Medical Care Advisory Committee
Saturday, May 3, 2008

Homer Site Visit
Teleconference 1-800-770-2121 (2478)

Members Present:

NP, Deb Kiley, Chair
Dr. David Alexander
John Bringhurst
Tracy Charles-Smith
Marie Darlin
Gary Given
Megan LaCross
Karen Sidell

DHSS Staff

Jerry Fuller, Medicaid Director
Sally Bowers, HCS

Members Absent:

Amber Doyle
Mark Walker

1. **Continuation of discussion of business items carried over from Thursday and Friday**

Approval of Minutes: Marie Darlin made a motion that was seconded by Gary Given that the minutes from the March 14th meeting be approved.

Change date for next meeting: Teleconference October 3rd 9 AM – 12 PM
Teleconference October 31st 9 AM -12 PM

Suggestions for next site visit:
Communities suggested – Dillingham & Cordova. Members remarked they are interested in ensuring they visit a variety of different communities – on the road system, off the road system. It would be great to keep up the momentum as demonstrated in the successful Homer meeting. If it is related to being on the road system, consideration should be given to other communities on the road system.

Tok - May 2009 - Friday and Saturday May 15th - 16th
Tracy Charles Smith suggested Tok and the Tetlin/Southwest area. This could involve inviting health aides from Mount Sanford Tribal Consortium that is about an hour drive from Tok. Committee members can either fly or drive (about an 8 hour drive) to Tok.

Tracy will assist with the logistics/making arrangements. Contact will be made with Victor Joseph with Tanana Chiefs Conference (TCC) to set up transportation while in Tok. The committee could fly to Fairbanks and then catch a commuter flight to Tok. The plan would be to invite local communities/tribes to a central meeting place in Tok (TCC has an office in Tok that likely has a meeting room) and perhaps also make a site visit to the Tetlin and Tanacross clinics. A Best Western motel is available for accommodations and Fast Eddies restaurant for meals.

2. **Presentation of ideas to prepare recommendation for the Commissioner**
   Ideas & suggestions were discussed but all are summarized at the end of the morning discussion.

3. **Discussion of MCAC vacancies and prospective members**
   Sally has sent information to:
   - Douglas Eby, MD(sent 4/21/08) - Southcentral Foundation (VP Medical Services for Southcentral Foundation) – no response/no letter of interest
   - Dr. Frank Ellenson (sent 2/7/08) –Neurologist – no response/no letter of interest
   - Jim Towle (sent 3/17/08)-Executive Director, Alaska Dental Society – no response/no letter of interest
   - Nancy Davis (sent 2/4/08) – Pharmacy Association – she was going to distribute at the Association meeting that month
   - Dan Nelson, RPh (sent 2/21/08) – his initial email expressed interest but no response/no letter

- Roger Penrod, RPh (sent 2/19/08) – received his letter of application 2/29/08 – presented at the March 14th meeting.
- Richard Mandsager, MD sent a letter of application dated March 12, 2008- presented at the March 14th meeting
- Elizabeth Turgeon, MD (sent 4/28/08) family practice physician in Wasilla, formerly of Cordova

MCAC needs 2 new consumer members.

- Tracy has been working with a special needs nurse at Chief Andrew Isaac who was supposed to forward information to a consumer to have the consumer contact Tracy since she personally cannot make the call due to HIPAA law. Sam Bush had emailed Tracy the name of an interested consumer position and Tracy will email information to her.
- It was suggested that we send information to Catriona Lowe who presented at the meeting yesterday.
- Alice Beok who runs the Medicaid office in Maniilaq and Nome/Norton Sound, works with consumers to help them with Medicaid questions. She would be a great addition to the committee as she is really aware of the issues. But she is not a consumer and does not have kids on DKC. However, one of her staff persons does have kids on DKC and may be interested.
- Marie Darlin's position expires in April 2009. She has contacted Pat Lube @ AARP regarding a senior advocate. This is a very important position and MCAC needs someone with time and knowledge of senior issues.

There was a brief discussion regarding applicants' qualifications. Although we received a resume from Dr. Turgeon, we are awaiting her letter of application. It was decided that the potential applicant's letter should be received by May 15th. At that time, we will submit what we have received to the Commissioner. It was noted that Tracy-Charles Smith's position will expire in October. It was recommended that she send an email to Sally to acknowledge her interest in being reappointed. The committee again reinforced the importance of having members representing all parts of the state; not too many from Anchorage. This goal will be kept in mind as names are presented to the Commissioner. Also noted is the importance of Mark Walker's participation to ensure a strong behavioral health advocate.

Action Item: Gary Given volunteered to check in with Dan Nelson regarding the pharmacist position.

Public Comment telephone conference line was open from 9:30 AM to 10:00 AM. No calls/comments received.

Open Community Forum Guest Provider – Dentist
Dr. Douglas Lien, DDS and his wife/office manager, Carla

Dr. Lien and Carla offered a summary of their experiences in their dental practice in Homer. Initially they set up a part time practice in Homer and commuted one week a month from Anchorage and basically were seeing only Medicaid patients. Eventually, they started seeing some self-pay and insurance patients – no more than 30 % of their practice has ever been anything other than Medicaid. They have seen first hand the challenges the patients have to encounter.

Although they have had a reputation as the Medicaid dentist, Dr. Lien has also pursued extensive cosmetic training and does whole mouth reconstruction. They continue to feel they have a moral obligation to serve people without money. They are grateful for the opportunity to improve someone's health. The Homer area recently has become the home of many retired dentists who want to continue to work, so their income has dropped considerably in the past year. The Seldovia Tribal Health Clinic which has a sliding scale has had an impact on their business since parents tend to go where the kids go. They often would see 8-12 patients/day under DKC but have been somewhat restrictive with adult dental because the patients were not very responsible and did not keep appointments. Often the patient would come in and have an initial emergent type procedure i.e. I & D and never return for the follow up care. The parents bringing DKC kids seem to keep most of their appointments and they seem to understand the value of what they are receiving. The new adult dental services

have greatly improved access to care because they can provide some restorative services rather than what used to amount to an extraction.

The Seldovia Clinic receives a subsidy to make up the difference between what DKC pays and usual reasonable and customary fees. The clinic is able to offer better wages and benefits to their employees, vacation time etc. They refer their patients to Kenai rather than to dentists in Homer; perhaps an IHS clinic there.

They noted with changes in the community health care dynamics, they feel like they are struggling to survive after many years of being "good guys" providing services for Medicaid. Dr. Lien noted as a result of new adult coverage they are seeing some new appointments. Issues they have dealt with Medicaid patients/services:

- low payment (fee for service)
- unreliability of patients to keep appointments
- minimal professional reward because people don't follow through and come back to complete the work that has been started. This also ends up being a professional liability when people have work that is only half done; especially those that are opened and drained and they don't come back for a two step procedure. Until adult dental, the options were basically to remove the tooth and then there was no way to replace it.
- electronic billing has helped considerably with the problems that they had been challenged dealing mostly on paper claims.
- adult dental prior authorizations working well
- Medicaid pays about 50 % of customary/reasonable which creates a problem when the dentist has to have crowns or work done at labs that expect payment immediately
- currently they have to write off over $100-200 K/yr

Recommendations from Dr. Lien and Carla:

- For practitioners who work with Medicaid patients, consider interest free loans for new equipment or perhaps donations of used equipment from places that are upgrading their equipment.
- Increase fees paid for dentists. Although the enhanced dental is a great help, consider higher reimbursement for adult; $1100 is not enough to do a whole set of dentures; $2200 covers cost of the dentures with no profit. Medicaid covers the surgery for the removal of teeth under other benefits. It is not applied to enhanced dental limits. There is no profit for the dentist who basically donates his time to provide services to Medicaid patients.

Jerry voiced his appreciation for the work that Dr. & Mrs. Lien have done and continue to do for the Medicaid patients. His 20+ years in Medicaid has made him aware of the significance of a practitioner who takes on what the Liens have done for their patients. He also noted that the legislature has authorized an increase in dental rates as of July 1, 2008 and will go back to the legislature again next year for additional increase. Currently Medicaid pays about 50% of what private insurance reimburses. Medicaid's goal is to increase the rate and at least completely cover all the costs for dentists and increase access to care. Dentists should not be subsidizing the patients' care or the federal/state government.

There was a brief discussion about Health Resources and Services Administration (HRSA). Clinics (referred to as 330 grantee) that receive funding that may allow them to use the sliding fee scale. Tribes save money if they refer within the tribal system. Whenever a patient goes outside the system, it costs the tribe more money. Because they receive federal funds, they cannot restrict to native only.

There also was a brief discussion about the shortage of dentists in some areas of the state i.e. Bethel where it seems impossible to get a dental appointment. Temporary duty jobs for dentists are readily available if a dentist is willing to do locum tenens jobs. Fairbanks Chief Andrew Isaac also has a long waiting list and would appreciate an itinerant dentist.

Open Community forum Guest Provider - ACCESS Alaska

Rhonda Crawford, Program Manager & Carletta Gemmel, Program Associate

ACCESS Alaska has a main office in Anchorage that provides a variety of services. They also have satellite offices throughout the State. The Kenai office focuses only on consumer directed program PCA, chore and respite services through the waiver. Their average census is about 75-80.

Issues discussed:

1. Delayed time for assessments – In the Fairbanks office the wait time is anywhere from 2-6 months for the initial assessment. PCA services are generally the front line services that enable a person to stay in their home; people need the services every day. To wait 2-6 months is almost asking for institutional placement if they are not able to get the help. If they don't have families or relatives, they do end up in a nursing home which costs the state more.

   In the Kenai area, it takes as much as 2 months to get the assessments. They serve all ages; children to older Alaskans; basically they serve everybody. The issue is getting the nurse to come out to do an assessment. For example, if they get a referral from the hospital or a referral for someone coming off a DD waiver who is going to try to live independently, the ACCESS Alaska staff goes in and do their initial assessment and sends everything in to the state. They have to wait for contact from the state nurse to schedule the assessment; then it takes another 2-6 weeks to get authorization for that assessment back. Currently, all the information goes into one email box set up specifically to receive the information. Everything from all PCA agencies goes to this one email address. Whoever takes care of it sends the information to the appropriate staff to handle it. (PCAmailbox@alaska.gov - Brenda Martin currently is in charge of it).

   ACCESS Alaska staff noted they have an option to ask for an expedite if someone is in a crisis situation. Although they can make that request; criteria is very difficult. SDS wants the explanation on the form to be very brief but you lose the urgency in brevity. The request generally gets denied and then the consumer/agency has to appeal it. It does not make sense to ask for the expedite if it is going to get denied and then you have to go through the appeal process.

   The providers gave an example of a client who is completely wheelchair bound and unable to do anything for herself but was denied services. The agency was finally able to get services approved after they called and explained the circumstances on the phone. This worked effectively. Their suggestion is that they be able to offer more information in the initial paper work to prevent having to go into the appeal.

Action item: Jerry will invite staff from SDS to present information on the assessment process at the October MCAC meeting.

2. The appeal pre-hearing process

   Serious concerns were voiced about this process. Often times, the paper work is submitted to the state/FHSC and the agency/consumer feels they have done what they need to do and the services will stay in place until the appeal is at least heard. However, the paper work often gets lost. The appeal process never even was started. The consumer/agency wait for the paperwork to come telling them of the date/time for the pre-hearing, but they continue to provide services. Then they learn services are being denied and the agency has to stop providing since they cannot bill for the services. The consumer only has 30 days to request the appeal and when the paper work gets lost and the agency/consumer does not know that, often it is over the 30 day limit. Calls are being made to FHSC. Basically they tell the consumer they missed the 30 day limit and there is nothing that can be done. There seems to be no respect for the recipient when a call is made to FHSC. Although FHSC loses the paper work; it is the consumer that is denied the appeal.

The agency and consumer has had to appeal to get an appeal. They have had to request phone records (one consumer had to pay $25 to get her phone records) to prove when they have called FHSC. Rhonda indicated they have talked with other agencies/providers that have complained about the same problem (FHSC losing paper work). The time spent repeatedly sending in paper work is ridiculous. They rarely are able to send the paper work once; nearly always they have to mail/fax the papers 2-3 times. ACCESS Alaska staff keep all their fax and phone records and have determined it takes at least 2-3 times before the paper work actually is accounted for. They gave an example of information that was mailed in September and had to be mailed again for the third time last week. The time spent sending the information and also documenting all their activities related to sending the information is phenomenal.

This loss of paper work happens both at SDS and FHSC. This has been a long standing problem since the new regulations in 2006. They did not scan and email directly to the email box. Prior to the 2006 changes, the agency staff worked more directly with a person at SDS (caseworker of the consumer) and it seemed to be the direct contact with a person that made the difference.

According to Rhonda and Carletta, the pre-hearing process has been horrible. They often go to the consumer's home when there is a pre-hearing scheduled because if they were not advocates for the consumer, the consumer would be beaten down. This is very intimidating and frightens consumers.

The agency staff assist the consumer by getting as much medical documentation as they can to support their appeal and go into the hearing prepared. In one situation they noted the hearing officers were not interested in the information and prescriptions from the doctor. They would not even listen to the argument about why the services should be provided. The consumer was a person with high physical needs, a seizure disorder as well as other health conditions. If was not for the care the consumer gets from her mom everyday, she would not be nearly as healthy, perhaps not even alive. The hearing officer totally disregarded the information from the doctor and did not even want to hear from the family saying they did not feel it was necessary. They said if the care was going to be given by the mom, she had to do it as the mom and not get paid for it. However, if the mom provides the care, she is not able to work outside the home. Because of the high needs care of the daughter and the size of Homer, there is not many highly trained staff and she cannot find anyone that is able to provide the care.

The indication from Rhonda and Carletta is that despite the fact that a physician has written a prescription for services a hearing officer in an administrative position makes a determination over the phone that the patient cannot receive the prescribed services. Although they were not sure where the hearing officers are from (the state or FHSC), Rhonda has the names of the hearing officers she works with and will provide them to enable follow up.

A discussion took place about the prescription provided by the doctor. Rhonda indicated that she has been providing these types of services for over 11 years and she has a good understanding of what is acceptable/not acceptable; what a person needs and doesn't need; what is fraudulent and what is necessary. In this case, the services were range of motion needed in order to prevent contracture in a client with scoliosis, muscle problems, seizure disorder. According to the regulations, the services did fall under the guidelines for approval.

Action Item: Jerry will research DHSS information regarding appeals (a federal mandate):

- **Who deals with the types of hearings as described by ACCESS Alaska providers**
- **Is the time for the appeal process the same for all Medicaid programs? If this is a federal process, the timing should be the same for all programs.**
- **Is there a web site that MCAC members can go to for additional information regarding appeals?**
- **What are the guidelines used to make the decisions regarding services? What consideration is given when the consumer has a prescription? Why would a prescription be disregarded?**
- **Describe the etiquette in dealing with fragile consumers (the consumer is intimidated by the hearing officer and they feel like they have been beaten up).**

- **Request a presentation for the October 3 meeting to discuss the actual pre-hearing process; how it works; the challenges of the department; what the are doing to serve the consumer; geographical statistics on the number of pre-hearings; how many were approved/denied. How many have gone to an actual fair hearing.**

Brenda and Carletta also noted that the consumer has a one hour pre-hearing. If the hearing officer calls 20 minutes late, then the consumer only gets what is left of that hour. Perhaps there needs to be some consideration given to changing the time limit.

If the consumer is not satisfied with the outcome of the pre-hearing, then they can go to fair hearing. It is tape recorded and very formal. The consumer will have to pay back Medicaid if they don't get the hours reinstated. It is very intimidating. The consumers are very scared and rarely will go to fair hearing. They are afraid they will have to pay Medicaid back if they are not granted the hours. Jerry noted that this is a Federal requirement. If services are provided, the consumer will have to pay back for the services if the decision is not in their favor. The consumer can chose to go without the services until the hearing. It is important to have the pre-hearing process work since it is informal and certainly less intimidating. Rhonda and Carletta feel they go into the pre-hearing very prepared. They know the regulations and get the medical information they feel support the services. They provided another example of a consumer who was requesting minimal hours to deal with a situation with her husband (3 hours of service) and the hearing officer had the woman in tears within minutes of starting the hearing and she just gave up saying it was not worth it. The agency felt the hearing officer had "bullied" the consumer. These are generally done by teleconference since the consumers cannot drive to Anchorage for face to face. The agency is now asking to have the pre-hearing recorded because they feel that the hearing officers are not very professional.

Concern was voiced about inappropriate comments made by state employees who have indicated that "the PCA program is like an 800 pound gorilla on their back and they want to dump it. It is too expensive, the budget is too high and there is a lot of abuse."

The alternative to this program is putting these consumers in an institution that would cost the state much more. It was noted that for the consumers who need the services and receive them, it is a beautiful program. Family members don't have to worry about leaving their loved ones when they have to go off to work.

3. There was a brief discussion about the fraud and abuse in the program as well as the changes to eliminate it. Initially providers could offer up to 35 hours of service without review by SDS and many consumers were receiving 34.5 hours of service – just under the limit, but they really did not need services. Another problem was lack of training. Several agencies opened and provided services to make money but now the process is changed. The regs were changed; Arbitrae started doing assessments because there was a conflict of interest when the agency had someone doing the assessments to give someone hours. At this time, the assessment process is the significant change. There still really isn't any significant state/federal control over the legitimacy of an agency, who runs it, and who do they serve.

ACCESS Alaska Recommendation:
Don't cut services overall. Don't do an across the board swipe. Look into areas where there is fraud and abuse and cut those out so that the people who really need this service have it. The regs have changed and the process is getting better.

ACCESS Alaska provides chore and respite services through the waiver. Every hour of chore & respite provided, they lose money. They offer medical benefits and started with a lower base rate. They have had to dip in savings in order to raise pay to stay competitive to keep direct service providers. They are a non-profit organization and they do not make a lot of money. They put a lot of money back into their community. The rate freeze has not been good for the agency. They have been stuck for years with the same rate. ACCESS Alaska is involved in the Meyers and Stauffer cost survey project.

4. Chore services
   The only way someone can get chore services is if they are on a Medicaid waiver – DD, OA waiver; maximum 10 hours/week. The problem is that they get a lot of calls when a consumer is coming out of the hospital. Usually, the first thing that people are not able to do when their health is declining or they are fragile due to old age is the normal household chores. This is generally a problem even before they need the personal care. So it seems backward that people are able to get PCA before get chore. There are two agencies in the area that have a grant to provide chore services. If a consumer needs chore, these agencies tell the consumer that if the agency is going to provide chore, they will need to do the care management and PCA services also. This takes away the consumer's choice.

   An example was offered: A consumer who had a knee replacement was sent home, a place where she had to have water hauled; she had no laundry facilities and her home was a mess. Despite a request for an expedited assessment, it took 3 weeks for the nurse to do the assessment. At that time, there still was no physical therapy started. The consumer was given 2 hours/week of chore services.

   ACCESS Alaska Recommendation: Assess the feasibility of chore as a straight Medicaid service similar to PCA. This likely would decrease injuries since consumers are doing things they should not (they fall, break hips or cause other serious injuries to themselves). It would help to make chore services more readily available, even if a limited number of hours. Although there is an effort to keep costs down, chore is truly a first line service people need. Chore services include cooking, cleaning, laundry - 10 hrs/week would be adequate. Currently ACCESS Alaska's rate is $12.48/hour and the provider pays staff $10/hr.

   If it is not possible to make chore a Medicaid service, make more grant options available. On the Peninsula, the same two agencies have had the grants for several years and they basically serve their area and their clientele. It would help a great deal of there were more grant options available for other agencies to also provide the services.

5. Lack of coordination of services between SDS PCA program and the waiver program.
   It seems there are inconsistencies when a consumer receives services under both programs and it is not clear if the staff from the different programs work together to ensure the consumer receives adequate services.

Action item: Jerry will research information from SDS to assess how staff in the different waiver programs and PCA work together to determine if there could be a better coordination of services.

Jerry noted that part of Medicaid reform is to look at the whole long term care service array because the State has added waivers but have not gone back to determine if there is a better way to provide care. Likely in the next few weeks there will be a contractor on board to start that work. They will be holding about six community meetings around the state.

Afternoon Session

Recognition of Members
Gary Given, RPh and Dr. Dave Alexander were each recognized for their nine years of dedicated volunteer services to the MCAC.

Development of recommendations for the Commissioner

1. Improve the timeliness for approval of applications for Denali KidCare
   a. Faster approval time – applications need to be reviewed and processed in a reasonable time frame – Committee recommends 10 day maximum
   b. Increase the length of DKC enrollment time from 6 months to 12 months. This has the potential to reduce the administrative burden.
2. Increase the percent of poverty level to 200%

3. Improve the timeliness of approval of Medicaid for pregnant women and in so doing, ensuring newborns immediately get on newborn Medicaid. Newborns can be on that type of Medicaid for one year.
4. Streamline and improve communication between providers, the State and FHSC
    a. Decrease paper work. Ensure that everything only has to be submitted once.
    b. Assess reasons for lost papers (fax and mail) and develop guidelines to improve the process.
    c. Develop some type of accountability/performance measures
    d. Audit the communication system between the State, FHSC and providers
    e. Determine appropriate response time
    f. Enhanced Communications for all users of Medicaid; electronic information

Action Item: NP Kiley will draft a statement for a recommendation to address the streamlining of communication as noted in # 4 (will capture the statement that the provider "should have known about a change in regulations because it was on the website".)

5. Continue to evaluate a reimbursement increase in Medicaid fee for services
    a. Dentists – analyze the fiscal impact of increasing the dental fee for service to 70% of usual customary rate (UCR) – generally sufficient to cover the overhead cost.
        i. is the adjustment going into effect on July 1, 2008 high enough
        ii. how does the low reimbursement impact access to adequate care; low number of Medicaid dental providers
        iii. overhead in a well run dental practice is 65% & Medicaid currently reimburses dentists at about 50% of the prevailing customary fee
    b. Nurse Midwives, Nurse Practitioners and Physicians Assistants - Analyze the fiscal impact of increasing payment for these services to 100% from the current 85%. This could potentially enhance the Alaska Medicaid program by acting as an incentive for Nurse Practitioners, Nurse Midwives and Physician Assistants to take up residence here and participate in Alaska Medicaid.
    c. Analyze the current reimbursement rate for all obstetrical procedures to consider an increase and the impact on access to care

Action Item: Karen Sidell will develop the language to provide a strong statement in the recommendation regarding an increase in the dental rates and fee for service for NM, NP and PAs; verbiage indicating the committee thinks they should really consider an increase in the fees as noted in # 5.

6. Develop a forum for discussion of ways to provide health care for Alaskans age 22-64
    a. Consider appointing a Commission to take this on as a state wide discussion; coordinate activities and funding over a longer period of time than was allowed for the Health Strategies Council (most states have some sort of Health Authority/Health Commission). MCAC may want to make recommendations for guidelines to indicate who should be appointed to the "Commission" to represent statewide consumers, providers, and others with less governmental control.
    b. Follow up to Health Strategies Council recommendations – although concerns were voiced that the final recommendations did not represent everything that was discussed. No real solutions to the problems presented.
    c. Bill that would have created a health commission did not pass
    d. Politicians looking at universal coverage-HB 160
    e. Assess ways to keep people well so they do not progress to severely ill which likely would be cost effective.
    f. Develop a mission statement for the "new health commission" – long term commission to figure out what the state is going to do or not do.
    g. John Bringhurst mentioned that the State Hospital Association has its # 1 agenda item as health care reform for Alaska. There is some interest and momentum that MCAC may be able to take advantage of – it would require someone to be at their meeting to help plan and direct that effort.

Action Item: Sally will provide a copy of the Health Strategies Council final report to MCAC members.

7. Develop and improve access to respite for Developmentally Disabled
   a. Design a pilot program for therapeutic respite homes that would demonstrate the value of such a service. It would be re-evaluated annually to determine if the evidence warrants its continuation. Professionals would provide intense service (inpatient treatment – potentially up to 2 weeks; could be a daily service)
   b. Respite is a waiver service if someone has a Medicaid waiver
   c. Dr. Brennan in Fairbanks and Dr. Holiday, child neurologist in Palmer could provide a paper with testimony on the value of the services and a letter of support
   d. Fairbanks Resource Agency (FRA) has a facility (about 6 beds) available; workers who currently work at residential DD homes are already trained and may be available as workers.
   e. Provide information regarding the need for funding for staff.
   f. Will need to research billing codes for DD diagnoses for respite
   g. Provide a good description of what a therapeutic respite home is in the framework of Medicaid. This can be a recommendation for FY10 but perhaps can be assessed even sooner.
   h. Teaching opportunity for parents with DD children – parents who want to use the facility would have to volunteer time to provide education for other families.
   i. Parents who have this burden need a place for respite
   j. Compare this with a child labeled as severely emotionally disturbed (SED), who has an opportunity to go to respite without a waiver. SED kids are able to care for themselves.
   k. DD children should have same access to respite as SED kids.
   l. Many parents are providing care 24 hours a day and cannot leave the child. Some families are letting their own health deteriorate in order to provide care for their loved ones.

Action Item: Tracy Charles-Smith will provide additional information on this proposal and how it fits into the Medicaid framework as noted in # 7.

8. Develop a plan to institute a program to advise Medicaid recipients of the cost of services they receive, a remittance advice or explanation of benefits. This would fit in well with the Governor's goal of transparency in health care.

Action Item: Marie Darlin will develop a recommendation regarding a plan to advise recipients of the cost of their services.

9. Continue addressing the needs across the lifespan
   a. Prenatal
   b. Infant
   c. Denali KidCare
   d. Progressively aging population. Alaskans are living longer and remaining in Alaska. Look at options for long term care and increasing the number of assisted living homes throughout the state that are more cost efficient than skilled nursing facilities. Assess how to deal with the deteriorating situation with seniors not being able to get Medicare services. If providers are not willing to see Medicare patients, there will be no preventative care and patients will end up much sicker. Many will end up needing institutional care and Medicaid.
10. Assess a plan to provide chore services for recipients on Medicaid but not on a waiver; a service equivalent to the PCA program. Currently chore services are not covered by Medicaid, except under the waiver program.
11. Adult dental sunsets next year. Recommend that the program is continued and consider increasing the benefit. Significant positive feedback has been received about the benefits that have been experienced as a result of this program.
12. Expedite SB 61 – modifying mental health funding and long term care
    a. Key concepts to broaden the services
    b. Include substance abuse
    c. Currently the State only pays for treating severely ill people who are a danger to themselves or others. People who might receive cheaper care are left out until they get worse and become severely ill; are sent to jail (annex of the mental health system) or someone can get them into

Southcentral where the waiting list is 4-6 month (unless coming out of jail or API and then they move up).

d. Encourage earlier treatment and substance abuse

13. Request the Commissioner to strongly consider an increase the number of site visit/face to face MCAC meetings. Meetings are an opportunity to meet with people, listen to their compelling stories, ask questions and receive answers. MCAC is improving the visibility of the Department and serving as ambassadors who are willing to give their time and are willing to participate despite the personal sacrifice because it is important. There is not another forum for this type of input.

Chronic, Acute Medical Assistance (CAMA) Process

Karen Sidell requested information regarding the process for chosing the diagnoses for CAMA (who and how do they pick the diagnoses) and the array of CAMA codes.

Action Item: Sally will request information from HCS regarding the CAMA process and codes.

Myers and Stauffer audits

There was a lengthy discussion about the external audits and their perceived effect on providers and consumers. Although MCAC would like to offer a recommendation with regard to the audits, they decided to learn more about them and then perhaps consider a recommendation for next year. It was noted that the process is entering into the 4th year but there is no annual report for the legislature; no performance measures/outcomes; no cost benefit analysis. The committee is interested in knowing more about:

a. the impact of the audits on providers and the trickle down effect to the consumers;
b. why no information is requested from the client; perhaps a phone interview;
c. could it be more user friendly;
d. is the State seeing qualitative change;
e. the record review may not necessarily be a true reflection of the care provided. In some cases there is great documentation and poor services while others provide wonderful services but did not document every little thing.

Action Item: Jerry Fuller to invite Roshana Fekrat to speak at the October meeting to provide a summary of the external auditing process through Myers and Stauffer. The Committee would like to see a report of the audits performed i.e. the number, what they have found; breakdown of the recoveries; what the State is accomplishing through the audits.

Potential Fall meeting recommendations:

Review the recommendation from the Health Strategies Council to determine what MCAC may want to advocate since HSC will not be able to follow up.