ALASKA LEGISLATURE COMMITTEE FILES, 2003-2004 8672
11122 SENATE HEALTH, EDUCATION & SOCIAL SERVICES

MS. BERRY continued:

> Hundreds of seniors and disabled person benefit from the choice waiver program and as our senior population is rapidly growing and is predicted to continue to grow, we need to enhance and improve our menu of services for seniors and for those with adult physical disabilities, but there are gaps in services for people with chronic illnesses. The safety net for people who are chronically ill is inadequate to meet the needs of our residents. There is the person who might be $10 over Medicaid or have a chronic illness that's not covered by the PMO. For example, if you have a respiratory illness, you're out of luck. You're not covered. Or there might be the person who hasn't worked enough quarters to be eligible for disability under [indisc].
>
> Oregon is one example of innovative ways to meet the needs of the chronically ill who might not be eligible for traditional Medicaid. I am asking that some consideration be given to this population with one area, the people with respiratory illnesses who are not currently eligible for Medicaid.

MS. KRIS MOORE, Wasilla parent, said she has four children, two have been adopted from within the family. She said that parents should plan to have their children and make sure they have coverage before they have children. Neither she nor her husband have jobs that offer reasonable health insurance and she was recently unexpectedly laid off. "Many families experience these kinds of unexpected transitions…In the case of a medical emergency or for the necessary basic care during these times, we would be set back financially for years were it not for Denali Kid Care coverage."

CHAIRMAN GREEN asked if she had received a message about Denali Kid Care.

MS. MOORE replied that she hadn't specifically heard anything.

CHAIRMAN GREEN said that tomorrow's discussion was going to be about how to find alternative methods of health insurance and get coverage in places. She did not think the Denali Kid Care model is the ideal model. She said it might need to be retooled where people have the ability to participate in the selection, the types of coverage and phase into a regular health insurance policy. She did not want to strip the Denali Kid Care. She said, "The CHIPS Program is in probably going to be changed. What does that do to Denali Kid Care when it comes down from the feds to

us? I don't know. It's a dilemma."

MS. MOORE responded that her point is that they need to make sure they are considering the resources parents and families receive in these programs. She urged them to find a way to deal with the fraud issues.

MS. ELAINE MANNING said she has a Medicaid waiver. Before it came, she and her husband didn't know if they could stay in their home where they want to be. "If we could keep, for instance, 100 people in their home where they want to be, we would save our state millions of dollars and I think we're going in the right direction…"

MS. MONTA FAYE LANE, President, Alaska Caregivers Association, said the assisted living homes are far more cost effective than they realize. SB 73 had a lot of support in the legislature, but now it seems that people want to change the intent, which was to give providers a raise in the daily room and board rate they receive for taking care of indigent and elderly people, alcoholics, chronically mentally ill, etc. She explained that when she worked with Senator Mike Miller on this bill, they were receiving $34.50 per day room and board to care for these people and they figured it should be $150 per day. There was no Medicaid money at that time. It was increased to $50 per day in 2000. In 2001 it went up to $60 and in 2002 it will be $70. She said that the State wants to take away 60 percent of that. "That's going to make us receive for room and board for these people less than the 1982 $31.90."

Additionally, people are being kicked out of hospitals quicker and sicker than they ever have before in the history of the United States. She said, "I can't see why they can't figure out what a savings assisted living is to the State of Alaska when you set and look at the numbers."

MS. LANE told the committee that she was taking care of a quadriplegic patient for $3,500 a month and he was kicked out of a nursing home that was charging $15,000. He was an alcoholic and there was no way to recover any damages he did to their home. She couldn't just kick him out and continues to take his abuse. She asked that the legislature:

> Redefine the way they handle the Medicaid Program of the PA numbers. When I talk about PA numbers, I'm talking about getting paid that little $68.41 a day. I had to wait 180 days to get my money and I think that's atrocious. I'm supposed to carry the State of Alaska on my back?

MS. MARY OLSON, physical therapist, said she worked for 25 years

with children and serves on the National Board of the American Physical Therapy Association's Pediatric Section. She got an e-mail stating the committee was going to address the Denali Kid Care Program and she sees the importance of the program to the Medicaid waivers. Her first job as a physical therapist was in a boarding school for kids 5 - 21 years old because they had a physical disability. The requirement was that they had a physical disability, but intellectually normal. She has since worked with other families where the Medicaid waivers have made it possible for patients to be at home.

> The important thing is that the services be financially accessible to all children, particularly. I'm a strong believer in early intervention. That's where were going to make a difference and a kids life…and to pregnant women…Stop these problems before they occur…If they are there, get these kids on as soon as possible doing the best they can.

MS. OLSON said in her private practice that regulation and paperwork are two-thirds of her cost. "If I would just get paid for the work I do and I love to do, I would be thoroughly satisfied, but you've got to pay me for that other stuff you make me do."

MS. OLSON asked if Medicaid in schools had been addressed. She said there are many ways people receive assistance and there was no coordination or any one to take ultimate responsibility.

MS. SUE DROVER said she was not representing anyone and wanted to talk about Denali Kid Care. Her son tried to commit suicide 14 months ago and the doctors said he needed long-term care. She would have had to take him home where he would have to be watched all the time, because she could not afford to send him to a long-term facility. Fortunately, he qualified for Denali Kid Care allowing him to get the treatment and round-the-clock care that he needed and she felt that was the only reason he was alive today. She requested that they fund an in-state residential treatment center. She said there is no alcohol or drug abuse involved in her son's case.

CHAIRMAN GREEN asked someone from the Department if he knew of any those facilities were being planned. He answered that there are two facilities in-state that are long-term - North Star Behavioral Health and Alaska Children's Services Center - and Providence in short-term.

CHAIRMAN GREEN asked if the two long-term facilities were residential. He answered that they are and added that they have vacancies.

MS. DROVER said that at the time it may have been an availability issue at the time, but now he is so ingrained with the treatment and doing well in Utah that he wouldn't want to leave.

CHAIRMAN GREEN thanked her for coming in and added that she thought they would be hearing more about these facilities.

MS. DROVER added that if anything happens outside of the facility, that their regular medical insurance takes care of it. Denali Kid Care covers the residential facility fees which are about $9,000 per month.

MS. RUTH TITLER said she is a 61-year old diabetic and had been dependent on insulin for 52 years. She has other major complications directly related to the diabetes. About three years ago, her physician requested that Circle of Care evaluate her needs at home. It was determined that she needed additional help with showers, cooking and laundry. Once she was approved by the Choice Labor Program, life became better. Her care coordinator contacts her at least twice a month - one of them is a face to face visit; they monitor how her outside help is doing. Her family lives in the Lower 48 and Circle of Care has given her emotional support as well, which is very important in a person's outlook on life.

MS. TITLER said because the state opted out of the Social Security System, she is denied disability and doesn't qualify for Medicare until she is 65. "If it was not for a Choice waiver, Medicaid and Circle of Care, I believe I would not be able to maintain independent living…"

She supported continuing Medicaid money to those who need it most.

DR. DAVID ALEXANDER, physician member of the Medical Care Advisory Committee (MCAC), said he faxed them a copy of his comments. The main thing is that the State Medicaid Program has been closely reviewed by the MCAC with Bob Labbe meeting with them for two days four times a year. This Committee came up with some recommendations. The first one was: "It ain't broke; so don't try to fix it. Beyond that, it can clearly be tweaked and improved."

As an example, he said there is money spent for disaster dental care for adults, but if you're going to do that, there should be some way to fund preventive care as well, because it's a lot cheaper in the long run. He said second, the issue of payment for transportation charges needs review; it's unclear why the state is trying to be fiscally conservative and insist on paying top dollar for air tickets, because tickets can only be purchase if

they are totally refundable so they have to wait until the last minute to buy it.

Speaking as a pediatrician, he said the federal government is proposing cost neutral health insurance flexibility and accountability waivers that will allow coverage for more adults, but only contracting the amount that's available to children (because it has to be cost neutral). In addition, some of the current Medicaid money would have to go to set up the program, which is complex. He thought it was poor economic policy to drop people from the program when they finally get just above the poverty level.

MR. DENNIS DUNN, Principal at Kenai Alternative High School, said that he is here to represent the voiceless. He has about 75 kids and about a third of them a different times qualify as homeless and well over half of his population utilize the Denali Kid Care Program.

> Without this program, it's unquestionably clear that they would not get the medical services that they are now providing. Now these students have access to vision services, general medical care and mental health care. In addition, some of our students are also parents that have children. In many cases both the student and our school as well as their child is a recipient of the Denali Kid Care. I just cannot emphasize the difference this is making in the lives of these kids. These are kids who have nowhere to go, no access to any kind of heal[illegible] care, whatsoever until this program came along.

MR. DUNN said a couple of problems he had with his kids is that several providers are reluctant to take Denali Kid Care, in particular dentists. He said some psychologists are now being allowed to bill. Also, many of his kids are on their own, but they can't be seen unless they have someone who is over 18. If they have a Denali Kid Care card, it would help if they could go without someone 18 years old. He strongly supported continuing the program.

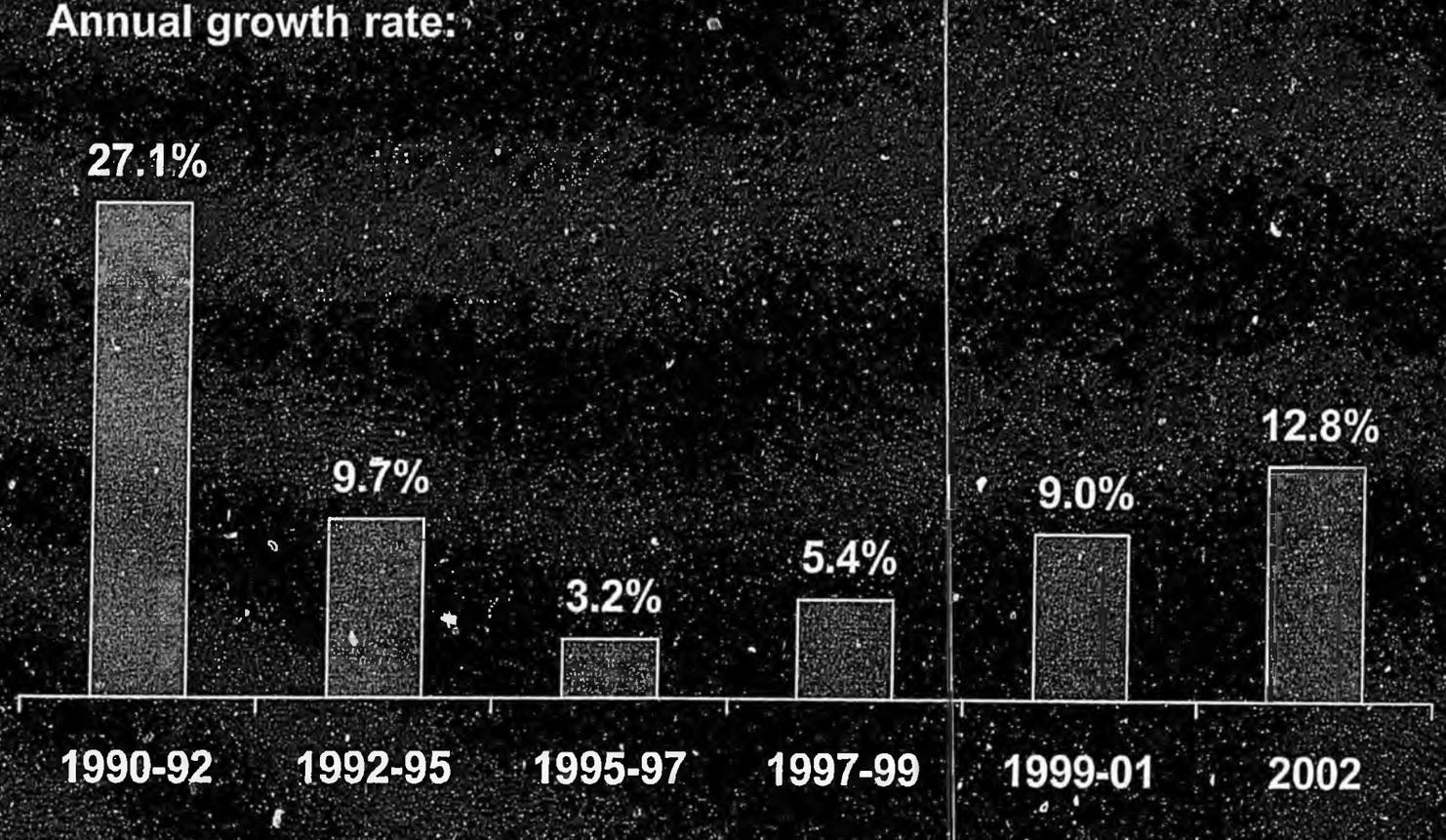
CHAIRMAN GREEN thanked him and said that emancipation was another issue they would have to deal with.

SENATOR TAYLOR said, "There's a whole series of things we need to take up, Madam Chairman. When it comes to parental responsibility, the idea of a throw away kid in Alaska is more than offensive to me…"

CHAIRMAN GREEN thanked everyone for their testimony and adjourned the meeting at 5:05 p.m.

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

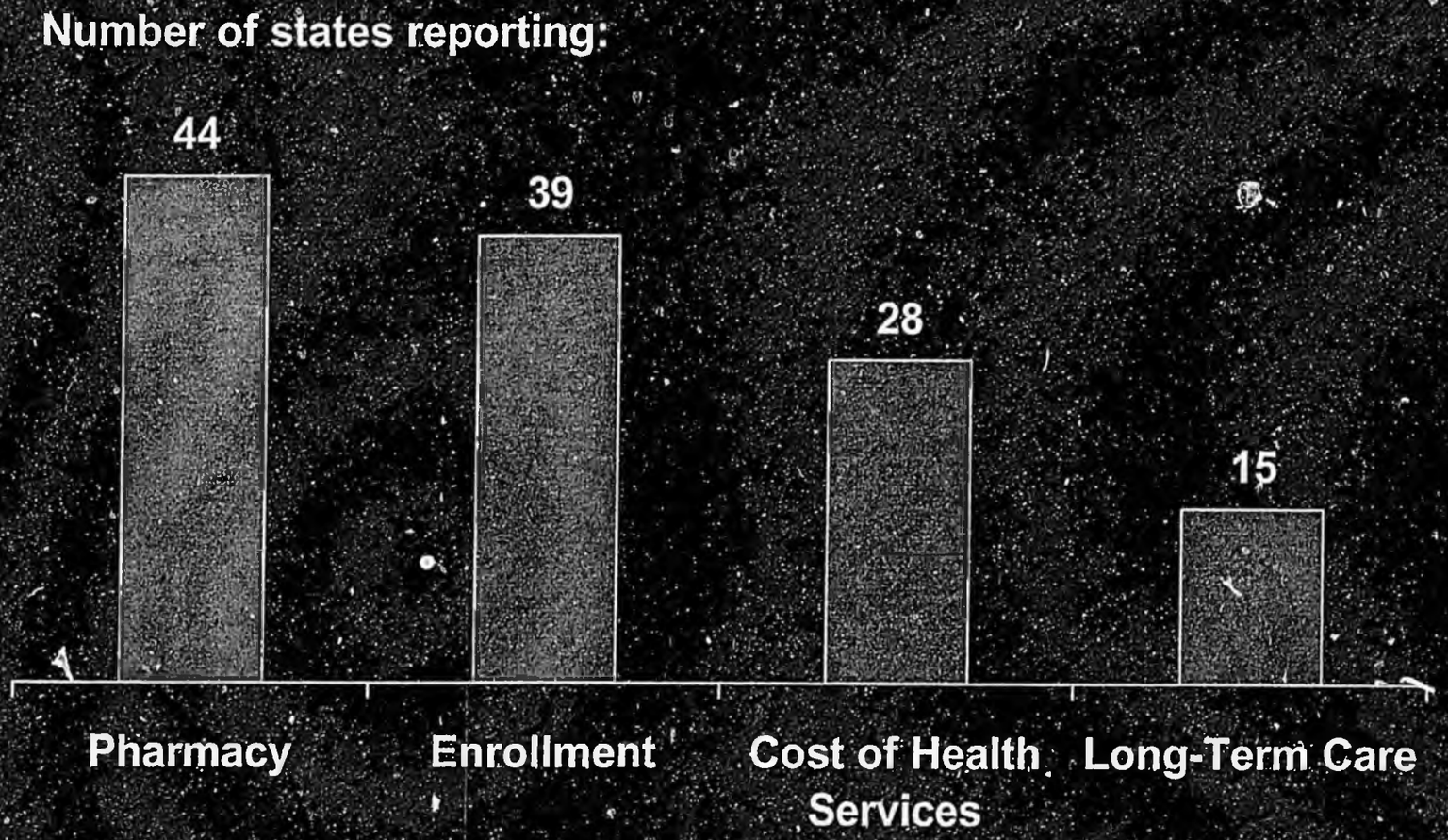
ALASKA MEDICAID PROGRAM EXPENDITURES ~ RECENT HISTORY							
Numbers and Language							
	Actuals	Actuals	Actuals	Actuals	Actuals	Enacted	Projected
	FY98	FY99	FY00	FY01	FY02	FY03	FY04
Medical Assistance							20% increase
Medicaid	**366,536.5**	**395,689.5**	**470,709.0**	**583,893.6**	**693,679.7**	**820,036.5**	**984,043.8**
General Purpose	129,731.2	141,522.9	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

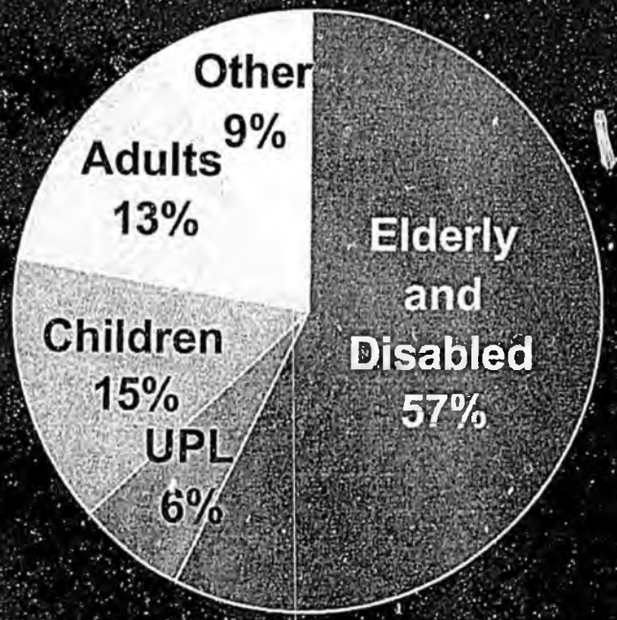


SOURCE: KCMU survey of Medicaid officials in 50 states and DO conducted by Health Management Associates, June 2002.

KAISER COMMISSION ON
Medicaid and the Uninsured

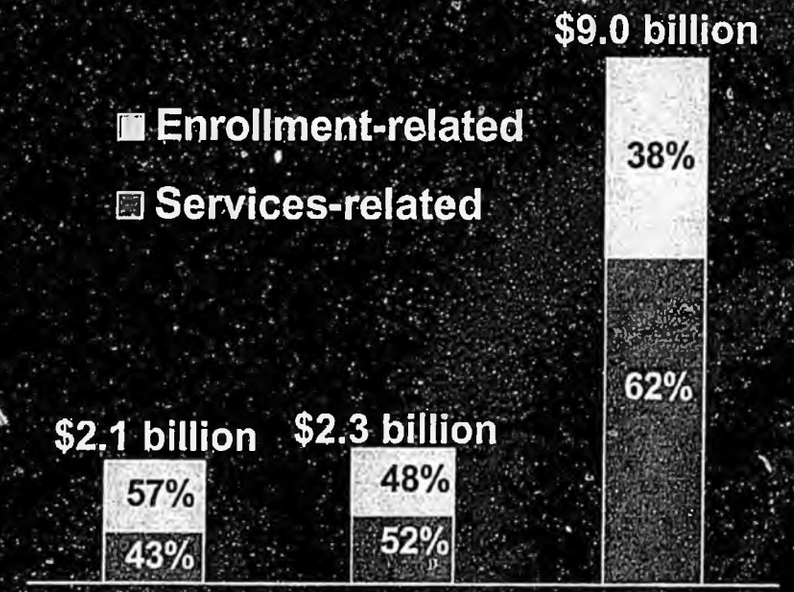
Figure 16

Sources of Growth in Federal Medicaid Expenditures, 2001-2002



Total Increase = $15.7 billion

Factors Behind Expenditure Growth for Beneficiaries

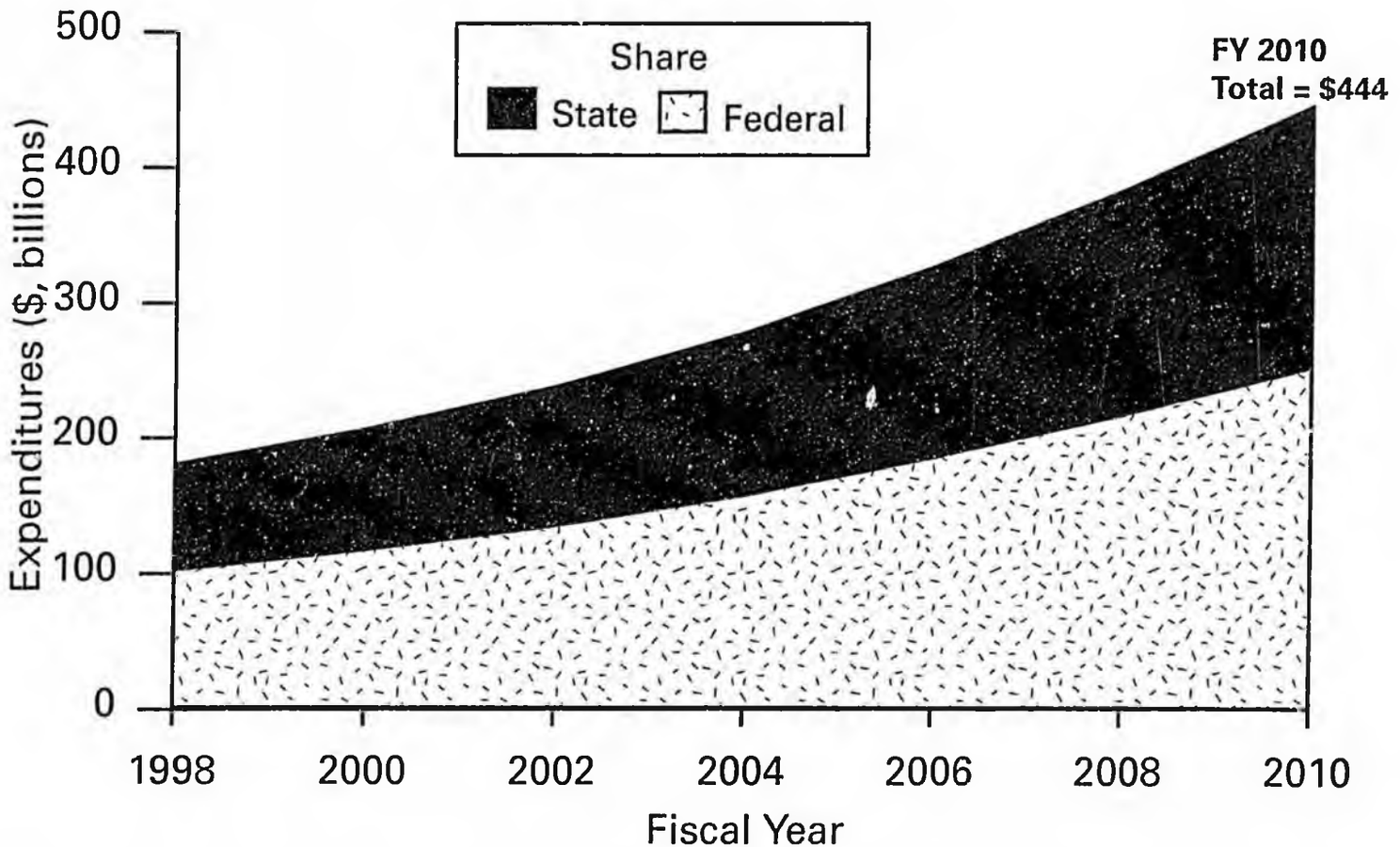


SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of CBO Medicaid baseline, March 2002.

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.

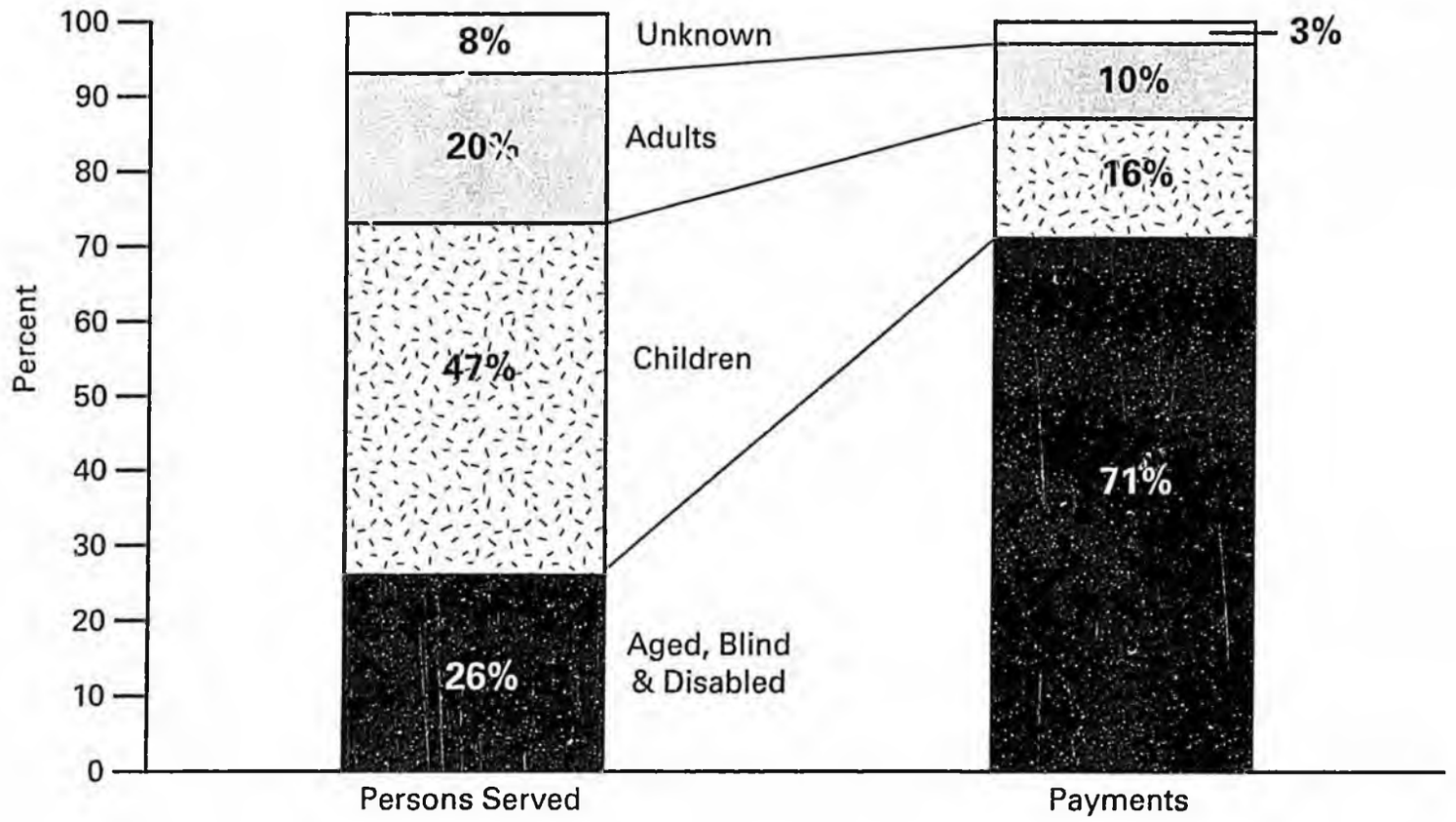


Note: (1) The projected increase in Medicaid expenditures can be explained by the following factors — case load accounts for about one-sixth of the increase, inflation one third, and the balance can be explained by spending-per-enrollee in excess of inflation; (2) data shown above are expressed in nominal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

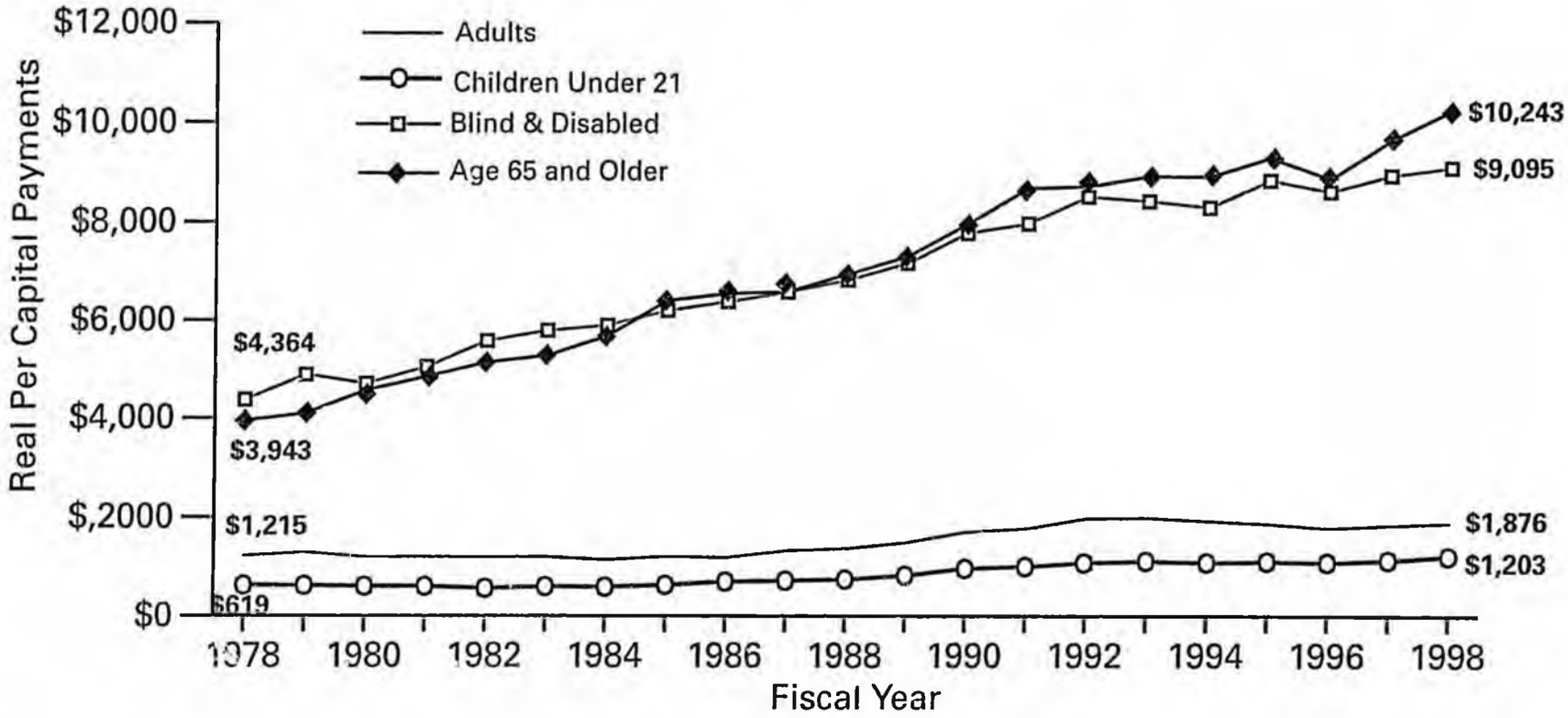


Note: (1) Totals may not equal 100% due to rounding; (2) "Payments" describe direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care (but exclude DSH payments, Medicare premiums and cost sharing on behalf of beneficiaries dually enrolled 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 "payment." 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 STATE LEGISLATURE

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SENATOR LYDA GREEN

MEMORANDUM

To: Senator Fred Dyson, Chair
Senate Health, Education and Social Services Committee

From: Senator Lyda Green
Sponsor, SB 41

Date: February 24, 2003

Re: Sponsor Substitute for Senate Bill 41

I have requested a sponsor substitute for Senate Bill 41 to be introduced on the Senate floor Wednesday. February 26, prior to the scheduled 1:30 p.m. hearing in Senate HESS. The changes in the sponsor substitute alter neither the purpose nor the substance of the legislation. Following is an explanation for each of the changes made to the original legislation:

Page 1, line 14, following "practice":

Inserted "or research"

It was brought to my attention by legislative legal counsel that the new language being added to AS 17.30.080(a) probably does not allow use of controlled substances for research projects. The definition of "practitioner" for the new criminal statutes in this bill is given as the definition found in AS 11.71.900. That definition contains the phrase "in the course of professional practice or research in the state."

This change brings AS 17.30.080 into harmony with AS 11.71.900.

Page 3, line 18:

Deleted "0.04"
Inserted "four"

The calculation of "0.04 percent" actually yields a multiplier of .0004 and would result in approximately 2 audits per year. My intent has always been to have a statistical sampling of not less than *four* percent, which would result in approximately 200 audits per year.

This change corrects the multiplier to four percent.

Page 3, line 23, following "law":

Inserted "in this state"

This is a change to the specifications of the contracted audit team requiring that not only is at least one member of the team *licensed* to practice law in Alaska, but that the person has also *actively practiced* criminal law in Alaska for at least 5 of the preceding 10 years.

This change ensures that someone experienced in Alaska criminal law is a member of the audit team.

Page 7, line 13:
Deleted "47.07.710"
Inserted "47.07.720"

This change corrects an oversight in the drafting of the bill that omitted the Medicaid misdemeanor from the requirements of the new section AS 47.07.730 "notice of charges." It has always been my intent for the Attorney General to notify the Department of Health and Social Services when a Medicaid provider has been charged with *any* misconduct involving Medicaid services.

Thank you for agreeing to hear the sponsor substitute in Senate HESS Committee on Wednesday, February 26. Your continued support as a co-sponsor is also greatly appreciated.

Cc: Senator Robin Taylor
Senator Ben Stevens
Senator Scott Ogan
Senator John Cowdery
Senator Ralph Seekins
Senator Thomas Wagoner

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 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
Office of Special Prosecutions and Appeals
310 K Street, Suite 308
Anchorage, AK 99501

E-MAIL at **medfraud@law.state.ak.us**

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)

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."***

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(a) is amended to clarify the meaning of a purpose that is solely medical by defining it as reasonably necessary for the treatment of a person's illness, injury, or medical condition.

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.

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 submits a claim to a medical assistance agency for providing services to a person who is not eligible under the medical assistance program;
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).

23-LS0204\I
Lauterbach
3/12/03

CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 41( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-THIRD LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS GREEN, Taylor, Dyson, Ben Stevens, Ogan, Cowdery, Seekins, Wagoner, Wilken

A BILL

FOR AN ACT ENTITLED

"An Act relating to medical care and crimes relating to medical care, including medical care and crimes relating to the medical assistance program."

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

*** Section 1.** AS 17.30.080 is amended to read:

Sec. 17.30.080. Unlawful administration, prescription, and dispensation of controlled substances. (a) A controlled substance classified under federal law or in a schedule set out in AS 11.71.140 - 11.71.190 may not be administered, prescribed, dispensed, or distributed other than for a [MEDICAL] purpose **that is solely medical. A person otherwise authorized may not administer, prescribe, dispense, or distribute a controlled substance classified under federal law or in a schedule set out in AS 11.71.140 - 11.71.190 unless the substance is reasonably necessary for treatment of a person's illness, injury, or medical condition, and the administration, prescription, dispensing, or distribution may only be provided within the usual course of professional medical practice or research and in**

New Text Underlined [DELETED TEXT BRACKETED]

accordance with a standard of medical care generally recognized and accepted within the medical profession in the United States.

(b) A person who violates (a) of this section, or who otherwise manufactures, distributes, dispenses, or conducts research with a controlled substance in the state without fully complying with 21 U.S.C. 811 - 830 (Controlled Substances Act), and regulations adopted under those sections, is guilty of misconduct involving a controlled substance under AS 11.71.010 - 11.71.070 in the degree appropriate to the circumstances as described in those sections. **Upon filing a complaint, information, presentment, or indictment charging a medical assistance provider with misconduct involving a controlled substance under AS 11.71.140 - 11.71.190, the attorney general shall, in writing, notify the commissioner of health and social services of the filing.**

* **Sec. 2.** AS 17.30.080 is amended by adding new subsections to read:

(c) Upon receiving a notice from the attorney general under (b) of this section, the commissioner of health and social services shall immediately undertake a review of all unpaid claims or requests for reimbursements attributable to services claimed to have been provided by the person charged.

(d) In this section, "claims" and "medical assistance provider" have the meanings given in AS 47.05.290.

* **Sec. 3.** AS 47.05 is amended by adding new sections to read:

Article 2. Medical Care Programs.

Sec. 47.05.200. Annual audits. (a) The department shall annually contract for independent audits of a statewide sample of all medical assistance providers in order to identify overpayments and violations of criminal statutes. The audits conducted under this section may not be conducted by the department or employees of the department. The number of audits under this section each year, as a total for the medical assistance programs under AS 47.07 and AS 47.08, shall be 0.75 percent of all enrolled providers under the programs, adjusted annually on July 1, as determined by the department, except that the number of audits under this section may not be less than 75. The audits under this section must include both on-site audits and desk audits and must be of a variety of provider types. The department may not award a contract

under this subsection to an organization that does not retain persons with a significant level of expertise and recent professional practice in the general areas of standard accounting principles and financial auditing and in the specific areas of medical records review, investigative research, and Alaska health care criminal law. The contractor, in consultation with the commissioner, shall select the providers to be audited and decide the ratio of desk audits and on-site audits to the total number selected.

(b) Within 90 days after receiving each audit report from an audit conducted under this section, the department shall begin administrative procedures to recoup overpayments identified in the audits and shall allocate the reasonable and necessary financial and human resources to ensure prompt recovery of overpayments unless the attorney general has advised the commissioner in writing that a criminal investigation of an audited provider has been or is about to be undertaken, in which case, the commissioner shall hold the administrative procedure in abeyance until a final charging decision by the attorney general has been made. The commissioner shall provide copies of all audit reports to the attorney general so that the reports can be screened for the purpose of bringing criminal charges.

(c) Each fiscal year, the state's share of recovered overpayments obtained because of the required contract audits under this section shall be deposited with the commissioner of revenue under AS 37.10.050 and separately accounted for by the commissioner of administration under AS 37.05.142. The legislature may appropriate a portion of the estimated balance in the account to the department to pay for the annual audits described in this section.

(d) As a condition of obtaining payment under AS 47.07 and AS 47.08 and for purposes of this section, a provider shall allow

(1) the department reasonable access to the records of medical assistance recipients and providers; and

(2) audit and inspection of the records by state and federal agencies.

(e) This section does not preclude the department from performing audits that are allowed or required under other laws.

Sec. 47.05.210. Medical assistance fraud. (a) A person commits the crime

of medical assistance fraud if the person

(1) knowingly submits or authorizes the submission of a claim to a medical assistance agency for property, services, or a benefit with reckless disregard that the claimant is not entitled to the property, services, or benefit;

(2) knowingly prepares or assists another person to prepare a claim for submission to a medical assistance agency for property, services, or a benefit with reckless disregard that the person being assisted is not entitled to the property, services, or benefit;

(3) except as otherwise authorized under the medical assistance program, confers, offers to confer, solicits, agrees to accept, or accepts property, services, or a benefit

(A) to refer a medical assistance recipient to a health care provider; or

(B) for providing health care to a medical assistance recipient if the property, services, or benefit is in addition to payment by a medical assistance agency;

(4) does not produce medical assistance records to a person authorized to request the records;

(5) knowingly makes a false entry in or falsely alters a medical assistance record;

(6) knowingly destroys, mutilates, suppresses, conceals, removes, or otherwise impairs the verity, legibility, or availability of a medical assistance record; or

(7) violates a provision of AS 47.07 or AS 47.08 or a regulation adopted under AS 47.07 or AS 47.08.

(b) Medical assistance fraud under (a)(1), (2), or (3) of this section is

(1) a class B felony if the portion of the claim or claims submitted in violation of (a)(1) or (2) of this section, or the value of the property, services, or benefit that is in violation of (a)(3) of this section, is $25,000 or more;

(2) a class C felony if the portion of the claim or claims submitted in violation of (a)(1) or (2) of this section, or the value of the property, services, or

benefit that is in violation of (a)(3) of this section, is $500 or more but less than $25,000;

(3) a class A misdemeanor if the portion of the claim or claims submitted in violation of (a)(1) or (2) of this section, or the value of the property, services, or benefit that is in violation of (a)(3) of this section, is less than $500.

(c) Medical assistance fraud under (a)(4), (5), or (6) of this section is a class A misdemeanor.

(d) Medical assistance fraud under (a)(7) of this section is a class B misdemeanor.

Sec. 47.05.220. Notice of charges. Upon the filing of a complaint, information, presentment, or indictment charging a medical assistance provider with a crime under AS 47.05.210, the attorney general shall, in writing, notify the commissioner of the filing. Upon receiving notice from the attorney general under this section, the commissioner shall immediately undertake a review of all unpaid claims or requests for reimbursements attributable to services claimed to have been provided by the person charged.

Sec. 47.05.230. Determination of value; aggregation of amounts. In AS 47.05.210, whenever it is necessary to determine the value of property, that value shall be determined in accordance with AS 11.46.980. In determining the degree or classification of a crime described under AS 47.05.210, amounts involved in criminal acts committed under one course of conduct, whether from the same person or several persons, shall be aggregated.

Sec. 47.05.240. Exclusion from medical assistance programs. (a) The commissioner may exclude an applicant to or disenroll a medical assistance provider in the medical assistance program in AS 47.07 or AS 47.08, or both, for a period of up to 10 years following unconditional discharge on a conviction

(1) for medical assistance fraud under AS 47.05.210 or misconduct involving a controlled substance under AS 11.71; or

(2) in a court of the United States or a court of another state or territory, for a crime with elements substantially similar to the crimes included under (1) of this subsection.

(b) After a period of exclusion under (a) of this section, an applicant may not participate in a medical assistance program under AS 47.07 or AS 47.08 until the applicant establishes to the commissioner by clear and convincing evidence that the applicant possesses all required licenses and certificates and is qualified to participate.

Sec. 47.05.290. Definitions. In AS 47.05.200 - 47.05.290,

(1) "benefit" has the meaning given in AS 11.81.900;

(2) "claim," in addition to its usual meaning, also means a request for payment for medical assistance services attempted to be provided, provided, or claimed to have been provided to another, whether the request is in an electronic format or paper format or both, made or submitted by a person or an organization that is or claims to be a medical assistance provider;

(3) "commissioner" means the commissioner of health and social services;

(4) "department" means the Department of Health and Social Services;

(5) "falsely alters" has the meaning given in AS 11.46.580;

(6) "knowingly" has the meaning given in AS 11.81.900;

(7) "makes a false entry" has the meaning given in AS 11.56.820;

(8) "medical assistance agency" means the department, an agency of the department, and an agent, contractor, or designee of the department or of one of its agencies that performs one or more of the activities of the department or an agency of the department;

(9) "medical assistance program" means a program under AS 47.07 or AS 47.08;

(10) "medical assistance provider" or "provider" means a person or organization that provides, attempts to provide, or claims to have provided services or products to a medical assistance recipient that may qualify for reimbursement under AS 47.07 or AS 47.08 or a person or organization that participates in or has applied to participate in a medical assistance program as a supplier of a service or product;

(11) "medical assistance recipient" means a person on whose behalf another claims or receives a payment from a medical assistance agency, without regard to whether the individual was eligible for benefits under a medical assistance

program;

(12) "medical assistance record" means records required to be kept by state or federal law or regulation regarding claims to a medical assistance agency;

(13) "organization" has the meaning given in AS 11.81.900;

(14) "person" has the meaning given in AS 11.81.900;

(15) "property" has the meaning given in AS 11.81.900;

(16) "reckless disregard" means acting recklessly, as that term is defined in AS 11.81.900;

(17) "services" means a health care benefit available to a medical assistance recipient, including health care benefits provided, attempted to be provided, or claimed to have been provided to another, by a medical assistance provider, or "services" as defined in AS 11.81.900;

(18) "unconditional discharge" has the meaning given in AS 12.55.185.

* **Sec. 4.** AS 47.07.010 is amended to read:

Sec. 47.07.010. Purpose. It is declared **by the legislature** as a matter of public concern that the needy persons of this state **who are eligible for medical care at public expense under this chapter should seek only** [RECEIVE] uniform and high quality medical care **that is appropriate to their condition and cost-effective to the state and receive that care**, regardless of race, age, national origin, or economic standing. **It is equally a matter of public concern that providers of services under this chapter should operate 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.** Accordingly, this chapter authorizes the **department** [DEPARTMENT OF HEALTH AND SOCIAL SERVICES] to apply for participation in the national medical assistance program as provided for under 42 U.S.C. 1396 - 1396p (Title XIX, Social Security Act).

* **Sec. 5.** AS 47.07.074(a) is amended to read:

(a) As a condition of obtaining payment under AS 47.07.070, a health facility shall allow

(1) the department and the commission reasonable access to the [FINANCIAL] records of medical assistance **recipients and providers** [BENEFICIARIES]; and

(2) audit and inspection of **the** [FINANCIAL] records by state and federal agencies.

CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 41(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-THIRD LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS GREEN, Taylor, Dyson, Ben Stevens, Ogan, Cowdery, Seekins, Wagoner, Wilken

A BILL

FOR AN ACT ENTITLED

"An Act relating to medical care and crimes relating to medical care, including medical care and crimes relating to the medical assistance program."

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

* Section 1. AS 17.30.080 is amended to read:

Sec. 17.30.080. Unlawful administration, prescription, and dispensation of controlled substances. (a) A controlled substance classified under federal law or in a schedule set out in AS 11.71.140 - 11.71.190 may not be administered, prescribed, dispensed, or distributed other than for a [MEDICAL] purpose <u>that is solely medical. A person otherwise authorized may not administer, prescribe, dispense, or distribute a controlled substance classified under federal law or in a schedule set out in AS 11.71.140 - 11.71.190 unless the substance is reasonably necessary for treatment of a person's illness, injury, or medical condition, and the administration, prescription, dispensing, or distribution may only be provided within the usual course of professional health care practice or research and in</u>

accordance with a standard of health care generally recognized and accepted within the health care profession in the United States.

(b) A person who violates (a) of this section, or who otherwise manufactures, distributes, dispenses, or conducts research with a controlled substance in the state without fully complying with 21 U.S.C. 811 - 830 (Controlled Substances Act), and regulations adopted under those sections, is guilty of misconduct involving a controlled substance under AS 11.71.010 - 11.71.070 in the degree appropriate to the circumstances as described in those sections. Upon filing a complaint, information, presentment, or indictment charging a medical assistance provider with misconduct involving a controlled substance under AS 11.71.140 - 11.71.190, the attorney general shall, in writing, notify the commissioner of health and social services of the filing.

* **Sec. 2.** AS 17.30.080 is amended by adding new subsections to read:

(c) Upon receiving a notice from the attorney general under (b) of this section, the commissioner of health and social services shall immediately undertake a review of all unpaid claims or requests for reimbursements attributable to services claimed to have been provided by the person charged.

(d) In this section, "claims" and "medical assistance provider" have the meanings given in AS 47.05.290.

* **Sec. 3.** AS 47.05 is amended by adding new sections to read:

Article 2. Medical Care Programs.

Sec. 47.05.200. Annual audits. (a) The department shall annually contract for independent audits of a statewide sample of all medical assistance providers in order to identify overpayments and violations of criminal statutes. The audits conducted under this section may not be conducted by the department or employees of the department. The number of audits under this section each year, as a total for the medical assistance programs under AS 47.07 and AS 47.08, shall be 0.75 percent of all enrolled providers under the programs, adjusted annually on July 1, as determined by the department, except that the number of audits under this section may not be less than 75. The audits under this section must include both on-site audits and desk audits and must be of a variety of provider types. The department may not award a contract

under this subsection to an organization that does not retain persons with a significant level of expertise and recent professional practice in the general areas of standard accounting principles and financial auditing and in the specific areas of medical records review, investigative research, and Alaska health care criminal law. The contractor, in consultation with the commissioner, shall select the providers to be audited and decide the ratio of desk audits and on-site audits to the total number selected.

(b) Within 90 days after receiving each audit report from an audit conducted under this section, the department shall begin administrative procedures to recoup overpayments identified in the audits and shall allocate the reasonable and necessary financial and human resources to ensure prompt recovery of overpayments unless the attorney general has advised the commissioner in writing that a criminal investigation of an audited provider has been or is about to be undertaken, in which case, the commissioner shall hold the administrative procedure in abeyance until a final charging decision by the attorney general has been made. The commissioner shall provide copies of all audit reports to the attorney general so that the reports can be screened for the purpose of bringing criminal charges.

(c) Each fiscal year, the state's share of recovered overpayments obtained because of the required contract audits under this section shall be deposited with the commissioner of revenue under AS 37.10.050 and separately accounted for by the commissioner of administration under AS 37.05.142. The legislature may appropriate a portion of the estimated balance in the account to the department to pay for the annual audits described in this section.

(d) As a condition of obtaining payment under AS 47.07 and AS 47.08 and for purposes of this section, a provider shall allow

(1) the department reasonable access to the records of medical assistance recipients and providers; and

(2) audit and inspection of the records by state and federal agencies.

(e) This section does not preclude the department from performing audits that are allowed or required under other laws.

Sec. 47.05.210. Medical assistance fraud. (a) A person commits the crime

of medical assistance fraud if the person

(1) knowingly submits or authorizes the submission of a claim to a medical assistance agency for property, services, or a benefit with reckless disregard that the claimant is not entitled to the property, services, or benefit;

(2) knowingly prepares or assists another person to prepare a claim for submission to a medical assistance agency for property, services, or a benefit with reckless disregard that the person being assisted is not entitled to the property, services, or benefit;

(3) except as otherwise authorized under the medical assistance program, confers, offers to confer, solicits, agrees to accept, or accepts property, services, or a benefit

(A) to refer a medical assistance recipient to a health care provider; or

(B) for providing health care to a medical assistance recipient if the property, services, or benefit is in addition to payment by a medical assistance agency;

(4) does not produce medical assistance records to a person authorized to request the records;

(5) knowingly makes a false entry in or falsely alters a medical assistance record;

(6) knowingly destroys, mutilates, suppresses, conceals, removes, or otherwise impairs the verity, legibility, or availability of a medical assistance record; or

(7) violates a provision of AS 47.07 or AS 47.08 or a regulation adopted under AS 47.07 or AS 47.08.

(b) Medical assistance fraud under (a)(1), (2), or (3) of this section is

(1) a class B felony if the portion of the claim or claims submitted in violation of (a)(1) or (2) of this section, or the value of the property, services, or benefit that is in violation of (a)(3) of this section, is $25,000 or more;

(2) a class C felony if the portion of the claim or claims submitted in violation of (a)(1) or (2) of this section, or the value of the property, services, or

benefit that is in violation of (a)(3) of this section, is $500 or more but less than $25,000;

(3) a class A misdemeanor if the portion of the claim or claims submitted in violation of (a)(1) or (2) of this section, or the value of the property, services, or benefit that is in violation of (a)(3) of this section, is less than $500.

(c) Medical assistance fraud under (a)(4), (5), or (6) of this section is a class A misdemeanor.

(d) Medical assistance fraud under (a)(7) of this section is a class B misdemeanor.

Sec. 47.05.220. Notice of charges. Upon the filing of a complaint, information, presentment, or indictment charging a medical assistance provider with a crime under AS 47.05.210, the attorney general shall, in writing, notify the commissioner of the filing. Upon receiving notice from the attorney general under this section, the commissioner shall immediately undertake a review of all unpaid claims or requests for reimbursements attributable to services claimed to have been provided by the person charged.

Sec. 47.05.230. Determination of value; aggregation of amounts. In AS 47.05.210, whenever it is necessary to determine the value of property, that value shall be determined in accordance with AS 11.46.980. In determining the degree or classification of a crime described under AS 47.05.210, amounts involved in criminal acts committed under one course of conduct, whether from the same person or several persons, shall be aggregated.

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(1) for medical assistance fraud under AS 47.05.210 or misconduct involving a controlled substance under AS 11.71; or

(2) in a court of the United States or a court of another state or territory, for a crime with elements substantially similar to the crimes included under (1) of this subsection.

(b) After a period of exclusion under (a) of this section, an applicant may not participate in a medical assistance program under AS 47.07 or AS 47.08 until the applicant establishes to the commissioner by clear and convincing evidence that the applicant possesses all required licenses and certificates and is qualified to participate.

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(8) "medical assistance agency" means the department, an agency of the department, and an agent, contractor, or designee of the department or of one of its agencies that performs one or more of the activities of the department or an agency of the department;

(9) "medical assistance program" means a program under AS 47.07 or AS 47.08;

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program;

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(14) "person" has the meaning given in AS 11.81.900;

(15) "property" has the meaning given in AS 11.81.900;

(16) "reckless disregard" means acting recklessly, as that term is defined in AS 11.81.900;

(17) "services" means a health care benefit available to a medical assistance recipient, including health care benefits provided, attempted to be provided, or claimed to have been provided to another, by a medical assistance provider, or "services" as defined in AS 11.81.900;

(18) "unconditional discharge" has the meaning given in AS 12.55.185.

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Sec. 47.07.010. Purpose. It is declared **by the legislature** as a matter of public concern that the needy persons of this state **who are eligible for health care at public expense under this chapter should seek only** [RECEIVE] uniform and high quality medical care **that is appropriate to their condition and cost-effective to the state and receive that care**, regardless of race, age, national origin, or economic standing. **It is equally a matter of public concern that providers of services under this chapter should operate 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.** Accordingly, this chapter authorizes the **department** [DEPARTMENT OF HEALTH AND SOCIAL SERVICES] to apply for participation in the national medical assistance program as provided for under 42 U.S.C. 1396 - 1396p (Title XIX, Social Security Act).

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(a) As a condition of obtaining payment under AS 47.07.070, a health facility shall allow

(1) the department and the commission reasonable access to the [FINANCIAL] records of medical assistance **recipients and providers** [BENEFICIARIES]; and

(2) audit and inspection of **the** [FINANCIAL] records by state and federal agencies.

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 2/26/03

FURTHER: Judiciary
Finance

Date of 5-Day Notice:_____
(in accordance with Uniform Rule 23)

DATE TURNED
IN TO OFFICE: 3.13.03

Health, Education and Social Services Committee considered

SPONSOR SUBSTITUTE FOR SENATE BILL NO. 41

SB 41 MEDICAID COSTS AND CRIMES

"An Act relating to medical care and crimes relating to medical care, including medical care and crimes relating to the medical assistance program."

and reccmmends:

Senate Bill:
[x] same title
[ ] new title
House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR #_____

[X] be **replaced** with _____ **CS** ~~for SS for SB 41~~ (HES)

[ ] adopt **previous** _____ **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
Debbie Breen	✓			
Fred Lyon	✓			
Bettye Davis			✓	
Tony Mueller	✓			
CHAIR:				

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.

SB

55

SENATOR FRED DYSON

SB 55

Sponsor Statement

"An Act relating to tampering with public records"

Updated: February 26, 2003
Contact: Senator Fred Dyson's office at (907) 465-2199

Public records must not be altered to cover up mistakes, incompetence, dereliction of duty, or crimes. SB 55 is intended to raise awareness and penalties related to deliberate alteration of records of persons in state custody. Accurate and complete records are essential to making critical decisions that can have profound and lasting effect on person's lives and the lives of their families when they cannot make those decisions for themselves.

Senate Bill 55 makes tampering with records of persons in state custody a class C felony. This means that if a person is convicted under this law he or she could be given up to a $50,000 fine and 5 years in prison.

Existing law provides this penalty when the tampering is done with the intent to obtain a benefit or to injure or deprive a person of benefits; SB 55 specifically broadens existing law to include intentional tampering with records of persons who are in state custody.

SB 55 purposefully includes children's and adult's records. Persons with disabilities, the elderly, the mentally ill, prisoners, and children are all vulnerable to abuse, neglect and exploitation. It is clearly logical to include this significant disincentive to record tampering in law to emphasize the responsibility we have as custodians and guardians.

SB 55 is not targeted at any specific state agency or persons, it is meant to act as a deterrent to potentially prevent tragedy. It was discovered in Florida last year that a child welfare caseworker had been falsely claiming to be maintaining contact with Rilya Wilson, age 5, for over a year, when in reality, Rilya had disappeared. In that case the social worker, possibly overworked, chose to submit records that indicated all was well, rather than admit that he or she had no idea about the child's welfare. Rilya is still missing. While there is no guarantee that stiffer penalties for falsifying records would have prevented this tragedy, it is true that Florida quickly passed a bill similar to SB 55. After the fact and too late to help Rilya...

During Session (January-May): Alaska State Capitol • Juneau, Alaska 99801 • (800) 342-2199 • (907) 465-2199 • (907) 465-4587 FAX
During Interim (June-December): 10928 Eagle River Road • Eagle River, Alaska 99577 • (907) 694-6683 • (907) 694-1015 FAX
Senator.Fred.Dyson@Legis.state.ak.us • www.akrepublicans.org

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 55
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Law
Title "An Act relating to tampering with public records."
BRU Criminal Division
Component All
Sponsor Senator Dyson
Requester Senate HESS Committee
Component No.

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 increases the penalty to a C felony for knowingly making a false entry in or falsely altering a public record; or knowingly destroying, mutilating, suppressing, concealing, removing, or otherwise impairing the verity, legibility, or availability of a public record, knowing that the person lacks the authority to do so, if the public record relates to a person in the care or custody of the state. This crime of tampering with public records is currently a class A misdemeanor.

Anytime a misdemeanor crime is changed to a felony, the costs of prosecution increase. However, the Department of Law does not expect many of these new felony prosecutions to arise, and does not anticipate a fiscal impact from passage of this legislation.

Prepared by: Joan M. Kasson
Phone (907) 465-5370
Division Attorney General's Office
Date/Time 3/4/03 2:33 PM
Approved by: Kathryn Daughhetee for Gregg D. Renkes, Attorney General
Date 3/4/2003
Agency Department of Law

(Revised 9/2002 OMB)

Sent: Saturday, August 10, 2002 2:24 PM
Subject: CPS = the *New Age Mob*

NATIONAL ADVISORY ON ORGANIZED CRIME
OPERATING IN THE CHILD PROTECTION SYSTEM

The recent horror story of a fifteen-month delay in Florida officials discovering that foster child Rilya Wilson had apparently been kidnapped by persons knowledgeable of the inner workings of the child protection system was due to the systematic falsification of child protection system records. This falsification of child protection system records is part of a national pattern of organized crime. It is not an isolated incident.

The Rilya Wilson case is the tip of a criminal iceberg. Beginning about 1973, criminal elements in the mental health and social work professions began cooperating to construct an organized criminal enterprise that exploits children behind the legislated secrecy of the child protection, juvenile justice, and mental health systems. The contemporary end result is a nationwide organized criminal operation that uses everything from sophisticated science-fraud- based "evaluation" instruments structured to produce false positives to third party state service contracts written to sustain a system of structural corruption in which state employees and contract service providers must falsify records and testimony or they will not continue to be employed or paid.

To maintain their existence, organized criminal operations must construct management bureaucracies with policies and procedures necessary to sustain daily operations, just like any other bureaucracy. The only adaptation required to run criminal operations in the government and quasi-government agencies which constitute the child protection system is that they must be integrated into the policies and procedures of the umbrella agency and not be detected as components of a criminal bureaucracy.

The existence of organized crime in the child protection system of any given state is not that difficult to detect. Prominent among the indicators are: (1) the annual number of founded child abuse allegations can be predicted from the number of conditional federal grant and reimbursement salary fund dollars needed to balance the state child protection agency payroll (the number of children taken into state custody each year will be the number sufficient to generate the federal fund claims necessary to balance the agency payroll); and (2) third party contracts to file state child protection agency federal fund claims will contain provisions that only compensate the contractor for increases in federal funds paid to the state over and above the amount paid in the previous contract for such claim filing services. The latter creates a system that will only result in compensation to the contractor if the number of children taken into state custody constantly increases and/or the total claims generated from each child in state custody increases each contract cycle. The net result is a system in which everyone stays employed only if the number of founded child abuse cases and children taken into state custody always increases and never decreases. An important byproduct of this criminal process of exploiting children independent of the true child abuse rate is the blind political support for the criminal operations generated by the constant flow of conditional federal funds into the respective State's economy. In the Rilya Wilson case, even the Foster Mother continued to receive and accept payments for the care of Rilya over a year after the child disappeared. Caseworkers reportedly told her to take the money.

There are similar lessons to be drawn from the embarrassment of the Bush Administration over numerous ignored warnings that Osama bin Laden planned to hijack planes and fly them into buildings and the embarrassment of Florida Officials having to explain fifteen months of falsified child protection records, sworn court testimony that Rilya Wilson was in Florida State custody and doing fine, and falsified federal fund claims for services delivered to a child that may have been dead the entire time. After the collapse of the World Trade Center, both the American Public and terrorists worldwide now

know the United States is vulnerable to attack, due in large part to corruption, incompetence and mismanagement in intelligence and law enforcement agencies. After the Rilya Wilson case in Florida, the Public and every child molester, pornographer and other criminal who need children for their misdeeds know that the corruption, incompetence and mismanagement in the child protection system can be exploited as cover to acquire children for their own illicit purposes. What happened to Rilya Wilson in Florida can happen in any state where the current organized criminal exploitation of children is allowed to continue. Sooner or later other criminals, including child molesters and child pornographers, are going to become sufficiently aware of the mechanisms the current organized criminals are using to manage their criminal bureaucracy that they will also be able to exploit the system, as were the people who reportedly kidnaped Rilya Wilson and returned a week later to collect her clothes. Among the obvious possibilities is obtaining information about the criminal activity (falsifying federal claims, official reports, insurance claims, etc.) of individual state employees or licensed professionals, like psychiatrists and psychologist, and blackmailing them to allow access to children for criminal exploitation or perversion.

Of major importance to prosecutors is that the systematic falsification of records by child protection system crime participants in psychiatry, psychology, social work and child abuse investigation units results in the systematic falsification of evidence used in child related criminal and civil judicial proceedings. While it may be tempting not to look to closely at experts and evidence which make convictions easier, relying on criminals who help conceal their nefarious enterprises by providing convenient services to the people who should be prosecuting them is a house of cards that will collapse locally or nationally at some pont. We have the contemporary examples of the falsification of evidence in the Los Angeles Police Department and the newly documented error rate in death row convictions.

Unless something is done to shut down the organized criminal activity in every state in which it exists, Rilya Wilson is not going to be the last horror story to capture national attention. Careers will be ruined, as they have been in Florida, and people will end up going to prison for crimes far beyond what they thought they were getting themselves into by falsifying a few reports to get federal funds into the state or for insurance claims. Prosecutors, Legislators, and other state officials who thought they were benefitting their state by looking the other way because federal funds were coming into the state's economy, may end up having to face situations far uglier than they ever thought. Former Arkansas State Senator Nick Wilson is now in federal prison for his sponsorship and participation in one such legislated criminal enterprise to exploit children. Other Arkansas attorneys involved lost their licenses to practice law. An Austin, Texas DHS Supervisor committed suicide after allegedly being caught running a foster child prostitution ring from his office computer. In a recent Arkansas Legislative Session, a bill drafted by Arkansas Department of Human Services employees was discovered to contain provisions that would have required employees to lie about records and facts, even if subpoenaed. The bill was withdrawn once the Legislator duped into being the primary sponsor was made aware of its contents. In a June 6, 2002 opinion, the Arkansas Supreme Court ruled that an infant Arkansas citizen had been illegally transferred to Florida State custody in what was essentially an interstate criminal conspiracy to seize and transport children in complete disregard of State and Federal law. (See Arkansas Department of Human Services v Cox, Supreme Court of Arkansas No. 01-1021, 349ark___, issue 3, sc 9, 6 June 2002 http://courts.state.ar.us/opinions/2002a/20020606/01-1021.wpd)

The important point being that these child protection system criminals will be pushing the envelop on what they can get away with, as in these examples, and sometimes that envelop will rupture, as in the Rilya Wilson case, exposing not only the criminals but government officials and private citizens who were indirectly benefiting from the criminal activity. The important question being how sophisticated, brutal and embarrassing will organized crime in the child protection system be allowed to become before it is addressed.

In the hope that my documentation of how the organized crime bureaucracy functions in the child protection system will help prevent any repeats of the Rilya Wilson horror story, I draw the material to your attention. Below is the master link page address for six articles I have written on how crime in the child protection is created, organized and managed. The six articles will provide an overview of the context in which a child's kidnapping can be concealed for over a year. Although written for the popular media, each article contains detailed instructions on how to detect various mechanisms used by organized criminals operating in the child protection system to sustain their operations. Part II contains a formula for determining if the annual number of founded child abuse allegations can accurately be predicted from the number of conditional federal salary fund dollars needed to balance the child protection agency payroll.

See links to Parts I-VI of "Crime Management in Government" at:
http://www.eighthcity.com/Articles/Rogerbrown/rogerbrown.htm

I sincerely hope you will use this information to determine if the child protection system in your state has an organized crime problem. I do not want to see any more stories like that of Rilya Wilson, when I know they can be prevented by ending the influence of organized crime in the child protection system.

If I may be of further assistance, please contact me at:

James Roger Brown
Director
THE SOCIOLOGY CENTER
220 North Willow, Suite 222
North Little Rock, AR 72114
(501) 374-1788
thesociologist@aol.com

SB 55 changes (underlined) in context of existing law:

ec. 11.56.815. Tampering with public records in the first degree.

(a) A person commits the crime of tampering with public records in the first degree if the person violates

(1) AS 11.56.820 (a)(3) with intent to obtain a benefit for that person or any person or to injure or deprive another person of a benefit.

(2) **AS 11.56.820(a)(1)or(2) and the public record relates to a person in the care or custody of the state.**

(b) Tampering with public records in the first degree is a class C felony.

Sec. 11.56.820. Tampering with public records in the second degree.

(a) A person commits the crime of tampering with public records in the second degree if the person

(1) knowingly makes a false entry in or falsely alters a public record;

(2) knowingly destroys, mutilates, suppresses, conceals, removes, or otherwise impairs the verity, legibility, or availability of a public record, knowing that the person lacks the authority to do so; or

(3) certifies a public record setting out a claim against a government agency, or the property of a government agency, with reckless disregard of whether the claim is lawful, or that payment of the claim is not authorized in the budget of the government agency.

(b) In this section

(1) "certifies" means attesting to the existence, truth, or accuracy of facts, or that one holds an opinion, stated in a public record; the term includes the responsibilities for state officials set out in AS 37.10.030;

(2) "falsely alters" has the meaning ascribed to it in AS 11.46.580 ; and

(3) "makes a false entry" means to change or create a public record, whether complete or incomplete, by means of erasure, obliteration, deletion, insertion of new matter, transposition of matter, or by any other means, so that the record so changed or created states or implies a fact that the maker knows is not true, or states or implies an opinion that the maker does not hold.

(c) Tampering with public records in the second degree is a class A misdemeanor.

FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB55 DOC 2 28
() Publish Date:

Revision Date/Time (Note if correction):
Dept Affected: Department of Corrections
Title: Tampering with Public Records
BRU: Administration & Operations
Component:
Sponsor: Senator Dyson
Requester:
Component No.:

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	0.0	0.0	0.0	0.0	0.0	0.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	0.0	0.0	0.0	0.0	0.0	0.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0
Grants & Claims	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CHANGE IN REVENUES ( )	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE (Thousands of Dollars)

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

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

POSITIONS

Full-time	0	0	0	0	0	0
Part-time	0	0	0	0	0	0
Temporary	0	0	0	0	0	0

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

This bill has no fiscal impact to the Department of Corrections.

Prepared by: Jerry D. Burnett, Director — Phone 465-3339
Division: Administrative Services — Date/Time 2/28/03 3:28 PM
Approved by: Portia C.K. Parker, Assistant Commissioner — Date 2/28/2003
Agency: Department of Corrections

(Revised 9/2002 OMB)

Sec. 11.56.815. Tampering with public records in the first degree.

(a) A person commits the crime of tampering with public records in the first degree if the person violates

(1) AS 11.56.820 (a)(3) with intent to obtain a benefit for that person or any person or to injure or deprive another person of a benefit**; or**

(2) AS 11.56.820(a)(1) or (2) which act has the potential to detrimentally affect the health, safety, or welfare of an individual.

(b) Tampering with public records in the first degree is a class C felony.

Sec. 11.56.820. Tampering with public records in the second degree.

(a) A person commits the crime of tampering with public records in the second degree if the person

(1) knowingly makes a false entry in or falsely alters a public record;

(2) knowingly destroys, mutilates, suppresses, conceals, removes, or otherwise impairs the verity, legibility, or availability of a public record, knowing that the person lacks the authority to do so; or

(3) certifies a public record setting out a claim against a government agency, or the property of a government agency, with reckless disregard of whether the claim is lawful, or that payment of the claim is not authorized in the budget of the government agency.

(b) In this section

(1) "certifies" means attesting to the existence, truth, or accuracy of facts, or that one holds an opinion, stated in a public record; the term includes the responsibilities for state officials set out in AS 37.10.030;

(2) "falsely alters" has the meaning ascribed to it in AS 11.46.580 ; and

(3) "makes a false entry" means to change or create a public record, whether complete or incomplete, by means of erasure, obliteration, deletion, insertion of new matter, transposition of matter, or by any other means, so that the record so changed or created states or implies a fact that the maker knows is not true, or states or implies an opinion that the maker does not hold.

(b) Tampering with public records in the second degree is a class A misdemeanor.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 10, 2003

SUBJECT: Tampering with Public Records - CSSB 55( )
(Work Order No. 23-LS0093\H)

TO: Senator Fred Dyson
Attn: Jason

FROM: Gerald P. Luckhaupt
Legislative Counsel

Enclosed is the CS ( ) you requested. I am not convinced that this change eliminates the ambiguity or lack of clarity that has been expressed about the bill. The language you inserted, while present in the Florida law, also depended upon some other language to provide needed clarity and specificity. The full text of the Florida provision is:

> Any person who knowingly falsifies by altering, destroying, defacing, overwriting, removing, or discarding an official record *relating to an individual in the care and custody of a state agency*, **which act has the potential to detrimentally affect the health, safety, or welfare of that individual** commits a felony of the third degree . . . .

So the care and custody is still there. Maybe something like another provision of the Florida legislation is what you want. That provision provides:

> Any person who knowingly falsifies by altering, destroying, defacing, overwriting, removing, or discarding records of the Department of Children and Family Services or its contract provider **with the intent to conceal a fact material to a child abuse protective investigation, protective supervision, foster care and related services, or a protective investigation or protective supervision of a vulnerable adult** . . . is guilty of a felony in the third degree . . . .

I did not choose to go this route originally due to the difficulty in proving specific intent crimes which is compounded in this instance by having to prove that a particular fact is material. But this may be what you want. It would look like this in AS 11.56.815(a):

> (a) A person commits the crime of tampering with public records in the first degree if the person violates

(1) AS 11.56.820(a)(3) with intent to obtain a benefit for that person or any person or to injure or deprive another person of a benefit**; or**

(2) AS 11.56.820(a)(1) or (2) with the intent to conceal a fact material to an investigation or the provision of services under AS 47.10, 47.12, 47.17, or 47.24.

AS 47.10 contains the child in need of aid provisions; AS 47.12 contains the delinquency provisions; AS 47.17 contains the child abuse provisions; and AS 47.24 contains the vulnerable adult provisions.

GPL:lmb
03-071.lmb

Enclosure

23-LS0093\H
Luckhaupt
3/10/03

CS FOR SENATE BILL NO. 55( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-THIRD LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR DYSON

A BILL

FOR AN ACT ENTITLED

"An Act relating to tampering with public records."

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

*** Section 1.** AS 11.56.815(a) is amended to read:

(a) A person commits the crime of tampering with public records in the first degree if the person violates

(1) AS 11.56.820(a)(3) with intent to obtain a benefit for that person or any person or to injure or deprive another person of a benefit**; or**

(2) AS 11.56.820(a)(1) or (2) and that violation has the potential to detrimentally affect the health, safety, or welfare of an individual.

New Text Underlined [DELETED TEXT BRACKETED]

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 2/3/03

FURTHER: Judiciary

Date of 5-Day Notice:_____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3.25.03

Health, Education and Social Services Committee considered

SENATE BILL NO. 55

SB 55 TAMPERING WITH PUBLIC RECORDS

"An Act relating to tampering with public records."

and recommends:

Senate Bill:
[X] same title
[ ] new title
House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR #_____

[X] be **replaced** with _____ **CS** SB 55 (HES)

[ ] adopt **previous** _____ **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#
LAW	3/4		X	

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:		DO PASS	DO NOT PASS	NO REC	AMEND
[signature]	Guess			✓	
[signature]	Green	✓			
[signature]	Dyson	✓			
[signature]	Wilken	✓			
[signature]	Davis	✓			✓
CHAIR:					

SB

78

ALASKA STATE LEGISLATURE

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(907) 376-3157 Fax

Session:
State Capitol
Juneau, Alaska 99801-1182
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SENATOR LYDA GREEN
SENATE DISTRICT G

SPONSOR STATEMENT
SB 78

"An Act relating to an optional group of persons eligible for medical assistance who require treatment for breast and cervical cancer; relating to cost sharing by those recipients under the medical assistance program; providing for an effective date."

Senate Bill 78, the Breast and Cervical Cancer program, removes the sunset provision of the 2001 legislation and continues treatment for women who have been participating in this program and for women who will be diagnosed in the future.

This bill gives authority to the Department of Health and Social Services to impose allowable cost sharing under federal authority for the breast and cervical cancer category. The State would then be able to work with the Federal government by submitting an amended state plan. It also provides for the implementation of a system by which these funds are collected.

I urge your support and swift passage of Senate Bill 78.

Breast & Cervical Cancer
Screening Facts

The Breast and Cervical Cancer Mortality Prevention Act of 1990, authorized the Centers for Disease Control and Prevention (CDC) to fund breast and cervical cancer screening service for low-income women. The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) provides:

- Breast and cervical cancer screening services to low income or un/underinsured women.
- Diagnostic medical follow-up, case management services and assurances for medical treatment.
- Public information and education programs to increase the use of screening services.
- Education to health professionals to improve the screening process.
- Quality monitoring of the screening process.
- Surveillance and epidemiological systems.
- Linkages with key partners.

In Alaska, there are five federally funded NBCCEDP grantees:

- Alaska Dept. of Health & Social Services' Breast and Cervical Health Check (BCHC) program;
- Southcentral Foundation (SCF);
- Southeast Alaska Regional Health Corporation (SEARHC);
- Yukon Kuskokwim Health Corporation (YKHC); and
- Arctic Slope Native Association (ASNA).

Together these programs provide services to nearly 18,000 Alaskan women annually.

Breast & Cervical Health Check (BCHC) is the State of Alaska Department of Health and Social Service's breast and cervical cancer screening program. In operation since March 1995, BCHC services are now available numerous communities statewide. BCHC works closely with tribal corporation colleagues to provide a network of coverage for native and non-native women throughout the State.

BCHC has screened more than 14,000 women since 1995. Seventy cases of breast cancer, 13 cases of cervical cancer, and 446 cases of pre-cancerous cervical disease have been detected among women enrolled in BCHC.

Alaska Native women receive NBCCEDP screening services from four tribal health programs:

- Arctic Slope Native Association (ASNA)
- Southcentral Foundation (SCF)
- Southeast Alaska Regional Health Corporation (SEARHC)
- Yukon/Kuskokwim Health Corporation (YKHC)

The four tribal health programs have screened more than 17,000 women since 1995.

The Burden of Cancer in Alaska

Breast & Cervical Cancer **Occurrence** (1996 – 1999)

	1996	1997	1998	1999
Breast Cancer	265	287	326	294
Cervical Cancer	27	27	31	18

State of Alaska, Cancer Registry Data 2003

Breast & Cervical Cancer **Mortality** (1996 – 1999)

	1996	1997	1998	1999
Breast Cancer	53	41	49	43
Cervical Cancer	6	4	5	6

State of Alaska, Cancer Registry Data 2003

Breast & Cervical Cancer
Treatment in Alaska

The U.S. Congress enacted the Breast & Cervical Cancer Treatment Act in 2000, with very strong bipartisan support. In response to this, the Alaska State Legislature passed legislation allowing women enrolled in CDC funded programs and diagnosed with cancer to access Medicaid funds for cancer treatment.

Who is eligible for "Breast and Cervical" Medicaid?
To qualify for "Breast and Cervical" Medicaid, a woman must be:

- an enrolled client in one of the 5 CDC funded programs in Alaska (BCHC, SCF, SEARHC, YKHC, ASNA) prior to being diagnosed;
- diagnosed by a clinician in one of the 5 CDC programs;
- a resident of the US and have a Social Security Number;
- a resident of Alaska;
- age 18 - 64; and,
- have no creditable medical coverage

How long will each patient's Medicaid coverage last?
Until completion of treatment is determined by the woman's private health care provider.

What treatment services are covered?
Only clinically proven medical or surgical cancer treatments are covered. Such treatments typically include: surgery, chemotherapy or radiation therapy.

Medicaid coverage would end when:

- a woman turns 65 (and becomes Medicare eligible);
- she is no longer a state resident;
- she obtains creditable medical coverage; or
- she is no longer eligible for services from one of the screening and diagnostic programs.

FY02 Statistics on Treatment

- From July 2001 through June 2002, Medicaid paid treatment costs for 44 women with breast or cervical cancer, or a pre-cancerous cervical condition.
- The total cost to the State of Alaska was $174,838.
- Federal funding paid $411,279 of the $586,118 total.
- The State of Alaska does not cover any costs for treatment of Alaska Native or Native American women under this special category of Medicaid. One hundred percent of IHS beneficiary treatment costs are paid for with federal dollars.

FY03 Treatment Projections
An estimated 69 women will qualify and need breast cancer treatment in FY03. Eleven women will need treatment for cervical cancer and 102 for pre-cancerous cervical conditions.

Breast & Cervical Cancer

Sec. 47.07.020. Eligible persons.

(a) All residents of the state for whom the Social Security Act requires Medicaid coverage are eligible to receive medical assistance under 42 U.S.C. 1396 - 1396p (Title XIX, Social Security Act).

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

Sec. 47.07.042. Recipient cost-sharing.

(a) Except as provided in (b) - (d) of this section, the state plan developed under AS 47.07.040 shall impose deductible, coinsurance, and copayment requirements on persons eligible for assistance under this chapter to the maximum extent allowed under federal law and regulations. The plan must provide that health care providers shall collect the allowable charge. The department shall reduce payments to each provider by the amount of the allowable charge. A provider may not deny services because a recipient is unable to share costs, but an inability to share costs imposed under this section does not relieve the recipient of liability for the costs.

(b) The state plan developed under AS 47.07.040 shall impose a copayment requirement for inpatient hospital services in an amount that is the lesser of

(1) $50 a day, up to a maximum of $200 per discharge; or

(2) the maximum allowed under federal law and regulations.

(c) If the department has clear and compelling reason to believe that application of the maximum allowable charges under (a) of this section to a specific service would not reduce state expenditures or would generate savings to the state that are insignificant in relation to the total cost containment possible,

then the department may waive the charges otherwise required under (a) of this section as to that specific service.

(d) In addition to the requirements established under (a) and (b) of this section, the department may require premiums or cost-sharing contributions from recipients who are eligible for benefits under AS 47.07.020(b)(13) and whose household income is between 150 and 200 percent of the federal poverty guideline. If the department requires premiums or cost-sharing contributions under this subsection, the department

(1) shall adopt in regulation a sliding scale for those premiums or contributions based on household income;

(2) may not exceed the maximums allowed under federal law; and

(3) shall implement a system by which the department or its designee collects those premiums or contributions

Sec. 300k. - Establishment of program of grants to States

(a) In general

The Secretary, **acting** through the Director of the Centers for Disease Control and **Prevention**, may make grants to States on the basis of an established competitive review process for the purpose of carrying out programs -

(1)

to screen women for **breast** and cervical **cancer** as a preventive health measure;

(2)

to provide appropriate referrals for medical treatment of women screened pursuant to paragraph (1) and to ensure, to the extent practicable, the provision of appropriate follow-up services and support services such as case management;

(3)

to develop and disseminate public information and education programs for the detection and control of **breast** and cervical **cancer**;

(4)

to improve the education, training, and skills of health professionals (including allied health professionals) in the detection and control of **breast** and cervical **cancer**;

(5)

to establish mechanisms through which the States can monitor the quality of screening procedures for **breast** and cervical **cancer**, including the interpretation

of such procedures; and

(6)

to evaluate activities conducted under paragraphs (1) through (5) through appropriate surveillance or program-monitoring activities.

(b) Grant and contract authority of States

(1) In general

A State receiving a grant under subsection (a) of this section may, subject to paragraphs (2) and (3), expend the grant to carry out the purpose described in such subsection through grants to public and nonprofit private entities and through contracts with public and private entities.

(2) Certain applications

If a nonprofit private entity and a private entity that is not a nonprofit entity both submit applications to a State to receive an award of a grant or contract pursuant to paragraph (1), the State may give priority to the application submitted by the nonprofit private entity in any case in which the State determines that the quality of such application is equivalent to the quality of the application submitted by the other private entity.

(3) Payments for screenings

The amount paid by a State to an entity under this subsection for a screening procedure under subsection (a)(1) of this section may not exceed the amount that would be paid under part B of title XVIII of the Social Security **Act** (42 U.S.C. 1395j et seq.) if payment were made under such part for furnishing the procedure to a woman enrolled under such part.

(c) Special consideration for certain States

In making grants under subsection (a) of this section to States whose initial grants under such subsection are made for fiscal year 1995 or any subsequent fiscal year, the Secretary shall give special consideration to any State whose proposal for carrying out programs under such subsection -

(1)

has been approved through a process of peer review; and

(2)

is made with respect to geographic areas in which there is -

(A)

a substantial rate of mortality from **breast** or cervical **cancer**; or

(B)

a substantial incidence of either of such **cancers**.

(d) Coordinating committee regarding year 2000 health objectives

The Secretary, **acting** through the Director of the Centers for Disease Control and **Prevention**, shall establish a committee to coordinate the activities of the agencies of the Public Health Service (and other appropriate Federal agencies) that are carried out toward achieving the objectives established by the Secretary for reductions in the rate of mortality from **breast** and cervical **cancer** in the United States by the year 2000. Such committee shall be comprised of Federal officers or employees designated by the heads of the agencies involved to serve on the committee as representatives of the agencies, and such representatives from other public or private entities as the Secretary determines to be appropriate

Next

Sec. 1396r-1b. - Presumptive eligibility for certain breast or cervical cancer patients

(a) State option

A State plan approved under section 1396a of this title may provide for making medical assistance available to an individual described in section 1396a(aa) of this title (relating to certain **breast** or **cervical cancer** patients) during a presumptive **eligibility** period.

(b) Definitions

For purposes of this section:

(1) Presumptive **eligibility** period

The term "presumptive **eligibility** period" means, with respect to an individual described in subsection (a) of this section, the period that -

(A)

begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1396a(aa) of this title; and

(B)

ends with (and includes) the earlier of -

(i)

the day on which a determination is made with respect to the **eligibility** of such individual for services under the State plan; or

(ii)

in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

(2) Qualified entity

(A) In general

Subject to subparagraph (B), the term "qualified entity" means any entity that -

(i)

is **eligible** for payments under a State plan approved under this subchapter; and

(ii)

is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

(B) Regulations

The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

(C) Rule of construction

Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

(c) Administration

(1) In general

The State agency shall provide qualified entities with -

(A)

such forms as are necessary for an application to be made by an individual described in subsection (a) of this section for medical assistance under the State plan; and

(B)

information on how to assist such individuals in completing and filing such forms.

(2) Notification requirements

A qualified entity that determines under subsection (b)(1)(A) of this section that an individual described in subsection (a) of this section is presumptively **eligible** for medical assistance under a State plan shall -

(A)

notify the State agency of the determination within 5 working days after the date on which determination is made; and

(B)

inform such individual at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

(3) Application for medical assistance

In the case of an individual described in subsection (a) of this section who is determined by a qualified entity to be presumptively **eligible** for medical assistance under a State plan, the individual shall apply for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made.

(d) Payment

Notwithstanding any other provision of this subchapter, medical assistance that -

(1)

is furnished to an individual described in subsection (a) of this section -

(A)

during a presumptive **eligibility** period;

(B)

by a [1] entity that is **eligible** for payments under the State plan; and

(2)

is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1396d(b) of this title

The National Breast and Cervical Cancer Early Detection Program

Get a free or low-cost mammogram and Pap test.
Go to our program contacts page or call 1-888-842-6355 (select option 7).

Cancer Conference 2003

- Conference Overview
- 2003 Cancer Conference Web Site*

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) builds the infrastructure for breast and cervical cancer early detection by supporting public and provider education, quality assurance, surveillance, and evaluation activities critical to achieving maximum utilization of the screening, diagnostic and case management services. Funded comprehensive early detection programs provide

Featured Article
Invasive Cervical Cancer Incidence Among Hispanic and Non-Hispanic Women — United States, 1992-1999

- Breast and cervical cancer screening services to women who are low income and to racial/ethnic minorities.
- Appropriate referrals, and when necessary, appropriate diagnostic follow-up, case management and assurances for medical treatment.
- Public information and education programs to increase the use of screening services.
- Education to health professionals to improve the screening process.
- Mechanisms to monitor the quality of the screening process.
- Appropriate surveillance and epidemiological systems.
- Linkages with key partnerships.

Breast Cancer and Mammography Information | Cervical Cancer and Pap test Information

"Early detection through screening is our best defense against morbidity and mortality from breast and cervical cancers and precancers. Since 1990, the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) has been working in states, U.S. Territories, and tribal organizations to ensure women with little or no insurance have access to lifesaving cancer screening, diagnostic, and treatment services. As of 2002, the NBCCEDP has provided breast and cervical cancer screening services to more than 1.5 million uninsured and underinsured women."

Julie L. Gerberding, MD, MPH, Director,
Centers for Disease Control and Prevention

Please note: Some of these publications are available for download only as *.pdf files. These files require Adobe Acrobat Reader in order to be viewed. Please review the information on using and downloading Acrobat Reader software.

Congress established The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) in 1991 by enacting the Breast and Cervical Cancer Mortality Prevention Act of 1990, Public Law 101-354 (PDF-37K). This act authorizes CDC to provide critical breast and cervical cancer screening services to underserved women, including older women, women with low incomes, and women of racial and ethnic minority groups. Reauthorization of the program and changes to the law since its passage are described in the document below.

National Breast and Cervical Cancer Early Detection Program: Authorizing and Related Legislation

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Páginas del internet sobre el cáncer en español

- Información sobre el cáncer de seno y la mamografia

Public Law 106–354
106th Congress

An Act

To amend title XIX of the Social Security Act to provide medical assistance for certain women screened and found to have breast or cervical cancer under a federally funded screening program, to amend the Public Health Service Act and the Federal Food, Drug, and Cosmetic Act with respect to surveillance and information concerning the relationship between cervical cancer and the human papillomavirus (HPV), and for other purposes.

Oct. 24, 2000
[H.R. 4386]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Breast Cancer Prevention and Treatment Act of 2000.
42 USC 1305 note.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Breast and Cervical Cancer Prevention and Treatment Act of 2000".

SEC. 2. OPTIONAL MEDICAID COVERAGE OF CERTAIN BREAST OR CERVICAL CANCER PATIENTS.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(A) in subclause (XVI), by striking "or" at the end;

(B) in subclause (XVII), by adding "or" at the end; and

(C) by adding at the end the following:

"(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients);".

(2) GROUP DESCRIBED.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following:

"(aa) Individuals described in this subsection are individuals who—

"(1) are not described in subsection (a)(10)(A)(i);

"(2) have not attained age 65;

"(3) have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention breast and cervical cancer early detection program established under title XV of the Public Health Service Act (42 U.S.C. 300k et seq.) in accordance with the requirements of section 1504 of that Act (42 U.S.C. 300n) and need treatment for breast or cervical cancer; and

"(4) are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)).".

(3) LIMITATION ON BENEFITS.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G)—

(A) by striking "and (XIII)" and inserting "(XIII)"; and

(B) by inserting ", and (XIV) the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer" before the semicolon.

(4) CONFORMING AMENDMENTS.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(A) in clause (xi), by striking "or" at the end;

(B) in clause (xii), by adding "or" at the end; and

(C) by inserting after clause (xii) the following:

"(xiii) individuals described in section 1902(aa),".

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920A the following:

"PRESUMPTIVE ELIGIBILITY FOR CERTAIN BREAST OR CERVICAL CANCER PATIENTS

42 USC 1396r-1b.

"SEC. 1920B. (a) STATE OPTION.—A State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(aa) (relating to certain breast or cervical cancer patients) during a presumptive eligibility period.

"(b) DEFINITIONS.—For purposes of this section:

"(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term 'presumptive eligibility period' means, with respect to an individual described in subsection (a), the period that—

"(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(aa); and

"(B) ends with (and includes) the earlier of—

"(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

"(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

"(2) QUALIFIED ENTITY.—

"(A) IN GENERAL.—Subject to subparagraph (B), the term 'qualified entity' means any entity that—

"(i) is eligible for payments under a State plan approved under this title; and

"(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

"(B) REGULATIONS.—The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

"(C) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

"(c) ADMINISTRATION.—

"(1) IN GENERAL.—The State agency shall provide qualified entities with—

"(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

"(B) information on how to assist such individuals in completing and filing such forms.

"(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

"(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

"(B) inform such individual at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

"(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made.

"(d) PAYMENT.—Notwithstanding any other provision of this title, medical assistance that—

"(1) is furnished to an individual described in subsection (a)—

"(A) during a presumptive eligibility period;

"(B) by a entity that is eligible for payments under the State plan; and

"(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).".

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: "and provide for making medical assistance available to individuals described in subsection (a) of section 1920B during a presumptive eligibility period in accordance with such section".

(B) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

(i) by striking "or for" and inserting ", for"; and

(ii) by inserting before the period the following: ", or for medical assistance provided to an individual described in subsection (a) of section 1920B during a presumptive eligibility period under such section".

(c) ENHANCED MATCH.—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended—

(1) by striking "and" before "(3)"; and

(2) by inserting before the period at the end the following: ", and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 2105(b) with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII)".

Applicability. 42 USC 1396a note.

(d) EFFECTIVE DATE.—The amendments made by this section apply to medical assistance for items and services furnished on or after October 1, 2000, without regard to whether final regulations to carry out such amendments have been promulgated by such date.

Approved October 24, 2000.

LEGISLATIVE HISTORY—H.R. 4386 (S. 662):

SENATE REPORTS: No. 106–323 accompanying S. 662 (Comm. on Finance).
CONGRESSIONAL RECORD, Vol. 146 (2000):
May 9, considered and passed House.
Oct. 4, considered and passed Senate, amended, in lieu of S. 662.
Oct. 12, House concurred in Senate amendment.
WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 36 (2000):
Oct. 24, Presidential statement.

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FISCAL NOTE

STATE OF ALASKA
2003 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB78
( ) Publish Date:

Revision Date/Time (Note if correction): Corrected 2/24/03
Dept. Affected: Health & Social Services

Title: MEDICAID FOR BREAST AND CERVICAL CANCER
BRU: Medical Assistance
Component: Medicaid Services

Sponsor: GREEN
Requester: SENATE (HES0
Component No.: 2077

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	970.0	1,108.8	1,265.6	1,442.6	1,642.5	1,867.8
Miscellaneous						
TOTAL OPERATING	**970.0**	**1,108.8**	**1,265.6**	**1,442.6**	**1,642.5**	**1,867.8**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts	687.5	785.8	896.9	1,022.4	1,164.0	1,323.7
1003 GF Match	282.5	323.0	368.7	420.2	478.5	544.1
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
TOTAL	**970.0**	**1,108.8**	**1,265.6**	**1,442.6**	**1,642.5**	**1,867.8**

Estimate of any current year (FY2003) cost: 847.3
Mark 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 legislation continues the optional breast and cervical cancer Medicaid eligibility category, which is due to sunset June, 30, 2003. This legislation also authorizes recipient premiums and cost-sharing to the maximum extent allowed under federal law.

In FY2002 Medicaid spent $584,364 ($403,032 Federal funds, $181,332 general funds) to pay for the treatment costs of 22 women diagnosed with breast cancer, 9 diagnosed with cervical cancer, and 13 with pre-cancerous cervical conditions. In future years we expect expenditures to grow at a rate typical of general Medicaid expenditures, but with only a slight increase in the number of individuals taking advantage of this eligibility category. See our assumptions on the next page.

Prepared by: Kevin Henderson — Phone 465-5821
Division: Medical Assistance — Date/Time 02/21/2003
Approved by: Joel S. Gilbertson, Commissioner — Date 02/24/2003
Agency: Department of Health and Social Services

FISCAL NOTE
FN #

STATE OF ALASKA
2003 LEGISLATIVE SESSION

BILL NO. SB7

ANALYSIS CONTINUATION

Assumptions used in making this fiscal note:

1. The number of women who have taken advantage of this program is lower than the numbers projected last year by the Division of Public Health. Part of the reason for the reduced number of eligibles is that Alaska Native women screened and diagnosed by the four tribal grantees are not applying for Medicaid. The number of anticipated recipients is expected to increase slightly. We assume a 5% increase in total recipients for each fiscal year.

2. To estimate future expenditures, we began by looking at the cost of services provided to women eligible under the breast and cervical cancer category in FY2002. The average cost per recipient in FY2002 was $24.0 for breast cancer, $4.9 for cervical cancer, and $.8 for precancerous cervical conditions. However, the trend for FY 03 appears to be 45% higher than FY2002. The program was new in FY 2002, so we believe the FY2003 increase seen so far is due to the fact that current recipients have had time to move from needing treatment to actually being in or having received full treatment. We established a FY2003 base cost that is 45% higher than FY2002. Beginning with FY 2004 we estimate that Medicaid expenditures in this category will grow at a rate of 10% per year, similar to the national average growth for Medicaid spending.

The enhanced federal match rate used is 70.87%.

Funding for this bill is in the Division's base budget, however, the Governor's FY2004 Budget has not been finalized at this point.

Cost-Sharing: This legislation authorizes the department to charge recipient premiums or impose the maximum allowed cost-sharing requirements on recipients based upon household income and using a sliding fee scale. Except for the Working Disabled Medicaid Buy-In eligibility category, Federal law and regulations prohibit states from imposing a premium on "categorically needy individuals", including the breast and cervical cancer category. The department does have authority to impose "nominal" deductibles, coinsurance, or co-payments for recipients in this category. 7 AAC 43.052 already imposes the maximum allowable co-insurance payment for outpatient hospital services, the maximum $3 co-payment for each physician visit, a $2 co-payment for each prescription drug filled, and $50 co-payment per day of inpatient hospitalization (up to a maximum $200). Federal regulations allow states to require a monthly deductible amount capped at $2 per month per family member, but prohibit states from imposing more than one type of charge at the same time. Slight increases may be made in hospital co-payments and prescription drugs (depending upon the cost of the drug), but considering the small number of recipients the revenue would be negligible and was not estimated.