State Legislature no later than February 1, 1981.

IN THE HOUSE .

BY REPRESENTATIVE MARTIN,
HAYES .

HOUSE BILL

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the Legislative Affairs Agency for an evaluation of the State's medicaid and general medical relief programs and an assessment of alternative means of health care financing."

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

* Section 1. The sum of \$200,000 is appropriated from the General Fund to the Legislative Affairs Agency with which to perform a study on the State of Alaska's medicaid and general medical relief programs and an evaluation of alternative means of health care financing.

* Sec. 2. This Act takes effect immediately in accordance with AS

* Sec. 3. A report of this study's findings shall be transmitted to members of the Twelfth Alaska State Legislature no later than February 1, 1981.

May 15, 1981

The Honorable George Bush
President of the Senate
United States Senate
Washington, D.C. 20510

Dear Mr. President:

Enclosed for consideration by the Congress is a draft bill "To provide a ceiling on Federal expenditures for Medicaid, to increase States' flexibility to determine the scope of their Medicaid programs, to make other amendments to the Medicare and Medicaid programs, and for other purposes." When enacted, the bill would be cited as the "Health Care Financing Amendments of 1981".

The draft bill would set a ceiling on Federal expenditures for Medicaid for fiscal year 1981 and succeeding fiscal years. Federal financial assistance for Medicaid would be limited to \$16,399,914,000 for fiscal year 1981, and \$16,995,308,000 for fiscal year 1982. For succeeding fiscal years, Federal funding for Medicaid would change by a factor equal to the Gross National Product Deflator. Federal funding for automated eligibility determination and Medicaid management information systems would be subject to a separate ceiling. Funds for State fraud control units, and funds to reimburse States' claims for program costs incurred before fiscal year 1981, would be outside the ceiling.

In order to enable States to control costs to the fullest extent consistent with maintenance of program quality, and to assure that States would not be forced because of the ceiling on Federal payments to absorb a greater share of Medicaid costs than under present law, the draft bill would repeal or modify many State plan and other statutory requirements. In addition, the Secretary would be authorized to waive other State plan requirements where he found that the waivers sought would be consistent with program goals.

The amendments proposed by this draft bill would greatly increase States' flexibility to determine the scope of their Medicaid programs and to assure that services are provided in an efficient and cost-effective manner, while continuing to safeguard the access of beneficiaries to an adequate supply of quality health services. States would be able to tailor their eligibility criteria, benefit packages, reimbursement methods, and plan administration to make the best use of the resources available to meet the needs of their population. To cite only a few examples, these amendments would permit

States to reimburse hospitals, physicians, and other providers of services in a more prudent manner, to use competitive bidding to obtain the most economical services, and to limit coverage of optional benefits to certain groups most in need of them (for example by providing influenza immunizations only to those groups most at risk).

In addition, the draft bill would enact reimbursement and systems reforms to allow more efficient and economical administration of the Medicare and Medicaid programs, and would enact amendments designed to reduce fraud and abuse in these programs.

The draft bill's provisions are described in detail in the enclosed sectional summary. We estimate that a net cost of \$201,000,000 for fiscal year 1981 and a net savings of \$2,131,000,000 for fiscal year 1982 would result from enactment of the draft bill. A net cost, rather than net savings, for fiscal year 1981 results solely from repeal of the postponement (enacted by the last Congress) from fiscal year 1981 to fiscal year 1982 of certain periodic Medicare payments to hospitals. An estimate of savings and costs (by section) for fiscal years 1981 through 1986 is enclosed.

We urge that the Congress give the draft bill its prompt and favorable consideration.

We are advised by the Office of Management and Budget that enactment of this draft bill would be in accord with the program of the President.

Sincerely,

/s/ Richard S. Schweiker

Secretary

Enclosures

**SUMMARY OF ESTIMATED COST IMPACT OF THE HEALTH FINANCING AMENDMENTS
OF 1981**

(to nearest million dollars)

| Section | FY 1981 | FY 1982 | FY 1983 | FY 1984 | FY 1985 | FY 1986 |
|---------|-----------|-----------|-----------|-----------|-----------|-----------|
| 101 | -100 | -1,039 | -2,012 | -2,963 | -3,950 | -5,055 |
| 102 | <u>1/</u> | <u>1/</u> | <u>1/</u> | <u>1/</u> | <u>1/</u> | <u>1/</u> |
| 103 | 0 | 4 | <u>1/</u> | <u>1/</u> | <u>1/</u> | <u>1/</u> |
| 104 | -122 | 0 | 0 | 0 | 0 | 0 |
| 105 | <u>1/</u> | <u>1/</u> | <u>1/</u> | <u>1/</u> | <u>1/</u> | <u>1/</u> |
| 201 | 0 | -23 | -47 | -78 | -119 | -127 |
| 202 | 0 | -2 | -2 | -2 | -2 | -2 |
| 203 | 0 | -4 | -4 | -4 | -4 | -4 |
| 204 | -35 | -250 | -285 | -350 | -435 | -530 |
| 205 | 0 | <u>1/</u> | <u>1/</u> | <u>1/</u> | <u>1/</u> | <u>1/</u> |
| 206 | -1 | -6 | -6 | -7 | -8 | -9 |
| 207 | -4 | -35 | -41 | -46 | -52 | -58 |
| 208 | -20 | -70 | -90 | -110 | -120 | -130 |
| 209 | -5 | -13 | -15 | -17 | -20 | -23 |
| 210 | 0 | -2 | -4 | -4 | -5 | -5 |
| 211 | -2 | -17 | -19 | -22 | -25 | -28 |

| | | | | | | |
|-------|-----------|-----------|-----------|-----------|-----------|-----------|
| 212 | -1 | -9 | -10 | -11 | -13 | -15 |
| 213 | -1 | -7 | -8 | -9 | -10 | -11 |
| 214 | 0 | -6 | -6 | -6 | -6 | -6 |
| 215 | 515 | -522 | 0 | 0 | 0 | 0 |
| 216 | -8 | -66 | -70 | -103 | -106 | -108 |
| 217 | -15 | -55 | -45 | -45 | -50 | -55 |
| 301 | 0 | -7 | -7 | -7 | -7 | -7 |
| 302 | <u>2/</u> | <u>2/</u> | <u>2/</u> | <u>2/</u> | <u>2/</u> | <u>2/</u> |
| 303 | 0 | 0 | 0 | 0 | 0 | 0 |
| 304 | 0 | 0 | 0 | 0 | 0 | 0 |
| 305 | 0 | 0 | 0 | -67 | -67 | -67 |
| 306 | 0 | 0 | 0 | 0 | 0 | 0 |
| 307 | 0 | 0 | 0 | 0 | 0 | 0 |
| 308 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL | 201 | -2,133 | -2,671 | -3,851 | -4,999 | -6,240 |

1/ Savings would not reduce Federal outlays below level set by section 101, but would provide some additional savings to States.

2/ No cost is anticipated since to date the Department has not assessed any penalties.

PROPOSED HEALTH CARE FINANCING AMENDMENTS OF 1981
SECTION-BY-SECTION SUMMARY

Short Title

Section 1 gives the short title of the draft bill. When enacted, it would be cited as the "Health Care Financing Amendments of 1981".

TITLE I - MEDICAID

Limitation on Authorization of Appropriations; Allotments to States

Section 101 would provide for a ceiling on appropriations for Medicaid for fiscal year 1981 and succeeding fiscal years. The bill would authorize appropriations of \$16,399,914,000 for fiscal year 1981 and \$16,995,308,000 for fiscal year 1982. For fiscal year 1983 and succeeding fiscal years, authorized appropriations would change by a factor equal to the Gross National Product Deflator published by the Department of Commerce. For fiscal years 1981 and 1982, the territories would receive an allotment from the total appropriation equal to their ceilings under present law; each of the fifty States and the District of Columbia would receive an allotment bearing the same ratio to the remainder as the State's estimate of Medicaid expenditures for fiscal year 1981 bears to the sum of all States' estimated expenditures for fiscal year 1981. For fiscal year 1983 and succeeding fiscal years, each State and territory would be allotted a share of the appropriation equal to its share of the appropriation for fiscal year 1982.

Federal funding for Medicaid fraud control units would be outside the ceiling. Federal funding for automated eligibility determination and Medicaid management information systems would be provided by a separate appropriation of \$210,000,000 for fiscal year 1982 and such sums as the Congress found necessary and appropriate for each succeeding fiscal year. Funds appropriated for automated information systems would be allocated to the States on a formula that took into consideration States' shares of the basic appropriation for Medicaid and their need for funds to develop or operate information systems. Federal funds to pay claims for expenditures prior to fiscal year 1981 would also be outside the ceiling. States would be required to file claims for program expenditures during fiscal year 1980 by October 1, 1981, or (where the requirement was waived in exceptional circumstances) by January 1, 1982.

Waivers and Modifications of Federal Requirements

Section 102 would modify and repeal certain statutory requirements and authorize the Secretary to waive others, in order to give States greater flexibility to control costs of their Medicaid programs.

The bill would modify some requirements with respect to eligibility and benefits and would repeal others, in order to permit States to focus delivery of medical care and services under the program on those most in need of them.

The bill would eliminate all requirements with respect to eligibility and benefits of the medically needy, and all requirements (other than requirements with respect to mandatory services for the categorically needy) to provide benefits of equal amount, duration, and scope to all medically needy and to all categorically needy. States would still be required to provide all mandatory services to the categorically needy (primarily individuals receiving cash assistance under Federal or Federal-State programs under the Social Security Act ("the Act")), but could use any reasonable criteria to determine eligibility and benefits for other needy individuals or groups, and to determine optional benefits available to categorically needy individuals or groups.

The bill would eliminate the requirement to provide coverage for 18-to 20-year-olds who would be eligible for AFDC if under 18; it would eliminate the requirement to extend for four months Medicaid eligibility of families losing AFDC eligibility because of increased income from employment; and it would leave to State discretion whether to continue Medicaid coverage of certain individuals who have become ineligible for SSI because of cost-of-living increases in Social Security benefits.

The requirement of present law to afford Medicaid beneficiaries "freedom of choice" of providers of medical care would be replaced by a requirement to provide such standards as could reasonably be expected to afford recipients covered medical care of adequate quality. Amendment of this requirement would enable States to effect significant cost savings while maintaining quality care, for example by soliciting competitive bids for provision of covered services.

Except for the general requirement described above, all requirements with respect to the amount and method of reimbursement of providers would be eliminated, including requirements for reimbursement of inpatient hospital services and nursing home services, barriers to reimbursement based on fee schedules, and requirements that have restricted reimbursement on a prepaid capitation basis to health maintenance organizations (HMOs).

The bill would repeal most requirements with respect to utilization review and utilization control, including review by Professional Standards Review Organizations (PSROs). Choice of methods to prevent unnecessary or inappropriate utilization of medical care and services would be left to the States' discretion. The bill would also revise the requirements for Medicaid management information systems (MMIS) and other automated information systems to preserve incentives to States to develop and operate these systems when Federal Medicaid funds are capped.

The bill would also permit States to cover non-medical support services to individuals who without them would require institutionalization; it would repeal the requirement that a State which has ever funded optometrists' services continue to do so; and it would make other amendments.

The Secretary could waive certain State plan requirements where the State demonstrated to his satisfaction that its alternative plan would be consistent with the goals of the Medicaid program. Requirements which could be waived would include requirements that all provisions of the State plan be in effect statewide; requirements to provide for cooperative arrangements with the State health and vocational rehabilitation agencies; procedural requirements with respect to reviews of care of nursing home patients; and requirements for licensing of nursing home administrators; prohibitions on copayment requirements for the categorically needy for certain hospital services; and provisions which would bar direct payments to Medicaid recipients to share savings realized from use of more economical types of medical care.

The bill would also require the Secretary to approve or disapprove proposed State plans or waiver requests within 90 days after receiving the State request (or, if later, 90 days after receiving information needed to make a final determination).

Increased Federal Matching for Automated Eligibility Assessment Systems

Section 103 would provide the same Federal matching rate for automated eligibility determination systems that is presently available for Medicaid Management Information Systems (90 percent for development and 75 percent for operation).

Recovery of Disputed Claims

Section 104 would provide that overpayments to States which were disallowed by the Secretary would be recovered by the Secretary pending the final determination with respect to the correct payment amount (rather than retained by the State, at State option, as provided by present law).

Attribution of Sponsor's Income and Resources to Aliens

Section 105 would permit States, if an alien seeks Medicaid coverage within the first three years after entering the United States, to attribute to the alien the income and resources of the alien's sponsor for purposes of determining his eligibility for medical assistance.

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TITLE II - MEDICARE

Contracts for the Administration of Benefits

Section 201 would make changes in the provisions of law under which Medicare contracts with outside organizations to determine and pay claims under Medicare. Providers of services would no longer have the right to nominate specific organizations to process Medicare claims, reimbursement on the basis of costs would no longer be required, contracts could be entered into with any public or private entity, and, after an initial five year phase-in period, all contracts would be subject to the same competition requirements as are other Federal contracts. Section 201 would also consolidate the contracting requirements into one section, and move to a more appropriate section of the Medicare title provisions concerned with defining "reasonable charge".

Elimination of Requirement for a Railroad Retirement Board Carrier Contract

Section 202 would eliminate the requirement for a separate Railroad Retirement Board carrier contract.

Repeal of Statutory Time Limitation on Agreements with Skilled Nursing Facilities

Section 203 would repeal the 12 month statutory limitation on agreements with skilled nursing facilities.

Limitation on Cost Differentials

Section 204 would bar payment for routine inpatient care, including nursing care, in hospitals and skilled nursing facilities, greater than the percentage of total allowable costs equal to the percentage of total patient days attributable to Medicare patients, unless it were demonstrated to the satisfaction of the Secretary that care of Medicare patients was more costly than care of other patients. This amendment would be effective July 1, 1981.

Withholding of Payments for Certain Medicaid Providers

Section 205 would provide a mechanism for withholding payments to institutional and individual providers of services under Medicare to offset overpayments to them under Medicaid, where they had terminated or substantially reduced their participation in Medicaid, leaving the State Medicaid agency and the Secretary unable to recover the amounts due.

Annual Limit of 200 Visits for Home Health Services

Section 206 would establish a 100 visit annual limit under the Hospital Insurance (HI) program and a 100 visit annual limit

under the Supplementary Medical Insurance (SMI) program for home health services.

Elimination of Need for Occupational Therapy as a Basis for Entitlement to Home Health Services

Section 207 would eliminate the need for occupational therapy as a basis for entitlement to home health services.

Elimination of Part A Coverage of Alcohol Detoxification Facility Services

Section 208 would eliminate coverage under the HI program of alcohol detoxification facility services.

Elimination of Part B Coverage of Outpatient Rehabilitation Facility Services

Section 209 would eliminate coverage under the SMI program of outpatient rehabilitation facility services.

Reduction in Limit for Outpatient Physical Therapy Services

Section 210 would reduce from \$500 to \$100 the annual limit for outpatient physical therapy services furnished by an individual physical therapist.

Elimination of Additional Dental Coverage

Section 211 would eliminate coverage under the HI program of hospitalization required solely because of the severity of a dental problem and would allow payments to dentists only for certain specified procedures.

Elimination of Unlimited Open Enrollment

Section 212 would restrict open enrollment for the SMI program to the first quarter of each year.

Restrictions on New Buy-in Agreements

Section 213 would eliminate any additional "buy-in" coverage under the SMI program requested during 1981 by State Medicaid programs.

Repeal of Requirement for End-Stage Renal Disease Networks

Section 214 would repeal the requirement for end-stage renal disease networks.

Elimination of Temporary Delay in Periodic Interim Payments

Section 215 would eliminate the temporary delay for the last 21 days of fiscal year 1981 in periodic interim payments to hospitals.

Repeal of Utilization Review Requirements

Section 216 would repeal utilization review requirements.

Elimination of Coverage for Pneumococcal Vaccine

Section 217 would eliminate Medicare coverage for pneumococcal vaccine.

TITLE III - OTHER PROVISIONS

Civil Monetary Penalties for Medicare and Medicaid Fraud

Section 301 would authorize the Secretary to impose a civil money penalty of up to \$2,000 for a fraudulent claim for reimbursement under the Medicare or Medicaid program, plus a fine of twice the amount of the fraudulent portion of a claim. The Secretary could also bar from participation in Medicare and Medicaid any person determined pursuant to this section to have filed a fraudulent claim. Before a penalty could be imposed, the Secretary would be required to give written notice and an opportunity for a hearing on the record with the right to be represented by counsel, to present witnesses, and to cross-examine. Use of this administrative procedure in any case would be subject to the agreement of the Department of Justice.

Repeal of Requirement to Notify Families With Dependent Children of Availability of Early and Periodic Screening, Diagnosis, and Treatment

Section 302 would repeal the requirement under part A of title IV of the Act that States notify families with dependent children of the availability under the Medicaid program of early and periodic screening, diagnosis, and treatment of children.

Notice, Hearing, and Judicial Review Requirements for Termination of a Professional Standards Review Organization Agreement; Agreements of Less Than a Year

Section 303 would eliminate the requirement that the Secretary provide a formal hearing to terminate an agreement with a professional standards review organization (PSRO), would require the Secretary to give 90 days notice of a termination, would preclude judicial review of a termination, and would permit the Secretary to enter into agreements of shorter duration than a year.

Abolition of Statewide Professional Standards Review Councils

Section 304 would abolish the statewide professional standards review councils.

Discretion of Secretary in Funding Professional Standards Review Organizations

Section 305 would give the Secretary the discretion to determine how much (if any) funding to provide to PSROs.

Voluntary Participation by State Medicaid Programs in Professional Standards Review

Section 306 would permit any State to withdraw its Medicaid program from the purview of professional standards review.

Repeal of Certain Requirements for Studies and Demonstrations

Section 307 would repeal requirements that the Secretary support --

- demonstration projects concerning a single coordinated appeal hearing to adjudicate cost items determined under a coordinated audit,
- a study of the need for skilled nursing facilities to participate in both Medicare and Medicaid,
- evaluations of the cost-effectiveness of review of particular health care services by PSROs,
- a nationwide study of regional differences in medical criteria and length-of-stay norms utilized by PSROs,
- a study concerning possible Medicare coverage of drug detoxification services,
- a demonstration project concerning nutritional therapy in early renal failure,
- a study concerning possible Medicare coverage as a home health benefit of services furnished by registered dietitians,
- demonstration projects as to making the services of clinical social workers more generally available as Medicare benefits,
- a study concerning possible Medicare coverage of orthopedic shoes,
- a study concerning possible Medicare coverage as a home health benefit of respiratory therapy services, and
- a study of the costs of various approaches to improving Medicare coverage for the treatment of foot conditions.

8
Section 307 would also postpone for one year, to December 1954, the date by which a report must be submitted on the provision of long-term care services by hospitals.

Repeal of Obsolete Authority for Medical Assistance

Section 308 would repeal obsolete authority to provide medical assistance together with cash assistance in State programs under titles I, IV-A, X, XIV, and XVI of the Act. This authority has been replaced by the Medicaid program under title XIX of the Act.



STATE OF ALASKA
LEGISLATIVE AFFAIRS AGENCY

GENE KENNEDY
DIRECTOR

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ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

January 29, 1981

MEMORANDUM

TO: Representative Ken Fanning

FROM: Christine Johnson
Research Staff

SUBJECT: Medicaid Expenditures and Claimants
Research Request 81-7

Attached please find several tables showing the Medicaid statistics you requested for FY78, FY79, and FY80.

Medicaid Data

Much of the information in the tables had to be compiled by the House Research Agency from records kept by the Department of Health and Social Services, as the Department does not regularly aggregate the state's Medicaid expenditures or the total number of Medicaid claimants.¹ Consequently, although the statistics presented in the tables have been verified with the Department of Health and Social Services, they should be viewed as approximations.

In particular, the claimant averages for each year and the average expenditure per service should be used with care; although again, these have been reviewed by the Department. The statistics we show for FY80 are estimates for the year based on the totals reported for the last six months. The number of claimants and the cost per service were only systematically compiled during the last half of FY80, after the Department contracted with a data processing firm to process Medicaid claims. The numbers for FY78 and FY79 were compiled by this Agency from "HCFA 120" forms which the Department prepared on a monthly basis during those years. According to the Department, these forms may not be entirely accurate, although they did not express major reservations about us using the data.

¹As you can see from attachment A to this memorandum, the Executive Budget for FY82 includes a separate Budget Request Unit for Medicaid; however, the totals which are reported in this BRU do not include Medicaid expenditures for patients in API and Harborview, and do not represent any of the administrative costs associated with the program.

Medicaid Funding

The State and the federal government equally share the costs of most of the medical services provided under Medicaid, and the cost of administering the program. The federal government assumes 100% of the cost of the Indian Health Care component of the program.

The annual Medicaid expenditures for FY78, FY79, and FY80 are shown on Table 1. The State's cumulative expenditure for these years was \$46.6 million. The federal government's share of program costs over this period equaled \$49.2 million, resulting in a total program expenditure of almost \$95.8 million for the three years. The FY80 expenditure represented almost a 50% increase over FY78 costs, or an increase of approximately \$12.6 million. According to Table 1, the largest growth during this period was in the category of payments to health care providers. The increase in this category is attributable to a number of factors, including rising cost of services, growth in the population eligible for Medicaid, increase in the number of health care services covered under Medicaid, and inflation.

Medicaid Claimants

As Table 2 indicates, the number of Medicaid claimants increased by 48% or 1600 people between FY78 and FY80. However, the average monthly expenditure per claimant remained approximately the same, fluctuating between \$620 and \$670.

It may be somewhat misleading to calculate an overall average monthly expenditure per claimant, as the average monthly expenditure differs significantly according to the medical service provided. For example, according to Table 2, in FY80 the average monthly expenditure per claimant was \$625. However, as Table 3 shows, 86% of the monthly claimants received care costing less than \$275. Clearly, the overall average is distorted by the small number of claimants receiving expensive institutional care. As Table 2 indicates, institutional care is extremely costly. Although there are only an average of 25 patients in the Alaska Psychiatric Institute who are eligible for Medicaid coverage, the monthly expenditure for those patients totals \$157,000 or \$6,200 per person. Harborview Developmental Center is slightly less expensive per patient; however, the total Medicaid expenditure for the 92 patients in that institution is over \$400,000 a month, or \$4,400 per person.

Medicaid Program Administration

As Table 1 indicates, it cost approximately \$1.1 million to administer Alaska's Medicaid program during FY80. Administration of the Medicaid

Representative Ken Fanning
January 29, 1981
Page 3

program currently requires the equivalent of 11.9 full-time employees, according to estimates computed by the Department of Health and Social Services and this Agency.

We did not anticipate that it would take nearly so long to collect his data, and apologize for the delay in delivering it to you. Should you require any further information, please do not hesitate to contact us.

CJ/dp

Attachments

TABLE 1
Medicaid Expenditures
FY78 - FY80

| | <u>FY78 Actual</u> | <u>FY79 Actual</u> | <u>FY80 Actual</u> |
|---|------------------------|------------------------|------------------------|
| <u>Medicaid Budget Request Unit</u> | \$18,789.5 | \$25,235.4 | \$30,036.2 |
| <u>State Institutions</u> | \$ 5,751.4 | | |
| API | | \$ 1,260.9 | \$ 1,888.5 |
| Harborview | | \$ 4,995.1 | \$ 4,841.8 |
| <u>Administration and Support</u> | <u>\$ 722.2</u> | <u>\$ 1,108.8</u> | <u>\$ 1,113.7</u> |
| Total Expenditure | \$25,263.1 | \$32,600.2 | \$37,880.2 |
| State Share of Program Cost ¹ | \$12,631.6 | \$15,577.2 | \$18,358.1 |
| Federal Share of Program Cost ¹ | \$12,631.6 | \$17,023.1 | \$19,522.2 |

¹The State and the federal government equally split the cost of most of the services offered under the Medicaid program. However, the federal government pays 100% of the costs incurred under the Indian Health Care component of the program. This component was added to the State's Medicaid program in FY79.

Source: Alaska Department of Health and Social Services

TABLE 2
Average Monthly Medicaid Expenditure Per Claimant
FY78 through FY80

| | <u>FY78</u> | <u>FY79</u> | <u>FY80</u> |
|--|---------------------|---------------------|---------------------|
| Average Monthly Health Care Expenditure¹ | \$ 2,045,075 | \$ 2,624,283 | \$ 3,063,875 |
| Average Monthly Claimants | 3314 | 3918 | 4902 |
| Average Monthly Expenditure Per Claimant | \$ 617 | \$ 670 | \$ 625 |

¹Average monthly health care expenditures were computed by dividing the annual expenditure for health care (see Table 1) by twelve.

Source: House Research Agency, 1/27/81, from data reported on HCFA 120 forms July 1977 - June 1980.

TABLE 3
Medicaid Expenditures Per Claimant¹
FY80

| | <u>Average Monthly Expenditure</u> | <u>Average Monthly Claimants</u> | <u>Average Monthly Expenditure Per Claimant</u> |
|--|--|--------------------------------------|---|
| Physician Services | \$ 321,417 | 2401 | \$ 134 |
| Clinic Services | \$ 29,057 | 158 | \$ 184 |
| Home Health Services | \$ 904 | 4 | \$ 226 |
| Family Planning | \$ 3,236 | 41 | \$ 79 |
| Lab/X-ray | \$ 11,102 | 158 | \$ 70 |
| Dental | \$ 51,632 | 362 | \$ 143 |
| Early Periodic Screening & Diagnosis | \$ 18,261 ² | 176 | \$ 104 ² |
| Other Services | \$ 114,105 | 420 | \$ 272 |
| <u>Hospitals</u> | | | |
| Inpatient Care | \$ 469,722 | 133 | \$ 3,532 |
| Outpatient Care | \$ 99,021 | 513 | 193 |
| <u>Nursing Homes</u> | \$1,194,308 | 419 | \$ 2,850 |
| <u>State Institutions</u> | | | |
| API | \$ 157,375 | 25 | \$ 6,295 |
| Harborview | \$ 403,483 | 92 | \$ 4,386 |

¹Amounts shown on this chart for FY80 are estimates based on data for six months of the year (January 1980 through June 1980.)

²Includes some costs of administering the EPSDT program.

Source: House Research Agency, 1/27/81, from data provided by the Department of Health and Social Services and HCFA 120 forms.

MEDICAID - HOSPITALS

1) States can design alternative reimbursement method

a) incentives for efficiency & economy

b) payments not to exceed Medicare "reasonable cost"

c) secure participation / quality of care

d) appeals mechanism

e) no payments in excess of those charged to the general public

Administration

2) Common audit for Medicare and Medicaid.

3) improve bill processing techniques

4) occupancy rate - imputed as actual

5) major operating cost allocated with capital improvements are a percentage of Medicare and Medicaid

6) States primarily allocate resources which pay for

a) laboratory reports

b) hospital contributions

c) total capital after 5 years rule

d) accreditation fees

7) transfer all costs for without administration

- 8) not know percentage contracts of physicians employed by hospital as they often receive % of payments from their department in addition to salary
- 9) deduct surpluses for grants, gifts and endowment incomes
- 10) Lab & x-ray reimbursed at rate no higher than large, automated units.
- 11) Federal Grants to outpatient care - screening mechanism for emergency rooms. Patients could be designed to utilize the appropriate setting for which the service should be rendered

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Utilization Control

HEALTH CARE FINANCING AMENDMENTS OF 1981

1. Limit Fed. contribution to Medicaid to \$6.4 billion (200 million less than 1981)
allowed to rise w/ rate of inflation as measured by GNP deflator
2. Medically needy - all Fed. requirements for eligibility and benefits eliminated
3. End FIDE coverage for 65 yr old
Also eliminate requirements for Medicaid to continue 6 months after age termination.
4. Reduce "random access" requirements
No longer can state opt out
5. Eliminate Federal matching requirement
No amount of federal matching required if provider
6. Eliminate specific medical & utilization rules
All states. Allowing states to be decided state by state (not subject to federal review or enforcement)
7. Reduce coverage of long-term care services
Coverage of private long-term care
8. Secretary can opt to not pay for certain services
a. Health services to which state can opt
b. Services to which state can opt to not pay
c. Health services to which state can opt to not pay
d. Health services to which state can opt to not pay
e. Health services to which state can opt to not pay
f. Health services to which state can opt to not pay

F. Requirements which prevent states from sharing with recipients savings of cost-efficient care.

9. Repeal ETO notification of AFDC children.
10. Eligibility of non-US citizens take in the income of the individual sponsor.
11. Civil penalties to prevent fraud. Providers fined up to \$500 plus twice the fraudulent claim.
12. Create Federal monitoring for automated eligibility systems. Make state expenditures of the system development and maintenance explicit.
13. Amend state welfare and federal health care financing approach. A state claim.

DAY CARE
CORRESPOND-
ENCE

DEPT. OF COMMUNITY & REGIONAL AFFAIRS

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March 13, 1981

Representative Don Clocksin, Chairman,
House H & SS Committee
House of Representatives
Pouch V
Juneau, Alaska 99801

Dear Representative *Don* Clocksin:

RE: DAY CARE FUNDING STUDY

Enclosed with this letter is a revised Day Care Funding Study dated February 20, 1981 prepared by Moebius Corporation of Anchorage. As I indicated when we testified on Representative Buchholdt's House Bill 43 last week before the House H & SS Committee, this revised study is intended to replace that which was transmitted to the Speaker of the House and President of the Senate on February 2, 1981. I presume that by now those reports have been transmitted to the respective Health and Social Services Committees.

Although I have not personally had an opportunity to read this report I did ask that Deputy Director Pat Poland and Child Care Coordinator Lare, review it. Mr. Poland indicated that, although there was room for some improvement in its presentation, the basic research data and recommendations are there and that this report is much more readable than the earlier report.

When I spoke with Mr. Poland earlier this week, he indicated that, pursuant to your request, copies of the current Day Care Regulations, policy statements, and other documents which might be of interest to Committee members concerning the administration of the Day Care Program have been transmitted to Juneau. As soon as those documents are received, I will transmit them to you, so that the Committee might hopefully have better background information prior to further deliberations on House Bill 43 and any other discussions relating to the Day Care Assistance Program.


We very much look forward to further Committee actions on Representative Buchholdt's House Bill 43 and would like to reiterate our strong support for passage of that Legislation, hopefully, incorporating the minor amendments which we suggested in the Department's position paper transmitted to you last week.

By copy of this letter I am forwarding copies of this Day Care Funding study to other Legislators who have expressed an interest in having a copy of this report.

If we can provide you or Committee members with other information concerning the various social services programs administered by this Division, please advise.

Sincerely,

LEE McANERNEY
COMMISSIONER


By Palmer McCarter
Director

cc: ~~Senator~~ Charles Parr, Chairman
Senate H & SS Committee w/attachment

Representative Jim Duncan w/attachment

Representative Thelma Buchholdt w/attachmnt

Representative Brian Rogers w/attachment

Keith Specking, Legislative Assistant
Office of the Governor w/attachment

CHARLIE PARR

ALASKA LEGISLATURE

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April 23, 1981

Ms. Patty Meritt
Director
Play 'N Learn
Seventh and Cushman
Fairbanks, Alaska 99701

Dear Ms. Meritt:

This is in response to your letter of April 14 concerning HB 43.

You should be aware that we will be introducing a Senate bill in the next few days for increased day care funding. Essentially, the bill will call for funding Centers at \$100 per child, per month. It also calls for some additional funding.

It is difficult to say at this time what success this bill or HB 43 will have. We may be able to get some increases this year.

Sincerely,

Charles H. Parr

CHP:vc

Play 'N Learn

Seventh and Cushman
Fairbanks, AK 99701
907-452-5997

April 14, 1981

Dear Fairbanks Legislators,

In a recent discussion with other professionals regarding the proposed CS5511B43 "Commitment Related to Day Care Assistance" someone said they thought the legislators didn't know how much money the centers really needed. With that comment in mind, I am writing the following letter.

I am the director for Play 'N Learn Inc, a non-profit corporation which operates 2 children's centers providing care and enrichment programs to approximately 140 families each month. Our children range from 6 weeks to 12 years of age. Their attendance ranges from a 1 hour drop-in paying \$3.00 to a 55 hour week of care paying up to \$170.00 per month.

We utilize USDA child care food program funds, CETA grants, and Alaska State Sr. Citizen grants. We also provide a



training ground for students in order to decrease the child-to-teacher ratio and to improve training in the field of Early Childhood. (Students are in several programs including: RSVP, Hutchinson Casie Center, TVCC, U of A and the State Dept. of Education - Vocational Rehabilitation.) Play N Learn has been operating year round since November 1974.

I believe the State of Alaska should provide financial assistance to licensed child development programs much as it does to school districts. Does the State believe young children and their development is less important than 6-18 year olds? I doubt it, particularly in view of the massive research showing the vital significance of the early childhood years. If the State believes that children from birth to 5 years are as important as older ones, CS554343 is a good vehicle for proving it.

As an elected officer I agree with the Fairbanks Association for Young Children's position regarding this bill. I strongly support and believe the quality controls and open eligibility are vital.

Speaking from my role as director I can say if we had the money the first month I would buy 2 new vans (desperately needed!) then I'd take the following actions to improve our service to families and programs for children:

- ① I would drastically increase Teacher salaries. I'd like to be able to raise them to \$6⁰⁴ or \$7⁰⁴ per hour to start. I currently start teachers about \$4.50 per hour. At the \$6⁰⁴ rate our teachers would be earning about 1/2 of what a 1st year public school teacher in our district earns per hour.*
- ② I'd also increase aides salaries to a minimum of \$5.00 per hour.... \$6⁰⁴ would be nice and they are worth it if we only had the money.*
- ③ I'd establish a savings account for a building fund in order to purchase facilities where we could assume quality programs permanently in the community.
- ④ I'd budget an extra \$1,000 per month for equipment desperately needed. Most programs, ones included, have to routinely make choices between one or another or a slide for the playground when we really need both!

③ I'd put money into employee benefits - such as an expansion of our health insurance program... and into training workshops, courses, and consultants.

My calculations indicate, at the present suggested level of \$150⁰⁰ per child per month, I could accomplish those 5 objectives. If our programs could qualify for additional \$100 per month I could accomplish some of the following goals:

- ① Consulting Child Psychologist
- ② Consulting Speech Therapist
- ③ Consulting Play Therapist
- ④ Curriculum Resource Teachers
- ⑤ fulltime office help
- ⑥ still higher teacher salaries*
- ⑦ increase custodian hours and pay*
- ⑧ hire a handyman 1 day per week*
- ⑨ raise director salary (although I am salaried I make approximately \$7.10 per hour based on what I actually work Monday through Friday, not counting weekends. The Board of Directors sets my salary so, there wouldn't be an abuse of funds)
- ⑩ install battery operated emergency lighting
- ⑪ repair, repair, replaced cracked windshield
- ⑫ Buy a chest freezer
- ⑬ purchase or rent a copy machine
- ⑭ install a burglar alarm
- ⑮ Buy a new vacuum cleaner

- ① increase staff benefits to include both sick day and vacation time annually
- ② install commercial lighting
- ③ buy a thermofax machine
- ④ buy a spirit duplicator
- ⑤ build an indoor gym area for wintertime
- ⑥ increase field trip budget
- ⑦ replace plumbing with commercial variety

These needs are considered basic in school districts - I believe children under 6 deserve the same benefits.

Additionally I believe this proposal might eliminate a lot of other requests. Currently I have been involved in requests for \$40,000 for vans, \$30,000 for training and \$200,000 for RT interest loans. I feel the ESSHB43 funds could meet many of these needs.

Once again, I strongly urge you to support this bill and smooth its way through the legislature. If I can be of any other help by providing statistics, testimony, or other information, please call me!

Sincerely,

Patty Meritt
Director
home - 479-5761

MEMORANDUM


State of Alaska

TO: Helen D. Beirne
Commissioner
Dept. of Health &
Social Services

DATE: March 18, 1981

FILE NO:

TELEPHONE NO:

FROM: 
Allen Korhonen
Deputy Commissioner
Department of Health &
Social Services

SUBJECT: Alaska Developmental
Center Status Report

The Alaska Developmental Center, Inc. (ADC) operates three programs for handicapped children and their families in the Anchorage area. Two of these are assisted by grants and contracts of the Department of Health and Social Services.

- 1) Infant Learning Program is funded by a grant from the Section of Family Health of the Division of Public Health. The grant award for FY-1981 is \$162,000 of which \$121,500 has been awarded to date.
- 2) The Respite Care Program is funded through a contract administered by the DD Section of the Division of Mental Health and Developmental Disabilities. The contract award for FY-1981 is \$249,369 of which \$165,160.44 has been paid to date.
- 3) The Day Care Program for non-handicapped as well as handicapped children is privately financed, with DCRA reporting that only two of the individuals and families using the day care program are eligible to receive day care subsidy.

The following points summarize the current status of ADC:

1. The most reliable information indicates that losses in the Day Care Program coupled with lack of information and timely action on the part of the previous Executive Director and Board of Directors are largely responsible for present difficulties.
2. ADC claims to need \$65,000 in addition to current revenue to meet obligations until June 30, 1981. Also, ADC claims a need of \$250,000 in addition to anticipated revenue to continue operations in the three areas listed above for FY-1982, and to meet past obligations.
3. Meetings with officials of the Municipality of Anchorage have led to a grant of \$25,000 by the municipality. Mr. Lee Reynolds, ADC Board Chairperson, indicates that this grant will enable continued operations only through March 31, 1981.

Re: Alaska Developmental
Center Status Report

4. State funds for the Infant Learning Program and the Respite Programs are adequate to meet the services needed and should not be increased.

5. In the event that ADC ceases operation on March 31:

- a. The Infant Learning Program and the Respite Care Program can continue by means of contracts with other private providers. Administrative steps have been taken to develop alternate contractors for the Infant Learning and Respite Programs. An ATN has been signed by the Department of Administration to allow contracting with alternate private organizations.
- b. The continuity of the specialized Day Care Program for families with handicapped children is unlikely. Specialized day care for severely handicapped children is non-existent in the State, except for the St. Jude Center in Juneau.

The Municipality of Anchorage does have a Day Care Assistance Program at 325 East 3rd Avenue. Parents can contact this office for information on 136 day care centers and homes in the Anchorage area.

Basically it will be up to parents to arrange for their own day care needs.

It may be that a private provider may enter into the specialized day care business if demand is sufficient.

Recommendation:

Because the State's responsibilities can be fulfilled by contracting with other agencies, it is recommended that the Department not try to assist ADC in paying past debts or to continue operation. Past experience has shown that we have no legal authority to use current money to pay for prior debts. Given the indebtedness of ADC, it is unlikely that we can be assured any additional funds would result in continued delivery of infant learning or respite care services. Our most wise course of action is to develop other contractors so that we can assure continuity in service to those families and children who are now receiving service through the ADC. Reprogramming funds will give us enough money to assure continued

P. 3

Re: Alaska Developmental
Center Status Report

service for the balance of the fiscal year.

I also recommend that Dr. Gragovich go to Anchorage next week to personally supervise the transition in services to new contractors. He will also coordinate with the Municipality and the ADC to assure a smooth transition.

If necessary individual families using the infant learning and respite care services can be contacted and informed of the service alternatives that will be available to them.

As we develop new contractors, every effort will be made for the continuity in employment for the current employees of the ADC.



Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Rep. Don Clocksin, Chairman
465-3797

Pouch V
State Capitol
Juneau, Alaska 99811

TO: House HESS Committee Members
FROM: Rep. Don Clocksin, Chair
RE: Additional Amendments to CS for SSHB 43
DATE: April 8, 1981

Proposed Amendments to CS for SSHB 43 (Conceptual language)

1. Page 2, line 8 (d)
amended to reflect the following concept:

Grants in addition to those in (c) of this section may be provided to day care centers for the sole purpose of training administrators and day care teachers.

The amount of grants will be determined according to availability of training services or types of potential contractual arrangements.

2. Page 2, line 28, insert words and parents after providers.
3. Page 4, lines 4 - 10 delete.
4. Page 4, line 15, after part-time enrollment, insert:

In addition, each day care facility receiving a grant under AS 44.47.250 - 44.47.310 - shall make at least 20% of its slots available for children eligible for day care assistance who may wish to pay based on the attendance policy.

DC:sp

Original sponsors: Buchholdt, Fuller,
and Zharoff

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

1 IN THE HOUSE

2 CS FOR SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 43 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 TWELFTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to child care facilities and child
7 care assistance; and providing for an effective date."

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

9 * Section 1. AS 44.33.245(a)(1) is amended to read:

10 (1) make loans for the construction, renovation, and equip-
11 ping of child care facilities, including private nonprofit child care
12 facilities;

13 * Sec. 2. AS 44.33.255(a) is amended to read:

14 (a) A loan to a child care facility under AS 44.33.240 - 44.33.-
15 275 may not exceed \$50,000 [\$30,000, AND NO MORE THAN ONE LOAN MAY BE
16 MADE TO A SINGLE CHILD CARE FACILITY UNDER AS 44.33.240 - 44.33.275].

17 * Sec. 3. AS 44.47 is amended by adding a new section to read:

18 Sec. 44.47.301. EARLY CHILDHOOD DEVELOPMENT GRANT PROGRAM. (a)
19 An early childhood development grant program is established in the
20 Department of Community and Regional Affairs to provide state assistance
21 in the operation of child care facilities. The department shall provide
22 grants for the operation of day care centers, including private nonpro-
23 fit child care facilities. Participation in the program is optional.

24 (b) To qualify for a grant under this section, the day care
25 facility must meet the following requirements:

26 (1) be currently licensed under AS 47.35.010 - 47.35.080 and
27 any applicable municipal licensing requirements;

28 (2) participate in the day care assistance program under
29 AS 44.47.250 - 44.47.310;

1 (3) provide care under both enrollment and attendance
2 policies as provided in AS 44.47.300(b).

3 (c) The ~~minimum~~^{maximum} grant under this section is \$150 per month for
4 each child the day care center is authorized to care for as determined
5 by the Department of Health and Social Services. The ~~minimum~~ grant
6 shall be increased on a geographic basis by the percentages as instruc-
7 tional unit allotments are increased under AS 14.17.051.

8 (d) Grants in addition to those in (c) of this section may be
9 provided to day care centers which provide a quality of care in excess
10 of that required by the licensing requirements of AS 47.35.010 -
11 47.35.080. To receive the supplemental grant, the center must meet all
12 the requirements of (b) of this section, and in addition, the center
13 shall meet or exceed criteria established by the Department of Health
14 and Social Services. Those criteria will include personnel training,
15 education and experience, staff-child ratio, establishment of programs
16 designed for early childhood development, improved nutrition, equipment
17 and space. A center meeting the requirements of this subsection will
18 receive at least an additional \$50 per child per month. Grants shall
19 vary based on the geographic region by the same method as provided in
20 (c) of this section.

21 (e) Application for a grant under this section shall be made in
22 the form established by the commissioner.

23 (f) A grant under this section shall be made monthly and shall be
24 based on the average daily enrollment in the child care facility during
25 the calendar month preceding the date on which application for a grant
26 is made.

27 (g) The commissioner shall, in consultation with interested day
28 care providers, ^{and parents} adopt regulations to carry out the purposes of this
29 section.

1 * Sec. 4. AS 44.47.250(a)(1) is amended to read:

2 (1) implement and administer a program to assist in providing
3 day care for the children of low and moderate income [LOW-INCOME];
4 families according to the requirements of AS 44.47.250 - 44.47.310;

5 * Sec. 5. AS 44.47.260 is amended to read:

6 Sec. 44.47.260. . CONTRACT ADMINISTRATION [LOCAL PARTICIPATION].

7 (a) When a contract is made under AS 44.47.250(b)(2) between the depart-
8 ment and a municipality, the department [MUNICIPALITY] shall pay half
9 of the following costs of administering the contractual duties within
10 the municipality: [ITS JURISDICTION]

11 (1) salaries of eligibility workers;

12 (2) accounting and bookkeeping expense;

13 (3) clerical expense directly attributable to administration
14 of the program;

15 (4) cost of monitoring the eligibility of persons receiving
16 benefits under the program;

17 (5) public information advising of the availability of the
18 program; and

19 (6) cost of report required by the department.

20 (b) In addition to payments under (a) of this section, the de-
21 partment shall pay to a municipality employing a program manager an
22 amount equal to 10 percent of the amount paid under (a)(1) of this sec-
23 tion to be allocated to the program manager's salary.

24 * Sec. 6. AS 44.47.270 is amended to read:

25 Sec. 44.47.270. CONDITIONS OF RECEIPT OF BENEFITS. Benefits may
26 be paid for the care of children of a low or moderate income family
27 only if a parent or guardian, because of the day care, is freed to work
28 or to seek work or to attend school. In no event shall benefits be
29 paid for the care of children of a family where one parent or guardian

1 is not working or attending school and is physically and mentally
2 capable of caring for the children.

3 * Sec. 7. AS 44.47.300(b) is amended to read:

4 (b) Benefits shall be paid by the department directly to the
5 municipality contracting with the day care facility or, outside of a
6 municipality, to the facility upon receipt of a billing from a municipi-
7 pality or facility. The payment of benefits shall be based on the
8 number of days that a child is enrolled at the facility or the number
9 of days that the child attends the facility, as elected by the parent
10 or guardian each month and specified to the facility.

11 * Sec. 8. AS 44.47.300 is amended by adding a new subsection to read:

12 (c) Each day care facility receiving a grant under AS 44.47.250 -
13 44.47.310, shall, when payment of benefits is based on the number of
14 days a child is enrolled at the facility, provide for full-time and
15 part-time enrollment, and provide for payment of benefits based on the
16 ~~number of days a child attends the facility. The number of children~~
17 ~~who may use the attendance payment policy shall be as determined by the~~
18 ~~department, based on the need for that policy and the economic impact~~
19 ~~on the facility.~~
20 *In addition, each day care facility -- -- shall*
21 *at least 20% of its slots available for children eligible for day care assist*
22 *based on the attendance policy.*

20 * Sec. 9. AS 44.47.310 is amended by adding a new paragraph to read:

21 (6) "child care facility" means an establishment licensed
22 under AS 47.35.010 - 47.35.080, including but not limited to day care
23 centers, family day care homes, and schools for preschool age children,
24 which provides care for children not related by blood, marriage, or
25 legal adoption to the owner, operator, or manager of the facility.

26 * Sec. 10. AS 44.33.250 and 44.33.260(2) are repealed.

27 * Sec. 11. This Act takes effect immediately in accordance with AS 01.-
28 10.070(c).

From: Nancy

Re: Day Care

Day Care Centers and Family homes in Alaska are having difficulty maintaining the level of service currently provided with little hope of expanding the quality of care. Some factors:

- 1) high staff turnover because of low salaries
- 2) lack of training for administrators and staff
- 3) inflation
- 4) loss of CEBA positions
- 5) loss of USDA money for lunches, snacks, and nutritional training
- 6) cutback in Medicaid funds for health and dental screening

The Department of Labor projections for the 80's estimates 9.9% (third highest) of the population will be in the 0 to 4 age group. At present 19% of the work force in Alaska are single parents, and the demand for day care is high. The business is not a sound financial investment, in fact, most of the centers are solidly in debt while providing the most minimal care.

The pre-school child is at a crucial time in his development, the personality is developed by the age of three, as well as the basis for socialization skills and personal responsibility. Women now make up over half of the work force, and coupled with the youth of our population base, the demand for day care will continue to rise (Alaska has the highest birth rate per capita in the country).

For these reasons, I've written up some ideas on making Day Care both available/affordable and of a better quality.

Establish a Day Care Grant Program to provide to all licensed day care centers and homes \$100/month/child enrolled to be administered through the Department of Community and Regional Affairs.

Regulations for the distribution of funds should specify the percentage of funds to be used for a specific purpose. Recommended are:

- 1) staff salaries
- 2) staff training/ inservice
- 3) nutritional assistance
- 4) equipment purchasing
- 5) debt retirement (this is a real need but I'm unsure about providing state funding for this purpose)

Establish Day Care Step Grants to encourage quality of care in day care centers and family homes. Extra money above the \$100 grant to be appropriated per child enrolled by a point system considering the following topics:

- 1) staff training/in-service
- 2) parent involvement
 - a) policy making
 - b) school programs
- 3) curriculum development/planning/philosophy
- 4) holistic approach
- 5) Nutritional development
 - a) based on menus: food variety, sugarless snacks etc.
- 6) health screening
- 7) staff/child ratio
- 8) space available per child
- 9) outdoor activities/field trips
- 10) age-appropriate activities/learning center concept
- 11) fund raising activities

Grant subsidy for the establishment of an intensive training workshop to be offered regionally as inservice training. (possible use of the U of A, H & S S training, or possibly lock into the Head Start training)

1. Administrative/Social Work

- a) planning/budgeting
- b) grant preparation
- c) information, referral for family support services
- d) group dynamics

2) Staff

- a) establishing a learning environment
- b) classroom dynamics/activities
- c) language development
- d) gross and fine motor skills
- e) socialization/self concept
- f) planning

Day Care Assistance Program(DCAP)

- 1) raise income level guidelines to provide DCAP on a sliding scale for moderate income families
- 2) provide 50% administrative costs to the municipalities through C&RA
- 3) if municipality has a Program Manager, provide 10% of that salary.

Expand the Revolving Loan Fund to include non-profit organizations

MEMORANDUM

State of Alaska

TO: Patrick K. Poland
Deputy Director

FROM: Lare'
Child Care Coordinator

DATE: February 19, 1981

FILE NO:

TELEPHONE NO:

SUBJECT: A Comparative Look
at Day Care

On average, the Day Care Assistance Program is serving 200 more children this year than last. This growth appears to be due to the increased funding this year. There are no longer any waiting lists in any municipalities. Two new programs have been added this year, Delta Junction and Kenai, but the small number of children served (19) does not account for the increase.

Some programs, especially Fairbanks and Sitka, have shown dramatic increases, almost double last year's service.

Other municipalities, such as Anchorage, Cordova, Juneau, Nome and Petersburg, show the same or nearly the same level of service as last year.

Only two municipalities, Anderson and Kotzebue, show a decrease this year.

Figures have been developed for FY 1979, but because of the waiting lists experienced by several municipalities, this comparison has not been made, although it appears the average number of children served was approximately 100 more in FY 1980 than in FY 1979.

Table I listed below shows the average number of children served by each municipality in FY 1981 (through December) and FY 1980 (total year).

TABLE I

Average Number of Children Served by Municipality

| <u>Municipality</u> | <u>FY '81</u> | <u>FY '80</u> |
|---------------------|---------------|---------------|
| Anchorage | 626 | 606 |
| Anderson | 2 | 4 |
| Bethel | 22 | 15 |
| Cordova | 9 | 9 |
| Delta Junction | 14 | (1) |
| Fairbanks | 242 | 129 |
| Fort Greely | 49 | 34 |
| Juneau | 121 | 120 |
| Kenai | 5 | (1) |
| Ketchikan | 37 | 32 |
| Kodiak | 48 | 44 |
| Kotzebue | 5 | 6 |
| None | 9 | 9 |
| Petersburg | 14 | 14 |
| Sitka | 29 | 14 |
| Wasilla | 19 | 16 |
| Total | 1,251 | 1,052 |

(1) New program, FY '81

L/sr

TABLE II

Average Number of Children Served by Municipality

| <u>Municipality</u> | <u>FY '81</u> | <u>FY '80</u> | <u>Difference FY '81-'80</u> |
|---------------------|---------------|---------------|----------------------------------|
| Anchorage | 626 | 606 | +20 |
| Anderson | 2 | 4 | - 2 |
| Bethel | 22 | 15 | + 7 |
| Cordova | 9 | 9 | 0 |
| Delta Junction | 14 | (1) | (1) |
| Fairbanks | 242 | 129 | +113 |
| Fort Greely | 49 | 34 | + 15 |
| Juneau | 121 | 120 | + 1 |
| Kenai | 5 | (1) | (1) |
| Ketchikan | 37 | 32 | + 5 |
| Kodiak | 48 | 44 | + 4 |
| Kotzebue | 5 | 6 | - 1 |
| Nome | 9 | 9 | 0 |
| Petersburg | 14 | 14 | 0 |
| Sitka | 29 | 14 | + 15 |
| Wasilla | <u>19</u> | <u>16</u> | <u>3</u> |
| Total | 1,251 | 1,052 | 180 |
| | | | <u>19</u> New program |
| | | | 199 |

(1) New program, FY '81

L/sr

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907.465.3810

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

April 10, 1981

SUBJECT: Constitutionality of state grants to church
 owned and operated day care providers

TO: Representative Donald E. Clocksin

FROM: Billy G. Berrier *BGB*
 Director
 Division of Legal Services

BY: Valerie Tehan *VT*
 Legislative Legal Extern

You have asked if a direct grant to day care providers would violate the establishment clause of the First Amendment to the United States Constitution if some of the day care centers are church owned and operated and perform sectarian as well as secular functions.

Under your proposal, all licensed day care providers in the state would be eligible for a direct grant of a certain amount of money per certified enrollment slot in their center. The centers would apply for the grant through the Department of Community and Regional Affairs in the same manner as parents who receive day care assistance.

The United States Supreme Court announced a three-part test for determining whether governmental activity is permissible under the establishment clause in Committee for Public Education v. Nyquist, 413 U.S. 756 (1973). The action must have a clearly secular legislative purpose, its primary effect must be one that neither advances nor inhibits religion, and the action must not foster excessive governmental entanglement with religion. Applying this test to your proposal, I do not believe that the United States Supreme Court or the Alaska Supreme Court would find that it violates the establishment clause. The legislative purpose is clearly secular. It is intended to provide aid to both

April 10, 1981

church and non-church owned organizations providing needed day care services for working parents. Its primary effect, adequate day care services in the state, neither advances nor inhibits religion and distribution of grant money on a per capita basis through the Department of Community and Regional Affairs would not lead to excessive administrative entanglements with religion.

The provision of the Alaska Constitution prohibiting payments from public funds for the direct benefit of religious or other private educational institutions does not apply because day care centers are not educational institutions and are outside the intent of Article VII, section 1.

Sheldon Jackson College v. State, 599 P.2d 127, 129 (1979), after citing from the Proceedings of the Alaska Constitutional Convention concluded that "Article VII, section 1 was thus designed to commit Alaska to the pursuit of public, not private education, without requiring absolute governmental indifference to any student choosing to be educated outside the public school system". As such, day care centers that incidentally teach some religious doctrine as well as reciting prayers do not appear to be the type of "educational institution" that Article VII, section 1 is directed at. They do not, in any way, offer an alternative to the public school system.

In any event, under the analysis used in Sheldon Jackson College v. State I believe this proposal would stand.

If you would like me to pursue this further, I would be happy to.

VT:BGB:ljb

To: Charlie
From: Nancy
Re: Day Care

Attached is the first draft I've been working on for the Day Care bill. Please let me know what you think. One thing I have included that we did not discuss is including job seeking in coverage through DCAP.

Another problem that I have come across which is vital to the financial problems of facilities is that DCAP has not raised the daily rate since 1977. The rate is \$12.00/day which is really not in line with the actual cost of day care or the rate of inflation. The document put out by House Research on day care cited a monthly loss for centers in Alaska of \$200 to \$2000, and I have verified that to be accurate through contact with local centers:

\$15.00/day - Wee Cottage Day Care Center

\$15.60/day - Children's Community Center

\$315.00/month - St. Ann's Day Care

Pat Marlin, of Juneau Day Care Providers, has been working with legislators for four years on the subject of day care, and has several times petitioned C&RA for a rate change, but when I spoke with the Anchorage office of DCAP on the subject I was told that no one had ever recommended a rate change and no public input had ever been received.

C&RA is in charge of setting rates, and it would seem unrealistic to me that no changes have been made in four years when the other fixed costs are so heavily affected by inflation.

STATE OF ALASKA

DEPT. OF COMMUNITY & REGIONAL AFFAIRS

OFFICE OF THE COMMISSIONER

JAY S. HAMMOND, Governor

POUCH B
JUNEAU, ALASKA 99811
PHONE: (907) 486-4700

March 26, 1981

The Honorable Charles Parr, Chairman
Senate Health & Social Services Committee
Alaska Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

RE: DAY CARE AND HEAD START PROGRAMS

Enclosed is a packet of information that should provide the data you have requested.

Our most current projections are as follows:

Day Care - State general fund

FY 81, the \$3,352,900 appropriation will serve approximately 1,300 children on a monthly average.

FY 82, the requested \$4,242,500 will serve approximately 2,350 children on a monthly average.

Municipalities contracting for day care funds provide local administrative costs. CETA cutbacks may impact local programs. This, and other issues, are discussed in the enclosed Research Report by the House Research Agency.

Head Start - State general fund

FY 81, the \$1,136,000 will benefit approximately 1,200 children.

FY 82, the requested \$1,226,900 is anticipated to benefit 1,200 children.


The Honorable Charles Ferr, Chairman
RE: Day Care and Head Start Programs
March 25, 1981
Page 2

There are several funding sources in support of the Head Start Program. These are analyzed in the Alaska Head Start Directors Association presentation which is enclosed.

We hope this information is useful. If you require more information or have any questions, please do not hesitate to contact me at 465-4700.

Sincerely,

LEE MCANEMEY
COMMISSIONER


by: Palmer McCarter
Director

- Attachments:
- 1) Copy of March 11, 1981 letter to Rep. Don Clocksin discussing number of communities operating (or interested in) Day Care Program. Day Care regulations (filed in D pt. of Law) and seven policy memos are attached to this letter.
 - 2) Copy of February 19, 1981 memo to Pat Poland entitled "A Comparative Look at Day Care", attaching a list, by contractor, of children served by community.
 - 3) Copy of March 13, 1981 letter from John Pugh to Rep. Clocksin about licensed facilities not participating in DCARA program.
 - 4) Copy of CARA position paper on SSMB 43.
 - 5) House Research Agency report on Day Care Assistance - Alternatives for Legislative Action (Research Request #80).
 - 6) Copy of March 13, 1981 letter to Rep. Jim Cotton discussing Head Start Program with Dept. justification for Head Start Directors' increased funding request (attached to letter).

cc: Keith Spackling, Legislative Assistant
Office of the Governor (w/o attachments)

Pat Poland/Lare - Anchorage LEAD (w/o attachments)

March 11, 1981

The Honorable Don Clocksin
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99811

RE: Day Care Assistance Program

Dear Representative Clocksin:

As you requested on March 4, we are enclosing a copy of the Day Care Assistance Program's regulations, as submitted to the Department of Law, and Policy Memorandums 1-7.

Currently there are 27 municipalities or communities that have licensed day care facilities. The Day Care Assistance Program has contracts with 16 of those municipalities. They are: The Municipality of Anchorage (including Eagle River, Girdwood and Chugiak), Anderson, Bethel, Cordova, Delta Junction, Fairbanks North Star Borough (including North Pole, Eielson, Mainwright and Ester), Fort Greely, Juneau, Kenai (where the City is also working with centers in Soldotna), Ketchikan Gateway Borough, Kodiak Island Borough, Ketchikan, Homer, Petersburg, Sitka (also includes Mt. Edgumbe) and Wasilla.

Communities that have licensed facilities and where we do not have a contract are: Dillingham, Haines, Homer, Palmer, Seward, Soldotna, Talkeetna, Tyonek, Unalaska, Valdez and Wrangell. However, we have been working with Seward and representatives from the Matanuska-Susitna Borough and are hopeful that a contract will be forthcoming from these municipalities.

In addition we have been working with Aniak, Hooper Bay, McGrath, Selawik and Whittier. These communities do not have licensed day care facilities and therefore the development work is more long range.

We hope this information is helpful to you. Should you have any questions, please do not hesitate to contact Ms. Lare', Child Care Programs Coordinator at 264-2201.

Sincerely,

Palmer McCarter
Director

PMcC:L:SP

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19 AAC 50.010

CHAPTER 50
DAY CARE ASSISTANCE PROGRAM

Article

1. Introductory Provisions (19 AAC 50.10 -- 19 AAC 50.40)
2. Conditions of Contracting (19 AAC 50.50 -- 19 AAC 50.90)
3. Contractor's Administrative Responsibilities (19 AAC 50.100 -- 19 AAC 50.140)
4. Standards for Determining Family Eligibility (19 AAC 50.150 -- 19 AAC 50.190)
5. Family's and Facility Operator's Responsibilities (19 AAC 50.200 -- 19 AAC 50.210)
6. General Provisions (19 AAC 50.220 -- 19 AAC 50.260)

ARTICLE I. INTRODUCTORY PROVISIONS

Section

10. Introduction
20. Delegation of Authority
30. Program Operation
40. Allocation of Funds

19 AAC 50.010. INTRODUCTION. The purpose of the Day Care Assistance Program is to provide financial assistance for the cost of licensed day care to enable low income parents or guardians to work, or participate in educational or training programs. The assistance helps eliminate licensed day care costs as a factor which may prevent a parent from becoming self-supporting and makes licensed day care available to children who might otherwise be left unattended or without adequate supervision while their parent works or trains. (Effective / / , Register)

Authority: AS 44.47.250

Register , 1980, COMMUNITY AND REGIONAL AFFAIRS 19 AAC 50.020
19 AAC 50.040

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19 AAC 50.020. DELEGATION OF AUTHORITY. The authority of the department under AS 44.47.250-310 is delegated by the Commissioner of the Department of Community and Regional Affairs to the division of local government assistance. (Effective / / ,
Register)

Authority: AS 44.47.250

19 AAC 50.030. PROGRAM OPERATION. (a) The division operates the day care assistance program through contracts with municipalities, with community based organizations within unincorporated communities, with organizations which serve regions within which two or more unincorporated communities are located, and directly with day care facilities located outside municipalities.

(b) If both a borough and a city within the borough apply for a day care assistance contract, the contract shall be awarded to the borough. This section does not preclude the city and borough from entering into an agreement to jointly administer the contract nor may it be construed to preclude the borough from subcontracting portions of its administrative responsibilities to one or more cities located within it. (Effective / / ,
Register)

Authority: AS 44.47.250

19 AAC 50.040. ALLOCATION OF FUNDS. (a) Each contractor eligible under section 30 of this chapter which applies for a contract shall be entitled to at least that percentage of day care assistance program funds determined by computing the following formula on June 15 each year:

the dollar amount appropriated to the program for the fiscal year
divided by

Register , 1900, COMMUNITY AND REGIONAL AFFAIRS 19 AAC 50.040
19 AAC 50.050

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the total number of current licensed day care slots within the political jurisdiction of all the contractors eligible under sections 30 and 50(c) of this chapter

multiplied by

the number of licensed day care slots within a particular eligible contractor's jurisdiction

equals

that contractor's allocation of program funds during the next fiscal year.

(b) Program funds are subject to reallocation during the fiscal year, subject to their utilization by the contractor and by mutual agreement between the contractor and the division. (Effective / / , Register)

Authority: AS 44.47.250

ARTICLE 2. CONDITIONS OF CONTRACTING

Section

- 50. Application
- 60. Administration
- 70. Separate Accounting
- 80. Provision of Program Data
- 90. Use of Program Funds

19 AAC 50.050. APPLICATION. (a) Application for a contract for day care assistance program funds under AS 44.47.250-310 shall be made on forms prescribed by the director.

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19 AAC 50.060

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(b) Not later than May 1 of each year the division will forward application forms to each municipality which has licensed day care facilities within its boundaries and to other non-municipal organizations participating in the program during the previous fiscal year. Applications for regional and/or community based organizations serving unincorporated communities are available upon request.

(c) As a condition to receiving a contract for day care assistance, an applicant must return the application to the division post marked no later than June 15. (Effective / / ,
Register)

Authority: AS 44.47.250

19 AAC 50.060. ADMINISTRATION. (a) In submitting an application for a day care assistance program contract, the applicant shall certify that personnel assigned responsibility for administration of the program have training or experience totalling at least two years in accounting, bookkeeping, records management, managing state or federal programs or related fields.

(b) A municipality may subcontract for the administration of a day care assistance program contract if:

- 1) It has the written permission of the division to do so;
- 2) It has advertised for a subcontract in such a fashion as to ensure that all interested parties are made aware that proposals for subcontracts are being accepted; and
- 3) The subcontractor meets the qualifications set forth in (a) of this section.

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19 AAC 50.090

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(c) All costs incurred by a municipality or other organization in administering a day care assistance program contract shall be borne by the contractor. The municipality or other organization shall certify at the time the application is submitted its willingness to pay for all administrative costs incurred. (Effective / / , Register)

Authority: AS 44.47.250

19 AAC 50.070. SEPARATE ACCOUNTING. Every municipality or other organization receiving a contract shall ensure that its accounting system establishes a separate fund and accounting codes for receipt and disbursement of day care assistance program funds. The contractor shall furnish the division with a copy of its annual audit or statement of income and expenditures. (Effective / / , Register)

Authority: AS 44.47.250

19 AAC 50.080. PROVISION OF PROGRAM DATA. The contractor will provide the division, upon written request, with program statistics, financial records or client case files, within 30 days of the date of receipt of the request or as otherwise required in the contract. (Effective / / , Register)

Authority: AS 44.47.250

19 AAC 50.090. USE OF PROGRAM FUNDS. Funds received by a contractor under the day care assistance program may be used only for subsidy payments to licensed day care facilities on behalf of eligible families. Violation of this section is cause for immediate termination of a contract. (Effective / / , Register)

Authority: AS 44.47.250

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ARTICLE 3. CONTRACTOR'S ADMINISTRATIVE RESPONSIBILITIES

Section

- 100. Appointment of Administrator
- 105. Applying for Day Care Assistance
- 110. Eligibility Determination
- 120. Processing of Billing Statements
- 130. Maintenance of Records
- 140. Use of Division Forms

19 AAC 50.100. APPOINTMENT OF ADMINISTRATOR. Each contractor or subcontractor shall have a person meeting the qualifications set forth in sections 60(a) of this chapter as the day care assistance program administrator. The day care assistance program administrator is responsible for day-to-day administration of the program, including, but not limited to:

- (1) maintenance of the program's financial and client records;
 - (2) preparation of statistical reports requested by the division;
 - (3) determination of family eligibility according to the standards set forth in Article 4 of this chapter;
 - (4) maintenance of a file of all licensed day care facilities, including the expiration date of each facility's license and the rates it charges for day care services;
 - (5) processing of facility billing statements; and
 - (6) other duties specifically set forth in this chapter.
- (Effective / / , Register)

Authority: AS 44.47.250

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19 AAC 50.105. APPLYING FOR DAY CARE ASSISTANCE. A parent or guardian or any other person who has the actual care and custody of a child may apply for day care assistance. In applying for day care assistance, the parent shall specify the members of the family group and the income available for the support of the eligible child. The local administrator shall consider income received from all sources for the support of the eligible child, whether from a legally responsible relative or any other person or source. (Effective / / , Register)

Authority: AS 44.47.250

19 AAC 50.110. ELIGIBILITY DETERMINATION. (a) Within fifteen days of receipt of a properly completed application for day care assistance, including all necessary documentation, the administrator shall, by applying the standards set forth in Article 4 of this chapter, determine if the applicant family is eligible. If the family does not meet the eligibility standards, the application shall be denied.

(b) If the administrator determines that a family is eligible, the administrator shall issue a day care authorization form stating the number of days and hours for which assistance will be provided, the amount of assistance the family will receive, and the facility at which day care will be provided.

(c) If the administrator determines that a family is eligible but that money is insufficient to pay for day care assistance for the family or that there is lack of space in a licensed facility, the administrator shall place the family's name on a waiting list.

(d) Wait listed families shall, within income groups, receive priority ranking as follows:

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- (1) displaced homemaker or victim of domestic violence with a job or job opportunity;
- (2) other single parent with a job or job opportunity;
- (3) two parent family with a job or job opportunity;
- (4) displaced homemaker or victim of domestic violence in a training program or with a training opportunity;
- (5) other single parent in a training program or with a training opportunity;
- (6) two-parent family in a training program or with a training opportunity. (Effective / / ,
Register)

Authority: AS 44.47.160

19 AAC 50.120. PROCESSING OF BILLING STATEMENTS. (a) Within 15 working days of receipt of a facility's monthly attendance forms and billing statement, the administrator shall review the forms and statement and determine if they are accurate and complete; if they are, the administrator shall authorize payment and forward them to the division. If there are errors or deficiencies in the billing statement and monthly attendance forms, the administrator shall correct the errors or deficiencies and forward the forms and statement to the division.

(b) Within 30 working days of receipt of properly completed monthly attendance forms and billing statements, the division shall process the statements and return payment to the contractor.

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19 AAC 50.130

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(c) Payment to a facility shall be made in accordance with service authorized for an eligible child and the schedules set forth in sections 170(a) and 190(c) of this chapter. (Effective / / , Register)

Authority: AS 44.47.250

19 AAC 50.130. MAINTENANCE OF RECORDS. (a) The administrator shall open and maintain a case file on each family in the program and shall keep in the family's case file current documents or verification forms addressing all aspects of eligibility including, but not limited to:

- (1) birth certificates of all dependent children;
 - (2) divorce decrees and all modifications;
 - (3) a notarized statement of guardianship, separation or non-child support;
 - (4) income records;
 - (5) class schedule for an educational or training program;
- and
- (6) other documents the administrator decides are appropriate.

(b) The contents of a case file are confidential and may be released or disclosed only with the written consent of the head of the family as shown by the file, by court order, or at the request of a duly authorized government official in the course of an official investigation. (Effective / / , Register)

Authority: AS 44.47.250

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19 AAC 50.140. USE OF DIVISION FORMS. Unless specifically authorized to the contrary, all forms used in administration of the day care assistance program shall be those prescribed by the division. (Effective / / , Register)

Authority: AS 44.47.250

ARTICLE 4. STANDARDS FOR DETERMINING FAMILY ELIGIBILITY

Section

- 150. Eligibility
- 160. Determining Monthly Adjusted Net Income
- 170. Subsidy
- 180. Review of Eligibility
- 190. Authorized Hours and Rate Schedule

19 AAC 50.150. ELIGIBILITY. (a) A family in which the parent is employed or participating in an educational or training program that is likely to enable the family to become self-supporting and whose adjusted net income does not exceed the maximum amount set forth in section 170(a) of this chapter is eligible for day care assistance.

(b) Notwithstanding the provisions of (a) of this section,

(1) If one of the parents in an eligible two-parent family is mentally or physically incapable of caring for a child, the employment or training requirement for the incapacitated parent is waived.

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(2) If the single parent in an eligible family is temporarily mentally or physically incapable of caring for a child, the employment or training requirement for that parent is temporarily waived, so long as that parent continues to be employed or enrolled in the education or training program.

(3) Determination that a parent is physically or mentally incapable of caring for a child shall be made by the administrator based on information obtained from a physician or psychologist licensed to practice under AS 08.64 or AS 08.86. Day care assistance may be authorized only for the period of time that the physician or psychologist estimates will be necessary for recovery to the point where the incapacitated parent can care for a child or return to employment or training. In no case may subsidy payments be authorized beyond 90 days without a redetermination of eligibility.

(c) In cases of an eligible family with a temporarily absent or incapacitated parent where a temporary caretaker assumes care and custody of a child, day care assistance may be authorized

(1) In a two-parent family, according to the provisions in section 190(a) of this chapter;

(2) In a single parent family, according to the unavailability of the temporary caretaker due to his/her verified work or training, or stated unwillingness to provide day care services;

(3) In cases where a temporary caretaker is unwilling to provide day care services, for no more than 10 hours a day.
(Effective / / , Register)

Authority: AS 44.47.250

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19 AAC 50.170

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19 AAC 50.160. DETERMINING NET INCOME. (a) A family's monthly adjusted net income is all the gross assets it received during the month from any and all sources, less the following:

- (1) federal income tax, according to the maximum deduction allowable under Internal Revenue Service tax tables;
- (2) state income tax;
- (3) social security tax (FICA) or Alaska State Benefit contributions;
- (4) mandatory benefit and retirement contributions;
- (5) unemployment insurance (ESC) contributions;
- (6) union dues or agency fees;
- (7) \$100 for each dependent child;
- (8) essential medical or dental expenses not covered by public or private insurance, including those costs directly incurred in the provision of medical or dental services that a licensed physician or dentist has determined must be performed for the person to function without significant impairment to his health or well-being. This does not include costs incidental to the provision of the essential medical or dental services, such as travel, lodging or meals; and
- (9) court-ordered payments which are actually being made.

(b) The base period for determining eligibility is the month preceding the month in which the application or redetermination of eligibility is made. (Effective / / Register)

Authority: AS 44.47.250

19 AAC 50.170 SUBSIDY. (a) The subsidy that an eligible family is entitled to is based on the following schedule:

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SUBSIDY SCHEDULE - BASE SCALE

| <u>MAXIMUM ADJUSTED NET INCOME</u> | <u>STATE SUBSIDY OF DAY CARE COSTS</u> |
|--|--|
| \$533 | 100% |
| 633 | 90% |
| 733 | 80% |
| 833 | 70% |
| 933 | 60% |
| 1033 | 50% |
| 1133 | 40% |
| 1233 | 30% |
| 1333 | 20% |

(b) The maximum family adjusted monthly net income is subject to the same percentage of geographic differential as that specified for basic salary schedules by AS 39.27.020.

(c) The division will distribute to each contractor a copy of the schedule adjusted to its locality, prior to entering into a new contract or upon request.

(d) The schedule shall be reviewed and may be revised annually by the division in consideration of changes in statewide median income and cost of living. (Effective / /)
Register)

Authority: AS 44.47.250

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19 AAC 50.180. REVIEW OF ELIGIBILITY. (a) If a family's income, as determined under sec. 160 of this chapter, is regular and recurring the administrator shall review the family's eligibility criteria once every three months and determine if the family continues to qualify, no longer qualifies, or needs to have its subsidy level, as determined under sec. 170 of this chapter, adjusted.

(b) If a family's income is not regular and recurring the administrator shall review the family's eligibility criteria on a monthly basis and enter a determination according to (a) of this section.

(c) At the time of each eligibility review, the administrator shall review the facility's billing records with the parent. The parent shall either attest to the validity of the billing records for the day care services provided for each eligible child in the family during the preceding eligibility period or dispute the facility's billing records. If the parent agrees that the billing records are accurate, he/she will sign a statement to that effect which shall be maintained in the family's case file.

(d) If the parent disputes the facility's billing records, the administrator shall attempt to determine the cause of the dispute between the facility and the parent, make necessary adjustments and advise the director of the situation. (Effective / / ,
Register)

Authority: AS 44.47.250

19 AAC 50.190. AUTHORIZED HOURS AND RATE SCHEDULE. (a) Day care assistance subsidy payments may only be made for day care authorized for an eligible child in conjunction with the specific activities set forth in this section:

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- (1) when the parent is working or training.
 - (2) when the parent is traveling to or from working or training; this activity is limited to one hour per day except where local transportation systems require a greater amount of time, the administrator may allow additional travel time;
 - (3) when the parent is sleeping on days when he/she has worked the night shift;
 - (4) when a parent is doing library or laboratory work, attending workshops or tutoring sessions, or similar activities required to satisfactorily complete an education or training program.
- (b) In no case shall subsidy payments be made when one or both parents is able to take care of a child.
- (c) Subsidy payment to a licensed facility shall be made on the basis of the family's authorized day care services, the family's subsidy level and the licensed facility's rate schedule, but not to exceed the following maximum rates:

MAXIMUM RATE SCHEDULE

| <u>UNIT OF CARE</u> | <u>NUMBER OF HOURS</u> | <u>INFANT RATE</u> | <u>CHILD RATE</u> |
|---------------------|--|--------------------|-------------------|
| part time | up to & including 5 a day | \$9 a day | \$7 a day |
| full time | more than 5 and up to & including 10 a day | \$11 a day | \$12 a day |