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 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). (§ 1 ch 182 SLA 1972; am § 6 ch 105 SLA 1986; am E.O. No. 72 § 3 (1989); am § 32 ch 126 SLA 1994)

Effect of amendments. — The 1994 amendment, effective July 1, 1994, deleted the former last sentence, relating to the annual departmental report concerning the status of the state plan for the provision of medical assistance and recommended changes in the coverage of eligible persons and services.

Sec. 47.07.042. Recipient cost-sharing. (a) Except as provided in (b) and (c) of this section, the state plan developed under AS 47.07.040 shall impose deductible, coinsurance, and copayment requirements or similar charges 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. (§ 20 ch 102 SLA 1994)

Cross references. — For legislative purposes in enacting this section, see § 1, ch. 102, SLA 1994 in the Temporary and Special Acts.

Effective dates. — Section 20, ch. 102, SLA 1994, which enacted this section, took effect on September 7, 1994.

Editor's notes. — Section 22, ch. 102, SLA 1994 provides that the charges provided for under this section "apply to services performed on or after July 1, 1994."

Sec. 47.07.055. Recovery of medical assistance from estates. (a) The estate of an individual who received medical assistance payments is subject to a claim for recovery of the medical assistance after the individual's death that, except as provided in (b) of this section, may be secured by a lien filed against the individual's real property during the individual's lifetime if the

(1) individual was an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution;

(2) department required the individual, as a condition of receiving medical assistance under this chapter, to spend for medical expenses all but a minimal amount of that individual's income; and

(3) department determined during the individual's lifetime, after notice and opportunity for hearing, that the individual could not reasonably be expected to be discharged from the institution and to return home.

(b) A lien may not be filed under (a) of this section against an individual's home if the home is lawfully occupied by the individual's

(1) spouse;

(2) child under age 21;

(3) blind or disabled child as described in AS 47.25.615(3) or (5) or 42 U.S.C. 1382(c); or

(4) sibling, if the sibling has an equity interest in the home and was residing in the home for at least one year before the date of the individual's admission to the institution.

(c) The state may not recover the costs of medical assistance under a lien on a home under (a) of this section until after the death of the individual's surviving spouse, if any, and only at a time when neither of the following is lawfully residing in the home:

(1) a sibling of the individual who was residing in the individual's home for a period of at least one year immediately preceding the date of the individual's institutionalization and who has continuously resided in the home since the institutionalization began; or

(2) a son or daughter of the individual who

(A) resided in the home for at least two years immediately preceding the date of the individual's institutionalization;

(B) has continuously resided in the home since the institutionalization began; and

(C) establishes to the department's satisfaction that the son or daughter provided care to the individual that allowed the individual to reside in the home rather than in an institution.

(d) A lien and claim authorized under (a) of this section are extinguished if, during the individual's lifetime, the individual is discharged from the institution and returns home. However, a new lien and claim are authorized for subsequent expenses if the circumstances described in (a) of this section occur after the individual returns home.

(e) In addition to recovery of medical assistance upon sale of property subject to a lien authorized under (a) — (d) of this section, after an individual's death, the individual's estate is subject to a claim for reimbursement for medical assistance payments made on behalf of the individual under this chapter for the following services to the extent that those services were provided when the individual was 55 years of age or older:

(1) services received while an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institutions; and

(2) home and community-based services provided through a waiver received from the federal government that allows home and community-based services to be covered under this chapter for persons who are eligible for coverage under this chapter while in an institution but who are able to avoid institutionalization because of the provision of home and community-based services.

(f) Other than a recovery upon sale of a home, a claim under this section may be made only after the death of the individual's surviving spouse, if any, and only at a time when the individual has no surviving child under age 21 and no surviving child who is blind or totally and permanently disabled.

(g) For purposes of AS 13.16.470, the claims authorized under this section are debts with preference under the laws of the state. (§ 21 ch 102 SLA 1994)

Cross references. — For legislative purposes in enacting this section, see § 1, ch. 102, SLA 1994 in the Temporary and Special Acts.

Effective dates. — Section 21, ch. 102, SLA 1994, which enacted this section, took effect on September 7, 1994.

Sec. 47.07.070. Payment to health facilities.

NOTES TO DECISIONS

"Fair rate" of compensation. — The state statutory standard of a "fair rate" does not require the state to compensate a provider fully for increases in workers' compensation insurance. State and federal law mandate only that the overall rate paid to a facility be fair in relation to the costs incurred by the facility, not that each component of a facility's costs be compensated at a fair rate. State, Dep't of Health & Social Serv. v. Hope Cottages, Inc., 863 P.2d 246 (Alaska 1993).

Federal reimbursement requirements. — Federal Medicaid law, specifically the Boren Amendment to 42 U.S.C. § 1396a, does not require actual reimbursement of a providers costs. State, Dep't of Health & Social Serv. v. Hope Cottages, Inc., 863 P.2d 246 (Alaska 1993).

Reimbursement on modified cost basis. — Under the regulatory scheme in Alaska, a Medicaid facility is reimbursed based on a modified "cost plus" basis—actual operating costs incurred two fiscal years ago plus an inflation factor anticipating capital improvement costs. State, Dep't of Health & Social Serv. v. Hope Cottages, Inc., 863 P.2d 246 (Alaska 1993).

Sec. 47.07.072. Report by the department [Repealed, § 35 ch 126 SLA 1994.]

Sec. 47.07.900. Definitions.

In this chapter

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

(2) "advanced nurse practitioner services" means services furnished by a person who is certified as an advanced nurse practitioner under AS 08.68.410 that are within the scope of the person's certified authority, whether or not the person is under the supervision of, or associated with, a physician or other health care provider;

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

(4) "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;

(5) "clinical social workers' services" means clinical social work services provided by a person licensed as a clinical social worker under AS 08.95;

(6) "commission" means the Medicaid Rate Advisory Commission;

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

(8) "emergency hospital services" means services that

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

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

(i) the conditions for participation under Medicare; or

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

(9) "emotionally disturbed or chronically mentally ill adults" and "severely emotionally disturbed persons under age 21" include only persons who receive mental health services from an entity that has a contract to provide community mental health services under AS 47.30.520 — 47.30.620;

(10) "eyeglasses" are lenses, including frames when necessary, and other aids to vision prescribed by a physician skilled in diseases of the eye, or by an optometrist, whichever the patient may select, to aid or improve vision;

(11) "health facility" includes a hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic;

(12) "hospice care" means services to a terminally ill individual of the type and under the circumstances described in 42 U.S.C. 1396d(o), as amended, and applicable federal regulations;

(13) "midwife services" means services within the practice of midwifery, as defined in AS 08.65.190, that are performed by a certified direct-entry midwife and miscellaneous fees, other than facility fees, for birth kits, oxygen, and other ancillary expenses necessary for a birth attended by a certified direct-entry midwife;

(14) "nurse midwife" means a registered professional nurse who is certified as an advanced nurse practitioner under AS 08.68.410(1) and authorized to practice as a nurse midwife under regulations adopted in accordance with AS 08.68.410(8);

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

(A) qualified to provide the services;

(B) supervised by a registered nurse; and

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

(16) "psychologists' services" means services within the practice of psychology provided by a person licensed as a psychologist or psychological associate under AS 08.86;

(17) "rehabilitative services" means services for substance abusers and emotionally disturbed or chronically mentally ill adults provided by

(A) a drug or alcohol treatment center that is funded with a grant under AS 47.30.475; or

(B) an outpatient community mental health clinic that has a contract to provide community mental health services under AS 47.30.520 — 47.30.620;

(18) "substance abuser" means a person who

(A) is an alcoholic, as defined in AS 47.37.270;

(B) participates in inhalant abuse, as defined in AS 47.37.270; or

(C) misuses illegal or prescription drugs;

(19) "targeted case management services" means case management services for substance abusers, chronically mentally ill adults, and severely emotionally disturbed persons under age 21 that are provided by

(A) a drug or alcohol treatment center that is funded with a grant under AS 47.30.475; or

(B) an outpatient community mental health clinic that has a contract to provide community mental health services under AS 47.30.520 — 47.30.620. (§ 1 ch 182 SLA 1972; am § 2 ch 12 SLA 1976; am § 3 ch 221 SLA 1976; am § 26 ch 40 SLA 1981; am § 4 ch 132 SLA 1982; am §§ 5, 10 ch 95 SLA 1983; am § 3 ch 20 SLA 1986; am §§ 9, 10 ch 105 SLA 1986; am E.O. No. 72 § 12 (1989); am § 3 ch 70 SLA 1991; am § 3 ch 38 SLA 1992; am § 3 ch 110 SLA 1992; am § 4 ch 51 SLA 1993; am § 3 ch 75 SLA 1993)

Revisor's notes. — Formerly AS 47.07.080. Renumbered in 1983, at which time it was reorganized to alphabetize the defined terms. Reorganized in 1986, 1991, 1992, and 1993 to maintain alphabetical order.

Effect of amendments. — The 1991 amendment, effective September 19, 1991, added paragraphs (4) (now (5)) and (12) (now (16)).

The first 1992 amendment, effective July 1, 1992, added paragraphs (9) and (15)-(17) (now (17) — (19)).

The second 1992 amendment, effective September 20, 1992, added paragraph (2).

The first 1993 amendment, effective July 1, 1993, added paragraph (13).

The second 1993 amendment, effective January 1, 1994, added paragraph (12).

Chapter 10. Delinquent Minors and Children in Need of Aid.

Article
1. Children's Proceedings (§§ 47.10.010, 47.10.020, 47.10.060 — 47.10.072, 47.10.080, 47.10.081, 47.10.084, 47.10.090 — 47.10.093, 47.10.097, 47.10.120 — 47.10.142)
2. Juvenile Institutions (§§ 47.10.150 — 47.10.190)
3. Care of Children (§§ 47.10.230, 47.10.270, 47.10.290)
4. Programs for Runaway Minors (§§ 47.10.300, 47.10.310, 47.10.330, 47.10.350)
4A. Shelters for Runaway Minors (§§ 47.10.392 — 47.10.399)
5. Citizens' Review Panel for Permanency Planning (§ 47.10.410)
6. General Provisions (§ 47.10.990)

NOTES TO DECISIONS

Cited in Allam v. State, 830 P.2d 435 (Alaska Ct. App. 1992).

Article 1. Children's Proceedings.

Section
10. Jurisdiction
20. Investigation and petition
60. Waiver of jurisdiction
70. Hearings
72. [Repealed]
80. Judgments and orders
81. Predisposition hearing reports
84. Legal custody, guardianship, and residual parental rights and responsibilities
90. Court records
92. Parental right to disclose information
93. Disclosure of agency records
97. Fingerprinting of minors
120. Support of minor
130. Detention
140. Temporary detention and detention hearing
141. Runaway and missing minors
142. Emergency custody and temporary placement hearing

ALASKA STATUTES

Title 47

Welfare, Social Services and Institutions

OCTOBER 1990

TN #: 95-06 DATE APPROVED: July 2, 1996
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Alaska Statutes

Title 47. Welfare, Social Services and Institutions.

Chapter

05. Administration of Welfare, Social Services and Institutions (§§ 47.05.010 — 47.05.080)
07. Medical Assistance for Needy Persons (§§ 47.07.010 — 47.07.900)
08. Catastrophic Illness Assistance (§§ 47.08.010 — 47.08.140)
10. Delinquent Minors and Children in Need of Aid (§§ 47.10.010 — 47.10.990)
15. Uniform Interstate Compact on Juveniles (§§ 47.15.010 — 47.15.080)
17. Child Protection (§§ 47.17.010 — 47.17.290)
20. Exceptional Children (§§ 47.20.005 — 47.20.050)
21. Adventure-Based Education (§§ 47.21.010, 47.21.020)
24. Protection of Elderly Persons and Disabled Adults (§§ 47.24.010 — 47.24.120)
25. Public Assistance (§§ 47.25.120 — 47.25.990)
30. Mental Health (§§ 47.30.350 — 47.30.915)
35. Private Institutions (§§ 47.35.010 — 47.35.900)
37. Uniform Alcoholism and Intoxication Treatment Act (§§ 47.37.010 — 47.37.270)
40. Purchase of Services (§§ 47.40.011 — 47.40.120)
45. Alaska Longevity Bonus (§§ 47.45.010 — 47.45.160)
55. Pioneers' Home (§§ 47.55.010 — 47.55.100)
60. Multi-Purpose Senior Centers (§§ 47.60.010 — 47.60.090)
65. Service Programs for Older Alaskans and Other Adults (§§ 47.65.010 — 47.65.290)
70. Interstate Compact on the Placement of Children (§§ 47.70.010 — 47.70.080)
75. Social Services Planning (§§ 47.75.010 — 47.75.060)
80. Persons with Handicaps (§§ 47.80.010 — 47.80.900)
90. Displaced Homemakers (§§ 47.90.010 — 47.90.070)

Revisor's notes. — The provisions of this title were redrafted in 1984 to remove personal pronouns pursuant to § 4, ch. 58, SLA 1982, and in 1984 and 1990 to make other minor word changes.

custody and care and adequate planning for permanent placement of the child. (§ 2 ch 152 SLA 1976; am § 2 ch 29 SLA 1990)

Effect of amendments. — The 1990 amendment substituted "unless efforts to preserve and strengthen the ties are likely to result in physical or emotional damage to the child" for "whenever possible" near the middle, and added "and adequate planning for permanent placement of the child" at the end of the section.

NOTES TO DECISIONS

Editor's notes. — Many of the cases cited in the notes below were decided under former AS 47.10.280.

Protection of children is the paramount purpose governing enactment of laws pertaining to children's courts and institutions. In re A Minor Child, 490 P.2d 658 (Alaska 1971).

Notions of benevolent protective policies cannot be used to validate departures from positive law relating to the adjudicative and dispositive phases of children's proceedings. In re A Minor Child, 490 P.2d 658 (Alaska 1971).

Nor to justify dispensing with constitutional safeguards. — The benevolent social theory supposedly underlying children's court acts does not furnish justification for dispensing with constitutional safeguards. In re A Minor Child, 490 P.2d 658 (Alaska 1971).

The purpose of the supervision or treatment contemplated by the creation of the child in need of supervision [now child in need of aid] and its predecessor noncriminal delinquency was reintegration of the child into her family and resumption of parental custody including parental control. L.A.M. v. State, 547 P.2d 827 (Alaska 1976).

Applied in E.A. v. State, 623 P.2d 1210 (Alaska 1981); Rita T. v. State, 623 P.2d 344 (Alaska 1981).

Quoted in In re J.R.B., 715 P.2d 1170 (Alaska 1986); In re A.S., 740 P.2d 432 (Alaska 1987).

Stated in D.H. v. State, 723 P.2d 1274 (Alaska 1986).

Sec. 47.05.070. Third party liability subrogation. (a) The department may not pay medical claims that are payable by a third party payor. Medical providers shall attempt collection from the third party payor before billing Medicaid. Before payment by Medicaid, evidence of third-party denial or partial payment shall be presented with the claim.

(b) If the department provides or pays for medical assistance for injury or illness under this title, the department is subrogated to the rights of the recipient of that medical assistance for any claim arising from the injury or illness and to the proceeds of an insurance policy covering the injury or illness to the extent of the value of the medical assistance provided.

(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. (§ 2 ch 105 SLA 1986)

Sec. 47.05.080. Retention of overpayments collected. Benefit overpayments collected by the department in administering programs under AS 47.25.120 — 47.25.300 (general relief), AS 47.25.310 — 47.25.420 (aid to families with dependent children), AS 47.25.430 — 47.25.615 (adult public assistance), and AS 47.25.975 — 47.25.990 (food stamps) shall be remitted to the Department of Revenue under AS 37.10.050(a). (§ 91 ch 36 SLA 1990)

Chapter 07. Medical Assistance for Needy Persons.

Section
10. Purpose
20. Eligible persons
30. Medical services to be provided
35. Priority of medical assistance
40. State plan for provision of medical assistance
50. Implementation of the medical assistance program
60. Receipt of federal money
65. Payment for prescribed drugs
70. Payment to health facilities
71. Reports by health facilities
72. Report by the department
73. Uniform accounting, budgeting, and financial reporting
74. Audits and inspections
75. Administrative procedure
110. Medicaid Rate Advisory Commission established
120. Composition of commission
130. Appointment of members
140. Term of membership
150. Compensation
160. Officers
170. Meetings and quorum
180. Duties
190. Employment of personnel
900. Definitions

Sec. 47.07.010. Purpose. It is declared as a matter of public concern that the needy persons of this state receive uniform and high quality medical care, regardless of race, age, national origin, or economic standing. Accordingly, this chapter authorizes the 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). (§ 1 ch 182 SLA 1972)

Collateral references. — 70A Am. Jur. 2d, Social Security and Medicare, §§ 450-548; 79 Am. Jur. 2d, Welfare Laws, §§ 38-41.

81 C.J.S., Social Security and Public Welfare, §§ 126-138.

Imposition of civil penalties, under state statute, upon medical practitioner for fraud in connection with claims under medicaid, medicare, or similar welfare programs providing medical services. 32 ALR4th 671.

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:

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

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

(5) persons under age 21 who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal aid to families with dependent children program;

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

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

(8) persons under age 21 and not covered under (a) of this section, who would be eligible for benefits under the federal aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal aid to families with dependent children program;

(10) *[Repealed, § 38 ch 168 SLA 1990.]*

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

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

(e) Notwithstanding (b)(4) of this section, a person is not eligible for Medicaid benefits until a final determination is made on the eligibility of that person for benefits under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act). (§ 1 ch 182 SLA 1972; am § 1 ch 105 SLA 1974; am § 1 ch 117 SLA 1975; am § 1 ch 221 SLA 1976; am § 1 ch 11 SLA 1978; am § 1 ch 132 SLA 1982; am § 13 ch 138 SLA 1982; am § 3 ch 105 SLA 1986; am § 1 ch 119 SLA 1988; am § 38 ch 168 SLA 1990)

Effect of amendments. — The 1986 amendment in subsection (b) in paragraphs (3), (5) and (7) substituted "age 21 who are" for "21 years of age," in paragraph (8) substituted "age 21 and not covered under (a) of this section," for "21 years of age" and "except that they have the care and support of both their natural and adoptive parents" for "but who do not qualify because they are not dependent children," in paragraph (9) deleted "women who are" at the beginning of the paragraph and added the language beginning "women not covered," made minor punctuation changes in paragraph (3), inserted "and" following "mentally retarded" in paragraph (5), and inserted "and" following "psychiatric hospital" in paragraph (7).

The 1988 amendment inserted subsection (b)(10).

The 1990 amendment, effective June 22, 1990, repealed paragraph (b)(10), which read: "pregnant women, and children five years of age or younger, with a household income that does not exceed 100 percent of the federal poverty level."

Sec. 47.07.030. Medical services to be provided. (a) The department shall offer all mandatory services required under 42 U.S.C. 1396 — 1396p (Title XIX of the Social Security Act).

(b) In addition to the mandatory services specified in (a) of this section, the department may offer only the following optional services: case management and nutrition services for pregnant women; personal care services in a recipient's home; emergency hospital services; long-term care noninstitutional services; medical supplies and equipment; clinic services; inpatient psychiatric facility services for individuals age 65 or older and individuals under age 21; prescribed drugs; physical therapy; occupational therapy; chiropractic services; treatment of speech, hearing, and language disorders; adult dental services; prosthetic devices and eyeglasses; optometrists' services; intermediate care facility services, including intermediate care facility services for the mentally retarded; skilled nursing facility services for

individuals under age 21; and reasonable transportation to and from the point of medical care. (§ 1 ch 182 SLA 1972; am § 1 ch 35 SLA 1973; am § 2 ch 105 SLA 1974; am § 1 ch 12 SLA 1976; am § 2 ch 221 SLA 1976; am § 1 ch 82 SLA 1978; am § 25 ch 40 SLA 1981; am § 2 ch 132 SLA 1982; am § 1 ch 20 SLA 1986; am § 4 ch 105 SLA 1986; am § 2 ch 119 SLA 1988; am § 3 ch 45 SLA 1989)

Effect of amendments. — The 1986 amendment rewrote this section. The 1986 amendment of this section by ch. 20 was incorporated in ch. 105.

The 1988 amendment inserted "case management and nutrition services for pregnant women" in subsection (b).

The 1989 amendment, effective July 1, 1989, inserted "prescribed drugs" near the middle of subsection (b).

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

(1) chiropractic services;
(2) adult dental services;
(3) emergency hospital services;
(4) treatment of speech, hearing, and language disorders;
(5) optometrists' services and eyeglasses;
(6) occupational therapy;
(7) prosthetic devices;
(8) medical supplies and equipment;
(9) clinic services;
(10) physical therapy;
(11) personal care services in a recipient's home;
(12) prescribed drugs;
(13) long-term care noninstitutional services;
(14) inpatient psychiatric facility services;
(15) intermediate care facility services for the mentally retarded;
(16) intermediate care facility services;
(17) *[Repealed, § 38 ch 168 SLA 1990.]*
(18) individuals under age 21 who are not eligible for benefits under the federal aid to families with dependent children program because they are not deprived of one or more of their natural or adoptive parents;
(19) skilled nursing facility services for persons under age 21;
(20) aged, blind, and disabled individuals who, because they do not meet the income requirements, do not receive supplemental security income under Title XVI of the Social Security Act, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility, to receive an optional state supplementary payment;

(21) 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;
(22) 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. (§ 3 ch 132 SLA 1982; am § 2 ch 20 SLA 1986; am § 5 ch 105 SLA 1986; am § 3 ch 119 SLA 1988; am § 4 ch 45 SLA 1989; am § 38 ch 168 SLA 1990)

Effect of amendments. — The 1986 amendment rewrote this section. The 1986 amendment of this section by ch. 20 was incorporated in ch. 105.

The 1988 amendment inserted present paragraph (16) and redesignated former paragraphs (16)-(20) accordingly.

The 1989 amendment, effective July 1, 1989, added present paragraph (12) and redesignated former paragraphs (12)-(21) accordingly.

The 1990 amendment, effective June 22, 1990, repealed paragraph (17), which read: "pregnant women, and children five years of age or younger, with a household income that does not exceed 100 percent of the federal poverty level."

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 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 1 of each year concerning the status of this program and recommendations, with supporting fiscal data, as to any changes in the coverage of eligible persons or services to be provided. (§ 1 ch 182 SLA 1972; am § 6 ch 105 SLA 1986; am E.O. No. 72 § 3 (1989))

Effect of amendments. — The 1986 amendment deleted "and" following "plan" in dividing the former third sentence into the present third and fourth sentences and in the present fourth sentence added "The department, including the Medicaid Rate Commission," and inserted "or regulatory changes" and "the optimum federal payment under."

The 1989 amendment, effective March 1, 1989, deleted "including the Medicaid Rate Commission" following "department" in the fourth sentence.

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

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

Sec. 47.07.065. Payment for prescribed drugs. The department shall pay for prescribed drugs under AS 47.07.030(b) under regulations adopted by the commissioner in conformity with applicable federal regulations. (§ 5 ch 45 SLA 1989)

Sec. 47.07.070. Payment to health facilities. (a) The department shall set the prospective rate of payment to a health facility under this chapter and AS 47.25.120 — 47.25.300 based on a fair rate for reasonable costs incurred by the facility. The department may not set a rate until after a public hearing before the Medicaid Rate Advisory Commission except that this hearing requirement is not applicable if a new rate is immediately necessary to afford exceptional relief to a facility as determined under regulations adopted by the department. The department shall by regulation list the factors it considers in making its rate determinations under this section. A rate set under this section does not take effect until it is approved in writing by the commissioner of health and social services or the agency assigned by the commissioner to perform this function. The written determination of a rate set by the department after a hearing must include a statement of the department's findings, a description of the basis of the findings and conclusions, a citation to the regulations supporting the findings and conclusions, and a statement of the decision.

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

(1) costs of current operations, including salaries and wages, purchased services, supplies, insurance, leases, depreciation, taxes, interest expense, maintenance and other health facility operating expenses; and

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

(c) In determining a rate of payment to a health facility under this section, the department may consider whether the rate of utilization of the facility has been reduced because of improvident or careless development of the facility.

(d) In determining a rate of payment to a health facility under this section, the department shall consider the appropriation limit set by the legislature for the department's programs under this chapter and under AS 47.25.120 — 47.25.300, and available federal revenue.

(e) When an actual rate paid by the department is reviewed at the end of the year for which the approved rate was established and the review is conducted to determine whether the actual rate paid was in conformance with the approved rate under this section, all or part of an adjustment for year-end conformance may be waived for the facility if the facility provides proof of manifest injustice resulting from application of the adjustment for year-end conformance. When the adjustment for year-end conformance of the base year is waived, in whole or part, for a facility under this subsection, the amount waived may not be included as part of the base upon which the prospective rate is determined if the nonconformity affects both costs and charges. When the adjustment for year-end conformance of the base year is waived, in whole or part, for a facility under this subsection, the amount waived shall be included as part of the base upon which the prospective rate is determined if the nonconformity affects only charges.

(f) The commissioner of health and social services shall appoint a technical advisory committee and hold public hearings on the department's rate setting regulations, rate setting methodology, and alternative payment systems. (§ 1 ch 182 SLA 1972; am § 3 ch 95 SLA 1983; am § 7 ch 105 SLA 1986; am § 1 ch 9 SLA 1989; am E.O. No. 72 § 4 (1989); am §§ 1, 2 ch 153 SLA 1990)

Cross references. — For transitional provisions for fiscal year 1989, see § 2, ch. 9, SLA 1989 in the Temporary and Special Acts; for legislative findings and purpose relating to the 1983 amendment of this section, see § 2, ch. 95, SLA 1983, in the Temporary and Special Acts.

Effect of amendments. — The 1986 amendment added subsection (d).

The first 1989 amendment, effective March 31, 1989, added subsection (e).

The second 1989 amendment, effective March 1, 1989, substituted "department" for "commission" where the word appears throughout the section; and in subsection (a), substituted "advise the department on the prospective" for "determine prospectively the" in the first sentence, added the

present second sentence, and added "after consideration of any recommendations made by the commission" at the end of the present third sentence.

The 1990 amendment rewrote subsection (a) and added subsection (f).

NOTES TO DECISIONS

Recoupment. — Although this section authorizes the commission prospectively to determine the rate of payment to be made to a health care facility, the statute is silent on the subject of prospective recoupment from a health care facility based on audit results. The section cannot fairly be read as implicitly authorizing the commission to consider audit results in its determination of prospective payment rates for the current fiscal year. City of Cordova v. Medicaid Rate Comm'n, 789 P.2d 346 (Alaska 1990) (decided prior to the second 1989 amendment).

Sec. 47.07.071. Reports by health facilities. Not later than 120 days after the end of each fiscal year of a health facility, the facility shall submit to the department a report on the facility's financial performance during the fiscal year. (§ 4 ch 95 SLA 1983; am E.O. No. 72 § 5 (1989))

Effect of amendments. — The 1989 amendment, effective March 1, 1989, substituted "department" for "commission."

Sec. 47.07.072. Report by the department. Not later than September 30 of each year, the department shall submit to the governor a report on the prospective payments made under this chapter during the current fiscal year and an estimate of the prospective payments that will be made during the remainder of the current fiscal year and the next fiscal year. The report must state the assumptions that are used as a basis for the estimates. (§ 4 ch 95 SLA 1983; am E.O. No. 72 § 6 (1989))

Effect of amendments. — The 1989 amendment, effective March 1, 1989, substituted "department" for "commission" in the first sentence.

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

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

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

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

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

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

(5) other factors the department considers relevant; and

(6) the recommendations of the commission.

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

(1) necessary to avoid excessive costs to the facility; and

(2) consistent with the policies of this chapter.

(d) Notwithstanding other provisions of this section, the department may, by regulation, modify the system of accounting, budgeting, and financial reporting required under this section for a health facility having fewer than 25 acute care beds in order to reduce the operating costs of that facility. (§ 4 ch 95 SLA 1983; am E.O. No. 72 § 7 (1989))

Effect of amendments. — The 1989 amendment, effective March 1, 1989, substituted "department" for "commission" throughout the section and added paragraph (b)(6), making related grammatical changes.

Sec. 47.07.074. Audits and inspections. 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 beneficiaries; and

(2) inspection of financial records by state and federal agencies to the extent required by federal law. (§ 4 ch 95 SLA 1983)

NOTES TO DECISIONS

Recoupment. — This section does not provide authority for recoupment from a health care facility based on audit results. The text of the statute does not state or imply that the amount of the payment will be affected by any audit. City of Cordova v. Medicaid Rate Comm'n, 789 P.2d 346 (Alaska 1990).

Sec. 47.07.075. Administrative procedure. (a) Actions of the department regarding health facility payment rates under this chapter and AS 47.25.120 — 47.25.300 are subject to the provisions of the Administrative Procedure Act (AS 44.62) except as provided in (b) of this section.

(b) The commissioner shall, by regulation, establish time limits applicable to the various phases of an administrative appeal process involving an appeal of the amount of a payment rate set by the department for a facility. The time limits set under the regulations supersede conflicting time limits in AS 44.62.330 — 44.62.630. The regulations must provide that

(1) a hearing for an appeal described in this subsection must be scheduled under AS 44.62.410 to occur no more than 120 days after written notice of rate appeal has been received by the department