State of Alaska
FY2009 Governor's Operating Budget

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

Health Care Services Results Delivery Unit

Contribution to Department's Mission

To provide health coverage to 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) supports the following Medicaid core services for:

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

Department wide, 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 and Treatment (EPSDT) Program - The EPSDT program assures that children enrolled in Medicaid receive preventive health care and additional diagnosis or treatment services as needed. Good quality preventive 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 notices 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; and coordinates and funds transportation reimbursement to preventive 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. Projects with tasks falling to HCS include developing policy that will enable tribes to bill for services under management contracts; reviewing 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 developing "due" lists to support tribes who have continuing care provider agreements.

End Result	Strategies to Achieve End Result

A: Mitigate Health Care Services (HCS) service reductions by replacing general funds with alternate funds. Target #1: Reduce by 1% the GF expenses and replace them with alternate funds. Measure #1: Percent of general funds replaced with alternate funding.	**A1: 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. **A2: Expand fund recovery efforts.** Target #1: Increase funds recovered by 2%. Measure #1: Change in amount of funds recovered.
End Result	**Strategies to Achieve End Result**
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.

FY2009 Resources Allocated to Achieve Results

FY2009 Results Delivery Unit Budget: $746,136,500

Personnel:	
Full time	91
Part time	0
Total	91

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 and replace them with alternate funds.
Measure #1: Percent of general funds replaced with alternate funding.

Health Care Services Actuals - Other Funds (in millions)

Year	% Federal	% General	% Other
FY 1999	66.0%	34.7%	.8%
FY 2000	65.3%	25.5%	9.2%
FY 2001	66.4%	22.7%	10.9%
FY 2002	66.6%	27.8%	6.1%
FY 2003	67.5%	25.5%	7.1%
FY 2004	71.1%	16.6%	12.4%
FY 2005	71.5%	17.5%	11.0%
FY 2006	65.3%	28.1%	6.6%
FY 2007	64.8%	31.0%	4.2%

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 the Alaska Budget System (ABS) as percentages.

As a joint federal-state program, the federal and state governments share the cost of Medicaid. Federal financial participation rates are set at the federal level, and largely outside of state control. The state's portion of Medicaid Service costs differs according to the recipient's Medicaid eligibility group, category of Medicaid service, provider of Medicaid-related service, and Native/Non-native status. For most Medicaid eligibility groups and services, the portion of state Medicaid benefits paid by the federal government is called Federal Medical Assistance Percentage (FMAP).

Note: FY 2004 is the first year reported after the reorganization. FY 2004 and earlier actuals will include the complete Medicaid program (not just Health Care Services) 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%	98%
2000	$268.4	$49.4	18%	32%
2001	$323.0	$73.3	23%	48%
2002	$385.9	$89.3	23%	22%
2003	$466.6	$134.9	29%	51%
2004	$503.6	$154.5	31%	15%
2005	$627.4	$187.2	30%	21%
2006	$628.4	$155.3	25%	-17%
2007	$594.3	$153.0	26%	-1%

Source: Total Expenditures include all direct services claim payments in HCS Medicaid less drug rebates. IHS direct services claim payments, including FairShare claims, for 1999 - 2004 are from MMIS-JUCE. 2005-2007 are from AKSAS. The drug rebate offset is from AKSAS.

The % Increase is the percent change in IHS expenditures from the prior year.

Analysis of results and challenges: Indian Health Service (IHS) expenditures decreased from FY06 to FY07 by $2.3 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. Certain 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 that is able to bill Medicaid, beneficiaries can access additional service areas if needed. Depending on the door beneficiaries enter, for example, whether it's behavioral health, clinic, or dental, 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 (TPL) 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%
2007	19.2	3.5	22.7	-28%

Analysis of results and challenges: Health Care Services has seen an overall decline in its collections for drug rebates and third-party liability by 28% from FY06 to FY07. 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	YTD FY2006	YTD FY2007
Physicians	6,440	7,076	6,486	6,406	5,553
Dentists	587	597	578	553	482
Pharmacies	359	356	287	224	198
Hospitals	734	841	739	751	602
Nursing Facilit	36	33	29	32	35
Sum	8,156	8,903	8,119	7,966	6,870

Source: DHSS, Finance & Mgmt Services

Medicaid Budget Group, MARS-MR-0-06-T

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

	FY02	FY03	FY04	FY05	FY06	FY07
Total Claims Paid (fiscal yea	4,202,677	4,776,730	5,106,692	6,150,027	6,082,318	5,606,347
Percent Paid with No Errors	74%	73%	76%	72%	74%	72%
Hospitals	60%	65%	64%	65%	64%	73%
Physicians	67%	65%	64%	63%	65%	63%
Dentists	73%	74%	74%	73%	74%	74%
Nursing Home Facilities	65%	62%	62%	49%	60%	65%
Pharmacy	83%	80%	77%	77%	79%	64%
Mental Health	73%	76%	77%	74%	75%	79%
Transportation	88%	86%	86%	75%	84%	85%
HCBC	77%	78%	81%	87%	81%	87%
Vision	80%	77%	69%	76%	75%	69%
Psych	71%	42%	47%	55%	54%	60%
Clinics	71%	58%	49%	65%	61%	62%
BRS	91%	86%	84%	87%	87%	92%
Chiropratic	60%	49%	51%	53%	53%	50%

Note: Prior year reports were based on six months of data. This report is based on annual data.
FY04 data is actual through May.

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 in Pharmacy. During FY06, the Department of Health and Social Services (DHSS) had two major initiatives that impacted pharmacy: Pharmacy Cost Avoidance and Medicare Part D.

Prior to Pharmacy Cost Avoidance, DHSS, 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. Therefore, the number of claims denied because of other insurance coverage is significant.

Additionally, Medicare Part D required DHSS 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.

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, and the technology has fallen far behind industry standards.

The Department awarded a contract to Affiliated Computer Systems (ACS) in September of 2007 for a new MMIS. It is anticipated that the implementation of a new system will be completed by May of 2010. 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 and Treatment (EPSDT) Program: Challenges include: reducing future medical costs by increasing the quality of preventive 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 assisting "dual eligible" recipients (individuals eligible for both Medicaid and Medicare) for the 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 composed 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 and 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 is working to prepare providers for the new federal Medicaid Payment Error Rate Measurement audits.

In order to more effectively respond to increased Federal and State interest in pursuing fraudulent providers, the department has established a department-level 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 an 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 is 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. 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 FY2009

The total expenditure in FY09 for Health Care Services Medicaid is projected to grow $41,381.6 (9%) above the FY08 authorized amount of $689,694.3. Growth is due mostly to changes in enrollment, utilization, and reimbursement rates for claims.

The annual rate the federal government reimburses the state for Medicaid benefits (FMAP) will decrease 1.95%. The department will need to replace lost federal revenues resulting from a 1.95% decrease that will take effect on October 1, 2008. Based on current estimated expenditures for Medicaid, the FFY09 change in FMAP will require an estimated $14,308.5 increase in GF to replace the lost federal funds and maintain services at the current level.

After several years of optimizing federal Medicaid funds and expanding services with an additional $36 million of federal funds through the Private Hospital Proportionate Share Program, the Centers for Medicare and Medicaid Services (CMS) notified the State on July 31, 2007, that the program must be discontinued. That decision means the loss of approximately $16 million in federal funds that DHSS had anticipated receiving for FY08. Through the Private Hospital Proportionate Share Program, or ProShare, the department made payments to hospitals and community health care providers for four years as an important part of the department’s strategy to provide access to quality health care services, and to maximize state resources by accessing federal Medicaid payments rather than using general fund grants. However, now a funding gap exists in grant programs; discontinuation of ProShare will affect the divisions of Juvenile Justice, Public Health, Behavioral Health, Senior and Disabilities Services and the Office of Children’s Services. The department is committed to continue funding services provided by these divisions at the same level in support of its mission to manage health care for Alaskans in need.

Major RDU Accomplishments in 2007

Health Care Services continued its efforts to implement, for the department, the federally-mandated National Provider Identifier (NPI). The NPI Project Team completed a provider ID crosswalk, collected NPIs and associated taxonomy codes for 90% of enrolled providers, developed a CMS-mandated contingency plan, transitioned all enrolled providers into a dual-use phase, and began sunsetting provider use of legacy identifiers. Significant progress was made on several initiatives including the National Provider Identifier project. This national provider identifier number must be used in the transmission of electronic transactions, including claims, to identify the provider of services. Health care payers, including the Alaska Medicaid program, are challenged to develop crosswalks and processes to match these identifiers to internal records of providers authorized to render services to ensure payment to the correct and authorized providers. The NPI Project Team completed a provider ID crosswalk, collected NPIs and associated taxonomy codes for 50% of

enrolled providers, and transitioned enrolled providers into a phase where use of both Medicaid ID and NPI numbers are required on billing transactions. This project is ongoing in FY 2008.

In addition HCS completed system implementation efforts relating to (1) the Enhanced Adult Dental Program initiative, (2) changes needed for expansion of claims processing for Targeted Case Management services to include services from the Division of Juvenile Justice, (3) federally-mandated changes to the patient eligibility process for coordination of Medicare to Medicaid claims, (4) changes needed for expansion of service coverage to include Tobacco Cessation products, and (5) processing of new paper claim forms mandated by the National Uniform Billing Committee, the National Uniform Claim Committee and the American Dental Association.

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 levels of services provided wherever possible. These efforts include:

- Expanded efforts to identify drug abuse through client lock-in to single physician.
- Continued expansion of the Preferred Drug List in conjunction with the National Medicaid Pooling Initiative.
- Continued work on prior authorization requirements for hospital visits.
- Implemented new edits for home and community based care services to more effectively enforce the regulation of these services.
- Implemented a new personal care service edit and personal care services tracking to more effectively enforce the regulation of these services.
- Increased efforts to eliminate duplicative services through MMIS claims editing.
- Identified and implemented administrative claiming activities with Indian Health Services facilities.
- Continue to use Behavioral Pharmacy Management System in conjunction with the Division of Behavioral Health to improve the quality of care and prescribing habits of those providers prescribing behavioral health medications.
- Continued expansion of Pharmacy clinical edits to improve quality of care and avoid costs.

Contact Information

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Health Care Services
RDU Financial Summary by Component

All dollars shown in thousands

	FY2007 Actuals				FY2008 Management Plan				FY2009 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	190,099.6	397,117.4	25,345.8	612,562.8	222,055.0	445,749.5	21,889.8	689,694.3	248,544.0	441,463.8	21,889.8	711,897.6
Catastrophic & Chronic Illness	1,327.4	0.0	0.0	1,327.4	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.	8,797.9	17,555.6	197.4	26,550.9	8,224.0	20,659.5	3.4	28,886.9	8,708.0	21,148.6	1,428.4	31,285.0
Rate Review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	704.7	778.2	0.0	1,482.9
Totals	**200,224.9**	**414,673.0**	**25,543.2**	**640,441.1**	**231,750.0**	**466,409.0**	**21,893.2**	**720,052.2**	**259,427.7**	**463,390.6**	**23,318.2**	**746,136.5**

Health Care Services
Summary of RDU Budget Changes by Component
From FY2008 Management Plan to FY2009 Governor

All dollars shown in thousands

	General Funds	Federal Funds	Other Funds	Total Funds
FY2008 Management Plan	**231,750.0**	**466,409.0**	**21,893.2**	**720,052.2**
Adjustments which will continue current level of service:				
-Medicaid Services	11,264.5	-15,308.5	0.0	-4,044.0
-Medical Assistance Admin.	484.0	489.1	9.8	982.9
-Rate Review	34.4	34.4	0.0	68.8
Proposed budget decreases:				
-Medicaid Services	-793.9	-16,840.4	0.0	-17,634.3
Proposed budget increases:				
-Medicaid Services	16,018.4	27,863.2	0.0	43,881.6
-Medical Assistance Admin.	0.0	0.0	1,415.2	1,415.2
FY2009 Governor	**259,427.7**	**463,390.6**	**23,318.2**	**746,136.5**