State of Alaska
FY2013 Governor's Operating Budget

Department of Health and Social Services
Health Care Services
Results Delivery Unit Budget Summary

Health Care Services Results Delivery Unit

Contribution to Department's Mission

To manage health care coverage for Alaskans in need.

Core Services

- Provide access to appropriate health care services.
- Assure access to a full range of health care service information to our customers.

Results at a Glance

(Additional performance information is available on the web at http://omb.alaska.gov/results.)

End Result A: Mitigate Health Care Services (HCS) service reductions by replacing general funds with alternate funds.

Target #1: Reduce by 1% the GF expenses and replace them with alternate funds.
Status #1: Due to an increase in Indian Health Services (IHS) billings, the target strategy of increasing IHS billings by 5% was realized, with an increase of approximately 6.7% from FY2010 to FY2011. In addition, the division far exceeded the target of a 2% increase in GF recovery. Recovered GF increased by approximately 28.7% in FY2011 when compared to FY2010.

*Note: The large increases in recovered GF during FY2011 can be attibuted to an expanded focus on estate recoveries during this period. THIS INCREASE IN RECOVERED GF MAY NOT BE NOTICED IN FUTURE FUNDING CYCLES.

(Source: FY2011 AKSAS Authorization Report/FY2011 TPL/Recovery Quarterly Recoupment Reports)

Strategy A1: Increase Indian Health Services (IHS) participation by 5% in expenditures.

Target #1: Increase IHS Medicaid participation by 5% in expenditures.
Status #1: IHS Medicaid participation increased from FY2010 to FY2011. Total IHS expenditures were $206.0 million in FY2011, compared to $192.7 million in FY2010, an increase of approximately 7% in FY2011. The increase in IHS participation is attributable to a number of factors, but the two projects which contributed the most to the increase were the updating of race codes in the Eligibility Information System to insure a higher percentage of IHS eligible claims were billed accordingly, and the addition of three new IHS facilities during FY2011.

(Source: FY2011 AKSAS Authorization Report, Tribal Health Team)

Strategy A2: Expand fund recovery efforts.

Target #1: Increase funds recovered by 2%.
Status #1: The division exceeded the 2% target for increasing GF recovery during FY2011. The division experienced an increase in recovered funds of approximately 29.7% in comparison to FY2010.

*Note: Increases in recovered GF during FY2011 can be directly be attributed to an expanded focus by the Third Party Liability (TPL) Unit on subrogation, AG restitution/subrogation, drug rebates, Miller Trust recoveries, and increased oversight of health services utilization.

*Note: The large increases in recovered GF may not be attainable in future funding cycles.

(Source: FY2011 TPL/Recovery Quarterly Recoupment Reports)

Strategy A3: Improve time for claim payment.

Target #1: Decrease average response time from receiving a claim to paying a claim.

Status #1: The division has witnessed a decrease of approximately 3 days in adjudication time from receipt of a claim to final adjudication, decreasing from 11 days in FY2010 to 8 days in FY2011. This represents a decrease in adjudication time of approximately 27%. The time required for claim processing depends largely on the method of claim submission, the type of claim submitted, and the day of the week the submission occurred. For example, a point-of-sale pharmacy claim submitted on Monday may take one day to process, whereas an inpatient hospital claim may take several days for processing due to claims pending for review, requests for additional documentation, etc. At this time, it can be safely assumed that an average processing time of 6 days from entry to adjudication for all claims would be the maximum efficiency attainable with the required constraints noted above.

(Source: MARS MR-O-08-T. No national average available.)

End Result B: To provide affordable access to quality health care services to eligible Alaskans.

Target #1: Increase the number of providers enrolled in Medicaid by 2%.

Status #1: The definition of enrolled provider has changed in FY2011 as the department makes a concerted push towards group enrollment, statutory requirements for enrollment of personal care attendants (PCAs) as a rendering provider, and similar changes in enrollment requirement statutes. This being said, there were 11,642 eligible enrolled during FY2010. This number has increased (due to the reasons mentioned above) to 16,441 eligible Medicaid providers in FY2011. This represents an increase of 41.2% in eligible providers.

(*Note: The comparison between FY2010 and FY2011 is for informational purposes only. A more accurate comparison of providers will be shown between FY2011 and FY2012 due to re-enrollment under the new statute parameters noted above.)

(Source: MARS MR-O-02-M Medical Assistance Program Status)

Strategy B1: Improve payment efficiency.

Target #1: Increase the percentage of adjudicated claims paid with no provider errors.

Status #1: The percentage of claims paid without error remained at 75% between FY2010 and FY2011.

(This measure is updated quarterly. Source: MARS MR-O-11-T.)

Key RDU Challenges

Medicaid Management Information System Development Project:

- A significant challenge is the effective control of the Medicaid Management Information System (MMIS) project to ensure the development and implementation timeline is strictly adhered to. The MMIS is the engine that processes claims for the Medicaid program. Health Care Services processes 189,759 claims per week in our existing Common Business Oriented Language (COBAL) based Legacy MMIS that is now 23 years old.

- This project has a fixed cost budget; therefore, any delays resulting in extension of the existing Legacy contract will fall on the State to absorb, with offset by Federal match. This project, like others of this nature nationwide, continues to have timeliness challenges. Of note, in nearly ten years, the Centers for Medicare and Medicaid Services (CMS) has not seen an MMIS project come in on time and on budget.

- In 2007, the department awarded a contract to Affiliated Computer Services (ACS) for a new MMIS, including design, development, and implementation. The new MMIS, known as Alaska Medicaid Health Enterprise, was scheduled for a June 2010 implementation. Delivery of the source code for the Enterprise product was delayed; therefore, Alaska Medicaid Health Enterprise implementation is delayed. Current estimates show a FY2013 implementation. ACS describes Alaska Medicaid Health Enterprise as a sophisticated, web-enabled solution for administering all Medicaid programs that will be available to providers and recipients who participate in the medical assistance programs. It will have features allowing users to access the system through a user-friendly web portal. This progressive MMIS system will incorporate innovative features and advancements that will grow as health care services grow.

- Other key challenges tied to this project include: 1) ensuring minimum disruption to state employees, providers, and recipients; 2) completing provider enrollment; 3) conducting provider/recipient training; and 4) meeting CMS mandates requiring MMIS configuration while still operating the old Legacy system.

Recipient Services:

- Support with eligibility and service coverage issues, and assistance with identification of providers who are accepting new Medicaid patients continue as the focus of recipient services. Challenges continue with assisting recipients with access to dental care and management of their enhanced dental benefits, as well as access to complex medical care. Each recipient call is unique and requires research and resourcefulness to identify appropriate intervention. The most problematic dispute occurs when the provider attempts to bill the Medicaid recipient for services.

Pharmacy Program:

- The HCS Pharmacy program faces multiple key challenges: 1) maintaining coordination of benefits as demand for services increases due to the protracted economic downturn; 2) implementation of the new HIPAA 5010 claims processing standards; 3) reviewing the current pharmacy reimbursement rates and payment methodology by conducting a new pharmacy cost of dispensing survey; and 4) managing provider expectation while operating an evidenced based, fiscally responsible program.

Significant Changes in Results to be Delivered in FY2013

- In FY2013, the department will continue with implementation of the mandate for International Classification of Diseases tenth revision (ICD-10). The increase from several thousand to more than 68,000 diagnosis codes and to 87,000 inpatient procedure codes is expected to improve health care quality, research, and public health reporting. It is also expected to promote accurate reimbursement. The ICD-10 changes must be implemented by October 1, 2013.

- To align with the MMIS replacement project efforts and timelines, and to reprioritize use of the new web-based portal for the enrollment of new providers, the reenrollment of all 12,000+ current providers that commenced in FY2012, will continue in FY2013. The department plans to conduct a complete re-enrollment of providers. This has not been accomplished in over 20 years in the current Medicaid processing system.

Major RDU Accomplishments in 2011

- HCS revamped its Utilization and Case Management contract requirements. The new contract was awarded to incumbent contractor Qualis Health. New contract requirements have resulted in faster, more efficient utilization review decisions, completion of non-clinical case management activities by a more appropriate level of staff, and a savings for HCS in excess of $121,000 monthly. These funds are reinvested in the Medicaid program and will help to off-set HCS' added expense of special case reviews necessary to identify health care acquired conditions, as required by the Patient Protection and Affordable Care Act.

- As mandated by the federal Patient Protection and Affordable Care Act, and amended by the Health Care and Education Reconciliation Act of 2010, HCS implemented an enrollment requirement for prescribing, referring and ordering providers. Rendering providers employed by Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and tribal health clinics were also enrolled to meet this federal requirement. HCS also implemented state regulations requiring that all individuals employed as Personal Care Assistants enroll as rendering providers. This will allow HCS to identify the individual providing personal care service and ensure that he/she has been properly credentialed, and will assist in identifying patterns of fraud, waste, or abuse.

- Changes to the Resource-Based Relative Value Scale (RBRVS) payment methodology for providers were drafted in regulation and issued for public comment. These changes are intended to eliminate unanticipated peaks and valleys in increases to provider payments under the old methodology.

- Centers for Medicare and Medicaid Services (CMS) approved HCS's Health Insurance Portability and Accountability Act (HIPAA) version 5010 Implementation Advance Planning Document (IAPD). This capital

project with 90% federal matching funds requires the state to implement these billing/claims processing rules within the MMIS no later than January 1, 2012.

- HCS continued planning activities related to the federally-mandated International Classification of Diseases 10th edition (ICD-10). This activity included drafting the IAPD for funding consideration by CMS. This is a capital project with 90% federal matching funds. The ICD-10 mandate must be implemented by October 1, 2013.

- The Office of Rate Review, in collaboration with Senior and Disabilities Services, completed new regulations relating to Home and Community Based Care (HCBC) waiver payment rates. This resulted in standardized rates for many HCBC services and geographical differentials for many HCBC and personal care services. These new payment rules became effective March 1, 2011.

- Medicaid Management Information System (MMIS) enhancements were made to respond to the National Correct Coding Initiative (NCCI) federal mandate and Alaska Senate Bill 199, (Ch. 60, SLA 2010). The results of these changes are cost-avoidance through specific edit rules to eliminate automatic payment for medically-unlikely situations and claims processing for dentures for adult recipients in the enhanced Adult Dental program. Additionally, changes were implemented that allows for payment to physicians and mid-level providers for limited dental services. Qualified providers may be eligible for payment for topical fluoride varnish application and oral evaluation for patients under the age of three as part of the effort to increase to oral health services.

- HCS implemented regulations adopting new evaluation criteria for authorization of orthodontia services. In addition to a description of the problem, panoramic films, and a treatment plan, the evaluating dentist must score the Handicapping Labiolingual Deviation (HLD) Index Report, which will allow for a more objective determination of need for orthodontia services. HCS also implemented regulations allowing reimbursement to pharmacists for the provision of tobacco cessation counseling, expanding the resources available to those who desire to cease their use of tobacco.

- HCS implemented measures to allow providers enrolled as both a pharmacy and as a durable medical equipment (DME) provider to submit claims for various supplies through the pharmacy point-of-sales (POS) system. For the applicable supplies, this change eliminates the need for claims submission, streamlines claims processing and expedites payments.

- HCS continues to play a major role in the implementation of cost containment measures in an effort to reduce the cost of Medicaid Services while maintaining levels of services provided wherever possible.

Contact Information

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Health Care Services
RDU Financial Summary by Component

All dollars shown in thousands

	FY2011 Actuals				FY2012 Management Plan				FY2013 Governor			
	UGF+DGF Funds	Other Funds	Federal Funds	Total Funds	UGF+DGF Funds	Other Funds	Federal Funds	Total Funds	UGF+DGF Funds	Other Funds	Federal Funds	Total Funds
Formula Expenditures												
Catastrophic & Chronic Illness	1,443.7	0.0	0.0	1,443.7	1,471.0	0.0	0.0	1,471.0	1,471.0	0.0	0.0	1,471.0
Non-Formula Expenditures												
Health Planning & Systems Develo	643.5	712.5	1,648.4	3,004.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Health Facilities Licensing & Ce	781.4	0.0	669.4	1,450.8	566.2	80.7	1,442.8	2,089.7	641.5	80.7	1,467.0	2,189.2
Certification and Licensing	0.0	0.0	0.0	0.0	2,969.0	13.0	2,692.0	5,674.0	3,006.9	263.0	2,730.9	6,000.8
Medical Assistance Admin.	10,933.6	2,990.5	18,396.6	32,320.7	5,150.1	5,657.4	9,450.8	20,258.3	5,161.2	5,211.0	6,831.5	17,203.7
Rate Review	1,020.2	0.0	866.6	1,886.8	1,237.3	0.0	1,301.8	2,539.1	1,588.4	0.0	1,647.4	3,235.8
Community Health Grants	2,134.8	0.0	0.0	2,134.8	2,153.9	0.0	0.0	2,153.9	2,153.9	0.0	0.0	2,153.9
Totals	**16,957.2**	**3,703.0**	**21,581.0**	**42,241.2**	**13,547.5**	**5,751.1**	**14,887.4**	**34,186.0**	**14,022.9**	**5,554.7**	**12,676.8**	**32,254.4**

Health Care Services
Summary of RDU Budget Changes by Component
From FY2012 Management Plan to FY2013 Governor

All dollars shown in thousands

	Unrestricted Gen (UGF)	Designated Gen (DGF)	Other Funds	Federal Funds	Total Funds
FY2012 Management Plan	**11,710.8**	**1,836.7**	**5,751.1**	**14,887.4**	**34,186.0**
Adjustments which will continue current level of service:					
-Health Facilities Licensing & Ce	15.3	0.0	0.0	24.2	39.5
-Certification and Licensing	30.5	7.4	250.0	38.9	326.8
-Medical Assistance Admin.	11.1	0.0	-196.4	-619.3	-804.6
-Rate Review	25.6	5.5	0.0	25.6	56.7
Proposed budget decreases:					
-Medical Assistance Admin.	0.0	0.0	-250.0	-2,000.0	-2,250.0
Proposed budget increases:					
-Health Facilities Licensing & Ce	0.0	60.0	0.0	0.0	60.0
-Rate Review	320.0	0.0	0.0	320.0	640.0
FY2013 Governor	**12,113.3**	**1,909.6**	**5,554.7**	**12,676.8**	**32,254.4**