State of Alaska
FY2005 Governor's Operating Budget

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

Contents

Health Care Services Results Delivery Unit

Contribution to Department's Mission

Health Care Services (HCS) is a new division and a new RDU in FY2004. The Department of Health and Social Services (DHSS) restructure placed certain Medicaid categories of service financed and managed by the Division of Medical Assistance with certain Maternal and Child Family Health services provided and managed by the Division of Public Health. The mission of the former Division of Medical Assistance *"to maintain access to health care and to provide health coverage for Alaskans in need"* continues to accurately state the mission of the collective Division of Health Care Services.

Core Services

Division of Health Care Services Responsibilities under the DHSS Restructure

Under the Department of Health & Social Services restructure, the Division of Health Care Services maintains the Medicaid "core" services including hospitals, physician services, pharmacy, dental services, transportation; and other services including physical, occupational, and speech therapy; laboratory; x-ray; durable medical equipment; hospice; and home health care. HCS administers, department-wide, the State Children's Health Insurance Program (SCHIP), the Medicaid Management Information System (MMIS), claims payments and accounting, third-party liability collections and recoveries, federal reporting activities, Medicaid State Plan Amendments, Medicaid financing activities, and the Chronic and Acute Medical Assistance Program.

In addition, the division finances and manages women's and children's programs previously within the Maternal & Child Family Health component in the Division of Public Health including Newborn Metabolic Screening; Early Hearing Detection and Intervention Program; Newborn Hearing Screening; Early Periodic Screening, Diagnosis & Treatment (EPSDT); Oral Health; Genetics; Health Care Program for Children with Special Needs (HCP-CSN); Specialty Clinics; Breast & Cervical Health Check (BCHC) Program; Family Planning; and the Women's Comprehensive Care Improvement Project Program.

HCS Medicaid

The Medicaid program is a jointly funded, cooperative venture between federal and state governments to assist in the provision of adequate and competent medical care to eligible needy persons. Alaska's Medicaid program impacts the service delivery of every division within the Department of Health and Social Services, as well as divisions in six other departments within the state system. There are six sources of federal funding that branch into a kaleidoscope of varying federal participation rates, allotments, and reimbursements, each with their own federal and state regulatory processes.

Federal financial participation (FFP), which is the federal government's share for states' Medicaid program expenditures, is generally claimed under two categories: administration and medical assistance payments with several subcategories within. The Health Care Services RDU incorporates all program activities and responsibilities associated with assuring medical assistance payments are made timely, accurately, and as efficiently and cost effectively as possible.

Medicaid Services Administration. FFP for Medicaid administrative activities are federally matched at a base rate of 50%. This means the federal government will provide funds equal to the sum the state contributes toward total administrative expenditures. However, higher matching rates of 75% and 90% are authorized by law for certain administrative functions and activities.

In order to receive federal matching dollars for medical services under the Medicaid program, states must maintain a Medicaid state plan. The state plan details the scope of each state's Medicaid program by listing the eligibility groups and standards, the services provided, any applicable service requirements, and payment rates for those services. While states generally have flexibility in forming their Medicaid programs, Medicaid state plans must include certain elements of information and must be consistent with mandates detailed in federal statutes.

Medicaid Services. Medicaid Services are reimbursed by the federal government at a statutory Federal Medical Assistance Percentage (FMAP). FMAP under Title XIX of the Social Security Act is determined by formula calculation

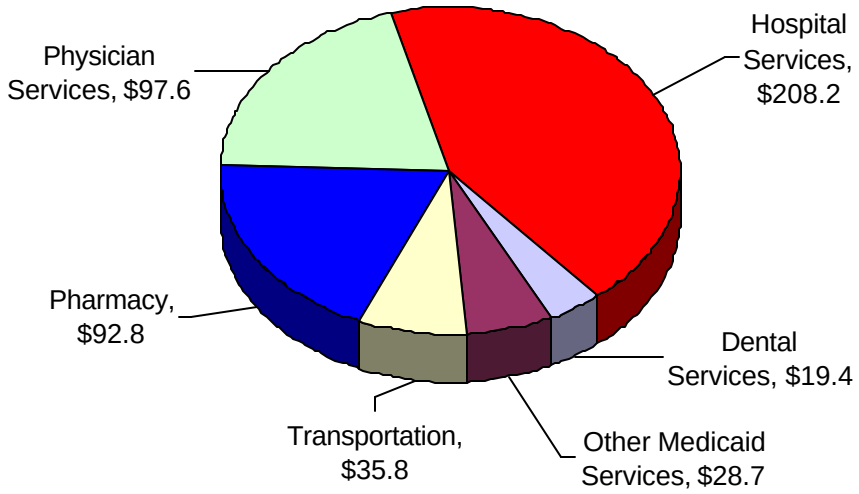
on the federal fiscal year (FFY). In addition to the Title XIX rate, certain Medicaid fund source categories are reimbursed at enhanced or fixed levels. Published formulated rates are not always available for timely Alaska budget development calculations resulting in necessary FMAP adjustments to projected or authorized funding levels.

The FY2005 budget includes change records replacing general funds realized in FY2004 as a result of the federal Jobs and Growth Tax Relief Reconciliation Act of 2003 (TRRA). Under this Act, increased FMAP rates were made available to states for five calendar quarters begining April 1, 2003 ending June 30, 2004.

Title XXI (SCHIP known in Alaska as the Denali KidCare Program (DKC)) and the Breast and Cervical Cancer program are reimbursed at enhanced rates which are also formula-based on the FFY. Family planning and the Indian Health Services (IHS) rates are fixed at 90% and 100% respectively.

The HCS Medicaid categories of service, while not necessarily the fastest growing, are in the aggregate the most costly. The categories of service administered by HCS supported more than 128,190 eligible Alaskans in FY2003 and provided services to more than 116,800 Alaskans during that same fiscal period. The total cost for services provided exceeded $482 million in FY2003.

HCS Medicaid Service Costs
FY2003
(Expenditures in Millions)



Growth rates for the HCS Medicaid service categories have averaged 17.6% annually for the past 5 years. Largest growth areas include transportation at an average of 25.9% and pharmacy at an average of 24.8%. In FY2003, nearly 18% of all Medicaid expenditures were 100% federally funded through IHS facilities.

Medicaid core services eligible numbers encompass all Medicaid eligibles statewide. Recipient numbers, persons using the services provided, have continue to grow for the past 4 years as shown below. Physician services is the most highly utilized category of services with pharmacy being second.

Medicaid Eligibles to Recipients

	Eligibles	Recipients	% Utilization
FY1999	94,500	79,770	84.4%
FY2000	111,100	92,100	82.9%
FY2001	118,100	100,150	84.8%
FY2002	124,920	110,570	88.5%
FY2003	128,190	116,840	91.1%

The Chronic and Acute Medical Assistance Program (CAMA)

The CAMA program provides a limited package of health services to those individuals with chronic medical conditions who do not qualify for the Medicaid program. CAMA's limited benefits are only available to low-income persons with an immediate need for medical care who are unable to secure other private or public assistance.

During the FY03 budget process, the CAMA appropriation was cut by 50%, leaving a total of $2 million to provide limited services to Alaska's indigent. The HCS implemented regulations that limited coverage making CAMA primarily a prescription drug program for the terminally ill, chemotherapy patients, and people with certain chronic conditions that without treatment would lead to disability or death.

Population-Based Services

Population-based services within the HCS are those administered and provided to Alaskans through federally funded or matched programs whereby the division manages and monitors primary care, screening, and preventive services.

AKInfo. The AKInfo information and referral line grant with the United Way of Anchorage is administered through HCS and funded through the Maternal and Child Health Grant. In order to meet federal funding requirements of the federal Health Resource Services Administration (HRSA) (Maternal, Child Health Bureau), Part C of the Individuals with Disabilities Education Act, and USDA (WIC), to help Alaskan families locate providers of other needed health and social services, the HCS allocates funding for statewide toll-free information and referral (I&R) services. Funding is currently provided to the United Way of Anchorage – AKInfo for 24 hour per day, seven days per week (24/7) operated-assisted toll-free I&R services and for the maintenance of an Internet-based information and referral database of service providers statewide.

Through AKInfo, anyone in Alaska with access to a phone or the Internet can obtain information on over 2000 health and social service providers in the state such as health care providers, food assistance programs, early intervention services, and shelters. At no cost to them, callers to the toll-free referral line can be telephonically transferred to service agencies in the database in order to obtain more information, register for programs or to make appointments.

Breast & Cervical Health Check (BCHC). BCHC is the State of Alaska's Breast & Cervical Cancer Early Detection Program solely funded by the Center's for Disease Control and Prevention (CDC). BCHC is part of a national program with the goal to reduce breast and cervical morbidity and mortality in medically underserved women. More than 4,200 Alaskan women were provided comprehensive breast and cervical cancer screening and diagnostic services in FY2003. Since 1995, more than 16,000 individual Alaskan women have been provided health screening services through this program.

Early Hearing Detection & Intervention (EHDI) Program. EHDI is funded solely through two federal grants from HRSA – Universal Newborn Hearing Screening (UNHS), and CDC – Early Hearing Detection & Intervention for the purposes of developing a statewide newborn hearing-screening program with the goal of preventing developmental delays through early detection and linkage with intervention services. Specifically the goals of the program include:

- Implementation of the universal newborn hearing screening program in all birthing hospitals and facilities throughout the state,
- Development of an Advisory Committee to assist with, and offer expertise in the area/s of early detection and intervention of hearing loss,
- Development of outreach materials for the general public, healthcare providers, and families of children with hearing loss to increase public awareness regarding the importance of newborn hearing screening, early intervention, and resources for referral,
- Development and implementation of a centralized database to simplify the collection process of newborn hearing screening data for birthing centers and hospitals to be submitted to the state. The data collection will assist the state and healthcare providers identify barriers to early intervention and track progress as well as explore options to ensure receipt of early intervention and other services for children with development delays.

The HCS is responsible for the overall development and maintenance of the newborn hearing screening program including all aspects of hospital screening, data collection and reporting, surveillance and tracking of identified newborns and at risk infants as well as linkages with early intervention services

Early, Periodic, Screening, Diagnosis & Treatment (EPSDT) Program. The EPSDT program assures that children enrolled in Medicaid receive well-child care and additional diagnosis or treatment services as needed. All Medicaid Services/EPSDT program activities are directed toward addressing federal EPSDT regulations or related federal initiatives.

The program sends notice to parents or guardians of children due for well-child exams; produces lists of providers (physicians, nurse practitioners, dentists, vision care providers, etc.) who accept new Medicaid patients; coordinates and funds (through Medicaid) transportation to health care appointments for children and pregnant women; and arranges home visits by nurses for women with high risk pregnancies. This assistance is available for health care appointments only if the family wouldn't be able to go to that appointment without it.

Family Planning. Family planning services are provided to high-risk, low-income women, men, and teens and include health history and physical exam, counseling regarding method of contraception/family planning and disease prevention, client education, follow-up referrals for further medical care if needed, and referrals to the Breast & Cervical Cancer Early Detection Program.

Family planning services are offered through a partnership with the Section of Nursing in State Public Health Nursing Clinics in Fairbanks, Bethel, Mat-Su, Kenai, Kodiak, Juneau, Ketchikan and Prince of Wales Island and provided on a fee for service basis in non-profit clinics (grantees) including Kachemak Bay Family Planning Clinic in Homer, Interior Neighborhood Health Center in Fairbanks, and Sunshine Clinic in Talkeetna.

Funding sources used to provide family planning services include Title V MCH Block Grant funds, Title X Family Planning funds and TANF (Temporary Assistance to Needy Families) funds from the Division of Public Assistance. Approximately 12,000 clients received family planning services during FY2002.

Genetics Program. The Alaska Genetic Clinics is a series of State of Alaska sponsored specialty medical clinics held throughout the state and centrally coordinated by the HCS.

Genetics refers to inherited disorders and birth defects (conditions that are present from before birth but may or may not be inherited). Clinics are staffed by physicians who are specialists in medical genetics and at least one other area of medicine such as pediatrics or neurology, and a genetics counselor. A subset of clinics that manages persons with rare metabolic disorders includes a physician, nutritionist, social worker, and a genetics counselor. This program is the only clinical genetic services offered in the State of Alaska. Funding is through the Maternal & Child Health Block Grant.

Health Care Program for Children with Special Needs (HCP-CSN). HCP-CSN provides funding for medical care for children with special needs from birth to 21 years of age. A child with special needs must meet eligibility criteria that are based on the child's medical condition and the family's financial status. The intent of the program is to supplement the total health care needs of an eligible child. Services include diagnostic evaluations; medical and surgical care; hospitalization; physical therapy, occupational therapy and speech therapy; rehabilitation equipment; and prescription medications. The program can also provide transportation and lodging for families that need to travel to medical centers for services. Children served by HCP-CSN with very limited coverage now have access to more comprehensive health services through improvements in the Medicaid program. In fiscal year 2002 eleven children were enrolled in HCP-CSN. Funding was provided for eight of them. Four of these children did not have another third party payer.

Newborn Metabolic Screening Program (NBMS). NBMS tests all Alaska newborns for congenital metabolic disorders as well as endocrine disorders. These diseases, not apparent at birth, lead to mental retardation or death if untreated. Very early treatment can prevent or reduce physical effects and brain damage. Alaska law requires that all newborns be screened before hospital discharge. Infants born out of hospitals must be screened within the first week of life. This approximates 10,000 babies per year.

Currently, Alaskan infants are tested for hypothyroidism, phenylketonuria (PKU), galactosemia, maple syrup urine disease, biotinidase deficiency, and congenital adrenal hyperplasia. Hemoglobinopathies are optional and can be done by request only. Parents are allowed to refuse the test on religious grounds under what it entitled "Informed Dissent". The back of the form is signed, forwarded to the Oregon Public Health Laboratory, and then on to the NBMS program manager where it is entered into a Refusal database.

The HCS is responsible for the overall integrity of newborn metabolic screening and surveillance. This involves tracking all tests that are abnormal or that have specimen collection problems. These cases are followed until they are closed or lost to follow-up. Letters are generated and sent to birthing facilities about specimen collection problems as well as

delivery to the testing laboratory problems. Letters are also sent to birthing facilities to inform them if Oregon Public Health Lab has not yet received their specimens. On site hospital laboratory visits and education are offered as indicated by the quality-monitoring program. In addition, special reports are run to assist hospitals in their own quality improvement programs.

Oral Health Program. The Oral Health Program was established in FY2003 with funding under a State Oral Health Infrastructure Cooperative Agreement Grant from the CDC. The initial focus of the oral health program is to develop an oral health surveillance system; improve Alaska's water fluoridation reporting in collaboration with the Department of Environmental Conservation and Alaska Native Tribal Health Consortium, and with input from stakeholders develop an oral health plan and policy recommendations to improve access to dental services; reduce disparities and improved oral health for all Alaskans.

Subsequent objectives for the program are the development of a water fluoridation program; and development of a dental sealant program – targeting high risk school-age children. The program works with the Children's Health Unit to assess utilization of dental services by children enrolled in Medicaid and to develop policy related dental reimbursement, dental provider relations and coverage policies to improve the oral health of populations at high-risk for dental disease.

Specialty Clinics. The Specialty Clinics Program provides access to care for children in need of consultation, screening, and follow-up services that is not locally available to most areas of Alaska. The program brings medical specialists to regional centers in or close to communities where special needs children and their families reside. Clinics offered throughout Alaska include cleft lip and palate clinics, neurodevelopmental clinics, and cardiac clinics. The Specialty Clinics Program is funded by the federal Maternal & Child Health Block Grant.

Women's Comprehensive Care Improvement (WCCI) Project. The WCCI program is funded by a three-year grant from Health Resources and Service Administration (HRSA) to develop a comprehensive integrated model for women's health care. The project objectives are 1) to create a client-centered, risk-based, coordinated, comprehensive service system that supports a woman in her efforts to seek and/or maintain health and well-being; 2) enhance the community health center service "system responsiveness" for women; 3) increase statewide partnerships and awareness of the Project's goals and activities; and 4) collect data and information to a) determine the impact and effectiveness of trial changes and b) scope of on-going needs among reproductive age women for program planning and statewide project replication purposes.

In partnership with the Anchorage Neighborhood Health Center (ANHC) and the Alaska Primary Care Association's Statewide Women's Health Partnership, the health and social service needs of women seeking care at ANHC are being studied. The ANHC will redesign their existing system using the quality improvement model to create a more responsive, comprehensive service that maximizes relationships with existing referral agencies and creates new partnerships as needed by the 'customer'. This model and the quality improvement process will then be implemented in three other Community Health Centers. The resulting system of care will include a health and social needs risk process that encompasses all aspects of the woman's life; care coordination that views the woman holistically; mechanisms to facilitate completion of referrals and 'customer feedback' about the referral experiences; gap-closing strategies for known system weaknesses such as mental health services; and a training/technical assistance process to facilitate the paradigm-shift needed for 'system' employees.

End Results	Strategies to Achieve Results
(1) Mitigate Health Care Services (HCS) service reductions by replacing general fund (GF) cuts with alternate funds. Target: Reduce by 1% the GF expenses replacing them with alternate funds. Measure: Percent of GF cuts replaced with alternate funding. **(2) To provide affordable access to quality health care services to eligible Alaskans.**	**(1) Increase federal and other funding sources. Maintain or decrease GF expenditures.** Target: Increase IHS participation by 5% in expenditures. Measure: Percentage of IHS participation. **(2) Expand fund recovery efforts.** Target: Increase funds recovered by 2%. Measure: Amount of funds recovered.

End Results	Strategies to Achieve Results
Target: Increase by 2% the number of providers enrolled. Measure: Number of providers enrolled. **(3) Increased screening and prevention activities for Alaskan families.**	**(3) Maintain or increase the number of providers enrolled in each census area.** Target: Increase by 2% the number of providers enrolled. Measure: Number of providers enrolled. **(4) Improve payment efficiency.** Target: Increase the % of error-free claims by .5%. Measure: Percent of error-free claims. **(5) Improve time for claim payment.** Target: Decrease by .5% the average time HCS takes to pay a claim. Measure: The average time HCS takes to pay a claim. **(6) Increase access to dental services through private dentists using 100% FMAP and contracting.** Target: 65% participation by Alaska's dental providers. Measure: Percent of participating dentists. **(7) Implement new Medicaid Management Information System (MMIS).** Target: 100% centralized payment capabilities with customer access to information. Measure: Percent of completion. **(8) Increase percent of newborns screened and confirmed who receive appropriate follow-up.** Target: 100% newborn screening and follow-up. Measure: Percentage of screening and follow-up activities provided. **(9) Increase the number of children with special needs age 0 to 18 who receive coordinated, ongoing, and comprehensive care.** Target: 54% of special needs children. Measure: Percent of special needs children receiving care. **(10) Increased number of children ages 19 to 35 months who receive full schedule of age appropriate immunizations.** Target: 93% of children ages 19 to 35 months who receive full schedule of age appropriate immunizations. Measure: Percent of children receiving age appropriate immunizations.

FY2005 Resources Allocated to Achieve Results

FY2005 Results Delivery Unit Budget: $676,289,800

Personnel:	
Full time	82
Part time	0
Total	82

Performance Measure Detail

(1) Result: Mitigate Health Care Services (HCS) service reductions by replacing general fund (GF) cuts with alternate funds.

Target: Reduce by 1% the GF expenses replacing them with alternate funds.
Measure: Percent of GF cuts replaced with alternate funding.

Analysis of results and challenges: Seek ways to maximize federal participation through Family Planning, IHS, BCC, and Title XXI expenditures.

(2) Result: To provide affordable access to quality health care services to eligible Alaskans.

Target: Increase by 2% the number of providers enrolled.
Measure: Number of providers enrolled.

Analysis of results and challenges: Encourage provider participation through prompt payment and customer service.

(3) Result: Increased screening and prevention activities for Alaskan families.

(1) Strategy: Increase federal and other funding sources. Maintain or decrease GF expenditures.

Target: Increase IHS participation by 5% in expenditures.
Measure: Percentage of IHS participation.

Average Monthly Medicaid Expenditures in Thousands by Fund Source

Year	Federal Fund	General Fund	Other Fund		YTD Total
1998	26,224.0	14,232.0	151.0	0	40,607.0
1999	27,649.0	13,916.0	72.0	0	41,637.0
2000	27,682.0	13,099.0	376.0	0	41,157.0
2001	32,816.0	12,941.0	748.0	0	46,505.0
2002	39,818.0	14,224.0	650.0	0	54,692.0

Analysis of results and challenges: For the past several years, concerted efforts have been directed at decreasing general fund expenditure growth within Medicaid. FMAP "fixes" obtained by Alaska's Congressional delegation have had great impact on federal fund participation increases. FFY1998 through FFY2000 FMAP rates were fixed at 59.8%; a FFY2201 adjustment boosted Alaska's FMAP to 60.13%; and a FFY2002 fix prevented a deeper plunge than the 57.38% awarded.

In addition to the help received from Washington, work efforts in Alaska have held general fund expenditures lower than projected need. Since FY1999, increases in the use of "other funds" has averaged 169% per year. This is mainly due to programs implemented such as ProShare, FairShare, and the increased use of available DSH funds.

The chart below shows the impact of these combined efforts on general fund expenditures.

(2) Strategy: Expand fund recovery efforts.

Target: Increase funds recovered by 2%.
Measure: Amount of funds recovered.

Analysis of results and challenges: In FY03 DHCS recovered approximately $25 million, of which $17 million was prescription drug rebate and $8 million was third party liability (TPL) recovery.

(3) Strategy: Maintain or increase the number of providers enrolled in each census area.

Target: Increase by 2% the number of providers enrolled.
Measure: Number of providers enrolled.

Analysis of results and challenges: Provider participation is divided up into types of providers as follows: Physicians, Dentists, Pharmacies, Hospitals, and Nursing Facilities. Information concerning the number of licensed providers in the State is provided by the Division of Occupational Licensing. In FY03 provider participation was as follows:

Physicians: of the 1,412 physicians licensed in the State, 958 were enrolled in Medicaid (67.9%).

Dentists: of the 605 dentists licensed in the State, 330 were enrolled in Medicaid (54.5%).

Pharmacies: of the 176 licensed pharmacies in the State, 154 were enrolled in Medicaid (87.5%).

Hospitals: of the 16 licensed hospitals in the State, 16 were enrolled in Medicaid (100.0%).

Nursing Facilities: of the 14 nursing facilities licensed in the State, 14 were enrolled in Medicaid (100.0%).

(4) Strategy: Improve payment efficiency.

Target: Increase the % of error-free claims by .5%.
Measure: Percent of error-free claims.

Analysis of results and challenges: In FY03 the percentage of claims with no errors categorized by the type of provider was as follows:

Hosptials: 62.5%,
Physicians: 64.8%,
Dentists: 74.4%,
Nursing Facilities: 61.8%,
Pharmacies: 80.1%

In FY02 the percentage of claims with no errors categorized by the type of provider was as follows:

Hospitals: 60.29%,
Physicians: 67.40%,
Dentists: 77.64%,
Nursing Facilities: 65.28%,
Pharmacies: 83.34%

(5) Strategy: Improve time for claim payment.

Target: Decrease by .5% the average time HCS takes to pay a claim.
Measure: The average time HCS takes to pay a claim.

Analysis of results and challenges: In FY03 the average time from receiving a Medicaid claim to paying that same claim was 10.5 days. In FY02 the average time from receiving a Medicaid claim to paying that same claim was 10.7 days.

(6) Strategy: Increase access to dental services through private dentists using 100% FMAP and contracting.

Target: 65% participation by Alaska's dental providers.
Measure: Percent of participating dentists.

Analysis of results and challenges: Work with dental care providers to increase participation. In FY02 the percentage of dental care providers enrolled in Medicaid was 60.0%

(7) Strategy: Implement new Medicaid Management Information System (MMIS).

Target: 100% centralized payment capabilities with customer access to information.
Measure: Percent of completion.

Analysis of results and challenges: Complete contract work for MMIS reprocurement.

(8) Strategy: Increase percent of newborns screened and confirmed who receive appropriate follow-up.

Target: 100% newborn screening and follow-up.
Measure: Percentage of screening and follow-up activities provided.

Analysis of results and challenges: Work with providers for 100% newborn screening. The percent of newborns screened for conditions mandated by the state sponsored newborn screening programs and who received appropriate follow up in FY03 was 99.8%

(9) Strategy: Increase the number of children with special needs age 0 to 18 who receive coordinated, ongoing, and comprehensive care.

Target: 54% of special needs children.
Measure: Percent of special needs children receiving care.

Analysis of results and challenges: Work with providers for ongoing, comprehensive care for special needs children ages 0 - 18. The percentage of children provided with such care in FY02 was 48%.

(10) Strategy: Increased number of children ages 19 to 35 months who receive full schedule of age appropriate immunizations.

Target: 93% of children ages 19 to 35 months who receive full schedule of age appropriate immunizations.
Measure: Percent of children receiving age appropriate immunizations.

Analysis of results and challenges: Work with providers for appropriate immunizations. In FY02 the percentage of children provided with appropriate immunizations was 87%.

Key RDU Challenges

Health Care Services is a newly created BRU in FY04. As part of a service integration plan, the Department of Health and Social Services is undertaking a major reorganization of programs. The goals of the reorganization are to bring financial stability to operations, maximize federal funds, provide more accountability in program management, and improve quality and customer service. The new program alignment will balance cost effectiveness and service delivery and improve services to clients.

Many internal and external transfers are needed within the FY04 budget to implement changes envisioned by the reorganization. This will be a continuing effort through structure changes and revised programs as the division settles into its new role and moves toward integration.

Medicaid Services

Medicaid Service Delivery and Program Management. Over the past four years, growth in the number of Alaskans enrolled in the department-wide Medicaid program has averaged 8.1% while the cost of services provided has grown an average of 18.3%. Current economic and health care trends in Alaska continue to exert increasing pressure on state health care managers and policymakers to provide clear and demonstrated evidence of the following:

- The ability to sustain an effective and responsive health care management capability while containing costs to the extent permissible by law;
- The capacity to consistently produce comprehensive, accurate, and timely information and data/trends analyses to provide legislators, policymakers, health care providers, and the public the base from which to measure how well that health care management capability is actually performing; and
- The ability to effectively and efficiently disseminate that information to policymakers, legislators, our clients, and the public.

The Division is committed to building and supporting a medical services program with quality technical and management expertise, and to developing and implementing innovative and effective business management practices to assure the department, the governor, the legislature, and the public will in fact receive and enjoy the benefits of a service delivery system capable of meeting state health care needs under an aggressive cost containment strategy.

Medicaid Management Information System Procurement Project. Federal law requires all states participating in the Medicaid program to operate an automated claims processing system which must be certified by the federal government as a Medicaid Management Information System (MMIS). Federal rules also require these fiscal agent contracts be competitively bid. The contract for HCS's current fiscal agent was negotiated and awarded in May 1987.

A priority goal for the division is to transition to a new MMIS system with minimum disruption to its service providers and clients. The new system and fiscal agent contract will not only satisfy the needs of the state, but also the needs of medical service providers and the community of clients they support.

HIPPA now mandates significant changes in electronic transaction standards, confidentiality, and system security. Prompted also by rapid advancements in technology, the division initiated the process to replace its current MMIS. This three-year project was divided into three primary phases: planning, development, and implementation. HCS is now within the development stage with an implementation date in 2005.

This project has placed extraordinary pressure on existing staff without benefit of additional resources lost in budget cuts. The HCS is working diligently to maintain adequate, knowledgable staffing levels to successfully complete this multi-facited, multi-year project in spite of several setbacks in the procurement and award process.

Cost Containment. The Division continues to work diligently at implementation of cost containment measures that are aimed at saving general fund dollars department wide. This significant increase in workload has been absorbed by HCS. Projects now in progress include Implementation of SB41; Surveillance, Utilaization, and Review enhancements and expansion of lock-ins; durable medical equipment criteria review and updates, preferred drug list, transportation brokerage, and enhanced fraud and abuse activities.

In addition, the HCS is playing an integral role in the Tribal Health Agenda spearheaded by the Office of Program Review. Projects with tasks falling to HCS include development of policy that will enable tribes to bill for services under management contracts, review of new estate recovery policy, assuring tribes that provide public health nursing services are included in the plan for Medicaid reimbursement, provide training for Medicaid administrative match agreements, support for data analysis, reporting, and training of tribes, and the development of "due" lists to keep tribes entering into continuing care provider agreements informed.

Alaska Medicaid Preferred Drug List (PDL). A PDL is a list of prescription medications within a therapeutic

class that represents Medicaid's first choice when prescribing for Medicaid patients. Pharmacy growth costs have averaged 17% to 27% over the past several years. To help control these costs, HCS is implementing a PDL for Medicaid beneficiaries as a cost containment measure consistent with our desire to maintain Medicaid services and eligibility to the greatest extent possible. The PDL will allow the State to manage the drug program by improving capacity and effectiveness as purchasers of pharmaceuticals and align the patient need, the physicians' knowledge, and the State's purchasing power.

Successful implementation takes cooperation for providers and prescribers. A Pharmaceutical and Therapeutics (P&T) Committee has been formed and is responsible for determining the most effective drug or reference drug on the PDL. The P&T Committee is comprised of a group of Alaskan medical professionals who prescribe or dispense prescription drugs. The Committee has state-wide representation and includes various physician specialties, pharmacists, dentists, and a nurse practitioner. A sub-committee of psychiatrists will be used when the department reviews mental health drugs.

Implementation is based on a phase-in approach whereby drug classes will be added to the PDL over time. The public input has primarily been related to the program continuing to provide uninterrupted access to specific brand drugs which have clearly proven beneficial to the patient. The program design will meet this need.

Beginning in January, HCS will implement the PDL in the claims processing system using soft edits. This means if a pharmacist bills for a non-preferred drug and does not key the over-ride, the claim will be paid but a message indicating this is a non-preferred drug will be sent. Following in about 60 or 90 days HCS will initiate the use of hard edits. Claims for non-preferred drugs will be denied if the override which indicates the medical need is not submitted.

Surveillance, Utilization & Review. HCS has committed to an aggressive recruitment and retention effort to build and sustain a highly competent resource infrastructure with substantive program and business management expertise and depth. This will assure the state continues to enjoy the benefits of a service delivery system of the highest caliber, and well-managed, comprehensive and consistent health program policy under an aggessive cost containment strategy.

The HCS and the Medicaid Provider Fraud Unit have agreed to an effort to assist with collections and recovery of claims. Expanded lock-in services and enhanced fraud and abuse activities are pending federal approval. Contract negotiations have begun with a scheduled implementation date of December under SB41.

Administration of the Medicaid Program. Programmatic and financial responsibility for Medicaid services previously housed in the Division of Medical Assistance is being integrated in the RDU whose customers are the major users of the services. Medicaid funding for mental health related services has been transferred from the Medicaid Services component to the newly created Behavioral Health Medicaid Services component, Behavioral Rehabilitation Services to Children's Medicaid Services component, and funding for nursing homes, personal care, and waivered services has been transferred to the Senior and Disabilities Medicaid Services component. Oversight of the program as a whole is under the umbrella of the Commissioner's Office with the Office of Program Review and the Office of Rate Review.

This change results in significant challenges for the HCS in the areas of MMIS production of data and the associated research. The restructuring of the Department has impacted fourfold the maintenance and production of data requests and financial projections in both the amount of time necessary to produce reports and the methodology used to generate them. Prior to the restructure research was responsible to one program, one budget and the necessary data, assumptions, and time it took to produce it. After the restructure, research became responsible to one program split between four divisions. HCS estimates the increased the time necessary to produce supporting data for information requests and budgeting to be five times greater than before. The result is a significantly decreased response time due increased pressure on existing staff and equipment with little hope for relief under budget constraints.

HCS consists of a number of functions formerly in the Division of Medical Assistance, with the addition of some functions formerly in the Division of Public Health. Administration of existing functions compounded by the distribution of the Medicaid program plus the addition of new unknown functions has tasked existing staff with increased workloads while losing positions to budget cuts.

CAMA

The CAMA program provided payment for 1,771 individuals within the appropriated general fund amount of $2 million although it was necessary to clear pended claims in FY2004. General fund expenditure cut backs during FY2004

budget development reduced the CAMA authorization to $1,471.0. The combination has put the CAMA program in a precarious position. The HCS continues to work case management and Medicaid retroactive claims and has been able to manage the expenditures thus far, but it is uncertain as to how long it can maintain.

Population-Based Services

The HCS Population-Based Services challenges are centered around establishing and maintaining an efficient and effective system for dealing with the funding of, administration of, and implementation of a wide array of comprehensive health care services to support Alaskans to achieve their best possible health and well being.

Breast & Cervical Health Check (BCHC). BCHC operates as a centralized system of service delivery, with all services coordinated at the State level, and all services provided by medical providers in local communities. The BCHC works in concert with the four Tribal CDC funded programs operating in the State. Significant effort is undertaken by the BCHC and its tribal colleagues to coordinate services, maximize resources, and provide consistent health messages and high quality care of all women throughout the State.

Early Hearing Detection & Intervention (EHDI) Program. Challenges for the EDHI program include moving newborn hearing screening to a mandatory program with mandatory reporting through the birth defects registry.

Early, Periodic, Screening, Diagnosis & Treatment (EPSDT) Program. One of the most commonly used measures of success for state EPSDT programs is the 'screening rate', which is the number of well child examinations recorded divided by the number that should have been received. Alaska's rate is not as high as it should be for a variety of reasons, including (a) federal regulations define the billing codes that we use to identify well-child exams: if a private sector provider uses a different code when seeking reimbursement for the service, we do not know that a well-child exam has occurred; (b) many parents do not think well-child services are important; and (c) access to care in some parts of Alaska is very limited. The Medicaid Services Program is constantly striving to address these and related issues both directly and indirectly, and the Division of Medical Assistance defines the scope of our reach.

Family Planning. Maintaining the current level of family planning services.

Genetics Program. Most states have enacted genetics laws to restrict health insurance discrimination, but Alaska has not. Patients and physicians have increasing concerns about discrimination (insurance, employment) based on genetic test results, a genetic diagnosis, and confidentiality of genetic information, and this impedes uses of genetic services. Educational efforts and/or protective legislation to deal with real and perceived concerns needs to be developed.

Health Care Program for Children with Special Needs (HCP-CSN). HCP-CSN is being phased out as a result of losing state general fund monies for the program. New applications are no longer accepted. A few families on the program do not have another third party payer and are not eligible for other funding programs because of their immigration status. It will be a challenge, but we are committed to developing a "safety net" to cover the cost of medical care for these children with complex medical needs who come from low-income families.

Newborn Metabolic Screening Program (NBMS). There continues to be problems with specimen collection and rapid transport to the testing facility in Oregon. Educational interventions and visits to hospital laboratories have begun with continuing education talks offered by the NBMS Program Manager. Letters are regularly sent out to the birthing facilities along with charts of adequate and inadequate specimens and used as a method to educate the collectors.

Oral Health Program. Changes to consolidate grant programs at the CDC will require development of a new cooperative agreement application, although it is being submitted through a non-competitive process. The major barrier to the development of the comprehensive oral health surveillance system has been the lack of baseline oral health data from a basic oral health screening survey (open-mouth screening data). Barriers to water fluoridation are the size of the village water systems, water operator training, lack of funding support for fluoride testing, safety issues with the small systems, and anti-fluoridation sentiments in some communities.

Specialty Clinics. Cardiac Clinics in northern and western Alaska are being privatized. The pediatric cardiologist who has been providing clinic services through Specialty Clinics Program is working with local health corporations and private practitioners to develop a plan for private clinics. Specialty Clinics Program needs to assure that families continue to have access to needed clinical services. Pediatric Neurology Clinics were added in FY2003. An Anchorage pediatric neurologist is contracting with the state to provide clinic services in interior and Southeast

Alaska. Specialty Clinics has continued to work with the logistics of the clinic services in these regions.

Women's Comprehensive Care Improvement (WCCI) Project. HCS needs to collaborate closely with the Division of Public Health Community Health/Emergency Medical Services (CHEMS) section on the issuance of grant funds to community health centers to assure use of the quality improvement process in the development of a model of health care focusing on 4-5 health indicators for the general population. The two Sections are working together and combining resources for training and technical assistance and to avoid duplication in work with the Community Health Centers.

Significant Changes in Results to be Delivered in FY2005

Health Care Services is a newly created RDU in FY04. As part of a service integration plan, the Department of Health and Social Services is undertaking a major reorganization of programs. The goals of the reorganization are to bring financial stability to operations, maximize federal funds, provide more accountability in program management, and maintain quality and customer service. The new program alignment will balance cost effectiveness and service delivery.

Many internal and external transfers were needed within FY04 to implement changes envisioned by the reorganization. This will be a continuing effort in FY05 that will require more changes as the division settles into its new role and moves toward integration.

If these changes can be implemented without major problems or breaks in service, no changes to results delivered to the public should be realized.

Major RDU Accomplishments in 2003

DHSS Restructure. Under the DHSS restruction, Phase I, the staff of the Division of Medical Assistance that was not transferred to other divisions to help implement Medicaid Services within those division were combined with staff from the Division of Public Health -- two seemingly separate organizations with very different functions, goals, and strategies. Through many false starts under different directorships, the new HCS's hard work and willingness to cooperate and learn has brought the division toward a single mission and successful integrate of functions and staff.

Health Insurance Portability and Accountability.

The national Health Insurance Portability and Accountability Act (HIPAA) is intended to protect health insurance coverage for workers and their families when they change or lose their jobs. The Administrative Simplification provisions of HIPAA are intended to reduce the costs and administrative burdens of health care by implementing the use of standard electronic transactions and code sets of many administrative and financial transactions that are currently carried out either through electronic transactions with local variation, or manually on paper.

The HIPAA legislation indicates a health plan may not refuse to conduct any transaction identified as a standard transaction (X12 transaction). These transactions are defined by national industry standards. HCS must insure compliance with the requirements of HIPAA. The HIPAA Privacy Act requirement implements the Administrative Simplification provisions of HIPAA, defining standards for the privacy of individually identifiable health information.

Implementation of HIPAA has been an ongoing project with statewide implications. HCS has continued to work within HIPAA implementation needs, and has thus far been successful in the implementation of changes in compliance with HIPAA requirements without benefit of compliance with the federal staffing recommendations.

Medicaid Management Information System Procurement Project. Federal law requires all states participating in the Medicaid program to operate an automated claims processing system which must be certified by the federal government as a Medicaid Management Information System (MMIS). Federal rules also require these fiscal agent contracts be competitively bid.

A priority goal for the division is to transition to a new MMIS system with minimum disruption to its service providers and clients. The new system and fiscal agent contract will not only satisfy the needs of the state, but also the needs of medical service providers and the community of clients they support.

This three-year project was divided into three primary phases: planning, development, and implementation. HCS is now within the development stage with an implementation date of September, 2005.

Cost Containment

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

Summary of Cost Containment regulations – HCS

- Established new eligibility verification requirements – Effective 3/26/03
- Revised inpatient hospital regulations to require authorization after 3 days for all stays except maternity – effective 3/26/03
- Established a lower rate for therapeutic transition days for stays at residential psychiatric facilities – effective 3/26/03
- Established prior authorization authority and limitations on prescription drugs – effective 3/26/03
- Established process for recovery of Medicaid expenditures related to program violations, abuse, and estate recoveries – effective 3/26/03
- Restricting CAMA coverage – effective 9/20/03
- Implementing CS SB 105 (HES) and revised poverty guidelines –effective 10/26/03
- Recognition of fraud statute established by CS SS SB 41 (FIN) – effective 10/26/03
- Establishes separate psychiatric rate for facilities establishing new psychiatric facilities or units – public comment ended 10/27/03
- Exclusion of home office costs from facility rates – public comment ended 10/27/03
- Reimburse LTC capital at a minimum 85% occupancy standard – public comment ended 10/27/03
- Establish reconsideration process as a requirement to filing a facility rate appeal – public comment ended 10/27/03

Oral Health Program. The Oral Health Program received funding under a 5-year cooperative agreement with the U.S. Centers for Disease Control and Prevention as a component of the Comprehensive Chronic Disease Prevention and Health Promotion Grant to support state infrastructure, develop an oral health surveillance system, improvements in water fluoridation reporting and promote evidence-based preventive dental interventions targeted towards at risk populations.

Program staff continued the grant project with the Southeast Alaska Regional Health Consortium (SEARHC) to provide access to dental care for children enrolled in Medicaid/Denali KidCare. The project provided 1,607 patient visits in FY2003 including 605 patient visits to non-Native children. The project is moving towards inclusion in a continuing care agreement with SEARHC to leverage increased federal Medicaid match for program activities.

Program staff worked with Medicaid Policy staff to assist development of a continuing care agreement, including itinerant pediatric dental visits, with Norton Sound Health Corporation.

The program continued project funding for itinerant pediatric dental visits for children enrolled in Medicaid/Denali KidCare to the Kenai/Soldotna region of the state. The project supports travel expenses for a private pediatric practice to provide itinerant visits to the region. In FY2003 there were 833 children seen by the practitioner participating in this project. Program staff assisted in discussions to coordinate these services with the newly established Community Health Center in that region.

Program staff participated with staff from the Denali Commission, Rasmuson Foundation, the Alaska Native Tribal Health Consortium and State Primary Care Office to develop criteria for funding of fixed and portable dental equipment in conjunction with Denali Commission funding of village clinic and Community Health Center construction/renovation.

EPSDT. The program staff completed reports on two immunization surveys that the Center for Medicare and Medicaid Services (CMS) requested for their reporting under the Government Performance and Review Act. For this series we selected a random sample from children who had been enrolled in Medicaid or Denali KidCare for at least 6 months during their second year of life. The first report, on two-year olds born during FY 98, found that 85% of the children in the sample were fully immunized by the time they were two. The second found an 88% completion rate for children born during FY 99.

A total of 70,606 letters were mailed to parents of children and teens who are enrolled in Medicaid or Denali KidCare and apparently due for a well-child exam. A database to track returned mail was created. With improved address searching prior to the mail outs, we tracked only 870 of these letters were returned.

For the first time, the program created regional reports based on the format for the annual EPSDT report to CMS. The results offer Native health corporations and state administrators a chance to better identify areas of concern.

Newborn Metabolic Screening. The Newborn Metabolic Screening program changed the fee regulations for screenings, finalized the Newborn Metabolic Screening Alaska Practitioner's Manual, reduced the number of first specimen refusals and increased the number of second specimens being collected through educational efforts, conducted onsight visits in the Anchorage area to improve the collection to transport process, improved lost to follow-up infants to 10 in FY03 from 30 in FY02, implemented regularly scheduled meeting process for the Metabolic Screening Advisory Committee, and developed a metabolic screening website that includes information on the process and the disorders screened.

Early Hearling Detection and Intervention Program. By the end of FY03, 21 of 23 birthing hospitals were implementing Universal Newborn Hearing Screening (UNHS). It is expected that all 23 birthing hospitals will have the equipment necessary for these screenings by the end of December.

The EHDI Loaner Program provides assistive devices to children whose families do not qualify for Denali KidCare and do not have private insurance that covers the devices through loans granted from the Mental Health Trust Authority. Currently there are three children using these devices.

EHDI developed six education materials for parents and providers as well as a website on the State of Alaska's web page, and a database. Currently, materials for public awareness are being developed.

A Family Issues Task Force for Alaskan parents of children with hearing loss has been developed to provide support and education to families.

Breast & Cervical Health Check (BCHC). BCHC provided $2.3 million in federal grant funds to provide comprehensive breast and cervical cancer screening and diagnostic services to 4,200 Alaskan women in FY2003.

Significant effort was undertaken by BCHC, Southcentral Foundation, Arctic Slope Regional Corporation, SouthEast Alaska Regional Health Corporation, and the Yukon-Kuskokwim Health Corporation to coordinate services, maximize resources and provide consistent messages and quality care throughout the State for all women. The five programs, now called the Alaska Breast and Cervical Health Partnership, are working collaboratively to develop, for example, professional education opportunities which will benefit "breast and cervical" medical personnel throughout the State; public education messages which can be used statewide and reference all programs thus reducing costs for any single program; and policies which ensure that women in need of medical care not available in her community or service area can seamlessly access that care in another community or service area.

Weekly teleconferences have been established to ensure that Directors of each of the five programs can share ideas and collectively solve problems. The Alaska partnership has been recognized by the Centers for Disease Control (CDC) and is expected to become a model of operation for other CDC programs throughout the Nation.

Women's Comprehensive Care Improvement (WCCI) Project. In partnership with the Anchorage Neighborhood Health Center (ANHC) and the Alaska Primary Care Association's Statewide Women's Health Partnership, the health and social service needs of women seeking care at ANHC are being studied. The ANHC will redesign their existing system

using the quality improvement model to create a more responsive, comprehensive service that maximizes relationships with existing referral agencies and creates new partnerships as needed by the 'customer'. This model and the quality improvement process will then be implemented in three other Community Health Centers. The resulting system of care will include a health and social needs risk process that encompasses all aspects of the woman's life; care coordination that views the woman holistically; mechanisms to facilitate completion of referrals and 'customer feedback' about the referral experiences; gap-closing strategies for known system weaknesses such as mental health services; and a training/technical assistance process to facilitate the paradigm-shift needed for 'system' employees.

Family Planning Services. Family planning services were provided to 12,000 high-risk, low-income women, men, and teens throughout the State in FY2002. Services are offered through a partnership with the Section of Nursing in State Public Health Nursing Clinics in Fairbanks, Bethel, Mat-Su, Kenai, Kodiak, Juneau, Ketchikan and Prince of Wales Island and provided on a fee-for-service basis in non-profit clinics (grantees) including Kachemak Bay Family Planning Clinic in Homer, Interior Neighborhood Health Center in Fairbanks, and Sunshine Clinic in Talkeetna.

Contact Information

Contact: Janet Clarke, Director, Administrative Services
Phone: (907) 465-1630
Fax: (907) 465-2249
E-mail: Janet_Clarke@health.state.ak.us

Health Care Services
RDU Financial Summary by Component

All dollars shown in thousands

	FY2003 Actuals				FY2004 Authorized				FY2005 Governor			
	General Funds	Federal Funds	Other Funds	Total Funds	General Funds	Federal Funds	Other Funds	Total Funds	General Funds	Federal Funds	Other Funds	Total Funds
Formula Expenditures												
Medicaid Services	0.0	0.0	0.0	0.0	95,983.7	441,019.1	83,351.3	620,354.1	101,101.0	470,221.8	77,935.4	649,258.2
Catastrophic & Chronic Illness	0.0	0.0	0.0	0.0	1,471.0	0.0	0.0	1,471.0	1,471.0	0.0	0.0	1,471.0
Children's Health Eligibility	0.0	0.0	0.0	0.0	535.9	1,743.7	0.0	2,279.6	0.0	0.0	0.0	0.0
Non-Formula Expenditures												
Medical Assistance Admin.	0.0	0.0	0.0	0.0	556.5	2,235.0	783.1	3,574.6	1,378.7	4,345.3	1,146.2	6,870.2
Medicaid State Programs	0.0	0.0	0.0	0.0	2,422.7	16,231.4	0.0	18,654.1	0.0	0.0	0.0	0.0
Health Purchasing Group	0.0	0.0	0.0	0.0	4,157.0	11,130.7	0.0	15,287.7	4,069.9	11,536.3	0.0	15,606.2
Certification and Licensing	0.0	0.0	0.0	0.0	341.4	781.5	0.0	1,122.9	0.0	0.0	0.0	0.0
Hearings and Appeals	0.0	0.0	0.0	0.0	174.6	193.9	0.0	368.5	236.2	255.4	0.0	491.6
Women's and Adolescents Services	0.0	0.0	0.0	0.0	158.6	1,770.7	873.2	2,802.5	152.7	2,304.3	135.6	2,592.6
Totals	**0.0**	**0.0**	**0.0**	**0.0**	**105,801.4**	**475,106.0**	**85,007.6**	**665,915.0**	**108,409.5**	**488,663.1**	**79,217.2**	**676,289.8**

Health Care Services
Summary of RDU Budget Changes by Component
From FY2004 Authorized to FY2005 Governor

All dollars shown in thousands

	General Funds	Federal Funds	Other Funds	Total Funds
FY2004 Authorized	**105,801.4**	**475,106.0**	**85,007.6**	**665,915.0**
Adjustments which will continue current level of service:				
-Medicaid Services	6,367.8	2,289.2	-7,544.0	1,113.0
-Medical Assistance Admin.	1,005.3	2,223.0	0.0	3,228.3
-Medicaid State Programs	-2,422.7	-16,231.4	0.0	-18,654.1
-Health Purchasing Group	-289.6	-302.2	0.0	-591.8
-Hearings and Appeals	61.7	61.6	0.0	123.3
-Children's Health Eligibility	-535.9	-1,743.7	0.0	-2,279.6
-Women's and Adolescents Services	6.2	86.4	0.0	92.6
Proposed budget decreases:				
-Medicaid Services	-15,225.7	-19,235.1	0.0	-34,460.8
-Medical Assistance Admin.	-183.1	-112.7	-301.9	-597.7
-Health Purchasing Group	-53.5	-60.3	0.0	-113.8
-Hearings and Appeals	-0.1	-0.1	0.0	-0.2
-Women's and Adolescents Services	-12.1	-7.9	-737.6	-757.6
Proposed budget increases:				
-Medicaid Services	13,975.2	46,148.6	2,128.1	62,251.9
-Medical Assistance Admin.	0.0	0.0	665.0	665.0
-Health Purchasing Group	256.0	768.1	0.0	1,024.1
-Women's and Adolescents Services	0.0	455.1	0.0	455.1
FY2005 Governor	**108,409.5**	**488,663.1**	**79,217.2**	**676,289.8**