State of Alaska
FY2008 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

Manage health care coverage for Alaskans in need.

Core Services

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

The Division of Health Care Services (HCS) maintains the Medicaid core services by:

- Hospitals, physician services, pharmacy, dental services, transportation, physical, occupational, and speech therapy;
- Laboratory and x-ray;
- Durable medical equipment; and
- Hospice and home health care

Departmentwide, HCS administers 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 Administrative Claiming, Medicaid Error Rate program, and the Chronic and Acute Medical Assistance program.

HCS also administers the following programs:

- Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Program. The EPSDT program assures that children enrolled in Medicaid receive preventative health care and additional diagnosis or treatment services as needed. Good quality preventative health care reduces subsequent medical care costs for these children. All Medicaid Services/EPSDT program activities are directed toward addressing federal EPSDT regulations and related federal initiatives. The program sends notice to parents or guardians of children due for well-child exams and immunizations; assists families in finding physicians, nurse practitioners, dentists and vision care providers, in their home community who accept new Medicaid patients; coordinates and funds transportation reimbursement to preventative health care appointments for children and pregnant women. Reimbursement assistance is available for health care appointments if the family would not otherwise be able to afford to attend the appointment.

- 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.

- Tribal Health Agenda. 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, ensuring tribes that provide public health nursing services are included in the plan for Medicaid reimbursement, providing administrative, training and claims processing services for Tribal Medicaid Administrative Claims (Tribal MAC) agreements, providing support for data analysis, reporting, and training of tribes, and the development of "due" lists to support tribes who have continuing care provider agreements.

End Results	Strategies to Achieve Results
A: Mitigate Health Care Services (HCS) service	**A1: Increase Indian health services (IHS) participation**

reductions by replacing general funds with alternate funds. Target #1: Reduce by 1% the GF expenses replacing them with alternate funds. Measure #1: Percent of general funds replaced with alternate funding.	**by 5% in expenditures.** Target #1: Increase Indian health services (IHS) Medicaid participation by 5% in expenditures. Measure #1: Percentage of IHS direct service expenditures. **A2: Expand fund recovery efforts.** Target #1: Increase funds recovered by 2%. Measure #1: Change in amount of funds recovered.
End Results	**Strategies to Achieve Results**
B: To provide affordable access to quality health care services to eligible Alaskans. Target #1: Increase by 2% the number of providers enrolled in Medicaid. Measure #1: Change in number of providers enrolled in Medicaid.	**B1: Improve time for claim payment.** Target #1: Decrease by .5% the average time HCS takes to pay a claim. Measure #1: Change in the average time HCS takes to pay a claim. **B2: Improve payment efficiency.** Target #1: Increase percentage of claims paid by provider without error to promote timely and accurate payment. Measure #1: Change in percentage of adjudicated claims paid with no provider errors.

FY2008 Resources Allocated to Achieve Results

FY2008 Results Delivery Unit Budget: $810,002,600

Personnel:	
Full time	56
Part time	1
Total	57

Performance Measure Detail

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

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

HCS Medicaid Actuals - Other Funds (in millions)

Year	% Federal	% General	% Other
1999	66.0%	34.7%	.8%
2000	65.3%	25.5%	9.2%
2001	66.4%	22.7%	10.9%
2002	66.6%	27.8%	6.1%
2003	67.5%	25.5%	7.1%
2004	71.1%	16.6%	12.4%
2005	71.5%	17.5%	11.0%

Analysis of results and challenges: Seek ways to maximize federal participation through Family Planning, Indian Health Service, Breast and Cervical Cancer, and Title XXI expenditures.

Charted numbers represent actual expenditures recorded in ABS as percentages. Note FY04 is the first year reported after the reorganization. Prior year actuals will include the complete Medicaid Program and therefore do not provide exact comparisons between fiscal years.

A1: Strategy - Increase Indian health services (IHS) participation by 5% in expenditures.

Target #1: Increase Indian health services (IHS) Medicaid participation by 5% in expenditures.
Measure #1: Percentage of IHS direct service expenditures.

Health Care Services IHS Participation (in millions)

Year	Total Exp	IHS	% of Total	% Increase
1999	228.6	37.5	16%	
2000	268.4	49.4	18%	2%
2001	323.0	73.3	23%	5%
2002	385.9	89.3	23%	0%
2003	466.6	134.9	29%	6%
2004	503.6	154.5	31%	2%
2005	558.2	177.8	32%	1%
2006	316.5	98.4	31%	-45%
2007	119.5	33.6	28%	-1%

Source: Total Expenditures include all direct services claim payments in HCS Medicaid less drug rebates. IHS Direct services claim payments, including FairShare claims, are from MMIS-JUCE. The drug rebate offset is from AKSAS.

The FY2007 data is for the first quarter of FY2007 only.

DHSS, Finance and Management Services, Medicaid Budget Group using AKSAS and MMIS-JUCE data.

Analysis of results and challenges: Indian Health Service (IHS) expenditures decreased from first quarter FY06 to first quarter FY07 by $12 million. The decrease is largely due to the termination of the FairShare Program, a federally-approved program wherein the state increased payments to a tribally-operated hospital. When the program ended, provider rates, as well as expenditures, decreased.

As the program readjusts itself to not including FairShare, evaluation of quarters and state fiscal years will yield more accurate comparisons.

IHS facilities are reimbursed for Medicaid services at a 100% federal participation whereas non IHS facility patient costs require a state match on expenditures.

Background:

Increased IHS billing capacity by tribal entities assists with revenue generation. This directly contributes to tribal entities being able to maintain and hire staff to serve recipients closer to home on a more consistent basis. It also decreases the number of American Indian/Alaska Native (AI/AN) beneficiaries going to non-tribal facilities. Tribal entities with 638 status receive 100% FMAP for service delivery to AI/AN beneficiaries, thus assisting the State with maximizing federal reimbursement through Centers for Medicare and Medicaid Services IHS. In addition, the Department of Health and Social Services (DHSS) completes periodic data matches between IHS and Management Information System (MMIS) to ensure that AI/AN beneficiaries are appropriately coded in the Eligibility Information System (EIS). This allows DHSS to capture 100% FMAP vs. the standard match for non-native.

Once an AI/AN beneficiary is connected to a tribal healthcare delivery system which is able to bill Medicaid, beneficiaries can access additional service areas if needed. Depending on the door the beneficiary enters, whether it's behavioral health, clinic, or dental for example, they become a part of the larger tribal healthcare delivery system of that region. The more revenue they generate per service category, the more consistent the long term system becomes.

A2: Strategy - Expand fund recovery efforts.

Target #1: Increase funds recovered by 2%.
Measure #1: Change in amount of funds recovered.

Medicaid Recoveries: Drug Rebates & Third Party Liability Collections (in millions)

Year	Drug Rebates	TPL	Total	% Change
2003	17.0	8.0	25.0	N/A
2004	19.4	10.1	29.5	18%
2005	30.2	8.7	38.9	24%
2006	27.5	9.4	36.9	-5%

Analysis of results and challenges: Health Care Services has seen an overall decline in its collections for drug rebates and third-party liability by 5% from FY05 to FY06. This is mainly attributable to a decline of drug rebate receipts that resulted from the implementation of the Medicare Part D program. More prescription drugs are covered by this federal program. Therefore, there are less state expenditures that qualify for drug rebate recoveries.

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

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

Number of Providers in Selected Provider Types Enrolled in Medicaid

	FY2003	FY2004	FY2005	FY2006	FY2007 (YTD)
Physicians	6,440	7,076	6,486	6,406	6,002
Dentists	587	597	578	553	540
Pharmacies	359	356	287	224	205
Hospitals	734	841	739	751	634
Nursing Facilities	36	33	29	32	35
Sum	8,156	8,903	8,119	7,966	7,416

Source: DHSS, Finance & Mgmt Svcs,
Medicaid Budget Group, MARS MR-0-06-T. The FY07 YTD information is for 1st quarter FY07.

Analysis of results and challenges: Provider enrollment is difficult to compare from any one period to another for a variety of reasons:

1. Provider enrollment and participation in the Alaska Medical Assistance programs is voluntary; providers may choose to end their enrollment at any time and do so for various reasons. A participating provider may enroll without rendering services, and a provider may be enrolled and stop billing for services without dis-enrolling.
2. The time limit for submission of claims is one year from the date services were rendered and some providers wait many months to bill, which may be a factor in participation and enrollment from year to year;
3. Out-of-state providers may be prompted to enroll when they see an Alaska Medicaid client or when they attempt to bill for the services rendered to our clients. These providers typically cease to participate and/or maintain their enrollment status once the few claims have been paid for these out-of-state health care encounters;
4. There are, at present, no strategies to increase provider enrollment or participation.

Timely payment is part of the strategy for retaining providers who participate in Medicaid. Provider retention is necessary if the department is to meet its goal of affordable access to health care. While it probably does not contribute to increased provider participation, failure to pay timely could negatively impact access to care if

dissatisfied providers stop seeing Medicaid patients.

B1: Strategy - Improve time for claim payment.

Target #1: Decrease by .5% the average time HCS takes to pay a claim.
Measure #1: Change in the average time HCS takes to pay a claim.

Analysis of results and challenges: This measure is reported at the department level.

B2: Strategy - Improve payment efficiency.

Target #1: Increase percentage of claims paid by provider without error to promote timely and accurate payment.
Measure #1: Change in percentage of adjudicated claims paid with no provider errors.

Error Distribution Analysis – Percentage of Adjudicated Claims Paid with no Provider Errors [1,2,3]

	FY02	FY03	FY04	FY05	FY06	FY07 (YTD)
Total Claims Paid (fiscal year) [2]	4,202,677	4,776,730	5,106,692	6,150,027	6,082,318	1,363,276
Percent Paid with No Errors (total claims)	74%	73%	76%	72%	74%	72%
Hospitals	60%	65%	64%	65%	68%	74%
Physicians	67%	65%	64$	63%	66%	64%
Dentists	73%	74%	74%	73%	80%	75%
Nursing Home Facilities	65%	62%	62%	49%	54%	68%
Pharmacy	83%	80%	77%	77%	72%	64%
Mental Health	73%	76%	77%	74%	76%	78%
Transportation/Lodging	88%	86%	86%	75%	84%	86%
Home and Community Based Care	77%	78%	81%	87%	89%	88%
Vision	80%	77%	69%	76%	76%	81%
Psychiatric Hospital (Inpatient)	71%	42%	47%	55%	60%	65%
Clinics	71%	58%	49%	65%	67%	69%
Behavioral Rehabilitation Services	91%	86%	84%	87%	88%	92%
Chiropractic	60%	49%	51%	53%	54%	54%

Notes
[1] Between SFY02 and SFY03 reports were based on six months of data. Since SFY04 reports have been based on annual data.
[2] Total claims include all provider types.
[3] Source: MARS MR-O-11-T. FY07 YTD numbers are based on the 1st quarter of FY2007.

Analysis of results and challenges: Error distribution analysis is designed to capture the percentage of adjudicated claims paid with no provider errors. To ensure correct claim submission from providers, Health Care Services works with providers to resolve problem areas and to get claims paid. First Health, Medicaid's fiscal agent, provides training to providers on billing procedures, publishes billing manuals, and has a website for providers with information tailored to each provider type.

The sharpest decrease in percentage of adjudicated claims paid with no provider errors was between the first quarter of FY06 and FY07 is in Pharmacy. During FY06, the Department of Health and Social Services (HSS) had two major initiatives that impacted pharmacy: Pharmacy Cost Avoidance and Medicare Part D.

Prior to Pharmacy Cost Avoidance, HSS, as the State Medicaid Agency, paid the pharmacy claims for recipients who had insurance primary to Medicaid and then attempted to recover the costs from liable third parties. The Pharmacy Cost Avoidance initiative changed this practice and therefore the number of claims denied because of other insurance coverage is significant.

Additionally, Medicare Part D required HSS to deny pharmacy claims for Medicare-covered drugs for those recipients of both Medicaid and Medicare. Previously, Medicaid paid for this same population. This results in a significant denial of claims.

These major changes to the Pharmacy program were surely noteworthy enough to result in the decrease of claims paid, and as such, claims paid without error.

Key RDU Challenges

The goals of the organization are to bring financial stability to operations, maximize federal funds, provide more accountability in program management, and improve quality and customer service. Continued program alignment will balance cost effectiveness and service delivery and improve services to clients. This realignment of duties and responsibilities remains a challenge in FY06 and FY07.

Transportation. The State Travel Office began booking Medicaid Recipient travel for all non-emergent, medically necessary travel on 1/1/05. The State Travel Office receives an average of 1,921 calls and processes travel for an average of 1,479 travelers each week.

Medicaid Management Information System Development 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 must satisfy the needs of the state, medical service providers and the clients they serve.

Early and Periodic Screening, Diagnosis & Treatment (EPSDT) Program. Reducing future medical costs by increasing the quality of preventative medical services for children without increasing current care reimbursement levels; providing new, cost effective vaccines to teenagers who are a "devil-may-care group" known for avoiding doctors; and, providing parents with targeted, age appropriate well-child exam and immunization information they need to protect the health of their children.

Recipient Services. Challenges to the recipient services program include educating and preparing "dual eligibles" (individuals eligible for both Medicaid and Medicare) for the new Medicare Part D drug benefit plan. Educational materials have been developed and distributed, and networks of volunteers are trained to provide information and assist dual eligibles to enroll in a drug plan beneficial to them.

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 up to 27% over the past several years. To help control these costs, HCS has implemented 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 allows 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. Alaska Medicaid participates in the National Medicaid Pooling Initiative to obtain the best rebates available for the drugs that are included on the PDL.

The success of a PDL takes cooperation from providers and prescribers. The Pharmaceutical and Therapeutics (P&T) Committee is responsible for determining if the drugs within a therapeutic class exhibit a class effect and are therapeutically equivalent. The P&T Committee is comprised of a group of Alaskan medical professionals who prescribe or dispense prescription drugs. The committee has statewide representation and includes various physician specialties, pharmacists, dentists, and a nurse practitioner. The sub-committee of psychiatrists was used when the department reviewed mental health drugs.

Implementation was based on a phase-in approach whereby drug classes are added to the PDL over a period of time. Public input has primarily been related to the program's continued, uninterrupted access to specific brand drugs which have clearly proven beneficial to the patient. The program design meets this need.

Surveillance, Utilization & Review. HCS is 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 aggressive cost containment strategy.

Expanding healthcare service programs and federal mandates have required HCS to focus on preparedness and training to meet the needs associated with these changes. HCS has been instrumental in working on the Payment Error Rate Measurement grant project and is preparing for the new Medicaid Error Rate federal regulations.

In order to more effectively respond to increased Federal and State interest in pursuing fraudulent providers the Department has established within the Commissioner's Office a contact individual to address issues and requests from the Medicaid Fraud Control Unit and the Federal Office of the Inspector General.

Increased emphasis on curbing fraudulent and abusive behavior has also led the Department to establish a high level Audit Committee to assure consistent and effective Program Integrity efforts.

Administration of the Medicaid Program and Chronic and Acute Medical Assistance (CAMA). Programmatic and financial responsibility for Medicaid services and for CAMA are housed under the RDU whose customers are the major users of the services: Medicaid funding for mental health related services are housed in the Behavioral Health Medicaid Services component; Behavioral Rehabilitation Services are housed in the Children's Medicaid Services component; and funding for nursing homes, personal care, and waivered services are housed in 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. HCS maintains the operations aspects of the programs, i.e., claims payments; contract management; provider, facility and client services.

Significant Changes in Results to be Delivered in FY2008

New development work began in FY06 to implement third party insurance cost avoidance rules and prepare the pharmacy claims processing system for the Medicare Part D program. A new Medicare Part D prescription drug benefit available to all Medicare recipients became effective January 1, 2006. States' direct spending on drugs for dual eligibles will decrease, but savings are offset by the states' phased-down contribution known as the clawback. The clawback is a provision of the new law requiring states to pay the federal government according to a formula intended to estimate those savings. States will then be required to pay 90% of the estimated savings in the first year, phasing down in subsequent years.

Major RDU Accomplishments in 2006

The EPSDT Program experienced two major accomplishments this last year. First, we increased the ratio of actual preventative health exams to a desired number of exams for the fourth year in a row, by almost 3% for the year; and secondly we increased the percent of children receiving at least one needed preventative health exam from 56.8% to 58.0%.

The CAMA program provided payment for 1,046 individuals within the appropriated general fund amount in FY05 through regulations that reduced services provided and aggressive management of claiming adjustments for payments made by CAMA for individuals who become Medicaid eligible. This was necessary to stay within the reduced budget allowed for CAMA in FY04 and carried through FY05.

Contact Information

Contact: Janet Clarke, Assistant Commissioner
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

	FY2006 Actuals				FY2007 Management Plan				FY2008 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	175,348.5	412,026.8	43,741.0	631,116.3	191,080.7	513,005.7	21,139.8	725,226.2	219,082.5	538,166.6	21,889.8	779,138.9
Catastrophic & Chronic Illness	1,521.0	0.0	0.0	1,521.0	1,471.0	0.0	0.0	1,471.0	1,471.0	0.0	0.0	1,471.0
Non-Formula Expenditures												
Medical Assistance Admin.	7,932.9	17,729.3	72.3	25,734.5	8,314.0	20,361.5	194.3	28,869.8	8,536.4	20,662.0	194.3	29,392.7
Totals	**184,802.4**	**429,756.1**	**43,813.3**	**658,371.8**	**200,865.7**	**533,367.2**	**21,334.1**	**755,567.0**	**229,089.9**	**558,828.6**	**22,084.1**	**810,002.6**

Health Care Services
Summary of RDU Budget Changes by Component
From FY2007 Management Plan to FY2008 Governor

All dollars shown in thousands

	General Funds	Federal Funds	Other Funds	Total Funds
FY2007 Management Plan	**200,865.7**	**533,367.2**	**21,334.1**	**755,567.0**
Adjustments which will continue current level of service:				
-Medicaid Services	2,581.9	-11,016.1	0.0	-8,434.2
-Medical Assistance Admin.	-83.7	-89.6	0.0	-173.3
Proposed budget increases:				
-Medicaid Services	25,419.9	36,177.0	750.0	62,346.9
-Medical Assistance Admin.	306.1	390.1	0.0	696.2
FY2008 Governor	**229,089.9**	**558,828.6**	**22,084.1**	**810,002.6**