State of Alaska
FY2008 Governor's Operating Budget

Department of Health and Social Services
Medicaid Services
Component Budget Summary

Component: Medicaid Services

Contribution to Department's Mission

The Division of Health Care Services (HCS) 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.

Core Services

The Medicaid program is a jointly funded, cooperative entitlement program between federal and state governments to assist in the provision of adequate and competent medical care to eligible needy persons. The State Children's Health Insurance Program (SCHIP), operated through Denali KidCare, is an expansion of Medicaid which provides health insurance for uninsured children whose families earn too much to qualify for Medicaid, but not enough to afford private coverage.

Health Care Medicaid Services can be grouped into three elements: Direct Services provided to the client and processed through the Medicaid Management Information System (MMIS), Non-MMIS Services for services that are not tracked in MMIS, and Medicaid Financing Services for activities that maximize federal funding.

Direct Services include these service categories: inpatient and outpatient hospital, physician, health clinic, surgical clinic, prescribed drugs, durable medical equipment, prosthetic devices, dental, transportation, physical therapy, occupational therapy, speech pathology/audiology, laboratory, x-ray, optometrist, midwife, family planning, nutrition, home health, and hospice.

Non-MMIS Services include payments for insurance premiums (primarily Medicare), contracts for Medicaid operations and cost containment activities, third-party liability services, and supplemental payments to hospitals for uninsured and uncompensated care (Disproportionate Share Hospital program or DSH).

Medicaid Financing Services include the ProShare and FairShare programs. ProShare makes payments for certain medical assistance services to qualified private hospitals. The hospital in turn provides services directly or grants funds to qualified providers to secure services in rural, remote areas. ProShare helps ensure continued access to services for Alaska citizens and to make optimum use of federal participation for inpatient hospital services and allows the state to obtain federal matching funds for what otherwise would be state general funds. FairShare is a payment method for tribal-operated hospitals. Under FairShare, the state made increased payments to tribal-operated hospitals who then returned 90% of the payments to the state through an intergovernmental transfer. The returned funds were treated as match to finance part of the state's share of the Medicaid program.

FY2008 Resources Allocated to Achieve Results

FY2008 Component Budget: $779,138,900

Personnel:	
Full time	0
Part time	0
Total	0

Key Component Challenges

- The State Children's Health Insurance Program (SCHIP) is facing a funding crisis. SCHIP is a part of Alaska's Medicaid program operated through Denali Kid Care. As with Medicaid, the federal and state governments jointly

fund SCHIP but the FMAP is higher. The total amount of federal funds available for SCHIP at the enhanced FMAP rate is capped. Once the allotment is exhausted, claims are reimbursed at the regular FMAP instead of the enhanced FMAP. Alaska will have only 41% of the federal SCHIP funding needed to cover program expenditures in 2008. Health Care Services' share of SCHIP costs will increase by $2,612.1 GF.

- In order to provide affordable access to quality health care services to eligible Alaskans, a sufficient supply of providers must be enrolled in Medicaid. A strategy to maintain provider participation is for provider reimbursement rates to keep pace with health care costs. Since provider participation in Medicaid is voluntary, if Medicaid's rates are too low providers may stop seeing Medicaid clients. In FY08 there are several budget proposals to increase rates.

    - Health care facility rates will be recalculated beginning in FY08. By regulation, payment rates for most health care facilities must be recalculated at least every four years [7 AAC 43.685(a)(6)(B)]. Facilities were last re-based in FY04. For Health Care Services' Medicaid, this means that non-tribal inpatient hospital payment rates for FY08 will be adjusted. The new rate for each facility will become effective at the start of that facility's 2008 fiscal cycle. The Department estimates that the average adjustment will be 8%. Less than a third (29%) of payments for non-tribal hospital services will be impacted by re-based rates in FY08. The additional cost to Medicaid from re-basing in FY08 will be $6004.2 (2,779.4 GF/3,224.8 Fed).

    - The State bases its reimbursement rates for non-tribal Medicaid primary care physician services (fee for service only) on the Medicare rate schedule, and needs to change them as Medicare rates change. The Centers for Medicare and Medicaid Services (CMS) determine Medicare rates through a resource-based relative value scale formula to determine reimbursement rates for each covered procedure billed by primary care physicians. CMS is re-basing Medicare reimbursements effective January 1, 2007. The state's methodology formula has separate components adjusting for the cost of work, operating costs, and insurance/malpractice costs and state conversion factor established in Alaska regulation [7 ACC 43.108]. The Medicaid conversion factor has not been changed since its implementation in 1997 when the current rate-setting methodology was adopted. Fee for service claims comprised almost 95% of physician services payments in 2005 and about two thirds of that was for procedures billed by non-IHS physicians. The additional cost to Medicaid in FY08 for physician fees will be $8,000.0 (3,742.4 GF and 4,257.6 Fed).

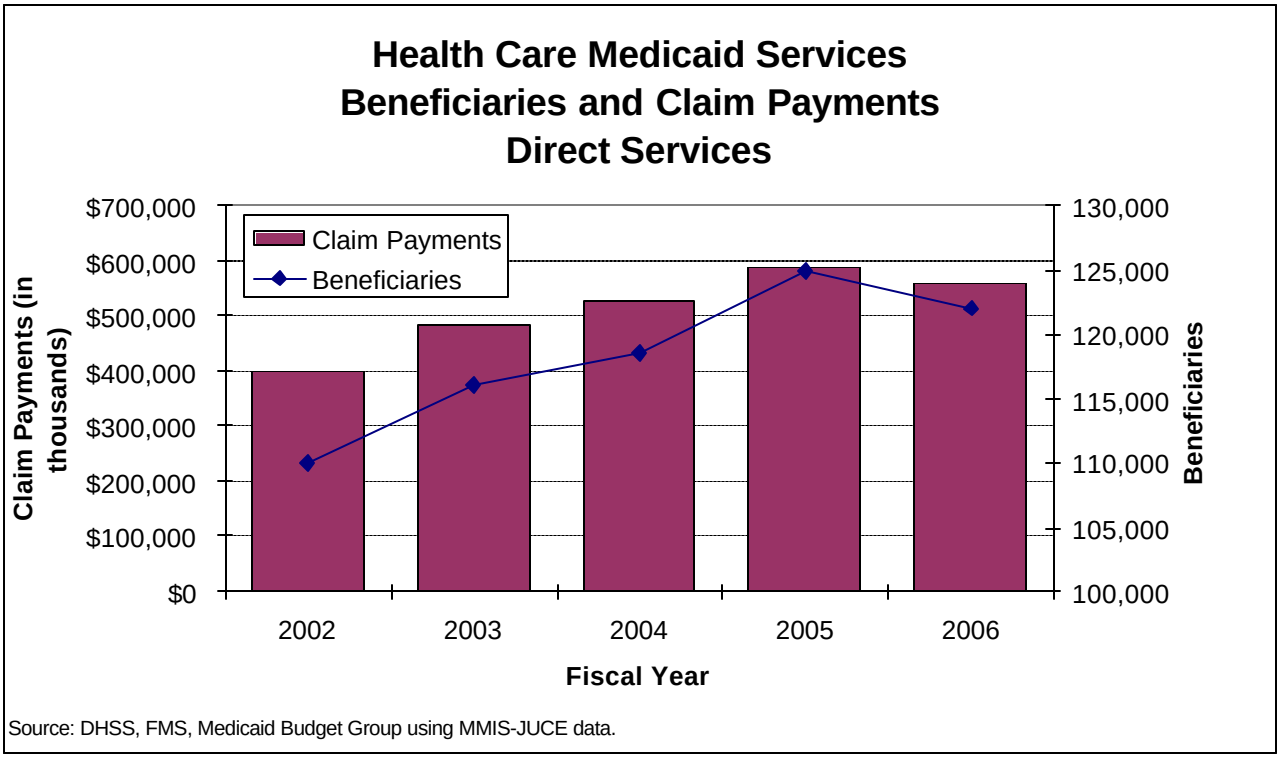
- General hospitals are required to see patients regardless of their income or insurance coverage. The Alaska Medicaid Upper Payment Limit program (ProShare) allows the state to make payments to qualifying hospitals to compensate these hospitals for the cost of providing care to persons who are publicly insured. ProShare funds have supported rural health care, mental health care, and children's health care programs that benefit many Alaskans. The funding need arose because an audit finding changed the way the department calculates the upper payment limit and shortened the amount of time to expend it which resulted in an allotment lower than our current ProShare payment level. Without the Medicaid ProShare program the same services would have to be funded through grant programs that are totally GF. The division is requesting an additional $4,044.0 in GF to replace the lost federal funds.

- The department wishes to fully utilize its annual Medicaid Disproportionate Share Hospital (DSH) federal allotment by providing the necessary GF match. Hospitals that provide a disproportionately high share of care to persons who are uninsured or underinsured may qualify for DSH payments to help offset their loss of revenue for uncompensated charity care. The state plans to negotiate agreements with qualifying hospitals to preserve or expand health care services that will benefit the state or local community. Alaska's allotment of federal DSH funds increases by 16% each federal fiscal year; however, the level of funding in the state's budget for DSH has not increased in many years. The department does not currently have sufficient funding to expend the full allotment. The department is requesting $22,701.6 (11,201.9 GF/11,499.7 fed) to fully fund the DSH program in FY08.

Significant Changes in Results to be Delivered in FY2008

- Expenditures in FY08 for Health Care Services' Medicaid Services are projected to grow $25,641.1 (7,696.2 GF/17,194.9 Fed/750.0 SDPR), a 3% increase over the authorized amount of $725,226.2. This increment request is necessary to maintain the current level of health services in Medicaid. The Medicaid Services component funds acute health care services such as hospitals, physicians, pharmacy, and dental and other Medicaid services such

as premium assistance and supplemental hospital payments.



Source: DHSS, FMS, Medicaid Budget Group using MMIS-JUCE data.

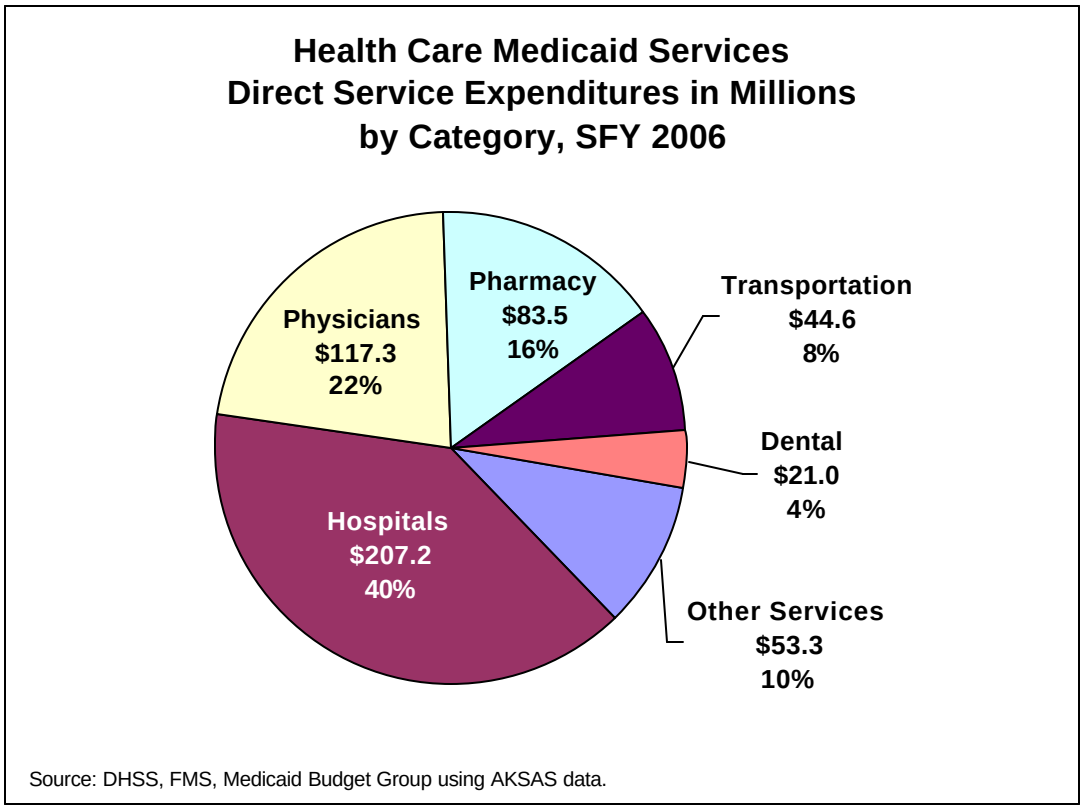
- HB 426 concerning Medicaid eligibility and insurance coverage passed last session, and contains provisions that help to ensure repayment to the Medicaid program for cases involving Medicaid recipients receiving settlements or judgments from third party payers and changed medical assistance eligibility for minors and persons eligible for Medicaid. The majority of cost reductions are anticipated from the provision that requires Medicaid enrollees who are also Medicare eligible to enroll in Medicare, thereby shifting health costs to the federally-funded Medicare program. These changes will reduce the number of persons eligible for Medicaid and assure that Medicaid is the payer of last resort. Medicaid costs in Health Care Services are estimated to decrease by $8,149.7 (-3,931.7 GF/--4,218.0 Fed) in FY08.

Major Component Accomplishments in 2006

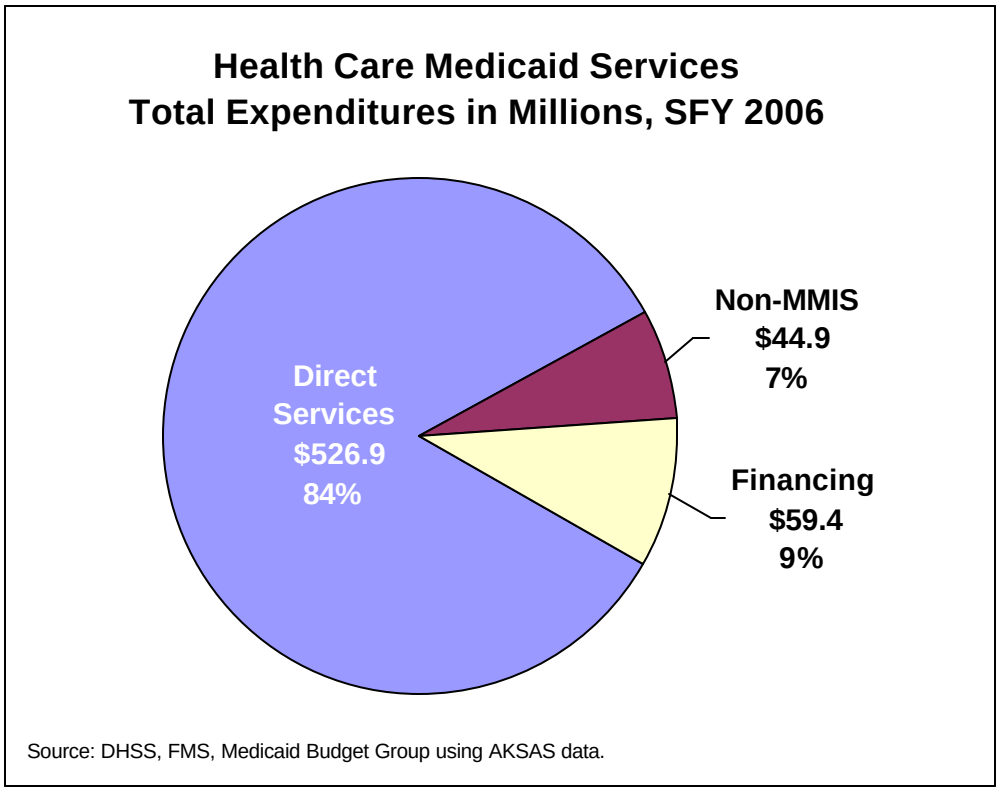
- In FY06 Health Care Services' Medicaid provided services to approximately 122,000 beneficiaries at an average cost of $379 per person per month.

- Medicaid Services' expenditures grew 3% from FY04 to FY06. While overall growth was about 3%, growth in direct services was around 5%. The projection for FY08 is for the growth rate to remain at 3%.

- Most of the increase in direct services can be attributed to hospital services which experienced a 6% increase from FY05 to FY06 due to an increase in the number of hospitalizations. The fastest growing segments are some of the smallest categories of service and therefore do not affect the total growth rate by much. Diagnostic services (laboratory and x-ray), durable medical equipment, and rehabilitation services (occupations/physical/speech therapy and chiropractic) all grew more than 10%. Another contributing factor is an increase in tribal claims for early, periodic, screening, diagnosis and treatment services, which are 100% federally funded.



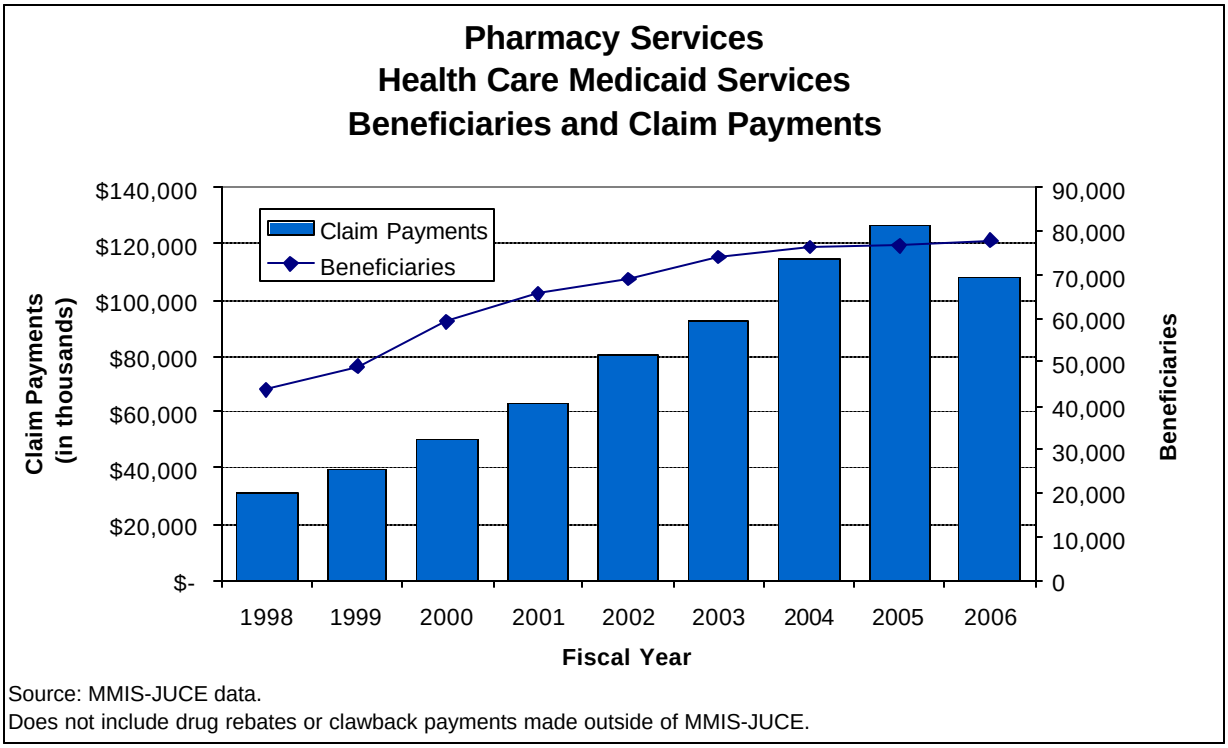
- The total cost for direct services provided was $526.9 million in FY06. Eighty-four percent of the Health Care Medicaid Services budget is spent on direct services to Medicaid clients. Following is the percentage breakout of the direct services portion of the Health Care Medicaid Services budget in FY06.



- The Medicare Prescription Drug Improvement and Modernization Act of 2003 created a new Medicare Part D prescription drug benefit available to all Medicare recipients, effective January 1, 2006. Medicare recipients who qualify for Medicaid (called “dual eligibles“) now receive prescription drug coverage through Medicare instead of Medicaid. This was the biggest change to Medicare in its 40 year history and had a profound impact on pharmacy and recipient services.

    - The division developed and distributed Part D educational materials, and networks of volunteers were trained to provide information and assistance to the more than 11,000 dual eligibles in Alaska. In addition to the dual eligibles, division staff also offered assistance to any Alaskan who qualified for Medicare Part D in selecting and enrolling in the drug plan most beneficial to them.

    - Due to the new Medicare Part D, the state’s direct spending in FY06 on prescription drugs after rebates decreased by approximately 16% from the FY05 level to $83.5 million. The new Medicare benefit began January 1, 2006 so the cost reduction reflects only six months of pharmacy claims. Current projected pharmacy benefits for FY07 are $70,000.0 and for FY08 $75,000.0.



Source: MMIS-JUCE data.
Does not include drug rebates or clawback payments made outside of MMIS-JUCE.

    - The federal law requires states to pay the federal government a portion of the estimated reduction in state’s pharmacy costs (also known as the "clawback"). In FY06, the department paid approximately $7.5 million GF in clawback payments for the first six months of the new program. Estimates are for $16.2 million in payments in FY07 and $19.2 million in FY08. The clawback rate is a function of the number of dual eligibles, the estimated pharmacy costs, national inflation, and the federal reimbursement rate for Medicaid. Each year for 10 years the proportion of the total estimated savings are “phased-down” from 90% in calendar year 2006 to 75% in 2015. The net effect of Medicare Part D on pharmacy claims and clawback payments is included in the calculation for the increment for program growth.

Statutory and Regulatory Authority

Alaska Statutes:
AS 47.07 Medical Assistance for Needy Persons

AS 47.08 Assistance for Catastrophic Illness and Chronic or Acute Medical Conditions
AS 47.25 Public Assistance

Social Security Act:
Title XVIII Medicare
Title XIX Medicaid
Title XXI Children's Health Insurance Program

Administrative Code:
7 AAC 43 Medicaid
7 AAC 48 Chronic and Acute Medical Assistance

Code of Federal Regulations:
Title 42 CFR Part 400 to End

Contact Information

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Medicaid Services
Component Financial Summary

All dollars shown in thousands

	FY2006 Actuals	FY2007 Management Plan	FY2008 Governor
Formula Program:			
Component Expenditures:			
71000 Personal Services	0.0	0.0	0.0
72000 Travel	0.0	0.0	0.0
73000 Services	13,228.5	10,000.0	10,000.0
74000 Commodities	0.0	0.0	0.0
75000 Capital Outlay	0.0	0.0	0.0
77000 Grants, Benefits	617,887.8	715,226.2	769,138.9
78000 Miscellaneous	0.0	0.0	0.0
Expenditure Totals	**631,116.3**	**725,226.2**	**779,138.9**
Funding Sources:			
1002 Federal Receipts	412,026.8	513,005.7	538,166.6
1003 General Fund Match	173,514.6	138,860.0	148,742.3
1004 General Fund Receipts	1,833.9	52,220.7	70,340.2
1007 Inter-Agency Receipts	22,817.5	20,233.5	20,233.5
1108 Statutory Designated Program Receipts	20,923.5	156.3	906.3
1156 Receipt Supported Services	0.0	750.0	750.0
Funding Totals	**631,116.3**	**725,226.2**	**779,138.9**

Estimated Revenue Collections

Description	Master Revenue Account	FY2006 Actuals	FY2007 Management Plan	FY2008 Governor
Unrestricted Revenues				
None.		0.0	0.0	0.0
Unrestricted Total		**0.0**	**0.0**	**0.0**
Restricted Revenues				
Federal Receipts	51010	412,026.8	513,005.7	538,166.6
Interagency Receipts	51015	22,817.5	20,233.5	20,233.5
Statutory Designated Program Receipts	51063	20,923.5	156.3	906.3
Receipt Supported Services	51073	0.0	750.0	750.0
Restricted Total		**455,767.8**	**534,145.5**	**560,056.4**
Total Estimated Revenues		**455,767.8**	**534,145.5**	**560,056.4**

Summary of Component Budget Changes
From FY2007 Management Plan to FY2008 Governor

All dollars shown in thousands

	General Funds	Federal Funds	Other Funds	Total Funds
FY2007 Management Plan	**191,080.7**	**513,005.7**	**21,139.8**	**725,226.2**
Adjustments which will continue current level of service:				
-Upper Payment Limit Decline - Proshare	4,044.0	-4,044.0	0.0	0.0
-FFY08 Medicaid SCHIP Allotment Shortfall	2,612.1	-2,612.1	0.0	0.0
-Year 2 Fiscal Note (HB426) Medical Assistance Eligibility & Insurance Coverage	-3,931.7	-4,218.0	0.0	-8,149.7
-Transfer funds to Support Rate Review Medicaid Activities	-142.5	-142.0	0.0	-284.5
Proposed budget increases:				
-Increase Disproportionate Share Hospital (DSH) - Hospitals Uncompensated Care	11,201.9	11,499.7	0.0	22,701.6
-Medicaid Rate Increase - Primary Care	3,742.4	4,257.6	0.0	8,000.0
-Medicaid Facility Rates Rebased - Hospitals	2,779.4	3,224.8	0.0	6,004.2
-FY08 Projected Medicaid Growth	7,696.2	17,194.9	750.0	25,641.1
FY2008 Governor	**219,082.5**	**538,166.6**	**21,889.8**	**779,138.9**