416, 76 L. Ed. 2d 687, 103 S. Ct. 2481 (1983). See *ante, 505 U.S. at 876.* n3 Because [***786] the three Justices now wish to "set forth a standard [**2877] of general application," the joint opinion announces that "it is important to clarify what is meant by an undue burden." *Ibid.* I certainly agree with that, but I do not agree that the joint opinion succeeds in the announced endeavor. To the contrary, its efforts at clarification [*986] make clear only that the standard is inherently manipulable and will prove hopelessly unworkable in practice.

n3 The joint opinion is clearly wrong in asserting, *ante, 505 U.S. at 874,* that "the Court's early abortion cases adhered to" the "undue burden" standard. The passing use of that phrase in JUSTICE BLACKMUN's opinion for the Court in *Bellotti v. Baird, 428 U.S. 132, 147, 49 L. Ed. 2d 844, 96 S. Ct. 2857 (1976) (Bellotti I),* was not by way of setting forth the *standard* of unconstitutionality, as JUSTICE O'CONNOR's later opinions did, but by way of expressing the *conclusion* of unconstitutionality. Justice Powell for a time appeared to employ a variant of "undue burden" analysis in several nonmajority opinions, see, *e. g., Bellotti v. Baird, 443 U.S. 622, 647, 61 L. Ed. 2d 797, 99 S. Ct. 3035 (1979) (Bellotti II); Carey v. Population Services International, 431 U.S. 678, 705, 52 L. Ed. 2d 675, 97 S. Ct. 2010 (1977)* (opinion concurring in part and concurring in judgment), but he too ultimately rejected that standard in his opinion for the Court in *Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416, 420, n. 1, 76 L. Ed. 2d 687, 103 S. Ct. 2481 (1983) (Akron I).* The joint opinion's reliance on *Maher v. Roe, 432 U.S. 464, 473, 53 L. Ed. 2d 484, 97 S. Ct. 2376 (1977),* and *Harris v. McRae, 448 U.S. 297, 314, 65 L. Ed. 2d 784, 100 S. Ct. 2671 (1980),* is entirely misplaced, since those cases did not involve regulation of abortion, but mere refusal to fund it. In any event, JUSTICE O'CONNOR's earlier formulations have apparently now proved unsatisfactory to the three Justices, who — in the name of *stare decisis* no less — today find it necessary to devise an entirely new version of "undue burden' analysis. See *ante, 505 U.S. at 877-879.*

The joint opinion explains that a state regulation imposes an "undue burden" if it "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Ante, 505 U.S. at 877;* see also *ante, 505 U.S. at 877-879.* An obstacle is "substantial," we are told, if it is "calculated[,] [not] to inform the woman's free choice, [but to] hinder it." *Ante, 505 U.S. at 877.* n4 This latter statement cannot [*987] [***787] possibly mean what it says. *Any* regulation of abortion that is intended to advance what the joint opinion concedes is the State's "substantial" interest in protecting unborn life will be "calculated [to] hinder" a decision to have an abortion. It thus seems more accurate to say that the joint opinion would uphold abortion regulations only if they do not *unduly* hinder the woman's decision. That, of course, brings us right back to square one: Defining an "undue burden" as an "undue hindrance" (or a "substantial obstacle") hardly "clarifies" the [**2878] test. Consciously or not, the joint opinion's verbal shell game will conceal raw judicial policy choices concerning what is "appropriate" abortion legislation.

n4 The joint opinion further asserts that a law imposing an undue burden on abortion decisions is not a "permissible" means of serving "legitimate" state interests. *Ante, 505 U.S. at 877.* This description of the undue burden standard in terms more commonly associated with the rational-basis test will come as a surprise even to those who have followed closely our wanderings in this forsaken wilderness. See, *e. g., Akron I, supra, at 463* (O'CONNOR, J., dissenting) ("The 'undue burden' . . . represents the required threshold inquiry that must be conducted before this Court can require a State to justify its legislative actions under the exacting 'compelling state interest' standard"); see also *Hodgson v. Minnesota, 497 U.S. 417, 458-460, 111 L. Ed. 2d 344, 110 S. Ct. 2926 (1990)* (O'CONNOR, J., concurring in part and concurring in judgment in part); *Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747, 828, 90 L. Ed. 2d 779, 106 S. Ct. 2169 (1986)* (O'CONNOR, J., dissenting). This confusing equation of the two standards is apparently designed to explain how one of the Justices who joined the plurality opinion in *Webster v. Reproductive Health Services, 492 U.S. 490, 106 L. Ed. 2d 410, 109 S. Ct. 3040 (1989),* which adopted the rational-basis test, could join an opinion expressly adopting the undue burden test. See *id., at 520* (rejecting the view that abortion is a "fundamental right," instead inquiring whether a law regulating the woman's "liberty interest" in abortion is "reasonably designed" to further "legitimate" state ends). The same motive also apparently underlies the joint opinion's erroneous citation of the plurality opinion in *Ohio v. Akron Center for Reproductive Health, 497 U.S. 502, 506, 111 L. Ed. 2d 405, 110 S. Ct. 2972 (1990) (Akron II)* (opinion of KENNEDY, J.), as applying the undue burden test. See *ante, 505 U.S. at 876* (using this citation to support the proposition that "two of us" — *i. e.*, two of the

the interest as "compelling" throughout pregnancy would have been, shall we say, a "substantial obstacle" to the joint opinion's determined effort to reaffirm what it views as the "central holding" of *Roe*. See *Akron I, 462 U.S. at 420, n.1.)* And "viability" is no longer the "arbitrary" dividing line previously decried by JUSTICE O'CONNOR in *Akron I, id., at 461;* the Court now announces that "the attainment of viability may continue to serve as the critical fact," *ante, 505 U.S. at 860.* n5 It is difficult to [*990] [***789] maintain the illusion that we are interpreting a Constitution rather than inventing one, when we amend its provisions so breezily.

n5 Of course JUSTICE O'CONNOR was correct in her former view. The arbitrariness of the viability line is confirmed by the Court's inability to offer any justification for it beyond the conclusory assertion that it is only at that point that the unborn child's life "can in reason and all fairness" be thought to override the interests of the mother. *Ante, 505 U.S. at 870.* Precisely why is it that, at the magical second when machines currently in use (though not necessarily available to the particular woman) are able to keep an unborn child alive apart from its mother, the creature is suddenly able (under our Constitution) to be protected by law, whereas before that magical second it was not? That makes no more sense than according infants legal protection only after the point when they can feed themselves.

Because the portion of the joint opinion adopting and describing the undue burden test provides no more useful guidance than the empty phrases discussed above, one must turn to the 23 pages applying that standard to the present facts for further guidance. In evaluating Pennsylvania's abortion law, the joint opinion relies extensively on the factual findings of the District Court, and repeatedly qualifies its conclusions by noting that they are contingent upon the record developed in these cases. Thus, the joint opinion would uphold the 24-hour waiting period contained in the Pennsylvania statute's informed consent provision, 18 Pa. Cons. Stat. § 3205 (1990), because "the record evidence shows that in the vast majority of cases, a 24-hour delay does not create any appreciable health risk," *ante, 505 U.S. at 885.* The three Justices therefore conclude that "on the record before us, . . . we are not convinced that the 24-hour waiting period constitutes an undue burden." *Ante, 505 U.S. at 887.* The requirement that a doctor provide the information pertinent to informed consent would also be upheld because "there is no evidence on this record that [this requirement] would amount in practical terms to a substantial obstacle to a woman seeking an abortion." *Ante, 505 U.S. at 884.* Similarly, the joint opinion would uphold the reporting requirements of the Act, §§ 3207, 3214, because "there is no . . . showing on the record before us" that these requirements constitute a "substantial obstacle" [*991] to abortion decisions. *Ante, 505 U.S. at 901.* But at the same time the opinion pointedly observes that these reporting requirements may increase the costs of abortions and that "at some point [that fact] could become a substantial obstacle." *Ibid.* Most significantly, the joint opinion's conclusion that the spousal notice requirement of the Act, see § 3209, imposes an "undue burden" is based in large measure on the District Court's "detailed findings of fact," which the joint opinion sets out at great length, *ante, 505 U.S. at 888-891.*

[**2880] I do not, of course, have any objection to the notion that, in applying legal principles, one should rely only upon the facts that are contained in the record or that are properly subject to judicial notice. n6 But what is remarkable about the joint opinion's [***790] fact-intensive analysis is that it does not result in any measurable clarification of the "undue burden" standard. Rather, the approach of the joint opinion is, for the most part, simply to highlight certain facts in the record that apparently strike the three Justices as particularly significant in establishing (or refuting) the existence of an undue burden; after describing these facts, the opinion then simply announces that the provision either does or does not impose a "substantial obstacle" or an "undue burden." See, *e. g., ante, 505 U.S. at 880, 884-885, 887, 893-894, 895, 901.* We do not know whether the same conclusions could have been reached on a different record, or in what respects the record would have had to differ before an opposite conclusion would have been [*992] appropriate. The inherently standardless nature of this inquiry invites the district judge to give effect to his personal preferences about abortion. By finding and relying upon the right facts, he can invalidate, it would seem, almost any abortion restriction that strikes him as "undue" — subject, of course, to the possibility of being reversed by a court of appeals or Supreme Court that is as unconstrained in reviewing his decision as he was in making it.

n6 The joint opinion is not entirely faithful to this principle, however. In approving the District Court's factual findings with respect to the spousal notice provision, it relies extensively on nonrecord materials, and in reliance upon them adds a number of factual conclusions of its own. *Ante, 505 U.S. at 891-893.* Because this additional factfinding pertains to matters that surely are "subject to reasonable dispute," Fed. Rule Evid. 201(b), the joint opinion must be operating on the premise that these

the "undue burden" regime (as applied today, at least) it generally is not. *Ante, 505 U.S. at 900-901.*

> **"Where, in the performance of its judicial duties, the Court decides a case in such a way as to resolve the sort of intensely divisive controversy reflected in *Roe* . . ., its decision has a dimension that the resolution of the normal case does not carry. It is the dimension present whenever the Court's interpretation of the Constitution calls the contending sides of a [*995] national controversy to end their national division by accepting a common mandate rooted in the Constitution."** *Ante, 505 U.S. at 866-867.*

[2882]** The Court's description of the place of *Roe* in the social history of the United States is unrecognizable. Not only did *Roe* not, as the Court suggests, *resolve* the deeply divisive issue of abortion; it did more than anything else to nourish it, by elevating it to the national level where it is infinitely more difficult to resolve. National politics were not plagued by abortion protests, national abortion lobbying, or abortion marches on Congress before *Roe v. Wade* was decided. Profound disagreement existed among our citizens over the issue — as it does over other issues, such as the death penalty — but that disagreement was being worked out at the state level. As with many other issues, the division of sentiment within each State was not as closely balanced as it was among the population of the Nation as a whole, meaning not only that more people would be satisfied with the results of state-by-state resolution, but also that those results would be more stable. Pre-*Roe*, moreover, political compromise was possible.

Roe's mandate for abortion on demand destroyed the compromises of the past, rendered compromise impossible for the future, and required the entire issue to be resolved uniformly, at the national level. At the same time, *Roe* created a vast new class of abortion consumers and abortion proponents by eliminating the moral opprobrium that had attached to the act. ("If the Constitution *guarantees* abortion, how can it be bad?" — not an accurate line of thought, but a natural one.) Many favor all of those developments, and it is not for me to say that they are wrong. But to portray *Roe* as the statesmanlike "settlement" of a divisive issue, a jurisprudential Peace of Westphalia that is worth preserving, is nothing less than Orwellian. *Roe* fanned into life an issue that has inflamed our national politics in general, and has obscured with its smoke the selection of Justices to this Court **[*996]** in particular, ever since. And by keeping us in the abortion-umpiring business, it is the perpetuation of that disruption, rather than of any *Pax Roeana*, that the Court's new majority decrees.

> **"To overrule under fire . . . would subvert the Court's legitimacy . . . .**
>
> **". . . To all those who will be . . . tested by following, the Court implicitly undertakes to remain stead-fast . . . . The promise of constancy, [***793] once given, binds its maker for as long as the power to stand by the decision survives and . . . the commitment [is not] obsolete.**
>
> . . .
>
> **"[The American people's] belief in themselves as . . . a people [who aspire to live according to the rule of law] is not readily separable from their understanding of the Court invested with the authority to decide their constitutional cases and speak before all others for their constitutional ideals. If the Court's legitimacy should be undermined, then, so would the country be in its very ability to see itself through its constitutional ideals."** *Ante, 505 U.S. at 867-868.*

The Imperial Judiciary lives. It is instructive to compare this Nietzschean vision of us unelected, life-tenured judges — leading a Volk who will be "tested by following," and whose very "belief in themselves" is mystically bound up in their "understanding" of a Court that "speaks before all others for their constitutional ideals" — with the somewhat more modest role envisioned for these lawyers by the Founders.

> "The judiciary . . . has . . . no direction either of the strength or of the wealth of the society, and can take no active resolution whatever. It may truly be said to have neither Force nor Will, but merely judgment . . . ." The Federalist No. 78, pp. 393-394 (G. Wills ed. 1982).

Or, again, to compare this ecstasy of a Supreme Court in which there is, especially on controversial matters, no **[*997]** shadow of change or hint of alteration ("There is a limit to the amount of error that can plausibly be imputed to prior Courts," *ante, 505 U.S. at 866),* with **[**2883]** the more democratic views of a more humble man:

> "The candid citizen must confess that if the policy of the Government upon vital questions affecting the whole people is to be irre-

(2) Has *Roe* succeeded in producing a settled body of law? If the answer to both questions is no, *Roe* should undoubtedly be overruled.

In truth, I am as distressed as the Court is — and expressed my distress several years ago, see *Webster, 492 U.S. at 535* — about the "political pressure" directed to the Court: the marches, the mail, the protests aimed at inducing us to change our opinions. How upsetting it is, that so many of our citizens (good people, not lawless ones, on both sides of this abortion issue, and on various sides of other issues as well) think that we Justices should properly take into account **[*1000]** their views, as though we were engaged not in ascertaining an objective law but in determining some kind of social consensus. The Court would profit, I think, from giving less attention to the *fact* of this distressing phenomenon, and more attention to the *cause* of it. That cause permeates today's opinion: a new mode of constitutional adjudication that relies not upon text and traditional practice to determine the law, but upon what the Court calls "reasoned judgment," *ante, 505 U.S. at 849,* which turns out to be nothing but philosophical predilection and moral intuition. All manner of "liberties," the Court tells us, inhere in the Constitution and are enforceable by this Court — not just those mentioned in the text or established in the traditions of our society. *Ante, 505 U.S. at 847-849.* Why even the Ninth Amendment — which says only that "the enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people" — is, despite our contrary understanding for almost 200 years, a literally boundless source of additional, unnamed, unhinted-at "rights," definable and enforceable by us, through "reasoned judgment." *Ante, 505 U.S. at 848-849.*

What makes all this relevant to the bothersome application of "political pressure" against the Court are the twin facts that the American people love democracy and the American people are not fools. As long as this Court thought (and the people thought) that we Justices were doing essentially lawyers' work up here — reading text and discerning our society's traditional understanding of that text — the public pretty much left us alone. Texts and traditions are facts to study, not convictions to demonstrate about. But if in reality our process of constitutional adjudication consists primarily **[***796]** of making *value judgments;* if we can ignore a long and clear tradition clarifying an ambiguous text, as we did, for example, five days ago in declaring unconstitutional invocations and benedictions at public high school graduation **[**2885]** ceremonies, *Lee v. Weisman, 505 U.S. 577, 120 L. Ed. 2d 467, 112 S. Ct. 2649 (1992);* if, as I say, our pronouncement of constitutional law rests primarily on value **[*1001]** judgments, then a free and intelligent people's attitude towards us can be expected to be (*ought* to be) quite different. The people know that their value judgments are quite as good as those taught in any law school — maybe better. If, indeed, the "liberties" protected by the Constitution are, as the Court says, undefined and unbounded, then the people *should* demonstrate, to protest that we do not implement *their* values instead of *ours.* Not only that, but confirmation hearings for new Justices *should* deteriorate into question-and-answer sessions in which Senators go through a list of their constituents' most favored and most disfavored alleged constitutional rights, and seek the nominee's commitment to support or oppose them. Value judgments, after all, should be voted on, not dictated; and if our Constitution has somehow accidently committed them to the Supreme Court, at least we can have a sort of plebiscite each time a new nominee to that body is put forward. JUSTICE BLACKMUN not only regards this prospect with equanimity, he solicits it. *Ante, 505 U.S. at 943.*

* * *

There is a poignant aspect to today's opinion. Its length, and what might be called its epic tone, suggest that its authors believe they are bringing to an end a troublesome era in the history of our Nation and of our Court. "It is the dimension" of authority, they say, to "call the contending sides of national controversy to end their national division by accepting a common mandate rooted in the Constitution." *Ante, 505 U.S. at 867.*

There comes vividly to mind a portrait by Emanuel Leutze that hangs in the Harvard Law School: Roger Brooke Taney, painted in 1859, the 82d year of his life, the 24th of his Chief Justiceship, the second after his opinion in *Dred Scott.* He is all in black, sitting in a shadowed red armchair, left hand resting upon a pad of paper in his lap, right hand hanging limply, almost lifelessly, beside the inner arm of the chair. He sits facing the viewer and staring straight out. There **[*1002]** seems to be on his face, and in his deep-set eyes, an expression of profound sadness and disillusionment. Perhaps he always looked that way, even when dwelling upon the happiest of thoughts. But those of us who know how the lustre of his great Chief Justiceship came to be eclipsed by *Dred Scott* cannot help believing that he had that case — its already apparent consequences for the Court and its soon-to-be-played-out consequences for the Nation — burning on his mind. I expect that two years earlier he, too, had thought himself "calling the contending sides of national controversy to end their national division by accepting a common mandate rooted in the Constitution."

It is no more realistic for us in this litigation, than it was for him in that, to think that an issue of the **[***797]** sort they both involved — an issue involving life and

Attachment F

T. Joyce, S.K. Henshaw, J.D. Skatrud, "The Impact of Mississippi's Mandatory Delay Law on Abortions and Births," *The Journal of the American Medical Association*, Volume 278, Number 8, August 27, 1997

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waiting period statute on 4 outcomes: abortions, abortions performed outside the state of residence, abortion delay, and births. Toward this end, we examined changes in live births and induced abortions for all women and then separately by age and race to residents of Mississippi before and after August 1992, the month Mississippi's mandatory delay statute went into effect. We compared the experience of Mississippi residents with changes in births and abortions in Georgia and South Carolina, 2 southern states with no mandatory delay statute.

METHODS

Data

Data on births and induced abortions are from vital records in Mississippi, Georgia, and South Carolina. We chose South Carolina and Georgia as comparison states for several reasons. First, neither state imposed a 24-hour waiting period between 1989 and 1994. Second, both are southern states with comparably large nonwhite populations, permitting a race-specific analysis. Third, except for mandatory delay, abortion policies in Mississippi, Georgia, and South Carolina are similar: none of the states funds abortions through Medicaid except in cases of rape or incest, and all 3 states began enforcement of parental notification or consent statutes between 1990 and 1993. Finally Mississippi, South Carolina, and Georgia all maintain computerized records of induced termination as part of their vital statistics and all have reciprocal agreements with neighboring states to exchange information on residents who have abortions out of state.

Completeness of Abortion Data

Comparison with data from the Alan Guttmacher Institute (AGI), New York, NY, which periodically surveys all abortion providers (defined as clinics, hospitals, and physicians' offices where abortions are performed, here and throughout the text), indicates that counts of abortion by state of occurrence are quite complete for Mississippi and reasonably complete for Georgia and South Carolina. The Mississippi Department of Health reported 7555 abortions performed in the state in 1992 (AGI, 7550). The South Carolina Department of Health reported 11 008 abortions (AGI, 12 190), and the Georgia State Department of Health reported 38 052 abortions (AGI, 39 680).[6,5]

Counts of abortions by state of residence are more difficult to assess, yet consistent counts by state of residence are important to our assessment. If, for instance, more residents of Mississippi seek abortions in other states in response to a mandatory waiting period and if a proportion of these abortions are not recorded by the Mississippi Department of Health, then we will overestimate the effect of the law on abortion rates to residents of Mississippi. As a partial check on the quality of reporting across states, we compared resident data on abortions as reported by the Mississippi Department of Health with occurrence data as collected by agencies in Tennessee and Alabama on Mississippi residents. The Tennessee Department of Health[7] reported that 793 abortions to residents of Mississippi were performed in Tennessee in 1992. The Mississippi Department of Health[8] reported that 785 abortions to residents of Mississippi were performed in Tennessee. The Alabama Department of Health[9] recorded 766 abortions to residents of Mississippi as compared with 762 abortions reported by the Mississippi Department of Health. The agreement among the 3 states indicates that reciprocal reporting arrangements of known abortions are effective.

Another potentially important border state, Louisiana, does not collect data on abortions to residents of Mississippi. However, a sample survey of Louisiana abortion providers by AGI suggests that about 1000 Mississippi residents have abortions in Louisiana each year (S. K. H., unpublished data, March 1996). Finally, the Arkansas Department of Health recorded only 9 abortions to Mississippi residents in 1991.

We analyzed births and abortions for all women and then separately by age (≤19 years or ≥20 years) and race (white or nonwhite). We analyzed data for teens separately since during the time period under study all 3 states imposed parental consent or notification statutes for minors seeking abortion. Except for a subgroup of minors in South Carolina, parental involvement laws are associated with a relatively minor decline in teen abortions to residents of Mississippi and South Carolina. Parental involvement laws, however, are associated with an increase in the number of minors who obtain abortions out of state.[10,11] They may also be associated with increases in abortions performed later in gestation.

Abortion rates are expressed as abortions per 1000 women aged 15 to 44 years. For the subgroup analysis, we used race-specific women aged 15 to 19 years or 20 to 44 years as denominators. For birth rates, we lagged population figures by 6 months to match births and abortions to women who became pregnant during the same time period. Population figures by age, race, sex, and state for July 1 for each year from 1988 through 1993 were taken from US Census Bureau data files (Larry Sink, MA, MS, unpublished data for 1988-1993, Population Branch, US Bureau of the Census, Washington, DC, November 1995). For July 1994, we estimated rates of growth for each age, race, and sex grouping based on national figures for July 1, 1993, and July 1, 1994.[12] We projected state-specific totals by age and race for 1993 by the national rate of growth to obtain state estimates for July 1994. Monthly totals incorporate proportionate changes between annual totals. Rates for 12-month periods are based on the average of the monthly population estimates for the period.

Stratification by age and race resulted in a minor loss of data because of missing information on one or both of the characteristics (ie, age or race). In Mississippi and South Carolina, we eliminated less than 0.5% of abortions and less than 0.1% of births due to missing age, race, or both. In Georgia, we eliminated 5.2% of abortions. This percentage was relatively stable between 1989 and 1994, and almost half of these cases were to residents of Georgia who obtained an abortion out of state. As a result of the small number of reported abortions to residents of Georgia performed in another state, we do not analyze out-of-state abortions to residents of Georgia.

Gestational age was computed as the difference between the date of the termination and the date of the last menstrual period. If data were lacking on the day of the last menstrual period but were available for month and year, we assumed the last menstrual period took place on the 15th day of the month. If more than the day was missing, we used the physician's estimate of gestational age. Based on this algorithm, we had no missing information on gestational age in any of the 3 states after elimination of cases with missing data on age and race.

Statistical Methods

Mississippi's mandatory waiting statute took effect on August 8, 1992. To assess the impact of the law on abortion, we compared abortion rates for the 12 months preceding August 8, 1992, with those for the 12-month period after the law took effect. For births, we used the same preperiod as abortions, but we defined March 1993 through February 1994 as the postlaw period since we would not expect any change in births for at least 6 months after the law went into effect.

We used rate ratios (RRs) to measure association between Mississippi's mandatory delay law and birth and abortion rates. Specifically, we divided the abortion rate for the 12 months after enforcement of the law by the abortion rate for the 12 months prior to the law. We used the large sample standard error of the natural logarithm of the RR to estimate 95% confidence intervals (CIs) around the RR.[13] We analyzed birth rates similarly. To compare the change in abortion rates in Mississippi to changes in South Caro-

Table 2.—Resident Abortions in Mississippi, South Carolina, and Georgia, by Age and Race, 12 Months Before and After Mississippi's Mandatory Delay Law

	Before, No. (Rate)*	After, No. (Rate)*	RR (95% CI)†	Relative RR (95% CI)‡
White adults, ≥20 y§				
Mississippi	2850 (9.27)	2168 (7.08)	0.76 (0.72-0.80)	...
South Carolina	5591 (11.38)	5456 (11.13)	0.98 (0.94-1.01)	0.78 (0.73-0.83)
Georgia	13110 (13.40)	12518 (12.73)	0.95 (0.93-0.97)	0.80 (0.75-0.85)
Nonwhite adults, ≥20 y§				
Mississippi	2979 (15.37)	2745 (13.98)	0.91 (0.86-0.96)	...
South Carolina	4564 (19.32)	4522 (18.94)	0.98 (0.94-1.02)	0.93 (0.87-0.98)
Georgia	13762 (31.19)	14287 (30.94)	0.99 (0.97-1.02)	0.92 (0.87-0.97)
White teens, ≤19 y‖				
Mississippi	987 (17.53)	762 (13.62)	0.78 (0.71-0.85)	...
South Carolina	1789 (22.74)	1573 (20.34)	0.89 (0.84-0.96)	0.87 (0.77-0.97)
Georgia	3302 (21.87)	3188 (20.96)	0.97 (0.92-1.02)	0.80 (0.72-0.89)
Nonwhite teens, ≤19 y‖				
Mississippi	985 (20.15)	911 (18.58)	0.92 (0.84-1.01)	...
South Carolina	1431 (28.06)	1219 (23.88)	0.85 (0.79-0.92)	1.08 (0.96-1.22)
Georgia	3612 (43.96)	3449 (41.37)	0.94 (0.90-0.98)	0.98 (0.89-1.08)

*Period before law defined as August 1991 through July 1992, and after law defined as August 1992 through July 1993. Resident abortions include all known abortions to residents of a state regardless of where they are performed. For Mississippi, this includes all abortions to residents performed in Mississippi, Alabama, or Tennessee.

†For each outcome, the rate ratio (RR) is the outcome 12 months after the law divided by the outcome 12 months before the law. CI indicates confidence interval.

‡The relative RR is the RR for Mississippi divided by the RR for South Carolina or Georgia. The SE for the relative RR is the square root of the sum of the variances for the respective RRs. Ellipses indicate referent.

§White adult abortion rates are all resident abortions to women aged 20 years or older per 1000 white female residents aged 20 to 44 years. Nonwhite adult abortion rates are defined analogously.

‖White teenager abortion rates are all resident abortions to adolescents aged 19 years or younger per 1000 white female residents aged 15 to 19 years. Nonwhite teenager abortion rates are defined analogously.

Georgia. The relative RRs indicate that the increase in the percentage of late abortions was 39% greater in Mississippi compared with South Carolina or Georgia during the 12 months after the law.

Birth rates decreased in all 3 states after the law. Relative RRs indicate that birth rates declined approximately 5% less in Mississippi relative to South Carolina [(0.98/0.94)−1]×100), but declined by the same percentage in Mississippi and Georgia.

Age-specific and race-specific resident abortion rates are shown in Table 2. Abortion rates in the year ensuing the law were 0.76 of their prelaw level among white adults, 0.78 among white teens, 0.91 among nonwhite adults, and 0.92 among nonwhite teens. The decline in abortion rates for each group except nonwhite teens was greater in Mississippi than in each of the 2 comparison states. Abortion rates declined 22% more among white adults in Mississippi relative to South Carolina and 20% more relative to adults in Georgia. Abortion rates for white teens in Mississippi decreased 13% compared with South Carolina and 20% more compared with Georgia. For nonwhite adults, the decline in Mississippi was 7% and 8% relative to South Carolina and Georgia, respectively. There was no difference between nonwhite teens in Mississippi as compared with nonwhite teens in either South Carolina or Georgia.

The percentage of abortions performed after 12 weeks' gestation rose among the 4 age and racial groups in Mississippi, but the relative increase was greater for whites than nonwhites (Table 3). The RR was 1.55 for white adults, 1.69 for white teens, 1.25 for nonwhite adults, and 1.27 for nonwhite teens. Except for nonwhite teens, the proportion of late abortions by age and race increased in Mississippi compared with South Carolina and Georgia.

Regression Analysis

Table 4 displays the average change in the natural logarithm of abortion rates between Mississippi and South Carolina and between Mississippi and Georgia in the period following implementation of Mississippi's mandatory delay statute by age and race. Changes were adjusted for state-specific linear and curvilinear trends in the natural logarithm of monthly resident abortion rates. Interpreting changes in the natural logarithm as proportionate changes, we showed that overall abortion rates declined between 10% and 13% in Mississippi after the law compared with South Carolina and Georgia. Among white adults, abortion rates decreased between 17% and 23% in Mississippi relative to South Carolina and Georgia, and among white teens there was an 18% decline in Mississippi relative to white teens in Georgia. Changes among nonwhites, although consistent in magnitude to changes in the relative RRs in Table 2, were statistically insignificant. Regarding differences in variance between the binomial and regression approaches, the binomial was likely to underestimate the variance as it did not incorporate between-month variation.

COMMENT

Beginning in August 1992, women seeking abortion in Mississippi had to wait 24 hours from the time they received state-mandated information on complications of abortion and birth, fetal development, abortion alternatives, and financial assistance for prenatal and infant care before the abortion could be performed. In response to the law, abortion providers required women to make at least 2 separate visits to the abortion facility. There were only 8 abortion providers in Mississippi in 1992, 5 of whom were located in Jackson, Miss.[6] For some women then, 2 visits may present a substantial cost in terms of time and out-of-pocket expenses. In this study, we have investigated whether Mississippi's delay statute is associated with changes in abortion and birth rates by comparing Mississippi's rate with those of 2 neighboring states lacking this requirement.

We found a substantial and statistically significant decline in abortion rates among residents of Mississippi 12 months after the law went into effect. From this we conclude that the fall in abortion rates is unlikely spurious and is related to enforcement of the 24-hour mandatory delay statute. Our conclusion is bolstered by corroborating increases in the percentage of abortions performed out of state and the percentage of abortions performed after 12 weeks' gestation. We also found no similar increases in abortion rates, the percentage of late abortions, or the percentage of out-of-state abortions in 2 comparison states, Georgia and South Carolina. Finally, our findings do not appear to be an artifact of underreporting. The numbers of abortions performed in Mississippi in 1992 as measured by vital records are almost identical to totals obtained by the AGI survey of providers.[5,6]

The percentage decline in the abortion rate of teens in Mississippi was about as great as that of adults, but the comparisons with Georgia and South Carolina show less difference because teen abortion rates also fell in those states. In South Carolina, teen abortion rates decreased 11% among whites and 15% among nonwhites, compared with a 2% decline among adults. The large decline in teen rates relative to adult abortion rates of both races in South Carolina implies that factors specific to South Carolina had a unique impact on the abortion rate of teens in that state.

One explanation for these findings is that enforcement of the parental consent statute enacted in May 1990 in South Carolina may have precipitated a downward trend in teen abortion rates. Georgia also enacted a parental notification statute in September 1991 that may have

Definitive tests of the hypothesis were impossible because the expected effects on the birth rates of the observed decline in abortions are small and can be masked by unmeasured state-specific factors that also affect the birth rate. For example, abortions declined by 1210 a year after the law took effect (Table 1). If carried to term, these pregnancies would have resulted in approximately 1089 live births after adjustment for fetal loss. This would have increased the postlaw birth rate by 1.79 per 1000 women aged 15 to 44 years, or 2.5%. In fact, the birth rate decreased by 2% in Mississippi, 6.4% in South Carolina, and 2.4% in Georgia after the law. Thus, although the law may have contributed to the relatively slower decline in Mississippi, other factors may have played an even larger role.

The delay law may have stimulated greater contraceptive use, causing unintended pregnancies to decrease. If this happened, the relative increase in the birth rate among residents of Mississippi would be less than the 2.5% that would have been observed had the decline in abortions resulted in a one-for-one increase in births. In this case, the power of our statistical procedures to detect an effect on birth rates would be even further diminished.

We have no way of assessing whether illegal abortions increased as a result of the law. An analysis of illegal abortion following enforcement of the Hyde amendment found no evidence of a meaningful increase in illegal abortions associated with a decrease in Medicaid-financed abortions.[14] Another assessment estimated that there may have been a 1% increase in illegal abortion associated with the Hyde amendment.[15] An increase in illegal abortion of 1% in Mississippi would not alter our conclusions.

Could other changes have occurred in Mississippi during the study period to precipitate the observed decline in abortion rates? Although we cannot exclude the possibility, our research design eliminated several sources of potential confounding. A before-and-after analysis within a state removes state-specific confounders that do not vary during the study period. Marital status, for instance, is an important correlate of abortion, but unless the marriage rate within a state changes during the 24-month study period, marital status cannot be a confounder for the law. The same argument pertains to other potential confounders such as the percentage of the population residing in metropolitan areas or per capita income. In fact, we could find no demographic or socioeconomic shifts to explain the decline. The marriage rate and per capita income varied by less than 3% in the 3 study states between 1992 and 1993, and the percentage of the population living in metropolitan areas varied by less than 2% between 1992 and 1993.[3,16] There were no major changes in abortion service availability to account for the observed decline. The number of abortion providers in Mississippi increased from 7 to 8 between 1991 and 1992, while the number of abortion providers fell from 59 to 55 in Georgia and from 20 to 18 in South Carolina (S. K. H., unpublished data, March 1996).

A before-and-after analysis, however, will not eliminate confounding by factors that vary during the study period. If, for example, abortion rates in Mississippi have been trending downward because of changing attitudes toward abortion, then a decline in abortion rates after the law may reflect changing sentiment toward abortion and not the effects of the mandatory delay statute. We attempted to eliminate time-varying confounders in 2 ways. First, we divided the RR for abortion and births in Mississippi by the RR for abortion and births in Georgia and South Carolina. We termed these relative RRs. The objective was to eliminate time-varying factors common across Mississippi and our comparison states that were related to abortion and birth rates, but unrelated to the law. If, for example, the abortion rate were to decline 10% in Mississippi after the law, but also decline 10% for the same period in South Carolina, the relative RR would be 1. We would interpret such a finding to mean that changes in Mississippi's abortion rate associated with the law were indistinguishable from general trends in abortion that existed in comparative states. Finally, we used regression analysis to control for state-specific linear and quadratic trends in the natural logarithm of monthly abortion rates. The pattern of results was consistent across methodologies.

Are the results from Mississippi relevant to the effects of mandatory delays in other states? We believe so, but our findings are most germane to states in which the law has been interpreted as requiring 2 visits to an abortion provider. Of the 10 states in addition to Mississippi with enforced mandatory delay statutes, only Louisiana and Utah have interpreted their laws to require 2 separate visits to an abortion provider. Other states permit counseling and state-mandated information regarding the fetus and alternatives to abortion to be communicated via the telephone or through the mail.

The availability of abortion providers is also important to consider. The effect of mandatory delay statutes necessitating 2 visits to a provider may be greater in states that have relatively fewer abortion providers. In Mississippi, there were only 8 abortion providers in the entire state in 1992 or 1.3 providers per 100 000 women aged 15 to 44 years; South Carolina had 2.1, Georgia had 3.3, and the national average was 4.0.[6] Thus, the large decline in abortion rates we observed in Mississippi may not occur in states with greater availability of abortion providers both within state and among neighboring states. Still, some women in all states have difficulty gaining access to abortion services, and a law that created a barrier for a substantial proportion of Mississippi women would undoubtedly have a similar effect on many women in other states.

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Alaska State Legislature

Please enter into the record my testimony to the Judiciary ~~House Health, Education, and Social Services~~
Committee name

Committee on Informed Consent House bill No 292 (HES), dated 5-17-03
Bill/Subject

This is an excellent bill for providing information to women prior to Abortion. Women need to be informed because many and this is quite recent, have not known what to expect and had no knowledge of the procedure or its side effects.

Parental consent should be mandatory.

Signed: Judith Ann Lewis
Testifier

Representing (Optional)

Address

907 ~~745~~ 745-5983
Phone number

Alaska State Legislature

Please enter into the record my testimony to the Judiciary HOUSE ~~HESS~~ COMM.
Committee name

Committee on INFORMED CONSENT FOR ABORTION dated 5-17-03
Bill/Subject

I am very much in favor of this bill. abortion is so final, that young girls need to be informed about the repercussion of the decision. Parental consent will help girls have a more unemotional person aid in such a decision.
As a grandmother, I would certainly not want my granddaughters to be able to get an abortion without any counseling or the knowledge of their parents.

Signed: Ellen Lynch
Testifier

Representing (Optional)

751 LANARK, WASILLA AK 99654
Address

357-6535
Phone number

Subject: sb30
Date: Mon, 23 Feb 2004 09:15:02 -0900
From: "Jason M. Hooley" <jason.hooley@legis.state.ak.us>
Organization: Alaska State Legislature
To: Vanessa Tondini <Vanessa_Tondini@legis.state.ak.us>

Thanks Vanessa--

As you talk with the Committeeand the chair, here is a summary of the information I was trying to relay from DHSS...

The Division of Public Health stated in a letter last year that "*all information posted can be referenced back to multiple authoritative sources, such as the Centers for Disease Control, Office of Women's Health, peer reviewed published research, etc. For complex documents related to medical care guidance, the Department has a committee of experts in the field co-author and review the document prior to distribution.*"

thanks--

jason

Jason M. Hooley <jason.hooley@legis.state.ak.us>
Office of Senator Fred Dyson
Alaska State Legislature

Ok Delete THIS

carolyn V. Brown, M.D., MPH
PO Box 240289
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women's health

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cvbrown@ptialaska.net

MEMORANDUM

Please add to my informed consent re SB30 Thx

DATE: February 23, 2004

TO: House Judiciary Committee

FROM: carolyn V. Brown, M.D., MPH

SUBJECT: House CS for CS for Senate Bill 30 (JUD)

In review of House CS for CS for SB 30, I ask that the following comments be considered by the House Judiciary Committee and that these comments be entered into the record.

- To avoid discriminatory care, it would appear that this bill must apply to all pregnant women – regardless of their initial plan to carry a pregnancy to term to terminate the pregnancy – if they are to have informed consent.
- There is no documented evidence that the "scientific information on the Internet" will protect, inform, and promote…choices". This would appear to be clearly erroneous.
- Does the legislation presume to tell physicians what informed consent for abortion is? Will further legislation presume to tell physicians what informed consent is for other procedures? This does not appear to provide equal protection under the law.
- Who will maintain the indexed material, names of agencies-clinics, services, and facilities? This information is dynamic and changes very quickly. Who will do this and who will bear the cost? The $20,000 fiscal note surely will not do it. Who is the watch dog?
- All facilities that provide or sell contraceptives will have to be included in the "list" of agencies-clinics, services, and facilities? This is equally

dynamic information and changes quickly. Who will do this and who will bear the cost. Who is the watch dog?

- Information about survival statistics for a fetus is extremely problematic and cannot be agreed upon by neonatologists and experts across the nation. How would this Internet information piece presume to keep up with this information in an accurate, scientific, and evidence-based manner?
- Who will decide just what the "accurate scientific information" is?
- The 30-day wait period is a delay tactic and is potentially harmful for the women who choose a pregnancy termination. Does a woman who chooses to carry the pregnancy to term have to wait for 30 days before she gets her first pre-natal care? This is discriminatory.
- Will women be mandated to watch the program or read the material? If a woman refuses, what is the penalty?
- To be non-discriminatory, all women who are pregnant must watch this program or read this information if they are to make an informed consent about their pregnancy.
- How will this bureaucratic nightmare be paid for on an on-going basis? The rule of reasonableness would suggest that the $20,000 note won't do it.
- What is meant by a "medical emergency"?
- Does a "major bodily function" also include the brain, neurotransmitters, and psychological aspects of pregnancy? This term has no rational meaning for the physical, mental, emotional, and socio-psychological parameters of a pregnancy.

I consider that this bill is clearly not in the best interests of the women of Alaska, health care professionals who provide care, or the State's best interests. I ask that this bill be defeated.

Carolyn V. Brown, M.D., MPH
February 23, 2004

Subject: [Fwd: HB 292/SB30]
Date: Mon, 23 Feb 2004 12:03:30 -0900
From: Lesil Mcguire <Representative_Lesil_Mcguire@Legis.state.ak.us>
Organization: Alaska State Legislature
To: Vanessa Tondini <Vanessa_Tondini@legis.state.ak.us>

-------- Original Message --------
Subject: HB 292/SB30
Date: Mon, 23 Feb 2004 11:57:26 -0900
From: "Ozer, Kerry" <KOzer@SouthcentralFoundation.com>
To: <Representative_Tom_Anderson@legis.state.ak.us>,"Gara, Les" <Representative_Les_Gara@legis.state.ak.us>,"Gruenberg, Max" <Representative_Max_Gruenberg@legis.state.ak.us>,"Holm, Jim" <Representative_Jim_Holm@legis.state.ak.us>,<Representative_Lesil_McGuire@legis.state.ak.u Dan" <Representative_Dan_Ogg@legis.state.ak.us>,"Samuels, Ralph" <Representative_Ralph_Samuels@legis.state.ak.us>

This proposed legislation is clearly not in the best interest of patients, the State of Alaska, or physicians and other health care providers.

A major concern with this legislation is the invasion of physician-patient relationship, confidentiality and privilege. When this vital aspect of health care is breached, trust is broken and health care is compromised.

These bills are redundant. Physicians already provide informed consent. To suggest otherwise is to insult our profession and undermine our patient-physician relationships.

The legislature is attempting to micro-manage health care. All pregnant women need to have appropriate informed consent. HB292/SB30 calls for the discriminatory treatment of pregnant women. Physicians know that the risk of dying from an abortion related complication is 0.4 deaths/100,000 procedures. We know that the risk of dying as a result of pregnancy and childbirth is 7 deaths/100,000 live births. These bills warn women about the risk of abortion, but not about the greater risk of carrying a pregnancy to term.

I strongly oppose HB 292/SB30 and ask that you do what is necessary to stop this invasion into the provision of health and medical care for women in Alaska.

Please contact me if you have questions.

OK V –
plz add to
my HB 30
file then
delete
THX U

Subject: [Fwd: HB 292/SB30]
Date: Wed, 25 Feb 2004 08:36:00 -0900
From: Lesil Mcguire <Representative_Lesil_Mcguire@Legis.state.ak.us>
Organization: Alaska State Legislature
To: Vanessa Tondini <Vanessa_Tondini@legis.state.ak.us>

-------- Original Message --------
Subject: HB 292/SB30
Date: Tue, 24 Feb 2004 13:48:58 -0800 (PST)
From: Meghan McKeever <megstar77@yahoo.com>
To:
Representative_Lesil_McGuire@legis.state.ak.us,Representative_Tom_Anderson@legis.state

Date: February 24th 2004

To: House Judiciary Committee.

Re: HB 292/SB30. "An Act relating to information and services available to pregnant women and other persons; and ensuring informed consent before an abortion may be performed, except in cases of medical emergency"

This proposed legislation is clearly not in the best interest of patients, the State of Alaska, or physicians and other health care providers.

A major concern with this legislation is the invasion of physician-patient relationship, confidentiality and privilege. When this vital aspect of health care is breached, trust is broken and health care is compromised.

These bills are redundant. Physicians already provide informed consent. To suggest otherwise is to insult our profession and undermine our patient-physician relationships.

The legislature is attempting to micro-manage health care. All pregnant women need to have appropriate informed consent. HB292/SB30 calls for the discriminatory treatment of pregnant women. Physicians know that the risk of dying from an abortion related complication is 0.4 deaths/100,000 procedures. We know that the risk of dying as a result of pregnancy and childbirth is 7 deaths/100,000 live births. These bills warn women about the risk of abortion, but not about the greater risk of carrying a pregnancy to term.

I strongly oppose HB 292/SB30 and ask that you do what is necessary to stop this invasion into the provision of health and medical care for women in Alaska.

Thank you,

Meghan McKeever
Alaska resident and senior Medical Student
University of Washington School of Medicine

=====

V- Great Letter PB distribute this to all Jud members THKS ☺ a brief response to her re: THKS for her input & comments on her

progress in Judicial School I look forward to hearing

senior PA

Re: HB 385 (2)

Lazetta Lundberg (cont.)

for a minimum period of 30 days any consideration for visitation by the non-awarded custodian must will only be allowed visitation with a child under the supervision by a 3rd party court appointed custodian.

What our community has recently experienced bad decisions of tragic consequence. We cannot afford to compromise defending the voice of the silent & innocent young.

Thank you

Subject: **[Fwd: RE: HB 292]**
Date: Mon, 23 Feb 2004 10:59:18 -0900
From: Lesil Mcguire <Representative_Lesil_Mcguire@Legis.state.ak.us>
Organization: Alaska State Legislature
To: Vanessa Tondini <Vanessa_Tondini@legis.state.ak.us>

For judiciary

-------- Original Message --------
Subject: RE: HB 292
Date: Mon, 23 Feb 2004 09:47:13 -0900
From: "rwkeller" <rwkeller@alaska.net>
To: <Representative_Lesil_McGuire@legis.state.ak.us>

Lesil - It sounds from my reading of the bill that the legislature wants/desires some input on the amount/type of informed consent given to patients for a procedure. This is not their job. We are and have been legally responsible for informed consent forever (amount, type, adequacy, method and documentation). Legislative intrusion is unwelcome and unnecessary. Doctors (surgeons esp.) are getting good at this having been sued many times for inadequacy in the courts eyes. Any standard of the legislature adds a burden, may actually lessen the full information given to a patient (i.e. meet the 'law' only). Please vote against this provision. (I suspect you're feelings are in agreement already, but please assist in the fight). Thank you..... R.W. Keller MD (Pediadoc)
3340 Providence Drive #466
Anchorage, Alaska 99508
rwkeller@alaska.net

Subject: [Fwd: HB292]
Date: Mon, 01 Mar 2004 10:44:44 -0900
From: Lesil Mcguire <Representative_Lesil_Mcguire@Legis.state.ak.us>
Organization: Alaska State Legislature
To: Vanessa Tondini <Vanessa_Tondini@legis.state.ak.us>

For committee

-------- Original Message --------
Subject: HB292
Date: Sun, 29 Feb 2004 20:03:44 -0900
From: Larry Marshburn <larrym@xyz.net>
To: Representative_Lesil_McGuire@legis.state.ak.us

DATE: 29 FEB, 2004

To: House Judiciary Committee

Re: HB 292/SB30 "An Act relating to information and services available to pregnant women and other persons: and ensuring informed consent before an abortion may be performed, except in cases of medical emergency"

I am a physician who has been licensed and practicing in the state of Alaska since 1971, first in Anchorage (until 1977) and then in Homer. For a number of years, while practicing in Homer, I performed therapeutic abortions. My practice is now limited to anesthesiology (since 1986). I am aware of the possible physical and psychological sequelae of this procedure. I can say with confidence that all of the women who availed themselves of this service were given full informed consent.

It is my opinion that this proposed bill is not in the best interests of patients, physicians and other health-care providers, nor the State of Alaska. The proposed bill is redundant.

The medical profession already has the duty to perform informed consent for any procedure which we recommend. This is mandated by our professional societies as well as our malpractice insurance carriers. This bill suggests that this is either being done poorly or not at all. I perceive this as an insult to my profession. It also gives an indication to patients that we are not doing a good job in providing informed consent, a viewpoint that can only undermine the patient-physician relationship.

My major concern is that this proposed legislation will undermine the physician-patient relationship, confidentiality, and privilege. It seems that the Legislature is attempting to micromanage health-care. I feel that HB 292/ SB30 is discriminatory to pregnant women.

I strongly oppose HB 292/SB 30 and request that you do whatever is necessary to derail this invasion into the provision of health and medical care for women in Alaska.

Please contact me if you have questions.

Laurance A. Marshburn, M.D.
P O Box 277
Homer, AK 99603
(907) 235-7978
Cell: 299-2212

Subject: HB292/SB30
Date: Wed, 3 Mar 2004 14:06:08 -0900
From: "Gilson, George J" <gjgilson@anmc.org>
To: "'representative_lesil_mcguire@legis.state.ak.us'" <representative_lesil_mcguire@legis.state.ak.u

Date: March 3, 2004

To: House Judiciary Committee.

Re: HB 292/SB30. "An Act relating to information and services available to pregnant women and other persons; and ensuring informed consent before an abortion may be performed, except in cases of medical emergency"

This proposed legislation is clearly not in the best interest of patients, the State of Alaska, or physicians and other health care providers.

A major concern with this legislation is the invasion of physician-patient relationship, confidentiality and privilege. When this vital aspect of health care is breached, trust is broken and health care is compromised.

These bills are redundant. Physicians already provide informed consent. To suggest otherwise is to insult our profession and undermine our patient-physician relationships.

The legislature is attempting to micro-manage health care. All pregnant women need to have appropriate informed consent. HB292/SB30 calls for the discriminatory treatment of pregnant women. Physicians know that the risk of dying from an abortion related complication is 0.4 deaths/100,000 procedures. We know that the risk of dying as a result of pregnancy and childbirth is 7 deaths/100,000 live births. These bills warn women about the risk of abortion, but not about the greater risk of carrying a pregnancy to term.

I strongly oppose HB 292/SB30 and ask that you do what is necessary to stop this invasion into the provision of health and medical care for women in Alaska.

Please contact me if you have questions

George J. Gilson, MD
Anchorage

George J. Gilson, MD
Maternal Fetal Medicine

Alaska Native Medical Center
4315 Diplomacy Drive
Anchorage, AK 99508
907-729-3239

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FAX:

TO: Lesil

FROM: David Becker

DATE: 2.20.04 *TOTAL # OF PAGES:* 3

RE:

NOTES:

Peninsula Communications, Inc.
P.O. Box 109 • Homer, AK 99603 • (907) 235-6000 • 262-6000 • 224-6000 • 486-6000 • FAX (907) 235-"NOTE" (6683)

PREGNANCY CARE CENTER OF HOMER
P.O. BOX 2
HOMER, ALASKA 99603
907-235-7899

FROM: Eileen Becker, Director
DATE: February 19,2004
TO: Representative Lesil McGuire & Judiciary Committee.
RE; Senate Bill 30 and House Bill 292

Dear Rep. McGuire & Judiciary Committee,

Because of time restraints I had to leave the LIO before testimony could be taken on Wednesday. Thank you for adding this written comments. Eileen Becker.

My name is Eileen Becker, I have served as Director of the PCC of Homer for the past 6 years, Assistant Director for 3 years and peer counselor for 2 years. I have lived, ran our own business and raised 4 sons and an adopted daughter here in Alaska since 1973.

After the last public hearing on HB 292 I did some searching on the internet and found more information that certainly back up my previous testimony. A recent survey of 450 women found that over 40% of all the women survey regretted their decision and another 15% mildly regretted their choice. Of those surveyed 80% said they could never do it again. Another question dealt with information. Over 60% stated little or no information was given to them regarding fetal development, risk or procedure of abortions or the possible feelings of sadness and remorse that they would carry the rest of their lives. Many women stated that they did not even know the name of the doctor preforming the abortion. Abortion can not be compared to just another surgery, there is stress, pressure and emotions unlike anything else. The woman is not sick , diseased or dying and needs time and information to empower her to make the best decision.

The law that was passed in the Supreme Court in 1973, Roe v. Wade was based on a case of Norma McCovey using the false statement that she had been raped. Later this was shown to be not true. Medical information on fetal development has

come a long way in the past 31 years. Much more is know and need to be shared with all women. This bill would be an excellent avenue for education for all, especially if it is readily available on the internet.

Another survey that I pulled up showed states that have "informed consent" see a 30% reduction in abortions. This is a bill worth the effort. There definitely needs to be a civil liability clause, in this SB30 and added back to the House version. Otherwise it basically not worth the paper it written.

I know that those opposed to this bill have only their personal interest at hand and not the well being of Alaskan women. Final details can be ironed out in committee after its passed....Please pass it on for a final vote of the House and Senate as soon as possible. Please do not let it get bogged down with nit picky details that will allow time to run out and nothing to be done this session. Starting all over would be a sad mistake.. This is a good bill, a necessary bill and one that's time has come. Thank you.

carolyn V. Brown, M.D., MPH
PO Box 240289
1640 Second Street
Douglas, Alaska
99824-0289

obstetrics-gynecology
preventive medicine
women's health

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fax 907-364-2727
cvbrown@ptialaska.net

MEMORANDUM

DATE: February 23, 2004

TO: House Judiciary Committee

FROM: carolyn V. Brown, M.D., MPH

SUBJECT: House CS for CS for Senate Bill 30 (JUD)

In review of House CS for CS for SB 30, I ask that the following comments be considered by the House Judiciary Committee and that these comments be entered into the record.

- To avoid discriminatory care, it would appear that this bill must apply to all pregnant women – regardless of their initial plan to carry a pregnancy to term to terminate the pregnancy – if they are to have informed consent.
- There is no documented evidence that the "scientific information on the Internet" will protect, inform, and promote…choices". This would appear to be clearly erroneous.
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- All facilities that provide or sell contraceptives will have to be included in the "list" of agencies-clinics, services, and facilities? This is equally

dynamic information and changes quickly. Who will do this and who will bear the cost. Who is the watch dog?

- Information about survival statistics for a fetus is extremely problematic and cannot be agreed upon by neonatologists and experts across the nation. How would this Internet information piece presume to keep up with this information in an accurate, scientific, and evidence-based manner?
- Who will decide just what the "accurate scientific information" is?
- The 30-day wait period is a delay tactic and is potentially harmful for the women who choose a pregnancy termination. Does a woman who chooses to carry the pregnancy to term have to wait for 30 days before she gets her first pre-natal care? This is discriminatory.
- Will women be mandated to watch the program or read the material? If a woman refuses, what is the penalty?
- To be non-discriminatory, all women who are pregnant must watch this program or read this information if they are to make an informed consent about their pregnancy.
- How will this bureaucratic nightmare be paid for on an on-going basis? The rule of reasonableness would suggest that the $20,000 note won't do it.
- What is meant by a "medical emergency"?
- Does a "major bodily function" also include the brain, neurotransmitters, and psychological aspects of pregnancy? This term has no rational meaning for the physical, mental, emotional, and socio-psychological parameters of a pregnancy.

I consider that this bill is clearly not in the best interests of the women of Alaska, health care professionals who provide care, or the State's best interests. I ask that this bill be defeated.

carolyn V. Brown, M.D., MPH
February 23, 2004

Heather McCullough
4960 E. 43rd Ave. #B1 , Anchorage, Alaska 99508

February 16, 2004 04:11 PM

Representative Lesil McGuire
Alaska State Legislature
State Capitol, MS 3100
Juneau, AK 99801

Subject: Oppose SB 30 Biased Consent!

Dear Representative McGuire:

I strongly urge you to oppose Senate Bill 30. This legislation discriminates by creating excessive undue burdens for the women of Alaska who seek an abortion.

SB 30 includes burdens such as requiring a patient to review State prepared information that uses biased language such as "unborn child", as well as a mandated 24-hour waiting period prior to the procedure. Given the time necessary to travel from many rural Alaskan communities to a physicians care, this mandate is not only unfair but could create unnecessary delays that could increase the risk to a woman's health. The 24-hour requirement clearly discriminates against women seeking abortion. Women who decide to carry their pregnancy to term are NOT required to wait 24 hours prior to receiving prenatal care.

In addition, a woman seeking an abortion must be able to prove either that she is a resident or has been physically present in Alaska for the last 30 days. If she does not meet this criteria she will be forced to wait which could possibly put her health at risk. Again, a woman seeking prenatal care need not prove residency prior to receiving prenatal care.

SB 30 is unnecessary. Physicians and clinics are already required and DO provide patients the necessary information to ensure that they are able to make an informed decision regarding ANY surgical procedure, including abortion. For the past two legislative sessions SB30 was heard in the Senate and physicians testified on record that they already spend a great deal of time counseling and advising patients before performing an abortion or any other surgical procedure! SB 30 unjustly singles out the abortion procedure.

The intent of SB 30 is clear. Once again, this bill represents another attempt to interfere with the Doctor-Patient relationship and discriminates solely based on a woman's reproductive choice.

I strongly urge you to vote against SB 30.

Sincerely,
Heather McCullough

SB

41

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE MCGUIRE
TO: CSSS SB 41(FIN)

Page 3, following line 28:

Insert:

"(f) The procedures authorized under this section shall be conducted in accordance with applicable state and federal laws and regulations to protect the privacy of individual medical assistance recipients."

Page 8, following line 4:

Insert:

"(b) The procedures authorized under this section shall be conducted in accordance with applicable state and federal laws and regulations to protect the privacy of individual medical assistance recipients."

Explanation:

This language is an assurance that the privacy of individuals' health information will be fully protected to the extent of the law. Specifically, the Health Insurance Portability and Accountability Act of 1996 required the establishment of federal regulations to protect individuals regarding the use and disclosure of individually identifiable health information. 45 CFR 164 sets forth those regulations in detail.

AMENDMENT

OFFERED IN THE HOUSE
TO: CSSB SB 41(FIN)

BY REPRESENTATIVE MCGUIRE

Page 4, line 19, following "record":

Insert: "knowing that the person lacks the authority to do so"

Explanation:

This amendment conforms the language to AS 11.56.820(a)(2) "Tampering with public records in the second degree," which is also a Class A Misdemeanor. This is the statutory basis upon which the Department of Law crafted the criminal statute for SB 41.

State of Alaska Department of Health and Social Services
NOTICE OF USE OF PRIVATE HEALTH CARE INFORMATION

Effective Date April 14, 2003

For Your Protection

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Health Care Information Is Private

We understand that information we collect about you and your health is personal. Keeping your health care information private is one of our most important responsibilities. We are committed to protecting your health care information and following all laws about its use. You have the right to discuss with the privacy officer your concerns about how your health care information is shared. The law says:

1. We must keep your health care information from others who do not need it.
2. You may ask us not to share certain health care information. Sometimes, we may not be able to agree to your request.

Who Sees And Shares My Health Care Information?

Your health caregivers, such as nurses, doctors, therapists and social workers may see, use and share your health care information to determine your plan of care. This use may cover health care services you had before now or may have later.

We review your health care information and bills (claims) to make sure that you get quality care and that all laws about providing and paying for your health care are being followed. We may also use your information to remind you about appointments or to tell you about treatment alternatives.

How Is Payment Made?

We may share your health care information with health plans, insurance companies, tribal or government programs to help you get your benefits and so that we can be paid or pay for your health care services.

May I See My Health Care Information?

In most cases, you may see your health care information. There may be legal reasons or safety concerns that may limit the amount of information that you may see. You may ask in writing to receive a copy of your health care information. We may charge a small amount for copying costs.

If you think some of your health care information is wrong, you may ask in writing that we correct or add to it. You may ask that the corrected or new information be sent to others who have received your health care information from us. You may ask us for a list of where we sent your health care information.

What If My Health Care Information Needs To Go Somewhere Else?

You may ask to have your health care information sent to others. You will be asked to sign a separate form, called an authorization form, permitting your health care information to go to them.

The authorization form tells us what, where and to whom the information must be sent. You can stop or limit the amount of information sent at any time by letting us know in writing.

Note: If you are younger than 18 years old **and, by law, you are able to give consent for your own health care,** then your health care information is kept private from others unless you sign an authorization form.

Could My Health Care Information Be Released Without My Authorization?

We follow laws that tell us when we have to share health care information, even if you do not sign an authorization form. We always report:

1. contagious diseases, birth defects and cancer;
2. firearm injuries and other trauma events;
3. reactions to problems with medicines or defective medical equipment;
4. to the police when required by law;
5. when the court orders us to;
6. to the government to review how our programs are working;
7. to a provider or insurance company who needs to know if you are enrolled in one of our programs;
8. to Workers Compensation for work related injuries;
9. birth, death and immunization information;
10. to the federal government when they are investigating something important to protect our country, the President and other government workers;
11. abuse, neglect and domestic violence, if related to child protection or vulnerable adults.

We may also share health care information for permitted research purposes, for matters concerning organ donations and for serious threats to public health or safety.

May I Have a Copy of this Notice?

This notice is yours. You may ask for a copy at any time. If there are important changes to this notice, you will get a new one within 60 days if you are enrolled in a health plan, such as Medicaid. An electronic version of this notice is available at www.hss.state.ak.us.

Questions or Complaints?

If you have questions or feel your privacy rights have been violated you can contact the Department Privacy Official by calling 907-465-2150, or by writing to State of Alaska, DHSS Privacy Official, PO Box 110650, Juneau, AK 99811-0650, or by e-mailing PrivacyOfficial@health.state.ak.us.

You can also complain to the federal government Secretary of Health and Human Services (HHS) or to the HHS Office of Civil Rights. **Your health care services will not be affected by any complaint made to the Department Privacy Official, Secretary of Health and Human Services or Office of Civil Rights.**

Privacy Issues:

Public Law 104-191, August 21, 1996 = HIPAA
Sec. 264. Required the Secretary of Health and Human Services to make recommendations on standards with respect to the privacy of individually identifiable health information, and to establish regulations addressing: 1) the rights than an individual should have regarding their health information; 2) the procedures established for the exercise of such rights; and 3) the uses and disclosures of such information that should be authorized or required.

This same section provides that federal regulation shall not supercede state law if the state law imposes more stringent requirements. If a state does not have more stringent requirements, then federal regulations apply.

45 CFR 164 Subpart E – Privacy of Individually Identifiable Health Information
There is a ream of federal regulations here that govern individuals' privacy. In brief:

Section 164.501 Definitions:

Required by law means a mandate contained in law that compels a covered entity to make a use or disclosure of protected health information and that is enforceable in a court of law....including, but not limited to.....statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

Section 164.510 Uses and disclosures requiring an opportunity for the individual to agree or to object.

This is where a Medicaid recipient would have signed a form in order to participate in the program that allows the disclosure of health information for the purposes of administering the state plan.

Section 164.512 Uses and disclosures for which consent, an authorization, or opportunity to agree or object is not required.

"...to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law."

42 CFR Part 431 – State Organization and General Administration

Subpart F – Safeguarding Information on Applicants and Recipients
Sec. 431.301-302. A State plan must provide for the safeguarding of information and restriction of use to purposes directly connected with the administration of the plan that includes:

1) Establishing eligibility;
2) Determining the amount of medical assistance;
3) Providing services for recipients; and
4) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan.

Subpart C – Administrative Requirements: Provider Relations
Sec. 431.107. Requires the State plan must provide for an agreement between the Medicaid agency and each provider....that agrees to keep any records necessary to disclose the extent of services the provider furnishes to recipients.

7 AAC 43.030 specified that providers are required to keep the following records for seven years from the date the service is provided:

1) patient information;
2) financial information; and
3) a clinical record

Alaska State Medical Association

cc: Traci

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

05/06/2003

Honorable Lyda Green
State of Alaska
Senate
State Capitol, Room 516
Juneau, AK 99801

Transmitted by Fax:
907-465-3805

RECEIVED
MAY 06 2003

Re: SB 41

Dear Senator Green:

You have not heard from The Alaska State Medical Association (ASMA) regarding SB 41 until now because it has struggled with formulating a position. ASMA cannot support SB 41 because serious unintended consequences may result. The potential lack of access to care is the most significant unintended consequence.

Attached is a copy of a letter to Representative Lesil McGuire dated 4/14/03, in which ASMA's Executive Director relayed some of the experiences related to the FY 98 Medicaid Audits involving 70 physicians. A number of physicians are no longer seeing Medicaid patients due to the manner in which those audits were conducted.

The criminalization of honest mistakes is also a concern. The payment methodology (RBRVS) and coding schema (CPT) for Medicaid in Alaska is the same as for Medicare. With the Medicare program, honest coding mistakes and legitimate differences of opinion about coding have occurred and will continue to occur. The coding for many treatments is not an exact science. Coding questions posed to Medicare administrative personnel have not resulted in either consistent or accurate answers. It is my understanding that neither Medicaid officials nor its contractors will provide responses to individual questions regarding coding. When a physician cannot get a definitive answer from the administering agency, how can she/he know that they won't be charged criminally for an honest mistake or a legitimate difference in opinion over proper coding?

The above uncertainty, the experiences of the FY 98 audits, and the relative low level of payment provides the basis for an easy decision not to see Medicaid patients. ASMA's concern remains the same as it was during the whole FY 98 audit process – access to care for Medicaid patients.

Until SB 41 positively addresses the above concerns, ASMA cannot support it.

Sincerely,

Jeanne Bonar

By: Jeanne Bonar, MD, President
For: Alaska State Medical Association

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

04/14/2003

Honorable Lesil McGuire
State of Alaska
House of Representatives, Room 118
Juneau, AK 99801-1182

Transmitted by Fax:
907-465-6592

Re: SB 41

Dear Representative McGuire:

It is my understanding that you will be "carrying" this bill in the House. Also, you have asked for input regarding SB 41. To date, ASMA has not taken a position on this bill. ASMA has repeatedly stated that anyone committing medical assistance fraud needs to be removed from the system and appropriately punished.

Because ASMA has not taken a position on SB 41, I cannot comment on the bill. However, I will share with you the experiences that physicians had with the Department of Health and Social Services in regards to Medicaid audits begun in FY 98.

The physician community was used as the test group for audits done under contract with DHSS by the accounting firm Deloitte and Touche. Audits of 70 physicians were begun in FY 98. Unfortunately, some of the audits are still in process. In general, the experience of those initial audits was that DHSS was slow in completing the administrative process. The process was slow to be started but even slower to complete (e.g. to get to a point of giving a "clean" audit result or to make a formal charge of inappropriate billing, etc).

Below, I will share some of the common complaints about the audit process that have been made by physicians:

- Do not like any overpayments found being extrapolated over their entire Medicaid patient base. (Regulations provide for extrapolation.)
- Had to wait too long for the audit results.
- No requests for additional time to produce records were honored. (Regulations require production within a specific time period, but for the department to grant extension in its discretion.)
- Inappropriate requests were made for records of non-Medicaid patients.
- Some settings are not appropriate for "on-site" audits. For example, a stranger (an auditor) in the office of a psychiatrist is disruptive for some patients.

- Go after the "outliers" and do not waste time auditing those that fall within pre-set parameters.
- The "hassle factor" with Medicaid is reaching the levels of the Medicare program.

As per usual, the "devil is in the details". My concern during the whole FY 98 audit process and now is the same – access to care for Medicaid beneficiaries. As has happened across the country with Medicare, a combination of "hassle factor" elements and low payment to physicians is resulting in our elderly having a difficult time finding a doctor. Its not that physicians don't want to treat them, its that they can't treat them when the payment rates don't come near to covering office overhead.

Please let me know if you have any questions.

Sincerely,

James J. Jordan
Executive Director

Cc: Board of Trustees
Thyes Shaub

STATE OF ALASKA
OFFICE OF VICTIMS' RIGHTS

Representative Lesil McGuire, Chair
Representative Tom Anderson, Vice-Chair
House Judiciary Committee
State Capitol Building
Juneau, AK 99801

May 12, 2003

Re: CS For Sponsor Substitute For Senate Bill No. 41 (FIN) – "An Act relating to medical care and crimes relating to medical care, including medical care and crimes relating to the medical assistance program, catastrophic illness assistance, and medical assistance for chronic and acute medical conditions."

Dear Representatives McGuire and Anderson:

On behalf of the Alaska Office of Victims' Rights, I offer this written testimony in support of SB 41 and would ask that it be included as part of the record when your committee convenes to consider this milestone legislation. The Senate unanimously passed this Bill on April 22, 2003.

Approximately 18 months ago I appeared before Senator Green's HES committee in Wasilla to testify about the role of the Alaska Medicaid Fraud Control Unit, and some of the difficulties facing prosecutors who wish to investigate Medicaid health care providers in this state. When I addressed that committee on November 8, 2001, I had been the director of the Alaska Medicaid Fraud Control Unit for some 2 ½ of my 27-year career as a prosecutor and knew all too well the problems health care prosecutors face in Alaska.

What I said then is equally true today: unscrupulous Medicaid providers can easily cheat Alaska's Medicaid program through fraudulent or inflated billings and the problem of waste and mismanagement in the program itself continues to cost the public millions of dollars each year. For example, Alaska's Medicaid costs have escalated an average of 15% a year over the last 6 years and the FY 2004 proposed

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TELEPHONE: 1-907-272-2620 • FACSIMILE: 1-907-272-2640

budget is approaching $1 billion. In this era of declining state revenues, one has to wonder where the money will come from?

One big reason for the rapid escalation of such health care costs is due to theft, waste and mismanagement in the administration of Alaska's Medicaid programs that divert limited dollars that ought to be spent to treat sick Alaskans. As I explained in detail to Senators Green, Senator (then Representative) Dyson, Senator Taylor and the other HES Committee members present that day, it is very easy under present Alaska statutes for dishonest practitioners to steal from the Medicaid program and there is a critical need for new statutes specifically tailored to combat such unnecessary losses.

Alaska is the only state that has *no* specific health care criminal theft statutes on the books. As a result, prosecutors must use non-specific criminal statutes to prosecute healthcare professionals who operate in a highly technical field and are able to mount expensive and well-financed (and often successful) defenses. Consequently, the record shows that there have been very few prosecutions-far less than one would expect-given the hundreds of millions of dollars which flow through Alaska's Medicaid program each year to less than 10,000 participating Medicaid providers. For example, between 1995 and 2000 a total of $1.99 *Billion* has passed through the Division of Medical Assistance (DMA) to a relatively small number of providers yet there have been far less than a dozen criminal prosecutions.

I retired from the Criminal Division of the Department of Law in January 2002 and in May the Alaska legislature confirmed my appointment to be the Director of the newly created Alaska Office of Victims' Rights (OVR) whose purpose is to help victims of crime. It is in that capacity that I write this letter to this committee for I believe that when limited funds earmarked to be spent on needy patients are diverted from the Medicaid program due to theft, waste and mismanagement, the public is victimized and the suffering of patients is unnecessarily prolonged.

Based on my training and experience I have worked with Senator Green and members of the departments of law and health and social services, to fashion a comprehensive package of new statutes, and amendments to existing statutes, which are all designed to address Medicaid fraud and mismanagement in our Medicaid program. The following is a brief overview of some of the highlights of SB 41, which is now before you.

1. <u>PROPOSED AMENDMENT TO AS 17.30.080</u>

All states, including Alaska, (and the federal government) have drug laws that say that prescriptions for controlled substances (medications) may *only* be issued by practitioners such as doctors, dentists, etc. when there is present a <u>legitimate medical purpose</u>, e.g. controlled substances and prescriptions may *only* be issued in order to treat a patient's illness or medical condition. If the required medical purpose is

absent, then the doctor is treated under AS 17.71 the same way as any drug dealer who delivers controlled substances. All the controlled substances in Alaska are classified in AS 11.71.140-.190 on the basis of how dangerous they are. Thus, the only factor that exempts doctors from criminal liability is the presence of a medical purpose when he or she writes prescriptions. If it's absent, the doctor, dentist, etc. is subject to prosecution.

Problem With The Present Law:

In Alaska we have a number of problem practitioners who issue vast numbers of prescriptions without a real and legitimate medical need (or where the claimed medical need is very questionable). Usually, the "patients" are drug dependent and drug seeking individuals, who simply want to get high or sell their prescription drugs on the street to get cash in order to purchase illicit street drugs they can't obtain from a pharmacy such as cocaine, crack, heroin, etc. Most of these "patients" are on Medicaid so the Medicaid fund is impacted twice: Once when the doctor bills for a service claimed to have been rendered (the office visit) and again when the "patient" presents the prescription to a pharmacist and the drugs are dispensed. After you multiply this several thousand times over a year the amount of money is substantial.

The drafters of present AS 17.30.080, attempted to protect the public and prevent this from happening but the way they tried to do so has proved very ineffective. They incorporated the requirement that there exist a legitimate medical necessity by inserting the words "medical purpose." However, the legislature never defined exactly what that term means. The statute simply says that practitioners need a "medical purpose" to stay out of trouble.

The result is that Alaska prosecutors are very reluctant to accept cases for prosecution because of this ambiguity, and this has been my personal experience as well. I would always run into big problems with this key statute whenever I prosecuted health care practitioners because what is or isn't a "medical purpose" is vague in the absence of a statutory definition. And because there have been very few health care criminal prosecutions in Alaska, there are no cases from our appellate courts interpreting this term.

When cases against doctors are not accepted for prosecution by prosecutors it doesn't take too long for the drug enforcement authorities to re-focus their limited resources to other more "traditional" crimes. This lack of prosecutorial-police oversight and enforcement has emboldened dishonest Alaska practitioners and increased abuse of the Medicaid fund.

The Solution To This Problem

The proposed amendment to AS 17.30.080 contained in Section 2 of SB 41 [page 2 starting at line 11] will make it easier to convict unethical practitioners because the requirement of medical necessity will now be defined in that statute. The amendment provides that controlled substances may only be delivered or prescribed for a purpose that is "solely medical" which is defined as being "...reasonably necessary for treatment of a person's illness, injury, or physical or mental health, and that is provided by a practitioner while acting within the usual course of professional practice or research and in accordance with a standard of care generally recognized and accepted within the medical profession in the United States." This amendment will make it easier to effectively investigate and prosecute professional abuses.

2. NEW SUBSECTION AS 17.30.080 REQUIRES NOTICE BY THE A.G.

This new subsection is found in Section 1 [at page 1 starting at line 11] and will impose an affirmative obligation on the Attorney General to notify the Commissioner of Health and Social Services whenever a Medicaid provider is charged with any drug offense under AS 11.71. Upon receiving that notice, the Commissioner is required to "...immediately undertake a review of all unpaid claims or requests for reimbursements attributable to services claimed to have been provided by the person charged."

This much needed change will require DMA to take a hard look at providers who are facing criminal drug charges. It has been my experience that when a provider is charged with a drug crime, DMA takes no action to scrutinize that person's billing history. I know this from cases I have prosecuted. And, if the defendant posts bail so as to be able to continue to provide services while awaiting trial, Medicaid continues to conduct business as usual.

Pre-trial delays can take many months, and even years because such cases involving medical practitioners involve thorny questions regarding "medical necessity" and "quality of care" issues where thousands of documents are involved, prosecutors have little experience in medicine and pharmacology so are forced to hire medical experts to help them understand the evidence and prepare for trial. Under this amendment, a provider's billings would be subject to a review by those who administer Alaska's Medicaid fund during that entire period, which is presently not the case.

3. PROPOSED AMENDMENT TO THE PURPOSE LANGUAGE INAS 47.07.010

This amendment to the "Purpose" statute in title 47 (the title which contains the Medicaid statutes) can be found in Section 4 on page 7 [starting at line 12] of the

bill. It embodies the legislature's declaration that the Medicaid fund is a limited resource and, that to conserve that limited resource for the benefit of indigent patients, providers must conduct themselves "...honestly, responsibly, and in accordance with applicable laws and regulations in order to maintain the integrity and fiscal viability of the state's medical assistance program, and that those who do not operate in this manner should be held accountable for their conduct. It is vital that the department administer this chapter in a manner that promotes effective, long-term cost containment of the state's medical assistance expenditures while providing medical care to recipients."

It reaffirms the concept that, those in state government who administer the fund have a special duty, as well as a firm public responsibility, to employ effective cost containment measures to safeguard this limited fund for the benefit of all needy recipients and to reverse annual increases in the Medicaid budget.

This amendment will give Medicaid administrators a much needed directive about which way the Medicaid program must go: effective and long term cost containment. This will also provide the legislature the means, in the months and years to come, to measure DMA's performance and conduct in managing the Medicaid program regarding whether this legislative philosophy has been observed.

4. CREATION OF AS 47.05.200 WILL NOW REQUIRE ANNUAL AUDITS

The language of this new statute may be found on page 2 [starting at line 20]. It would require the Commissioner of Health and Social Services to undertake annual statewide audits of Medicaid providers, similar to the successful Deloitte & Touche audits conducted in 1998-2001. The number of audits each year would be based upon 0.75 percent of all enrolled providers in the Medicaid program adjusted annually but the number of audits could not be less than 75. The audits must include both on-site as well as desk audits and must be of a variety of provider type. The D&T audits not only served a deterrent purpose to unethical Medicaid providers, but they were very cost effective. For example, the D&T audits cost the Division of Medical Assistance $477,250 annually for three years and identified more than $20 million dollars in overpayments. $2.1 million dollars of that amount was recovered by the Alaska Medicaid Fraud Control Unit and returned to the Medicaid fund during my tenure in that office. The amendment also permits the legislature to appropriate a portion of recovered funds to pay for the annual audits.

This statute would also require DMA to commence administrative procedures to recoup overpayments identified in the audits and to "...allocate the reasonable and necessary financial and human resources to ensure prompt recovery of overpayments..." In time, it is probable that the recovered funds will more than pay

for the audits, as was the case with the Deloitte & Touche audits conducted in 1998-2001.

5. AS 47.05.210 WILL CREATE CRIMINAL STATUTES SPECIFICALLY DESIGNED TO PROSECUTE MEDICAL ASSISTANCE FRAUD

Problem With The Present Law:

At the beginning of this letter I characterized SB 41 as "milestone legislation" for good reason. Alaska is the only state that has no criminal statutes that are specific to health care crimes. This bill closes that door. Currently, prosecutors must use the traditional theft statutes contained in AS 11.46.100-.295 that are non-specific and unsuited to health care crime prosecutions. This is primarily due to the high culpable mental state (the highest in Alaska's criminal code)) that is specified in such statutes. They require the state to prove beyond a reasonable doubt that the defendant acted "intentionally." This term is defined in the law (AS 11.81.900(a)(1)) to require the state to prove the defendant had a "conscious objective" to steal.

This standard makes it exceedingly difficult to convict health care providers because such crimes are all circumstantial in nature. For example, unlike most "regular" crimes there is no crime scene in a health care crime case nor is there any physical evidence to send to a crime lab for analysis. There are seldom any witnesses to crimes of dishonesty and health care crimes are in a league of their own in terms of specialization. Those who commit such crimes are intelligent, well educated and able to afford the best criminal defense. They also work in very specialized areas involving health care and are no match for most police officers or prosecutors.

Often, such crimes depend on a showing by the state through expert testimony that medical services were not provided in accordance with complex Medicaid rules and Regulations. This raises thorny issues regarding the quality of care provided by a practitioner to his patient, something juries find difficult to understand. In fact, these crimes are so difficult to investigate and prosecute that most states, including Alaska, have a special office to prosecute health care providers who cheat the Medicaid fund. In Alaska we have the Medicaid Fraud Control Unit within the Office of Special Prosecutions and Appeals within the Criminal Division of the Department of Law. The problem is that they lack the appropriate tools to be effective. With its new criminal statutes, SB 41 will help overcome that handicap.

The Solution To This Problem

The statutes proposed in this section will make it easier to prosecute health care crimes because they criminalize conduct by providers who "knowingly" (as opposed to "intentionally") make false statements and engage in dishonest behavior.

The term "knowingly" is defined in AS 11.81.900(a)(2) and "is established if a person is aware of a substantial probability" of a fact (as opposed to crimes where the mental state is "intentionally" e.g. where prosecutors have to show a "conscious objective" to steal).

The range of conduct criminalized is appropriately broad because there are many ways to cheat the Medicaid program, e.g. making false statements, concealing material facts, and solicitation of others to do so.

When the Attorney General files criminal charges, a new statute, AS 47.05.220 [page 5 starting at line 7] would require him to notify the HES commissioner. Upon receiving such notice, the commissioner "...shall immediately undertake a review of all unpaid claims or requests for reimbursement" from the provider.

6. EXCLUSION FROM MEDICAL ASSISTANCE PROGRAMS

Another new statute, AS 47.05.240, will permit the HES commissioner, in the exercise of his or her discretion, to exclude an applicant to the Medicaid program or to disenroll a Medicaid provider, for a period of up to 10 years following the person's unconditional discharge on a conviction for medical assistance fraud or a drug conviction in a court of this state or another state or federal court.

7. SB 41 PROVIDES MANY NEEDED DEFINITIONS FOR PROSECUTORS

Finally, this bill provides prosecutors with needed definitions regarding a variety of legal terms of art used in this new package of laws. The definitions permit all participants to the criminal justice process, as well as the Medicaid practitioners in this state, to gain a clear understanding of what is prohibited under the law. It will likewise assist appellate courts that, hopefully, will now be called upon more frequently to decide appeals by convicted defendants. Such appeals will result in appellate decisions that will provide further guidance to practitioners in this field.

CONCLUSION

In sum, the provisions of SB 41 will load prosecutors' guns with real ammunition in a state that is presently all but defenseless against unscrupulous Medicaid providers. For the first time, Alaska will join the rest of the country and will have a set of workable and effective health care criminal statutes on her books. In future years, the benefit of experience will tell us if and how these statutes should be amended to correct problems presently unseen.

The proposed statutes will also mandate annual audits that will uncover crimes. If there is a commitment on the part of the executive to allocate prosecution resources within DOL's Medicaid Fraud Control Unit, those audits will result in investigations, prosecutions, convictions, and recovery of audit expenses. The sentences will be commensurate with the seriousness of the crimes involved. Convictions will allow for recovery of stolen Medicaid funds through restitution ordered by the court. The combination of annual financial audits and convictions will have a decidedly deterrent effect on dishonest Medicaid practitioners.

Happily, as you can see from the fiscal notes prepared by Commissioner Gilbertson, the Federal Medicaid match is calculated at 75% for the costs associated with this legislation

I want to close by offering my thanks and appreciation to Senator Green's staff and to the very capable professionals of the Department of Law and the Department of Health and Social Services with whom I worked on this legislation over the last several months. I will be present telephonically at the hearing before your committee and would be glad to answer questions. As you consider these proposed Medicaid cost reform statutes and amendments I hope that you will permit me to be a continuing resource to your committee. For the above reasons I urge all committee members to vote for passage of SB 41 as drafted

Respectfully,

Stephen E. Branchflower, Director
Office of Victims' Rights

CC: Senator Lyda Green
Attorney General Gregg D. Renkes
Commissioner Joel S. Gilbertson

DMA notes on ASMA SB 41 comments

- A number of physicians are no longer seeing Medicaid patients due to the manner in which those audits were conducted.
  While some physicians have indicated that they were going to stop treating Medicaid patients, there is no evidence to indicate that this has occurred to any significant degree. Access to care has not been negatively impacted. (It is worth noting that some of the ASMA concerns might have resulted from MFCU investigations.)

- It is my understanding that neither Medicaid officials nor its contractors will provide responses to individual questions regarding coding
  If this statement refers to inquiries to First Health Provider Services staff or DMA staff in regard to choosing the most appropriate code to bill, the statement is correct. It is DMA policy to adhere to American Medical Association's Current Procedural Terminology, Healthcare Common Procedure Coding System, American Dental Association and other industry guidelines and standards. However when DMA has specifically prohibited code usage, or has a stricter or different requirement, the policy is outlined in the Provider billing manual and/or Remittance Advice messages. It is expected that providers deliver and bill for services in the same manner as they serve the general public.

- Do not like any overpayments found being extrapolated over their entire Medicaid patient base. (Regulations provide for extrapolation.)
  Current regulations do allow the division to use its discretion in the use of statistical sampling in audits or overpayment calculations. As the regulations are not specific, provider's concerns are understandable. It would be beneficial to undertake new audits using standard published protocols.

- Had to wait too long for the audit records.
  This is true. Timelines should be established and followed.

- No requests for additional time to produce records were honored. (Regulations require production within a specific time period, but for the department to grant extension in its discretion.)
  In the DMA audits, providers were sometimes given additional time to produce records. However, not all requests were honored. Again protocols in regard to timeframes and circumstances which would be considered should be addressed before audits are initiated.

- Inappropriate requests were made for records of non-Medicaid patients.
  The DMA audits only requested records on claims and Medicaid recipients which our system had record of. However, in a few instances the financial

• privacy issues

records which were requested included financicl records of family members who were not recipients. Also in a few instances, the claim was billed under a Medicaid recipient's ID, but the service was actually provided to another individual who was not a recipient. These circumstances are unavoidable. (This also could have occurred with some other type of investigation.)

- Some settings were no appropriate for "on-site" audits. For example, a stranger (an auditor) in the office of a psychiatrist is disruptive for some patients.
  DMA staff did give providers a window of time in which the audit had to be scheduled. The audit team attempted to perform the reviews in a manner and at a time which was least disruptive. For example, the auditors used a corner office or a room across the hall. In some cases records were copied and reviewed offsite. There should be consideration given to improving the process. Possibly giving the providers the opportunity to do the reviews after business hours or on weekends.

- Go after the "outliers" and do not waste time auditing those that fall within pre-set parameters.
  The method for choosing audits should be published –random or those meeting specified parameters. The audit process must be established in an efficient manner so providers are informed timely and effort is not wasted on marginal cases.

- The "hassle factor" with Medicaid is reaching the levels of the Medicare program.
  Audits are required and inevitable, but should be conducted in a reasonable, fair and efficient manner.

ALASKA STATE LEGISLATURE

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SENATOR LYDA GREEN

Memorandum

To: Representative Lesil McGuire, Chair
House Judiciary Committee

From: Senator Lyda Green, Sponsor
Senate Bill 41

Date: 4/24/2003

Re: Scheduling Request for House Judiciary Committee

Attached is a committee packet for Senate Bill 41 relating to Medicaid costs and crimes. This bill passed the Senate by unanimous vote and I very much look forward to having it heard in the House. Included in the committee packet are the following:

1) The current version of the bill, CSSS SB 41(FIN).
2) Two fiscal notes, one from DHSS and one from Law.
3) My sponsor statement.
4) A sectional analysis.
5) Relevant statutes.
6) Supporting background information.

It is crucial this legislation be heard as soon as possible to ensure its passage this session. I appreciate your support and respectfully request SB 41 be scheduled for a hearing in the House Judiciary Committee at your earliest convenience.

Please call Traci Carpenter, at 465-3841, if she can be of assistance. Thank you for your consideration.

Attachments

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CS SS SB 41 (HES)
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: MEDICAL CARE AND MEDICAID FRAUD
BRU: Medical Assistance Admin
Component: Health Purchasing Group

Sponsor: GREEN
Requester:

Component No.: 243

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Personal Services	66.5	65.7	66.9	68.1	69.4	70.7
Travel						
Contractual		1,024.9	1,045.4	1,066.3	1,087.6	1,109.3
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	66.5	1,090.6	1,112.3	1,134.4	1,157.0	1,180.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts	49.9	818.0	834.2	850.8	867.8	885.0
1003 GF Match	16.6	272.6	278.1	283.6	289.2	295.0
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
TOTAL	66.5	1,090.6	1,112.3	1,134.4	1,157.0	1,180.0

Estimate of any current year (FY2003) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time	1	1	1	1	1	1
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill creates more accountability from providers, recipients, and the Department of Health and Social Services (DHSS) in the administration of the Medicaid and CAMA programs, primarily through provider audits. The department is ordered to contract for independent financial audits in order to identify overpayments and criminal violations. This bill establishes named criminal acts for medical assistance fraud and corresponding degrees of felony or misdemeanor crimes. This bill provides for disenrollment of a health care provider for fraud or misconduct involving a controlled substance.

Prepared by: Kevin Henderson — Phone 465-5821
Division: Medical Assistance — Date/Time 03/17/2003
Approved by: Joel S. Gilbertson, Commissioner — Date 03/17/2003
Agency: Department of Health and Social Services

STATE OF ALASKA
2003 LEGISLATIVE SESSION

BILL NO. CS SS SB 41 (HES)

ANALYSIS CONTINUATION

ESTIMATED EXPENDITURES

The department has limited experience with contracting for provider audits. Audits for which DHSS has contracted in the past did not include the search for illegal activity required by this bill. Factoring in our limited experience, we make the following assumptions:

The .75% sample of all enrolled providers required by this bill means at least 75 providers would have to be audited each year. We estimate that two of the provider audits would be medical facilities, which require a more complex audit. The remaining 73 providers chosen by the contractor would be a cross section of provider types who exhibited characteristics that indicate recovery was likely.

To estimate the cost of an audit, we started with the historical cost of both facility and non-facility audits and increased that amount by 50%. This increase is to compensate for the added requirements of this bill, including the search for illegal activity, using a contractor with attorney staff, and the higher cost of short term contracting with a firm large enough to complete the complexity and number of audits required. The FY04 base cost of a facility audit is $26,100 per audit and there would be at least 2 of these completed per year. The base cost of a non-facility audit is $13,050 and there would be at least 73 of these per year.

DMA would require one full-time auditor (Range 16) to coordinate the non-facility audits, assist in management of the contract, and coordinate fair hearings as a result of DMA recovery enforcement. Additional administrative costs of equipment, supplies, office space, travel, etc are factored in.

Expenditures are anticipated to grow at an annual rate of 2%. Federal Medicaid match is calculated at 75%.

STATE OF ALASKA
2003 LEGISLATIVE SESSION

BILL NO. CS SS SB 41 (HES)

ANALYSIS CONTINUATION

ESTIMATE OF RECOVERIES

Of the 75 providers audited each year, we estimate that 75% of them will result in a claim for recovery. We estimate a 1 to 2 ratio of audit costs to recoveries. Historically, for every 1$ of the cost of an audit we recovered $2.

Annual growth in recovery of Medicaid and CAMA is estimated at 4%, which is a balance between inflationary growth in medical costs and a reduction in the frequency of provider violations and related recoveries as the program matures. We anticipate no recovery in FY04, because that year will be needed to develop, advertise, and award a contract for audit and recovery functions. In addition, some regulations changes will be needed in order to make a clear distinction between rate-setting audits and financial/misconduct audits.

Estimated recovery is shown below:

FY04	FY05	FY06	FY07	FY08	FY09
$0	$1,567.5	$1,630.2	$1,695.4	$1,763.2	$1,833.8

Section 3: AS 47.05.200(c) requires recovered overpayments obtained because of an audit to be deposited with the Department of Revenue.

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 41
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Law
Title "An Act relating to medical care and crimes relating to medical care, including . . . medical assistance program."
BRU Criminal Division; Civil Division
Component Criminal Appeals/Special Litigation; Human Services
Sponsor Senator Green
Requester Senate HESS Committee
Component No. 2203;2208

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2003) cost: 0.0
Check this box (X) if funding for this bill is included in the Governor's FY 2004 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill establishes new crimes specifically addressing Medicaid fraud, including misconduct involving the prescription and dispensing of controlled substances. The bill further requires a specified percentage of financial/misconduct audits be performed by the Department of Health and Social Services each year.

The Department of Law does not anticipate many new cases will result from the criminal provisions contained in the bill and so does not anticipate a fiscal impact.

Prepared by: Joan M. Kasson
Phone (907) 465-5370
Division Attorney General's Office
Date/Time 2/25/03 12:10 PM
Approved by: Kathryn Daughhetee for Gregg D. Renkes, Attorney General
Date 2/25/2003
Agency Department of Law

(Revised 9/2002 OMB)

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SENATOR LYDA GREEN

COMMITTEE SUBSTITUTE FOR SPONSOR SUBSTITUTE FOR SENATE BILL 41

SPONSOR STATEMENT

"An Act relating to medical care and crimes relating to medical care, including medical care and crimes relating to the medical assistance program, catastrophic illness assistance, and medical assistance for chronic and acute medical conditions."

Since 1999, the costs of the Medicaid program have risen throughout the nation at an average rate of 11 percent per year. Alaska's Medicaid program has averaged annual increases of 20 percent, or more than $100 million per year, bringing the total projected program costs in FY2004 to just under $1 billion ($695 million in federal funds and $289 million in state funds).

Factors such as increased participant enrollments, increased use of health services, and the increasing costs of pharmaceuticals and long-term care are the greatest contributors to the rise in Medicaid program costs. While we have limited ability to contain these cost factors, we can control program integrity by targeting waste and fraud.

Nationally, the error rate of overpayments in the Medicare program is 7 percent, a number that could be inferred to the Medicaid program as well. In addition, the commonly held perception of the amount of fraud committed against the Medicaid program nationwide is 10 percent. Whether these two numbers are inclusive of one another or should be compounded, they represent a sizeable amount of spending -- between $70 and $170 million -- in Alaska's Medicaid program on activities that are, at best, questionable and at worst, criminal.

To preserve the integrity and fiscal viability of Alaska's Medicaid program, the system should be held to rigorous controls and frequent scrutiny. Relevant laws should be in place to prosecute those who commit fraud and abuse related to medical care. Alaska has no specific health care criminal theft statutes. Currently, in order to prosecute those who commit Medicaid fraud, prosecutors must use criminal statutes related to actions coincidental to the misconduct. Alaska theft statutes require proving the conduct was intentional, a very high standard to meet for a crime where there is no crime scene or physical evidence. Consequently, there have been relatively few prosecutions. Senate Bill 41 provides the legal tools for the fiduciaries of the Medicaid program to establish program integrity and maintain maximum fiscal control.

The legislation establishes the crime of medical assistance fraud, defines the elements that constitute the fraud, and classifies the crime committed as either a felony or a misdemeanor. It requires independent financial audits to identify errors, overpayments, and criminal violations made to, or by, Medicaid providers and requires administrative action within 90 days of receipt of each audit. It completes the loop between the Department of Health and Social Services and the Department of Law by requiring copies of all audits be provided to the Attorney General and by directing the Attorney General to notify the Department of Health and Social Services of any charges of misconduct filed against a Medicaid provider. Such notice requires the Department to undertake a complete review of any outstanding claims of that provider. Finally, Senate Bill 41 provides that financing of the audits may be made from the recovery, due to the audits, of misspent funds.

It is vital that the State of Alaska administer its Medicaid program in a manner that ensures effective, long-term cost containment while providing needed medical care to its intended recipients. Medicaid providers must operate honestly, responsibly and in accordance with the law. Those who do not should be held accountable. Senate Bill 41 provides the State with the means to better implement this philosophy.

SB 41: ***"An act relating to medical care and crimes relating to medical care, including medical care and crimes relating to the medical assistance program, catastrophic illness assistance, and medical assistance for chronic and acute medical conditions."***

Note: throughout this document, the references to "commissioner" and "department" mean the commissioner of the Department of Health and Social Services.

Section 1.

AS 17.30.080 (b) is amended to require the attorney general to notify the commissioner of health and social services when a medical assistance provider is charged with misconduct involving a controlled substance.

Section 2.

AS 17.30.080(c) is added to require the commissioner of health and social services to undertake a complete review of any outstanding claims of a medical assistance provider charged by the attorney general with misconduct involving a controlled substance.

AS 17.30.080(d) is added to provide definitions for: "claims"; "medical assistance provider"; "medical purpose"; and "practitioner".

Section 3.

Adds new sections to AS 47.05 regarding medical assistance fraud.

AS 47.05.200. Annual audits. Subsection (a) requires the department of health and social services to contract for annual independent audits of a sample of all medical assistance providers in order to identify overpayments and criminal statute violations.

Audit parameters:

- The number of audits contracted annually shall be .75 percent of all enrolled medical assistance providers, but may not be fewer than 75.
- The audits must include both on-site and desk audits.
- The audits must be of a variety of provider types.

This subsection also gives general direction to the department as to the qualifications of the successful contractor.

Subsection (b) requires the department to begin administrative proceedings to recoup identified overpayments within 90 days of receiving each audit report. It also requires the commissioner to provide copies of all audit reports to the attorney general for purposes of screening for criminal violations.

Subsection (c) indicates legislative intent that the State's share of recovered overpayments are accounted for separately under AS 37.05.142 (accounting for program receipts), a portion of which may be appropriated to the department to pay for the annual audits.

Subsection (d) allows for audit and inspection of the records of a medical assistance provider that are pertinent to providing services to a medical assistance recipient.

Subsection (e) provides clarification that the department is not prohibited from performing other audits that are allowed or required under other laws.

AS 47.05.210. Medical assistance fraud. This section establishes new criminal statutes with penalties ranging from a class B felony to a class B misdemeanor. In the interests of brevity, the crimes are paraphrased below.

A person commits the crime of medical assistance fraud if the person:

1) knowingly and recklessly submits a claim to a medical assistance agency for which the claimant is not entitled;
2) knowingly and recklessly prepares or assists in the preparation of a claim to a medical assistance agency for providing services for which the claimant is not entitled;
3) requires payment for a referral to another health care provider;
4) requires payment for providing health care to a medical assistance recipient in addition to the payment by a medical assistance agency;
5) fails to produce medical assistance records to a person authorized to request them;
6) knowingly makes false entry in or falsely alters a medical assistance record;
7) knowingly damages, conceals, or otherwise impairs a medical assistance record.

AS 47.05.220. Notice of charges. Like its counterparts under sections 1 and 2 of this bill, this section is added to require the attorney general to notify the department when a medical assistance provider is charged with medical assistance fraud, and to require the commissioner to immediately undertake a complete review of any outstanding claims of that provider.

AS 47.05.230. Determination of value; aggregation of amounts. This section provides that the value of property shall be determined in accordance with AS 11.46.980, which essentially defines the value of property as market value at the time of the crime, or replacement value if market value cannot be determined. It also allows for aggregation of the amounts in order to determine the degree or classification of a crime under AS 47.05.210.

AS 47.05.240. Exclusion from medical assistance programs. This section allows the commissioner of health and social services to exclude a medical assistance provider from participating in the medical assistance programs under AS 47.07 and AS 47.08 if that provider was convicted for medical assistance fraud or misconduct involving a controlled substance.

- It includes persons convicted under both Alaska statutes and in a U.S. court or the court of another state for similar crimes.
- The period of exclusion may be up to 10 years following unconditional discharge from sentence served, including probation and parole.
- After a period of exclusion, an applicant for enrollment in the medical assistance programs may not participate until they establish to the commissioner of health and social services that they are qualified to participate.

Section 4.

AS 47.07.010. Purpose (of the medical assistance program for needy persons).

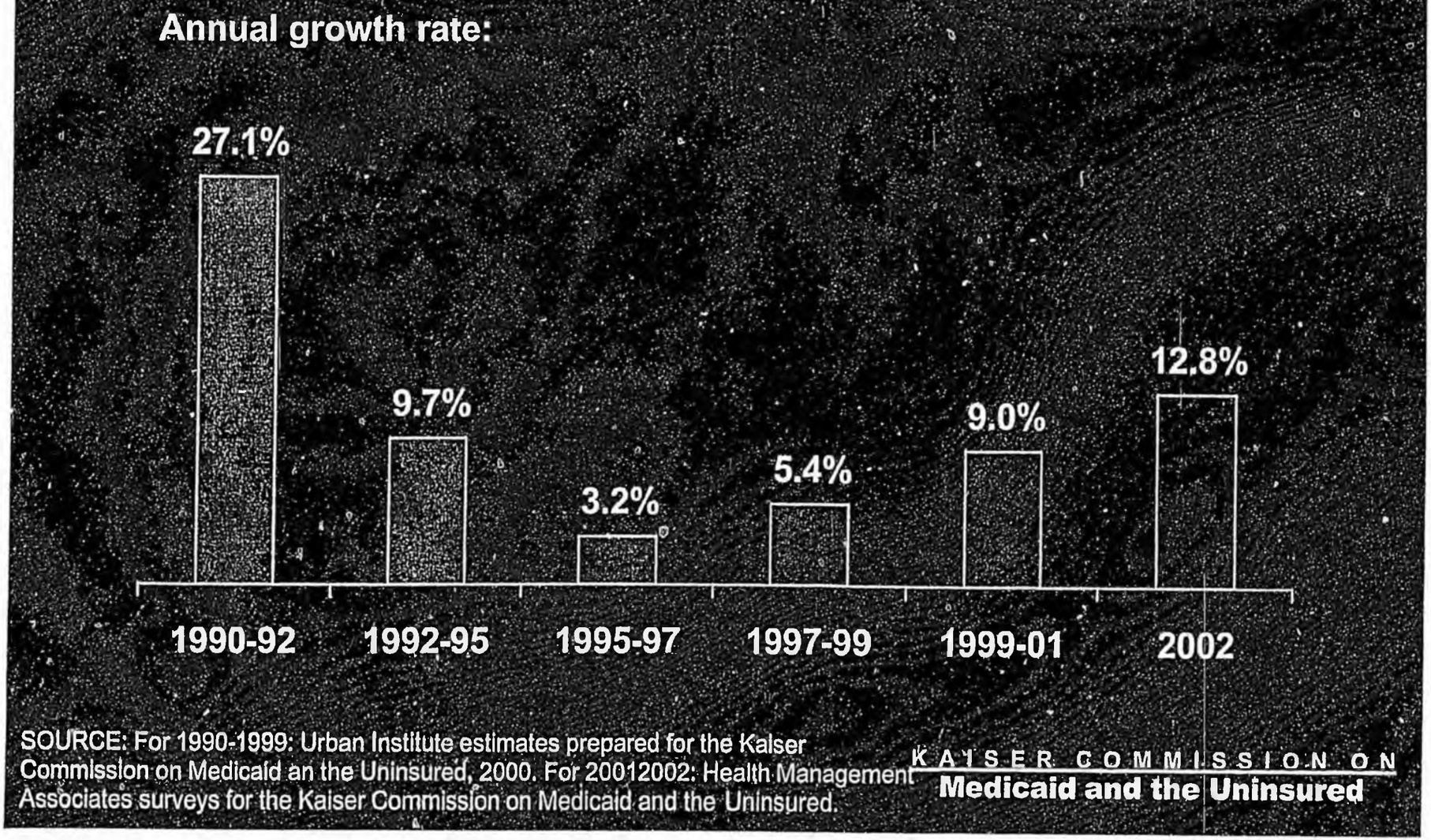
The purpose is amended to clarify the philosophy that care provided to needy persons at public expense must be appropriate and cost-effective; that providers of care to such persons must operate with honesty and integrity and be held accountable if they do not; and that the department of health and social services administer this chapter in a manner to promote effective, long-term cost containment while providing medical care to its intended recipients.

Section 5.

AS 47.07.074 is specific to health facilities. Subsection (a) is amended to clarify that *all* the records pertinent to providing services to a medical assistance recipient must be available for inspection, not just the financial records. This brings the statute into accord with the like audit provisions under the proposed AS 47.05.200(d).

Figure 13

Average Annual Growth Rates of Total Medicaid Spending



SOURCE: For 1990-1999: Urban Institute estimates prepared for the Kaiser Commission on Medicaid an the Uninsured, 2000. For 20012002: Health Management Associates surveys for the Kaiser Commission on Medicaid and the Uninsured.

KAISER COMMISSION ON
Medicaid and the Uninsured

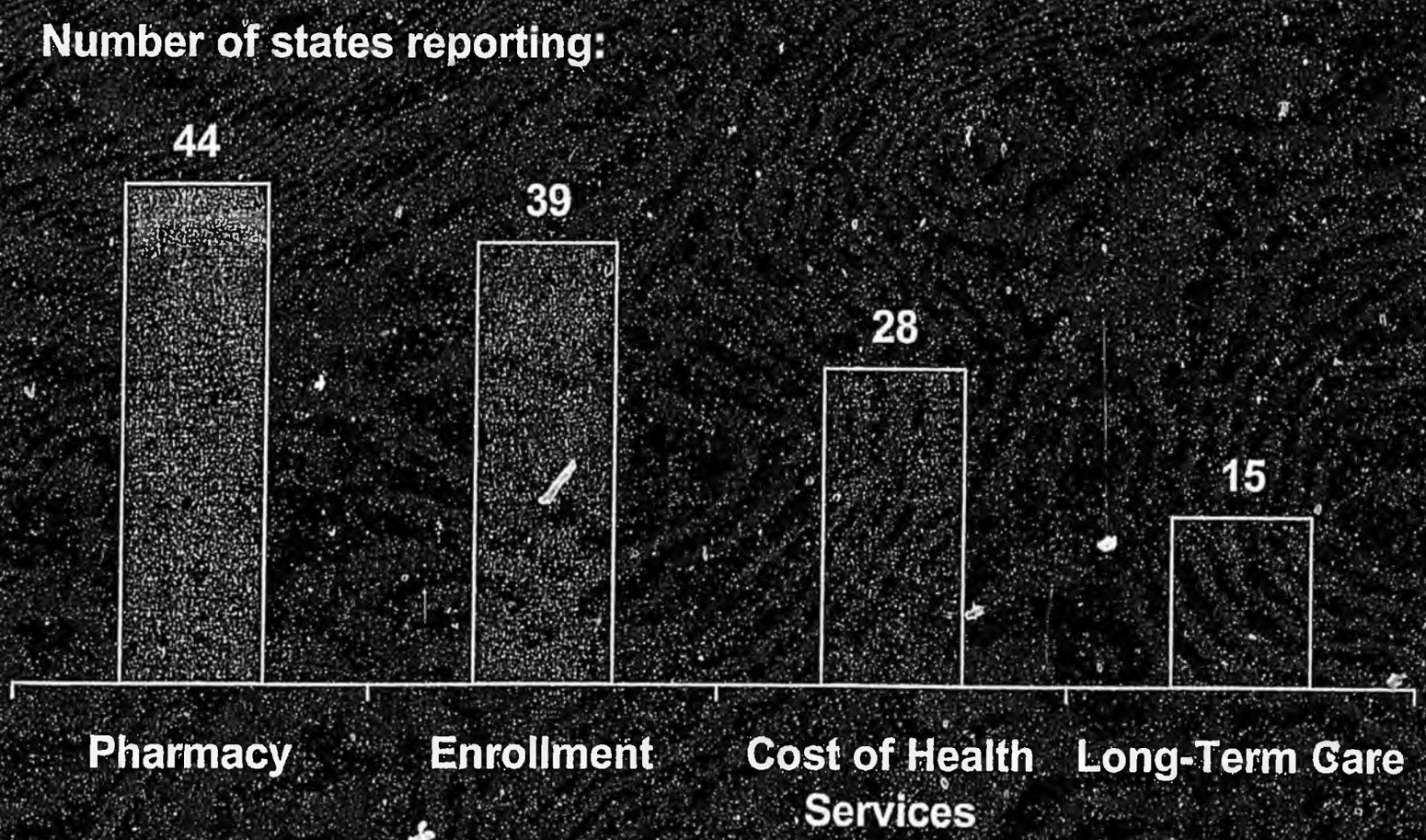
ALASKA MEDICAID PROGRAM EXPENDITURES ~ RECENT HISTORY							
Numbers and Language							
	Actuals	Actuals	Actuals	Actuals	Actuals	Enacted	Projected
	FY98	FY99	FY00	FY01	FY02	FY03	FY04
Medical Assistance							20% increase
Medicaid	**366,536.5**	**395,689.5**	**470,709.0**	**583,893.6**	**693,679.7**	**820,036.5**	**984,043.8**
General Purpose	129,731.2	131,522.9	145,514.7	152,791.1	192,921.5	173,294.8	207,953.8
Federal	231,329.7	261,315.7	307,508.4	387,431.9	461,846.9	579,552.0	695,462.4
Other	5,475.6	2,850.9	17,685.9	43,670.6	38,911.3	67,189.7	80,627.6
Total	**366,536.5**	**395,689.5**	**470,709.0**	**583,893.6**	**693,679.7**	**820,036.5**	**984,043.8**
% Increases from Prior Year		7.95%	18.96%	24.05%	18.80%	18.22%	20.00%
Total Medicaid Expenditures FY 99 - FY 02:				2,143,971.8			
Average annual increase between FY 99 and FY 02				20.60%			

Source: figures obtained from Legislative Finance Division
Presented by T. Carpenter of Senator Green's staff

2/24/2003

Figure 15

Factors States Reported as Among the "Top Three" Increasing Medicaid Spending

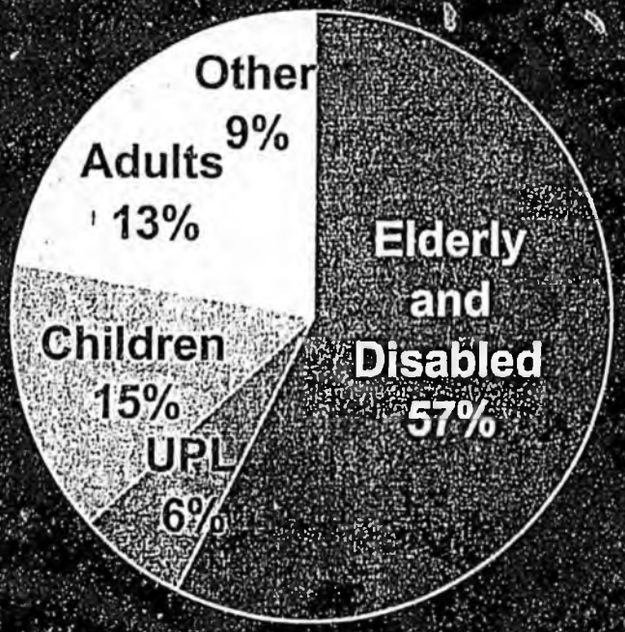


SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002.

KAISER COMMISSION ON
Medicaid and the Uninsured

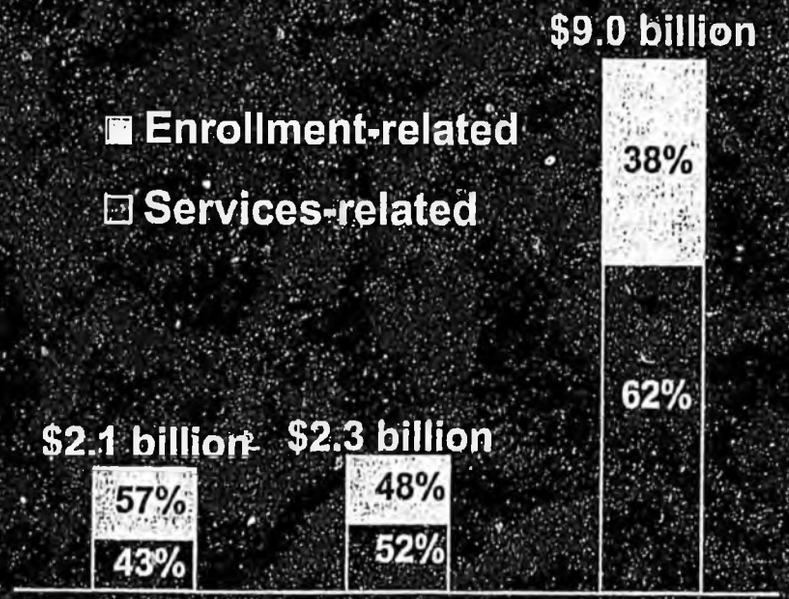
Figure 16

Sources of Growth in Federal Medicaid Expenditures, 2001-2002



Total Increase = $15.7 billion

Factors Behind Expenditure Growth for Beneficiaries

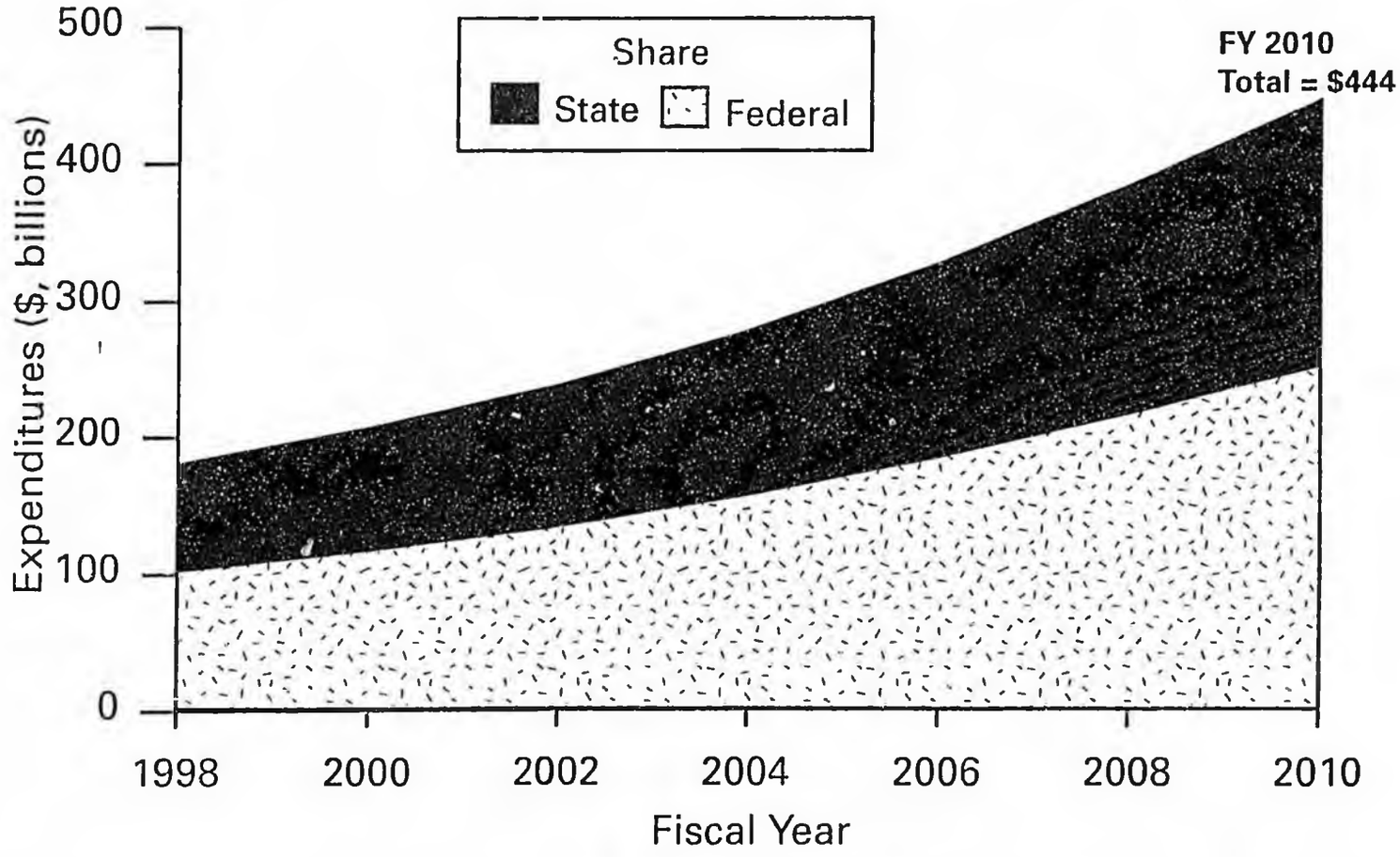


SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of CBO Medicaid baseline, March 2002.

KAISER COMMISSION ON Medicaid and the Uninsured

Figure 2.5 Projected Medicaid Expenditures, Fiscal Years1998-2010

Spending is projected to grow to $444 billion in FY 2010.

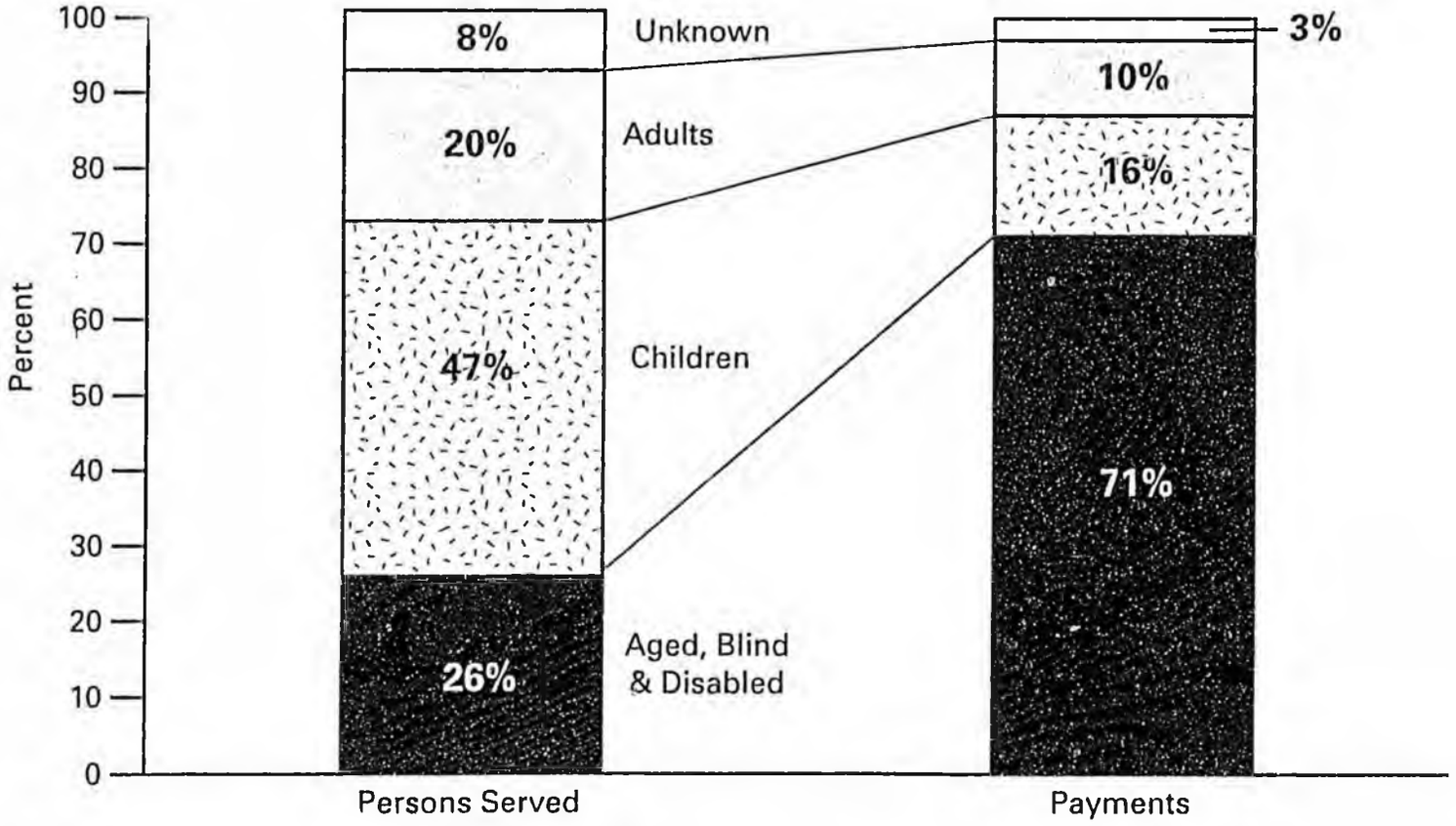


Note: (1) The projected increase in Medicaid expenditures can be explained by the following factors — case load accounts for about one-sixth of the increase, inflation one third, and the balance can be explained by spending-per-enrollee in excess of inflation; (2) data shown above are expressed in nominal terms.

Source: HCFA/Office of the Actuary, President's Fiscal Year 2001 baseline budget.

Figure 2.10 Distribution of Persons Served Through Medicaid and Payments by Basis of Eligibility, Fiscal Year 1998

Payments for the elderly, blind and disabled account for 71 percent of total payments.

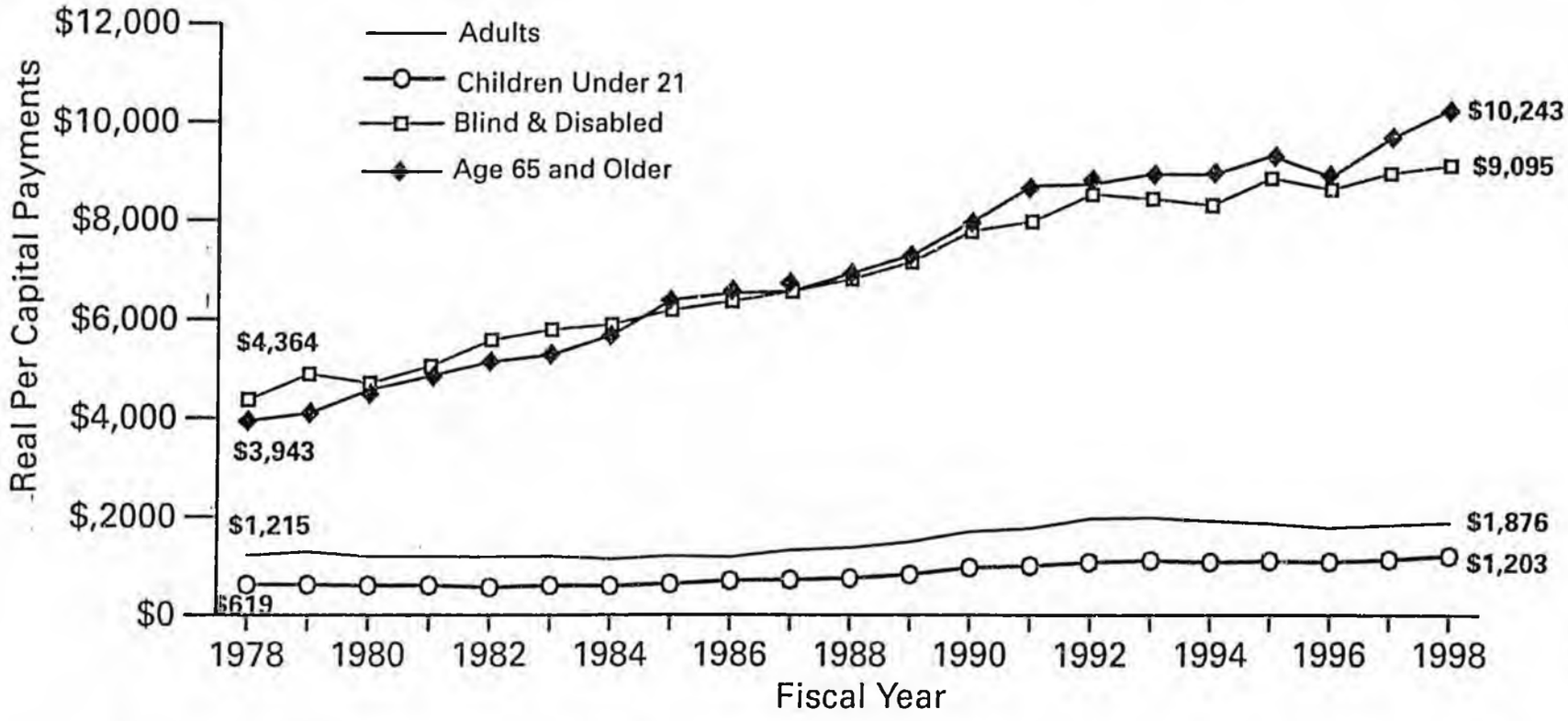


Note: (1) Totals may not equal 100% due to rounding; (2) "Payments" describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude DSH payments, Medicare premiums and cost sharing on behalf of beneficiaries dually enrolled in Medicaid and Medicare); (3) disabled children are included in the aged, blind & disabled category shown above.

Source: HCFA-2082.

Figure 2.12 Average Real Medicaid Payments per Person Served, Fiscal Years 1978-1998

Per capita payments for the elderly, blind and individuals with disabilities more than doubled while per capita payments for children and adults had modest growth rates.



Note: (1) Data shown above are expressed in 1998 dollars; (2) for FY 1998 "payments" describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude DSH payments, Medicare premiums and cost sharing on behalf of beneficiaries dually enrolled in Medicaid and Medicare), while data from previous years only include direct vendor payments; (3) the term "adults" as used above refers to a category of non-elderly, non-disabled adults; (4) disabled children are included in the blind & disabled category shown above.

Source: HCFA Form 2082.

ALASKA MEDICAID FRAUD CONTROL UNIT

Message Hotline to Report Medicaid Fraud 1-907-269-6279

The Alaska Medicaid Fraud Control Unit (MFCU) has been part of the Attorney General's Office since January 1992. The unit is located in Anchorage and has statewide jurisdiction. It has the responsibility for investigating and prosecuting Medicaid fraud and the abuse, neglect or financial exploitation of patients in any facility that accepts Medicaid funds. The Director of the MFCU is Assistant Attorney General Donald R. Kitchen, a career criminal prosecutor with more than a quarter centry of experience in the criminal justice system. There are 47 MFCU's across the U.S.

Although the vast majority of health care providers are honest and dedicated to providing the highest quality health care to their patients, Medicaid provider fraud costs American taxpayers hundreds of millions of dollars annually and threatens the integrity of the Medicaid program. Nationally, it is estimated that Fraud, Waste and Abuse account for 10 to 20 percent of the payments made by Medicaid. If the National trends hold true for the State of Alaska, these percentages equate to 30 million to 70 million Medicaid dollars annually, resulting in a substantial reduction in moneys available to provide necessary medical services to needy Alaskans.

Fraud is "intentional" deception or misrepresentation which results in an "unearned benefit", usually in the form of an excess payment. While health care fraud can take many forms, the most common involves billing for services not performed or billing for more expensive services than those actually provided. Medicaid patients may not suspect fraud, as they are seldom made aware of the procedures or dollar amounts billed to Medicaid. An unscrupulous provider can generate a fraudulent Medicaid payment simply by filing a false claim with an eligible recipient's identification number and a valid procedure code.

Examples Of Fraud Schemes In Health Care

- BILLING FOR SERVICES NOT RENDERED
- BILLING FOR HIGHER LEVEL OF SERVICES THAN ACTUALLY PERFORMED
- BILLING FOR MORE SERVICES THAN ACTUALLY PERFORMED
- CHARGING HIGHER RATES FOR SERVICES TO MEDICAID THAN OTHERS
- CODING BILLINGS TO GET MORE REIMBURSEMENT

- PROVIDING AND BILLING FOR UNNECESSARY SERVICES
- MISREPRESENTING AN UNALLOWABLE SERVICE IN A MEDICAID BILLING
- FALSELY DIAGNOSING SO MEDICAID WILL PAY FOR MORE SERVICES

ALASKA DIVISION OF MEDICAL ASSISTANCE	HCFA News	ALASKA DEPARTMENT OF LAW

If you suspect Medicaid health care fraud or patient abuse, do your part to protect the integrity of the Medicaid program and the public resources that fund it! Contact the Medicaid Fraud Control Unit Hotline at 1-(907) 269-6279 and ask to speak to an investigator or simply leave a message. Our fax is 1-(907) 269-6202. Or call the Crimestoppers Hotline at 1-(907) 561-7867. You need not give your name and you may be eligible for a reward.

Alaska Medicaid Fraud Control Unit
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Testimony
Before the Finance Committee
United States Senate

Improper Payments

Statement of
Michael F. Mangano
Acting Inspector General

April 25, 2001

Office of Inspector General
Department of Health and Human Services

Good morning Mr. Chairman. My name is Michael F. Mangano. I am the Acting Inspector General for the Department of Health and Human Services (HHS). It is my pleasure to be here today to give you an update on our work with regard to improper payments in Departmental programs.

Today, I will provide an overview of the types of payment errors revealed by our most recent Health Care Financing Administration (HCFA) audit. Over the past five years, the Office of the Inspector General (OIG) has undertaken audits of Medicare's fee-for-service claims to estimate the extent of payments that did not comply with Medicare laws and regulations. These payment errors, comprised of improper provider billings, make up the largest category of inappropriate payments in the Medicare program. These errors can include simple billing mistakes as well as fraudulent billings. We continue to believe that most health care providers do their best to provide high quality care and are honest in their dealings with Medicare. At the same time, we must be concerned about all errors, even those which are totally innocent. Our annual measurement of Medicare payment errors not only allows HCFA to focus on the areas where increased compliance is needed, but also enables HCFA to identify approaches to building a better Medicare program.

I will also describe instances of specific inappropriate payments made as a result of the complex, antiquated, and incompatible technology environment in which Departmental programs operate. These examples include Medicare and Medicaid payments made on behalf of deceased or incarcerated beneficiaries, as well as Temporary Assistance for Needy Families (TANF) payments made to fugitive felons. Taken together, these problems indicate systemic vulnerabilities which could lead to much more serious losses of funds if not remedied.

MEDICARE PAYMENT ERROR RATE

We recently released our report *Improper Fiscal Year 2000 Medicare Fee-for-Service Payments* (A-17-00-02000) in which we present the results of our review of Fiscal Year (FY) 2000 Medicare fee-for-service claims. Based on our statistical sample, we estimate that improper Medicare benefit payments made during FY 2000 totaled $11.9 billion, or about 6.8 percent of the $173.6 billion in processed fee-for-service payments reported by HCFA. It is important to note that this is an error rate estimate and not a fraud estimate. These improper payments could fall on a continuum anywhere from simple inadvertent mistakes to outright fraud and abuse.

When the sampled claims were submitted for payment to Medicare contractors, they contained no visible errors. We found that the contractors' claim processing controls were generally adequate for: (1) ensuring beneficiary and provider Medicare eligibility; (2) pricing claims based on information submitted; and (3) ensuring that the services as billed were allowable under Medicare rules and regulations. However, their controls were not effective in detecting the types of errors we found. Instead, reviews of patient records by medical professionals detected 92 percent of the improper payments. Our historical analysis of payment errors from FY 1996 through FY 2000 identified four major payment error categories: medically unnecessary services, unsupported services, coding errors, and noncovered services.

Medically unnecessary services, the largest error category this year, amounted to $5.1 billion in improper payments. This category covers situations in which the medical review staff found enough documentation in the medical records to make an informed decision that the medical services or products received were not medically necessary. The following is an example of services that were determined not medically necessary:

- A physician was paid $3,305 for 40 hypnotherapy sessions with an Alzheimer's patient. The medical records stated that the patient was neither attentive nor cooperative during the initial mental status exam. Since the patient could not participate in that exam, the medical reviewer determined that hypnotherapy treatment was not medically necessary, reasonable, or appropriate for a 95 year old Alzheimer's patient.

Unsupported services represented the largest error category in three of the last 5 years. In FY 2000, they accounted for an estimated $4.3 billion in improper payments. Such services include those where there is insufficient documentation to determine the patient's overall condition, diagnosis, and extent of services performed ($2.3 billion) or where there was no documentation to support the services provided ($2 billion). An example of unsupported services follows:

- A hospital was paid $722 for outpatient radiation therapy services. The medical records contained no documentation to support the provision of these services. After repeated unsuccessful attempts to obtain such documentation, the claim was denied.

Coding errors represented $1.7 billion in improper payments (the net of upcoding and downcoding errors). For most of the coding errors found, the medical reviewers determined that the documentation submitted by providers supported a lower reimbursement code. Physician and inpatient Prospective Payment System (PPS) claims accounted for over 90 percent of the coding errors over the 5 years reviewed. An example of incorrect coding includes:

- A hospital was paid $19,452 for providing a diagnostic related group service to a patient admitted with a chronic inflamation of the membrane lining the abdominal wall. The principal diagnosis code was shown as another infection. The medical reviewers concluded that the diagnosis code should have been related to an infection due to a dialysis catheter. As a result, $7,125 was denied.

Noncovered services and other errors consistently constituted the smallest error category. Noncovered services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. Such services include most routine physical examinations; eye and ear examinations to prescribe or to fit glasses or hearing aids; and, most routine foot care.

Since we developed the first error rate for FY 1996, HCFA has closely monitored Medicare payments and has instituted appropriate corrective actions. The HCFA has also worked with provider groups to clarify

reimbursement rules and to impress upon healthcare providers the importance of fully documenting services. Additional initiatives on the part of the Congress, HCFA, the Department of Justice, and the Office of Inspector General have focused resources on preventing, detecting, and eliminating fraud and abuse. All of these efforts, we believe, have contributed to reducing the improper payment rate by almost half -- from $23 billion, or about 14 percent of Medicare program expenditures, in FY 1996 to $11.9 billion, or about 6.8 percent of the $173.6 billion in Medicare payments, in FY 2000.

The decrease in improper payments has had a positive effect on Medicare's financial situation. From 1991 to 1996, the Congressional Budget Office (CBO) reported that Medicare's rate of inflation averaged 10.9 percent per year. In FY 1998, the rate of inflation for the Medicare fee-for-service program dropped to the lowest in the program's entire history (since 1965) -- 1.5 percent. Overall, CBO calculated the average Medicare inflation rate for FY 1997 to FY 2000 at 3.2 percent. CBO commented that: "Most of the decline can be explained by a strong effort to ensure compliance with payment rules." (The Budget and Economic Outlook: Fiscal Years 2002-2011, CBO, January 2001)

As of 1996, the Trustees of the Medicare Part A Trust Fund projected that the Trust Fund would be insolvent in 1999. However, over the past 5 years, the Trustees have extended their estimate of the financial life of the Trust Fund by 30 years, from 1999 until 2029. One of the primary contributing factors cited by the Trustees has been "the continuing efforts to combat fraud and abuse." (Status of the Social Security and Medicare Programs, Trustees Annual Report, March 1999). We believe that these positive economic findings with respect to the financial integrity of the Medicare program, which will positively impact on both taxpayers and beneficiaries, are due in large part to the fact that the vast majority of health care providers are engaged in submitting accurate claims to HCFA and providing high quality, medically necessary services.

INAPPROPRIATE MEDICARE AND MEDICAID PAYMENTS

Numerous OIG audits and investigations have revealed instances where antiquated and complex computer systems have resulted in inappropriate payments being made on behalf of Medicare beneficiaries and Medicaid recipients. Several recent OIG audits and inspections examined whether the Medicare or Medicaid programs were being billed for services which occurred after the date of a beneficiary's death and whether these programs were paying for such services. We have also recently completed work to identify inappropriate payments made on behalf of incarcerated Medicare beneficiaries.

Payments Made on Behalf of Deceased Beneficiaries

Medicare Services: In our inspection, *Medicare Payments for Services After Date of Death* (OEI-03-99-00200), we found that Medicare paid an estimated $20.6 million in 1997 for services that started after a beneficiary's date of death. These payments were made because of several system problems. Approximately $12.6 million was paid because Medicare had not yet received beneficiary date of death information from the Social Security Administration (SSA) Master Beneficiary Record at the time the claim was processed. For example, for one beneficiary who died in May 1997, HCFA did not receive the date of death information until October 1997. This delay allowed three months of rental payments for a nebulizer to be paid in June, July, and August 1997.

The remaining $8 million was paid for services where the beneficiary's date of death was in its system at the time the claim was processed and approved for payment, but HCFA's Common Working File system, the system used by fiscal intermediaries and carriers to process fee-for-services claims, did not prevent the claims from being paid. Over half of the $8 million was for durable medical equipment claims. For example, for one beneficiary who died in November 1997, HCFA received the date of death information in

that same month. However, in January 1998, HCFA paid claims on behalf of that beneficiary for durable medical equipment items with service dates in December of 1997.

We also found some payments for services where HCFA's Enrollment Database, which contains entitlement data for Medicare beneficiaries, and the Common Working File contained different dates of death. In one example, a beneficiary received four services relating to ambulance transport on May 12, 1997. Although data from the Enrollment Database indicated that the beneficiary died on May 9, 1997, the Common Working File contained a different date of death of May 13, 1997. In such examples, we found no indication of which file contained the accurate date of death and therefore do not know whether or not the claims were paid in error.

As a result of our findings, we recommended that HCFA require contractors to conduct annual post-payment reviews to identify and recover payments made for services after death; revise their Common Working File system edit to ensure that durable medical equipment payments are not made for deceased beneficiaries; and periodically reconcile date of death information between the Enrollment Database and Common Working Files. In January 2001, HCFA implemented the system change necessary to revise the Common Working File edits to prevent payment of durable medical equipment services billed after the beneficiary's date of death. HCFA has also recently issued instructions to Medicare contractors requiring them to conduct the necessary post-payment review activities to identify payments made on behalf of deceased beneficiaries. However, HCFA indicated that there is no way to systematically compare the Enrollment File and Common Working File to determine which date of death is accurate without a manual review; therefore, they will need to take into account contractor workload while implementing this recommendation.

Medicaid Services: In 1994, the OIG began an initiative to work more closely with State Auditors in reviewing the Medicaid program. Through this initiative, the OIG/State Audit Partnership Plan was developed to expand Medicaid program audits and allow State Auditors to apply methodologies we have successfully used in our Medicare audits. As an example, the State of Ohio's Office of the Auditor examined whether Medicaid was paying for services on behalf of deceased recipients (*Payments for Medicaid Services to Deceased Recipients*, A-05-00-00045). The audit determined that, during a period of almost 6 years, the Ohio Department of Human Services (ODHS) paid $82 million for services to Medicaid recipients after the recipients' date of death. This amount consisted of 115,000 payments to over 4,000 different providers for services provided to almost 27,000 apparently deceased recipients. The average time to discover and recover an overpayment was just over five months after the recipient's date of death. About 93 percent of the unrecovered payments were in four categories of service: skilled nursing facility (75 percent of the unrecovered payments), intermediate care facility (7 percent), pharmacy (6 percent), and durable medical equipment (5 percent).

Subsequent analysis by the Ohio Department of Human Services confirmed that information in the Medicaid recipient master file is not always accurate. Ohio auditors determined that almost 30 percent of 34,330 Medicaid recipients who died during 1997, according to the Ohio Department of Health's Vital Statistics file, did not have a date of death entered on the recipient master file (meaning that providers could still bill and be reimbursed for Medicaid services). Moreover, 4.6 percent of the 24,463 recipients who had a date of death on the recipient master file had a death date that differed from the Vital Statistics death date by more than one day.

The Office of the Auditor recommended that the Ohio Department of Human Services recover the outstanding amount when feasible and cost effective, make corrections to prevent additional overpayments from being made for deceased recipients, and seek legislative authority to develop and apply sanctions against providers who do not timely report a recipient's death or who bill for or retain unearned

reimbursements. The State has now recovered all of the overpayments identified in this audit.

Payments Made on Behalf of Incarcerated Beneficiaries

Medicare Payments: We are currently conducting a series of audits on Medicare payments provided on behalf of beneficiaries who were in the custody of Federal, State, or local law enforcement agencies at the time services were provided. Under current Federal law and regulations, payments for such services are generally unallowable. The State or other government component operating the prison is presumed to be responsible for the medical needs of its prisoners.

The rules for determining whether Medicare will pay are complex and administratively cumbersome. Under sections 1862(a)(2) and (3) of the Social Security Act, the Medicare program will not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. Regulations at 42 Code of Federal Regulations (CFR) 411.4(b)(1) and (2) state the Medicare program may not pay for services provided to beneficiaries who are in the custody of penal authorities *unless* the authorities require that all individuals pay for such services and enforce that requirement by pursuing collection for repayment. The State or other Government component operating the prison is presumed to be responsible for the medical needs of its prisoners. According to HCFA's procedural manuals for its contractors, this is a rebuttable presumption that may be overcome only at the initiative of the Government entity. The entity must establish that it enforces the requirement to pay by billing and seeking collection from all individuals in custody, whether insured or uninsured, with the same vigor it pursues the collection of other debts. It must pursue collection, including the filing of lawsuits to obtain liens against an individual's assets outside the prison and income from non-prison sources.

The Social Security Administration, on the other hand, has a simple rule regarding payments to prisoners. A person's Social Security benefits are suspended if he/she is incarcerated for a month or more.

In our report *Review of Medicare Payments for Services Provided to Incarcerated Beneficiaries*(A-04-00-05568), we found that the Medicare program is vulnerable to improper payments for services provided to incarcerated beneficiaries. According to data provided to us by the SSA, there were 38,600 Social Security beneficiaries entitled to Medicare who were incarcerated as of July 2000. We used this data to determine whether Medicare claims have been paid on behalf of any of these beneficiaries during Calendar Years 1997 through 1999. To date, we have identified $32 million in Medicare fee-for-service payments on behalf of 7,438 incarcerated beneficiaries during Calendar Years 1997 through 1999. We also found that some incarcerated beneficiaries were enrolled in Medicare managed care plans during their incarceration.

We are in the process of determining the amount of Medicare payments made on behalf of incarcerated beneficiaries which may be improper. We are concerned, however, because, in general, no Medicare payments should be made for services rendered to prisoners unless certain strict conditions are met by the government component (i.e., Federal, State, or local) which operates the prison. We are now determining if the government components operating prisons meet the strict conditions for Medicare payments to be allowable. The development underway includes researching State laws to determine if prisoners are required to repay their medical expenses. If such a law exists, the government entity must then prove that it enforces this requirement. Examples we are investigating include:

- Medicare paid $25,423 for services to an inmate charged with killing his mother.
- In another State, Medicare paid a facility $97,283 on behalf of nine inmates who were incarcerated

for various crimes including arson, attempted assault, breaking and entering, and burglary.

The HCFA does not identify Medicare beneficiaries who are in prison, making it virtually impossible for Medicare contractors to prevent improper payments. To minimize this risk, we recommend that HCFA formalize its efforts to obtain additional data from SSA in the daily transmission of enrollment data, which identifies incarcerated beneficiaries, and design and implement system controls in the Enrollment Database and Common Working File to alert contractors when a Medicare claim is submitted for services for an incarcerated beneficiary. We recognize that implementing the routine transfer of necessary information from SSA and making the necessary system enhancements will take time. In the interim, we recommend that HCFA periodically obtain a file on incarcerated beneficiaries for post-payment reviews from SSA similar to the file we obtained during our review.

Medicaid Payments for Inmates of Public Institutions: We are in the process of reviewing Medicaid payments for services provided to inmates of public institutions. Our involvement began with information received from the Louisiana Office of Legislative Auditor. The Auditor was concerned that the Louisiana Department of Health and Hospitals was including the cost of services provided to inmates in determining its Medicaid net uncompensated care costs for disproportionate share hospital payments made to State operated hospitals. The Louisiana Office of Legislative Auditor had interpreted that neither disproportionate share hospital payments nor Federal financial participation payments are allowable for services provided to inmates of public institutions, specifically prisoners in a penal institution.

Based on audit work to date, we found that HCFA has not established a definitive coverage policy that is consistent with the intent of the governing statute that generally prohibits Federal financial participation payments for inmates of public institutions. The current Medicaid coverage policy contains a provision allowing for Federal financial participation payments for services provided to inmates of public institutions when the inmate is an inpatient in a medical institution. We believe this provision is contrary to the intent of the Medicaid statute. We believe the intent was to ensure that Medicaid funds are not used to finance care that has traditionally been the responsibility of the State and local governments. Also, HCFA has no specific guidance on the availability of disproportionate share hospital payments to hospitals for uncompensated care provided to inmates. We expect to complete our review this summer.

Other OIG Work

In addition to the improper payments described above, we have also done extensive work through audits and inspections to identify duplicate payments made in the Medicare and Medicaid programs. For example, we have examined if Medicare fee-for-service payments were made on behalf of beneficiaries enrolled in Medicare managed care plans. This work involves identification of specific overpayments, as well as identification of the system vulnerabilities, which have allowed such payments to occur. Additionally, we have work underway to identify whether Medicare payments are being made on behalf of deported aliens. Preliminary results indicate that such payments are being made.

TANF BENEFICIARIES WHO ARE FUGITIVE FELONS

The problems of ensuring the appropriateness of payments in a complex program environment are not limited to Medicare and Medicaid. This is illustrated in the following account of income assistance payments which we discovered were being made to fugitive felons.

The U.S. Department of Health and Human Services, Administration for Children and Families, Office of Family Assistance, oversees the Temporary Assistance for Needy Families (TANF) program. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 increased the flexibility of the States in

operating the TANF program. The Act allows States to provide assistance so that children may be cared for in their own home; promote job preparation, work and marriage; prevent and reduce the incidence of out-of-wedlock pregnancies; and encourage the formation and maintenance of two parent families. Section 408 of the Act identifies prohibitions and other requirements for the TANF program including a requirement that States not use any part of the grant to provide assistance to any individual who is fleeing to avoid prosecution, custody or confinement after conviction for a felony, as defined under the laws of the place from which the individual flees.

Project Cornhusker is an initiative of our Office to reduce fraudulent TANF payments in the metropolitan area of Omaha, Nebraska. This is the first such joint project we have undertaken with local law enforcement to identify individuals with felony fugitive warrants who are recipients of federal assistance in violation of the Welfare Reform Act of 1996. As part of this effort, the active felony warrants for Douglas County, including Omaha, were matched with the active TANF beneficiary files maintained by the Nebraska Department of Health and Human Services. This computer match produced 64 wanted individuals.

On March 21 and 22, 2001, OIG agents assisted the Douglas County Sheriff's Office and the Omaha Police Department in the arrest of 24 individuals wanted for felonies committed in their jurisdiction. These arrests were made possible because of the cooperation of the Nebraska Department of Health and Human Services, local police and OIG. Twelve additional arrests were made without OIG assistance.

The majority of the arrested subjects were wanted for non-violent crimes, such as felony theft, bad checks, burglary and crimes against property. Three subjects were arrested on warrants for assault, one with a deadly weapon. Specific information concerning some of the arrests are identified below:

- A subject was arrested and found to have three Social Security cards in another individual's name. He also had a birth certificate in that subject's name with two passport photos of himself. This information was sent to the Social Security Administration, Office of Inspector General, Office of Investigations.

- An individual was arrested and found to be in possession of black tar heroin.

- Upon request, an individual present during the arrest of a TANF recipient produced identification. A check of law enforcement records showed that the individual was currently wanted in Louisiana for failure to pay court ordered child support. He was subsequently arrested on that charge.

Because of the success of this effort, we are considering replicating this type of joint initiative in the future.

MODERNIZING DEPARTMENT INFRASTRUCTURE

The Secretary of the Department of Health and Human Services has named reforming the management of the Department's operations as one of his top priorities. Specific priorities include improving the management of HCFA and making appropriate investments in Department management and infrastructure.

Improve the Management of the Health Care Financing Administration:. The demands on HCFA have grown dramatically in the last few years. On the one hand, the agency needs adequate resources to successfully administer the Medicare, Medicaid, and State Children's Health Insurance programs; on the other hand, it must be recognized that patients, providers and States have legitimate complaints about the scope and complexity of the regulations and paperwork that govern these programs. The Department has

therefore begun a thorough examination of HCFA's missions, its competing demands, and its resources.

Invest in Department Management and Infrastructure: The Secretary has noted that one of the major challenges in a large, decentralized Department such as HHS is finding ways to bring together diverse activities and to develop coordinated systems for managing its programs.

In the area of financial management, the Secretary has proposed an additional $50 million investment in a unified financial accounting system. The OIG has found major problems with the Department's current system structure, which involves separate accounting systems operated by multiple agencies. Department plans to replace these antiquated systems with one or two unified financial management systems should help to increase standardization, reduce security risks, and allow HHS to produce timely and reliable financial information needed for management decision-making, and provide accountability to the external customers.

In the information technology arena, the Secretary has proposed $30 million to improve information technology systems through investments in the Information Technology, Security and Innovation Fund. As seen in my examples today, these systems are highly antiquated, incompatible, and vulnerable to exploitation. The Secretary has proposed that funds would be used to implement an Enterprise Infrastructure Management approach across the Department that would minimize vulnerabilities while maximizing cost savings and the ability to share information

We fully support these proposals and continue to promote adequate departmental resources to ensure efficient and effective claims processing, policy development and regulation, and quality assurance. We remain concerned that the currently inadequate internal controls leave the Medicare program vulnerable to potential loss of funds, misstated financial statements, disclosure of sensitive information, and disruption of critical claim processing. Further, out of-date and overly complex computer systems are not adequately preventing inappropriate program payments.

Over the past 5 years, the Trustees have extended their estimate of the financial life of the Trust Fund by 30 years, from 1999 until 2029. The expanded solvency projection provides a window of opportunity to develop a departmental technology infrastructure for the 21st century. Over time, such an investment will lead to further savings -- by reducing payment errors of all types and by making program operations more efficient.

This concludes my testimony. I would be happy to answer any questions.

ALASKA STATE LEGISLATURE
SENATE HEALTH, EDUCATION & SOCIAL SERVICES COMMITTEE
Health Care and Welfare Subcommittee Hearing
Mat-Su Legislative Information Office
November 8, 2001
9:00 a.m.

MEMBERS PRESENT

Senator Lyda Green, Chair
Senator Bettye Davis

See pp. 37-49
Testimony of S. Branchflower

MEMBERS ABSENT

Senator Jerry Ward

OTHER LEGISLATORS PRESENT

Senator Robin Taylor
Representative Fred Dyson
Representative Sharon Cissna

SUBCOMMITTEE CALENDAR

The future of health care costs and welfare reform in Alaska.

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ACTION NARRATIVE

TAPE 01-47, SIDE A
Number 001

CHAIRWOMAN LYDA GREEN called the Senate Health, Education & Social Services Subcommittee meeting to order at 9:00 a.m. Present were Senators Davis, Taylor, and Chairwoman Green. Chairwoman Green announced that the subcommittee is meeting to consider in what direction Alaska should go regarding Medicaid coverage and possible legislation. She noted that priorities regarding services to be covered under Medicaid have changed since the events of September 11. She pointed out that one item on the agenda today is rural health care. When looking through the budget last year, Senate Finance Committee members noticed there would be a budget item to provide a service at the state level that other groups were providing. They tried to find as many funding sources coming into rural health care sites to get them aligned and not duplicative. She asked a representative

from the Denali Commission to present to the committee.

MR. KRAG JOHNSON, the Alaska Legislature's staff representative on the Denali Commission, introduced Joel Neimeyer, the Commission's rural health expert. He distributed an update on Denali Commission activities to committee members and the public. The update contains a generalized list of projects the Denali Commission has been working on and funding levels for those projects. He noted Mr. Neimeyer came to the Denali Commission after 17 years with the Indian Health Service and has worked with the Alaska Native Tribal Health Consortium.

MR. JOEL NEIMEYER, program manager for the Health Facilities Program, informed the committee that since September of 1999, he has been working with the Denali Commission on infrastructure, originally with rural energy projects. When the health care program started developing, it was consuming so much time he became the Health Facilities Program Manager.

CHAIRWOMAN GREEN asked Mr. Neimeyer if he spent all 17 years with the Indian Health Service (IHS) in rural Alaska.

MR. NEIMEYER said all but three years, which he spent in Western Washington. He noted that he would address four bullets issues, one being the role of the state and federal government, the Denali Commission and Native non-profit health corporations in rural health care.

First, the Denali Commission was created by federal legislation in 1998 to look at training, economic development, and infrastructure development. The legislation allows the Commission to work with many different partners in many different areas. The legislation established an administrative cap at 5 percent, which does not allow the Commission to run its own program. That cap forces the Commission to find partners who are already doing the work and have the same mission.

CHAIRWOMAN GREEN asked who a typical partner would be.

MR. NEIMEYER said that varies by interest. In the Denali Commission's health care program, its two primary partners are the State of Alaska and the Alaska Native Tribal Health Consortium. In the Commission's rural energy program, it primarily partners with the Alaska Energy Authority and the Alaska Village Electric Authority. He said in 1999, Congress passed legislation [P.L. 105-277] that amended the Denali Commission act and focuses it particularly on health care programs. It gives the Commission the authority to plan, design

and construct hospitals, mental health facilities, elder care, childcare, and primary care facilities.

MR. NEIMEYER said one of the first things the Denali Commission did when that legislation passed was to put together a steering committee to do a needs assessment of primary care. Its original partners were the Alaska Native Tribal Health Consortium and Indian Health Service. The goal of the needs assessment was to quantify what the primary care needs are across the state. They chose to look at 288 communities without an in-patient care facility at the hospital and more than 20 year-round residents. The study results determined a need for $253 million to address primary care facilities statewide.

CHAIRWOMAN GREEN asked him to describe some typical communities identified in the study.

MR. NEIMEYER stated that some communities have no health clinics, but many have very small clinics. The Steering Committee found that many clinics were built based upon available funds from HUD community development block grant funds and State of Alaska community development block grant funds. The Steering Committee found the small facilities restrict the amount of health care programs offered in the community so that health care access is restricted by capital funds, not by health program services that can be offered. The Steering Committee decided to change its perspective and requirement of a community for primary care services based upon geographic isolation and population size.

When the Steering Committee put together the needs assessment, it found that it could not compare the health care needs of large and small communities and felt it was unfair to make communities compete with one another. The outcome was to develop three funding processes as demonstrated in the following chart. Large clinics work for communities with a population larger than 750 or communities that serve as a sub-regional clinic or a multi-community clinic. Small clinics work in communities where that clinic is a "stand alone" clinic for that community. The third funding process is for the repair or renovation of existing clinics.

MR. NEIMEYER pointed out that none of the Denali Commission's projects to date have required a Certificate of Need but that will be incorporated into the program in case one is needed.

Where the Commission goes with funding these projects will be guided by the Health Care Steering Committee. That Committee was organized in early 2000 and is made up of four agencies: the

Denali Commission, the IHS, the Alaska Native Tribal Health Consortium and the State of Alaska. Over time, more partners were added: the Alaska Primary Care Association, the Alaska Mental Health Trust, the University of Alaska and the Alaska Native Health Board. The Steering Committee took on the responsibility for developing the Request for Proposals process for capital funding of health care facilities. Recently, the Committee was restructured so that it takes a more policy advisory role and less of a work-group function. Karen Perdue will represent the University of Alaska.

CHAIRWOMAN GREEN asked for a description of the Alaska Primary Care Association.

MR. NEIMEYER explained that it is a non-profit member organization made up of about 40 or 50 members, located in Anchorage.

MR. NEIMEYER informed the subcommittee that Karen Pearson is the chair of the Steering Committee.

CHAIRWOMAN GREEN noted the presence of Senator Taylor.

MS. KAREN PEARSON informed the committee that the primary role of the Alaska Primary Care Association (APCA) is to support its membership, which is made up predominantly of the rural community health centers and the two larger ones in Fairbanks and Anchorage. The APCA helps them to do joint purchasing and to help with board development.

CHAIRWOMAN GREEN asked if the APCA has any members from the private sector.

MR. NEIMEYER said several decisions were made about who would have a seat on the Steering Committee, one being that each seat would be filled by a representative from a statewide organization. The concern was that if a regional organization was selected, other regional organizations would fear that funds would be steered toward that region. The Steering Committee gives advice to the seven commissioners on the Denali Commission about what the Commission should be doing in the health care arena. The Steering Committee gets its advice from the seven member organizations.

CHAIRWOMAN GREEN asked how a conflict of interest is avoided if the Steering Committee is funding organizations that belong to it.

MS. PEARSON said that is a question the Steering Committee has grappled with and was partly responsible for the restructuring of the board. She pointed out the State of Alaska, University of Alaska and Native Health Board will not receive funding and all members work very hard to be cognizant of that issue.

MR. NEIMEYER said once decisions are made, it has to find partners because it has a 5 percent limit on administrative costs.

CHAIRWOMAN GREEN asked for an explanation of the administrative costs.

MR. NEIMEYER said administrative costs include utilities, staff, and whatever else it takes to run an operation. To put projects on the ground in rural Alaska takes more than five percent, so the Steering Committee finds partners to help. In the health care arena, the State (the Department of Health and Social Services - DHSS) is the pre-award partner. Ms. Pearson and her staff assist the Steering Committee in getting the RFPs out and in putting together evaluation teams to review the applications. Once the decision has been made about what projects should be funded, the Steering Committee works with its post-award partner, the Alaska Native Tribal Health Consortium (ANTHC), on small clinic projects and repair projects. The ANTHC represents the Steering Committee's interests in the individual communities. The Steering Committee found that many of the proposals for large clinics are from large organizations.

CHAIRWOMAN GREEN asked for an example of a large organization.

MR. NEIMEYER replied that the Steering Committee funded a large clinic through the Yukon Kuskokwim Corporation (YKC). YKC has a health facility manager, professional engineer, and several staff who run the project. The Steering Committee funded SEARHC projects in Angoon and Haines, who also have health facilities managers and contracting departments, so they are capable of putting the projects on the ground. The Steering Committee entered into agreements with those organizations for the large clinic funding. Routinely, small clinics are built in smaller communities.

CHAIRWOMAN GREEN asked if Mr. Neimeyer is referring to the large clinic in Kotzebue.

MR. NEIMEYER said he was not and that, in general, a small clinic is about 1,500 to 2,500 square feet. Large clinics are 2,500 to 10,000 square feet.

CHAIRWOMAN GREEN asked if, in general, a clinic is a 24-hour, overnight stay facility.

MR. NEIMEYER said they are not. He explained that ANTHC represents the regional health corporations, such as YKC and the Tanana Chiefs Conference (TCC). When the Steering Committee selected ANTHC, it required ANTHC to agree to represent all communities in the state that the Denali Commission funds.

CHAIRWOMAN GREEN asked if ANTHC was pre-ordained to participate from the beginning.

MR. NEIMEYER said it was not. The Steering Committee looked into what different organizations could be program partners and everything pointed to ANTHC as being the organization most ready to take on this work. ANTHC agreed to serve all communities that the Steering Committee recommends projects in.

CHAIRWOMAN GREEN asked if they are audited regularly.

MR. NEIMEYER said they are; they fall under the federal single audit act so they are monitored regularly. He said this past fiscal year, the Steering Committee put 12 projects on a fast-track process; ANTHC represented the Steering Committee on those projects. Mr. Neimeyer told the committee that if the Denali Commission decides to expand its program to include health facilities other than primary care facilities, such as hospitals, it will have to explore the question of who to partner with.

CHAIRWOMAN GREEN asked if totally different standards would apply to a hospital program.

MS. PEARSON said that is correct and that is the reason the Denali Commission has not gone into that arena. The Denali Commission is only looking at communities that do not have a hospital. Primary care includes, in addition to physical care, mental health and substance abuse services. With the maturation of this process, communities are thinking about their total primary care needs.

CHAIRWOMAN GREEN asked if the Haines clinic, a one-person outfit, is an example of a primary care health care facility. She pointed out that managing a one-person clinic is a very stressful job.

MS. PEARSON said the Haines clinic is an example of a primary care facility. The Steering Committee is approaching the design of these facilities in a systematic way that focuses on physical