State of Alaska
FY2010 Governor's Operating Budget

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

Health Care Services Results Delivery Unit

Contribution to Department's Mission

To manage health care coverage for Alaskans in need.

Core Services

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

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. Status #1: Due to decreases in IHS billings and FFP rate no success towards target was realized.	**A1: Increase Indian health services (IHS) participation by 5% in expenditures.** Target #1: Increase Indian health services (IHS) Medicaid participation by 5% in expenditures. Status #1: IHS Medicaid participation continues to decline as IHS providers realign their array of services to respond to continuing decline in IHS support. **A2: Expand fund recovery efforts.** Target #1: Increase funds recovered by 2%. Status #1: The division was only able to meet a target of 1% due to a decrease in collections of subrogation, Medicare, and TPL Contractor. The Program Integrity Unit is no longer associated with HCS and its recoveries are not available.

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. Status #1: While there has been success in expanding provider mix and numbers, the greatest gains have been in the array of services available to be delivered by anciliary providers and physician extenders.	**B1: Improve time for claim payment.** Target #1: Decrease average response time from receiving a claim to paying a claim. Status #1: The division has decreased the average time to pay a claim from 18 days to 11 days from FY2007 to FY2008. This represents a 39% reduction. **B2: Improve payment efficiency.** Target #1: Increase the percentage of adjudicated claims paid with no provider errors. Status #1: The percentage of claims without error and paid within ten days decreased to 70% in FY2008 compared to 72% in FY2007.

FY2010 Resources Allocated to Achieve Results

FY2010 Results Delivery Unit Budget: $705,255,900

Personnel:	
Full time	127
Part time	0
Total	127

Performance

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.
Status #1: Due to decreases in IHS billings and FFP rate no success towards target was realized.

Health Care Services Actuals - Other Funds (in millions)

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

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.
Status #1: IHS Medicaid participation continues to decline as IHS providers realign their array of services to respond to continuing decline in IHS support.

Health Care Services IHS Participation (in millions)

Fiscal Year	Total Exp	IHS	% of Total	% Increase
FY 2008	$366.6	$94.6	26%	-29%
FY 2007	$490.2	$134.2	27%	-14%
FY 2006	$528.9	$155.6	29%	-12%
FY 2005	$558.2	$177.8	32%	15%
FY 2004	$503.6	$154.5	31%	15%
FY 2003	$466.6	$134.9	29%	51%
FY 2002	$385.9	$89.3	23%	22%
FY 2001	$323.0	$73.3	23%	48%
FY 2000	$268.4	$49.4	18%	32%
FY 1999	$228.6	$37.5	16%	98%

Methodology: 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 % increase is the percent change in IHS expenditures from the prior year.

DHSS, FMS, Medicaid Budget Group using AKSAS and MMIS-JUCE data.

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%.
Status #1: The division was only able to meet a target of 1% due to a decrease in collections of subrogation, Medicare, and TPL Contractor. The Program Integrity Unit is no longer associated with HCS and its recoveries are not available.

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

Year	Drug Rebates	TPL	Total	% Change
2008	21.9	8.5	30.4	1%
2007	15.5	14.5	30.0	19%
2006	27.5	9.4	36.9	5%
2005	30.2	8.7	38.9	32%
2004	19.4	10.1	29.5	18%
2003	17.0	8.0	25.0	N/A

Analysis of results and challenges: Overall TPL collections for Health Care Services has remained relatively unchanged for fiscal years FY07 and FY08. In FY08 there was only a 1% increase over FY07. Most of the leveling off can be attributable to a decline in receipts recoverd by the TPL contractor, subrogation, and Medicare.

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.
Status #1: While there has been success in expanding provider mix and numbers, the greatest gains have been in the array of services available to be delivered by anciliary providers and physician extenders.

Number of Providers Enrolled in Medicaid

Year	Applications Received	Applications Denied	Applications Approved	Providers Inactivated	Enrolled Providers
2007	2,485 +1.22%	275 -30.73%	2,020 -2.93%	1,536 -28.49%	11,915 -4.64%
2006	2,455	397	2,081	2,148	12,495

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 average response time from receiving a claim to paying a claim.
Status #1: The division has decreased the average time to pay a claim from 18 days to 11 days from FY2007 to FY2008. This represents a 39% reduction.

Operations Performance Summary-Annual Average Days/Entry Date to Claims Paid Date

Fiscal Year	Medicaid Claims	Avg Days	Days Changed
FY 2008	7,263,956	11	-7
FY 2007	7,293,304	18	6
FY 2006	7,721,709	12	-1
FY 2005	7,903,523	13	3
FY 2004	6,690,344	10	0
FY 2003	5,615,072	10	-2
FY 2002	4,959,864	12	0
FY 2001	4,409,121	12	2
FY 2000	3,720,254	10	0

Methodology: Note: Between FY02 and FY03 reports were based on six months data. Since FY04 reports are based on annual data. Source: MARS MR-0-08-T. No national average available.

Analysis of results and challenges: Average days to pay between FY 2007 and FY 2008 decreased from 18 days to 11 days.

Three new initiatives, two in the second half of FY 2006 and the other in first quarter 2007 may provide explanations for the increase of average days. The Personal Care Program instituted a prior authorization process during the third quarter 2006. As part of this new initiative, claims became subject to prior authorization editing. Additionally, regulatory changes for certain Durable Medical Equipment (DME) high-volume supplies occurred during the second half of FY 2006. This resulted in additional claims pending for evaluation and pricing. Lastly, during the first quarter 2007, several new home and community-based waiver program edits were initiated.

Adding to the hindrance, the Department of Health and Social Services' (HSS) contractor experienced a data entry backlog as they converted from outsourced data entry services to in-house data entry. The decease from FY2007 to third quarter FY2008 is a result of completion of training and increased staff proficiecy.
All of the above would have had impact on processing time.

B2: Strategy - Improve payment efficiency.

Target #1: Increase the percentage of adjudicated claims paid with no provider errors.
Status #1: The percentage of claims without error and paid within ten days decreased to 70% in FY2008 compared to 72% in FY2007.

Error Distribution Analysis-Change in the percentage of adjudicated claims paid with no provider errors

Year	Medicaid Claims Paid	% No Errors	% Change
2009	1,538,356	68%	-2%
2008	5,562,537	70%	-2%
2007	5,606,347	72%	-2%
2006	6,082,318	74%	2%
2005	6,150,027	72%	-4%
2004	5,106,692	76%	3%
2003	4,776,730	73%	-1%
2002	4,202,677	74%	1%
2001	3,670,331	73%	1%
2000	3,076,978	72%	0%

Methodology: Chart Notes
1. Between FY01 and FY03 reports were based on six months of data. Since FY04 reports have been based on annual data.
2. This measuer was updated annually through FY05; beginning with FY2006, it is being updated quarterly.
3. FY09 numbers are through first quarter of FY09.
4. Source: MARS MR-0-11-T.

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 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.

Medicaid Management Information System Development Project: The Department awarded a contract to Affiliated Computer Services (ACS) for a new Medicaid Management Information System (MMIS). The new MMIS, known as Alaska Medicaid Health Enterprise, is scheduled to be in operation as of June 2010. The system will be available to providers and recipients who participate in the medical assistance programs as well as the fiscal agent and state staff.

Alaska Medicaid Health Enterprise is a sophisticated, web-enabled solution for administering all Medicaid programs. It will have self-service features so users can access the system through a user-friendly web portal. This progressive MMIS system will incorporate innovative features and advancements that will satisfy the needs of the state, providers and recipients.

A priority goal for the division is to transition to the new Alaska Medicaid Health Enterprise with minimum disruption to state employees, providers, and recipients while overcoming the challenges of provider enrollment, and provider / recipient training.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program: The greatest challenge to the EPSDT program remains to provide cost-effective preventive care to eligible infants, children and teens to ensure that health problems are diagnosed and treated early, before the health issue becomes more complex and treatment becomes more costly. The Department strives to meet this challenge by informing parents of the EPSDT benefit through frequent mailings, providing age appropriate information on well-child exams and expanding the coverage of vaccines and immunizations for all ages including hard to reach teens.

Recipient Services: The focus of recipient services is threefold; 1) to assist recipients in accessing health care and maintaining eligibility, 2) to explain covered services and complicated coordination of benefits, and 3) to assist in resolving disputes between provider and recipients. Challenges to recipient services this year revolved around assisting recipients to access and manage their enhanced dental benefit.

Pharmacy Program: Currently the Alaska Medicaid Preferred Drug List (PDL) provides many dollars back to the pharmacy program to reduce the net cost of medications. Over the coming years there are uncertainties in the pharmaceutical marketplace. These uncertainties such as Medicare Part D negotiation for prescription drugs may decrease the rebates Alaska receives and raise the net cost and challenge the Department to find new cost advantages. Other challenges include gaining provider and CMS approval for the coming reimbursement challenges when dispensing fees and drug cost calculations change. Another challenge is a possible decrease in coordination of benefits as more people become unemployed with this economic downturn.

Significant Changes in Results to be Delivered in FY2010

In FY2010 the department plans to implement Phase II reimbursement rate increases for non-Tribal Medicaid dental providers. Medicaid pays dental claims for about 42,000 persons a year, mostly children.

In FY2010 the department plans to conduct a complete enrollment of providers. This has not been accomplished in the 20 years of the current Medicaid system.

Major RDU Accomplishments in 2008

During FY2008 Health Care Services (HCS) made significant progress in implementing the federally-mandated National Provider Identifier (NPI). This national provider identifier number must be used in the transmission of electronic transactions, including claims, to identify the billing, rendering and referring service providers who meet the federal definition for a provider of health care. Alaska Medicaid developed a crosswalk and processes to match these national identifiers to internal records of providers authorized to render services in the Alaska Medicaid Program. In addition, Alaska Medicaid conducted major outreach efforts to gather NPI-related information from the provider community and to train the provider community on the use of this information in their claims transactions. Alaska Medicaid successfully converted pharmacy, institutional, dental and certain professional provider electronic claims to this NPI standard. Alaska Medicaid continues a dual-identification process for certain professional electronic claims to permit ongoing payment for services while provider outreach and training efforts continue. This project is ongoing in FY2009.

Health Care Services initiated a project to upgrade the pre-payment auditing software tool Claim Check®. This software evaluates procedure codes used on claims to ensure correct payment of services. Claim Check® uses Current Procedural Terminology guidelines of the American Medical Association and health-care industry standards to evaluate for appropriate relationships of procedure codes submitted on claims. This upgrade will not only ensure continued support and application of the software tool, but will also provide for new edits and guidelines. This project is ongoing in FY2009.

Health Care Services transitioned from the planning phase to development and implementation of changes needed to comply with the federal Deficit Reduction Act (DRA) requirements for use of national drug codes (ndc's), instead of J-codes, on professional and outpatient facility claims. These billing changes are required to satisfy DRA rules for Drug Rebate claiming. Solutions were implemented in April, 2008 for processing claims based on the new federal requirements. Completion of remaining DRA J Code Drug Rebate project components is slated for FY2009.

Health Care Services initiated a project to comply with the federal Deficit Reduction Act requirements relating to partial-month beneficiary eligibility. This project is ongoing in FY2009.

Health Care Services implemented reporting processes to satisfy requirements relating to the federally-mandated Payment Error Rate Measurement (PERM) project. This project focuses on both claims payment and beneficiary eligibility determination. Reporting processes were developed to support both areas of PERM. HCS participated in department-wide coordination efforts. Completion of activities related to the current PERM review cycle continues in FY2009.

In addition, HCS completed system implementation efforts relating to

1. unique collocation codes in support of the Enhanced Adult Dental Program initiative,
2. rules and edits relating to the payment of home infusion therapy services to the medical supply provider community
3. a methodology to allow for payment of Birthing Center services
4. changes to the Captiva data entry software used for paper claims (this enabled the capture of data required under the NPI project and the Deficit Reduction Act and improved the information captured on paper Medicare-to-Medicaid crossover claims)
5. reporting processes to comply with Office of Foreign Asset Control requirements
6. pricing rules for payment of capped rental on durable medical equipment
7. a new edit designed to improve proper payment of disability examination services
8. provider file structural changes to support the NPI project and improve provider group cross references and, in addition,

9. coordinated the department's decision support system server conversion in cooperation with the department's IT services section and Decision Support System contractor.

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:

- Continued expansion of the Preferred Drug List in conjunction with the National Medicaid Pooling Initiative.
- Add Atypical Antipsychotics to the Preferred Drug List for enhanced supplemental rebates.
- Implemented new edits for home and community based care services to more effectively enforce the regulation of these services and a new personal care service edit and personal care services tracking.
- Increased efforts with Tribal Health organizations to verify recipient Medicaid enrollment and re-enrollment to decrease the number of “not eligible on date of service” edits.
- Continued expansion of Pharmacy clinical edits to improve quality of care and avoid costs.
- Continued work on Medicaid Reform (SB61) activities with Tribal Health organizations to sustain infrastructure for the expansion of service delivery to Alaska Native/American Indian (AI/AN) Medicaid eligible beneficiaries at Tribal facilities.

Contact Information

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Health Care Services
RDU Financial Summary by Component

All dollars shown in thousands

	FY2008 Actuals				FY2009 Management Plan				FY2010 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	219,902.9	365,459.9	6,024.7	591,387.5	231,744.1	423,593.2	21,889.8	677,227.1	229,212.5	422,052.1	11,071.7	662,336.3
Catastrophic & Chronic Illness	1,081.4	0.0	0.0	1,081.4	1,471.0	0.0	0.0	1,471.0	1,471.0	0.0	0.0	1,471.0
Non-Formula Expenditures												
Health Facilities Survey	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	206.7	1,260.1	80.0	1,546.8
Medical Assistance Admin.	8,823.7	17,525.3	1,867.3	28,216.3	8,710.6	21,809.4	1,499.3	32,019.3	9,903.4	22,973.5	1,499.3	34,376.2
Rate Review	0.0	0.0	0.0	0.0	758.5	832.0	0.0	1,590.5	805.4	933.7	0.0	1,739.1
Health Planning & Infrastructure	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	153.7	3,397.9	234.9	3,786.5
Totals	**229,808.0**	**382,985.2**	**7,892.0**	**620,685.2**	**242,684.2**	**446,234.6**	**23,389.1**	**712,307.9**	**241,752.7**	**450,617.3**	**12,885.9**	**705,255.9**

Health Care Services
Summary of RDU Budget Changes by Component
From FY2009 Management Plan to FY2010 Governor

All dollars shown in thousands

	General Funds	Federal Funds	Other Funds	Total Funds
FY2009 Management Plan	**242,684.2**	**446,234.6**	**23,389.1**	**712,307.9**
Adjustments which will continue current level of service:				
-Medicaid Services	-6,696.9	6,690.6	0.0	-6.3
-Health Facilities Survey	206.7	1,260.1	0.0	1,466.8
-Medical Assistance Admin.	392.8	364.1	0.0	756.9
-Rate Review	46.9	101.7	0.0	148.6
-Health Planning & Infrastructure	1.0	48.9	-76.6	-26.7
Proposed budget decreases:				
-Medicaid Services	-9,700.0	-30,700.0	-10,818.1	-51,218.1
-Health Planning & Infrastructure	-250.0	0.0	0.0	-250.0
Proposed budget increases:				
-Medicaid Services	13,865.3	22,468.3	0.0	36,333.6
-Health Facilities Survey	0.0	0.0	80.0	80.0
-Medical Assistance Admin.	800.0	800.0	0.0	1,600.0
-Health Planning & Infrastructure	0.0	0.0	106.0	106.0
FY2010 Governor	**241,752.7**	**450,617.3**	**12,885.9**	**705,255.9**