

ALABAMA LEGISLATIVE COMMITTEE REPORTS 1901-1900 7100

3975 SHEETS - HB 92 - HB 98

138

Subur

bill does:

changing some law to comply w/ fed. law.

- ① required income withholding when sum is at least 1 month in arrears. was optional before. employees rights, etc.
- ② spousal support - st. has to make a person pay alimony if there's a child support enforcement order, don't award alimony very much in AR.
- ③ medical support - Sds. trying to cut cost of Medicaid. so child support order must require that the person continue health insurance for his kids. probably only if available - don't have res. yet so not sure what the story is of it.
- ④ **COLA** for child support enforcement orders.
- ⑤ notice provisions - 1st class rather than certified mail. so person doesn't have to sign - they always avoid it. stretches out service time for year or so.

STATE OF ALASKA

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

BILL SHEFFIELD, GOVERNOR

REPLY TO:

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JUNEAU, ALASKA 99811
PHONE: (907) 465-3600

465-3603

February 5, 1985

The Honorable Max Gruenberg,
Alaska State Legislature
Pouch V
Juneau, AK 99811

Re: HB 92 Child and Spousal
Support

Dear Representative Gruenberg:

During the House HESS committee meeting on January 30, 1985, you asked me to look into the constitutional issue of due process in relation to the use of regular mail as a means of affording notice to obligors in child support enforcement actions. 1/ Your question was predicated on the Child Support Enforcement Division's proposal that the agency be allowed to use regular mail to notify an obligor of enforcement actions.

The seminal United States Supreme Court case concerning notice continues to be Mullane v. Central Hanover Bank and Trust Co., 399 U.S. 306, 314, 315 (1950) which provides that:

An elementary and fundamental requirement of due process in any proceeding which is to be accorded finality is notice reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections. ... The reasonableness and hence the constitutional validity of any chosen method may be defended on the ground that it is in itself reasonably certain to inform those affected, ... or, where conditions do not reasonably permit such notice, that the form chosen is not substantially less likely to bring home notice than other of the feasible and customary substitutes.

1/ My focus is limited to the case where a child support amount has been established and the obligor had notice and an opportunity to be heard in the establishment proceeding.

The Alaska Supreme Court has relied upon this standard in its own decisions regarding procedural due process requirements. 2/ In Balchen v. Balchen 566 P.2d 1324, 1327 (Alaska 1977) the Alaska Supreme Court found that the formal complaint-summons service requirements of Civil Rule 4 are inappropriate in proceedings which seek to enforce terms of a prior divorce decree relating to child support payments, for, unlike most judgments, divorce decrees can be modified at anytime. The appropriate procedure to be followed in such cases is set forth in the Civil Rule 5. 3/

Civil Rule 5 provides in part:

(b) Service -- How Made. Whenever under these rules service is required or permitted to be made upon a party represented by an attorney the service shall be made upon the attorney unless service upon the party himself is ordered by the court. Service upon the attorney or upon a party shall be made by delivering a copy to him or by mailing it to him at his last known address or, if no address is known, by leaving it with the clerk of the court. Delivery of a copy within this rule means: handing it to the attorney or to the party; or leaving it at his office with his clerk or other person in charge thereof; or, if there is no one in charge, leaving it in a conspicuous place therein; or, if the office is closed or the person to be served has no office, leaving it at his dwelling house or usual place of abode with some person of suitable age and discretion then residing therein. Service by mail is complete upon mailing....

2/ In State v. Bowers Office Products, Inc. 621 P.2d 11, 13 (Alaska 1980) the court found that the use of regular mail was adequate service to notify potential bidders of a bid amendment.

In Wickersham v. State Commercial Fisheries Entry Commission, 680 P.2d 1135, 1145, 1147 (Alaska 1984) the Alaska Supreme Court found that the Commission's efforts to notify potential applicants for limited entry permits through bulk mailing and media advertisements were constitutionally adequate, even if the materials sent by the Commission never actually reached the potential applicants.

3/ In Balchen three years had elapsed between the divorce decree and the modification hearing.

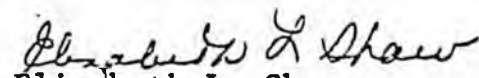
The Honorable Max Gruenberg
Alaska State Legislature
Re: HB 92 Child and Spousal Support

February 5, 1985
Page 3

It is the contention of the Child Support Enforcement Division that as in other continuing civil litigation the obligor bears responsibility for keeping the agency or the court informed of his or her current address. 4/ In the child support cases in question an obligor has participated, or had the opportunity to participate, in a prior judicial proceeding regarding his or her child support obligation. The court has continuing jurisdiction of the child support matter. To require the agency to meet the requirements of Civil Rule 4, as if each enforcement proceeding were a new action appears unduly onerous and would interfere unnecessarily with the enforcement process.

Sincerely yours,

NORMAN C. GORSUCH
ATTORNEY GENERAL

By: 
Elizabeth L. Shaw
Assistant Attorney General

ELS:bap

4/ AS 47.23.265(b) provides:

SERVICE; NOTIFICATION OF CHANGE OF ADDRESS. (a) Except as otherwise provided under this chapter, when a notice, paper, or other document is required by this chapter to be given or served upon a person by the agency, the notice, paper, or other document may be sent by registered or certified mail to the last known address of that person. Service by mail under this chapter is effected when the notice, paper, or other document is properly addressed, registered or certified, and mailed.

(b) A person required by court order to make child support payments through the agency shall keep the agency informed of the person's current address.

Sectional Summary. Relates to PL 98-378
★ - effective earlier than 10/1/85

Child Support Enforcement Amendments of 1984

Section 1 Bill title.

★ Section 2 Would amend section 451 of the Social Security Act to clarify that assistance in obtaining support must be available to all children for whom such assistance is requested.

Equal Treatment
eff. with
enactment

Section 3 Would amend section 454 of the Social Security Act to require States to have laws in effect October 1, 1985 requiring procedures for:

eff date
applies to all
mandatory
practices!

provisions

- o automatic wage withholding in the case of all IV-D child support payments delinquent in an amount equal to one month's support obligation, or upon request by the absent parent, or any time earlier which the State may choose. Withholding must be paid through public or publicly-accountable entities with accurate recordkeeping and monitoring. Advance notice must be given to the absent parent. If contested, State has 45 days from the advance notice to inform absent parent if withholding will occur and (if so) when. The amount to be withheld could include a fee to cover employer costs, at State option. Employer may waive the fee. Provisions must be made for withholding in interstate cases and terminating withholdings in all cases. At the States' option, income other than wages may be subject to withholding.
- o expedited processes, either through the judicial or administrative system for the establishment and enforcement of support obligations. States may include establishment of paternity in these processes.
- o offsetting State tax refunds to collect overdue support for AFDC and non-AFDC cases, except in appropriate cases.
- o imposing liens against real and personal property for amounts of overdue support, except in appropriate cases.
- o authorizing the court to require a security, bond, or other guarantee to secure support obligations from absent parents with a pattern of overdue support, except in appropriate cases.
- o permitting the establishment of paternity for both AFDC and non-AFDC children until their 18th birthdays.
- o making information available to the consumer credit agencies upon request if amounts of overdue support are in excess of \$1000, except in appropriate cases. States may recover costs of this activity from the credit agencies.
- o all support orders issued or modified after October 1, 1985 to include a provision for wage withholding.
- o Secretary may grant States exemption from the eight requirements above if such State demonstrates that the use of such procedure(s) would not increase the effectiveness or efficiency of the State child support program.

Alaska State Legislature

BETTYE FAHRENKAMP, Chairman
ARL ISS STURGULEWSKI, Vice Chairman
JOE JOSEPHSON
PAUL FISCHER
EDNA ARMSTRONG-DE VRIES



POUCH V
STATE CAPITAL
JUNEAU, ALASKA 99811
(907) 465-3834
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Senate Committee on Health, Education and Social Services

MEMORANDUM

TO: Members, Senate Committee on Health, Education and Social Services

FROM: Committee Staff

RE: Committee Meeting, April 23, 1985

DATE: April 19, 1985

On Tuesday, April 23, at 1:30 pm in the Beltz Room, the Senate Committee on Health, Education and Social Services will hear the following bills:

HB 92, Relating to child and spousal support.

The U.S. Department of Health and Human Services' Child Support Enforcement Program was created in 1975 to help collect court-ordered support from absent parents. The program in Alaska is operated through the Child Support Enforcement Agency (CSEA), which was established in the Department of Revenue in 1976 (AS 47.23). Recent amendments to the federal law have placed the state program out of compliance and \$1.1 million of our federal funding for the Aid to Families with Dependent Children program is at risk.

CS HB 92 (Jud) would bring the state program into compliance by:

- 1) providing for an income withholding order to be part of any order of child support,
- 2) changing the current time frame of 45 days in arrears to 30 days as the trigger to invoke an income withholding order,
- 3) increasing the limit of income withholding from 50% to 55%,
- 4) providing for withholding income in interstate cases,
- 5) providing for the enforcement of spousal support orders when child support is being enforced,

- 6) requiring the court to issue a medical support order as part of a child support order under certain conditions, and
- 7) imposing a \$1000 civil penalty on employers who retaliate against an obligor.

The bill makes two additional changes not required by federal law:

- 1) provides for service of a withholding order by first class mail (rather than certified mail) if the obligor was notified of the withholding law at the time the support order was obtained, and
- 2) requires employers to provide an obligor's employment information to CSEA upon request, and imposes a \$1000 fine for noncompliance.

Nationwide, absent parents pay only half the support owed, and two-thirds of these payments are delinquent by more than 30 days at least once a year. As of April 2, 1985, CSEA had 7198 cases in arrears with an outstanding arrearage balance of over \$30 million. CS HB 92 (Judiciary) is intended to enhance the collection of support payments from absent parents.

A sectional analysis of the bill is attached.

SB 263, Relating to the disqualification for certain state loan programs for failure to pay child support.

SB 263 would disqualify persons who have an overdue child support obligation from participating in state loan programs. It is anticipated that at the time of loan application the state agency administering the loan program would request delinquency information from the state Child Support Enforcement Agency (CSEA). Existing loans would not be affected.

SB 226, Relating to the violation of compulsory education laws.

SB 226 would delete the provision of the state's compulsory education law which releases and discharges a parent or guardian from all penalties associated with their child's truancy at the end of the school year. Under current statute, a parent who fails to send a child to school is guilty of a misdemeanor punishable by a fine or imprisonment but these penalties expire at the end of each school year. SB 226 is intended to enhance enforcement of the truancy law, since court proceedings can often not be completed within the term of one school year.

Also scheduled for committee action are:

SB 51, State aid for school construction, and

SCR 13, Relating to infant learning programs (which requests an examination of the public school foundation program as an alternate funding source for the Infant Learning Program).

SECTIONAL ANALYSIS CSHB 92 JUD

Income Withholding (Required by Federal Law)

Section 1: Subsection (a) provides for an income withholding order to be part of any order of child support. The prior language refers to an income assignment order rather than withholding order. The language change keeps us consistent with Federal Law. In addition, service has been changed to provide service by first class mail if the obligor had knowledge of the income withholding at the time the support order was obtained. If the obligor did not have notice because the case is older than 1983, when the income withholding law went into effect, service is to be by certified mail or by personal service.

Subsection (b) requires employers or any other person owing money to the obligor to withhold such funds and pay the money to the Child Support Enforcement Division.

Subsection (c) changes the current time frame of 45 days in arrears to one month in arrears as the triggering mechanism to invoke an income withholding order.

Subsection (d) changes the manner of service to first class mail and tightens the time frames for court hearings brought by obligors to dispute the income withholding. It also limits the defenses allowed to be raised at the hearing to mistakes of fact and specifically provides that it is not a defense to pay some amount of money prior to the hearing to dip below the threshold of one month owed.

Subsection (e) requires the Division to send notice of the relevant withholding statutes and an explanation of the effect of the statutes to any person who owes money to the obligor. It also requires withholding to begin either fourteen days after the notice of withholding or the next pay period, whichever is earlier.

Subsection (f) imposes a penalty of not more than \$1000.00 to any employer who retaliates against an obligor solely on the basis of income withholding.

Subsection (g) makes language changes to be consistent with the remaining sections.

Subsection (h) allows the payment of court costs to either party successful in the outcome of the withholding hearing.

Income Withholding (Required by Federal Law)

Section 2: Subsection (i) sets the maximum limits of income withholding to the Federal level: 55% for obligors who have second spouses or families; 65% for obligors with no other dependants. Alaska Law had been at 50%.

Subsection (j) provides convenience to the employer who has more than one employee on income withholding orders by allowing

payments to the Division to be made in one lump sum as long as specific employees' payments are identified.

Subsection (k) provides notice of termination to the Division by the employer and includes a requirement to include with the notice the obligor's last known address and addresses of other known employers.

Subsection (l) allows the obligor to petition the court to set aside income withholding upon good cause.

Cost of Living Increases/Decreases (Not Required by Federal Law)

Section 3: This section was added by the HESS Committee and amends AS 25.24.150 to allow the court to include cost of living adjustments in support orders.

Amendments to Duties of the Division (Required by Federal Law)

Section 4: Subsection (a)(1) adds to the Division's responsibilities the obtaining and enforcement of interstate orders.

Subsection (a)(7) provides the same intent as (a)(1) and in addition allows the Division to use the laws of the State of Alaska to obtain and enforce interstate orders.

Subsection (a)(8) provides for the enforcement of spousal support orders when child support is also being enforced by the Division.

Subsection (a)(9) requires the Division to obtain medical insurance as part of a support order if the costs to the obligor are reasonable.

Interstate Cases (Required by Federal Law)

Section 5: Subsections (a and b) provide for the process to obtain and enforce interstate orders from other Child Support Enforcement programs.

Rates of Penalty and Interest (Partially Required by Federal Law)

Section 6: This section eliminates the imposition of penalties for non-payment or late payment of child support. The new federal law only allows a maximum rate of 6% penalty provisions while Alaska had set a rate of 12%. The HESS and Judiciary Committees chose to eliminate all penalties since the recovery rate is minimal and the administrative burden outweighs the results.

Determination of Support Obligation (Required by Federal Law)

Section 7: This section adds language regarding the enforcement of spousal support if child support is also being administered by the Division.

Medical Support (Required by Federal Law)

Section 8: This section adds language regarding obtaining medical insurance in support orders when the cost to the obligor is reasonable.

Employment Information (Not Required by Federal Law)

Section 9: This section was added by the Judiciary Committee. It requires employers and labor unions to provide obligor's employment information to the Division upon request and imposes a \$1000.00 maximum penalty for knowingly violating the section.

Service (Not Required by Federal Law)

Section 10: This section rectifies an oversight in HB 688 of the Thirteenth Legislature to eliminate service provisions in this section in light of enactment of AS 47.23.265(a) which provides specific service provisions for all of AS 47.23.

Collection of Child Support (Not Required by Federal Law)

Section 11: This section amends AS 47.23.265 to modify service provisions to conform to changes in section 1.

Exemptions (Required by Federal Law)

Section 12: This section amends AS 47.250(i) to be consistent with exemptions in Section 2.

Income Withholding (Required by Federal Law)

Section 13: This section changes language to be consistent with section 1.

Civil Liability (Required by Federal Law)

Section 14: This section changes language to be consistent with Section 1.

Service (Not Required by Federal Law)

Section 15: This section provides general service provisions for all of AS 47.23 enforcement of child support order sections to allow service by first class mail in accordance with case law.

Payments Not Disbursed (Not Required by Federal Law)

Section 16: This section was added by the HESS Committee to provide for return of payments not disbursed to the obligor after seven years rather than to the State.

Effective Date (Required by Federal Law)

Section 17: October 1, 1985 is the effective date of the new Federal Law.



RECORDS CERTIFICATION



I, the undersigned, an employce of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.

James O. Smith
Signature of Camera Operator

10/31/89
Date

HB

98

Senate Health, Education and Social Services Committee

Legislation Checklist

Bill number: HB 98
Sponsor: GOVERNOR
Date referred to committee: 5/10
Synopsis completed:
Fiscal note:
Further referrals: JUDICIARY

CONTACTS:

Rod Betit, DHSS 3355

testify
2-27

Bob Franken, Gov's Council
694-8986

Dennis DeWitt, Hospitals 6-1790

Ed Hein, Legal 2450

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

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JUNEAU, ALASKA 99811
907-465-3800

May, 1986

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS date base CM 14. In order to save space copies of minutes have not been left in the files.

Jeanie Henry

Senate Health Education and Social Services Committee 2/4/86, 1:44 pm
" " " " " " 2/27/86, 1:36 pm

STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

STATEWIDE HEALTH COORDINATING COUNCIL

APR 18 1986

NRN - file
HB 98
BILL SHEFFIELD, GOVERNOR

POUCH H-01A
JUNEAU, ALASKA 99811
PHONE:

April 17, 1986

The Honorable Bill Sheffield
Governor
State of Alaska and
Members of the Alaska State Legislature

RE: HOUSE BILL 98

The Statewide Health Coordinating Council endorses passage of Senate CS for CS for House Bill 98 (Finance) with the improvements recommended in the Department of Health and Social Services position paper dated March 12, 1986. House Bill 98 provides several technical amendments to existing law, however, the issues with which the SHCC is most concerned are:

CLARIFICATION OF THE RELATIONSHIP OF THE MEDICAID RATE COMMISSION'S RATE SETTING RESPONSIBILITIES TO THE MEDICAID BUDGETING PROCESS.

The SHCC believes a means of assuring containment of medical costs to reasonable levels while preserving a prospective rate setting structure is an essential part of HB 98. This Bill will create an equitable consideration by the Medicaid Rate Commission between the financial needs of Alaska's health facilities, and the financial constraints of the Department of Health and Social Services budget.

INCLUSION OF PERSONAL CARE SERVICES PROVIDED IN A RECIPIENT'S HOME AS A SERVICE PAYABLE UNDER MEDICAID.

Personal care services are those services necessary to "accommodate long-term maintenance or supportive care, at a skill level less than most duties included under home health care as performed by Home Health Aides." The SHCC believes these services should be made available under the Medicaid program to persons in need.

INCLUSION OF DENTAL CARE UNDER THE MEDICAID PROGRAM.

Adult emergency dental care has been offered to Medicaid recipients under the General Relief Medical program since 1972. Although it has been necessary for such services to be deleted under the General Relief Medical program, HB 98 provides a means of restoring these services under the Medicaid program using 50% federal funding.

RE: House Bill 98

PRIORITIZING OF MEDICAL SERVICES PAYABLE UNDER THE MEDICAID PROGRAM.

It has been several years since the existing priority of payment for services under the Medicaid program was adopted. HB 98 provides a more equitable prioritization of services given the changing needs of Alaskans and financial considerations affecting the Medicaid program.

To demonstrate our firm support for passage of House Bill 98 the members of the SHCC have signed this endorsement.

STATEWIDE HEALTH COORDINATING COUNCIL

MEMBER

Paul Akerman

Paul Young

Arthur E. Willman

James Munn

Charlotte Barnes

Alma P. Cook

Maria Osterlund

Jim Oskum

James A. Keene

Hertie E. Smailka

Sharon L. King

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Alaska State Legislature

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ARLISS STURGULEWSKI, Vice Chairman
JOE JOSEPHSON
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EDNA ARMSTRONG-DE VRIES



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Senate Committee on Health, Education and Social Services

MEMORANDUM

TO: Members, Senate Committee on Health, Education and Social Services

FROM: Committee Staff

RE: Committee Meeting, February 4, 1986

DATE: January 31, 1986

On Tuesday, February 4, from 1:30-3:30 pm in the Beltz Room the Senate Committee on Health, Education and Social Services will hear two bills relating to Medicaid.

Draft SCS CSHB 98 (HESS) proposes to:

1. Amend the filing deadlines on claims for Medicaid and general relief assistance. Under current statute the Department may only pay a claim filed within six months of the date of service, an impractical period of time if a third party payor or a court hearing is involved. Section 1 would extend the payment period in these specified circumstances, and give the Department authority to approve partial payment of a claim filed at any time if the provider demonstrates good cause for failure to meet the statutory deadline.
2. Give the Department statutory basis for "first right" to recovery of medical assistance expenses from any insurance or court settlement awarded to a Medicaid recipient. Federal law requires all Medicaid applicants to assign their rights to third party payments as a condition of receiving Medicaid assistance. State statute is silent on the issue and as a result the Department must go to court to obtain recovery. Expenses recovered would be shared with the federal government.
3. Amend Alaska's Medicaid statutes to bring them into conformance with federal law. This is necessary due to changes enacted by Congress in the Deficit Reduction Act of 1984. Specifically, when a state accepts the Medicaid program it must

agree to offer certain mandatory services and may elect to offer a variety of additional services. Section 1 places in the mandatory category coverage of children under age 5 and pregnant women who meet eligibility criteria. These services are currently covered by the state as one of our options.

4. Add to the state's optional programs personal care services in a recipients' home. In past years funding for personal care attendants has been 100% state funded through the General Relief Medical program. Adding the service under Medicaid would allow costs to be shared with the federal government.

5. Clarify the order in which optional services are to be deleted if the Medicaid program runs into funding difficulties. To date, the Department has not needed to use this deletion provision.

6. Requires that in determining payment rates to health facilities the Medicaid Rate Commission consider the amount of state and federal funds that are available. Established under AS 47.07.110 in 1983, the Commission is charged with setting rates based on costs of current operations and appropriate capital development. The rate of increase approved by the Commission has been averaging over 15% a year. The Department will be proposing an additional change to the Medicaid Rate Commission statute (see document marked "For Discussion") which would mandate that rates set by the Commission not exceed the amount budgeted by the Department for the fiscal year.

CSHJR 58 urges the United States Department of Health and Human Services to ease the restrictions against granting Medicaid waivers for Home and Community Based Services. The waiver provision was intended to contain rapidly rising medical costs by offering payment for services within the community rather than in high cost institutions. Since 1982 the Department has been in the process of applying for a waiver. The latest application was returned to be rewritten according to new federal regulations which have construed the waiver so strictly as to effectively preclude eligibility. Specifically, the regulations require that the cost of care in the community, including all associated medical costs, be 25% less than the cost of institutional care.

*adopted
Conf Comm*

file

STATE OF ALASKA 1986 LEGISLATIVE SESSION FISCAL NOTE

Revision Date: _____

REQUEST

Bill/Resolution No. : SCS/CSHB98 (HSS)
Title : An act relating to Medical Assistance
Sponsor : Rules/Governor
Requestor : _____
Date of Request : 5/7/86

FISCAL DETAIL

Agency Affected : Health and Social Services
BRU : Medical Assistance Non-Facility
Components : Medicaid Non-Facility

EXPENDITURES/REVENUES : (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES		45.2	47.0	48.8	50.8	52.8
TRAVEL		8.6	8.9	9.3	9.7	10.1
CONTRACTUAL		.8	.8	.9	.9	.9
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS		1,959.1	3,459.5	3,597.9	3,741.8	3,891.5
MISCELLANEOUS						
TOTAL OPERATING		2,013.7	3,516.2	3,656.9	3,803.2	3,955.3

CAPITAL						
---------	--	--	--	--	--	--

REVENUE		250.0	270.0	292.0	315.0	340.0
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FUNDING : (Thousands of Dollars)

GENERAL FUND		881.9	1,623.1	1,682.4	1,744.1	1,807.7
FEDERAL FUNDS		881.8	1,623.1	1,682.5	1,744.1	1,807.6
OTHER		250.0	270.0	292.0	315.0	340.0
TOTAL		2,013.7	3,516.2	3,656.9	3,803.2	3,955.3

POSITIONS :

FULL-TIME		1.0	1.0	1.0	1.0	1.0
PART-TIME						
TEMPORARY						

ANALYSIS : Attach a separate page if necessary

Prepared by : Rod Betit, Director *RB* Phone : 465-3355
Division : Medical Assistance Date : 5/7/86

Approved by Commissioner : John St. Onge Date : 5/7/86
Agency : Department of Health and Social Services

Distribution (by Agency preparing fiscal note) :

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget

ace

Fiscal Note
Summary SCS CSHB98 (HESS)

FY87

5/7/87

<u>Section</u>	<u>Subject</u>	<u>FY87 Total</u>	<u>FY87 State</u>
I	Six Month Law	29.2	14.6
II	Subrogation	(250.0)	(125.0)
III	Optional Needy Groups	-0-	-0-
IV	Optional Medical Services	2,157.5	1,078.7
A.	<u>Personal Care</u>		
	(a) 190 recipients X 600 hours X \$9.00/hour =	1,029.2	Total
	(b) New position and associated costs =	54.6	Total
B.	<u>Adult Dental</u>		
	(a) 2716 recipients X \$331.63 =	900.7	Total
V	Priority Medical Services	-0-	-0-
VI	Medicaid Rate Commission	<u>-0-</u>	<u>-0-</u>
	Total \$ Impact	1,763.7	881.9

file HB 98

SCS CSHB 98 (FIN)

- 7. Physical Therapy] combined in .035
- 7. Occupational Therapy]
- 8. Speech, Hearing and Language Disorder Treatment
- 9. Optometrist Services
- 10. Intermediate Care Facility for Services
- 11. Eyeglasses] combined in .035
- * Prosthetic Devices]
- * Skilled Nursing Facility for Under Age 21
- * Emergency Hospital Services

C. Optional Services Not Offered in Alaska

- * Chiropractors Services
- . Other Practitioners Services
- . Private Duty Nursing
- * Dental Services
- . Prescribed Drugs
- . Dentures Services
- . Diagnostic Services
- . Screening Services
- . Preventive Services
- . Rehabilitative Services
- . Services for Age 65 or Older in TB Institutions
- * Personal Care Services
- . Christian Science Nurses
- . Christian Science Sanitoria

* These optional services and eligible groups are not currently listed in AS 47.07.035 but have been included in the revision proposed in HB98.

SCS CSHB 98 (FIN)

REQUEST FISCAL DETAIL
 Bill/Resolution No.: SCS CSHB98(F Agency Affected: Health and Social
 Title: As Act Relating to Program Category Affected:
 Medical Assistance
 Sponsor: Rules/Governor BRU, Program or Subprogram(s) Affected:
 Requestor: Medical Assistance Non-Facility/
 Date of Request: 5/2/86 Medicaid-None-Facility

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
OPERATING						
100 PERSONAL SERVICES			45.2			
200 TRAVEL			8.6			
300 CONTRACTUAL			20.8			
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS			2000.0			
800 MISCELLANEOUS						
TOTAL OPERATING			2074.6			

CAPITAL	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90

FUNDING: (Thousands of Dollars)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
FEDERAL FUND			912.3			
FEDERAL FUNDS			912.3			
OTHER						
TOTAL			1824.6			

POSITIONS:

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
FULL-TIME			1.0			
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

- (1) Funding is net after revenue to program.
- (2) See attached detail financial summary.

Prepared By: Senator Frank R. Ferguson Phone: 465-4923
 Division: Legislature Date: 5/2/86

Approved by Commissioner: _____ Date: _____
 Agency: _____

SCS CSHB 98 (FIN)

Section	Subject	FY87 Total	FY87 State
I	Six Month Law	29.2	14.6
II	Subrogation	(250.0)	(125.0)
III	Optional Needy Groups	-0-	-0-
IV	Optional Medical Services	2157.5	1078.7
A. Personal Care			
	(a) 190 recipients X 600 hours X \$9.00/hour =	1,029.2	Total
	(b) New position and associated costs =	54.6	Total
B. Chiropractor			
	(a) 600 recipients X \$255 average =	153.0	Total
	(b) One time computer costs =	20.0	Total
C. Adult Dental			
	(a) 2716 recipients X \$331.63 =	900.7	Total
V	Priority Medical Services	-0-	-0-
VI	Medicaid Rate Commission	-0-	-0-
	Total \$ Impact	1936.7	968.3

MEDICAID
ELIGIBLE GROUPS

A. Mandatory Eligible Groups:

- .AFDC Recipients
- .Deemed Recipients of AFDC
- .Families that lost AFDC because of employment
- .Individuals ineligible for AFDC because of requirements inapplicable under Medicaid] Win MMR
- .Individuals eligible for AFDC except for the SSA increase in 1972
- .Qualified pregnant women and children under 5 born after 9/30/83
- .Newborn children of Medicaid - eligible women
- .Children for whom adoption assistance or foster care maintenance payments are made under Title IV-E
- .The Aged, Blind, or Disabled under SSI
- .Individuals ineligible for SSI or State supplements because of requirements inapplicable under Medicaid
- ."Grandfathered" individuals

B. Optional Eligible Groups Covered in Alaska

11. Individuals under 21 who cannot qualify for AFDC because they are not dependent children
12. Institutionalized individuals under a special income eligibility level
13. Individuals who do not receive SSI but qualify for Adult Public Assistance
14. Pregnant women
 - * Individuals eligible for financial assistance but not receiving it
 - * Individuals eligible for financial assistance except for institutional status (not listed in draft bill under .035)

C. Optional Eligible Groups Not Covered

- .Noninstitutionalized disabled children
- .Noninstitutionalized individuals receiving home and community based service under a special income eligibility level
- .The medically needy
- .Individuals who could qualify for AFDC if AFDC were as broad as federally allowed
- .Individuals eligible for assistance under AFDC if child care costs were paid from earnings

* These optional services and eligible groups are not currently listed in AS 47.07.035 but have been included in the revision proposed in HB98.

MEDICAID
SERVICES

A. Mandatory Services:

- .Inpatient Hospital Services
- .Outpatient Hospital Services
- .Rural Health Clinics Services
- .Other Laboratory and X-Ray Services
- .Skilled Nursing Facilities Services
- .Home Health Services
- .Nurse Midwife Services
- .Early and Periodic Screening Diagnosis and Treatment for Individuals under 21
- .Physician Services
- .Medical Transportation

A. Optional Services Offered in Alaska

1. Long-Term Care Noninstitutional Services
2. Medical Supplies and Equipment
3. Surgical Care Center Services] under clinic services in .035
4. Clinic Services
5. Inpatient Psychiatric Service for Under Age 22] combined in .035
5. Inpatient Psychiatric Service for over Age 65]
6. Intermediate Care Facility for Mentally Retarded

Distributed by Sen. Fahrenkamp

HB 98 MEDICAL ASSISTANCE

ADOPT FINANCE COMMITTEE SUBSTITUTE.

- SEC. 1 ALLOWS DEPT. TO PAY "PAST DUE" (MORE THAN 6 MONTHS OLD) MEDICAID CLAIMS UNDER CERTAIN CONDITIONS
- SEC. 2 PROHIBITS DEPT. FROM PAYING CLAIMS THAT ARE PAYABLE BY A 3rd PARTY (I.E. INSURANCE)
- SEC. 3 MAKES CHANGES IN MANDATORY SERVICES AS REQUIRED BY FEDERAL LAW.
- SEC. 4 ADDS PERSONAL CARE ATTENDANTS, ADULT DENTAL, AND CHIROPRACTIC AS MEDICAID SERVICES COVERED IN ALASKA.
- SEC. 5 RE-PRIORITIZES MEDICAID OPTIONS ON A LIFE-SAVING TO LIFE-ENHANCING SCALE. PRIORITY WOULD BE USED IF FUNDING WERE INSUFFICIENT TO PAY FOR ALL SERVICES AUTHORIZED.
- SEC. 6-8 ALLOWS MEDICAID RATE COMMISSION TO REDETERMINE RATES FOR FACILITIES, AND TO CONSIDER STATE BUDGET WHEN DOING SO.
- SEC. 9-10 DEFINITIONS OF SERVICES BEING ADDED
- SEC. 11 ALLOWS DEPT. TO CONTRACT FOR MEDICAL SERVICES OF THE NEEDY.
- SEC. 12 ALLOWS DEPT. TO PRORATE PAYMENTS UNDER GENERAL RELIEF MEDICAL.
- SEC. 13 PRIORITIZES GENERAL RELIEF MEDICAL SERVICES. HIGHEST PRIORITY IS INPATIENT HOSPITAL SERVICES; THIS MAY BE ALL FUNDING IS AVAILABLE FOR.
- SEC. 14 REPEALS OLD LANGUAGE ON PAYMENT OF CLAIMS (SEE SEC. 1).
- SEC. 15 IMMEDIATE EFFECTIVE DATE.

(added in Finance)

added in Finance

(NOTE: BILL DOES NOT ADD PRESCRIPTION DRUGS TO MEDICAID.)

SUPPORTED BY: HEALTH ASSOCIATION OF ALASKA (DENNIS DEWITT)
 DEPARTMENT OF HEALTH AND SOCIAL SERVICES
 GOVERNOR'S COUNCIL ON HANDICAPPED AND GIFTED
 ACCESS ALASKA
 AND OTHERS...

HB 98, relating to medical assistance, was heard by the Senate Committee on Health, Education and Social Services on February 4, 1986. The bill proposes some revisions to the administration of the Medicaid program, and adds personal care services under Medicaid.

Also discussed at the hearing was expansion of the Medicaid program to maximize the use of federal dollars in light of 1) a potential federal "cap" on the Medicaid program, and 2) the Governor's proposed reductions to the state's General Relief Medical (GRM) program.

The following programs currently offered under GRM are available under Medicaid:

	FY 87 GRM COST	# SERVED ANNUALLY	FY 87 ESTIMATED MEDICAID COST (STATE SHARE)	# SERVED ANNUALLY
PERSONAL CARE SERVICES	\$200,000	8	\$527,000	455
Services under GRM are provided under a waiver granted by the Commissioner. Medicaid services would include those necessary to accommodate long-term maintenance or supportive care.				
ADULT DENTAL	\$725,546	2,216	\$450,352	2716
Services under GRM are limited to emergency care. Medicaid services could be expanded to include diagnostic, preventive, and corrective procedures.				
PHARMACEUTICALS	\$2.53 M	14,767	\$1.25 M	15,000

Eligibility criteria for Medicaid and GRM differ. Adding services to Medicaid will expand coverage for Medicaid-eligibles, but a certain population will continue to need coverage under GRM. The Department estimates that approximately 3,990 of the 16,690 persons who used GRM in FY 85 were not Medicaid eligible. (The use of the GRM program by Medicaid eligibles was mainly for dental and pharmaceutical coverage).

With no change to services offered or program eligibility, the funding need of GRM for FY 87 is \$12 million; the Governor's budget contains \$5 million. He has introduced HB 678, which is intended to effect some cost savings to the program through establishing a co-payment provision, limiting the amount of assistance to any one individual, requiring repayment of medical assistance under certain conditions, and allowing the Department to prioritize services and pro-rate payments in the event of a funding shortfall.

Other programs available under Medicaid not currently offered by the state include:

	STATE COST	# SERVED
CHIROPRACTIC	\$80,000	600

SB 109, which adds chiropractic services under Medicaid, has passed the Senate and is awaiting scheduling on the House floor.

MEDICALLY NEEDY	\$709,938	1525
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Services would be limited to children and pregnant women whose income before deducting medical expenses is above the Medicaid qualifying level, but whose income once medical bills have been paid is reduced to 133% or less of the income eligibility level.

ADULT PREVENTIVE SERVICES

Services include physicals, TB tests, flu shots and other immunizations such as hepatitis and tetanus. Currently provided to children under Medicaid.

REHABILITATIVE SERVICES

Services include psychiatric or other day treatment services, child development centers for children who are developmentally disabled or mentally retarded, adult day health centers, rehabilitation centers providing physical therapy, occupational therapy and speech, language and hearing services.

The costs of the Medicaid program are shared 50-50 by the state and federal governments. The Governor's budget contains \$36.5 million as the state's share for FY 87 (up from \$33.2 million in FY 86).

A new draft committee substitute, making the following changes, is attached:

1. Establishes a new prioritization of optional services, ranging from life sustaining to life enhancing. Developed with advice from the Department.

2. Adds language developed by the Department intended to more closely tie hospital and nursing home rates to legislative appropriations for Medicaid. Since the February 4 HESS meeting, the Medicaid Rate Commission has adopted emergency regulations to prohibit the accounting of bad debt and charity in figuring rates. (This should result in a \$2 million cost savings to the state annually). No decision has been made on freezing rates for FY 87.

- 1- payment of claims
- 2- 3rd party paymerits
- 3- conform to federal law
- 4- personal care services
- Original sponsor: Rules/governor
- 5- prioritization of options
- 6-8 - Medicaid Rate Commission
- 9-10 - definitions
- 11 - old language on payment
- 12- effective date

Hein
2/24/86.

DRAFT

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

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SENATE CS FOR CS FOR HOUSE BILL NO. 98 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - S^{COND} SESSION

A BILL

For an Act entitled: "An Act relating to medical assistance; and providing
for an effective date."

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

* Section 1. AS 44.77 is amended by adding a new section to read:

Sec. 44.77.015. CLAIMS FOR MEDICAL SERVICES. (a) For the purposes of filing claims for medical services provided under AS 47.07 or 47.25.120 - 47.25.300, "promptly," in AS 44.77.010(a), means (1) within six months after the date of service, or as provided in (b) of this section, if there is no third-party claim, or (2) within 12 months after the date of service if there is a third-party claim. Except as provided in (c) of this section, a claim may not be paid if it is not filed promptly; an inference to the contrary may not be drawn from AS 09.10.050, AS 09.50.250 - 09.50,300, or AS 37.25.010.

(b) In accordance with (a) of this section, a claim may be considered to be filed promptly if (1) the claim was filed more than six months after the date of service because the medical provider had reason to believe that the beneficiary was ineligible for service under AS 47.07 or AS 47.25.120 - 47.25.300; (2) a court of competent jurisdiction or an administrative hearing officer finds that the beneficiary was eligible for service under AS 47.07 or AS 47.25.120 - 47.25.300 on the date of service; and (3) the claim is filed within six months after the date that the court or administrative finding is rendered. The beneficiary is responsible for notifying the medical provider of the judicial or administrative finding.

1 (c) The commissioner of health and social services may authorize
2 payment to a medical provider of a claim not promptly filed, upon good
3 cause shown. Payments under this subsection may not exceed 50 percent
4 of the allowable charges presented in the claim. In this subsection,
5 "good cause" does not include a beneficiary's failure to notify a
6 provider of a judicial or administrative finding of eligibility.

7 (d) In this section,

8 (1) "beneficiary" means a person who is found to be eligi-
9 ble to receive medical services under AS 47.07 or AS 47.25.120 -
10 47.25.300;

11 (2) "medical provider" means a person, firm, corporation,
12 association, or institution that, on the date of service, was approved
13 to provide medical assistance, in accordance with regulations adopted
14 by the Department of Health and Social Services.

15 * Sec. 2. AS 47.05 is amended by adding a new section to read:

16 Sec. 47.05.070. SUBROGATION. (a) If the department provides or
17 pays for medical assistance for injury or illness under this title,
18 the department is subrogated to the rights of the recipient of that
19 medical assistance for any claim arising from the injury or illness
20 and to the proceeds of an insurance policy covering the injury or
21 illness to the extent of the value of the medical assistance provided.

22 (b) If a recipient of medical assistance under this title set-
23 tles a claim or obtains an award or judgment arising from the injury
24 or illness for which the medical assistance was received, the depart-
25 ment shall reimburse the recipient for attorney fees and costs commen-
26 surate with the amount of the settlement, award, or judgment to which
27 the department is entitled under (a) of this section. Regardless of
28 the manner in which the amount of the attorney fees is derived, reim-
29 bursement of attorney fees shall be in accordance with the applicable

1 rules of court governing the award of attorney fees in civil matters.

2 * Sec. 3. AS 47.07.020(b) is amended to read:

3 (b) In addition to the persons specified in (a) of this section,
4 the following optional groups of persons for whom the state may claim
5 federal financial participation are eligible for medical assistance:

6 (1) persons eligible for but not receiving assistance under
7 any plan of the state approved under 42 U.S.C. 601 - 615 (Title IV-A,
8 Social Security Act, Aid to Families with Dependent Children) or 42
9 U.S.C. 1381 - 1383c (Title XVI, Social Security Act, Supplemental
10 Security Income);

11 (2) persons in a general hospital, skilled nursing facility
12 or intermediate care facility, who, if they left the facility, would
13 be eligible for assistance under one of the federal programs specified
14 in (1) of this subsection;

15 (3) persons under age 21 who are [YEARS OF AGE] under
16 supervision of the department, for whom maintenance is being paid in
17 whole or in part from public funds, and who are in foster homes or
18 private child-care institutions;

19 (4) aged, blind, or disabled persons, who, because they do
20 not meet income requirements, do not receive supplemental security
21 income under 42 U.S.C. 1381 - 1383c (Title XVI, Social Security Act),
22 and who do not receive a mandatory state supplement, but who are
23 eligible, or would be eligible if they were not in a [GENERAL HOSPITAL
24 OR] skilled nursing facility or intermediate care facility to receive
25 an optional state supplementary payment;

26 (5) persons under age 21 who are [YEARS OF AGE] in an
27 institution designated as an intermediate care facility for the men-
28 tally retarded and who are financially eligible as determined by the
29 standards of the federal aid to families with dependent children

1 program;

2 (6) persons in a medical or intermediate care facility
3 whose income while in the facility does not exceed 300 percent of the
4 supplemental security income benefit rate under 42 U.S.C. 1381 - 1383c
5 (Title XVI, Social Security Act) but who would not be eligible for an
6 optional state supplementary payment if they left the hospital or
7 other facility;

8 (7) persons under age 21 who are [YEARS OF AGE] receiving
9 active treatment in a psychiatric hospital and who are financially
10 eligible as determined by the standards of 42 U.S.C. 601 - 615 (Title
11 IV-A, Social Security Act, Aid to Families with Dependent Children);

12 (8) persons under age 21 and not covered under (a) of this
13 section, [YEARS OF AGE] who would be eligible for benefits under the
14 federal aid to families with dependent children program, except that
15 they have the care and support of both their natural and adoptive
16 parents [BUT WHO DO NOT QUALIFY BECAUSE THEY ARE NOT DEPENDENT CHILD-
17 REN];

18 (9) [WOMEN WHO ARE] pregnant women not covered under (a) of
19 this section and who meet the income and resource requirements of the
20 federal aid to families with dependent children program.

21 * Sec. 4. AS 47.07.030 is repealed and reenacted to read:

22 Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. (a) The de-
23 partment shall offer all mandatory services required under 42 U.S.C.
24 1396 - 1396p (Title XIX of the Social Security Act).

25 (b) In addition to the mandatory services specified in (a) of
26 this section, the department may offer only the following optional
27 services: personal care services in a recipient's home; emergency
28 hospital services; long-term care noninstitutional services; medical
29 supplies and equipment; clinic services; inpatient psychiatric

1 facility services for individuals age 65 or older and individuals
2 under age 21; physical therapy; occupational therapy; treatment of
3 speech, hearing, and language disorders; prosthetic devices and eye-
4 glasses; optometrists' services; intermediate care facility services,
5 including intermediate care facility services for the mentally re-
6 tardated; skilled nursing facility services for individuals under age
7 21; and reasonable transportation to and from the point of medical
8 care.

9 * Sec. 5. AS 47.07.035 is repealed and reenacted to read

10 Sec. 47.07.035. PRIORITY OF MEDICAL ASSISTANCE. If the depart-
11 ment finds that the cost of medical assistance for all persons eligi-
12 ble under this chapter will exceed the amount allocated in the state
13 budget for that assistance for the fiscal year, the department shall
14 eliminate coverage for optional medical services and optionally eligi-
15 ble groups of individuals in the following order:

- 16 (1) emergency hospital services;
- 17 (2) treatment of speech, hearing, and language disorders;
- 18 (3) optometrists' services and eyeglasses;
- 19 (4) occupational therapy;
- 20 (5) prosthetic devices;
- 21 (6) medical supplies and equipment;
- 22 (7) clinic services;
- 23 (8) physical therapy;
- 24 (9) personal care services in a recipient's home;
- 25 (10) long-term care noninstitutional services;
- 26 (11) inpatient psychiatric facility services;
- 27 (12) intermediate care facility services for the mentally
28 retarded;
- 29 (13) intermediate care facility services;

1 (14) individuals under age 21 who are not eligible for
2 benefits under the federal aid to families with dependent childrer
3 program because they are not deprived of one or more of their natural
4 or adoptive parents;

5 (15) skilled nursing facility services for persons under age
6 21;

7 (16) aged, blind, and disabled individuals who, because they
8 do not meet the income requirements, do not receive supplemental
9 security income under Title XVI of the Social Security Act, but who
10 are eligible, or would be eligible if they were not in a skilled
11 nursing facility or intermediate care facility, to receive an optional
12 state supplementary payment;

13 (17) individuals in a hospital, skilled nursing facility, or
14 intermediate care facility whose income while in the facility does not
15 exceed 300 percent of the supplemental security income benefit rate
16 under Title XVI of the Social Security Act, but who, because of in-
17 come, are not eligible for the optional state supplementary payment;

18 (18) individuals under age 21 under supervision of the
19 department, for whom maintenance is being paid in whole or in part
20 from public money and who are in foster homes or private child-care
21 institutions.

22 * Sec. 6. AS 47.07.040 is amended to read:

23 Sec. 47.07.040. STATE PLAN FOR PROVISION OF MEDICAL ASSISTANCE.
24 The department shall prepare a state plan in accordance with the
25 provisions of 42 U.S.C. 1396 1396p (Title XIX, Social Security Act,
26 Medical Assistance) and submit it for approval to the United States
27 Department of Health and Human Services. The plan shall designate
28 that the Department of Health and Social Services is the single state
29 agency to administer this plan. The department shall act for the

1 state in any negotiations relative to the submission and approval of
2 the plan. The department, including the Medicaid Rate Commission,
3 [AND] may make those arrangements or regulatory changes, not inconsis-
4 tent with law, as may be required under federal law to obtain and
5 retain approval of the United States Department of Health and Human
6 Services to secure for the state the optimum federal payment under the
7 provisions of 42 U.S.C. 1396 - 1396p (Title XIX, Social Security Act,
8 Medical Assistance). In addition, the department shall provide a
9 report to the legislature no later than March 15 of each year concern-
10 ing the status of this program and recommendations, with supporting
11 fiscal data, as to any changes in the coverage of eligible persons or
12 services to be provided.

13 * Sec. 7. AS 47.07.070 is amended by adding a new subsection to read:

14 (d) In determining a rate of payment to a health facility under
15 this section, the commission shall consider the appropriation limit
16 set by the legislature for the department's programs under this chap-
17 ter and under AS 47.25.120 - 47.25.300, and available federal revenue.
18 The commission shall set rates for health facilities in the state so
19 that, taking into account projected rates of utilization, the aggre-
20 gate state payments to health facilities should not exceed the budget-
21 ed amounts for the state fiscal year.

22 * Sec. 8. AS 47.07.180 is repealed and reenacted to read:

23 Sec. 47.07.180. DUTIES. (a) The commission shall review
24 proposed payment rates for health facilities under this chapter and
25 AS 47.25.120 - 47.25.300.

26 (b) The commission may review budgets of, and ~~shall~~ ^{shall} establish
27 payment rates for, health facilities under this chapter and AS 47.-
28 25.120 - 47.25. 300.

29 (c) The commission shall consult with the department on the

1 state plan as it relates to health facilities. The commission may not
2 change the unit of payment without the written consent of the depart-
3 ment.

4 (d) By March 1 of each year, the commission shall develop for
5 the [REDACTED] fiscal year ^{starting the next July 1} an annual estimate of medical assistance program
6 expenditures in health facilities under the jurisdiction of the com-
7 mission. The estimate shall consider anticipated utilization and
8 payment rates for each facility. The methodology used by the
9 commission to develop the estimate shall be consistent with the
10 regulations governing the commission's rate-setting process.

11 * Sec. 9. AS 47.07.900(1) is amended to read:

12 (1) "clinic services" means services provided by state-
13 approved outpatient community mental health clinics that receive
14 grants under AS 47.30.520 - 47.30.620, state-operated community mental
15 health clinics, outpatient surgical care centers, and physician clin-
16 ics;

17 * Sec. 10. AS 47.07.900 is amended by adding new paragraphs to read:

18 (7) "emergency hospital services" means services that

19 (A) are necessary to prevent the death or serious
20 impairment of the health of the individual; and

21 (B) because of the threat to the life or health of the
22 individual, necessitate the use of the most accessible hospital
23 available that is equipped to furnish the services, even if the
24 hospital does not currently meet

25 (i) the conditions for participation under Medi-
26 care; or

27 (ii) the definitions of inpatient or outpatient
28 hospital services under 42 C.F.R. secs. 440.10 and 440.20.

29 (8) "personal care services in a recipient's home" means

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services prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is

- (A) qualified to provide the services;
- (B) supervised by a registered nurse; and
- (C) not a member of the recipient's family.

* Sec. 11. AS 44.77.010(b) is repealed.

* Sec. 12. This Act takes effect immediately in accordance with AS 01.-10.070(c).

STATE OF ALASKA 1986 LEGISLATIVE SESSION FISCAL NOTE

Revision Date : _____

REQUEST

Bill/Resolution No. : SCS CSHB98 (HESS)
 Title : An act relating to medical assistance and providing for an effective date.
 Sponsor : HEIN
 Requestor : _____
 Date of Request : 2/1/86

FISCAL DETAIL

Agency Affected : Health & Social Services
 BRU : Medical Assistance Non-Facility

 Components : Medicaid Non-Facility

EXPENDITURES/REVENUES : (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES		45.2	47.0	48.8	50.8	52.8
TRAVEL		8.6	8.9	9.3	9.7	10.1
CONTRACTUAL		.8	.8	.9	.9	.9
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS		1,029.2	2,446.6	2,544.5	2,646.3	2,752.2
MISCELLANEOUS						
TOTAL OPERATING		1,083.8	2,503.3	2,603.5	2,707.7	2,816.0

CAPITAL						
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REVENUE		250.0	270.0	292.0	315.0	340.0
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FUNDING : (Thousands of Dollars)

GENERAL FUND		416.9	1,116.6	1,155.7	1,196.3	1,238.0
FEDERAL FUNDS		416.9	1,116.7	1,155.8	1,196.4	1,238.0
OTHER						
TOTAL		833.8	2,233.3	2,311.5	2,392.7	2,476.0

POSITIONS :

FULL-TIME		1.0	1.0	1.0	1.0	1.0
PART-TIME						
TEMPORARY						

ANALYSIS : Attach a separate page if necessary

* Note: Funding is net after revenue to program.

Summary of sections to bill.

Prepared by : *Rod Ballew*
 Division : Med. Medical Assistance

Phone : 465-3355
 Date : 2/4/86

Approved by Commissioner : *John A. Dwyer*
 Agency : Department of Health & Social Services

Date : 2/4/86

Distribution (by Agency preparing fiscal note):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

Fiscal Note
 Summary SCS CSHB98 (HESS)
 FY87

<u>Section</u>	<u>Subject</u>	<u>SGFM</u>	<u>Federal</u>
I	Six Month Law	14.6	14.6
II	Subrogation	(125.0)	(125.0) <i>(1st right)</i>
III	Optional Needy Groups	-0-	-0-
IV	Optional Medical Services	527.3	527.3 P.C.A.
V	Priority Medical Services	-0-	-0-
VI	Medicaid Rate Commission	-0-	-0-

gen funded

Committee Substitute House Bill 98
Assumptions

This projection for personal care services is based on the following:

- (a) personal care services can be divided into two categories of allowed Title XIX services (personal care and medically related home care).
- (b) Oregon showed an average of 21.2 hours personal care and 38.12 hours of home care per case per month.
- (c) unit cost is based on 1 hour of work.
- (d) recipient utilization figures for the Oregon personal care services program showed total utilization equal to 8.6% of the Aged, Disabled, and Blind eligibles. Alaska has approximately 5,200 APA recipients of which 455 is the estimated number of recipients of this program.
 - 1. 30% Personal Care (PC) reimbursed at \$11.90 per hour. (Oregon's hourly rate multiplied by 1.25).
 - 2. 70% Home Care (HC) at \$8.13. (Oregon's hourly rate multiplied by 1.25)

Projected Cost Personal Care Services

	<u>Hours</u>	<u>Rate</u>	<u>Cost</u>
Single recipient PC/mo.	11.2 x	11.90 =	\$133.28
Single recipient HC/mo.	<u>38.1</u> x	8.13 =	<u>309.92</u>
Single recipient PC&HC/mo.	49.3		\$443.20
Single recipient yearly	591.6		5,318.40
Total 455 recipients	<u>269,178</u>		<u>\$2,419,872.00</u>

While the analysis projects a total annual cost of \$2,419,872, the Division estimates the first year cost at \$1,000,000. The Division anticipates that both a 10/1/86 program start date, as well as client unfamiliarity with the program will reduce the programs first year cost.

Committee Substitute House Bill 98

Division of Medical Assistance

Personal Services:

1 - New Medical Assistance Administrator position
at range 17A \$2,895 x 12 months x 30% benefits = \$45,162

Travel:

Semi-annual travel to personal care sites by Medical
Assistance Administrator to monitor the personal care
services each client is receiving.
Estimate transportation 7,000
Estimate per diem, 20 days at \$80 per day 1,600

Contractual:

Printing and advertising for personal care services 800

Increases from fiscal year to fiscal year are budgeted at 4% for all lines.

Attachment A

MEDICAID
SERVICES

A. Mandatory Services:

- .Inpatient Hospital Services
- .Outpatient Hospital Services
- .Rural Health Clinics Services
- .Other Laboratory and X-Ray Services
- .Skilled Nursing Facilities Services
- .Home Health Services
- .Nurse Midwife Services
- .Early and Periodic Screening Diagnosis and Treatment for Individuals under 21
- .Physician Services
- .Medical Transportation

A. Optional Services Offered in Alaska

1. Long-Term Care Noninstitutional Services
2. Medical Supplies and Equipment
3. Surgical Care Center Services] under clinic services in .035
4. Clinic Services
5. Inpatient Psychiatric Service for Under Age 22] combined in .035
5. Inpatient Psychiatric Service for over Age 65]
6. Intermediate Care Facility for Mentally Retarded
7. Physical Therapy] combined in .035
7. Occupational Therapy]
8. Speech, Hearing and Language Disorder Treatment
9. Optometrist Services
10. Intermediate Care Facility for Services
11. Eyeglasses] combined in .035
- * Prosthetic Devices]
- * Skilled Nursing Facility for Under Age 21
- * Emergency Hospital Services

C. Optional Services Not Offered in Alaska

- .Chiropractors Services
- .Other Practitioners Services
- .Private Duty Nursing
- .Dental Services
- .Prescribed Drugs
- .Dentures Services
- .Diagnostic Services
- .Screening Services
- .Preventive Services
- .Rehabilitative Services
- .Services for Age 65 or Older in TB Institutions
- .Personal Care Services
- .Christian Science Nurses
- .Christian Science Sanitoria

* These optional services and eligible groups are not currently listed in AS 47.07.035 but have been included in the revision proposed in HB98.

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

POUCH H-07
JUNEAU, ALASKA 99811
PHONE:

February 12, 1986

BRIEFING PAPER
GENERAL RELIEF MEDICAL

I. HISTORY OF GENERAL RELIEF MEDICAL PROGRAM

The GR Medical Program has been in existence since 1953. The number of persons covered and medical services offered varied depending on the funding available each year. During that early period, the GR Medical Program primarily offered major medical care to low income persons not otherwise covered by private health insurance, or covered under other federal programs such as the Indian Health Service. The largest group in the GR Medical population consisted of public assistance recipients (Aid to Families with Dependent Children, Old Age Assistance, Aid to the Blind and Aid to the Disabled).

In 1972, Alaska became the 49th State to enter the federal Medicaid Program. All public assistance recipients were at that time moved from GR Medical to Medicaid and became eligible for a broad range of preventative as well as major medical services. The GR Medical was concurrently redefined to cover only those low income adults and children who did not qualify for Medicaid, and who had no other medical coverage. After 1972, the single biggest group of GR Medical eligibles were low income families with young children who did not qualify for AFDC because both parents lived with the children. After 1972, GR Medical recipients were provided virtually the same range of medical services as were available to Medicaid recipients. These services included:

- . Inpatient hospital
- . Outpatient hospital
- . Skilled nursing facility
- . Intermediate care facility
- . Intermediate care facility for mentally retarded persons
- . Laboratory and X-ray services
- . Visual care services, dispensing and ophthalmic materials
- . Medical transportation
- . Speech, hearing and language services
- . Nurse midwife services
- . Home health care services
- . Physician services
- . Physical and occupational therapy
- . Prosthetic devices and medical supplies
- . Family planning services (including elective abortions)
- . Outpatient surgical care centers
- . Rural health clinic services
- . Emergency dental services for adults
- . Hearing aids

Three medical services were not picked up by the Legislature under Medicaid in 1972. These were prescription drugs, elective abortions, and emergency dental services for adults. These services were left under GR Medical but Medicaid recipients were allowed access to them if they had no other coverage. This remains the case through FY86.

not available under Medicaid

The last major change to GR Medical was made in 1982. The Alaska Legislature moved two more eligible groups from GR Medical into Medicaid. The first group consisted of pregnant women who did not qualify for Aid to Families with Dependent Children (AFDC) because this was their first child, or they were living with the father of the child. The second group consisted of all low income children who did not qualify for AFDC because they were living with both parents. These 1982 changes further reduced the population covered under GR Medical to only those adults between the ages of 21 and 64, who were either unemployed or under employed, and who met the income requirement.

The evolution of Alaska's GR Medical program is not unlike that found in many other states. In fact, most states have a residual statewide program like GR Medical to meet the needs of medically indigent individuals who are not covered under Medicaid, or other state and federal programs. As of July 1985, 34 states offered statewide programs designed to assist the medically indigent using state funds, and in some instances, local fund match. In the remaining 16 states, counties and municipalities carry some legal obligation to provide medical care to those without any other coverage.

however AK pays rates at 75th percentile; many states pay 50th percentile.

II. CURRENT ELIGIBILITY REQUIREMENTS

In order to qualify for Alaska GR Medical at the present time, an adult must:

- have income under \$300 a month,
- have liquid assets under \$500 (excluding their home and vehicle),
- have no other medical coverage to meet the need

In certain circumstances, the Commissioner of Health and Social Services has "waived" the income and asset eligibility requirements under the authority of AS 47.25.252, and extended medical benefits to persons who would otherwise not be eligible. Less than 30 such waivers have been approved to date with an approximate annual cost of \$700,000.

III. DEMOGRAPHICS OF GR MEDICAL POPULATION

Because Medicaid recipients access certain medical services under GR Medical the demographics of GR Medical users is heavily skewed by the Medicaid population. TABLES I, II and III demonstrate this clearly. In analyzing the data in Tables I, II, and III we note that of the 16,696 persons who used GR Medical in FY85 (See TABLE I) 14,767 or 88% used prescription drugs. Most of these individuals were Medicaid recipients crossing over to use GR Medical services. The same close interrelationship to Medicaid is evidenced with respect to dental services. Here again, most would be Medicaid recipients. Adjusting for the Medicaid recipient cross-over factor, we estimate that approximately 3990 Alaskans used only GR Medical in FY85, and had no connection to Medicaid.

TABLE I

GR MEDICAL UTILIZATION BY AGE - FY85

TYPE OF MEDICAL CARE OR SERVICE	AGE IN YEARS				

	UNDUPLICATED TOTAL (1)	UNDER 6 (2)	6 - 20 (3)	21 - 64 (4)	65 AND OVER (5)
1. TOTAL	16,696	3,705	3,576	8,210	1,205
2. INPATIENT HOSPITAL SERVICES	657	6	15	629	7
3. SNF/ICF SERVICES - ALL OTHER	45	0	0	25	20
4. PHYSICIANS' SERVICES	2,205	42	144	1,997	22
5. DENTAL SERVICES	2,216	8	32	2,076	100
6. OTHER PRACTITIONERS' SERVICES	702	8	18	673	3
7. OUTPATIENT HOSPITAL SERVICES	994	14	33	937	10
8. FAMILY PLANNING SERVICES	55	0	3	52	0
9. LAB AND X-RAY SERVICES	135	3	2	128	2
10. PRESCRIBED DRUGS	<u>14,767</u>	<u>3,663</u>	3,477	6,475	1,152
11. EARLY AND PERIODIC SCREENING	45	12	6	16	11
12. RURAL HEALTH CLINIC SERVICES	4	1	2	1	0
13. OTHER CARE	642	12	86	533	11

TABLE II

GR MEDICAL UTILIZATION BY SEX - FY85

TYPE OF MEDICAL CARE OR SERVICE	SEX		
	MALE	FEMALE	UNKNOWN
1. TOTAL	5,696	10,866	134
2. INPATIENT HOSPITAL SERVICES	309	348	0
3. ICF SERVICES - ALL OTHER	20	25	0
4. PHYSICIANS' SERVICES	936	1,269	0
5. DENTAL SERVICES	573	1,643	0
6. OTHER PRACTITIONERS' SERVICES	422	280	0
7. OUTPATIENT HOSPITAL SERVICES	477	517	0
8. FAMILY PLANNING SERVICES	0	55	0
9. LAB AND X-RAY SERVICES	48	87	0
10. PRESCRIBED DRUGS	4,809	9,819	139
11. EARLY AND PERIODIC SCREENING	10	35	0
12. RURAL HEALTH CLINIC SERVICES	0	4	0
13. OTHER CARE	207	435	0

TABLE III

GR MEDICAL UTILIZATION BY RACE - FY85

TYPE OF MEDICAL CARE OR SERVICE	-----RACE/ETHNICITY-----					
	WHITE NOT OF HISPANIC ORIGIN	BLACK NOT OF HISPANIC ORIGIN	AMERICAN INDIAN OR ALASKAN NATIVE	ASIAN AMERICAN	HISPANIC	UNKNOWN
1. TOTAL	11,801	1,332	2,261	286	406	610 = 16,696
2. INPATIENT HOSPITAL SERVICES	545	28	20	12	12	40
3. ICF SERVICES - ALL OTHER	31	1	7	2	0	4
4. PHYSICIANS' SERVICES	1,766	126	132	52	42	87
5. DENTAL SERVICES	1,667	20	162	53	62	72
6. OTHER PRACTITIONERS' SERVICES	430	39	199	7	13	14
7. OUTPATIENT HOSPITAL SERVICES	839	57	32	22	17	27
8. FAMILY PLANNING SERVICES	47	2	2	2	1	1
9. LAB AND X-RAY SERVICES	107	7	5	7	3	6
10. PRESCRIBED DRUGS	10,613	1,259	1,741	253	369	532
11. EARLY AND PERIODIC SCREENING	29	6	5	1	2	2
12. RURAL HEALTH CLINIC SERVICES	0	0	4	0	0	0
13. OTHER CARE	350	50	207	9	7	19

Table IV demonstrates another interesting fact[?] about the GR Medical program. Approximately 32% of the persons open for GR Medical coverage in January 1986 were individuals awaiting a disability determination from Social Security, which if favorable would entitle the individual to state and federal cash assistance payments as well as Medicaid. Typically, a pending disability client must wait an average of 2 to 3 months to learn whether their eligibility for cash assistance and Medicaid will be approved. GR Medical meets many of these individuals medical needs in the interim.

TABLE IV

GRM CASES OPEN IN JANUARY 1986

DISTRICT	# GRM	PENDING DISABILITY	TOTAL
21 Juneau	13	3	16
22 Sitka	2	1	3
23 Ketchikan	20	7	27
24 Petersburg	2		2
41 Fairbanks	76	24	100
44 Fairbanks Field Unit	1		1
45 Barrow	1		1
49 Minto	5		5
78 Tok	3	1	4
46 Nome	3		3
47 Kotzebue		1	1
51 Bethel	18	14	32
55 Aniak	6	2	8
71 Anchorage Intake	17	83	100
83 Anchorage Maintenance	102		102
72 Valdez	3		3
75 Kodiak	14		14
76 Kenai	31	12	43
77 Palmer	<u>31</u>	<u>12</u>	<u>43</u>
Total	348	160	508

In summary, the average GR Medical recipient has these characteristics:

- . white adult - fairly equal number of men and women
- . between the age of 21 and 64
- . medically in need - many having filed for disability
- . predominantly live in Anchorage, Fairbanks, Juneau or Ketchikan
- . predominantly unemployed or unable to work because of disability

IV. MEDICAL SERVICES BEING USED

Tables V, VI and VII give total expenditures for GR Medical in FY85 by type of medical service by age, race and sex of those using the services. Again, these numbers must be adjusted for the Medicaid cross-over to isolate the services used by the GR Medical only population. The principal service categories used solely by the GR Medical population are hospital services (both inpatient and outpatient) and physician services.

TABLE V

AMOUNTS OF MEDICAL PAYMENTS BY AGE - FY85

TYPE OF MEDICAL CARE OR SERVICE	TOTAL (1)	AGE IN YEARS			
		UNDER 6 (2)	6 - 20 (3)	21 - 64 (4)	65 OR OVER (5)
1. TOTAL	10,861,550.42	241,987.74	390,445.50	9,368,367.12	860,750.06
2. INPATIENT HOSPITAL SERVICES <i>maintained from budget</i>	4,533,962.29	8,774.62	45,137.92	4,428,529.30	51,520.45
3. SNF/ICF SERVICES - ALL OTHER	308,239.75	0	0	81,675.64	226,564.11
4. PHYSICIANS' SERVICES	2,001,164.57	11,547.89	55,011.90	1,917,309.17	17,295.61
5. DENTAL SERVICES	677,806.50	1,216.00	7,519.50	640,233.50	22,837.50
6. OTHER PRACTITIONERS' SERVICES	127,461.66	1,052.54	2,141.39	123,907.82	359.91
7. OUTPATIENT HOSPITAL SERVICES	400,234.09	2,893.46	9,001.61	386,415.16	1,923.86
8. CLINIC SERVICES	0	0	0	0	0
9. HOME HEALTH SERVICES	0	0	0	0	0
10. FAMILY PLANNING SERVICES	61,663.28	0	224.00	61,439.28	0
11. LAB AND X-RAY SERVICES	8,732.31	94.32	61.88	8,498.11	78.00
12. PRESCRIBED DRUGS	2,528,103.87	212,093.68	246,425.67	1,537,660.24	531,924.28
13. EARLY AND PERIODIC SCREENING	3,499.43	435.51	273.25	1,121.53	1,669.14
14. RURAL HEALTH CLINIC SERVICES	1,281.70	58.93	626.01	596.76	0
15. OTHER CARE	215,400.97	3,820.79	24,022.37	180,980.61	6,577.20

TABLE VI

AMOUNTS OF MEDICAL PAYMENTS BY SEX - FY85

TYPE OF MEDICAL CARE OR SERVICE	MALE	FEMALE	UNKNOWN
1. TOTAL	4,892,562.42	5,961,246.53	7,711.47
2. INPATIENT HOSPITAL SERVICES	2,438,429.56	2,095,532.73	0
3. SNF/ICF SERVICES - ALL OTHER	167,812.70	140,427.05	0
4. PHYSICIANS' SERVICES	972,219.78	1,028,944.79	0
5. DENTAL SERVICES	166,066.60	505,739.90	0
6. OTHER PRACTITIONERS' SERVICES	85,992.52	41,469.14	0
7. OUTPATIENT HOSPITAL SERVICES	194,001.33	206,232.76	0
8. FAMILY PLANNING SERVICES	0	61,633.28	0
9. LAB AND X-RAY SERVICES	3,054.71	5,677.60	0
10. PRESCRIBED DRUGS	778,715.13	1,741,677.27	7,711.47
11. EARLY AND PERIODIC SCREENING	689.91	2,809.52	0
12. RURAL HEALTH CLINIC SERVICES	0	1,281.70	0
13. OTHER CARE	85,580.18	129,820.79	0

TABLE VII
AMOUNTS OF MEDICAL PAYMENTS BY RACE - FY85

TYPE OF MEDICAL CARE OR SERVICE	RACE/ETHNICITY					
	WHITE NOT OF HISPANIC ORIGIN	BLACK NOT OF HISPANIC ORIGIN	AMERICAN INDIAN OR ALASKAN NATIVE	ASIAN AMERICAN	HISPANIC	UNKNOWN
1. TOTAL	8,560,794.22	801,469.40	636,265.91	224,703.14	171,331.28	474,305.
2. INPATIENT HOSPITAL SERVICES	3,521,843.74	365,201.56	114,942.31	113,865.92	53,691.42	264,412.
3. SNF/ICF SERVICES - ALL OTHER	283,201.55	601.90	25,841.38	0	0	5,918.
4. PHYSICIANS' SERVICES	1,610,992.33	141,944.01	67,692.98	36,445.34	40,907.25	103,183.
5. DENTAL SERVICES	534,915.35	49,984.35	33,271.80	12,055.00	25,248.00	16,332.
6. OTHER PRACTITIONERS' SERVICES	78,204.54	20,927.64	23,813.19	1,020.97	1,770.21	1,725.
7. OUTPATIENT HOSPITAL SERVICES	342,399.25	23,746.31	10,715.69	7,811.90	7,857.75	7,703.
8. FAMILY PLANNING SERVICES	51,022.78	3,645.00	1,042.00	3,253.50	2,312.00	300.
9. LAB AND X-RAY SERVICES	6,769.71	686.52	271.08	485.60	118.12	401.
10. PRESCRIBED DRUGS	1,886,524.54	180,433.89	307,946.51	46,186.86	37,772.69	69,239.
11. EARLY AND PERIODIC SCREENING	2,227.76	602.41	216.02	102.79	77.54	272.
12. RURAL HEALTH CLINIC SERVICES	0	0	1,281.70	0	0	
13. OTHER CARE	142,692.67	13,695.81	49,231.25	3,475.26	1,576.30	4,729.

V. CHANGES PROPOSED FOR FY87

Insufficient funds were available to the Department in FY87 to continue funding both Medicaid and GR Medical at maintenance levels. Departmental priority was placed on programs targeted at children, pregnant women, the elderly and the disabled. Within this priority, Medicaid was funded at a level adequate to continue all existing medical services, and to cover new eligibles expected in FY87. As a result of this prioritization, major reductions were required in GR Medical.

The ~~estimated need~~ for GR Medical in FY87 is \$12 million. Approximately \$2.5 ~~million~~ of this was for continuation of prescription drugs, primarily benefiting Medicaid eligible children and adults. Since HB209 is being considered restore this \$2.5 million to GR Medical, the GR Medical program need in FY87 excluding drugs is \$9.5 million. Only \$5 million is requested in the Governor's FY87 budget which represents a reduction of 45% below FY86 (FY86 authorized was \$9.4 million excluding prescription drugs).

A number of FY87 program reductions were considered. Some were not viewed reasonable, such as attempting to continue offering all medical services but ~~reducing payments for those services to nearly 50¢ on the dollar~~. Since acceptance of GR Medical patients by hospitals and physicians is voluntary, individuals could experience serious ~~difficulty in accessing health care if this option were selected~~.

under
FY 87
budget

On the other hand, the Department deemed it essential to cover medically necessary **hospital based procedures**, and their associated expenses (physician, transportation etc.). Under this model, all hospital admissions, except those of an emergency nature, would require prior approval from the Division to be eligible for payment. While this "major medical" program was estimated to cost nearly \$5 million in FY87, financing essential hospital care was considered extremely important because:

- (1) Unlike other states, Alaska has not required local governments to meet the acute care needs of medically indigent Alaskans. The only place where this responsibility exists is at the state level.
- (2) Hospital care triggers the largest financial liability a person will experience. The financial impact on a family could be disastrous, particularly for persons who could not meet the \$10,000 minimum applicant share under Catastrophic Illness.
- (3) A predictable number of adults need medically necessary hospital care each year and there must be an on-going state commitment to meet this need.

Another area considered essential was continued financing of pregnancy related services, specifically elective abortions. Financing for these services would not be otherwise available for either Medicaid or GR Medical recipients. A decision to discontinue this medical service would likely face serious legal challenge under Alaska Statutes in view of Alaska's abortion statute and previous Attorney General's advice.

General outpatient care, not directly related to either a medically necessary hospital admission or a pregnancy related service was deemed important but only if funds were available after covering necessary hospital care and pregnancy related services. Ideas for reducing state expenditures to achieve savings to cover some outpatient care were examined. These ideas, which have been included in a ~~BPP~~ **to be introduced by the Governor**, include:

- (1) ~~Looking at~~ an individual's annual income rather than monthly income. Some individuals qualify for GR Medical under current rules because they do not maximize their annual, mostly seasonal, earnings.
- (2) Clarifying in statute that related household members must contribute to the medical care of another household member.
- (3) Limiting the per individual amount of assistance available under GR Medical to **\$25,000 maximum annually.**
- (4) Requiring a **\$50 per day deductible**, not to exceed \$200 per hospital admission.
- (5) Requiring an individual to ~~repay~~ **repay** the full amount of assistance received under GR Medical ~~if~~ **if** the individual receives income and resources sufficient to do so **within two years.**

It was hoped that these measures and others (such as paying only a percent of hospital charges) might permit enough savings to offer a limited set of outpatient medical services. Additionally, special contracts might be possible to maximize the services purchased for the dollars available in the larger urban settings such as Anchorage. Delivery of these services could likely not be limited to certain communities as previous court decisions have ruled that statewide programs must be available to all qualified persons in need of the services.

Because of their cost or lack of essential nature, certain services might not be available at all for GR Medical recipients such as GR Medical waivers, adult dental care, visual care and glasses, hearing aids, and nursing home care.

Within the limitations of a \$5 million program, the Department is committed to offering the maximum amount of medical assistance possible. While the very limited funding available will result in some medical services no longer being offered, the Department would be in a position to seek out competitive arrangements with medical providers to reduce the unit service cost for the most essential medical services below that possible under the present financing arrangements. Unfortunately, ~~until some experience is gained~~ relative to the competitiveness of the Alaska medical market, it is difficult to forecast what can be purchased for \$5 million beyond major medical care and pregnancy related services. It is anticipated that some basic outpatient program could be defined and afforded within the \$5 million, particularly if a percentage reduction is applied to hospital bills.

Specific questions or concerns not addressed by this GR Medical summary may be directed to Mr. Rod Betit, Director Medical Assistance, at 465-3355.

DRAFT

Original sponsor: Rules/Governor:

IN THE HOUSE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

SENATE CS FOR CS FOR HOUSE BILL NO. 98 (HESS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to medical assistance; and providing
for an effective date."

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

* Section 1. AS 44.77 is amended by adding a new section to read:

Sec. 44.77.015. CLAIMS FOR MEDICAL SERVICES. (a) For the purposes of filing claims for medical services provided under AS 47.07 or 47.25.120 -- 47.25.300, "promptly", in AS 44.77.010(a), means (1) within six months after the date of service, or as provided in (b) of this section, if there is no third-party claim, or (2) within 12 months after the date of service if there is a third-party claim. Except as provided in (c) of this section, a claim may not be paid if it is not filed promptly; an inference to the contrary may not be drawn from AS 09.10.050, AS 09.50.250 -- 09.50.300, or AS 37.25.010.

(b) In accordance with (a) of this section, a claim may be considered to be filed promptly if (1) the claim was filed more than six months after the date of service because the medical provider had no reason to believe that the beneficiary was ineligible for service under AS 47.07 or AS 47.25.120 -- 47.25.300; (2) a court of competent jurisdiction or an administrative hearing officer finds that the beneficiary was eligible for service under AS 47.07 or AS 47.25.120 -- 47.25.300 on the date of service; and (3) the claim is filed within six months after the date that the court or administrative finding is rendered. The beneficiary is responsible for notifying the medical provider of the judicial or administrative finding.

1 (c) The commissioner of health and social services may authorize
2 payment to a medical provider of a claim not promptly filed, upon good
3 cause shown. Payments under this subsection may not exceed 50 percent
4 of the allowable charges presented in the claim. "Good cause" does
5 not include a beneficiary's failure to notify a provider of a judicial
6 or administrative finding of eligibility.

7 (d) For the purposes of this section,

8 (1) "beneficiary" means a person who is found to be eligi-
9 ble to receive medical services under AS 47.07 or AS 47.25.120 --
10 47.25.300;

11 (2) "medical provider" means a person, firm, corporation,
12 association, or institution that, on the date of service, was approved
13 to provide medical assistance, in accordance with regulations adopted
14 by the Department of Health and Social Services.

15 * Section 2. AS 47.05 is amended by adding a new section to read:

16 Sec. 47.05.070. SUBROGATION. (a) If the department provides or
17 pays for medical assistance for injury or illness under this title,
18 the department is subrogated to the rights of the recipient of that
19 medical assistance for any claim arising from the injury or illness
20 and to the proceeds of an insurance policy covering the injury or
21 illness to the extent of the value of the medical assistance provided.

22 (b) If a recipient of medical assistance under this title set-
23 tles a claim or obtains an award or judgment arising from the injury
24 or illness for which the medical assistance was received, the depart-
25 ment shall reimburse the recipient for attorney fees and costs commen-
26 surate with the amount of the settlement, award, or judgment to which
27 the department is entitled under (a) of this section. Regardless of
28 the manner in which the amount of the attorney fees is derived, reim-
29 bursement of attorney fees must be in accordance with the applicable
rules of court governing the award of attorney fees in civil matters.

(old SB 91)

9 * Section 3 AS 47.07.020(b) is amended to read:

10 (b) In addition to the persons specified in (a) of this section
11 the following optional groups of persons for whom the state may claim
12 federal financial participation are eligible for medical assistance:

13 (1) persons eligible for but not receiving assistance under
14 any plan of the state approved under 42 U.S.C. 601 -- 615 (Title IV--
15 Social Security Act, Aid to Families with Dependent Children),
16 42 U.S.C. 1381 -- 1383c (Title XVI, Social Security Act, Supplemental
17 Security Income);

18 (2) persons in a general hospital, skilled nursing facility
19 or intermediate care facility, who, if they left the facility, would
20 be eligible for assistance under one of the federal programs specified
21 in (1) of this subsection;

22 (3) persons under age 21 who are [YEARS OF AGE] under
23 supervision of the department, for whom maintenance is being paid in
24 whole or in part from public funds, and who are in foster homes or
25 private child-care institutions;

26 (4) aged, blind, or disabled persons, who, because they do
27 not meet income [REDACTED] requirements, do not receive supple-
28 mental security income under 42 U.S.C. 1381 -- 1383c (Title XVI,
29 Social Security Act), and who do not receive a mandatory state

1 supplement, but who are eligible, or would be eligible if they were
2 not in a ~~skilled nursing facility or intermediate~~ skilled nursing facility or intermediate
3 care facility to receive an optional state supplementary payment;

4 (5) persons under age 21 who are [YEARS OF AGE] in
5 institution designated as an intermediate care facility for
6 mentally retarded and who are financially eligible as determined
7 the standards of the federal aid to families with dependent children
8 program;

9 (6) persons in a medical or intermediate care facility
10 whose income while in the facility does not exceed 300 percent of the
11 supplemental security income benefit rate under 42 U.S.C. 1382
12 1383c (Title XVI, Social Security Act) but who would not be eligible
13 for an optional state supplementary payment if they left the hospital
14 or other facility;

15 (7) persons under age 21 who are [YEARS OF AGE] receiving
16 active treatment in a psychiatric hospital and who are financially
17 eligible as determined by the standards of 42 U.S.C. 601 -- 613 (Title
18 IV-A, Social Security Act, Aid to Families with Dependent Children);

19 (8) individuals under age 21 not covered under (a) of
20 this section who would be eligible for the federal Aid to
21 Families with Dependent Children program except that they
22 have the care and support of both their natural or adoptive
23 parents;

24 (9) pregnant women not covered under (1) of this
25 section who meet the income and resource requirements of the
26 federal Aid to Families with Dependent Children program.

27 * Sec. 4 AS 47.07.030 is repealed and reenacted to read:

28 Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. (a) The
29 department shall offer all mandatory services required under 42 U.S.C.
30 1396 -- 1396p (Title XIX of the Social Security Act).

31 (b) In addition to the mandatory services specified in (a)
32 this section, the department may offer only the following optional
33

services: personal care services in a recipient's home; emergency hospital services; long-term care noninstitutional services; medical supplies and equipment; clinic services; inpatient psychiatric facility services for individuals age 65 or older and individuals under age 21; physical therapy; occupational therapy; treatment of speech, hearing, and language disorders; prosthetic devices and eyeglasses; optometrists' services; ^{including intermediate care facility services for the mentally retarded} intermediate care facility services; nursing facility services for individuals under age 21; and reasonable transportation to and from the point of medical care.

* Sec. 6 AS 47.07.035 is repealed and reenacted to read:

Sec. 47.07.035. PRIORITY OF MEDICAL ASSISTANCE. If the department finds that the cost of medical assistance for all persons eligible under this chapter will exceed the amount allocated in the state budget for that assistance for the fiscal year, the department shall eliminate coverage for optional medical services and optionally eligible groups of individuals in the following order:

- (1) personal care services in a recipient's home;
- (2) emergency hospital services;
- (3) long-term care noninstitutional services;
- (4) medical supplies and equipment;
- (5) clinic services;
- (6) inpatient psychiatric facility services;
- (7)

intermediate care facility services for the mentally retarded;

- (8) physical therapy and occupational therapy;
- (9) treatment of speech, hearing, and language disorders;
- (10) prosthetic devices and eyeglasses;
- (11) optometrists' services;

(12) intermediate care facility services;

(13) individuals age five and over, but under age 11, who are not eligible for benefits under the federal aid to families with dependent children program because they do not meet the definition of dependent children;

(14) individuals under age 21 under supervision of the department, for whom maintenance is being paid in whole or in part from public money and who are in foster homes or private child-care institutions;

(15) individuals in a health facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under Title XVI of the Social Security Act and who would not be eligible for the optional state supplementary payment if they left the facility;

(16) aged, blind, and disabled individuals who, because they do not meet the income and resource requirements, do not receive supplemental security income under Title XVI of the Social Security Act, and who are not eligible to receive a mandatory state supplement but who are eligible, or would be eligible if they were not in a general hospital or skilled nursing facility or intermediate care facility, to receive an optional state supplementary payment;

(17) skilled nursing facility services for persons under age 21.

* Sec. 6 AS 47.07.070 is amended by adding a new subsection to read:

(d) Notwithstanding (a) -- (c) of this section, the commission shall also consider available state and federal revenue when making rate decisions.

* Sec. 7 AS 47.07.900(1) is amended to read:

(1) "clinic services" means services provided by state-

1 approved outpatient community mental health clinics that receive
2 grants under AS 47.30.520 -- 47.30.620, state-operated community
3 mental health clinics, outpatient surgical care centers ~~and~~ and
4 physician clinics;

5 * Sec. 4 AS 47.07.900 is amended by adding new paragraphs to read:

6 (7) "emergency hospital services" means services that

7 (A) are necessary to prevent the death or serious
8 impairment of the health of the individual; and

9 (B) because of the threat to the life or health of the
10 individual, necessitate the use of the most accessible hospital
11 available that is equipped to furnish the services, even if the
12 hospital does not currently meet

13 (i) the conditions for participation under
14 Medicare; or

15 (ii) the definitions of inpatient or outpatient
16 hospital services under 42 C.F.R. secs. 440.10 and 440.20;

17 (8) "personal care services in a recipient's home" means
18 services prescribed by a physician in accordance with the recipient's
19 plan of treatment and provided by an individual who is

20 (A) qualified to provide the services;

21 (B) supervised by a registered nurse; and

22 (C) not a member of the recipient's family.

23 * Sec. 9. AS 44.77.010(b) is repealed.

24 * Sec. 10. This Act takes effect immediately in accordance with AS 01-
25 10.070(c).

BILL SHEFFIELD
GOVERNOR



*Personal care
services*

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

January 29, 1986

Honorable Bettye Fahrenkamp
Chairman, Health, Education and
Social Services Committee
Alaska State Senate
P.O. Box V
Juneau, AK 99811

Dear Senator Fahrenkamp:

During the last legislative session, I sponsored HB 98, a bill relating to the provision of mandatory and optional medical services under the state Medicaid program. Seeking to amend portions of AS 47, the bill addressed which medical services must be provided and which are optional under the Medicaid program, and in what order individuals and optional services will be eliminated in the event costs exceed state budget allocations for medical assistance.

These amendments became necessary due to recent changes in the federal Medicaid laws, with which the state must conform as a prerequisite to the state's eligibility for federal financial participation in the state Medicaid program. Conformance with federal law will not only ensure Alaska's receipt of the full amount of federal financial participation, but will aid us in avoiding federal fiscal sanctions for program noncompliance.

A House Finance Committee substitute made minor choice-of-language changes in sec. 3 of the bill; that amendment was supported by this office. The House passed CSHB 98(Fin); that bill currently resides in your committee.

In recent months, the executive branch has received public support for the inclusion in our Medicaid program of another optional service, personal care services in a recipient's home. Provision of personal care services in a recipient's home is expected to ease the current waiting lists that

exist for nursing home admission. In addition, this measure may reduce the number of hospital and nursing home admissions, and the high cost of those admissions, where a recipient may as easily be cared for at home by a qualified attendant. In the event of a budget shortfall, this optional service would be the first to be eliminated.

The inclusion in our Medicaid program of personal care services in a recipient's home offers a desirable alternative to institutional care for our disabled and senior citizens, and I urge your committee to consider sponsoring a substitute for CSHB 98(Fin) to include this optional service. A proposed committee substitute, accomplishing that, accompanies this letter.

The proposed committee substitute differs from CSHB 98(Fin) only in that it adds provisions relating to personal care services in a recipient's home in the following places: page 3, line 1; page 3, line 17; and page 5, lines 17 -- 22.

Passage of such a bill will not only assure needy persons in the state of uninterrupted, necessary medical care, but will also offer this desirable alternative to institutional care within the budgetary limits set by the legislature.

Sincerely,


Bill Sheffield
Governor

now Sec. 2 of 303HB99 (Hess)
BILL SHEFFIELD
GOVERNOR



STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

91

January 23, 1985

The Honorable Don Bennett
President of the Senate
Alaska State Legislature
Pouch V
Juneau, AK 99811

Dear Senator Bennett:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill relating to subrogation. The bill establishes, for the Department of Health and Social Services, a statutory right to subrogation in cases in which the department provides medical assistance for which a third party is liable.

Current Alaska statutes are silent on the department's right to recover medical assistance expenses when it is determined that a third party is liable for those expenses. Almost every claim by the department for reimbursement has been challenged, and, absent a statutory basis for such claims, time-consuming and expensive legal proceedings have been required to obtain reimbursement. Consequently, the department has had to expend excessive amounts of money or forego reimbursement in many cases. The department estimates that at least several hundred thousand dollars every year would be saved if this bill were enacted.

Additionally, the bill provides that the department will reimburse a recipient of medical assistance, in accordance with the rules of court, for the attorney fees incurred in establishing third-party liability for the medical assistance provided.

In the interest of fairness and efficiency, I urge your prompt and favorable consideration of this bill.

Sincerely,

A handwritten signature in cursive script that reads "Bill Sheffield".

Bill Sheffield
Governor

PERSONAL ATTENDANT CARE

Alaskans with permanent physical disabilities resulting from accident, illness, or other health conditions may require life-long help to meet basic self-care needs. While today's technology allows for many of these individuals to work and to live outside hospitals and nursing homes, these people cannot live independently in the community without assistance. Personal attendant care provides individual help in bathing, dressing, lifting, eating, and care of physically dependent people who may be paralyzed, have respirators, catheters or other adaptive devices which need frequent monitoring.

Such care is required by people with physical disabilities who may be in their early twenties as well as by older people, or families with a severely health impaired son or daughter.

By amending the state's Medicaid law to include these services, Alaska can obtain 50% of the cost from the federal government and reduce the amount of hospital nursing home care which would otherwise be required.

For the last three years, Alaska has served a small number of physically disabled individuals in Anchorage and Fairbanks through the GR Med program and through special appropriation to the Division of Vocational Rehabilitation.

Without continued funding those people now being served at \$85 per day will be required to move to nursing homes which cost up to \$250 per day.

For F87 the proposed budget deletes use of the GR Med funds for this purpose. However, the Department of Health and Social Services requested \$500.0 in state funds for attendant care and the Council expects legislation to be introduced to amend the Medicaid statute and obtain 50% federal funding for personal attendant care.

RECOMMENDATION:

The Council supports introduction of legislation to amend the state's Medicaid program to include personal attendant care and appropriation of \$500.0 of state funds for program implementation in F87.

~~Personal services without position~~
STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date : 12/26/85

REQUEST

Bill/Resolution No. : CSHR 98
 Title : An Act relating to medical assistance; and providing for an effective date.
 Sponsor : Governor
 Requestor : _____
 Date of Request : _____

FISCAL DETAIL

Agency Affected : Health & Social Services
 BRU : Medical Assistance
 Components : Medical Assistance - Non Facility

EXPENDITURES/REVENUES : (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES		45.2	47.0	48.8	50.8	52.8
TRAVEL		8.6	8.9	9.3	9.7	10.1
CONTRACTUAL		8	8	9	9	9
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS		1,000.0	2,419.9	2,516.7	2,617.4	2,722.1
MISCELLANEOUS						
TOTAL OPERATING		1,054.6	2,476.6	2,575.7	2,678.8	2,785.9

CAPITAL						
---------	--	--	--	--	--	--

REVENUE						
---------	--	--	--	--	--	--

FUNDING : (Thousands of Dollars)

GENERAL FUND		527.3	1,238.3	1,287.8	1,339.4	1,392.9
FEDERAL FUNDS		527.3	1,238.3	1,237.9	1,339.4	1,392.9
OTHER						
TOTAL		1,054.6	2,476.6	2,525.7	2,678.8	2,785.9

POSITIONS :

FULL-TIME		1.0	1.0	1.0	1.0	1.0
PART-TIME						
TEMPORARY						

ANALYSIS : Attach a separate page if necessary

See the attached.

Prepared by : *Red Bell*
 Division : Medical Assistance

Phone : 465-3355
 Date : 12/26/85

Approved by Commissioner : *John A. Gagnier*
 Agency : DHSS

Date : 12/31/85

Distribution (by Agency preparing fiscal note) :

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

Committee Substitute House Bill 98
Assumptions

This projection for personal care services is based on the following:

- (a) personal care services can be divided into two categories of allowed Title XIX services (personal care and medically related home care).
- (b) Oregon showed an average of 21.2 hours personal care and 38.12 hours of home care per case per month.
- (c) unit cost is based on 1 hour of work.
- (d) recipient utilization figures for the Oregon personal care services program showed total utilization equal to 8.6% of the Aged, Disabled, and Blind eligibles. Alaska has approximately 5,200 APA recipients of which 455 is the estimated number of recipients of this program.
 - 1. 30% Personal Care (PC) reimbursed at \$11.90 per hour. (Oregon's hourly rate multiplied by 1.25).
 - 2. 70% Home Care (HC) at \$8.13. (Oregon's hourly rate multiplied by 1.25)

Projected Cost Personal Care Services

	<u>Hours</u>	<u>Rate</u>	<u>Cost</u>
Single recipient PC/mo.	11.2	x 11.90 =	\$133.28
Single recipient HC/mo.	<u>38.1</u>	x 8.13 =	<u>309.92</u>
Single recipient PC&HC/mo.	49.3		\$443.20
Single recipient yearly	591.6		5,318.40
Total 455 recipients	<u>269,178</u>		<u>\$2,419,872.00</u>

While the analysis projects a total annual cost of \$2,419,872, the Division estimates the first year cost at \$1,000,000. The Division anticipates that both a 10/1/86 program start date, as well as client unfamiliarity with the program will reduce the programs first year cost.

Committee Substitute House Bill 98

Division of Medical Assistance

Personal Services:

1 - New Medical Assistance Administrator position
at range 17A \$2,895 x 12 months x 30% benefits = \$45,162

Travel:

Semi-annual travel to personal care sites by Medical
Assistance Administrator to monitor the personal care
services each client is receiving.
Estimate transportation 7,000
Estimate per diem, 20 days at \$80 per day 1,600

Contractual:

Printing and advertising for personal care services 800

Increases from fiscal year to fiscal year are budgeted at 4% for all lines.

STATE OF ALASKA 1985 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: _____

REQUEST
 Bill/Resolution No.: SB91
 Title: An Act relating to recovery of Medical Assistance expenses
 Sponsor: Governor
 Requestor: _____
 Date of Request: 1/23/85

FISCAL DETAIL
 Agency Affected: Health & Social Services
 Program Category Affected: _____
 BRU, Program or Subprogram(s) Affected: Medical Assistance

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS						
800 MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	250	270	292	315	340	367

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

This bill would redirect approximately 1,000 man hours of effort per year currently utilized due to a lack of clear State authority to have first right of collection. These redirected man hours are estimated to generate recoveries at a rate of approximately \$250 per hour. A 3% escalator was added to reflect increases in health care costs from one year to the next.

Prepared By: Rod Betit, Director *RPB 2/6/85* Phone: 465-3355
 Division: Medical Assistance Date: _____

Approved by Commissioner: *J. G. [Signature]* Date: 2/18/85 *JCC*
 Agency: HEALTH & SOCIAL SERVICES

Distribution (by Agency preparing fiscal note):
 Legislative Finance
 Legislative Sponsor
 Requestor
 Office of Management and Budget

FOR DISCUSSION

1 BILL

2 IN THE LEGISLATURE OF THE STATE OF ALASKA

3 LEGISLATURE

4 A BILL

5 For an Act entitled: "An Act relating to payments to health
6 facilities."

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

8 * Section 1. 47.07.040 is amended to read:

9 Sec. 47.07.040. STATE PLAN FOR PROVISION OF MEDICAL
10 ASSISTANCE. The department shall prepare a state plan in
11 accordance with the provisions of 42 U.S.C. 1396 -- 1396p
12 (Title XIX, Social Security Act, Medical Assistance) and
13 submit it for approval to the United States Department of
14 Health and Human Services. The plan shall designate that
15 the Department of Health and Social Services is the single
16 state agency to administer this plan. The department shall
17 act for the state in any negotiations relative to the
18 submission and approval of the plan. The department,
19 including the medicaid rate commission, may make those
20 arrangements, or regulatory changes, not inconsistent with
21 law, as may be required under federal law to obtain and
22 retain approval of the United States Department of Health
23 and Human Services to secure for the state the optimum
24 federal participation under the provisions of 42 U.S.C. 1396
25 -- 1396p (Title XIX, Social Security Act, Medical Assis-
26 tance). In addition, the department shall provide a report
27 to the legislature no later than March 15 of each year
28 concerning the status of this program and recommendations,
29

1 with supporting fiscal data, as to any changes in the
2 coverage of eligible persons or services to be provided.

3 * Sec. 2. 47.07.070(a) is amended to read:

4 Sec. 47.07.070(a). PAYMENT TO HEALTH FACILITIES. (a)

5 The Commission shall determine prospectively the rate of
6 payment to a health facility under this chapter and
7 AS 47.25.120 - 47.25.300 based on a fixed rate, not to
8 exceed the facility's customary charges, for reasonable
9 costs incurred by the facility. The commission shall by
10 regulation list the factors it considers in making its rate
11 determinations under this section.

12 * Sec. 3. 47.07.070 is amended by adding new subsections:

13 Sec. 47.07.070(d) In determining rates of payment to
14 health facilities, the commission shall consider the appro-
15 riation limit set by the legislature for the department's
16 programs under this chapter and under AS 47.25.120 --
17 47.25.300. The commission shall set rates for facilities in
18 the state so that, taking into account projected rates of
19 utilization, the aggregate state payments to health facil-
20 ities will not exceed the budgeted amounts for the state
21 fiscal year.

22 (e) For the state fiscal year 1987, beginning July 1,
23 1986, the commission may establish new prospective payment
24 rates for any facility whose rate for any part of state
25 fiscal year 1987 was set before the effective date of this
26 amendment, if a new rate is necessary to allow the commis-
27 sion to carry out the intent of subsection (d) above.

28 * Sec. 4. 47.07.180 is amended to read:
29

1 Sec. 47.07.180. DUTIES. (a) The commission shall
2 review proposed payment rates [AND BUDGETS] of health
3 facilities and establish payment rates for health facilities
4 under this chapter and AS 47.25.120 -- 47.25.300.

5 (b) The commission shall consult with the department
6 on the state plan as it relates to health facilities, and
7 shall coordinate the payment rate methods used by the
8 commission with the state plan and with the administrative
9 needs of the department's medical assistance payment
10 program.

11 (c) The commission will make available facility-
12 reported budget data to any health facility which has need
13 of budgeting or management assistance, including assistance
14 by the commission in a facility's request to the United
15 States Department of Health and Social Services for a waiver
16 of federal reimbursement rules or limits.

17 (d) By March 1 of each year, the commission shall
18 adopt a target dollar amount estimating Medicaid
19 utilization, revenues, and payment rates of facilities for
20 the state fiscal year beginning the next July 1. The
21 methodology used by the commission to develop the target
22 shall be the basis used for establishing payment rates for
23 the facilities during the applicable state fiscal year.

health association of alaska

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

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Physician Member of
the Board
Morris Morning, M.D.
Anchorage

President
Dennis DeWitt
Juneau

January 30, 1986

Senator Bettye M. Fahrenkamp
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Senator Fahrenkamp,

Thank you for the opportunity to review a draft bill proposal that I understand the Department of Health and Social Services has ask the Senate HESS committee to consider, titled "An Act relating to payment to health facilities". I will be in Washington D.C. the full week of February 3-7 thus will not be able to attend the committee session Tuesday February 4. I would appreciate any possible consideration in the committee not acting on this measure until I return. I will be distributing this draft to the Executive Committee of the Health Association of Alaska so that we can develop and communicate a formal position to you. In the interim I will offer preliminary comments.

Section 1. This appears somewhat simple, however it could well cause the demise of many nursing homes in Alaska. The current fight is over whether the current costs of nursing homes in Alaska are reasonable in spite of the fact that most exceed federal limits. We believe that this is because we treat a heavier case load than is typical in the other states. We believe that many patients in Alaskan nursing homes would be in hospitals in other states. This section gives the state the clear direction to back away from that fight. We believe that it would be disastrous to the quality of patient care. Perhaps the first step to the problems we read about in other states but as yet not in Alaska.

Section 2. While this seems simple and equitable, it is not. We have to consider the payment structure developed by the Medicaid Rate Commission (MRC) and how it is compared to the customary charges of a facility. Currently every acute facility in Alaska is on a cafeteria style charge structure but the Medicaid program through the MRC has chosen to pay on a per diem basis. The second problem is that the typical outcome of this language is to take advantage of any discount price but not pay the higher charge in other areas to offset the loss. This gives the state the ability to shop in a very different manner than any other purchaser.

FORMERLY

alaska
state
hospital
association

Senator Fahrenkamp
January 30, 1986
Page two

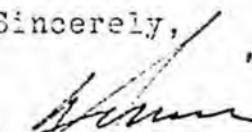
Section 3. This issue is addressed in House Bill 93 which is the outcome of negotiations between this association and Commissioner Pugh last year. This is their original position. At best this, in my opinion, shows poor judgement of the process. As I have told them in the past, the Federal law provides that rates of payment must reflect rates which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. I would refer you to 42 U.S.C. Section 1396a(a)(13)(A) and 42 C.F.R. Section 447.252 and Nebraska Health Care Association, Inc. v. Dunning, 575 F. Supp. 176 (D. Neb. 1983).

There seems to be a notion in this section that legislative appropriation is per se an aggregate reasonable and adequate cost determinate. I suggest that that would not survive any test. The subsection (e) is your basic "Kings X". Gosh guys we really didn't mean your rate and the legislature agrees!

Section 4. The new verbiage is somewhat of a mystery. I am not sure that it is necessary or beyond the ability of the MRC currently. The omission of the words "and budgets" is quite a different issue. That takes the discussion of the impact of MRC decisions off the table. The MRC then has the ability to determine that an arbitrary rate is justified based on national criteria, for example, and ignore the impact it might have in Petersburg, Glennallen or Home.

I have attempted to get this to you quickly so that you will be aware that these proposals are not "technical" but are substantive. I appreciate your courtesy in sharing this proposal. It would be well for the proponents to consider the same level of courtesy.

Sincerely,


Dennis L. DeWitt
President

cc: Executive Committee
Commissioner Pugh
Ray Gillespie

under the federal aid to families with dependent children program, but who do not qualify because they are not dependent children:

(9) women who are pregnant.

(c) Receipt of medical assistance under this chapter is considered to be an additional benefit to these individuals and does not affect other assistance payments, federal or state, for which the recipient is eligible.

(d) Additional groups may not be added unless approved by the legislature.

(e) Notwithstanding (b) (4) of this section, a person is not eligible for medicaid benefits until a final determination is made on the eligibility of that person for benefits under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act). (§ 1 ch 182 SLA 1972; am § 1 ch 105 SLA 1974; am § 1 ch 117 SLA 1975; am § 1 ch 221 SLA 1976; am § 1 ch 11 SLA 1978; am § 1 ch 132 SLA 1982; am § 13 ch 138 SLA 1982)

Effect of amendments. — The first 1982 amendment added paragraphs (b) and (9) to subsection (b). The second 1982 amendment added subsection (e).

Sec. 47.07.030. Medical services to be provided. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, nurse midwife, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age, clinic services, treatment of speech, hearing and language disorders, physical therapy, occupational therapy, prosthetic devices and medical supplies, long-term care noninstitutional services, and reasonable transportation to and from the point of medical care. Additional services may not be provided unless approved by the legislature. (§ 1 ch 182 SLA 1972; am § 1 ch 35 SLA 1973; am § 2 ch 105 SLA 1974; am § 1 ch 12 SLA 1976; am § 2 ch 221 SLA 1976; am § 1 ch 82 SLA 1978; am § 25 ch 40 SLA 1981; am § 2 ch 132 SLA 1982)

Effect of amendments. — The 1981 amendment added "nurse midwife" following "skilled and intermediate nursing home, physician" in the first sentence. The 1982 amendment inserted "physical therapy, occupational therapy, prosthetic devices and medical supplies, long-term care noninstitutional services" near the end of the first sentence.

Sec. 47.07.035. Priority of services. If the funding in a fiscal year is inadequate to finance the total medical assistance program under this chapter, the department shall, to the extent that federal law and funding permits, provide medical assistance in the following order:

§ 47.07.040 WELFARE, SOCIAL SERVICES AND INSTITUTIONS § 47.07.040

- (1) aged, blind, or disabled persons who
 - (A) do not receive supplemental security income under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) because they do not meet income and resources requirements; and
 - (B) are eligible to receive an optional state supplementary payment;
- (2) persons in a medical or intermediate care facility
 - (A) whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act); and
 - (B) who would not be eligible for an optional state supplementary payment if they left the facility;
- (3) persons under 21 years of age
 - (A) who are under the supervision of the department;
 - (B) whose maintenance is paid in whole or in part from public funds; and
 - (C) who are in foster homes or private child-care institutions;
- (4) persons under 21 years of age who
 - (A) receive treatment in a psychiatric hospital; and
 - (B) are financially eligible as determined by the standards of 42 U.S.C. 601 — 615 (Title IV-A, Social Security Act, Aid to Families with Dependent Children);
- (5) persons under 21 years of age who are
 - (A) in an institution designated by the department as an intermediate care facility for the mentally retarded; and
 - (B) financially eligible as determined by the standards of the federal aid to families with dependent children program;
- (6) women who are pregnant;
- (7) persons under 21 years of age who do not qualify for benefits under the federal aid to families with dependent children program because they are not dependent children;
- (8) intermediate nursing home services;
- (9) eye examinations by an ophthalmologist or optometrist; or eyeglasses prescribed by a physician skilled in the diseases of the eye or by an optometrist;
- (10) treatment of speech, hearing, or language disorders;
- (11) physical or occupational therapy;
- (12) care at an intermediate care facility for the mentally retarded;
- (13) care at an inpatient psychiatric facility;
- (14) community mental health clinic services;
- (15) surgical care center services;
- (16) nurse midwife services;
- (17) medical supplies and equipment;
- (18) long-term care noninstitutional services. (§ 3 ch 132 SLA 1982)

Sec. 47.07.040. State plan for provision of medical assistance.
The department shall prepare a state plan in accordance with the

provisions of 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act, Medical Assistance) and submit it for approval to the United States Department of Health and Human Services. The plan shall designate that the Department of Health and Social Services is the single state agency to administer this plan. The department shall act for the state in any negotiations relative to the submission and approval of the plan and may make those arrangements, not inconsistent with law, as may be required under federal law to obtain and retain approval of the United States Department of Health and Human Services to secure for the state the provisions of 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act, Medical Assistance). In addition, the department shall provide a report to the legislature no later than March 15 of each year concerning the status of this program and recommendations, with supporting fiscal data, as to any changes in the coverage of eligible persons or services to be provided. (§ 1 ch 182 SLA 1972)

Sec. 47.07.050. Implementation of the medical assistance program. The department shall take the steps necessary to adopt those regulations, prepare necessary documentation for the state and providers and undertake the systems design that may be necessary to implement the provisions of this chapter on or before November 1, 1972. Implementation of the medical assistance program shall include appropriate controls and reporting capabilities as required by the United States Department of Health and Human Services, and the department shall make those necessary reports as required by that federal agency or as requested by the legislature. (§ 1 ch 182 SLA 1972)

Sec. 47.07.060. Receipt of federal money. The Department of Administration shall accept and receive all grants of money awarded to the state under 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act, Medical Assistance). All money received shall be deposited by the Department of Administration in a special account of the general fund and shall be used by the state exclusively for medical assistance and the administration of medical assistance under the provisions of this chapter. This money shall be paid from the account on a certified disbursement voucher from the department. (§ 1 ch 182 SLA 1972)

Sec. 47.07.070. Payment to health facilities. (a) The commission shall determine prospectively the rate of payment to a health facility under this chapter and AS 47.25.120 — 47.25.300 based on a fair rate for reasonable costs incurred by the facility. The commission shall by regulation list the factors it considers in making its rate determinations under this section.

(b) In determining a rate of payment to a health facility under this section, the commission shall consider the proportionate share of the facility's financial requirements for patient care for

(1) costs of current operations, including salaries and wages, purchased services, supplies, insurance, leases, depreciation, taxes, inter-

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est expense, maintenance and other health facility operating expenses:
and

(2) education, research, and appropriate capital development.

(c) In determining a rate of payment to a health facility under this section, the commission may consider whether the rate of utilization of the facility has been reduced because of improvident or careless development of the facility. (§ 1 ch 182 SLA 1972; am § 3 ch 95 SLA 1983)

Cross references. — For legislative findings and policy relating to ch. 95, SLA 1983, see § 2, ch. 95, SLA 1983, in the Temporary and Special Acts.

Effect of amendments. — The 1983 amendment rewrote this section.

Editor's notes. — Section 8, ch. 95, SLA

1983, provides: "INTERIM PROSPECTIVE PAYMENT SYSTEM. The department shall establish an interim system of prospective payments for health facilities under this Act for the period July 1, 1983, to June 30, 1984."

Sec. 47.07.071. Reports by health facilities. Not later than 120 days after the end of each fiscal year of a health facility, the facility shall submit to the commission a report on the facility's financial performance during the fiscal year. (§ 4 ch 95 SLA 1983)

Sec. 47.07.072. Report by the commission. Not later than September 30 of each year, the commission shall submit to the governor a report on the prospective payments made under this chapter during the current fiscal year and an estimate of the prospective payments that will be made during the remainder of the current fiscal year and the next fiscal year. The report shall state the assumptions that are used as a basis for the estimates. (§ 4 ch 95 SLA 1983)

Sec. 47.07.073. Uniform accounting, budgeting, and financial reporting. (a) The commission by regulation shall require a uniform system of accounting, budgeting, and financial reporting for health facilities receiving prospective payments under this chapter. The regulations shall provide for reporting revenues, expenses, assets, liabilities, and units of service. The commission shall specify the date the system becomes effective for each health facility.

(b) In adopting regulations under this section, the commission shall consider

(1) accounting, budgeting, and financial reporting procedures used by health facilities;

(2) variations among health facilities in the types of health care services provided by health facilities;

(3) the size and organizational structure of health facilities;

(4) the methods used by health facilities to obtain payments; and

(5) other factors the commission considers relevant.

(c) The commission may waive or modify a requirement for accounting, budgeting, or financial reporting for a health facility if waiver or modification is

I. PURPOSE OF HB98

There are six major components of HP98 as passed out of Senate HESS.

1. A provision clarifying the Legislature's intent regarding the six-month limitation placed on medical providers for filing medical billings (SECTION 1).
2. A provision strengthening the Department's ability to recover medical payments made on behalf of a recipient who subsequently was awarded an insurance or court settlement (SECTION 2).
3. A provision amending Alaska Medicaid Statutes making technical changes to bring them into conformance with federal law (SECTION 3).
4. A provision adding personal care services, chiropractor services, and adult dental care under Medicaid (SECTION 4).
5. A provision clarifying the order in which optional Medicaid services will be deleted by the Department in the event of funding difficulties (SECTION 5).
6. A provision clarifying the relationship between the Medicaid Rate Commission and the Department's annual budget (SECTION 6, 7 and 8).

II. SECTIONAL ANALYSIS

. SECTION 1

This section amends the filing deadlines on claims, for Medicaid and General Relief Medical, to eliminate inequities that result under the current six month rule. Under existing AS 44.77.010(b), the Department of Health and Social Services may only pay a claim for Medicaid or General Relief Medical services if the claim is filed "promptly". "Promptly" is defined for these purposes as within six months after the date that the service was rendered or third-party payment was received.

SECTION 1 would correct the following inequities:

- (1) Those situations where the third-party payor was so late in responding to the claim that more than six months elapsed before the medical provider received the negative response. The medical provider cannot then "promptly" file the claim, and is left with no recourse. The bill would eliminate this inequitable result by amending the definition of "promptly" to mean within 12 months after the date of service in those situations where a third-party is involved.
- (2) Another inequitable situation arises where a person has been found ineligible for Medicaid or General Relief Medical, and then successfully appeals that finding through a judicial or adminis-

trative proceeding only to discover that more than six months have elapsed since the medical services were provided. SECTION 1 would correct this inequity by permitting a medical provider to file claims within six months after the date upon which a court or administrative hearing officer finds that a person was improperly found to be ineligible for Medicaid or General Relief medical. Further, this section would make it the responsibility of the recipient to inform his or her medical provider(s) of the judicial or administrative decision.

- (3) Finally, SECTION 1 recognizes that some claims are filed late for good reasons. Under current statutes, the Commissioner has no discretion to consider "good cause" for late filings. SECTION 1 authorizes the Commissioner of Health and Social Services to approve payment, at no more than 50 percent of the allowed charges, of a claim not "promptly" filed, if the medical provider shows "good cause" for the failure to meet the filing deadline. "Good cause" does not include a recipient's failure to timely inform the provider of a judicial or administrative reversal of the department's finding of ineligibility.

The estimated state fund impact of SECTION 1 is \$14.6 in additional expenditures annually.

SECTION 2

SECTION 2 gives the Department of Health & Social Services clear statutory basis for undisputed "first right" to recovery of medical assistance expenses from any insurance or court settlement awarded to a Medicaid recipient. Current Alaska statutes are silent on the Department's right to first recovery of medical assistance expenses, and as a result, many Department claims are challenged requiring time-consuming and expensive legal proceedings to obtain recovery.

The estimated state fund impact of SECTION 2 is (\$125.0) savings through increased revenue.

SECTION 3

SECTION 3 clarifies the optional groups of needy persons covered under the Alaska Medicaid Program.

Alaska statutes specify the groups that are federally mandated to cover under AS 47.07.020(a). These groups include, among others, recipients of Aid to Families with Dependent Children, Old Age Assistance, Aid to the Blind, Aid to the Disabled, certain children not eligible for AFDC, and pregnant women. A complete list of mandatory groups is shown in Attachment A.

In addition to these mandatory groups, AS 47.07.020(b) sets out the optional groups the Alaska Legislature has elected to cover. Of the 10 optional groups, Alaska covers 5.

The purpose of SECTION 3 is simply to recognize that parts of two optional groups have been made mandatory by Congress in 1984. No

optional groups are being added or deleted from the program under SECTION 3.

There is no state fund impact as a result of SECTION 3.

. SECTION 4

As with the eligible groups, the State must also offer certain "mandatory" medical services, and may elect to offer certain "optional" medical services (see Attachment B).

Of the 28 optional Medicaid services, the Alaska Legislature has elected to offer 13 under Medicaid. Two of the remaining 15 services have been offered to Medicaid recipients under the 100% state funded General Relief Medical program (dental services and prescribed drugs).

SECTION 4 would pick up two additional optional services for Medicaid recipients that have not previously been offered under either Medicaid or General Relief Medical (personal care services and chiropractor services), and one service previously offered under GR Medical (adult dental care). A brief explanation of each follows:

A. Personal Care

Personal care services are those services necessary to "accommodate long-term maintenance or supportive care, at a skill level less than most duties included under home health care as performed by Home Health Aides." Personal care would include such tasks as assistance with personal hygiene, dressing, eating, using the toilet, and getting in or out of a bed or chair. Attachment C also gives one case example of when personal care would be appropriate, and two examples of when it would not be.

The cost estimate for adding personal care was derived using an average of 50 hours per month. However, the Division proposal would allow up to 170 hours of personal care per month per recipient.

The estimated state general fund cost to add personal care is \$1.2 million. However, an October 1, 1986 start date, client unfamiliarity with the service, and lack of personal care providers will reduce the program's first year's costs to \$527.3.

B. Adult Dental Care

Adult emergency dental care has been offered to Medicaid recipients under the General Relief Medical program since 1972. The Governor's FY87 budget eliminates adult dental services effective July 1, 1986. Section 5 would restore adult dental services under Medicaid rather than GR Medical where 50% federal funding can be earned. Adult dental care would be limited to the relief of "pain and acute infection" as has been the practice under GR Medical. Preventative dental services and dentures will not be covered.

Approximately 2716 adult Medicaid recipients will receive services in FY87 at an average per person cost of \$331.63 for a total estimated cost of \$900.7 (450.3 state and 450.4 federal).

C. Chiropractor Services

Chiropractor services would be a new service limited to manual manipulation of the spine and necessary x-ray, the only services reimbursable under Medicaid rules. This provision of CSCSHB98 (HESS) is identical to that contained in CSSB109 (HESS) which has passed the Senate and is awaiting House floor action.

Approximately 600 Medicaid recipients will receive services in FY87 at an average per person cost of \$255 for a total cost of \$153.00 (76.5 state and 76.5 federal).

. SECTION 5

SECTION 5 identifies the order in which optional medical services and optional eligible groups would be deleted if the program encountered funding difficulties. The present statute is unclear and therefore, open to misinterpretation. The present statute also includes services which are now mandatory for Medicaid coverage under federal laws, and may no longer be deleted if funding difficulties arise.

There is no state fund impact as a result of SECTION 5.

. SECTIONS 6, 7 and 8

These sections seek to create equitable consideration by the Medicaid Rate Commission between the financial needs of Alaska's health facilities, and the financial constraints of the Department budget.

The Medicaid Rate Commission is an independent body which was established in 1983 to set Medicaid rates for Alaska health facilities. Members are appointed by the Governor to three year terms.

As an example of the problem addressed by SECTION 6, the Department advised the Medicaid Rate Commission in February 1985 that only 7.5% was budgeted for facility price increases in FY85. However, data available to the Department indicates that the Medicaid Rate Commission approved a rate process that resulted in FY85 price increases averaging 16% for hospitals and 13% for nursing homes. This has not only created an over expenditure situation for FY85, but has placed the Department out-of-compliance with the state plan filed with federal Medicaid officials. The state plan is essentially a contract between the state and federal government describing the operation of Medicaid in Alaska. The state plans for FY85 and FY86 have not been approved by federal officials because there are significant differences between what federal rules permit, and what the Rate Commission has adopted as rate setting policies. Failure to remedy these differences could lead to significant reductions in federal funding, and worse case, total withdrawal of federal Medicaid funding in Alaska.

The potential problems addressed by Section 6 are significant, and if not adopted, could result in a major adverse impact on the Department's budget. The Department urges additional language further strengthening the legislative expectation that the Medicaid Rate Commission establish rates which, in the aggregate, are affordable within the Department's appropriated funds each fiscal year. The Department also urges an additional section requiring the Medicaid Rate Commission to reset any facility fiscal year 86 rates which extend into State Fiscal Year 1987, if new rates are necessary so that commission-set rates for Fiscal Year 87 do not exceed the final FY87 legislative appropriation. The present language of Section 6 in CSCSHB98 is an improvement over the present statute, but still leaves open the possibility of the Medicaid Rate Commission to exceed budgeted funds as occurred for FY85. (The final outcome for FY86 is not yet known.) The Department therefore urges the insertion of the language in Attachment D.

. SECTIONS 9 AND 10

These sections clarify one existing term, and add definitions for new terms introduced by CSHB98 (Senate HESS). These new terms are found in AS 47.07.030 and in AS 47.07.035.

. SECTION 11

This section deletes the existing six month billing provisions being replaced by Section 1 of Senate CS for CS HB98 (HESS).

DEPARTMENT POSITION

The Department supports CSCSHB98 (HESS) as written, but strongly recommends further strengthening of Section 7 to prevent a funding shortfall in FY87. The additional language recommended is included in Attachment D. CSCSHB98 has become an omnibus medical assistance measure of considerable importance to the Department. The net state general fund impact of CSCSHB98, with the proposed program additions in SECTION 4, is \$968.3 in FY87.

Recommended By:

Rod Betit

Rod Betit, Director
Division of Medical Assistance

Date:

3/12/86

Approved By:

John R. Pugh

John R. Pugh, Commissioner
Department of Health & Social
Services

Date:

3/12/86

STATE OF ALASKA 1986 LEGISLATIVE SESSION FISCAL NOTE

Revision Date : _____

REQUEST

Bill/Resolution No. : SCS CSHB98 (HESS)
 Title : An act relating to Medical Assistance
 Sponsor : Rules/Governor
 Requestor : _____
 Date of Request : 3/5/86

FISCAL DETAIL

Agency Affected : Health & Social Services
 BRU : Medical Assistance Non-Facility
 Components : Medicaid Non-Facility

EXPENDITURES/REVENUES : (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES		45.2	47.0	48.8	50.8	52.8
TRAVEL		8.6	8.9	9.3	9.7	10.1
CONTRACTUAL		20.8	.8	.9	.9	.9
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS		2112.3	3612.5	3757.0	3907.2	4063.6
MISCELLANEOUS						
TOTAL OPERATING		2186.7	3669.2	3816.0	3968.6	4127.4

CAPITAL						
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REVENUE		250.0	270.0	292.0	315.0	340.0
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FUNDING : (Thousands of Dollars)

GENERAL FUND		968.3	1599.6	1762.0	1826.8	1893.7
FEDERAL FUNDS		968.4	1699.6	1762.0	1826.8	1893.7
OTHER						
TOTAL		1936.7	3399.2	3524.0	3653.6	3787.4

POSITIONS :

FULL-TIME		1.0	1.0	1.0	1.0	1.0
PART-TIME						
TEMPORARY						

ANALYSIS : Attach a separate page if necessary

- (1) Funding is net after revenue to program.
- (2) Grants inflated by 4% after FY88.
- (3) See attached detailed financial ~~summary~~.

Prepared by : Rod Betit, Director *R. Betit*
 Division : Medical Assistance

Phone : 465-3355
 Date : 3/5/86

Approved by Commissioner : John R. Poy
 Agency : Department of Health & Social Services

Date : 3/12/86

Distribution (by Agency preparing fiscal note):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

Fiscal Note
 Summary SCS (SHB98 (HESS)
 FY87

<u>Section</u>	<u>Subject</u>	<u>FY87 Total</u>	<u>FY87 State</u>
I	Six Month Law	29.2	14.6
II	Subrogation	(250.0)	(125.0)
III	Optional Needy Groups	-0-	-0-
IV	Optional Medical Services	2157.5	1078.7
A. <u>Personal Care</u>			
	(a) 190 recipients X 600 hours X \$9.00/hour =	1,029.2	Total
	(b) New position and associated costs =	54.6	Total
B. <u>Chiropractor</u>			
	(a) 600 recipients X \$255 average =	153.0	Total
	(b) One time computer costs =	20.0	Total
C. <u>Adult Dental</u>			
	(a) 2716 recipients X \$331.63 =	900.7	Total
V	Priority Medical Services	-0-	-0-
VI	Medicaid Rate Commission	<u>-0-</u>	<u>-0-</u>
	Total \$ Impact	1936.7	968.3

Attachment A

MEDICAID
ELIGIBLE GROUPS

A. Mandatory Eligible Groups:

- .AFDC Recipients
- .Deemed Recipients of AFDC
- .Families that lost AFDC because of employment
- .Individuals ineligible for AFDC because of requirements inapplicable under Medicaid
- .Individuals eligible for AFDC except for the SSA increase in 1972
- .Qualified pregnant women and children under 5 born after 9/30/83
- .Newborn children of Medicaid - eligible women
- .Children for whom adoption assistance or foster care maintenance payments are made under Title IV-E
- .The Aged, Blind, or Disabled under SSI
- .Individuals ineligible for SSI or State supplements because of requirements inapplicable under Medicaid
- ."Grandfathered" individuals

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B. Optional Eligible Groups Covered in Alaska

11. Individuals under 21 who cannot qualify for AFDC because they are not dependent children
12. Institutionalized individuals under a special income eligibility level
13. Individuals who do not receive SSI but qualify for Adult Public Assistance
14. Pregnant women
- * Individuals eligible for financial assistance but not receiving it
- * Individuals eligible for financial assistance except for institutional status (not listed in draft bill under .035)

C. Optional Eligible Groups Not Covered

- .Noninstitutionalized disabled children
- .Noninstitutionalized individuals receiving home and community based service under a special income eligibility level
- .The medically needy
- .Individuals who could qualify for AFDC if AFDC were as broad as federally allowed
- .Individuals eligible for assistance under AFDC if child care costs were paid from earnings

* These optional services and eligible groups are not currently listed in AS 47.07.035 but have been included in the revision proposed in HB98.