LAWS OF ALASKA

1986

Source

SCS CSHB 98(Fin)

Chapter No.

105

AN ACT

Relating to medical assistance; and providing for an effective date.

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

THE ACT FOLLOWS ON PAGE 1, LINE 9

UNDERLINED MATERIAL INDICATES TEXT THAT IS BEING ADDED TO THE LAW AND BRACKETED MATERIAL IN CAPITAL LETTERS INDICATES DELETIONS FROM THE LAW; COMPLETELY NEW TEXT OR MATERIAL REPEALED AND RE-ENACTED IS IDENTIFIED IN THE INTRODUCTORY LINE OF EACH BILL SECTION.

Approved by the Governor: June 6, 1986
Actual Effective Date: June 7, 1986

Chapter 105

AN ACT

Relating to medical assistance; and providing for an effective date.

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

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

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

1 shall make a good faith effort to notify the medical provider of the
2 judicial or administrative finding if the department has reason to
3 believe that services have been provided to the beneficiary.
4 (c) The commissioner of health and social services may authorize
5 payment to a medical provider of a claim not promptly filed, upon good
6 cause shown. Payments under this subsection may not exceed 50 percent
7 of the allowable charges presented in the claim.
8 (d) In this section,
9 (1) "beneficiary" means a person who is found to be eligi-
10 ble to receive medical services under AS 47.07 or AS 47.25.120 -
11 47.25.300;
12 (2) "medical provider" means a person, firm, corporation,
13 association, or institution that, on the date of service, was approved
14 to provide medical assistance, in accordance with regulations adopted
15 by the Department of Health and Social Services.
16 * Sec. 2. AS 47.05 is amended by adding a new section to read:
17 Sec. 47.05.070. THIRD PARTY LIABILITY SUBROGATION. (a) The
18 department may not pay medical claims that are payable by a third
19 party payor. Medical providers shall attempt collection from the
20 third party payor before billing Medicaid. Before payment by
21 Medicaid, evidence of third-party denial or partial payment shall be
22 presented with the claim.
23 (b) If the department provides or pays for medical assistance
24 for injury or illness under this title, the department is subrogated
25 to the rights of the recipient of that medical assistance for any
26 claim arising from the injury or illness and to the proceeds of an
27 insurance policy covering the injury or illness to the extent of the
28 value of the medical assistance provided.
29 (c) If a recipient of medical assistance under this title

settles a claim or obtains an award or judgment arising from the injury or illness for which the medical assistance was received, the department shall reimburse the recipient for attorney fees and costs commensurate with the amount of the settlement, award, or judgment to which the department is entitled under (b) of this section. Regardless of the manner in which the amount of the attorney fees is derived, reimbursement of attorney fees shall be in accordance with the applicable rules of court governing the award of attorney fees in civil matters.

(d) The department is authorized to enter into contracts for the collection of medical expenses already paid by Medicaid from potential third-party payors. The department may pay, from the funds recovered by the contractor, any amounts owing to the federal government as its share of the Medicaid paid claim, and the costs of collecting the funds.

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

(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:

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

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

(3) persons under <u>age</u> 21 <u>who are</u> [YEARS OF AGE] under

1 supervision of the department, for whom maintenance is being paid in
2 whole or in part from public funds, and who are in foster homes or
3 private child-care institutions;

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

11 (5) persons under age 21 who are [YEARS OF AGE] in an
12 institution designated as an intermediate care facility for the men-
13 tally retarded and who are financially eligible as determined by the
14 standards of the federal aid to families with dependent children
15 program;

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

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

26 (8) persons under age 21 and not covered under (a) of this
27 section, [YEARS OF AGE] who would be eligible for benefits under the
28 federal aid to families with dependent children program, except that
29 they have the care and support of both their natural and adoptive

1 parents [BUT WHO DO NOT QUALIFY BECAUSE THEY ARE NOT DEPENDENT CHILD-
2 REN];
3 (9) [WOMEN WHO ARE] pregnant women not covered under (a) of
4 this section and who meet the income and resource requirements of the
5 federal aid to families with dependent children program.
6 * Sec. 4. AS 47.07.030 is repealed and reenacted to read:
7 Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. (a) The de-
8 partment shall offer all mandatory services required under 42 U.S.C.
9 1396 - 1396p (Title XIX of the Social Security Act).
10 (b) In addition to the mandatory services specified in (a) of
11 this section, the department may offer only the following optional
12 services: personal care services in a recipient's home; emergency
13 hospital services; long-term care noninstitutional services; medical
14 supplies and equipment; clinic services; inpatient psychiatric facili-
15 ty services for individuals age 65 or older and individuals under age
16 21; physical therapy; occupational therapy; chiropractic services;
17 treatment of speech, hearing, and language disorders; adult dental
18 services; prosthetic devices and eyeglasses; optometrists' services;
19 intermediate care facility services, including intermediate care
20 facility services for the mentally retarded; skilled nursing facility
21 services for individuals under age 21; and reasonable transportation
22 to and from the point of medical care.
23 * Sec. 5. AS 47.07.035 is repealed and reenacted to read:
24 Sec. 47.07.035. PRIORITY OF MEDICAL ASSISTANCE. If the depart-
25 ment finds that the cost of medical assistance for all persons eligi-
26 ble under this chapter will exceed the amount allocated in the state
27 budget for that assistance for the fiscal year, the department shall
28 eliminate coverage for optional medical services and optionally eligi-
29 ble groups of individuals in the following order:

1 (1) chiropractic services;
2 (2) adult dental services;
3 (3) emergency hospital services;
4 (4) treatment of speech, hearing, and language disorders;
5 (5) optometrists' services and eyeglasses;
6 (6) occupational therapy;
7 (7) prosthetic devices;
8 (8) medical supplies and equipment;
9 (9) clinic services;
10 (10) physical therapy;
11 (11) personal care services in a recipient's home;
12 (12) long-term care noninstitutional services;
13 (13) inpatient psychiatric facility services;
14 (14) intermediate care facility services for the mentally
15 retarded;
16 (15) intermediate care facility services;
17 (16) individuals under age 21 who are not eligible for
18 benefits under the federal aid to families with dependent children
19 program because they are not deprived of one or more of their natural
20 or adoptive parents;
21 (17) skilled nursing facility services for persons under age
22 21;
23 (18) aged, blind, and disabled individuals who, because they
24 do not meet the income requirements, do not receive supplemental
25 security income under Title XVI of the Social Security Act, but who
26 are eligible, or would be eligible if they were not in a skilled
27 nursing facility or intermediate care facility, to receive an optional
28 state supplementary payment;
29 (19) individuals in a hospital, skilled nursing facility, or

intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under Title XVI of the Social Security Act, but who, because of income, are not eligible for the optional state supplementary payment;

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

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

Sec. 47.07.040. STATE PLAN FOR PROVISION OF MEDICAL ASSISTANCE. The department shall prepare a state plan in accordance with the provisions of 42 U.S.C. 1396 1396p (Title XIX, Social Security Act, Medical Assistance) and submit it for approval to the United States Department of Health and Human Services. The plan shall designate that the Department of Health and Social Services is the single state agency to administer this plan. The department shall act for the state in any negotiations relative to the submission and approval of the plan. The department, including the Medicaid Rate Commission, [AND] may make those arrangements or regulatory changes, not inconsistent with law, as may be required under federal law to obtain and retain approval of the United States Department of Health and Human Services to secure for the state the optimum federal payment under the provisions of 42 U.S.C. 1396 - 1396p (Title XIX, Social Security Act, Medical Assistance). In addition, the department shall provide a report to the legislature no later than March 15 of each year concerning the status of this program and recommendations, with supporting fiscal data, as to any changes in the coverage of eligible persons or services to be provided.

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

1 (d) In determining a rate of payment to a health facility under
2 this section, the commission shall consider the appropriation limit
3 set by the legislature for the department's programs under this chap-
4 ter and under AS 47.25.120 - 47.25.300, and available federal revenue.
5 * Sec. 8. AS 47.07.180 is repealed and reenacted to read:
6 Sec. 47.07.180. DUTIES. (a) The commission shall review pro-
7 posed payment rates and may review budgets of health facilities and
8 establish payment rates for health facilities under this chapter and
9 AS 47.25.120 - 47.25.300.
10 (b) The commission shall consult with the department on the
11 state plan as it relates to health facilities. The commission may not
12 change the unit of payment without the written consent of the depart-
13 ment.
14 (c) When the department enters into a substantially revised
15 state plan under AS 47.07.040, and when, as part of the revised state
16 plan, the commission adopts regulations which substantially change the
17 methods used or the factors considered in determining the prospective
8 payment rates, the commission may, at its discretion, redetermine the
9 prospective payment rates for all facilities from the effective date
of the new regulations forward. Each redetermined rate will be effec-
tive from the date of the commission's new order as to each facility.
(d) By March 1 of each year, the commission shall develop for
the fiscal year starting the next July 1 an annual estimate of medical
assistance program expenditures in health facilities under the juris-
diction of the commission. The estimate shall consider anticipated
utilization and payment rates for each facility. The methodology used
by the commission to develop the estimate shall be consistent with the
regulations governing the commission's rate-setting process.
* Sec. 9. AS 47.07.900(1) is amended to read:

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

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

7 (7) "adult dental services" means minimum treatment for the
8 immediate relief of pain and acute infection provided by a licensed
9 dentist;

10 (8) "chiropractic services" includes only services that are
11 provided by a chiropractor licensed under AS 08.20 that consist of
12 treatment by means of manual manipulation of the spine and x-rays
13 necessary for treatment;

14 (9) "emergency hospital services" means services that

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

17 (B) because of the threat to the life or health of the
18 individual, necessitate the use of the most accessible hospital
19 available that is equipped to furnish the services, even if the
20 hospital does not currently meet

21 (i) the conditions for participation under Medi-
22 care; or

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

25 (10) "personal care services in a recipient's home" mean
26 services prescribed by a physician in accordance with the recipient'
27 plan of treatment and provided by an individual who is

28 (A) qualified to provide the services;

29 (B) supervised by a registered nurse; and

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

2 * Sec. 11. AS 47.25.130 is amended by adding a new subsection to read:

3 (b) The department may enter into competitively awarded group
4 service agreements with providers, and may require needy persons under
5 AS 47.25.120 - 47.25.300 to obtain services from these designated
6 providers.

7 * Sec. 12. AS 47.25.195 is amended by adding new subsections to read:

8 (d) If insufficient money is appropriated to fund medical assis-
9 tance under AS 47.25.120 - 47.25.300 when taking into consideration
10 projected use and the health facility payment rates established in
11 accordance with (b) of this section, the department may, by regu-
12 lation, establish at any time in the fiscal year a prospective pro
13 rata reduction of the facilities' established payment rates that will
14 be paid by the department for services provided by facilities under
5 AS 47.25.120 - 47.25.300;

(e) Notwithstanding (a) - (d) of this section, the department
may enter into agreements with any facility to provide services at a
payment rate lower than the rate established in accordance with (b) of
this section.

* Sec. 13. AS 47.25 is amended by adding a new section to read:

Sec. 47.25.205. PRIORITY OF GENERAL RELIEF MEDICAL ASSISTANCE.
If the department finds that the cost of medical assistance for all
persons eligible under AS 47.25.120 - 47.25.300 will exceed the amount
allocated in the state budget for that assistance for the fiscal year,
the department shall eliminate coverage for medical services in the
following order:

(1) treatment of speech, hearing, and language disorders;

(2) optometrists' services and eyeglasses;

(3) occupational therapy;

(4) emergency dental services for adults;

(5) prosthetic devices not including dentures;

(6) medical supplies and equipment;

(7) physical therapy;

(8) outpatient laboratory and outpatient x-ray services;

(9) ambulatory surgical center services;

(10) nonemergency medical transportation;

(11) outpatient physician services;

(12) outpatient hospital services;

(13) intermediate care facility services;

(14) skilled nursing facility services;

(15) emergency medical transportation;

(16) pharmaceuticals;

(17) inpatient physician services;

(18) inpatient hospital services.

* Sec. 14. AS 44.77.010(b) is repealed.

* Sec. 15. This Act takes effect immediately in accordance with AS 01.-10.070(c).